Public Board meeting

Thu 03 August 2023, 09:30 - 12:45

Pinewood House Education Centre

NHS Stockport NHS Foundation Trust

Agenda

09:30 - 09:30
0 min

1. Apologies for absence

09:30 - 09:30
0 min

2. Declaration of Interests

09:30 - 09:35
5 min

3. Patient Story

Information

09:35 - 09:35
0 min

4. Minutes of Previous Meeting - held on 1 June 2023

Decision *Tony Warne*

04 - Public Board Minutes - 1 June 2023.pdf (12 pages)

09:35 - 09:40
5 min

5. Action Log

Information *Tony Warne*

05 - Public Board Action Log - August 2023.pdf (1 pages)

09:40 - 09:50
10 min

6. Chair's Report

Discussion *Tony Warne*

06 - Chairs Report - August 2023.pdf (6 pages)

09:50 - 10:00
10 min

7. Chief Executive's Report

Discussion *Karen James*

07 - Chief Executive Officer Report - August 23.pdf (7 pages)

STRATEGY & PLANNING

10:00 - 10:15
15 min

8. Annual Corporate Objectives

Decision *Karen James*

8.1. Review of Outcome Measures 2022/23

08.1 - Corporate Objectives Key Outcome Measures 2022-23.pdf (15 pages)

8.2. Outcome Measures 2023/24

08.2 - Corporate Objectives Outcome Measures 2023-24.pdf (6 pages)

10:15 - 10:25
10 min

9. Stockport Locality Board Priorities

Discussion *Jonathan O'Brien*

09 - Stockport Locality Board Priorities.pdf (5 pages)

PERFORMANCE

10:25 - 10:45
20 min

10. Integrated Performance Report

Discussion *Karen James / Executive Directors*

- Quality
- Operational Performance
- Workforce
- Finance

10a - Integrated Performance Report - Front Sheet - August 2023.pdf (2 pages)
10b - Integrated Performance Report (June 23 data).pdf (22 pages)

QUALITY

10:45 - 10:55
10 min

11. Patient Safety Incident Response Framework Update

Discussion *Nicola Firth*

11. PSIRF Presentation.pdf (8 pages)
11.1 - Patient Safety Incident Response Plan - August 2023.pdf (19 pages)

10:55 - 11:10
15 min

12. Maternity Services Improvement Presentation

Discussion *Nicola Firth & Maternity Team*

12a - Maternity Service Highlight Report - August 2023.pdf (6 pages)
12b - Maternity Services Presentation.pdf (20 pages)

11:10 - 11:20
10 min

COMFORT BREAK

11:20 - 11:30
10 min

13. Annual Research, Innovation & Development Strategy Report 2022/23

Discussion *Andrew Loughney*

13 - Research Development & Innovation Annual Report 2022-23.pdf (28 pages)

11:30 - 11:55

14. Safeguarding

25 min

Nicola Firth

14 - Safeguarding Annual Report & Plan Summary Presentation.pdf (10 pages)

14.1. Annual Safeguarding Report 2022/23

Discussion

14.1a - Annual Safeguarding Report 2022-23 - Front Sheet.pdf (2 pages)
14.1b - Annual Safeguarding Report 2022-23.pdf (38 pages)

14.2. Safeguarding Plan 2023 - 2026

Discussion

14.2a - Trust Safeguarding Plan - Front Sheet.pdf (2 pages)
14.2b - Trust Safeguarding Plan 2023-26.pdf (15 pages)

PEOPLE

11:55 - 12:10
15 min

15. People & Organisational Development Plan Progress Report

Discussion *Amanda Bromley*

15 - People & Organisational Development Plan Progress Report - August 2023.pdf (8 pages)

12:10 - 12:15
5 min

16. Wellbeing Guardian Report (Verbal)

Discussion *Marisa Logan-Ward*

GOVERNANCE

12:15 - 12:25
10 min

17. Board Assurance Framework 2023/24

Decision *Karen James*

17a - Opening Board Assurance Framework 2023-24 - Front Sheet.pdf (5 pages)
17b - Appendix 1 - Board Assurance Framework 2023-24 - August 2023.pdf (18 pages)
17c - Appendix 2 - Significant Risk Register (July 2023).pdf (1 pages)

STANDING COMMITTEE REPORTS

12:25 - 12:45
20 min

18. Board Committees - Key Issues Reports

18 - Board Committee Key Issues Reports - Front Sheet.pdf (3 pages)

18.1. Finance & Performance Committee

Discussion *Anthony Bell*

18a - Finance & Performance Committee Key Issues Report - June 2023.pdf (4 pages)
18b - Finance & Performance Committee Key Issues Report - July 2023.pdf (4 pages)

18.2. People Performance Committee

Discussion *Beatrice Fraenkel*

18c - People Performance Committee Key Issues Report - July 23.pdf (8 pages)

18.3. Quality Committee - including LMNS Return

Decision *Mary Moore*

18d - Quality Committee Key Issues Report - June & July 2023.pdf (7 pages)
18e - Appendix 1 - LMNS Assurance Return - Front Sheet June 2023.pdf (6 pages)
18f - Appendix 2 - Annex A SFT Ockenden-Kirkup Return April 2023.pdf (12 pages)

18.4. Audit Committee - including Annual Review 2022/23

Decision *David Hopewell*

18g - Audit Committee Key Issues Report - July 2023.pdf (4 pages)
18h - Appendix 1 Audit Committee Annual Review 2022-23.pdf (17 pages)

CLOSING MATTERS

12:45 - 12:45
0 min

19. Any Other Business

DATE, TIME & VENUE OF NEXT MEETING

12:45 - 12:45
0 min

20. Thursday, 5 October 2023, 9.30am, Pinewood House Education Centre

12:45 - 12:45
0 min

21. Resolution:

"To move the resolution that the representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to commercial interests, sensitivity and confidentiality of patients and staff, publicity of which would be premature and/or prejudicial to the public interest".

CLOSE

STOCKPORT NHS FOUNDATION TRUST

Minutes of the meeting of the Board of Directors held in public on Thursday, 1 June 2023 9.30am in Lecture Theatres, Pinewood House, Stepping Hill Hospital

Present:

Prof T Warne	Chair
Dr S Anane	Non-Executive Director
Mr A Bell	Non-Executive Director
Mrs A Bromley	Director of People & OD
Mrs N Firth	Chief Nurse
Mr D Hopewell	Non-Executive Director
Mrs K James	Chief Executive
Dr M Logan-Ward	Non-Executive Director / Deputy Chair
Dr A Loughney	Medical Director
Mrs J McShane	Director of Operations
Mrs M Moore	Non-Executive Director
Dr L Sell	Non-Executive Director
Mr M Vadiya	Associate Non-Executive Director *

** indicates a non-voting member*

In attendance:

Mrs R McCarthy	Trust Secretary
Mrs K Wiss	Director of Finance
Mrs H Howard	Deputy Chief Nurse
Ms A Brierley	Director of Transformation
Ms H Silcock	Head of Transformation
Dr P Nuttall	Director of Information

Observing:

Mrs S Alting	Lead Governor
Mrs M Slater	Public Governor

Ref	Item	Action
67/23	**Apologies for Absence** Apologies for absence were received from Mrs Beatrice Fraenkel (Non-Executive Director), Mr John Graham (Chief Finance Officer), Mr Jonathan O'Brien (Director of Strategy & Partnerships), and Mrs Caroline Parnell (Director of Communications & Corporate Affairs). The Chair welcomed Board members, attendees and observers to the meeting.	
68/23	**Declaration of Interests** There were no conflicts of interests.	
69/23	**Patient Story** The Board of Directors listened to a story relating to experience of a patient with a developmental disability within the Radiology Department, and lessons learnt, and action taken to improve communication and support provide patient centred support. The Board of Directors welcomed the improvements made in the Radiology department and highlighted the importance of sharing the learning across the organisation.	

	The Board of Directors received and noted the Patient Story.	
70/23	**Minutes of Previous Meeting** The minutes of the previous meeting of the Board of Directors held on 6 April 2023 were agreed as a true and accurate record of proceedings.	
71/23	**Action Log** The action log was reviewed and annotated accordingly.	
72/23	**Chair's Report** The Chair presented a report reflecting on recent activities within the Trust and the wider health and care system. The Chair advised the Board of Directors that he had attended a Greater Manchester (GM) Integrated Care Board (ICB) leadership and governance workshop to discuss the report and outcome from recent consultation work. He noted that the that the report had specifically highlighted the need for an operational plan to enable the delivery of the GM Strategy. **The Board of Directors received and noted the Chair's Report.**	
73/23	**Chief Executive's Report** The Chief Executive presented a report providing an update on local and national strategic and operational developments. She briefed the Board on the content of the report and highlighted the following areas: • NHS England's Delivery and Continuous Improvement Review • Hewitt Review • Urgent and Emergency Care Performance • Trust Plan 2023-24 • Industrial Action • First Digital Pathology Go Live Site • £3m Endoscopy Redevelopment • New Cardiac Pacing Unit • Public Sector Catering Awards • Recruitment and Retention In response to a question from a Non-Executive Director regarding the impact of GM being placed in Tier 1 based on their urgent care performance, the Chief Executive and Chair confirmed that specific action and/or support had not yet been determined, albeit support may be different for each locality within Tier 1 based on specific circumstances. In response to a question from a Non-Executive Director regarding response to the Hewitt Review, the Chief Executive noted that the Department of Health & Social Care would be reviewing the recommendations in due course, albeit no specific response to the recommendations at this time. **The Board of Directors received and noted the Chief Executive's Report.**	
74/23	**Trust Planning 2023/24** The Director of Operations presented a report summarising the Trust's final operational plan submission for 2023/24. She briefed the Board of Directors on the content of the report and advised that a further update had been made to GM at the end of April 2023, which showed a movement in the financial position previously reported to the Board of Directors on 6 April 2023. The Board of Directors noted that the GM ICS had submitted an overall balanced revenue plan in May 2023, with achievement of the plan predicated on the delivery of £130m system savings. The Director of Operations	

	highlighted the associated risks and advised that a review of GM system governance was underway, including development of a system programme management office and financial recovery plan. In response to a question from the Associate Non-Executive Director seeking further view on the identification and delivery of further efficiencies in light of several years of cost and efficiency savings, the Director of Operations and Director of Finance briefed the Board of Directors on actions in this area, including the awaited outcome of the GM financial diagnostic review, and cross reference to the Trust's Stockport Trust Efficiency Programme (STEP), and the Working Intelligently Programme to identify potential opportunities for further efficiencies. **The Board of Directors noted and approved the final Trust Plan submission for 2023/24.**	
75/23	**Opening Budgets** The Director of Finance presented an Opening Budgets Report and advised that the report detailed an income and expenditure financial plan with a deficit of £31.5 for 2023/24, aligned with the activity and workforce plans. The Director of Finance highlighting the assumptions made in the plan, the key areas for investment to deliver the plan, and risks to delivery of the plan which had been recommended to the Board for approval by the Finance & Performance Committee. **The Board of Directors noted and approved the opening budgets for 2023/24.**	
76/23	**Corporate Objectives 2023/24** The Chief Executive presented a report detailing the proposed Corporate Objectives for 2023/24, as follows: 1. Deliver Personalised, Safe and Caring Services 2. Support the health and wellbeing needs of our community and colleagues 3. Develop effective partnerships to address health and wellbeing inequalities 4. Develop a diverse, talented and motivated workforce to meet future service and user needs 5. Drive service improvement through high quality research, innovation and transformation 6. Use our resources efficiently and effectively. 7. Develop our Estate and Digital Infrastructure to meet service and user needs. The Chief Executive advised that key outcome measures had been drafted from national and local requirements and would be finalised during June 2023. She confirmed that the outcome measures would be presented to the Board of Directors in August 2023. In response to a question from a Non-Executive Director regarding the organisational approach to achieving Objective 3 (Develop effective partnerships to address health and wellbeing inequalities), the Chief Executive provided further clarity on the approach being taken within the locality, with priorities of the Locality Board focussed on population health including broader determinants of health, and the Provider Partnership focussed on key workstreams around primary and secondary determinants of health. **The Board of Directors noted and approved the Corporate Objectives**	

	2023/24.	
77/23	**Integrated Performance Report** The Chief Executive introduced the Integrated Performance Report (IPR), which included exception reports for areas of most significant note. QUALITY The Chief Nurse and Medical Director presented the quality section of the IPR and highlighted challenges and mitigating actions regarding mortality and sepsis (particularly antibiotic stewardship), infection rates and complaints due to under-achievement in month. It was noted that the Quality Committee would be undertaking a deep dive regarding infection prevention and control at its meeting in June 2023. OPERATIONAL The Director of Operations presented the operational performance section of the IPR and highlighted challenges and mitigating actions regarding Emergency Department (ED) performance, patient flow, diagnostics, cancer, Referral to Treatment (RTT), activity vs. plan, outpatient efficiencies, and theatre utilisation due to under-achievement in month. The Board heard that current performance against the ED 4-hour standard remained a challenge to good patient flow, although the Trust continued to benchmark well across GM. The Director of Operations reported that bed occupancy continually exceeded 92%, which was beyond the recognised safe limits for effective flow. The Director of Operations advised that diagnostics performance was above target, yet showed a much improved position due to outsourcing to support Endoscopy. She noted that the cancer 28-day standard showed signs of improving performance, and reported positive performance in Did Not Attend (DNA) rates, which had reduced to 7.5%, the lowest for over 12 months. In response to a question from a Non-Executive Director regarding 12-hour waits and specifically those patients waiting for specialist mental health support, the Director of Operations and Chief Nurse briefed the Board on partnership work in this area, noting strengthened escalation processes in place, albeit highlighted challenges in social care and No Criteria to Reside (NCTR). The Director of Operations highlighted the importance of admitting patients into the appropriate areas to ensure they received the right level of care. In response to a question from a Non-Executive Director regarding challenges around out of area discharges, the Director of Operations briefed the Board on the latest position, including continued discussions with East Cheshire and North Derbyshire Integrated Care Boards. She noted an improved position with East Cheshire, however further assurances were required from North Derbyshire to ensure sustainability of plans to discharge patients in a timely manner and improve the patient experience. WORKFORCE The Director of People & Organisational Development (OD) presented the people section of the IPR and highlighted performance and mitigating actions around turnover, bank and agency costs, and learning and education due to under-achievement in month. She reported that the appraisal rate was 89.5% against the target of 95% and that mandatory training, whilst on an increasing compliance trajectory, remained below target. The Board heard that workforce turnover remained slightly above target, and that temporary staffing spend remained a concern.	

	In response to a question from the Chair querying if there were any plans to close the escalation wards noting impact on finance and operational performance, the Director of Operations highlighted that this would be a challenge until bed occupancy and NCTR reduced and highlighted the Programme of Flow work to support this. In response to a question from a Non-Executive Director querying if the deterioration of patients because of delayed discharges was being reviewed, the Director of Operations and Medical Director provided an overview of several harm review processes and measures in place, as reported through the Quality Committee, albeit also acknowledging the national evidence regarding deconditioning of patients whilst in hospital and poorer patient experience. <u>FINANCE</u> The Director of Finance presented the finance section of the IPR and advised that the Trust had submitted a plan with an expected deficit of £31.5m for the financial year 2023/24, excluding the GM system efficiency requirement. She reported that at month 1, the Trust position was a deficit of £3.3m, which was £0.8m adverse to plan. The Board heard that the adverse variance was driven by the costs of additional cover during the industrial action, inflation and continued high costs of temporary staffing to support additional demand. The Director of Finance highlighted risks relating to the pay award where not fully funded.. The Director of Finance reported that the Trust efficiency plan for 2023/24 was £26.2m (£10.3m recurrent), and that at month 1 the Trust was £1.1m behind plan. She confirmed that the Trust had maintained sufficient cash to operate during April 2023. It was noted that the Capital plan for 2023/24 was £62.7m but this was subject to confirmation as the GM position remained oversubscribed. The Board heard that £1.5m had been delivered in month 1. In response to questions from the Chair regarding the costs associated with the industrial action, the Director of Finance highlighted work taking place across GM to calculate the cost, which would be significant. The Director of Finance confirmed that forecasting continued, with a confirmed process in place if forecasting plan would not be met. **The Board of Directors received and noted the Integrated Performance Report.**	
78/23	**Safer Care Report** The Chief Nurse and Medical Director presented a report providing assurances and risks associated with safe nurse and midwifery, medical and other staffing groups and actions to mitigate the risks associated with patient safety and quality, based on patients' needs, acuity, dependency and risks. They highlighted the adverse impact of the continued operational challenges and provided an overview of the continued activity to maintain safe staffing levels and drive improvement. In response to a question from a Non-Executive Director regarding doctors in training and the potential impact of gaps in training, the Medical Director highlighted work with the General Medical Council (GMC) regarding plans for doctors in training, albeit acknowledged there remained challenges in filling gaps for future years. The Chair welcomed the improved appointment process for consultants, noting a high calibre of applicants. In response to a question from the Chair regarding the provision of workforce solutions from external organisations to support recruitment, the Director of People & OD confirmed the Trust was considering the level of skills and expertise to undertake specific work	

	internally, such as reaching target audiences through social media. **The Board of Directors received and noted the Safer Care Report.**	
79/22	**Quality Strategy Report** *The Deputy Chief Nurse joined the meeting.* The Deputy Chief Nurse presented the Year 2 update against the Trust Quality Strategy (2021-2024). Update was presented against key aims and measures for: - Start well – Improve the first 1,000 days of life - Live well – Reduce avoidable harm - Age well – Reduce avoidable harm - Die well with dignity – Improve the last 1,000 days of life A Non-Executive Director noted triangulation with the Stockport Accreditation and Recognition Scheme (StARS) reports and queried if there were plans to establish a trajectory for medicines management, particularly in community setting. The Chief Nurse and Deputy Chief Nurse provided contextual information regarding this matter and confirmed that action would be overseen via the Medicines Management & Optimisation Group and progress monitored through the StARS. The Medical Director welcomed the Stockport wide approach to improving end of life care, acknowledging the importance of utilising and sharing data appropriately. A Non-Executive Director welcomed the improvement in falls and sought confirmation that required resources were in place to sustain improvement amidst the current financial challenges. The Deputy Chief Nurse confirmed planned resources remained in place, including Healthcare Assistants that had completed specific training for bay nursing. Board members welcomed the progress report and in response to questions from Non-Executive Directors, received confirmation of the robust Quality Impact Assessment (QIA) process in place for efficiency savings considerations to ensure quality and safety was not adversely impacted. **The Board of Directors received and noted the Quality Strategy Report.** *The Deputy Chief Nurse left the meeting.*	
80/23	**Annual Health & Safety Report 2022/23** The Chief Nurse presented the Annual Health & Safety Report providing a summary of principal activity and outcomes relating to the key performance indicators (KPI) for health and safety within Stockport NHS Foundation Trust during 2022/2023. She confirmed the data was reported via the standing monthly and quarterly reports to Health and Safety Joint Consultative Group and key issues and assurance reported to the Quality Committee. The Chair welcomed the comprehensive report. **The Board of Directors received and noted the Annual Health & Safety Report 2022/23.**	
81/23	**Equality, Diversity and Inclusion (EDI) Strategy Report** The Director of People & OD presented a report providing progress against each of the EDI targets set out within the EDI Strategy relating to workforce, culture, assurance and compliance and health inequalities.	

	The Director of People & OD confirmed all statutory reporting had been completed for 2022/23, including submission and publication of the annual Workforce Race Equality Standard (WRES) Report and annual Workforce Disability Equality Standard (WDES) Report and the annual Gender Pay Gap Report. She highlighted the following headlines: • Increases in the proportion of BAME staff at all bands for both clinical and non-clinical staff. • Relative likelihood that white candidates will be appointed from a shortlist compared to BAME candidates remained high. • Increase in the proportion of BAME respondents in the staff survey reporting bullying or harassment from managers. • No change in the proportion of staff who are disabled, including Board of Directors. • Increase in the relative likelihood of disabled staff entering the formal capability process compared to non-disabled staff. • Reduction in the proportion of disabled staff reporting discrimination from managers or team leaders. • Trust mean gender pay gap remained higher than the target. In response to questions from a Non-Executive Director regarding work to address bullying and harassment concerns, the Director of People & OD advised that the work was taking place to develop the staff networks and ensure appropriate support was available through the networks around bullying and harassment. A Non-Executive Director expressed her view, that whilst staff networks had positive senior leader visibility and support, colleagues had expressed the challenge in attending the networks and further support was required to ensure colleagues had time and opportunity to attend the sessions. In response to a question from a Non-Executive Director about the Clinical Excellence Award process, noting the action to provide coaching to support this, the Medical Director briefed the Board on the process for awarding Clinical Excellence Awards, noting discussion taking place across GM to ensure an aligned process across the system and enable learning to be shared. In response to a question from the Associate Non-Executive Director regarding the lived experiences of staff and understanding of this, the Director of People & OD noted some increases in staff with protected characteristics experiencing bullying and harassment. She highlighted the importance of staff feeling safe to raise issues and provide this feedback via staff forums to enable the Trust to understand and address these issues. Non-Executive Directors fully acknowledged this and reaffirmed the importance of psychological safety. The Chair noted the expectation that an EDI objective is agreed for every Board member. **The Board of Directors received and noted the update on the Trust's Equality, Diversity & Inclusion Strategy 2022-25.**	
82/23	**Freedom to Speak Up** The Chief Executive presented a report providing an overview of the activity of the Freedom to Speak Up Guardian since the last report to the Board, including themes and trends from referrals. She confirmed that a new Freedom to Speak Up (FTSU) Guardian had been jointly appointed across this Trust and Tameside & Glossop Integrated Care NHS Foundation Trust, and FTSU champions had also been recruited to support the role.	

	In response to a question from a Non-Executive Director who queried if the previous FTSU Guardian had provided any further learning points, the Chair commented that he had spoken to the previous FTSU Guardian, with feedback reflected in the work of the FTSU self-assessment. **The Board of Directors received and noted the Freedom to Speak Up Report.**	
83/23	**Transformation Programme Report** *The Director of Transformation and Head of Transformation joined the meeting.* The Director of Transformation and Head of Transformation presented a report providing an update on service transformation programmes across this Trust, alongside transformation programmes at Tameside & Glossop Integrated Care NHS Foundation Trust to facilitate joint learning opportunities. The Head of Transformation highlighted a number of service transformation initiatives that had led to, or were leading to, improvements whilst continuing to build and nurture a culture of continuous improvement. It was noted several of these have also contributed to supporting wider organisational effectiveness that is often difficult to capture. The Board of Directors acknowledged the additional technical support for marketing and communications of transformation programmes as highlighted within the report, and supported utilisation of such resources more broadly and strategically across the Trust. In response to a question from a Non-Executive Director querying whether the waiting list triage programme underway at Tameside & Glossop may be transferred to Stockport NHS Foundation Trust, the Director of Transformation confirmed that the Chief Executive and Director of Operations were leading this area. Furthermore, a Non-Executive Director noted the delirium programme underway at Tameside & Glossop and encouraged the sharing of learning, noting this was a matter considered by Quality Committee. In addition, she suggested consideration of language used for initiatives within this programme. Discussion took place between Board members regarding benefits realisation, specifically the importance of clear articulation of the financial and non-financial benefits, including improved productivity, to demonstrate holistic impact of the transformation programmes. **The Board of Directors received and confirmed the Transformation Programme Report** *The Director of Transformation and Head of Transformation left the meeting*	
84/23	**Digital Strategy Report** *The Director of Information joined the meeting* The Director of Information presented a report providing an update on the delivery of the Trust's Digital Strategy. He briefed the Board on the content of the report and provided a progress update around the seven digital ambitions. The Board of Directors were informed that the delivery of the Digital Strategy was progressing well, supported by the significant external investment.	

	Specific reference was made to the Trust's major digital ambition of a new Electronic Patient Record (EPR) solution, which was progressing in collaboration with Tameside & Glossop Integrated Care NHS foundation Trust. In response to the Chair's request for further information and scope of the data warehouse project, the Director of Information briefed the Board of Directors on progress to house all the Trust's data in a single data warehouse. The Director of Information commented that the scope of the project did not cover the integration of population health based data. He confirmed that the Trust did not have legal access to all population health data, and that GM were developing systems in this regard, that alongside the Trust's internal data, could be utilised to collaboratively plan and improve services. The Medical Director highlighted the importance of the EPR project to ensure engagement of staff in digital programmes and welcomed the walkarounds led by the Clinical Information Officer. In response to a question from the Associate Non-Executive Director querying the opportunities and risks of Artificial Intelligence (AI), the Director of Information commented that AI terminology was not used consistently within healthcare. He briefed the Board on certain areas of AI that were well tested and part of the digital strategy including robotic technology, and support for administrative processes. More broadly, the Chair highlighted the importance of communicating key messages of the Digital Strategy, the importance of working collaboratively across GM to utilise the various information available. The Director of Information acknowledged these comments and advised of developments in business intelligence systems that would provide greater insight to benchmarking data. **The Board of Directors received and confirmed the Digital Strategy Report.** *The Director of Information left the meeting.*	
85/23	**Communications & Engagement Strategy** The Board of Directors received and noted the Communications & Engagement Strategy update report. The Chair referred to the marketing and communications developments associated with transformation programmes as previously discussed, and highlighted the importance of considering different resources that may be available to enable improved communications and engagement. **The Board of Directors received and noted the Communications & Engagement Strategy update report.**	
86/23	**Governance Declarations** The Trust Secretary presented a report seeking the Board's approval to endorse the Trust's position against the annual governance declarations 2022/23 and support rationale for each of the confirmed statements. She briefed the Board on the content of the report and advised that the governance declarations related to the following NHS Provider Licence conditions: • General Condition 6 • Continuity of Services Condition 7	

	• Corporate Governance Statement FT4 • Governor Training In response to a question from the Associate Non-Executive Director who queried when the extant licence conditions would be removed, the Chief Executive noted that while NHS England had acknowledged the improvements made by the Trust, there was not a mechanism to remove the licence conditions at this stage. The Chair referred to the declarations relating to governor training, noting that the training and development opportunities had been welcomed by the Council of Governors. **The Board of Directors approve the Audit Committee recommendation to endorse the Trust's position against the annual governance declarations 2022/23 and support the rationale for each of the confirmed statements.**	
87/23	**Going Concern** The Board of Directors considered a report asking the Board to approve the recommendation from Audit Committee, and support the declaration that, in accordance with International Accounting Standard 1 and the NHS Foundation Trust Annual Reporting Manual (ARM) 2022/20223, the Directors of the Trust had a reasonable expectation of the continued provision of Stockport NHS Foundation Trust's services and, for this reason, the Directors should continued to adopt the going concern basis in preparing the accounts for 2022/2023. **The Board of Directors approved the declaration that the Trust continued to adopt the going concern basis in the preparation of the accounts.**	
88/23	**Proposed Amendments to the Trust's Constitution** The Trust Secretary presented the proposed amendments to the Trust's Constitution, summarised as: - Amendments made in line with the Health & Care Act 2022 & modified Provider Licence including provision to enable joint working and delegation, and the Trust's commitment to exercise its functions effectively, efficiently and economically with regard to the wider effects of its decisions. - Amendments made in line with the Code of Governance for NHS provider trusts including arrangements for appointment and reappointment of non-executive directors. - Amendments to Membership & Council of Governors including alignment of public constituencies with outcome of the Stockport electoral ward boundary review and increase in minimum age for membership from 11 to 16. In addition, removal of Appointed Governor for Stockport Clinical Commissioning Group (CCG) following disestablishment of CCG's in the 2022 Act. The Trust Secretary advised that, subject to approval by the Board of Directors, the proposed amendments would be presented to the Council of Governors for approval at its meeting on 7 June 2023. Subsequently, NHS England would be notified of changes and provided with a copy of the approved Constitution. **The Board of Directors reviewed and approved the amendments to Stockport NHS Foundation Trust Constitution.**	
89/23	**Board Committees – Key Issues & Assurance Reports**	

	FINANCE & PERFORMANCE COMMITTEE The Chair of Finance & Performance Committee (Non-Executive Director) presented a key issues and assurance report from Finance & Performance Committee meetings held on 20 April 2023 and 18 May 2023. He briefed the Board on the content of the report and highlighted key operational issues considered, including patient flow, no criteria to reside, particularly those from out of area. He also briefed the Board on financial issues considered, highlighting challenges in achieving the financial plan and noting comprehensive Committee discussions in this area. The Chair of Finance & Performance Committee referred to discussions at the Finance & Performance Committee and Audit Committee about the Internal Audit Cost Improvement Programme (CIP) review, noting that further discussion would take place about the scope of the audit. **The Board of Directors reviewed and confirmed the Finance & Performance Committee Key Issues & Assurance Report, including actions taken.** PEOPLE PERFORMANCE COMMITTEE The Board of Directors received and noted the key issues and assurance report from the People Performance Committee meeting held on 24 May 2023, noting the highlights reported. **The Board of Directors reviewed and confirmed the People Performance Committee Key Issues & Assurance Report, including actions taken.** QUALITY COMMITTEE The Chair of the Quality Committee (Non-Executive Director) presented a key issues and assurance report from Quality Committee meetings held on 25 April 2023 and 23 May 2023. She briefed the Board on the content of the report and noted continued monitoring of incidents in A&E, including review of resultant themes. **The Board of Directors reviewed and confirmed the Quality Committee Key Issues & Assurance Report, including actions taken.** AUDIT COMMITTEE The Chair of Audit Committee (Non-Executive Director) presented a key issues and assurance report from the Audit Committee meeting held on 23 May 2023. He briefed the Board on the content of the report, noting that the meeting had mainly focused on year-end matters. **The Board of Directors reviewed and confirmed the Audit Committee Key Issues & Assurance Report, including actions taken.**	
90/23	**Any Other Business** There was no other business.	
91/23	**Date, time and venue of next meeting** The next meeting of the Board of Directors held in public would be held on Thursday, 3 August 2023, commencing at 9.30am in the Lecture Theatres, Pinewood House Education Centre.	

92/23	**Resolution** The Board resolved that: *"The representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to commercial interests, sensitivity and confidentiality of patients and staff, publicity of which would be premature and/or prejudicial to the public interest".*	

Signed:_____Date:_____

BOARD OF DIRECTORS PUBLIC MEETING ACTION TRACKER

Meeting	Minute reference	Subject	Action	Bring Forward	RO
1 Dec 2022	199/22	Freedom to Speak Up Toolkit	The Board of Directors agreed that a workshop / group maybe established to further consider and progress the toolkit prior to bringing it back to the People Performance Committee and Board if required. **Update February 2023** – Date to be confirmed. **Update March 2023** – Freedom to Speak Up Report, including update regarding Action Plan to progress recommendations from toolkit to be presented at PPC in May 2023, and determine if requirement for further workshop. **Update June 2023** – Discussed via PPC and agreed to defer establishing a working group at this time. Further action to be determined as required.	TBC	Director of People & OD / Director of Communications & Corporate Affairs
1 Dec 2022	201/22	Wellbeing Guardian Report	It was agreed that further clarity and exploration of the wellbeing principles was required outside of the meeting, with the outcome reported through next Wellbeing Guardian Report to the Board. **Update February 2023** – Next Wellbeing Guardian Report to be presented – August 2023 (In line with PPC Work Plan & Board of Directors Work Plan)	August 2023	Wellbeing Guardian / Board members

On agenda
Not due
Overdue
Closed

Meeting date	3rd August 2023	x	Public		Confidential	Agenda item
Meeting	Board of Directors					
Title	Chair's Report					
Lead Director	Chair, Professor Tony Warne		Author	Professor Tony Warne		

Recommendations made / Decisions requested

The Board of Directors is asked to note the content of the report.

This paper relates to the following Annual Corporate Objectives

	1	Deliver personalised, safe and caring services
	2	Support the health and wellbeing needs of our community and colleagues
	3	Develop effective partnerships to address health and wellbeing inequalities
	4	Develop a diverse, talented and motivated workforce to meet future service and user needs
	5	Drive service improvement through high quality research, innovation and transformation
	6	Use our resources efficiently and effectively
	7	Develop our estate and digital infrastructure to meet service and user needs

The paper relates to the following CQC domains

	Safe		Effective
	Caring		Responsive
x	Well-Led		Use of Resources

This paper relates to the following Board Assurance Framework risks

x	PR1.1	There is a risk that the Trust does not deliver high quality care to service users
	PR1.2	There is a risk that patient flow across the locality is not effective
	PR1.3	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan
x	PR2.1	There is a risk that the Trust is unable to sufficiently engage and support our people's wellbeing
x	PR2.2	There is a risk that the Trust's services do not fully support neighbourhood working
x	PR3.1	There is a risk in implementing the new provider collaborative model to support delivery of Stockport ONE Health & Care (Locality) Board priorities

	PR3.2	There is a risk that the Trust does not deliver a joint clinical strategy with East Cheshire NHS Trust
	PR4.1	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit and retain the optimal number of staff, with appropriate skills and values
x	PR4.2	There is a risk that the Trust's workforce is not reflective of the communities served
x	PR5.1	There is a risk that the Trust does not implement high quality transformation programmes
	PR5.2	There is a risk that the Trust does not implement high quality research & development programmes
	PR6.1	There is a risk that the Trust does not deliver the annual financial plan
	PR6.2	There is a risk that the Trust does not develop and agree with partners a multi-year financial recovery plan
	PR7.1	There is a risk that the Trust does not implement the Digital Strategy to ensure a resilient and responsive digital infrastructure
	PR7.2	There is a risk that the estate is not fit for purpose and/or meets national standards
	PR7.3	There is a risk that the Trust does not materially improve environmental sustainability
	PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus

Executive Summary

This report advises the Trust Board of the Chair's reflections on recent activities within the Trust and wider health and care system.

1. PURPOSE OF THE REPORT

The purpose of this report is to advise the Trust Board of the Chair's reflections on his recent activities.

2. EXTERNAL PARTNERSHIPS

The invasion and war in Ukraine continues' and as I write this report, we are on day 510 of this dreadful conflict. Whilst currently, there appears to be no end in sight, I'm certain that standing together, love not hate will eventually triumph. Until then we should keep all those caught up in the Ukraine/Russia war and in other conflicts around the world, in our thoughts and prayers.

In my last report to Board, I spoke about the Leadership and Governance Workshop, facilitated by Carnall Farrar and the Greater Manchester Integrated Care Board (ICB) I attended. During July there was a follow up workshop. This was aimed at taking colleagues from across the GM ICS through the draft Operational Plan – how the ICB intends to operate. This was an early opportunity to explore and contribute to the proposed new ways of working.

I attended one NHSE North West Regional System Leaders meeting, and one extraordinary NHSE national meeting. The latter was given over to a pre-launch discussion of the long term workforce plan. This was a session led by Amanda Pritchard, Chief Executive of NHSE. It was an opportunity to feed in ideas, concerns, and agreement for the proposed objectives of the workforce plan. Whilst many colleagues were in agreement with the plan's proposals, there were concerns over the funding, both in the short and long term.

At the Greater Manchester Chairs June meeting, Richard Leese, GM ICB Chair was in attendance. It was an opportunity to share with him the issues faced by acute, mental health, community and ambulance Trusts across Greater Manchester. Most providers expressed concern over the negative impact of the continuing industrial action on the planned recovery and elective work.

The June meeting of the Stockport Health and Care Board signed off, among other decisions, the Better Care Fund proposals for the next two years. If Stockport MBC receives the funding anticipated, it will mean that keeping people out of hospital, and getting people in hospital discharged in a more appropriate and patient centred way, would be easier to achieve.

I continued to make an active contribution to the work of the Good Governance Institute participating in two webinars that have looked at the impact of national reviews on provider Trusts and changes to the regulatory framework (whether the CQC retains the confidence of provider leaders and managers).

I attended the quarterly meeting of the NHS Providers North West Regional group of Chief Executives and Chairs. The session considered the Long Term Workforce Plan, issues around perceptions of productivity, the problems of capital flows and the 40 new hospital programme, and what NHS Providers saw as the strategic challenges in the run up period to the next general election. I was appointed Chair of the group, taking over from Chris Outram, outgoing Chair from the Christie.

I participated in the second GM NED Network event. There were considerably more colleagues in attendance, which made networking more effective. Mark Fisher, Chief Executive of the GM ICB attended and provided colleagues with an opportunity to hear his three main objective (financial stability, ICB operating plan, and the development of locality working). I was also pleased to be able to take part in the second NHS Leadership Academy NED Network workshop. This workshop explored the concepts of structural racism, and disability and what the NED role might be in responding to the issues these concepts present for Trusts. The event was co-facilitated by Shelly Rubenstein from Impact Psychology for Business. Amazingly for me (and Shelly) the last time we had worked together was some 30 years ago at what, at the time was Salford Mental Health Service (Prestwich hospital).

I was able to attend the NHS Confederation Expo, which had a wonderful stand celebrating the 75 years of the NHS. It was also the second time in the month that I heard Amanda Pritchard lay out her short and medium term ambitions for the NHS.

I have met Jane McCall, Chair at Tameside and Glossop Integrated Care FT to start the planning for our next 12 months of collaborative working. Amongst other decisions we committed to adopting an externally facilitated qualitative approach to the review of joint Executive Director posts, underpinned by a repeat of the Benefits, Opportunities and Challenges assessment process carried out previously and which was jointly presented to both Boards at an in-person Board to Board meeting.

We had our first in-person Board to Board meeting with East Cheshire NHS Trust under its new Chair and Chief Executive. It was good to be in the same room together, something that has not been possible before. The focus of the meeting was on acknowledging the progress being made on the sustainable hospital project, and what the next step were for both organisations.

Finally, I attended the Stockport Fair and Inclusive Summit. Held in the Stockport Town Hall, it was an opportunity to hear about the great work going on across Stockport that either promoted greater fairness and inclusion or of projects that had benefited from the One Stockport ambition to create a fair and more inclusive Stockport. There were several speakers from the voluntary, community and faith-based groups, and social enterprises (VCFSE) and charitable organisations across Stockport. There was also an opportunity to share ideas as to what might take this ambition forward at pace. It was also an interesting event to network and meet up

with colleagues from the Council and Greater Manchester. I was particularly pleased to be able to talk to Dame Robina Shah. She was a former Chair here at Stockport, and during her time as Chair brought together our community and acute services, and of course led the work in Stockport becoming a Foundation Trust.

3. TRUST ACTIVITIES

I was very pleased to be able to join Helen Howard, Deputy Chief Nurse, and Graham Lindley, Hospital Chaplin, in presenting another group of our volunteers with Long Service medals. It is always a privilege to acknowledge the wonderful contribution they make to our Stockport NHS family.

Likewise, it was brilliant to join with Karen James, Chief Executive in a 'Steel Signing' ceremony in our under construction Urgent and Emergency Care building. It is something I have never done before. We had to wear 5 pieces of PPE before we were allowed on site, and I'm not sure a high viz jacket and protective boots were my best look. Karen and my names and signatures are now forever more written on one of the structural beams in the building. I was also able to take a guided tour of the whole project and could see the huge progress that has been made.

Karen and I were able to meet with William Wragg, one of our Stockport MPs. It was an interesting meeting where he was able to share the experiences and concerns of some of his constituents and we were able to help him better understand the issues and challenges we faced as a NHS Trust.

My two planned visits, to our Emergency Department and to the new Transfer Hub, were both postponed due to operational pressures, but I was able to visit colleagues in our Finance Department. Like many of my visits, I came away knowing a great deal more about that area of our organisation than I did before the visit. It was highly educational, and it was great to meet so many interesting and knowledgeable colleagues.

Finally, I was delighted to learn that Dr Marisa Logan-Ward, our Vice Chair, has been appointed as a Non-Executive Director for the Health Services Safety Investigations Body (HSSIB). This is a hugely prestigious position, with a very competitive national recruitment process. Marisa's appointment required sign off from the Secretary of State for Health and Social Care. I'm sure you will want to join me in congratulating Marisa on this achievement. I'm sure she will fly the flag for Stockport NHS FT as well.

4. STRENGTHENING BOARD OVERSIGHT

We have been able to hold one Board Development event since I last reported to the Board. We took the opportunity to trial a new approach to Board walkabouts. Whilst

hosted, these visits are less formal and structured than the existing Wednesday Walkabouts and they won't replace them or any other engagement activity. The plan is that these will be built into our Board development sessions over the course of the year. Board members spent an hour going out onsite, followed by opportunity to share feedback from the visit. It proved to be a very successful experience.

NHS
Stockport
NHS Foundation Trust

Meeting date	3 August 2023	x	Public		Confidential	Agenda item
Meeting	Board of Directors					
Title	Chief Executive's Report					
Lead Director	Chief Executive		Author	Director of Communications & Corporate Affairs		

Recommendations made / Decisions requested

The Board of Directors is asked to note the content of the report.

This paper relates to the following Corporate Annual Objectives

x	1	Deliver personalised, safe and caring services
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	4	Develop a diverse, talented and motivated workforce to meet future service and user needs
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	6	Use our resources efficiently and effectively
	7	Develop our estate and digital infrastructure to meet service and user needs

The paper relates to the following CQC domains

	Safe	x	Effective
	Caring		Responsive
x	Well-Led		Use of Resources

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	PR7.3	There is a risk that the Trust does not materially improve environmental sustainability
	PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus

Where issues are addressed in the paper-

	Section of paper where covered
Equality, diversity and inclusion impacts	N/A
Financial impacts if agreed/ not agreed	N/A
Regulatory and legal compliance	N/A
Sustainability (including environmental impacts)	N/A

Executive Summary

The purpose of this report is to advise the Board of Directors of national and local strategic and operational developments including:

- NHS Workforce Plan
- NHS 75th anniversary
- Industrial action
- Community diagnostic centre
- Emergency and urgent care centre
- Health Service Journal Awards
- Clinical Audit Team of the Year
- Catering awards
- Quality data provider

1. PURPOSE OF THE REPORT

The purpose of this report is to advise the Board of Directors of strategic and operational developments.

2. NATIONAL NEWS

2.1 NHS Workforce Plan

The NHS Long Term Workforce Plan was published on 31 June 2023. It considers the challenges facing the workforce over the next 15 years and sets out actions to address them, focusing on three key areas:

- Recruit - growing the workforce,
- Retain - existing talent, embedding the right culture and improving retention;
- Reform - working and training differently.

The plan aims to significantly expand domestic education, training and recruitment, to ensure there are more doctors, nurses and other healthcare professionals working in the NHS over the next 15 years, and the system is less reliant on overseas recruitment.

It aims to reduce the number of staff leaving the NHS by improving culture, leadership and wellbeing, and it sets out some ways the NHS will work different to ensure staff can spend more time with patients, harness digital innovations and enables new and innovative ways of working. It also sets out an ambition to reform training so learners have a better experience.
We are assessing how the long term plan will impact on our services and what actions we may need to take to support delivery of its ambitions. These will be reported to the Board of Directors via our People Performance Committee.

2.2 NHS 75th Anniversary

The NHS reached a huge milestone on 5 July 2023 – the 75th anniversary of its creation, coming just a few days after the 75th anniversary of Windrush.
We used the opportunity to celebrate the people who have, and continue to, contribute so much to the success of our services, and also raise money to help support our staff and patients.

Working with local radio we showcased the work of some of our brilliant volunteers, who also celebrate their 75th birthday this year, and we mounted a new Then and Now display in the hospital's "glass corridor" highlighting how our services have developed over the last 75 years. This will be on display for visitors, staff and patients to enjoy throughout 2023.

Our Trust charity organised a week of events including encouraging staff and volunteers to get involved in a fundraising static cycle-a-thon, collectively pedalling

75 miles in a day. We joined other NHS organisations across the country in running an NHS Big Tea party in our hospital restaurant, along with a fun fundraising games event and a silent auction.

3. TRUST NEWS

3.1 Industrial Action

There have been a number of developments regarding industrial action across many staff groups during the last couple of months.

The Royal College of Nursing staged a national ballot for further strike action which could potentially last for the rest of this year. We have been notified that the ballot results did not meet the required threshold for further action and the RCN have confirmed that this particular dispute is now ended. Similarly the Society of Radiographers has confirmed that their ballot for industrial action has not met the required threshold for action.

We were notified of further action by the British Medical Association (BMA) and the Hospital Consultants and Specialists Association for a further walkout of junior doctors on 13-18 July (five consecutive 24 hour periods) and notified of strike action by consultants on 20 and 21 July. Consultants provided what was described as Christmas Day levels of cover i.e. covering emergency services, with others being encouraged to strike. Detailed planning ensured staffing levels were safe during the two recent periods of industrial action.

3.2 Community diagnostic centre

We have had Government approval to build a new community diagnostic centre (CDC) in partnership with Tameside and Glossop Integrated Care NHS Foundation Trust.

The centre at Crown Point Retail Park in Denton will offer a range of diagnostic tests including MR scans, CT scans, Dexa scans, ECG, Phlebotomy and Spirometry for the people of Stockport, Tameside and the surrounding area. Once fully operational it will have the capacity to offer 129,000 extra tests a year for patients referred by a hospital or acute professional.

Our centre will be part of a national network currently being planned and opened across the country, as part of the recommendations from Professor Sir Mike Richards, the first NHS National Cancer Director, who conducted a review of diagnostic services as part of the NHS Long Term Plan.

The aim is to provide easier, faster, and more direct access to the full range of diagnostics, reduce the need for hospital visits, and contribute to the NHS ambitions

to cut carbon emissions and air pollution by providing multiple tests at one visit, by reducing the number of patient journeys.

Our new centre is expected to be in use by early 2024, and by the end of 2025 there will be 26 CDCs across the North West, including in Greater Manchester.

3.3 Emergency and urgent care campus

The Chair and I recently signed the steel framework of our new emergency and urgent care campus to mark an important stage in the build of this £30.5m centre. The ceremony organised by building contractors Tilbury Douglas marked completion of the main building structure, and now work is underway on the external cladding, and internal mechanical and electrical fittings. We expect work on the campus to be complete by the end of March 2024.

The campus will include new assessment, treatment and consultation areas for several key emergency and urgent care services including the children's emergency department, mental health, and medical same day emergency care.

3.4 Health Service Journal Awards

Our services have been shortlisted in three categories of the prestigious Health Service Journal (HSJ) national Patient Safety Awards.

Our pain management team is in the running for the Patient Involvement in Safety Award for the co-designed project they have worked on with patients living with chronic pain. The aim of the successful project was to help patients to develop a self-management approach to dealing with pain in a way that best meets their own individual needs.

Our surgical division has been recognised in the Safe Restoration of Elective Care Services *c*ategory for developing and implementing a new digital dashboard, which has helped to safely increase rates of day case elective surgery, reduced the number of people waiting for surgery as a result of the pandemic, and cut waiting times.

Our maternity department is shortlisted for the Improving Health Outcomes for Minority Ethnic Communities Award for their response to the maternity needs of asylum seekers in the Stockport area. The community midwifery team has been particularly responsive to the needs of this vulnerable group, performing with outstanding care and compassion, and the department has established close collaborative working with partners in Stockport in responding to their needs. The winners of the awards will be announced at a ceremony on 18 September.

3.5 Clinical Audit Team of the Year

The team which runs our clinical audits has been judged as the best in the country, winning a national award.

The team was named as Clinical Audit Team of the Year in the first national awards run by the Clinical Audit Support Centre, which works across the UK to support audits to help improve the delivery and safety of healthcare for patients.

Clinical audits are a crucial part of our efforts to ensure our services are meeting national standards and continuing to make improvements in the care we offer. Our 12 strong clinical audit team is currently registering around 300 projects a year and supports an average of 180 clinical audits annually.

The team was recognised for being passionate about improving care, holding regular events to showcase the importance of clinical audits, implementing new management and tracking software, and for the time devoted to chairing the local regional clinical audit network.

3.6 Catering Awards

Our award winning catering team have done it again – adding two more trophies to their impressive list of honours.

Our Trust is an exemplar site for NHS hospital catering and recently our catering team won the Team of the year award at the Health Estates and Facilities Management Association (HEFMA) awards.

Asela Kuruwita, assistant catering manager, also won the Junior Manager of the Year award presented at the North West Hospital Caterers' Association Annual Summer Ball.

3.7 Quality Data Provider

The Trust has been awarded quality data provider status from the National Joint Registry (NJR).

It recognises our teams' achievements in meeting the NJR's six ambitious targets for best practice over the last year, increasing engagement and awareness of the importance of quality data collection in promoting patient safety, and contributing to a national audit.

The NJR monitors the performance of hip, knee, ankle, elbow and shoulder joint replacement operations to improve clinical outcomes for patients, and also support the work of orthopaedic clinicians.

4. RECOMMENDATION

The Board of Directors is asked to note the content of the report.

NHS
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Meeting date	3rd August 2023	X	Public		Confidential	Agenda item
Meeting	Board of Directors					
Title	Progress against Trust Objectives & Key Outcome Measures 2022/23					
Lead Director	Karen James, Chief Executive		Author	Jonathan O'Brien, Director of Strategy and Partnerships		

Recommendations made / Decisions requested

The Board of Directors is invited to review the delivery against the agreed Corporate Objectives and Key Outcome Measures for 2022/23.

This paper relates to the following Corporate Annual Objectives-

x	1	Deliver safe accessible and personalised services for those we care for
x	2	Support the health and wellbeing needs of our communities and staff
x	3	Develop effective partnerships to address health and wellbeing inequalities
x	4	Drive service improvement, through high quality research, innovation and transformation
x	5	Develop a diverse, capable and motivated workforce to meet future service and user needs
x	6	Use our resources in an efficient and effective manner
x	7	Develop our Estate and Digital infrastructure to meet service and user needs

The paper relates to the following CQC domains-

x	Safe	x	Effective
x	Caring	x	Responsive
x	Well-Led	x	Use of Resources

This paper relates to the following Board Assurance Framework risks

x	PR1.1	There is a risk that the Trust does not deliver high quality care to service users
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Where issues are addressed in the paper-

	Section of paper where covered
Equality, diversity and inclusion impacts	Objective 3
Financial impacts if agreed/ not agreed	Objective 6
Regulatory and legal compliance	Throughout
Sustainability (including environmental impacts)	Objective 7

Executive Summary

The paper provides a high level overview of delivery against the Objectives and Key Outcome Measures for 2022/23.

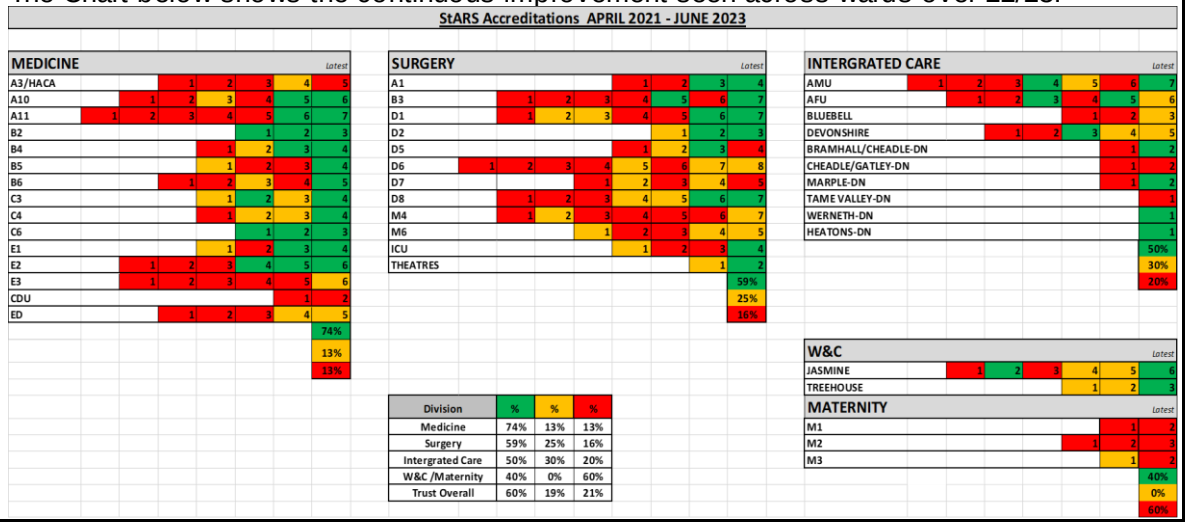
The Board will note that papers discussed at Board and its Committees are aligned with the corporate objectives.

The key outcome measures relating to the Corporate Objectives for 2022/23 will be familiar to Trust Board members as these are discussed at the relevant Trust Board Committees.

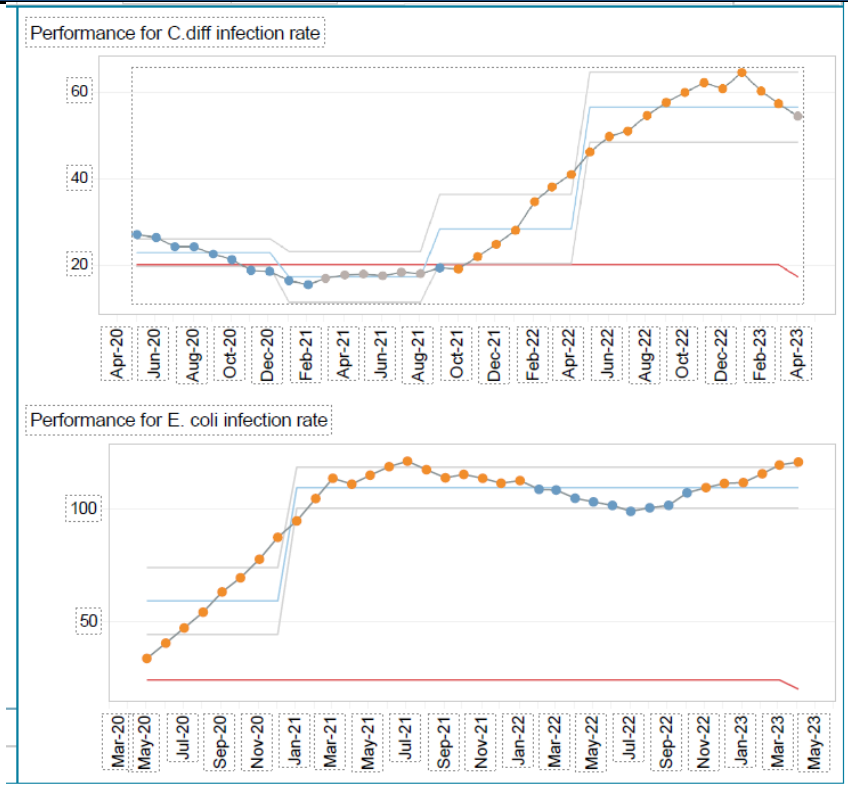
The corporate objectives for 2022/23 were:

1. Deliver safe accessible and personalised services for those we care for.
2. Support the health and wellbeing needs of our communities and staff
3. Develop effective partnerships to address health and wellbeing inequalities.
4. Drive service improvement, through high quality research, innovation and transformation
5. Develop a diverse, capable and motivated workforce to meet future service and user needs
6. Use our resources in an efficient and effective manner
7. Develop our Estate and Digital infrastructure to meet service and user needs.

The Trust Board is asked to note delivery against key outcomes for 2022/23 by year end.

Corporate Objectives 2022/23 We will:	Key Outcome Measures *How will we know we will have achieved our objectives?*	Full Year Outcome
Deliver safe, accessible and personalised services for those we care for	All CQC identified areas for improvement are delivered and embedded including plans to achieve a CQC 'Good' rating.	Maternity Services have been exited from the national Maternity Services Support Programme. The midwifery team have been asked to present at national conferences on the improvement journey. The StARS process assesses and reviews clinical areas in line with CQC standards. Data is reviewed at assurance committees as was the CQC Insight report prior to it being paused.
	There is a reduction in harms from the 2020/21 baseline.	The Trust achieved its target for Summary Hospital-level Mortality Indicators, with the rate for the period April 2022 – March 2023 at 98.65. The Medication Incident Rate is reported monthly to Trust Board - no major harm concerns reported.
	Plans for the strategic use of the LFD (learning from deaths) process is agreed and implemented.	The Quality Committee receives a quarterly LFD report to update on learning and changes implemented, with key issues reported to the Board.
	There is a reduction in full and grade 2 pressure ulcers by 10%.	At the end of the year, there were 92 pressure ulcers acquired in the acute setting. We achieved an **8% reduction** against the target set to reduce by 10%. Pressure ulcer prevention is monitored through Harm Free Care panel, divisional governance processes, StARS, weekly review by Chief Nurse, Patient Safety Group and Quality Committee.
	The STARS accreditation framework is expanded and implemented across Paediatrics, Community, Maternity and Theatres. There is an increase in the number of areas that achieve STARS Green Status (50% compliance)	The StARS process has been expanded and has now been implemented in community, paediatrics, theatre and maternity services. Outcomes are reviewed and monitored through Patient Safety Group and Quality Committee. By April 2023 54% of all areas achieved a green status, above the target of 50%, and only 22% of areas were rated red, compared to a Trust target of 25%. The Chart below shows the continuous improvement seen across wards over 22/23. 

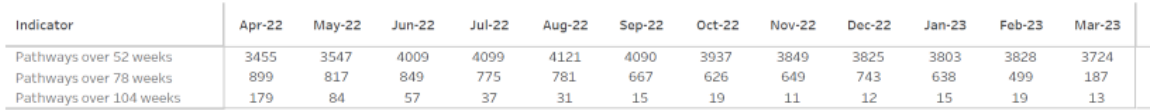
Corporate Objectives 2022/23 We will:	Key Outcome Measures *How will we know we will have achieved our objectives?*	Full Year Outcome
	A results governance management system is in place.	Results Governance Standards and Test Tracker SOPs have now been finalised. Pathology paper switch off for adult inpatients blood tests was implemented on the 1st July 2022. Test Tracker system improvements have been delayed due to developer resourcing issues and will be included in a major upgrade to Advantis CDSin 2023/24. Actions are in place to commence quarterly Results Governance audits by specialty.
	There is evidence that Ockenden, Kirkup and CNST Maternity standards are achieved.	The Board is sighted on the Maternity programme. Positive assurance continues in respect of the action plans and improvements across the key workstreams. Our maternity services have been formally stepped down from the Maternity Safety Support Programme (MSSP).
	A Community Safe Care Model is agreed and implemented.	This work is being undertaken in conjunction with NHSE.
	There is evidence of the outcome of a mock CQC inspection for all care services and well led standards and areas for improvement identified and actioned.	StARS process assesses wards, departments and community services in alignment with CQC standards. In addition, mock inspections, walk rounds and spot visits are organised ad hoc. Stockport & Tameside colleagues work in partnership to support.
	There is evidence of a reduction in hospital acquired infections in line with agreed targets.	HCAI trajectories were not achieved in 22/23, a position which was reflected across GM hospitals and peers.

Corporate Objectives 2022/23 We will:	Key Outcome Measures *How will we know we will have achieved our objectives?*	Full Year Outcome
		 All Divisions have reviewed their IPC action plans to assist the Trust in achieving the 2023/2024 National trajectories. All infections continue to be monitored and overseen by the Infection Prevention Team with monthly updates in the Integrated Performance Report to Board. The Quality Committee were assured that HCAI's were mostly deemed unavoidable with no lapses in care.
	System Strategy plans are agreed and implemented to support the reduction of delayed discharges.	The system is undertaking a review of Intermediate Tier services as part of a System Transformation Project. Review of all patients on the NCTR list is taking place daily to ensure patients are indeed on the correct pathway. The community bed base was maintained at 105 beds across the year with an additional 20 beds available over the winter period at Cherry Tree House, Romiley.

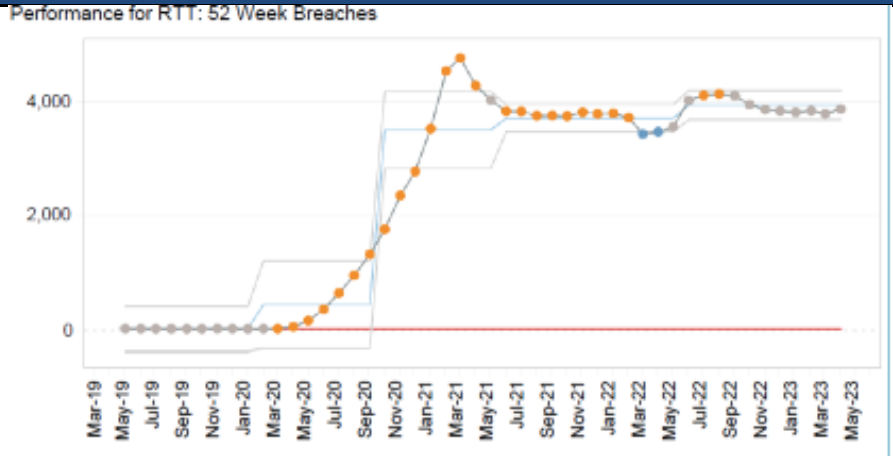
<table>
<tr><th>Corporate Objectives 2022/23
We will:</th><th>Key Outcome Measures
How will we know we will have achieved our objectives?</th><th>Full Year Outcome</th></tr>
<tr><td></td><td>Deliver national waiting time / performance requirements, including:
• 85% Theatre Utilisation</td><td>By year end, the Trust's capped theatre utilisation rate was 82.4%, while uncapped utilisation was 88.8%.

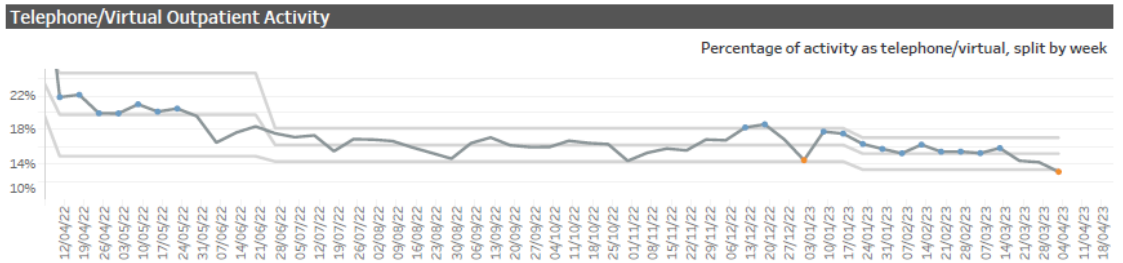
The theatre improvement transformation scheme continues to support productivity improvements and capped utilisation is forecasted to achieve the 85% national benchmark by the end of the the year. The Trust is benchmarking well against both peer and national medians.</td></tr>
<tr><td></td><td>• G&A bed occupancy at 90% and Critical Care and Paediatric bed occupancy at 85%</td><td>Adult bed occupancy has remained over 95% all year despite the opening of an additional elective ward. The winter escalation wards have also remained open. This has been driven by a significant, year on year increase in the number of patients with no criteria to reside.

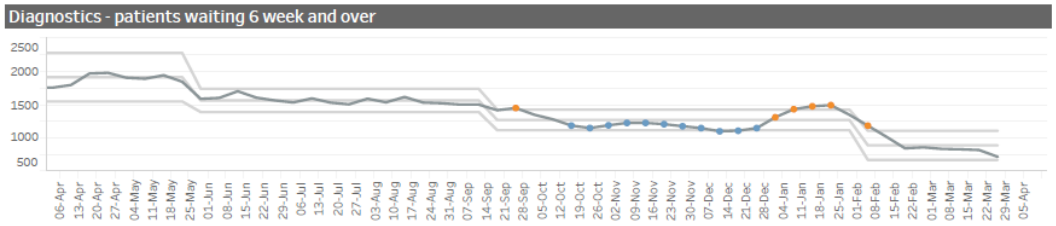
Paediatrics & critical care remains below the 85% plan.</td></tr>
<tr><td></td><td>• Priority to P2 category patients and then patients waiting over 104 weeks, eliminating 104 week waits.</td><td>In line with national waiting time standards all 104 waits were treated by the end of June 2022. The only exceptions were confirmed to be clinically complex, unfit, or patient choice to wait longer).</td></tr>
<tr><td></td><td>• Reduce waits over 78 weeks and conduct three-monthly reviews of these patients.</td><td>Over 2022/23 we saw significant improvements in the 78-week wait position, with the number of patients waiting over 78 weeks reduced from 899 in April 2022 to just 187 at the end of March 23.

 
<table>
<tr><th>Indicator</th><th>Apr-22</th><th>May-22</th><th>Jun-22</th><th>Jul-22</th><th>Aug-22</th><th>Sep-22</th><th>Oct-22</th><th>Nov-22</th><th>Dec-22</th><th>Jan-23</th><th>Feb-23</th><th>Mar-23</th></tr>
<tr><td>Pathways over 52 weeks</td><td>3455</td><td>3547</td><td>4009</td><td>4099</td><td>4121</td><td>4090</td><td>3937</td><td>3849</td><td>3825</td><td>3803</td><td>3828</td><td>3724</td></tr>
<tr><td>Pathways over 78 weeks</td><td>899</td><td>817</td><td>849</td><td>775</td><td>781</td><td>667</td><td>626</td><td>649</td><td>743</td><td>638</td><td>499</td><td>187</td></tr>
<tr><td>Pathways over 104 weeks</td><td>179</td><td>84</td><td>57</td><td>37</td><td>31</td><td>15</td><td>19</td><td>11</td><td>12</td><td>15</td><td>19</td><td>13</td></tr>
</table>
However, industrial action negatively impacted on our recovery and led to end of March breaches in the target. Teams have worked hard to provide additional capacity, prioritise long waiters and validate the waiting lists against the access policy.

All access standards are monitored by the Trust Elective & Cancer Care Delivery Group.</td></tr>
<tr><td></td><td>• Reduce waits over 52 weeks and conduct three-monthly reviews of these patients from July 2022.</td><td>At the start of 2022/23 there were 3,455 patients waiting over 52 weeks. The focus on increasing cancer 2ww referrals resulted in an increase by year end to 3,724 pathways.</td></tr>
</table>

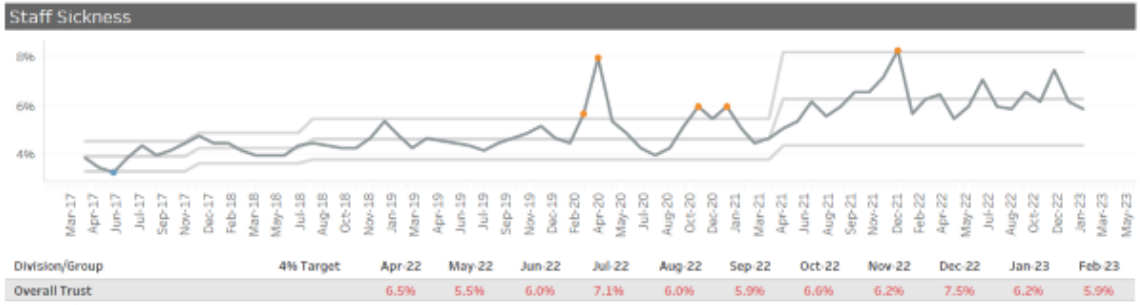
Corporate Objectives 2022/23 We will:	Key Outcome Measures *How will we know we will have achieved our objectives?*	Full Year Outcome
		 All patients are being reviewed and assurance provide at Quality Committee regarding any potential harms.
	• Reduce outpatient DNA rates by 2%	The Trust did not reach its aspirational target of reducing outpatient DNAs to 6%, with the final position in March 2023 at 7.7%. However, the trust's performance is the second best in Greater Manchester.
	• Move 5% of outpatient attendances to PIFU by March 2022.	The Trust has met and surpassed the annual target, moving 6% of outpatients to a patient-initiated follow-up pathway. Stockport is the best Performing Trust in GM for PIFU rates.
	• Increase outpatient utilisation by 5%	Outpatient Clinic Utilisation improved to 89% by year end - above the 85% target.
	• Maintain virtual outpatient consultations at 25%.	Virtual outpatient activity has gradually declined from 21% in April 2021 to 14.5% in March 2023 – an average of 17% across the year.

<table>
<tr><th>Corporate Objectives 2022/23
We will:</th><th>Key Outcome Measures
How will we know we will have achieved our objectives?</th><th>Full Year Outcome</th></tr>
<tr><td></td><td></td><td> 

<table>
<tr><th></th><th>Apr-22</th><th>May-22</th><th>Jun-22</th><th>Jul-22</th><th>Aug-22</th><th>Sep-22</th><th>Oct-22</th><th>Nov-22</th><th>Dec-22</th><th>Jan-23</th><th>Feb-23</th><th>Mar-23</th><th>YTD (Apr-Apr)</th></tr>
<tr><td>New</td><td>16.1%</td><td>16.0%</td><td>13.8%</td><td>13.2%</td><td>12.6%</td><td>11.8%</td><td>11.3%</td><td>12.1%</td><td>12.8%</td><td>11.5%</td><td>11.3%</td><td>11.8%</td><td>12.9%</td></tr>
<tr><td>Follow-up</td><td>23.9%</td><td>22.4%</td><td>19.9%</td><td>18.6%</td><td>17.6%</td><td>18.9%</td><td>18.5%</td><td>18.5%</td><td>19.9%</td><td>19.5%</td><td>18.3%</td><td>16.0%</td><td>19.3%</td></tr>
<tr><td>Overall</td><td>20.9%</td><td>20.1%</td><td>17.8%</td><td>16.6%</td><td>15.8%</td><td>16.4%</td><td>15.9%</td><td>16.2%</td><td>17.5%</td><td>16.7%</td><td>15.9%</td><td>14.5%</td><td>17.0%</td></tr>
</table>
Virtual appointments continue to be offered to patients where appropriate and work is underway to review the platform when GM funding ends in 2024.</td></tr>
<tr><td></td><td>• Maximum six-week diagnostic waits for 99% of patients.</td><td>Diagnostic activity has increased over 2022/23. All radiology modalities are now compliant with the diagnostic access standard. Over Q4 significant improvements have been seen in the 6ww backlog, however two issues remain:
• Echocardiography continues to have the biggest backlog (396 at year end)
• Endoscopy as a result of increased colorectal suspected cancer referrals (backlog of 380 at year end).
 

<table>
<tr><th></th><th></th><th>15-Jan</th><th>22-Jan</th><th>29-Jan</th><th>05-Feb</th><th>12-Feb</th><th>19-Feb</th><th>26-Feb</th><th>05-Mar</th><th>12-Mar</th><th>19-Mar</th><th>26-Mar</th><th>02-Apr</th></tr>
<tr><td rowspan="3">Diagnostic Backlog</td><td>Waiting Count 6+Weeks</td><td>1,485</td><td>1,502</td><td>1,357</td><td>1,193</td><td>1,026</td><td>853</td><td>867</td><td>844</td><td>838</td><td>827</td><td>725</td><td>686</td></tr>
<tr><td>Waiting Count: Total</td><td>5,997</td><td>5,952</td><td>5,665</td><td>5,640</td><td>5,640</td><td>5,487</td><td>5,224</td><td>5,267</td><td>5,324</td><td>5,111</td><td>5,257</td><td>5,177</td></tr>
<tr><td>% Over 6 Weeks</td><td>24.76%</td><td>25.24%</td><td>23.95%</td><td>21.15%</td><td>18.19%</td><td>15.55%</td><td>16.60%</td><td>16.02%</td><td>15.74%</td><td>16.18%</td><td>13.79%</td><td>13.25%</td></tr>
</table>
Both account for 13.79% non-compliance by the end of the financial year.</td></tr>
<tr><td></td><td>• Deliver Cancer Faster Diagnosis Standards.</td><td>FDS performance has improved by 10% throughout the year, but remains 3% short of the national standard of 75%, at 71.8%.</td></tr>
</table>

Corporate Objectives 2022/23 We will:	Key Outcome Measures *How will we know we will have achieved our objectives?*	Full Year Outcome
		Other Cancer Standards May-22 Jun-22 Jul-22 Aug-22 Sep-22 Oct-22 Nov-22 Dec-22 Jan-23 Feb-23 Mar-23 Apr-23 Cancer: 14-day standard (2WW) 96.9% 93.2% 96.3% 98.2% 98.2% 98.8% 99.0% 97.7% 96.7% 98.2% 97.5% Cancer: 28-day standard (FDS) 62.0% 60.5% 63.7% 64.5% 63.1% 67.8% 63.2% 68.9% 61.9% 73.9% 71.8% 31-day First Treatment 94.5% 95.9% 97.4% 95.2% 94.8% 96.5% 99.1% 96.4% 94.1% 92.2% 91.8% 31-day Subsequent Treatment (Chemo) 100.0% 100.0% 100.0% 100.0% 100.0% 100.0% 100.0% 100.0% 31-day Subsequent Treatment (Surgery) 100.0% 100.0% 100.0% 100.0% 90.9% 100.0% 100.0% 100.0% 100.0% 62-day Upgrades 83.1% 79.7% 69.4% 66.2% 87.7% 67.0% 74.5% 85.2% 87.8% 87.0% 85.7% 62-day Cancer Screening Programmes 100.0% 33.3% 100.0% 100.0% 50.0% 100.0% 0.0% 0.0%
	• 12 hour waits in ED at no more than 2%	Over 22/23, ED attendances were 6.8% above plan -a variance of +7065 attendances – and 11.2% above 2019/20 baselines. There were 177 12-hour trolley waits in ED in March. Performance for ED: 12hr Trolley Wait 400 200 0 -200 May-20 Jul-20 Sep-20 Nov-20 Jan-21 Mar-21 May-21 Jul-21 Sep-21 Nov-21 Jan-22 Mar-22 May-22 Jul-22 Sep-22 Nov-22 Jan-23 Mar-23 May-23
	• 65% ambulance handover at 15 mins. • 95% ambulance handover at 30 mins.	There continue to be challenges relating to ambulance handover. These are reported through regular performance reports. Stockport performs well comparatively for Ambulance handover within Greater Manchester ICB.

Corporate Objectives 2022/23 We will:	Key Outcome Measures *How will we know we will have achieved our objectives?*	Full Year Outcome
	• Zero ambulance handover over 60mins.	
	• Urgent community response services 8am to 8pm, 7 days a week with 70% of responses <2 hours by Q3	The Crisis Response Team are available 8am-10pm, 7 days per week 365 days per year. The 2 hour response time is being achieved.
Support the health and wellbeing needs of our communities and staff	The delivery of the objectives of the NHS People Plan for 2022/23.	87.4% of staff have had an annual appraisal (87.2% non-medical staff and 88.7% of medical Staff). Our 'Making A Difference Every day' awards celebration was held at Stockport Town Hall on the evening of Friday 7th October. Various health and wellbeing support initiatives and guidance documents are available for managers and staff including cost of living support initiatives, menopause support, dealing with child bereavement, domestic violence and pregnancy loss.
	The staff survey, sickness/absence levels demonstrate the effectiveness of the Trust Health and Wellbeing Services target (5%).	Staff sickness levels have remained constant across the year at c.6%. Support continues for absent staff resulting in several individuals returning to work with adjustments. Those who remain absent are being supported by OH and signposted to our health & wellbeing initiatives (e.g. SPAWS). 
	Community Services offer support to neighbourhood working and the needs of neighbourhood population requirements.	The Mobilising Neighbourhoods transformation programme is currently on track to deliver. The Neighbourhood toolkit has been updated and relaunched, SFT staff have been aligned to Primary Care Networks and PCN triage MDT meetings are being re-established.
	Evidence of a system wide frailty pathway.	The Frailty transformation programme is on track to deliver. NHS England's senior programme manager for same day emergency care recently met with Trust colleagues to hear about the work of our frailty service and their plans to make further improvements to the care being provided to local people.
	Improvement in the Staff Survey following publication of the 2021 results are achieved.	In September 2022 the People Committee received an update on the actions taken in relation to the previous annual staff survey and the planning and preparation for the forthcoming survey. They reported limited assurance due to the relevant information existing in a number of sources.

Division/Group	4% Target	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23
Overall Trust		6.5%	5.5%	6.0%	7.1%	6.0%	5.9%	6.6%	6.2%	7.5%	6.2%	5.9%

Corporate Objectives 2022/23 We will:	Key Outcome Measures *How will we know we will have achieved our objectives?*	Full Year Outcome
	Roll out health and wellbeing conversations across the Trust in line with the NHS People Plan.	Support continues across a range of health and wellbeing initiatives for staff including cost of living support initiatives. These continue to be reported to the People Committee.
	A collaborative Occupational Health function is achieved across Stockport/Tameside and Glossop.	Work is progressing towards a joint service with an implementation date anticipated of 1st September 2023.
Develop effective partnerships to address health and wellbeing inequalities	The locality Provider Collaborative Board is established and achieves its agreed priorities for 2022/23.	The Place-Based Provider Partnership has been established and developed a work plan for the year.
	Agreed service integration plans with Tameside and Glossop are progressed according to agreed timescales.	A joint bid for a Community Diagnostics Centre (CDC) across Stockport and Tameside has been approved nationally with funding allocation for mobilisation to commence in 2023/24. A baseline assessment is being completed for Diabetes and Gastroenterology services to scope out potential for service collaboration across the Trusts. An Ophthalmology business case in being developed with Tameside to scope the provision of a single service for the sector. October saw the launch of the Tameside & Glossop Digital Health Service in Stockport, which interacts with the local clinical assessment service & 111 to provide effective streaming to appropriate services to avoid attendance at the Emergency Department.
	A Joint Clinical Strategy with East Cheshire is agreed and supported by the Trust regulator and programme milestones are achieved according to agreed timescales.	A Case for Change was signed off in June 2022 by the Trust Boards and CCGs. Work has been undertaken over the Summer to develop a range of service proposals through clinical workshops. Further work is progressing in preparation for a PCBC with wider stakeholders. The Trust Board has been kept updated throughout.
	Evidence that we work with partners across GM in the development of the ICS Framework for resource allocation, prioritisation and utilisation.	Our Greater Manchester Integrated Care System (ICS) is established and the relevant Directors continue to work with colleagues across the ICS on resource allocation, prioritisation and utilisation. Stockport FT CEO has now taken over the role of Provider Federation Board Chair.
	Enhance reporting and disaggregate performance data to demonstrate progress against local health inequalities.	A paper focused upon waiting list health inequalities has been presented to Trust Board.
	Plans are agreed to deliver a Community Diagnostics Centre to the population of Stockport and Tameside & Glossop.	A Business Case has been completed and received national approval with funding allocation. Mobilisation will take place in 2023/24.

Corporate Objectives 2022/23 We will:	Key Outcome Measures *How will we know we will have achieved our objectives?*	Full Year Outcome
Drive service improvement through high quality research, innovation and transformation	Evidence of an agreed quality/performance metrics to support improvement programmes and board assurance.	Stockport`s Transformation Programmes are set and managed by the Service Improvement Group (SIG). Each programme is given a clear set of priorities and progress is reviewed at SIG, as part of the robust governance and assurance measures to ensure that programmes are delivering.
	A joint Research and Innovation Strategy across the Tameside and Glossop / Stockport sector is agreed and research teams are integrated.	The joint strategy was signed off in August 2022 and work is underway to integrate teams and enhance cross-site working.
	A Communications and Engagement Strategy is developed and year one strategy objectives are delivered.	The Communications and Engagement Strategy was completed and signed-off in October 2022 at Trust Board.
Develop a diverse, capable and motivated workforce to meet future service and user needs	A Leadership Development Plan is implemented across the Trust.	The Deputy Director of Organisation Development has been appointed and an OD Plan is being developed.
	A Civility Saves Lives cultural programme is implemented across the Trust.	As above Civility Saves Lives is currently being scoped and will form part of the OD Plan.
	A Workforce Strategy and Operational Plans to deliver the Strategy are deployed and agreed.	The Trust was on plan for the substantive workforce element of the operational plan, however use of agency and bank staff is taking the Trust significantly over plan. This is largely attributed to the additional wards that are in operation, operational activity and sickness – it is being closely monitored through the People Performance Committee.
	Implementation of the Trust's EDI Strategy is delivered.	A range of events have been held across the year, including support for PRIDE, black history month. Progress has been made in the overall BAME representation within the workforce, with significant further work to do to improve representation at senior levels and improvements in positive work-place experiences. The recently approved Equality, Diversity & Inclusion (EDI) Strategy work programme would be reviewed to re-prioritise actions identified in the WRES and WDES reviews taken to Board in August 2022.
	Improve staff retention rates with turnover increase of no more than 0.5%.	In the first half of the year, turnover rates have increased by around 1%.
	Improve the ethnic disparity ratio through implementing the six high impact actions.	Progress has been made in the overall BAME representation within the workforce, with significant further work to do to improve representation at senior levels.
	Expand international recruitment.	International recruitment for the 2022 has progressed in line with plans with 120 international nurses and 9 international radiographers joining in 2022/23.

Corporate Objectives 2022/23 We will:	Key Outcome Measures *How will we know we will have achieved our objectives?*	Full Year Outcome
		The Division of Medicine & ED has successfully held an international recruitment event for junior doctors and there has been a successful recruitment of radiographers from overseas.
Use our resources in an efficient and effective manner	A programme is in place to ensure all divisions understand the outputs from the model hospital and available benchmarking data to support their improvements in productivity and efficiency plans.	The Trust undertakes a monthly CIP meeting with Divisions and runs training to support understanding of benchmarking data. The Trust has a workplan called "Working Intelligently - Making Data Count", which deep dives Model Hospital, Logex for PLICs, People Analytics data, Safecare Live, Medical Job planning, GIRFT, specialty networks and NHSI data resources.
	Deliver the 2022/23 CIP; revenue; capital and cash annual plans following the receipt of national planning guidance.	The overall financial position at Month 12 was £19.7m favourable to plan. The year-end deficit was £3.3m which was in line with the forecast. The Trust maintained sufficient cash to operate during March. In 2022/23 the Trust delivered its planned Cost Improvement Programme of £18.1m: • £12.2m non-recurrent CIP • £5.9m recurrent CIP (with a full year effect of £7.0m) Our capital expenditure plan for 22/23 was £43.1m, including expected PDC awards. Following adjustments throughout the year the final agreed plan was £39.9m. Capital expenditure for 22/23 was £39.8m £0.1m below the revised plan.
	The development of a multi-year financial recovery plan to support the implementation of the long-term plan and recovery, optimising opportunities for financial recovery through system working.	The Executive presented to the F&P Committee a presentation covering the current financial position and actions being considered to address the financial challenge going forward. The GM system has requested a number or returns to highlight actions the Trust can take to improve the 22/23 position and the 23/24 position and beyond. Work continues into 2023/24.
Develop our Estate and Digital infrastructure to meet service and user needs	The data warehouse project is completed.	The Trust's data warehouse is now live for the majority of mandatory national data feeds (ED/Community/OP) and the work on inpatients is close to completion. This work has enabled the Trust to take control of the delivery of its daily mandatory returns, taking away the reliance on its PAS supplier.
	A new interactive Trust website is implemented.	A contract for the design and build of a new website has been awarded. All current website content has been reviewed. Website editors in services now being identified to move into the design and build phase.
	An OBC is completed and ratified for an EPR system.	The establishment of a formal Trust Acute EPR programme commenced in May 2022. Stockport and Tameside are now progressing jointly with this programme. Pre-market engagement activities with EPR suppliers have been completed. These details supported the narrative and affordability case of the OBC.

Corporate Objectives 2022/23 We will:	Key Outcome Measures *How will we know we will have achieved our objectives?*	Full Year Outcome
	The roll out of VDI (Virtual Desktop Informatics), single sign off and Office 365 is delivered in line with agreed plans.	Rollout of the new VDI solution is underway. By year end, the solution had been implemented in community services and for agile home workers. Acute roll-out is currently in planning stages.
	A successful roll out of the LIMS system achieved.	Stockport and Tameside have jointly procured their new LIMS solutions (Clinisys Winpath). Work is now underway to recruit project resourcing, with a planned 'go live' in spring 2024.
	The OBC for the new hospital development is completed.	The Trust had submitted an expression of interest to the New Hospitals Programme and was awaiting a response from the Department of Health & Social Care.
	There is evidence of a short/medium term Estates Strategy to improve the current hospital capital stock.	The Estates Development Strategy for Stepping Hill was presented to the Board of Directors in October 2022 and approved.
	The Trust Green Plan objectives for 2022/23 are delivered.	An update on the Green Plan was taken to Finance & Performance Committee in September. The Committee noted positive assurance regarding the work of the Green Plan Group.
	The FBC for the Urgent Care Campus is ratified by the Trust regulators and enabling works are delivered.	The FBC has been signed off by Trust board and now had national approval. Enabling works are well underway.
	A reduction in backlog maintenance is achieved including the delivery of clear risk assessments of critical infrastructure.	The Trust continues to invest in backlog maintenance at the Stepping Hill Hospital site. It should be noted that given the age of the estate, a long-term reduction in backlog maintenance is considered unachievable without significant investment. However, targeted investment continues centred around CIR to manage any associated risk, noting that all backlog investment is risk assessed.

NHS
Stockport
NHS Foundation Trust

Meeting date	3rd August 2023	x	Public		Confidential	Agenda item
Meeting	Board of Directors					
Title	Corporate Objectives Outcome Measures 2023/24					
Lead Director	Karen James, Chief Executive		Author	Jonathan O'Brien, Director of Strategy and Partnerships		

Recommendations made / Decisions requested:

The Board of Directors is asked to review the Trust Objectives and **approve** the key outcome measures for 2023/24.

This paper relates to the following Corporate Annual Objectives:

x	1	Deliver personalised, safe and caring services
	2	Support the health and wellbeing needs of our community and colleagues
	3	Develop effective partnerships to address health and wellbeing inequalities
	4	Develop a diverse, talented and motivated workforce to meet future service and user needs
	5	Drive service improvement through high quality research, innovation and transformation
	6	Use our resources efficiently and effectively
	7	Develop our estate and digital infrastructure to meet service and user needs

This paper relates to the following CQC domains:

x	Safe	x	Effective
x	Caring	x	Responsive
x	Well-Led	x	Use of Resources

This paper relates to the following Board Assurance Framework risks:

x	PR1.1	There is a risk that the Trust does not deliver high quality care to service users
	PR1.2	There is a risk that patient flow across the locality is not effective
	PR1.3	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan
	PR2.1	There is a risk that the Trust is unable to sufficiently engage and support our people's wellbeing
	PR2.2	There is a risk that the Trust's services do not fully support neighbourhood working
	PR3.1	There is a risk in implementing the new provider collaborative model to support delivery of Stockport ONE Health & Care (Locality) Board priorities
	PR3.2	There is a risk that the Trust does not deliver a joint clinical strategy with East Cheshire NHS Trust

	PR4.1	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit and retain the optimal number of staff, with appropriate skills and values
	PR4.2	There is a risk that the Trust's workforce is not reflective of the communities served
	PR5.1	There is a risk that the Trust does not implement high quality transformation programmes
	PR5.2	There is a risk that the Trust does not implement high quality research & development programmes
	PR6.1	There is a risk that the Trust does not deliver the annual financial plan
	PR6.2	There is a risk that the Trust does not develop and agree with partners a multi-year financial recovery plan
	PR7.1	There is a risk that the Trust does not implement the Digital Strategy to ensure a resilient and responsive digital infrastructure
	PR7.2	There is a risk that the estate is not fit for purpose and/or meets national standards
	PR7.3	There is a risk that the Trust does not materially improve environmental sustainability
	PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus

Where issues are addressed in the paper:

	Section of paper where covered
Equality, diversity and inclusion impacts	N/A
Financial impacts if agreed/ not agreed	N/A
Regulatory and legal compliance	N/A
Sustainability (including environmental impacts)	N/A

Executive Summary:

The attached paper outlines the Trust Objectives for 2023/24 and aligned key outcomes measures that will provide a basis for improvements.

The Trust Board has already approved the overarching Trust Objectives for 2023/24 and is now asked to **review** and **approve** the key outcome measures for 2023/24.

Our Objectives for 2023/24

NHS Stockport NHS Foundation Trust

1. Deliver personalised, safe and caring services.
2. Support the health and wellbeing needs of our community and colleagues.
3. Develop effective partnerships to address health and wellbeing inequalities.
4. Develop a diverse, talented and motivated workforce to meet future service and user needs.
5. Drive service improvement through high quality research, innovation and transformation.
6. Use our resources efficiently and effectively.
7. Develop our Estate and Digital infrastructure to meet service and user needs.

Our Vision

To work with partners to improve health and wellbeing outcomes for the communities we serve

Our Values & Our Mission

We Care
About each other; our patients and their families; the communities we serve; and the environment.

We Respect
Each other; our patients and their families; and our partners.

We Listen
To each other; our patients and their families; and our partners.

Our Mission
Making a difference every day.

Corporate Objectives 2023/24 We Will:	Key Outcome Measures *How will we know we will have achieved our objectives?*	Local Requirement	Greater Manchester Requirement	National Requirement	NHS Long Term Plan
1 - Deliver personalised, safe and caring services.	Deliver national waiting time / performance requirements, including: • 76% seen within 4hrs in ED by March 2024	✓	✓	✓	
	• 97% G&A bed occupancy by Mar 24 and Critical Care bed occupancy at 92%	✓	✓		
	• Eliminate waits of over 65 weeks for elective care by Mar 24	✓	✓	✓	
	• Reduce NCtR to 73 by Mar 24	✓	✓		
	• 100% ambulance handovers within 60 mins.	✓	✓	✓	
	• < 82 cancer patients waiting over 62 days by Mar 24	✓	✓	✓	
	• 75% performance against cancer faster diagnosis standard by Mar 24	✓	✓	✓	
	• 90% of diagnostic tests in under 6 weeks by Mar 24	✓	✓	✓	
	• 80% Virtual Ward beds occupancy by Mar 24	✓	✓	✓	
	• 85% Theatre Utilisation	✓	✓	✓	
	• Move5% of outpatient attendances to PIFU by Mar 24	✓	✓	✓	
	• 70% of Urgent community responses <2 hours	✓	✓	✓	
	Secure a local Ophthalmology service through a partnership with Tameside & Glossop Integrated Care NHS FT	✓	✓		
	New incident reporting system (PSIRF) is embedded across the organisation.			✓	
	Improve the quality and safety of our services through delivery of the Quality Strategy Objectives for 2023/24.	✓			
	Meet maternity safety standards and CNST maternity requirements.	✓	✓	✓	✓
	Enhance and embed the end of life care model.	✓			
	Continue the roll out of the STARS Accreditation Programme, improving the number of areas achieving 'green' status.	✓			
	SIs are reporting within 48 hours and a software system for all SIs is embedded across the organisation.	✓			
	Complete a well led assessment against key lines of enquiry.	✓		✓	
2 - Support the health and wellbeing needs of our community and colleagues	Reduce sickness and absence levels through the roll out of the Trust's new Health and Wellbeing Policy.	✓			✓
	The Locality Provider Collaborative has established programmes to improve primary/secondary health and wellbeing outcomes through evidence based interventions.	✓			
3 - Develop effective partnerships to address health and wellbeing inequalities.	In collaboration with partners and stakeholders, a Locality Plan is developed which is aligned with the GM ICP Strategy.	✓	✓		
	Begin to integrate corporate functions across Tameside and Stockport which includes HR, BI, IT, Strategy and Estates.	✓			
	Continue to explore areas for collaboration across clinical services across Tameside & Glossop and Stockport FTs.	✓			

Corporate Objectives 2023/24 We Will:	Key Outcome Measures *How will we know we will have achieved our objectives?*	Local Requirement	Greater Manchester Requirement	National Requirement	NHS Long Term Plan
	Progress the agreed plan to support a centralised model for Stockport's Intermediate Care Bed Base.	✓			
	The Trust Strategy is refreshed during 2023/24 financial year (Q4).	✓			
	The Trust Planning round is undertaken and completed in Q3-Q4 2023/24.	✓	✓	✓	
4 - Develop a diverse, talented and motivated workforce to meet future service and user needs	Increase integrated workforce models through the development of Trust outcomes.	✓			
	Complete a Medical Workforce Plan for those difficult to recruit specialties.	✓			
	Implement the Trust's Equality, Diversity and Inclusion Strategy objectives for 2023/24.	✓		✓	✓
	Improve retention and reduce bank and agency usage in accordance with the Trust improvement trajectories.	✓	✓	✓	✓
	Respond to staff survey feedback to demonstrate improvements.	✓			
5 - Drive service improvement through high quality research, innovation and transformation.	Develop locality-wide research programmes through facilitation of system wide trials.	✓			
	Implement the Trust Research and Development Strategy objectives for 2023/24.	✓			
	To deliver, in partnership, the Community Diagnostic Centre, to the agreed specification and within Q4 2023/24.	✓	✓	✓	
	Complete an update of the Trust's website.	✓			
6 - Use our resources efficiently and effectively.	Deliver the Trust's Financial, Revenue and Capital Plan.	✓	✓	✓	
	Deliver the Trust's financial efficiency programme (STEP/CIP).	✓	✓		
	Complete the final accounts for the year end which receive a compliant audit report.	✓		✓	
	Achieve greater productivity and efficiency levels in endoscopy, outpatients, theatre, day cases, LoS, to achieve upper quartile performance levels (model hospital).	✓			
7 - Develop our Estate and Digital infrastructure to meet service and user needs.	Deliver the Emergency Department (ED) expansion scheme.	✓			
	An EPR Business Case and recruitment process is completed across both Tameside and Stockport Foundation Trusts	✓		✓	
	The rollout of the new digital Laboratory Information System is completed.	✓	✓		
	Complete the Meadows PFI handback process.	✓			
	Develop and implement a Way Finding Strategy.	✓			
	Deliver the Trust's Green Plan objectives for 2023/24.	✓		✓	
	Continue the delivery of the PFI optimisation work and complete the PFI DRP process.	✓			
	Continue to engage key stakeholders in the development of the new	✓			

Corporate Objectives 2023/24 We Will:	Key Outcome Measures *How will we know we will have achieved our objectives?*	Local Requirement	Greater Manchester Requirement	National Requirement	NHS Long Term Plan
	hospital OBC and to complete a transition plan for the hospital site to address the poor capital stock which will include Outpatients B and Pathology.				

NHS
Stockport
NHS Foundation Trust

Meeting date	3rd August 2023	X	Public		Confidential	Agenda item
Meeting	Board of Directors					
Title	Stockport Locality Board Priorities					
Lead Director	Jonathan O'Brien, Director of Strategy & Partnerships		Author		Jonathan O'Brien, Director of Strategy and Partnerships	

Recommendations made / Decisions requested:

The Board of Directors is asked to discuss and note the priorities identified by the Stockport Health and Care (Locality) Board and the engagement of Trust Executives with emerging system architecture.

This paper relates to the following Corporate Annual Objectives:

	1	Deliver personalised, safe and caring services
x	2	Support the health and wellbeing needs of our community and colleagues.
x	3	Develop effective partnerships to address health and wellbeing inequalities.
	4	Develop a diverse, talented and motivated workforce to meet future service and user needs.
	5	Drive service improvement through high quality research, innovation and transformation.
	6	Use our resources efficiently and effectively.
	7	Develop our Estate and Digital infrastructure to meet service and user needs.

The paper relates to the following CQC domains:

	Safe	x	Effective
	Caring	x	Responsive
x	Well-Led		Use of Resources

This paper relates to the following Board Assurance Framework risks

x	PR1.1	There is a risk that the Trust does not deliver high quality care to service users
	PR1.2	There is a risk that patient flow across the locality is not effective
	PR1.3	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan
x	PR2.1	There is a risk that the Trust is unable to sufficiently engage and support our people's wellbeing
x	PR2.2	There is a risk that the Trust's services do not fully support neighbourhood working
x	PR3.1	There is a risk in implementing the new provider collaborative model to support

		delivery of Stockport ONE Health & Care (Locality) Board priorities
	PR3.2	There is a risk that the Trust does not deliver a joint clinical strategy with East Cheshire NHS Trust
	PR4.1	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit and retain the optimal number of staff, with appropriate skills and values
x	PR4.2	There is a risk that the Trust's workforce is not reflective of the communities served
x	PR5.1	There is a risk that the Trust does not implement high quality transformation programmes
	PR5.2	There is a risk that the Trust does not implement high quality research & development programmes
	PR6.1	There is a risk that the Trust does not deliver the annual financial plan
	PR6.2	There is a risk that the Trust does not develop and agree with partners a multi-year financial recovery plan
	PR7.1	There is a risk that the Trust does not implement the Digital Strategy to ensure a resilient and responsive digital infrastructure
	PR7.2	There is a risk that the estate is not fit for purpose and/or meets national standards
	PR7.3	There is a risk that the Trust does not materially improve environmental sustainability
	PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus

Where issues are addressed in the paper:

	Section of paper where covered
Equality, diversity and inclusion impacts	N/A
Financial impacts if agreed/ not agreed	N/A
Regulatory and legal compliance	N/A
Sustainability (including environmental impacts)	N/A

Executive Summary

The paper briefs the Board of Directors on:

- The Stockport Health and Care Board priorities.
- The Stockport Provider Partnership priorities.
- The Trust Executive engagement and leadership within the emerging locality structures.

The Trust Board is asked to discuss and note the paper and priorities identified, including the initial workstreams of the Provider Partnership which the Trust leads.

Stockport Locality Board

1.0 On 1 July 2022, statutory functions previously held by Stockport Clinical Commissioning Group transferred to the Greater Manchester Integrated Care Board (GMICB) as part of the legislative proposals outlined in the Health & Care Act (2022).

2.0 These legislative changes require adjustments to the local operating models. This involved the creation of a Stockport Locality Board and associated structures.

3.0 The changes represent an opportunity to build on previous integration efforts and seek to align the health and care providers of Stockport towards greater partnership working to improve outcomes for the local population.

4.0 The Stockport Health and Care Board was therefore formally established in July 2023 following the dissolution of Clinical Commissioning Groups (CCGs) and the establishment of the Greater Manchester Integrated Care Board (ICB).

5.0 As part of the new arrangements, Locality Boards were formed in each of the ten boroughs of Greater Manchester and the *Stockport Health and Care Board* is the borough's response to this requirement.

6.0 The membership of the Health and Care Board is varied and inclusive, as detailed below.

Leader - Stockport Metropolitan Borough Council (SMBC) - Chair
Place Based Lead for Health and Care Integration (Chief Executive) - SMBC
Deputy Place Based Lead for Heath and Care/Delivery Lead – GM ICS Stockport
Associate Medical Director - GM ICS Stockport
Chief Executive - Health Watch
Chief Executive or Deputy Chief Executive Officer - Pennine Care NHS Foundation Trust
Chief Executive - Sector 3
Chief Executive - Stockport Homes
Chief Executive - Stockport NHS Foundation Trust
Chief Finance Officer - Stockport NHS Foundation Trust
Chief Superintendent (Co-Chair of Safer Stockport Partnership) Greater Manchester Police
Corporate Director People and Integration (Chair of Stockport Family) - SMBC
Director of Adult Social Services - SMBC
Director of Public Health – SMBC
Director of Strategy & Partnerships - Stockport NHS Foundation Trust
Executive Representative GM Integrated Care (currently Chief Nurse GM ICS)
Primary Care Representative - Viaduct
Place Health and Care Finance Lead - SMBC
Place Health and Care Strategy Lead - SMBC

7.0 The Trust is represented by the Chief Executive, Chief Finance Officer / Deputy Chief Executive and the Director of Strategy and Partnerships.

8.0 The Health and Care Board meets monthly and all meetings are held in public.

9.0 The Health and Care Board is jointly accountable to the Stockport Health and Wellbeing Board and Greater Manchester Integrated Care Board, as laid out in the agreed Terms of Reference.

10.0 The Health and Care Board has identified 12 key priorities for it's work across the borough. These are:

I. Overall – Healthy Life Expectancy and Inequalities
II. Infant Mortality
III. Child Development at 2.5yrs
IV. % of young people Not in Education, Employment or Training (NEET)
V. Physical Activity levels children and adults
VI. Households in poverty
VII. Housing and homelessness
VIII. Smoking inequality between vulnerable groups and general population
IX. Age of onset of multimorbidity
X. Falls / frailty prevalence
XI. Dementia prevalence
XII. Alcohol related harm

11.0 Work programmes and deliverables are currently being established.

Stockport Provider Partnership

12.0 The Provider Partnership has also been established, reporting to the Health and Care Board. This has a broad membership of provider organisations in the Stockport locality.

13.0 The Provider Partnership is Chaired by the Chief Executive of Stockport NHS Foundation Trust (SFT) and is supported by the Director of Strategy and Partnerships and SFT's Strategy and Partnerships Team.

14.0 Core members of the Provider Partnership include:

Chief Executive - Stockport NHS Foundation Trust
Chief Nurse - Pennine Care NHS Foundation Trust
Director of Adult Social Services - SMBC
Director of Public Health – SMBC
Primary Care Representative - Viaduct
Chief Executive - Sector 3
Chief Executive - Health Watch
Director of Strategy & Partnerships - Stockport NHS Foundation Trust

Additionally, the Provider Partnership is supported by:

- Director of Public Health from Stockport MBC
- Senior Public Health Leads
- Associate Medical Director – GM ICS Stockport
- Director of Finance Representative – SMBC/SFT
- Director of Transformation - Stockport NHS Foundation Trust

15.0 The Stockport Provider Partnership has agreed four key areas of priority to work on in 2022/23 specifically relating to improving outcomes in four key areas for the population where key outcomes could be improved and inequalities persist. These four areas are:

I. Diabetes
II. Cardiovascular Disease
III. Frailty
IV. Alcohol Related Harm

16.0 These have also been chosen by the members of the Provider Partnership as they are areas which require a multi-provider response for true end-to-end pathway redesign and improvement of outcomes, for which one provider alone would be unable to effect.

17.0 These areas are currently undergoing scoping for work programmes to be put together. This will include a review of ongoing work in the areas, appointment of a Provider Partnership SRO, clarification of outcomes relating to these areas at neighbourhood level and a review of evidence based guidance of best practice in each area.

Recommendation

18.0 The emerging architecture of GM ICS and associated governance continues to evolve, informed in particular by the external review which is currently concluding and issuing recommendations. In the interim, the paper has described the latest position from a locality perspective on the Locality Board and Provider Partnership.

19.0 The Trust Board is asked to **discuss and note** the briefing, including priorities identified by the Locality Board and the initial workstreams of the Provider Partnership which the Trust leads.

NHS Stockport NHS Foundation Trust

Meeting date	3rd August 2023	x	Public		Confidential	Agenda item
Meeting	Board of Directors					
Title	Integrated Performance Report					
Lead Director	Chief Executive		Author	Director of Informatics		

Recommendations made / Decisions requested

The Board of Directors is asked to review and discuss:

- Performance against the reported metrics;
- The described issues that are affecting performance;
- The actions described to mitigate and improve performance in the exception reports.

This paper relates to the following Corporate Annual Objectives-

x	1	Deliver personalised, safe and caring services
x	2	Support the health and wellbeing needs of our community and colleagues.
	3	Develop effective partnerships to address health and wellbeing inequalities.
x	4	Develop a diverse, talented and motivated workforce to meet future service and user needs.
x	5	Drive service improvement through high quality research, innovation and transformation.
x	6	Use our resources efficiently and effectively.
	7	Develop our Estate and Digital infrastructure to meet service and user needs.

The paper relates to the following CQC domains-

x	Safe	x	Effective
x	Caring	x	Responsive
x	Well-Led	x	Use of Resources

This paper relates to the following Board Assurance Framework risks

x	PR1.1	There is a risk that the Trust does not deliver high quality care to service users
x	PR1.2	There is a risk that patient flow across the locality is not effective
x	PR1.3	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan
x	PR2.1	There is a risk that the Trust is unable to sufficiently engage and support our people's wellbeing
	PR2.2	There is a risk that the Trust's services do not fully support neighbourhood working
	PR3.1	There is a risk in implementing the new provider collaborative model to support delivery of Stockport ONE Health & Care (Locality) Board priorities
	PR3.2	There is a risk that the Trust does not deliver a joint clinical strategy with East

		Cheshire NHS Trust
x	PR4.1	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit and retain the optimal number of staff, with appropriate skills and values
	PR4.2	There is a risk that the Trust's workforce is not reflective of the communities served
x	PR5.1	There is a risk that the Trust does not implement high quality transformation programmes
	PR5.2	There is a risk that the Trust does not implement high quality research & development programmes
x	PR6.1	There is a risk that the Trust does not deliver the annual financial plan
	PR6.2	There is a risk that the Trust does not develop and agree with partners a multi-year financial recovery plan
	PR7.1	There is a risk that the Trust does not implement the Digital Strategy to ensure a resilient and responsive digital infrastructure
x	PR7.2	There is a risk that the estate is not fit for purpose and/or meets national standards
	PR7.3	There is a risk that the Trust does not materially improve environmental sustainability
	PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus

Where issues are addressed in the paper-

	Section of paper where covered
Equality, diversity and inclusion impacts	
Financial impacts if agreed/ not agreed	Highlight section
Regulatory and legal compliance	All sections
Sustainability (including environmental impacts)	

Executive Summary

Performance against the associated metrics for the last available month (June 2023 for the majority of indicators) is reported.

Exception reports have been provided for areas of most significant note.

Integrated Performance Report

Report Period June 2023

Integrated Performance Report - Introduction

Introduction

This report provides the Trust Board with an overview of the Trust's performance across a range of Quality, Operational, Workforce and Financial metrics. The report includes a dashboard that incorporates metrics from the Single Oversight Framework. The dashboard details the in-month and year- to- date performance for each metric along with an indicative forecast for next month.

Quality Highlights

Exception reports included this month relate to performance against Mortality, Sepsis, Infection Prevention metrics, Pressure Ulcers, and Complaints due to under-achievement in month.

Sepsis antibiotic compliance continues to be a challenge with the majority of red-flag fails during out-of-hours. Themes related to delayed prescribing and poor clinician compliance with completing Sepsis 6.

Infection rates for C.diff, E.coli, and MRSA and MSSA are all above the thresholds for improvement set by UKHSA, although C.diff infection rates have shown some recent improvement.

The medication incident rate and number of STEIS reportable incidents are both reported within the new thresholds set for 2023/24. All incidents continue to be reviewed on a weekly basis.

Performance against all falls measures have been within the thresholds for 3 consecutive months.

Complaints response rates are below the new thresholds set for 2023/24 for the second month running. Although most divisions are now compliant with their complaint response times, the Division of Surgery continues to underperform.. The Division is currently focusing on complaint processes in order to improve compliance.

Operational Highlights

Exception reports included this month relate to performance against ED, Patient Flow, Diagnostics, Cancer, RTT, Outpatient Efficiency and Theatre Efficiency metrics due to under-achievement in month.

ED is showing positive improvement against the 4-hour standard and new 12-hour metric, despite average attendances trending higher than the 2021/22 baseline. Patient flow continues to be impacted by challenges accessing timely care- home beds and community packages. The loss of an additional 20 discharge-to-assess beds with an independent provider has added to this challenge.

Diagnostics performance is showing significant improvement, although still above target thresholds. ECG remains the biggest area of challenge, with staffing being the biggest pressure.

Cancer activity remains extremely challenged and it is anticipated that performance will continue to be impacted by industrial action in the coming months.

Although the outpatient efficiency metrics fall short of local targets, the Trust continues to benchmark positively compared to GM and national peers for DNA rates and use of Patient Initiated Follow Up. Clinic utilisation is also performing well.

Theatre performance continues to benchmark well against both regional and national peers, and there have been good signs of improvement since April on both main theatre list utilisation and average cases per list.

Workforce Highlights

Exception reports included this month relate to Turnover, Mandatory Training, Appraisal Rates, and Agency Costs due to under-performance in month.

Workforce turnover has remained stable and reduced slightly in month; however, it remains over target at 13.8% for June against the 12.5% target.

While mandatory training continued to improve in month to 93.16%, it remains below target. To support improvement further mandatory training days will be held quarterly, providing colleagues with the opportunity to complete both their face-to-face and e-learning training elements within one day.

Agency usage was above the 3.7% target at 5.7%; the main drivers for this spend are additional staff required to cover vacancies, the impact of industrial action, and support of the continued use of escalation beds. Agency rates / usage continues to be scrutinised at the weekly Staffing Approval Group (SAG) and recruitment events are on-going in order to increase substantive staff in post to mitigate agency spend.

Financial Highlights

The Trust has submitted a plan with an expected deficit of £31.5m for the financial year 2023-24. The deficit assumes delivery of an efficiency target of £26.2m, of which £10.3m is recurrent.

At month 3, the Trust position is £0.9m adverse to plan – a deficit of £9.3m. This is an improvement of £0.3m in month, which relates to increased non-recurrent CIP delivery.

The drivers of the movement from plan are the impact of industrial action by junior doctors, undelivered efficiency savings, and the cost of the pay award for 2023-24 over and above expected funding.

The Trust continues to operate with additional capacity open in escalation beds and enhanced staffing levels to support the high level of attendances in the Emergency Department.

The CIP plan for 2023-24 is £26.2m (£10.3m recurrent). The CIP plan for month 3 was £6.1m; at this point the Trust is behind plan by £1.1m. The majority of the CIP delivered is non-recurrent. Further work is ongoing to identify recurrent schemes.

The Trust has maintained sufficient cash to operate during June.

The Capital plan for 2023-24 is £62.7m as per the latest plan submission, which is subject to final confirmation with GM ICS. At month 3, expenditure is behind plan by £3.3m; however, this spend will be re-profiled into future months.

Integrated Performance Report - Scorecard

	Reporting Period	Target 23/24	Actual YTD	6-mth Trend	Actual Month	Current Period	1-mth Forecast
Quality Scorecard							
Mortality: SHMI	Mar-22 to Feb-23	≤ 100		→	99	●	▲
Sepsis: Timely recognition	Jul-22 to Jun-23	≥ 90%		↓	94.1%	●	●
Sepsis: Antibiotic administration	Jul-22 to Jun-23	≥ 90%		↓	72.9%	▲	▲
C.diff infection rate	Jul-22 to Jun-23	≤ 17.63		↗	54.51	▲	▲
Covid-19 infection rate	Jul-22 to Jun-23	≤ 4.27		↑	3.96	●	●
E. coli infection rate	Jul-22 to Jun-23	≤ 20.27		↓	116.87	▲	▲
MRSA infection rate	Jul-22 to Jun-23	≤ 0		↓	2.62	▲	▲
Medication incident rate	Jan-23 to Jun-23	≤ 4.64		→	4.59	●	▲
Patient safety incident rate	Jan-23 to Jun-23	≤ 69.24		↘	70.78	▲	▲
STEIS reportable incidents	Jun-23	≤ 4	10	→	3	●	●
Stroke: Overall SSNAP Level	Mar-23	≥ C		→	A	●	●
Falls causing moderate+ harm	Jun-23	≤ 22	3	→	1	●	●
Falls due to lapses in care	Jun-23	≤ 425	75	↑	22	●	●
Falls rate	Jun-23	≤ 3.51	2.91	→	3.14	●	●
Pressure Ulcers: Hospital, Cat 2	Jun-23	≤ 79	14	→	5	●	●
Pressure Ulcers: Hospital, Cat 3&4	Jun-23	≤ 8	4	↘	1	▲	▲
Pressure Ulcers: Community, Cat 2	May-23	≤ 114	28	→	9	●	▲
Pressure Ulcers: Community, Cat 3&4	May-23	≤ 38	7	→	4	▲	▲
Complaints: Timely response	Jun-23	≥ 95%	85.7%	→	93.5%	▲	▲
Complaints: Written Complaints Rate	Jun-23	≤ 7.9	6.87	→	7.3	●	●
Early Neonatal Deaths	Jun-23	≤ 0	0	→	0	●	●
Registrable Stillbirths	Jun-23	≤ 0	1	→	0	●	●
Smoking In Pregnancy	Jun-23	≤ 10%	6.2%	↗	4.8%	●	●

	Reporting Period	Target 23/24	Actual YTD	6-mth Trend	Actual Month	Current Period	1-mth Forecast
Operational Scorecard							
Ambulance handover delays	Mar-23	≤ 5%	23%	→	22.6%	▲	▲
4hr Standard	Jun-23	≥ 76%	67%	↑	70.7%	▲	▲
Patients in department over 12 hrs	Jun-23	≤ 2%	6%	↑	4.8%	▲	▲
No criteria to reside (NCTR)	Jun-23	≤ 73	303	↑	101	▲	▲
Diagnostics: 6 Week Standard	Jun-23	≤ 5%	12.4%	↑	12.6%	▲	▲
62-day standard	Jun-23	≥ 85%	48.9%	↓	49.5%	▲	▲
28-day standard (FDS)	Jun-23	≥ 75%	64.6%	↘	64.2%	▲	▲
14-day standard (2WW)	Jun-23	≥ 93%	97.4%	→	97.5%	●	●
Incomplete pathways 18-week %	Jun-23	≥ 92%		↘	48.7%	▲	▲
52-week breaches	Jun-23	≤ 0		↓	4205	▲	▲
65-week breaches	Jun-23	≤ 0		↑	1171	▲	▲
Activity vs. Plan: Elective	Jun-23	≥ 100%	105.2%	↘	98.2%	▲	▲
Activity vs. Plan: Outpatient	Jun-23	≥ 100%	102.7%	↗	100.2%	●	●
Activity vs. Plan: ED Attendances	Jun-23	≤ 100%	98%	↗	100.1%	▲	▲
Outpatient DNA rate	Jun-23	≤ 6.3%	7.7%	↗	7.7%	▲	▲
Outpatient clinic utilisation	Jun-23	≥ 90%	89.9%	↑	89.9%	▲	▲
Patient initiated follow up (PIFU)	Jun-23	≥ 3.84%	3.1%	→	3%	▲	▲
Capped Touch Time Utilisation	Jun-23	≥ 85%	75.5%	↗	76%	▲	▲
Average cases per 4-hour session	Jun-23	≥ 2.4	2.12	↗	2.15	▲	▲
Workforce Scorecard							
Substantive Staff-in-Post	Jun-23	≥ 90%	91.4%	↘	91.2%	●	●
Sickness Absence: Monthly Rate	Jun-23	≤ 6%	5.8%	↗	5.7%	●	●
Workforce Turnover	Jun-23	≤ 12.5%	14.7%	→	13.8%	▲	▲
Staff Retention Rate	Jun-23		98.9%	→	99.1%	○	○
Appraisal Rate: Overall	Jun-23	≥ 95%	89%	↗	88.4%	▲	▲
Mandatory Training	Jun-23	≥ 95%	93.2%	↗	93.9%	▲	▲
Agency Costs %	Jun-23	≤ 3.7%	6.4%	↑	5.7%	▲	▲
Finance Scorecard							
Capital Expenditure	Jun-23	≤ 10%		↗	-50.9%	●	●
Cash Balance	Jun-23			→	36.5	○	○
CIP Cumulative Achievement	Jun-23	≥ 0%		↘	-18%	▲	▲
Financial Controls: I&E Position	Jun-23	≤ 0%		↘	11.1%	▲	▲

Legend

1-month Forecast

The 1-month Forecast is an informed prediction of the next month's performance, which may be based on part-month data, operational intelligence, or historical trends.

Current Period

- ● target achieved
- ▲ target not achieved

6-month Trend

- ↑ strong improvement
- ↗ improvement
- → no significant change
- ↘ deterioration
- ↓ strong deterioration

Integrated Performance Report - Exception

Quality: Mortality		Target	Actual	6-month Trend	Previous Performance	1-month Forecast
SHMI	The Summary Hospital-level Mortality Indicator (SHMI) shows the ratio of actual deaths to the expected number of deaths up to 30 days after discharge from hospital.	<= 100	99			

The SHMI shows the ratio of the observed to the expected number of deaths up to 30 days after discharge from hospital, multiplied by 100. A value greater than 100 means that the patient group being studied has a higher mortality level than expected based on English NHS averages. Data sourced from the Healthcare Evaluation Data (HED) system.

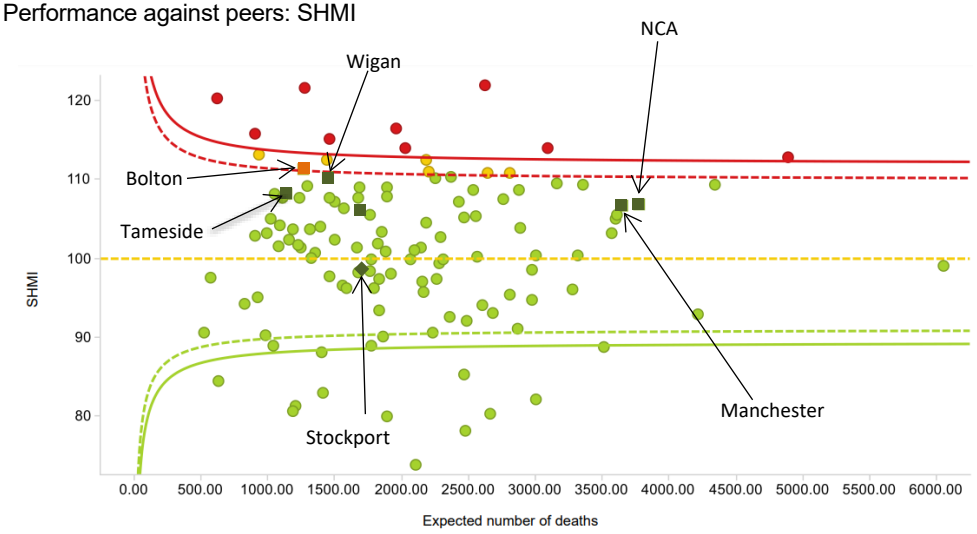
Stockport's mortality rate is reported as "within range" and is currently in the green zone. All other GM Trusts are reported this way.

The SHMI index is currently 99 for the period January 2023 to March 2023. This is currently below 100 hence our mortality is lower than expected.

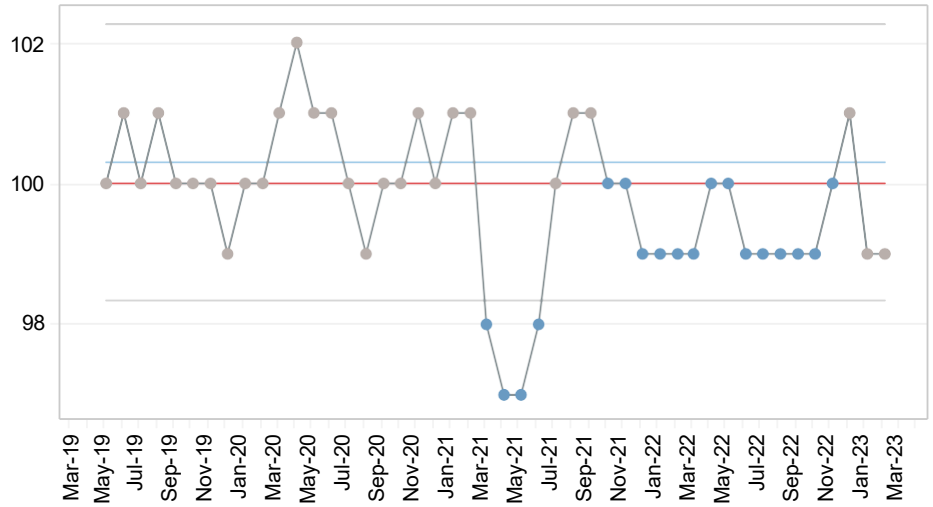
A lot of valuable work is ongoing in the areas of coding, sepsis, and missed and batched NEWS observations on wards. No issues identified.

Signed off by	Tushar Mahambrey
Executive Lead	Andrew Loughney

Performance against peers: SHMI



Monthly Performance for Mortality: SHMI



Integrated Performance Report - Exception

Quality: Sepsis		Target	Actual	6-month Trend	Previous Performance	1-month Forecast
Sepsis: Timely recognition	The number of patients who are screened for sepsis, as a percentage of those eligible patients audited.	>= 90%	94.1%	↓	● ● ● ● ● ●	●
Sepsis: Antibiotic administration	The number of patients who received IV antibiotics within agreed timescales for sepsis patients, as a percentage of eligible patients audited and found to have sepsis.	>= 90%	72.9%	↓	▲ ▲ ▲ ▲ ▲ ▲	▲

Performance is based on an audit sample of patients, and is based on data from a rolling 12-month period.

Timely Recognition
- 94% Timely Recognition June 2023.
- 12 month rolling figure now 94%.
- 77 records included in audit- 72 compliant.
- 4 fails related to Red Flag triggers, 1 amber flag fail.
- 4/5 fails occurred OOH.
- All fails occurred within Medicine Division.
- Themes- underutilisation 2222 and late completion screening tool.

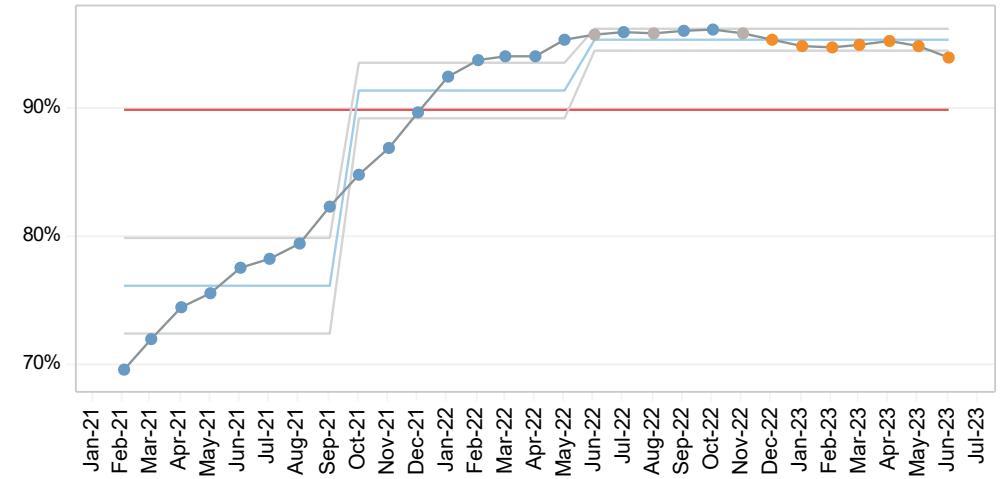
Key Actions July
- Toolbox Theme: Sepsis screening tool. 70 staff trained via toolbox sessions in June in addition to clinical induction, care certificate and AIMS courses. Ongoing daily toolboxes planned for July- focus night teams as needed.
- Next Webex link nurse meeting 19th July to focus upon cascade training- sepsis assessment tool.
- Distribute summer edition Sepsis Scoop to raise visibility of sepsis team.

Antibiotic Compliance
- June compliance at 73%.
- 12- month rolling figure now 73%.
- 15/77 patients audited were treated for suspected sepsis in June: of these 11 received antibiotics in accordance with trust guidelines.
- All 4 fails involved Red Flag Triggers.
- 3/4 fails occurred OOH.
- 3/4 fails occurred within Medicine Division.
- Average delay of antibiotics was 68 min.
- No incidents identified to have caused harm.
- Themes: delayed prescribing as a result of late/ incorrect escalation, nurse delays administering antibiotics, insufficient compliance completing sepsis6.

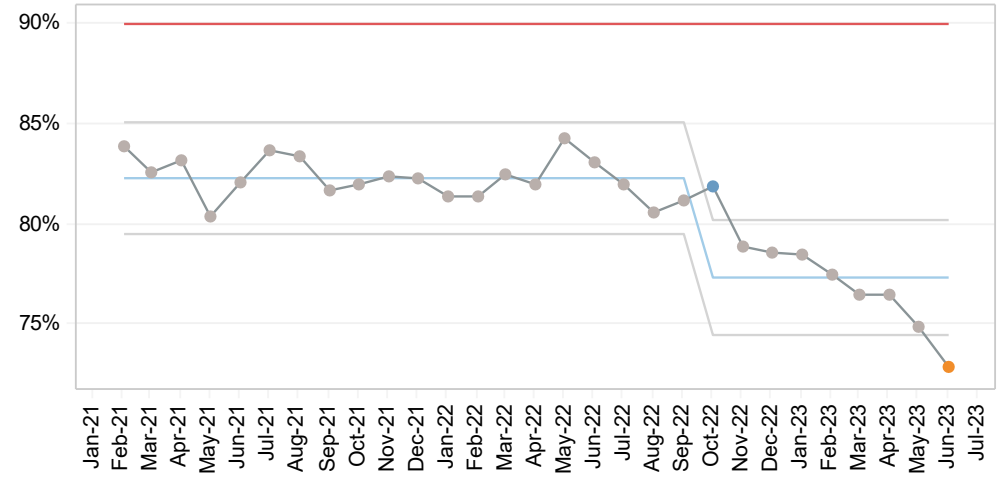
Key Actions July
- Distribute posters for clinicians to drive sepsis6 compliance.
- Webex link nurse meeting 19th July to drive cascade training.
- Datix all antibiotic fails regardless delay to drive focus.
- Await NICE guidance change to guidelines. Was due 28/6/23.

Signed off by	Emily Abdy
Executive Lead	Nicola Firth

Performance for Sepsis: Timely recognition



Performance for Sepsis: Antibiotic administration



Integrated Performance Report - Exception

Quality: Infection Rates

		Target	Actual	6-month Trend	Previous Performance	1-month Forecast
C.diff infection rate	The number of hospital-onset Clostridioides Difficile (C. diff) infections per 100,000 bed days for patients aged 2 years and older.	<= 17.63	54.51			
Covid-19 infection rate	The number of Covid-19 infections per 1,000 bed days.	<= 4.27	3.96			

Performance is based on data from a rolling 12-month period. Performance for the current month is based on pre-validated data, and a fully validated position is updated one month in arrears.

C.diff
There were 9 HOHA and 2 COHA cases in June, totalling 24 YTD. The Trust is over the projected threshold of 10 for the end of June.

17 cases have been presented to the HCAI Panel. 4 Cases have been deemed Avoidable and 13 Cases deemed Unavoidable. 1 case requires further investigation after panel review and 6 cases await panel review in July.

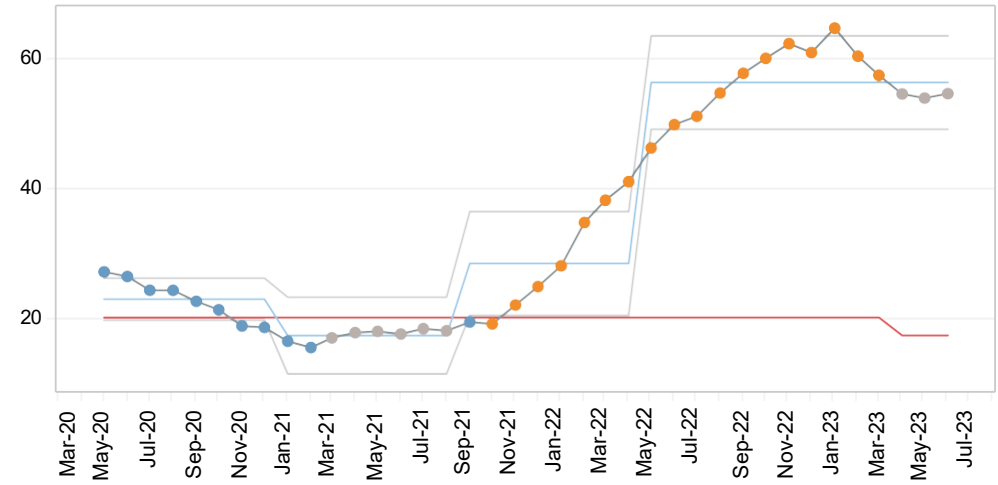
Actions
Stockport FT are part of a collaborative quality initiative project to improve shared learning around Clostridium difficile.

Covid-19
The Trust has reported 6 covid positive cases in June with 4 of these being nosocomial. This is a decrease of 11 positive cases and 8 HOC case numbers on the previous month. The Trust currently has a rate of 67% against a Northwest rate of 44%. This is a decrease of 4% in HOC rate from last month and a decrease in the Northwest rate of 4%.

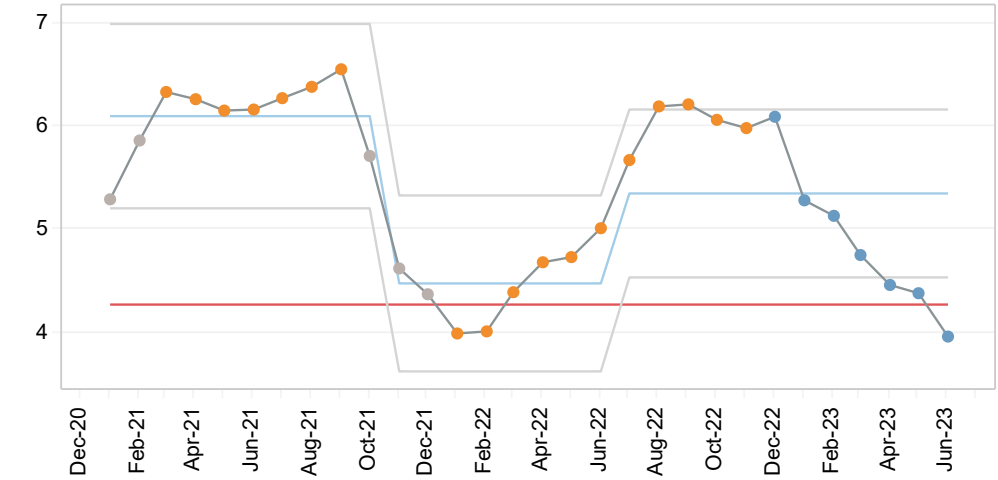
Actions
Continue to follow national government guidance.

Signed off by	Christine Glynn
Executive Lead	Nicola Firth

Performance for C.diff infection rate



Performance for Covid-19 infection rate



Integrated Performance Report - Exception

Quality: Infection Rates (continued...)		Target	Actual	6-month Trend	Previous Performance	1-month Forecast
E. coli infection rate	The number of Escherichia Coli (E. coli) bacteraemia infections per 100,000 bed days.	<= 20.27	116.87	↓	▲ ▲ ▲ ▲ ▲ ▲	▲
MRSA infection rate	The number of hospital-onset Methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemia infections per 100,000 bed days.	<= 0	2.62	↓	▲ ▲ ▲ ▲ ▲ ▲	▲

Performance is based on data from a rolling 12-month period. Performance for the current month is based on pre-validated data, and a fully validated position is updated one month in arrears.

E.coli
The UKHSA published their thresholds for 2023-24 in May and the Trust has been set a threshold of 46 cases. Each Division is apportioned a share of those cases. There were 7 HOHA cases in June, totalling 17 cases YTD. The Trust is over the projected threshold of 11.5 for the end of June.

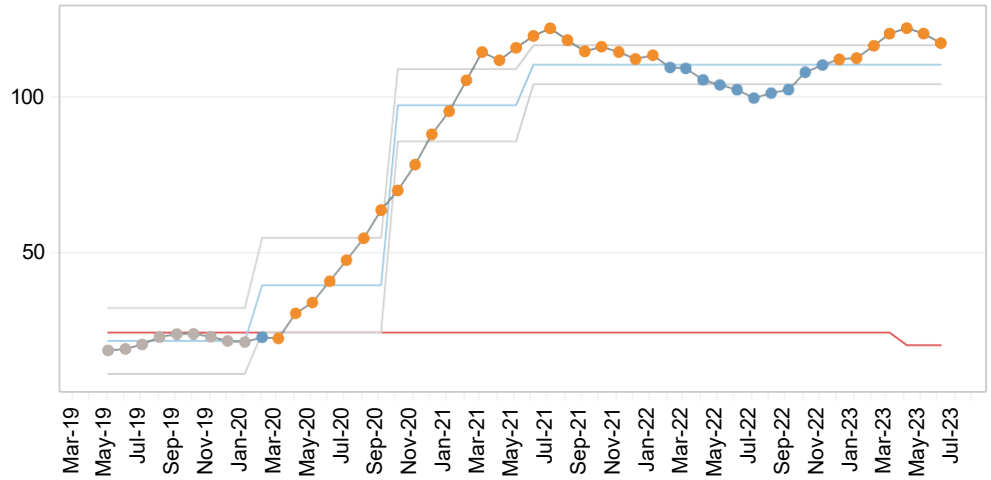
Actions
Due to the number of E coli cases the RCA process is under review prior to the introduction of PSIRF.

MRSA
The Trust has had 0 cases of MRSA in June against a zero-tolerance threshold set by the UKHSA.

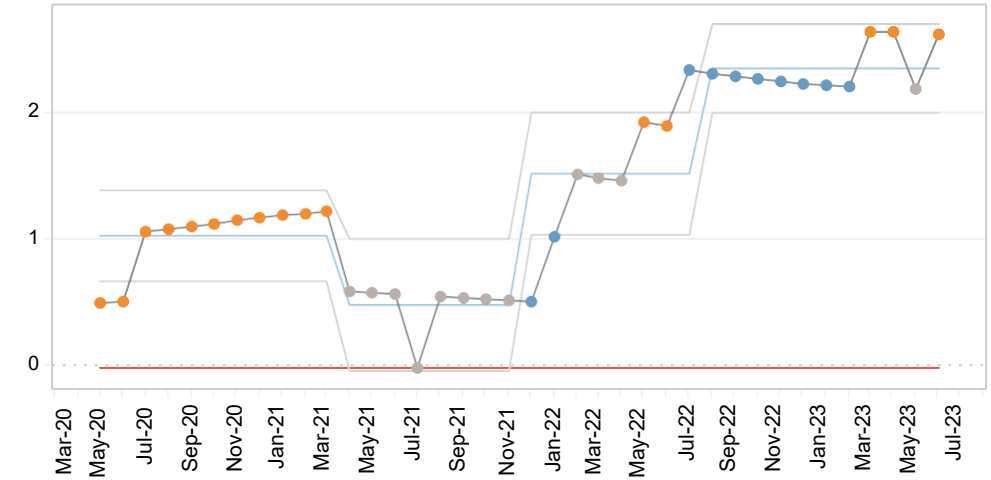
Actions
Continue to monitor compliance with MRSA screening.

Signed off by	Christine Glynn
Executive Lead	Nicola Firth

Performance for E. coli infection rate



Performance for MRSA infection rate



Integrated Performance Report - Exception

Quality: Pressure Ulcers		Target	Actual	6-month Trend	Previous Performance	1-month Forecast
Community, Cat 2	Total number of category 2 pressure ulcers in a community setting.	<= 9	9	→	▲ ● ▲ ▲ ● ▲	▲
Community, Category 3&4	Total number of category 3 and category 4 pressure ulcers in a community setting - includes device-related pressure ulcers.	<= 3	4	→	● ▲ ● ● ▲ ▲	▲
Hospital, Category 2	Total number of category 2 pressure ulcers in a hospital setting - includes device-related pressure ulcers.	<= 6	5	→	● ● ▲ ● ● ●	●
Hospital, Category 3&4	Total number of category 3 and category 4 pressure ulcers in a hospital setting - includes device-related pressure ulcers.	<= 0	1	↘	▲ ▲ ▲ ▲ ▲ ▲	▲

Hospital

This month (June data) we have had 5 category 2 pressure ulcers reported- of which 2 were as a result of a medical device. The Trust is on trajectory to meet the reduction target. The reduction targets and quality objectives have been set for this year with individualised divisional targets

The pressure- ulcer- collaborative event held in April showcased the improvements made so far and was a valuable learning event for all who attended on the quality requirements for the coming year.

The main work streams in progress are developing the purpose t pressure ulcer risk assessment tool into digital version (using patient track), and reviewing the training provision and role-specific requirements.

The Trust is aiming to achieve no hospital acquired Category 3 or 4 pressure ulcers resulting from lapses in care. In June there was 1 Category 4 pressure ulcer. This incident occurred at the discharge to assess community hospital. This incident has had an initial investigation which has identified some areas for learning- a full investigation and action plan is being completed.

Community

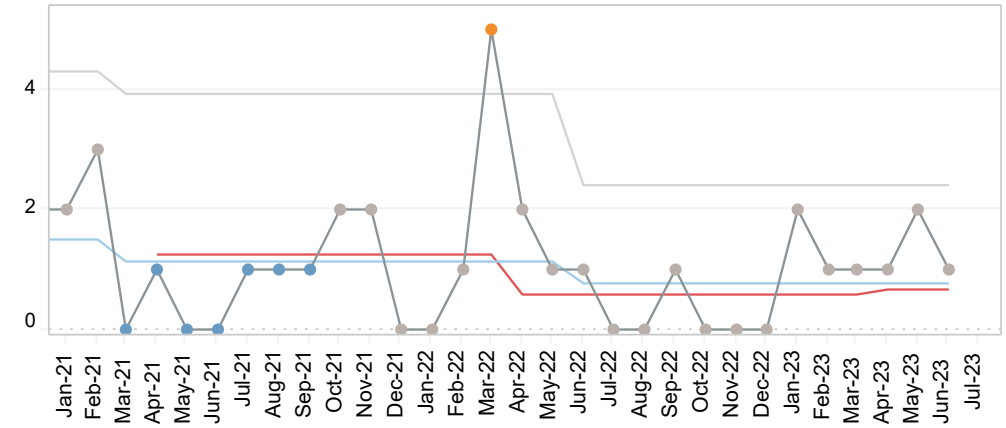
The community is currently over trajectory to meet the reduction target. The number of pressure- ulcer incidents in the community does need to be viewed within the context of the population, and number of patients on the community nursing caseload. The majority of incidents within the community setting are not as a result of lapses in care.

The Trust is aiming to achieve no Category 3 or 4 pressure ulcers resulting from lapses in care. In June there were 7 Category 3 or 4 pressure ulcers in the community. All these incidents have been investigation and scrutinised for any lapses in care, or areas for learning. Of these incidents, 2 cases have been identified to require further investigation with potential lapses in care identified.

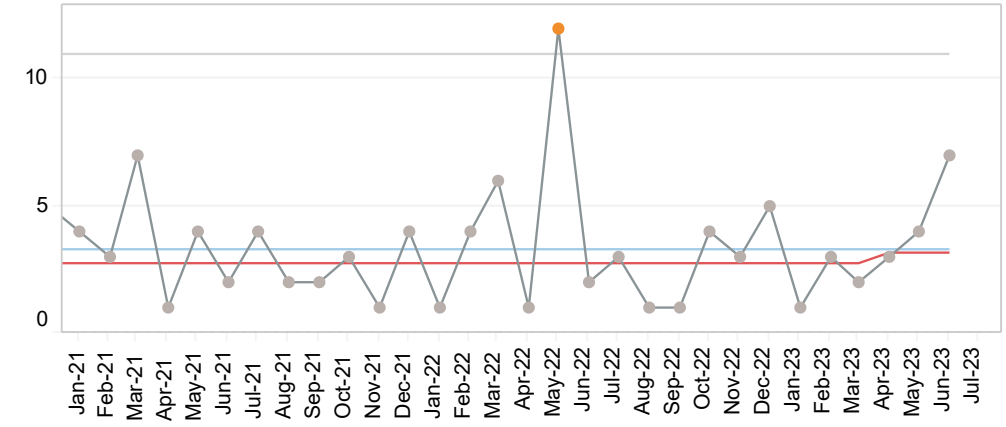
Actions within the community setting are specific to any identified lapses within an incident investigation. It was identified through investigation that a change in process was required for the D2A team regarding the initial assessments carried out by therapists. This introduced to the initial therapy assessment the purpose of the screening tool (preliminary pressure ulcer risk assessment) to identify those patients requiring a further nursing assessment. This has improved the multi-disciplinary working within the team and ensured that those patients at risk of developing pressure ulcers are identified promptly.

Signed off by	Lisa Gough
Executive Lead	Nicola Firth

Performance for Pressure Ulcers: Hospital, Cat 3&4



Performance for Pressure Ulcers: Community, Cat 3&4



Integrated Performance Report - Exception

Quality: Complaints		Target	Actual	6-month Trend	Previous Performance	1-month Forecast
Complaints: Timely response	The total number of formal complaints responded to within agreed timescales, as a percentage of all formal complaints responded to.	>= 95%	93.5%	→	▲ ▲ ▲ ▲ ▲ ▲	▲
Written Complaints Rate	Number of formal written complaints received, divided by the whole time equivalent staff per 1000.	<= 7.9	7.31	→	▲ ▲ ▲ ▲ ● ●	●

Written Complaints

39 formal complaints were received in June 2023 - Integrated Care = 5, Medicine = 6, Surgery = 17, Women & Children = 5 Corporate = 1, Estates & Facilities = 0, Emergency Department and Clinical Decision Unit = 3 and Clinical Support Services = 2

Top five themes for formal complaints in June 2023 was as follows:
1. communication 2. staff values and behaviours 3. patient care
4. clinical treatment 5. appointments.

Top five themes for informal concerns in June 2023 was as follows:
1. appointments 2. communication 3. admin procedures and record management
4. patient care 5. staff values and behaviours.

Concern around appointments continues to be constant challenge, with patients often unhappy with the long waiting times. The other area of concern that was particularly prevalent in June 2023 was staff values and behaviours, specifically attitude of staff.

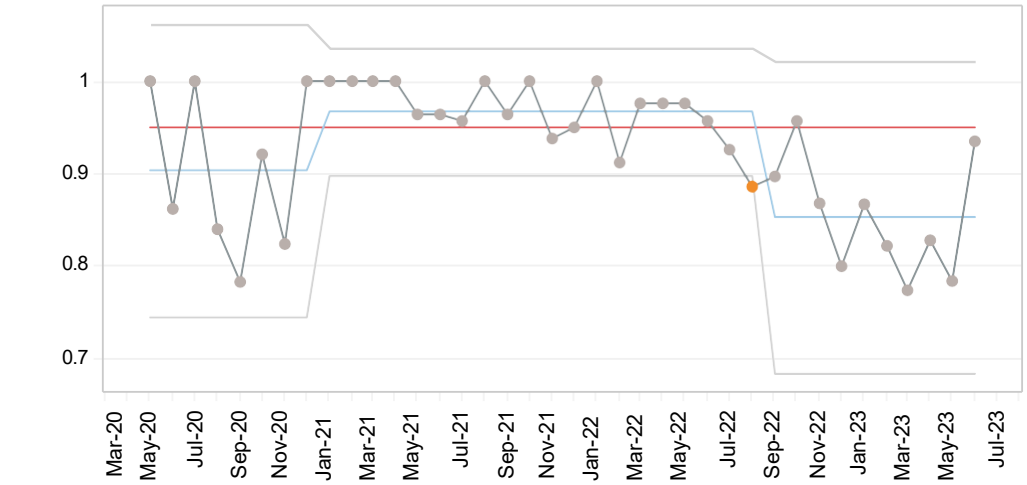
Complaints Response

46 responses were sent out in June 2023, 43 of which were sent within the agreed timeframe. This resulted in a 93.5 % response rate. The Divisions of Integrated Care, Clinical Support Services, Medicine and Urgent Care, and Women's and Children's, and corporate services all achieved a 100% response rate. The Division of Surgery achieved a 75% response rate and had the highest number of complaints (12 due for response). The Division of Surgery is currently focusing upon its complaint processes in order to improve performance.

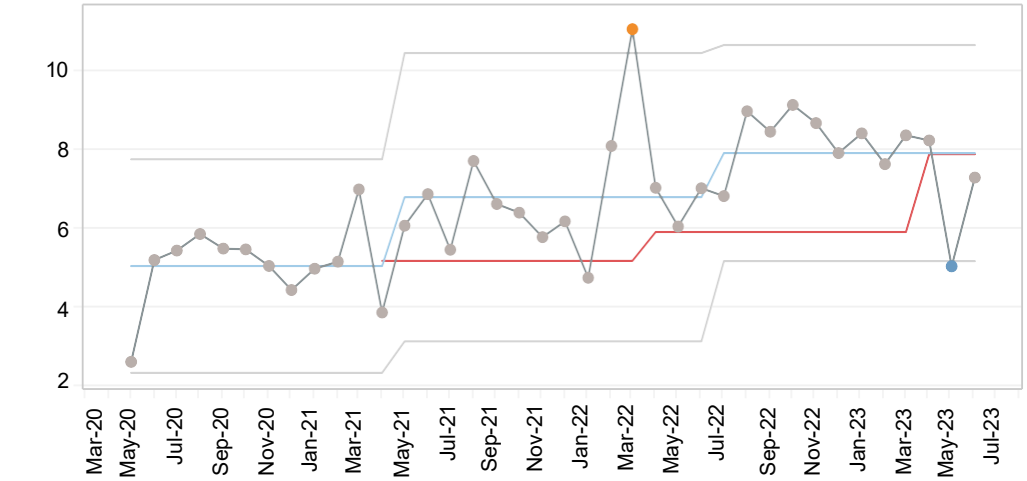
Due to the continued pressures at the Trust and on the availability of clinical staff to undertake administrative work, there have been a number of cases where the Divisions have not received responses/statements in a timely manner. This has meant that the Trust has not been able to respond to the complaint within the timescale provided at the outset of the investigation. When this occurs, the complainant is contacted and is kept informed. Where necessary, new timescales will be agreed with the complainant, particularly when the delay is as a result of staff absence or delay from another organisation involved with the complaint.

Signed off by	Natalie Davies
Executive Lead	Nicola Firth

Performance for Complaints: Timely response



Performance for Written Complaints Rate



Integrated Performance Report - Exception

Operations: ED		Target	Actual	6-month Trend	Previous Performance	1-month Forecast
Ambulance handover delays	The number of ambulance handovers delayed by 30 minutes or more, as a percentage of all ambulance handovers.	<= 5%	22.6%	→	▲ ▲ ▲	▲
4hr Standard	The number of patients who were admitted, discharged, or leave A&E within 4 hours of their arrival, as a percentage of all patients attending A&E.	>= 76%	70.7%	↑	▲ ▲ ▲ ▲ ▲ ▲	▲
Patients in department over 12 hrs	The number of patients spending 12 hours or more in department, as a percentage of all patients attending the emergency department.	<= 2%	4.8%	↑	▲ ▲ ▲ ▲ ▲ ▲	▲

Ambulance handover data is currently available for April 2022 to March 2023 only. This data is now being collated at a GM level, and the Trust is working with colleagues to source this data for future reporting.

June's performance against the UEC 4hr standard saw an increase to 70.70% compared to May's 64.20%. June saw a decrease in attendances from May; however, the average attendances continued to trend higher than the 2021/22 baseline.

Overall, performance benchmarks well across GM. Stockport's ED YTD performance is currently 67.04%, ranking 3rd in GM for Type 1 4hr performance.

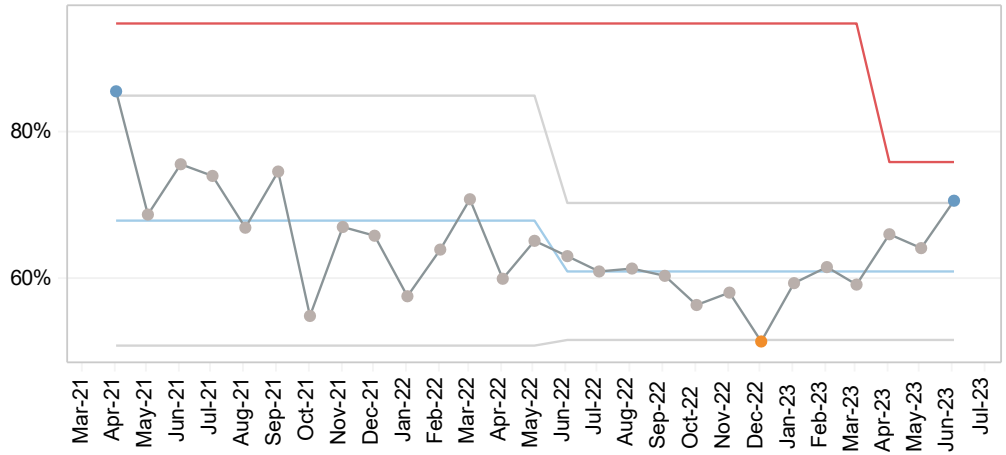
June saw a reduction is 12- hour waits in the ED to 55 compared to 107 in May. Robust processes for managing, reviewing and providing assurance for assessment of harm in respect to 12hr breaches are fully embedded within the service. The service continues to focus on ensuring that long waits are reduced by reviewing the ED workforce model.

Partnership collaboration continues with Pennine Care, with weekly and monthly meetings ongoing to discuss and resolve service challenges.

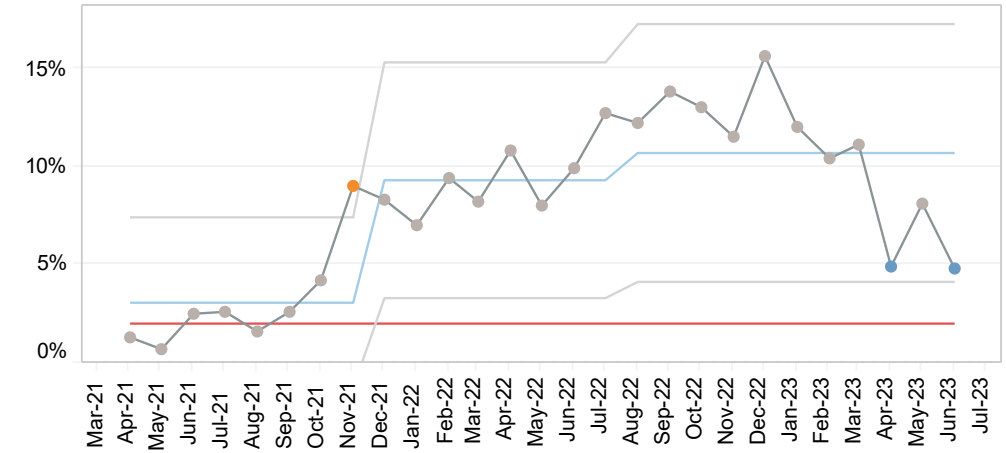
Weekly breach analysis forums with speciality teams are being established to focus on admitted performance, with the ED team continuing to focus on non-admitted performance.

Signed off by	Suzanne Woolridge
Executive Lead	Jackie McShane

Performance for 4hr Standard



Performance for Patients in department over 12 hrs



Integrated Performance Report - Exception

Operations: Patient Flow

		Target	Actual	6-month Trend	Previous Performance	1-month Forecast
No criteria to reside (NCTR)	Number of patients with "No Criteria to Reside". This metric is a mean average per day for each month.	<= 73	101	↑	▲ ▲ ▲ ▲ ▲ ▲	▲

The number of patients with no criteria to reside (NCtR) in month remains higher than the target level ;however, the Trust continues to show an improved position in reducing the average numbers, especially for Stockport residents.

June position saw an average of 101 patients in hospital beds with NCtR. Work continues to embed and improve operational system and processes within the wards and the Transfer of Care Hub to ensure improved discharges across pathways 1 and 2.

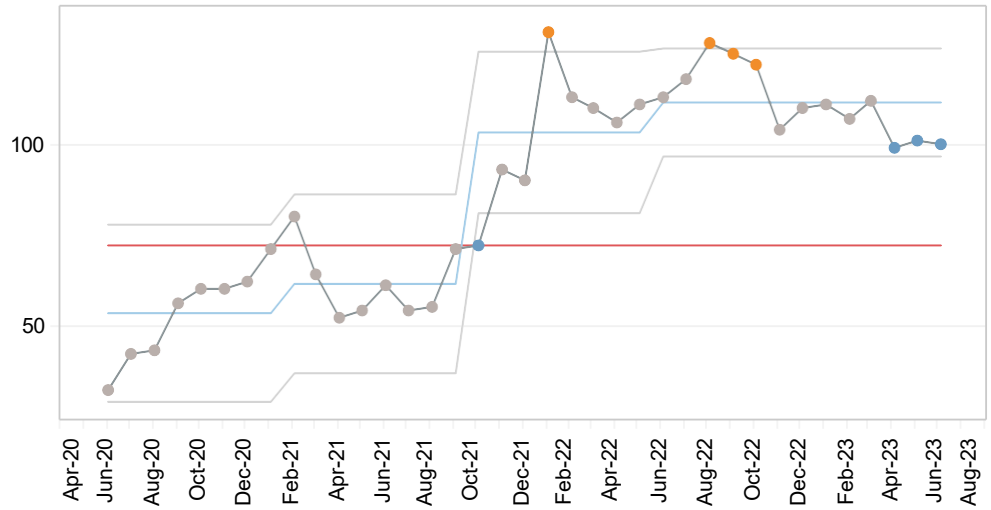
The challenges of accessing care- home beds and community packages of home care and reablement, is adversely impacting on patient flow both through the hospital and on flow through the community D2A beds and the community D2A Hub. The loss of 20 D2A beds with an independent provider has added to the challenge; however, system partners are meeting weekly to collaborate on a system response to discharge.

The number of out-of-area patients remains high with other localities struggling to access community capacity within their areas which is impacting on the ability to discharge / transfer patients to their local area. North Derbyshire and East Cheshire continue to have the highest number of out-of-area NCtR patients. Meetings are taking place weekly with out of area partners to support improved flow.

System tactical meetings held weekly continue with increases to daily if required. The Programme of Flow is reviewing all LLOS patients including those who have NCtR.
Other actions include:

- Review of all patients on the NCtR list daily to ensure patients are on the correct pathway.
- Meet and Greet initiative commenced to support discharge planning at the point of admission.
- Monitoring use of the community beds –System dashboard being established to enable visibility of capacity and flow through community beds.
- System Safe and Timely Discharge Meeting established to agree and plan for an Out of Hospital model for community bed and homecare.
- Monitoring of additional hours for packages of care, commissioned from Routes Healthcare, to support flow via Pathway 1.
- Reablement (REACH): Local Authority continuing to review and refine the operating model of reablement to facilitate a more efficient and effective use of resource.
- Internal Patient Flow project. A number of projects in place to support flow, which includes LLOS reviews taking place twice weekly across the trust to provide support to ward teams. These have been increased to support discharge ahead of junior doctor industrial action.
- Work with OOA partners with emphasis on improving the position with North Derbyshire along with ICB colleagues.
- Increased operational support to community bed base to improve flow.

Performance for No criteria to reside (NCTR)



Signed off by	Margaret Malkin
Executive Lead	Jackie McShane

Integrated Performance Report - Exception

Operations: Diagnostics		Target	Actual	6-month Trend	Previous Performance	1-month Forecast
6-week Standard	The percentage of patients referred for diagnostic tests who have been waiting for more than 6 weeks.	<= 5%	12.6%	↑	▲ ▲ ▲ ▲ ▲ ▲	▲

The diagnostic backlog continues to improve, with a further reduction of 94 patients by the end of June 23. 689 patients continue to wait over 6 weeks. This equates to 12.6% and is a small increase on the May position.

The endoscopy backlog has decreased to a total of 131 procedures now waiting over 6 weeks. Pressure on endoscopy remains, as a result of increased colorectal suspected cancer referrals, coupled with high sickness absence; however, the endoscopy backlog continues to trend downwards and the service is on track for DM01 compliance by September.

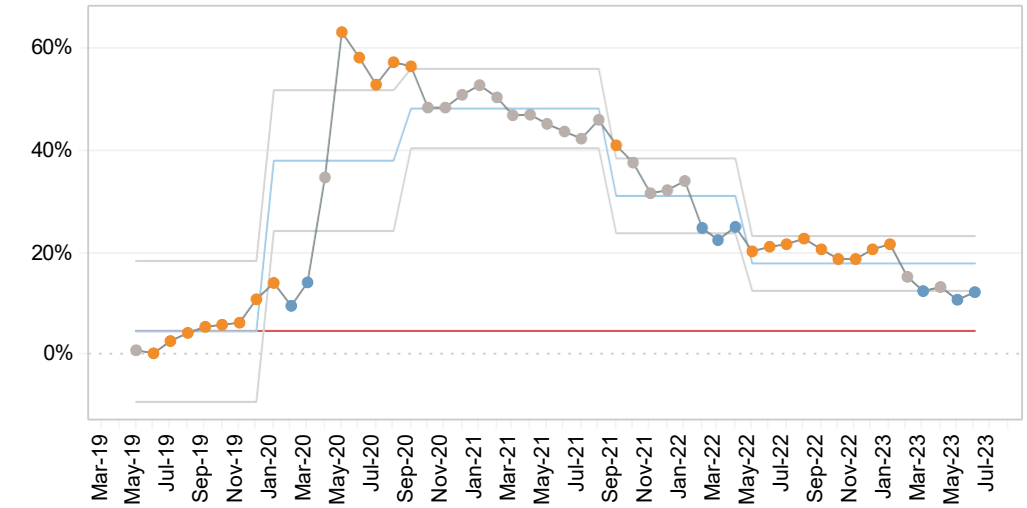
The imaging backlog has increased to 27 patients waiting over 6 weeks; however, all are patient choice. All the imaging modalities remain DM01 compliant.

The echocardiology (ECG) backlog has increase to 541 patients waiting over 6 weeks. This remains the biggest area of challenge. The service now has a 6th room for additional capacity and revised trajectory is being developed.

ECG staffing remains a pressure, with a Physiologist post remaining vacant despite several recruitment attempts. This role has now been re-designed to be a trainee role, which will be advertised shortly. In the interim, a bank post has been recruited to and WLIs will be undertaken by the substantive team.

Outsourcing to the new CDC will provide additional ECG capacity to significantly reduce the backlog of patients, whilst timescales are still in development, it is hoped that we will see activity commencing before the end of the calendar year.

Performance for Diagnostics: 6 Week Standard



Signed off by	Mike Allison / Catherine Cotton
Executive Lead	Jackie McShane

Integrated Performance Report - Exception

Operations: Cancer		Target	Actual	6-month Trend	Previous Performance	1-month Forecast
14-day standard (2WW)	The percentage of patients on a cancer pathway that have attended their first outpatient appointment within 14 days of their GP referral.	>= 93%	97.5%	→	● ● ● ● ● ●	●
28-day standard (FDS)	The percentage of patients that are notified whether or not they have cancer within 28 days from the date of referral.	>= 75%	64.2%	↘	▲ ▲ ▲ ▲ ▲ ▲	▲
62-day standard	The percentage of patients on a cancer two-week-wait pathway that have received their first treatment within 62 days of GP referral.	>= 85%	49.5%	↓	▲ ▲ ▲ ▲ ▲ ▲	▲

Cancer activity remains extremely challenged and it is anticipated that performance will continue to be impacted by industrial action in the coming months.

In addition, the Trust received the second highest number of cancer referrals in the month of May, with the latest June figure indicating a similar number. Significant growth in Q1 is see in Lung, ENT, Haematology, and Gynaecology compared to Q1 2022/23.

The final 62- day performance for May is 51.2%, showing some improvement from the April position. The latest 62- day performance for June is 49.5%.

28 day FDS (Faster Diagnosis Standard) performance has remained fairly static over the last three months at circa 64%.

The number of patients 63+ days on the cancer PTL has reduced in June. Performance against the 31- day standard has also improved in the last two months.

The Trust continues to perform strongly against the 2ww first seen standard, achieving 97.5% against the 93% standard in June. This remains the best performance in Greater Manchester.

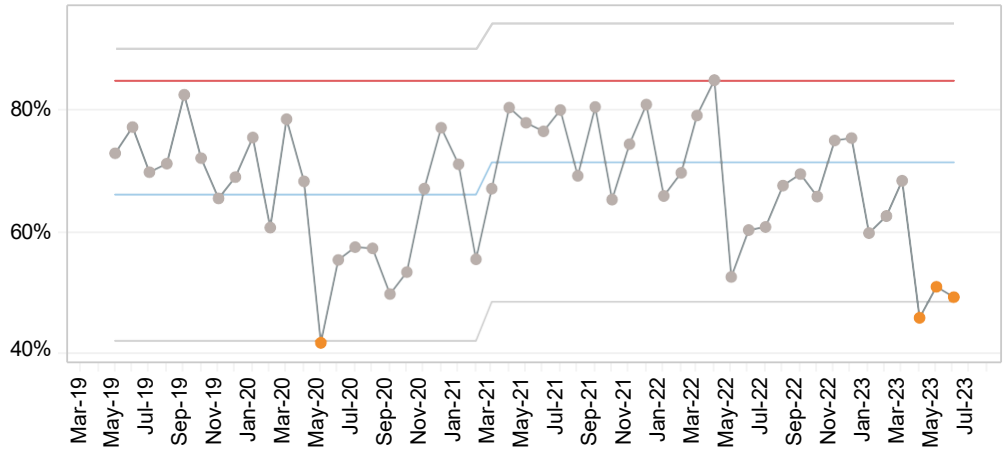
A Urology service review is planned to evaluate the current levels of demand across the sector. This will involve pathway mapping and sharing of good practice with other organisations.

Histopathology is commencing outsourcing of routine cases which will lead to an increase in urgent reporting capacity in the medium term.

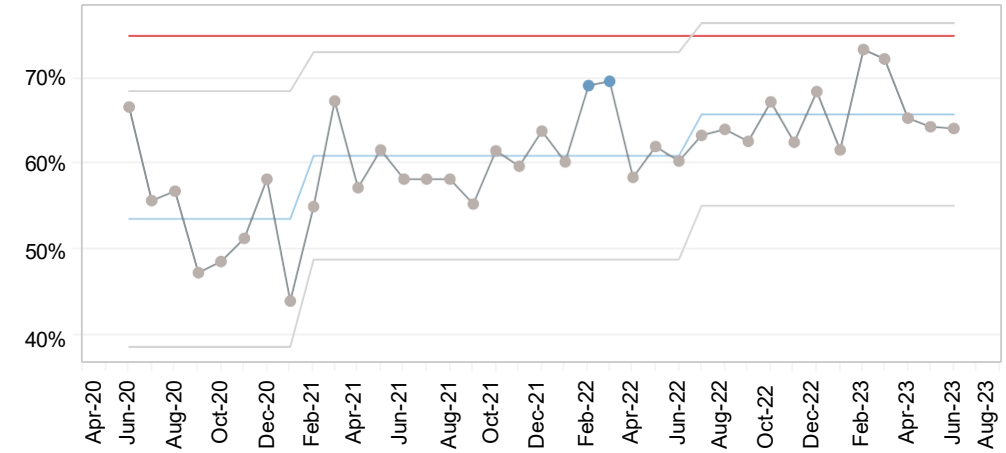
GM Cancer is undertaking an audit of lung referrals across the system to understand the acute growth rate.

Signed off by	Jo Pemrick
Executive Lead	Jackie McShane

Performance for 62-day standard



Performance for 28-day standard (FDS)



Integrated Performance Report - Exception

Operations: Referral to Treatment (RTT)		Target	Actual	6-month Trend	Previous Performance	1-month Forecast
Incomplete pathways 18-week %	Referral to treatment, the number of patients on an open pathway, whose clock period is less than 18 weeks, as a percentage of all patients on an open pathway.	>= 92%	48.7%	↘	▲ ▲ ▲ ▲ ▲	▲
52-week breaches	Referral to treatment, the total number of patients whose pathway is still open and their clock period is greater than 52 weeks at month end.	<= 0	4205	↓	▲ ▲ ▲ ▲ ▲ ▲	▲
65-week breaches	Referral to treatment, the total number of patients whose pathway is still open and their clock period is greater than 65 weeks at month end.	<= 0	1171	↑	▲ ▲ ▲ ▲ ▲ ▲	▲

The overall RTT position continues to remain very challenged. Validation exercises via the digital communications system continue to take place every 6 weeks.

The Trust still has a very small numbers of patients waiting 104 + weeks - only those where patient choice or clinical complexity are factors remain on the waiting list.

Circa 75 patients waiting over 78 weeks have been reported as being capacity breaches at the end of June-23. All could have been treated if capacity had not been curtailed during the 4- day BMA Industrial action in April. The Trust is working with GM partners to seek mutual aid for these patients. The impact of the BMA Strike action continues to be affect the delivery of the RTT performance with circa 2,500 patient cancellations year to date.

Teams have worked hard to provide additional capacity, prioritise long waiters, and validate the waiting lists against the access policy. Work has now started on the challenge of reducing to zero the number of patients waiting over 65 weeks by end March 2024, with speciality- specific trajectories being agreed and work with Independent- sector providers ongoing.

The levels of urgent and suspected cancer referrals remain high, resulting in extended waits for routine referrals in some services.

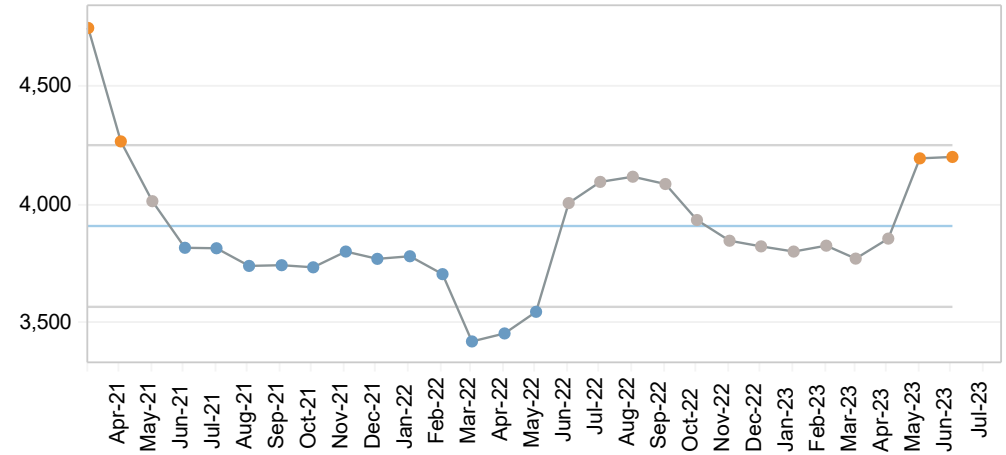
Validation of the admitted waiting list has been discussed at the CD forum. Roll out is awaited.

Trust elective performance meetings continue to focus on progressing patient pathways and eliminating long waits. The focus is on eliminating all patients who are waiting over 78 weeks at each month end and those waiting over 65 weeks by end March 2024.

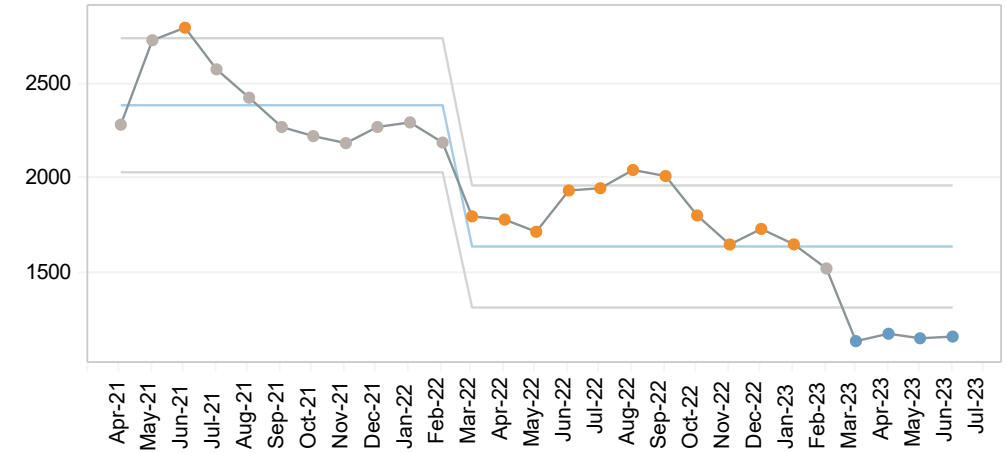
The Trust continues to maximise independent sector capacity under the GM independent sector contract, taking up increased capacity for Gynaecology, Urology, ENT, Oral Surgery, Gastroenterology, and General Surgery - this will now continue for the whole of 2023/24.

Signed off by	Dan Riley
Executive Lead	Jackie McShane

Performance for RTT: 52 Week Breaches & 52-week breaches



Performance for 65-week breaches



Integrated Performance Report - Exception

Operations: Outpatient Efficiencies

		Target	Actual	6-month Trend	Previous Performance	1-month Forecast
Outpatient DNA rate	The number of appointments where the patient did not attend, as a percentage of all booked appointments.	<= 6.3%	7.7%			
Outpatient clinic utilisation	The number of outpatient appointment slots booked, as a percentage of all outpatient appointment slots planned. Excludes cancelled clinic templates.	>= 90%	89.9%			
Patient initiated follow up (PIFU)	The number of patients moved to a PIFU pathway as a result of an outpatient attendance, as a percentage of all outpatient attendances.	>= 3.84%	3%			

DNA
DNA action plan is being reviewed.

Nudge text commenced in Ophthalmology resulting in the average DNA rate of 8.09% fall to 6.91% in June.

As a result of this and positive impact in DMOP and Paediatrics, reminder texts were rolled out to all specialties on 17th July. There will be ongoing monitoring of this.

The Trust has reached out to peer trusts outside of GM with lower DNA rates to review their processes. One response received and this will be reviewed in new OP Operational Group.

Clinic Utilisation
Clinics not managed by the Booking Team are at 87% utilisation, down from 92% in May.

Booking- Team- managed clinics at 94% utilisation, up from 92% in May.

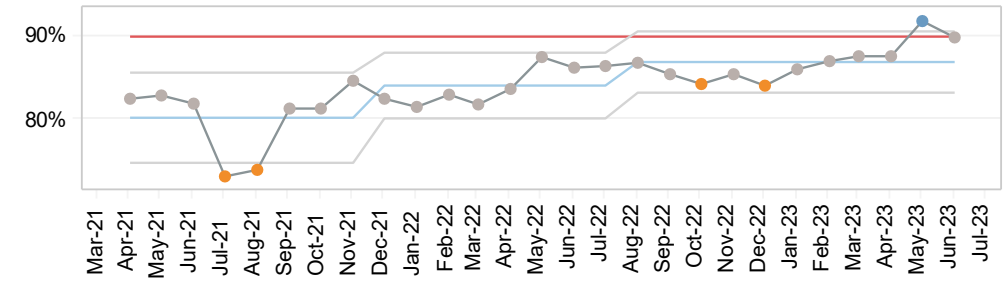
Detailed information of utilisation has been shared with the Divisions, CDs, and DMs. This has also been discussed at the Trust Performance and Elective Care forum and work is ongoing with areas with lower than the target utilisation.

Patient initiated follow up
Performance remains stable at 3%, which is the highest level in GM.

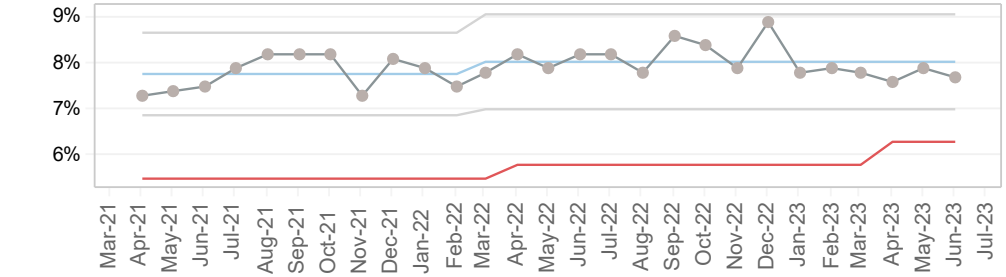
Specialities are continuing to utilise GIRFT guidance to identify opportunities for further roll out of PIFU.

Signed off by	Mike Allison
Executive Lead	Jackie McShane

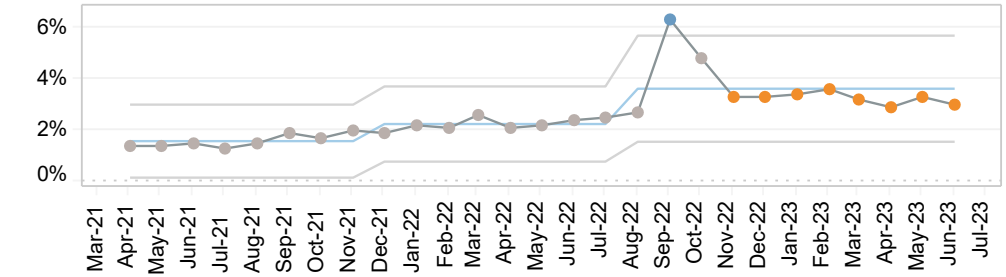
Performance for Outpatient clinic utilisation



Performance for Outpatient DNA rate



Performance for Patient initiated follow up (PIFU)



Integrated Performance Report - Exception

Operations: Theatre Utilisation

		Target	Actual	6-month Trend	Previous Performance	1-month Forecast
Capped Touch Time Utilisation	The overall time spent operating, calculated as a percentage of the overall planned session time. Session overrun time is excluded from the calculation of this measure.	>= 85%	76%			
Average cases per 4-hour session		>= 2.4	2.15			

Stockport continues to benchmark well against both peer and national medians for the most current data period, and there have been good signs of improvement since April on both main theatre list utilisation and average cases per list.

A new weekly meeting was introduced at the end of April with a dedicated focus on theatre booking and scheduling, and it appears to be having some early positive impact upon utilisation. This meeting supplements the existing 6-4-2 theatre scheduling structure and has had positive engagement from all surgical specialties, anaesthetics, theatres, and the central elective booking team.

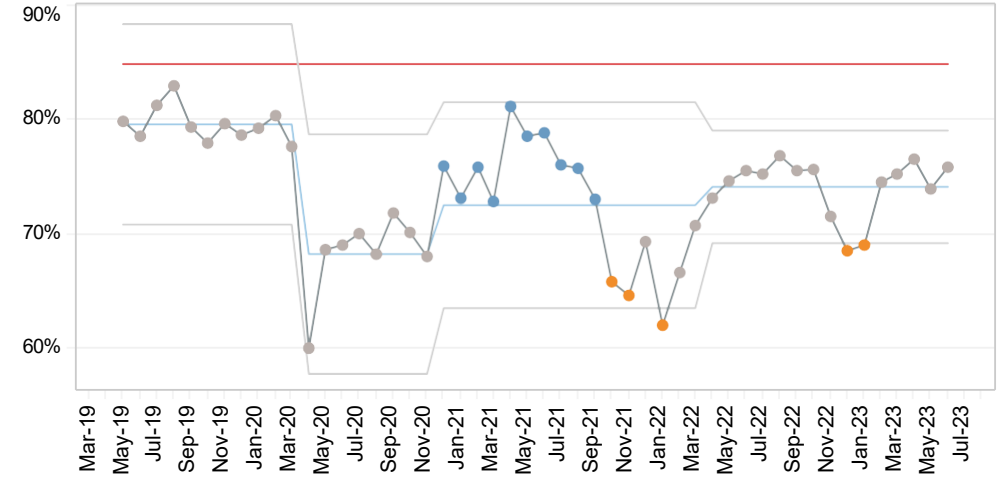
Nursing vacancies remain the key areas of challenge within the theatre complex. Although Anaesthetic vacancies have much improved, industrial action and workforce challenges continue to create some issues around optimising the use of some theatre sessions. Where required, services are converting some theatre sessions to local anaesthetic lists at relatively short notice to offer some mitigation while maintaining clinical activity.

A theatre efficiency programme is ongoing with work streams focused on pre-op assessment processes, booking and scheduling, and theatre flow on the day of surgery.

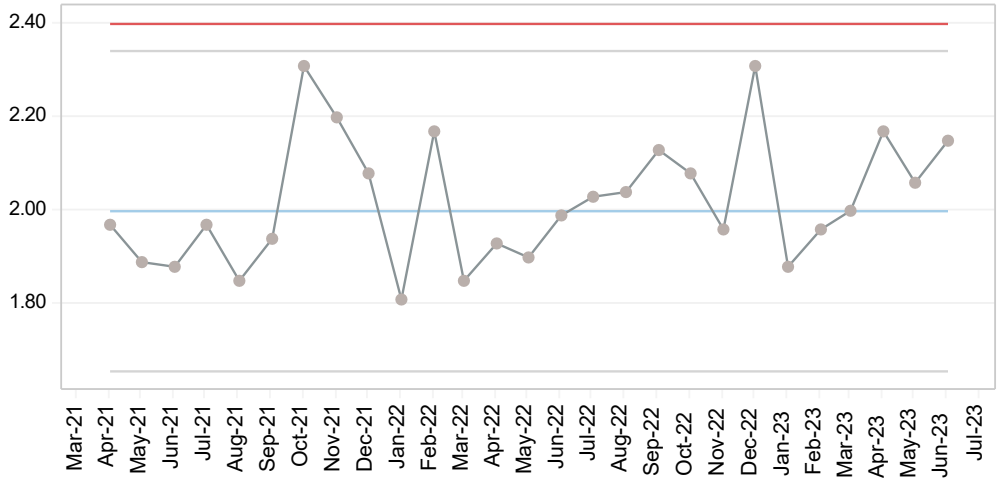
An Ophthalmology- specific theatre project has been launched within Stockport Eye Centre.
GIRFT supportive review of theatre productivity being completed and an action plan developed.

Signed off by	Andrew Tunnicliffe
Executive Lead	Jackie McShane

Performance for Capped Touch Time Utilisation



Performance for Average cases per 4-hour session



Integrated Performance Report - Exception

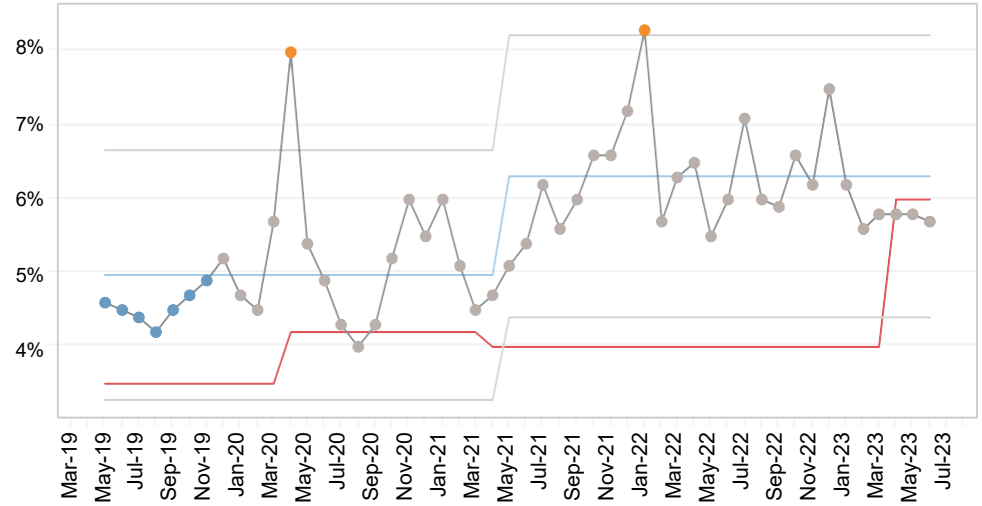
Workforce: Sickness Absence		Target	Actual	6-month Trend	Previous Performance	1-month Forecast
Sickness Absence: Monthly Rate	The total number of staff on sickness absence, calculated as a percentage of all staff-in-post whole time equivalent.	<= 6%	5.7%			

Overall Trust sickness has decreased in June 2023 to 5.7% compared to 5.8% in May 2023. Compared to June 2022, the sickness absence has improved from 6.1% dropping to 5.7%.

Stress / depression / Anxiety still remains the highest sickness reason with 28.9% for the 12 months to Jun 2023.

The HR team has undertaken a Divisional 'deep dive' focusing upon sickness absence, sharing good practice across Divisions, and identifying actions to review; including consistency of the approach to reviewing absence and the approach to flexibility of return to work. A number of actions have been identified to support reducing sickness by regularly reviewing staff off sick and on alternative duties to ensure a planned approach to a return to full duties.

Performance for Sickness Absence: Monthly Rate



Signed off by	Caroline Durdle
Executive Lead	Amanda Bromley

Integrated Performance Report - Exception

Workforce: Agency Costs

		Target	Actual	6-month Trend	Previous Performance	1-month Forecast
Agency Costs %	Total agency costs, as a percentage of total PAY costs.	<= 3.7%	5.7%			

In June 2023, the actual agency spend in month was £1.55m, which is 5.7% of the total pay bill. While this remains above the NHSE target of 3.7%, it was a 1% reduction from the previous month. This is also a reduction of 1.5% from June 2022.

The average agency percentage over the 2022-23 financial year was 7.08% and the rolling 12-month average to June 2023 remains at a similar level of 7.01%. All agency requests are considered on a weekly basis as part of the Staffing Approval Group (SAG) which is chaired by the Director of People and OD.

The highest divisional spends for agency usage are for Medicine (£580k) and Surgery (£418k); 53% of this spend was for medical staff and 40% on registered nursing. The Emergency Department, Medicine, and medical staff show the highest proportional cost for agency which relates to cover for escalation areas, the high levels of activity in ED, and vacancies.

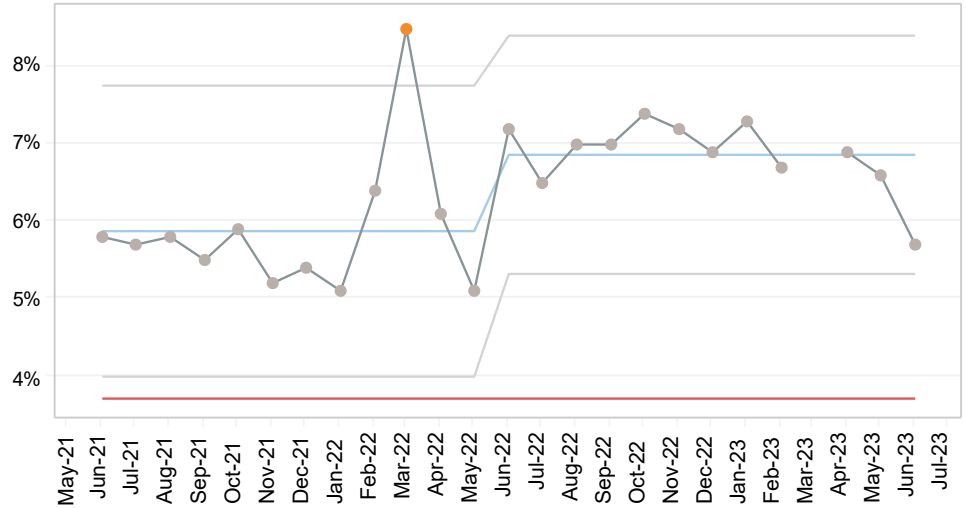
The following issues are currently considered to be a risk to the delivery of containing the agency spend within the plan:

- Continuation of additional beds without a substantive funding plan, and activity outside of plan as these drive the use of temporary staffing rather than substantive recruitment.
- Industrial action and agency usage to cover these gaps.
- Cost of living pressures presents difficulties in transferring workers from agency to bank.
- Long- term vacancies.

The following actions are underway to reduce agency spend:

- Targeted recruitment events.
- Exploration of 'grow our own' / apprenticeship options.
- The NHSP agency cascade parameters have been reduced from 21 days to 10 days.
- Review of governance arrangements for rostering in line with Levels of Attainment standards.
- The HR team has undertaken a Divisional deep dive focusing upon agency usage; this has identified a number of actions to review and introduce- including sharing detailed agency spend information with the Divisions, and encouraging discussions at senior team meetings and performance review meetings.

Performance for Agency Costs %



Signed off by	Caroline Durdle
Executive Lead	Amanda Bromley

Integrated Performance Report - Exception

Workforce: Turnover		Target	Actual	6-month Trend	Previous Performance	1-month Forecast
Workforce Turnover	The percentage of employees leaving the Trust and being replaced by new employees.	<= 12.5%	13.8%	→	▲ ▲ ▲ ▲ ▲ ▲	▲

The Trust's 12- month adjusted turnover rate remains above our 12.5% target but has remained stable at 13.8% in June 2023, a decrease of 0.4% from May 2023.

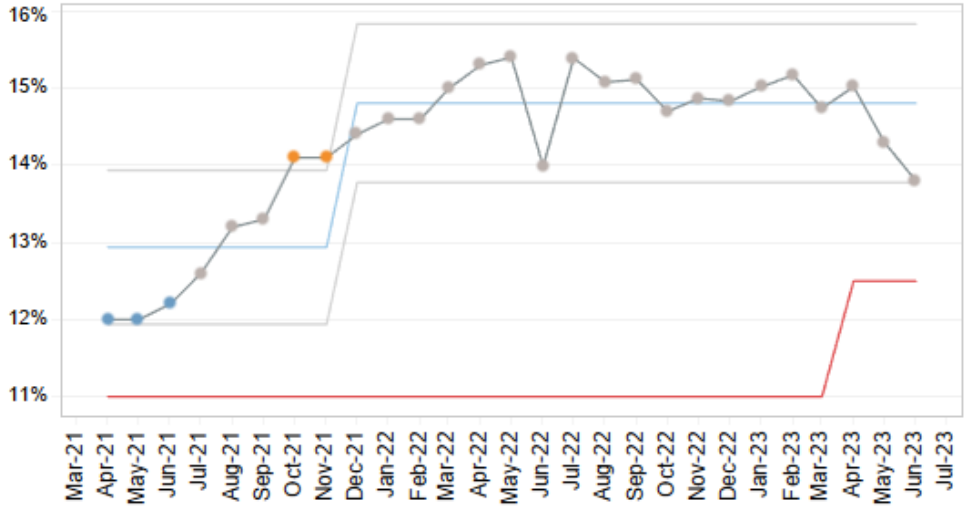
There has been a higher than average turnover for Additional Clinical Services staff group (17.58%). This is due to an increased the number Healthcare Support Worker (HSW) recruited through external recruitment events that have left within their first year. As a result, all new HSWs are now provided with a bespoke clinical induction and Care Certificate programme to support their induction and retention. We are also implementing basic literacy and numeracy pre-employment checks for HSWs to ensure all applicants meet the minimum requirements of the role. The Trust's Clinical Education Team is working alongside colleagues providing pastoral and clinical support within the first three months of employment.

During 2022-23, the Trust has reduced the numbers of voluntary leavers with under one year's service from 29.2% to 11.7%. This is due to the significant improvements in Nursing and Midwifery, and Allied Health Professional retention; however, the turnover of Additional Clinical Services staff with less than one year's service increased significantly during the same period. Evidence from exit interviews shows this is related to a significant number of Healthcare Assistants leaving as the role was not what they expected.

A review of the exit questionnaire process has recently been completed, consolidating the process into one questionnaire, supported by a follow-up reminder postcard, with QR code to encourage an increase in responses. It is anticipated that streamlining this process will encourage greater return rates and a better understanding of the reasons for leaving which will inform our response. The actions stated above will support improved retention, and turnover will be monitored during 2023/24.

Signed off by	Caroline Durdle
Executive Lead	Amanda Bromley

Performance for Workforce Turnover



Integrated Performance Report - Exception

Workforce: Appraisals		Target	Actual	6-month Trend	Previous Performance	1-month Forecast
Appraisal Rate: Overall	The percentage of overall staff that have been appraised within the last 15 months. Includes both medical staff and non-medical staff.	>= 95%	88.4%			

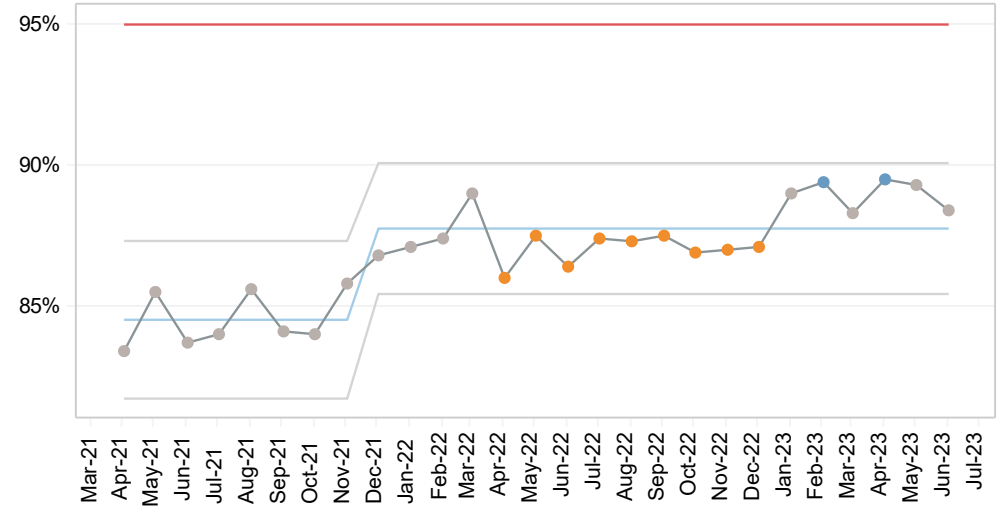
In June 2023 the Trust's overall consolidated appraisal rate remains below the 95% target remaining at a similar level to May 2023 (88%), and slightly above June 2022 (87%).

The medical appraisal rate decreased to 73.14%, while the non-medical appraisal rate remained at a similar level to last month, at 89.48%. Clinical Support Services and Women's and Children's Divisions both met the target.

Appraisal performance is addressed within the monthly performance review meetings. This has included targeted communications to line managers and employees.

Talent, Leadership & OD Consultancy Team delivers, on a monthly basis, short briefing sessions for managers on the appraisal process and, as part of the OD Plan, has established a task group to refresh the appraisal process to help improve compliance and the quality of appraisal discussions.

Performance for Appraisal Rate: Overall



Signed off by	Caroline Durdle
Executive Lead	Amanda Bromley

Integrated Performance Report - Exception

Workforce: Mandatory Training		Target	Actual	6-month Trend	Previous Performance	1-month Forecast
Mandatory Training	The percentage of statutory & mandatory training modules showing as compliant.	>= 95%	93.9%			

Overall mandatory training compliance level has increased to 93.87% against the target of 95%.

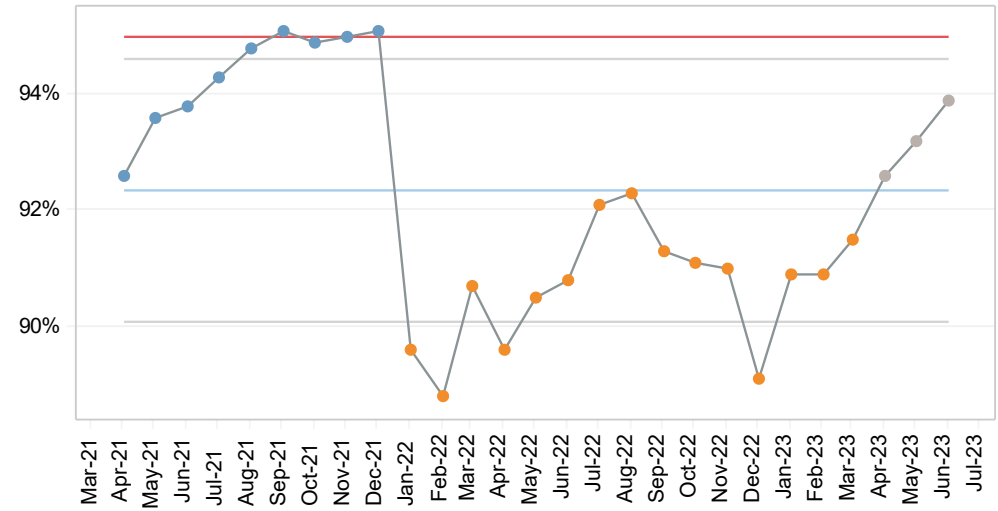
The Trust is above 95% in nine topics, and above 90% for six further topics. Performance remains below 90% for Resus Adult Levels 2 and 3, and Paediatric Resus Level 3, and Safeguarding Level 3 for adults and children.

Concerted efforts have been made to support the Divisions to improve their training compliance which is reflected in the month-on-month improvement. All colleagues who are non-compliant with their resus training have had a session offered and booked directly via ESR and into their health roster. The frequency of text reminders has increased to encourage attendance or rebooking of a session where the candidate is unable to attend. Weekly 'did not attend' reports continue to be circulated to senior teams and the reasons for non-attendance at training are reviewed.

Mandatory training days, to complement the suite of mandatory training offers, have been piloted for colleagues giving them the opportunity to drop in for adult resus sessions, moving and handling updates, and e-learning support. Following the first training day, evaluations from colleagues have been positive. In future, these events will be run quarterly.

Colleagues working in the community have been offered face- to- face training for resus at local community sites providing accessible training opportunities closer to their community bases. The impact of this programme is being evaluated.

Performance for Mandatory Training



Signed off by	Caroline Durdle
Executive Lead	Amanda Bromley

Integrated Performance Report - Exception

Finance		Target	Actual	6-month Trend	Previous Performance					1-month Forecast
Capital Expenditure	The actual capital expenditure, as a percentage of the planned capital expenditure. Performance is displayed as a percentage variance from the planned amount.	<= 10%	-50.9%	↘	●	●	●	●	●	●
Cash Balance	The amount of cash balance in Trust accounts. Figures displayed are millions per month.		36.5	→						
CIP Cumulative Achievement	The value of the actual CIP achievement, displayed as a percentage variance from the planned CIP achievement.	>= 0%	-18%	↘	●	●	▲	▲	▲	▲
Financial Controls: I&E Position	The actual financial position, displayed as a percentage variance from the planned financial position.	<= 0%	11.1%	↘	●	●	▲	▲	▲	▲

Risks

There is a forecast £1.2m pressure from pay award 2023-24 costs for Agenda for Change staff above national funding allocations. When the medical and dental pay award is agreed and paid there is likely to be a further gap between costs and funding.

The cost of industrial action was not included in the planning process. The cost of the industrial action to date is £0.7m. Further industrial action is planned by junior doctors and consultants in July. This will have a financial impact and also an impact on elective and outpatient activity.

There remains the risk of further industrial action if agreement is not reached on the pay award; however, no further dates beyond July have been confirmed. It has been confirmed that there will be no further industrial action taken by nurses; however, radiographers have voted for strike action, but no dates have yet been announced.

The risk of non-delivery of activity in accordance with ERF is not yet clear from a GM ICS point of view. The Trust continues to use independent sector activity as agreed from Q1; however, the allocation of income to cover this for the rest of the year is not agreed which could be £7m-£10m based on current activity levels.

Income Assumptions – there is a risk that some of the income that has been included in the planning assumptions, which has not yet been confirmed in the GM contract, may not be received.

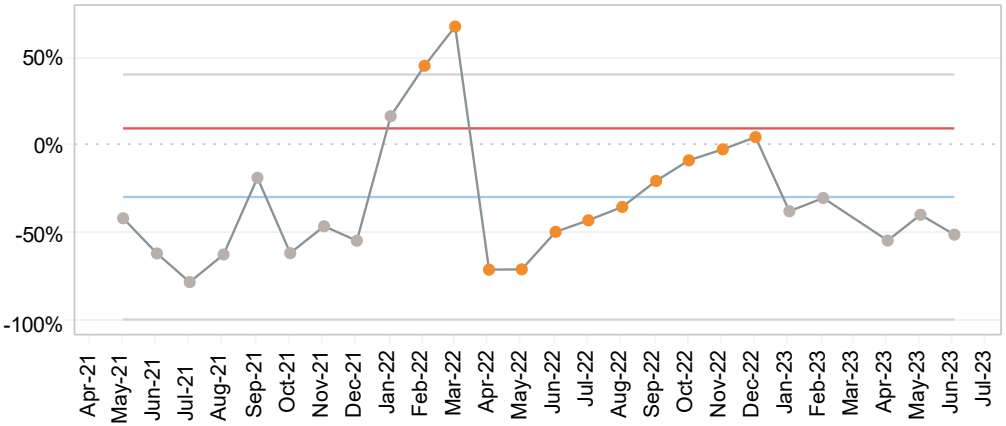
Escalation Capacity - alongside planned escalation capacity, additional beds over and above this level are open increasing the financial pressure.

CIP will be a challenge in 2023-24 with the recurrent target of £10.3m and a non-recurrent target of £15.9m; total £26.2m.

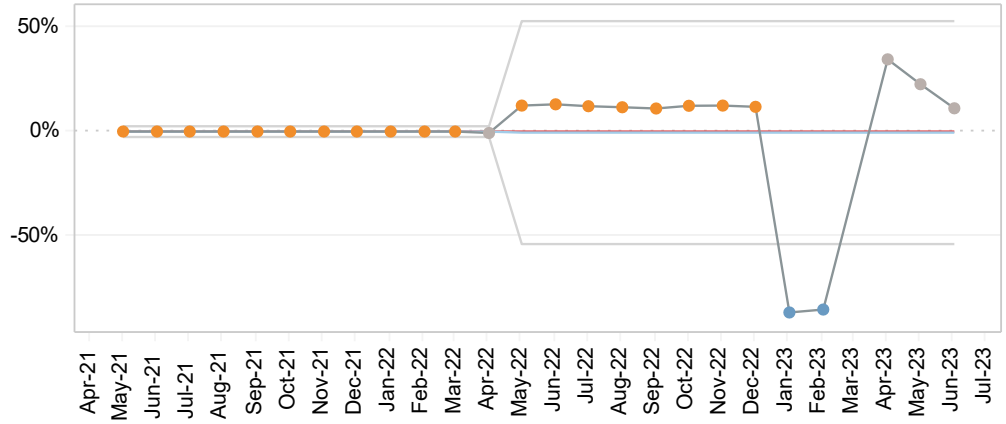
Cash-flow – Based on the planned deficit of £31.5m, the Trust will require revenue support in 2023-24. Support of £20m in quarter 3 has been assumed in the cash-flow forecast, with further support required in March 2024.

Signed off by	Tracy Coburn
Executive Lead	John Graham

Performance for Capital Expenditure



Performance for Financial Controls: I&E Position



Stockport's Patient Safety Incident Response Framework

NHS Stockport NHS Foundation Trust

Natalie Davies

Deputy Director of Quality Governance
Stockport NHS Foundation Trust

Patient Safety Incident Response

Stockport NHS Foundation Trust

In Autumn this year the way in which we are required to respond to patient safety incidents is changing.

We currently follow the Serious Incident Framework (SIF).

We are due to transition over to the Patient Safety Incident Response Framework (PSIRF).

As a part of PSIRF the Trust is required to create a Patient Safety Incident Response Plan (PSIRP).

The PSIRP requires sign off by Trust Board and includes the identification of local priorities for patient safety incident response.

Important messages

- The national serious incident framework will be replaced by the patient safety incident response framework.
- A move from declaring ‘serious incidents’ based on the outcome/ harm level.
- The term ‘serious incident’ will become redundant.
- A move towards the Trust making decisions on how it will manage it’s incidents and learn from them (within some national rules we must follow)
- **We will continue to report any near miss or incident**

Developing a Stockport NHS FT 'Patient Safety Incident Response Plan'

NHS Stockport NHS Foundation Trust

The PSIRP will follow a national template that includes:

- A description of our patient safety profile
- A description of our patient safety improvement profile
- Our patient safety incident response plan
  - National requirements
  - Local focus/ priorities

National responses to incidents

- Deaths clinically assessed as thought more than likely than not due to problems in care (incidents meeting the learning from deaths criteria for PSII)
- Death of a patient where the Mental Capacity Act 2005 applies where there is reason to think that the death may be linked to problems in care (incidents meetings the learning from deaths criteria)
- Incidents meeting the Never Event criteria 2018 or its replacement
- Maternity and neonatal incidents meeting Healthcare Safety Investigation Branch (HSIB/ HSSIB) criteria
- Child Deaths
- Deaths of persons with learning disabilities

National responses to incidents

Stockport NHS Foundation Trust

- Safeguarding incidents in which:
  - babies, children or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/ violence
  - adults (over 18 years old) are in receipt of care and support needs from their local authority
  - the incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery, and human trafficking or domestic abuse/ violence

- Incidents in NHS screening programmes
- Deaths in custody where health provision is delivered by the NHS
- Reportable infections meeting the national definition (HOHA, COHA)
- Incidents meeting the criteria for reporting to MHRA and SHOT (transfusion incidents)

Local priorities for patient safety incidents

NHS Stockport NHS Foundation Trust

- Acquired pressure ulcer incidents where:
  - a grade 3 or 4 pressure ulcer is acquired where lapses in care are identified as having contributed to skin deterioration.

- Delayed diagnosis of cancer in a patient where:
  - initial review of the incident identifies that the delay is due to an omission, and where the patient outcome and treatment options are materially impacted by the delay in diagnosis

- Nutrition and hydration incidents where:
  - there are identified lapses in care related to the weighing of patients, calculation of malnutrition universal screening tool (MUST) and dietician referral that led to weight loss of more than 5% of body weight and that is significant for that individual
  - there are delays in tube feeding or providing medication via tube, to a patient for more than 2 days due to lapses in care.

Local priorities for patient safety incidents

- Deterioration of patients on the waiting list where:
  - the patient has a significant event or irrecoverable deterioration and following review by the clinician this is confirmed as a result of the extended waiting time.

- Maternity and neo-natal related incidents, outside of the scope of Healthcare Safety Investigation Branch (HSIB/ HSSIB) criteria where:
  - following review the Trust consider considerable learning and improvement will be identified

Although the local priorities below have been agreed and will be the focus of resource until the plan is reviewed, it is recognised that the Trust may gain new insight or reason throughout the time of the plan that requires additional responses to be agreed and take place.

NHS
Stockport
NHS Foundation Trust

Meeting date	3 August 2023	x	Public		Confidential	Agenda item
Meeting	Board of Directors					
Title	Patient Safety Incident Response Framework & Plan					
Lead Director	Nicola Firth Chief Nurse		Author	Deputy Director of Quality Governance Natalie Davies		

Recommendations made / Decisions requested

The Board of Directors is asked to review and approve the Stockport Patient Safety Incident Response Plan to be rolled out across the organisation from 1 October 2023.

This paper relates to the following Corporate Annual Objectives

x	1	Deliver personalised, safe and caring services
	2	Support the health and wellbeing needs of our community and colleagues
	3	Develop effective partnerships to address health and wellbeing inequalities
x	4	Develop a diverse, talented and motivated workforce to meet future service and user needs
	5	Drive service improvement through high quality research, innovation and transformation
x	6	Use our resources efficiently and effectively
	7	Develop our estate and digital infrastructure to meet service and user needs

The paper relates to the following CQC domains

x	Safe	x	Effective
x	Caring	x	Responsive
x	Well-Led		Use of Resources

This paper relates to the following Board Assurance Framework risks

x	PR1.1	There is a risk that the Trust does not deliver high quality care to service users
	PR1.2	There is a risk that patient flow across the locality is not effective
	PR1.3	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan
	PR2.1	There is a risk that the Trust is unable to sufficiently engage and support our people's wellbeing
	PR2.2	There is a risk that the Trust's services do not fully support neighbourhood working

	PR3.1	There is a risk in implementing the new provider collaborative model to support delivery of Stockport ONE Health & Care (Locality) Board priorities
	PR3.2	There is a risk that the Trust does not deliver a joint clinical strategy with East Cheshire NHS Trust
	PR4.1	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit and retain the optimal number of staff, with appropriate skills and values
	PR4.2	There is a risk that the Trust's workforce is not reflective of the communities served
	PR5.1	There is a risk that the Trust does not implement high quality transformation programmes
	PR5.2	There is a risk that the Trust does not implement high quality research & development programmes
	PR6.1	There is a risk that the Trust does not deliver the annual financial plan
	PR6.2	There is a risk that the Trust does not develop and agree with partners a multi-year financial recovery plan
	PR7.1	There is a risk that the Trust does not implement the Digital Strategy to ensure a resilient and responsive digital infrastructure
	PR7.2	There is a risk that the estate is not fit for purpose and/or meets national standards
	PR7.3	There is a risk that the Trust does not materially improve environmental sustainability
	PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus

Where issues are addressed in the paper-

	Section of paper where covered
Equality, diversity and inclusion impacts	1.3.
Financial impacts if agreed/ not agreed	n/a
Regulatory and legal compliance	ALL
Sustainability (including environmental impacts)	n/a

Executive Summary

At the end of September 2023, the Trust will transition from the Serious Incident Framework (SIF 2015) to the Patient Safety Incident Response Framework (PSIRF), in relation to management of patient safety incidents.

The PSIRF requires that all organisations develop a Patient Safety Incident Response Plan (PSIRP) that describes current improvement and transformation work impacting upon patient safety at the Trust, national requirements for incident response which the Trust must provide, and agreement of local priorities for incident investigation agreed at Trust level.

This paper presents the PSIRP (Appendix 1) for approval by Board of Directors.

Stockport NHS Foundation Trust

Patient Safety Incident Response Plan

Effective date: 1 October 2023

Estimated refresh date: April 2025

	NAME	TITLE	SIGNATURE	DATE
Author	**Natalie Davies**	**Deputy Director of Quality Governance**		**27.7.2023**
Reviewer	**Nicola Firth**	**Chief Nurse**		**27.7.2023**
Authoriser	**Tony Warne on behalf of Trust Board**	**Trust Chair**		

Contents

1. Introduction

"Patient safety focuses upon the avoidance of unintended or unexpected harm to people during the provision of health care. We aim to minimise harm from patient safety incidents, learn and drive improvements in safety and quality. Patients should be treated in a safe environment and protected from avoidable harm."

1.1. Purpose

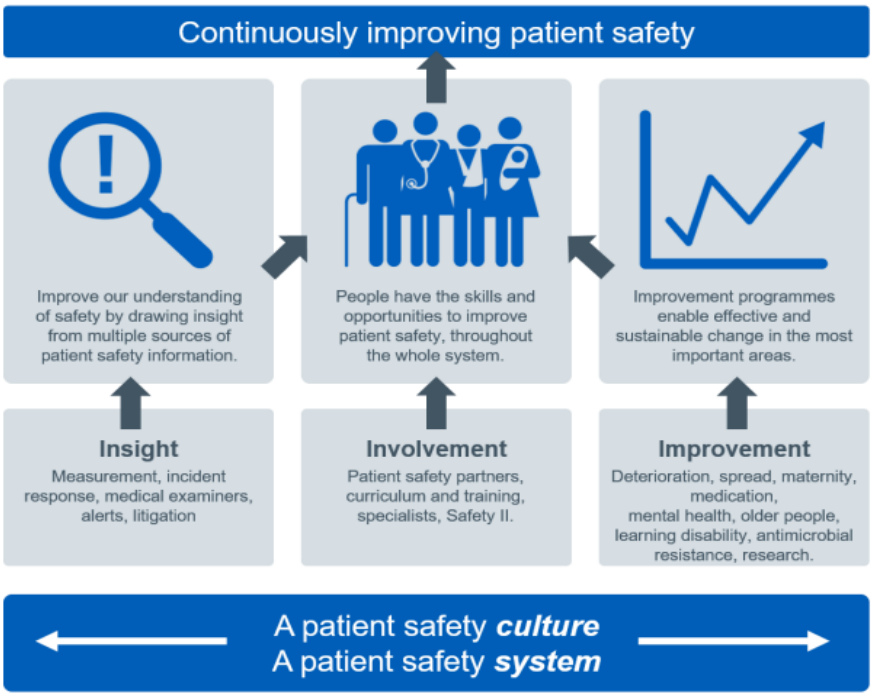
This Patient Safety Incident Response Plan (PSIRP) sets out how Stockport NHS Foundation Trust intends to respond to patient safety incidents over a period of 12 to 18 months from 1 October 2023 onwards. It explains how we will learn from patient safety incidents reported by staff, patients and their loved ones.

The Patient Safety Incident Response Plan is built upon the foundations of the NHS Patient Safety Strategy and the NHS Patient Safety Incident Response Framework. It has been created to support the continued development of a safe culture, safe systems and safe patient care. Central to the plan is the aim to learn and improve.

The NHS National Patient Safety Strategy first published in 2019 highlighted:

- The importance of understanding safety data to gain insight and understanding;
- The value of involvement of staff, patients and their loved ones to learn and improve;
- The impact that focused improvement can make to lead to sustainable change;
- That each organisation needs to develop and embed a culture of safety in order to continuously improve patient safety.

Figure 1: The NHS National Patient Safety Strategy



This plan is written with the principles of the NHS Patient Safety Strategy at its centre. By carrying out the actions agreed within this plan the Trust will be able to demonstrate how we seek to understand patient safety information, involve staff and patients to improve patient safety and how we will improve patient safety over the next 12 to 18 months.

In August 2022 the new NHS Patient Safety Incident Response Framework (PSIRF) was published. This will replace the NHS Serious Incident Framework (SIF) which provided principles and standards related to the identification, reporting and investigation of incidents based on harm categories. In Autumn 2023 Stockport NHS Foundation Trust will transition away from the SIF to utilise PSIRF as the framework for how it learns and improves from patient safety incidents.

> ***"The introduction of the NHS Patient Safety Incident Response Framework represents a significant shift in the way the NHS responds to patient safety incidents, increasing focus on understanding how incidents happen – including the factors which contribute to them."***
>
> Aiden Fowler, National Director of Patient Safety, NHS England

The Trust is clear that PSIRF is significantly different to the SIF and therefore our approach to learning and improving from patient safety incidents must also be different. It is an exciting opportunity for the Trust to take ownership of what and how it will investigate in relation to patient safety, in order to learn and improve.

PSIRF is a key part of the NHS Patient Safety Strategy and supports the development and maintenance of an effective patient safety incident response system that integrates four key aims:

- Compassionate engagement and involvement of those affected by patient safety incidents;
- Application of a range of system-based approaches to learning from patient safety incidents;
- Considered and proportionate responses to patient safety incidents;
- Supportive oversight focused on strengthening response system functioning and improvement.

Application of this plan will support the Trust to deliver a considered and proportionate response to patient safety incidents utilising a system-based approach to learning and improvement. The plan will be supported by updated Trust Incident Management Policies, including our approach to engagement and involvement of those affected by patient safety incidents.

1.2. Scope

This plan provides a description of how the Trust will apply PSIRF. The plan will focus upon:

- **Our understanding of our patient safety incident profile**
  What our data, both quantitative and qualitative tells us about patient safety at Stockport NHS Foundation Trust.
- **Our current patient safety improvement profile**
  As an organisation the Trust is committed to improving patient safety, we will describe all on-going improvement work across the organisation that impacts upon patient safety improvement.
- **Our Patient Safety Incident Response Plan**
  In light of what we have learnt about our incident profile and the already on-going improvement work the Board of Directors have signed off this Patient Safety Incident Response Plan (PSIRP) made up of two elements:
  - National requirements – here we describe the patient safety incidents that require a national response; what that response will be, and how we will learn from any incident response we undertake
  - Local focus – here we describe the patient safety incidents that have been agreed as locally priorities by the Trust Board; what our response to the incidents will be, and how we will learn from any incident response we undertake

This is the first Patient Safety Incident Response Plan developed by the Trust and it is intended that this plan be reviewed following a twelve month period, with a refreshed and updated PSIRP agreed by Board within eighteen months. The following timeframes will therefore apply:

PSIRP Update Timescales	
Launch of the PSIRP **(1 October 2023 –31 March 2024)**	1 October 2023
Full review of the PSIRP commences	1 October 2024
Updated PSIRP approved **(covering 1 April 2025 – 30 September 2026)**	1 April 2025

This patient safety incident response plan sets out how Stockport NHS Foundation Trust intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occur and the needs of those affected.

1.3. Health Inequalities

When the National Patient Safety Strategy was updated in 2021 a greater emphasis was rightly placed upon reducing inequalities. Healthcare inequalities 'are not inevitable and can be significantly reduced. Avoidable health inequalities are unfair and putting them right is a matter of social justice' (The Marmot Review 2010). When healthcare inequalities increase the risk of harm to patients in healthcare or cause harm, they are then defined as patient safety inequalities.

Stockport NHS Foundation Trust will seek to better understand healthcare inequalities across the organisation and seek to improve by:

- Reviewing the collection of health inequalities data for incidents and complaints reported within its risk management system.
- Creating an action plan on how we will improve the collection of data so that we have better insight.
- We will engage with staff, patients and loved ones in line with the NHS England guide to 'Engaging and involving patients, families and staff following a patient safety incident'.
- Using the data collected to identify areas for improvement.

2. Our services

2.1. Our Trust

Stockport NHS Foundation Trust holds a unique position in the Stockport community as the provider of healthcare. We are an integrated provider of acute hospital and community services to the people of Stockport, as well as serving the populations of East Cheshire and the High Peak in North Derbyshire.

We offer a number of specialist services and play a key partnership role with Greater Manchester, Stockport and East Cheshire. With an annual budget of around £300 million and about 5,000 staff we provide healthcare for residents in Stockport, East Cheshire and North Derbyshire as well as patients we treat from other boroughs in Greater Manchester who choose our services.

2.2. Our services

Our main hospital is currently known as Stepping Hill, which provides emergency, surgical and medical services for people living in Stockport and surrounding areas. Our stroke services have been rated as the best in England and we also run one of the largest orthopaedic services in the region. We offer a range of core district general hospital services as well as some specialist services, such as orthopaedics, stroke, and urology that have a national reputation for excellence. We are also one of four designated specialist sites for acute and general surgery in Greater Manchester.

We run a unit at the Meadows in Stockport which is a community Transfer to Access intermediate nursing care facility and Swanbourne Gardens which provides overnight breaks for children and young people with severe learning disabilities. We also run the Devonshire Centre for neuro-rehabilitation although this service will soon transfer to Salford NHS Foundation Trust.

We are proud of our community health services that run across 24 health centres and community clinics in Stockport. Our vision for neighbourhood services is to provide a joined up, high quality, sustainable, modern and accessible health and care system.

The new community models of care address the challenges of rising demand, supporting the growing number of people with complex and long-term conditions and the root causes of the financial challenges of Stockport.

We are an associate teaching hospital, helping to train a variety of health professionals for the future.

In our region, we are one of four specialist hospitals for emergency and high risk general surgery; one of three specialist stroke centres; and one of only two orthopaedic departments delivering c-spine surgery in Greater Manchester.

2.3. Mapping our services

Stockport NHS Foundation Trust provides a wide range of services both at Stepping Hill Hospital and within the community of Stockport. The services are mapped out below.

Hospital Services		Community Services	
• Acute care • Anti-coagulation • Audiology • Birth centre • Cardiology • Chaplaincy services • Children's continuing care • Colposcopy • Crisis Response Team • Diabetes and Endocrine • Ear, nose and throat • Echocardiogram and electroencephalogram • Emergency department • Endoscopy • Fertility • Gastroenterology • General surgery • Gynaecology • Haematology • Health mentors • Heart care unit • In-patient therapy • Intensive care and high dependency • Laboratory medicine • Maternity • Neonatal • Nephrology • Neuro-rehabilitation • Nutrition and dietetics service	• Older people services • Oncology • Ophthalmology • Orthodontics • Orthotics • Outpatient bookings • Outpatient hysteroscopy • Outpatient paediatrics • Outpatient speech and language therapy • Outpatient therapies including physio', hand, hydro', and dietetics • Paediatrics • Pain Clinic • Pharmacy • Pre-operative care and surgery pre-assessment • Radiology • Research and development • Respiratory medicine • Respiratory physiology • Rheumatology • Safeguarding • Stroke • Trauma and orthopaedics • Urology	• Active recovery • Adult continence service • Children's physiotherapy • Children's speech and language therapy • Children's community nursing team • Children's continence (PEBBLES) • Children's occupational therapy • Chronic fatigue syndrome (ME) • Chronic obstructive pulmonary disease (COPD) • Community advanced clinical practitioner and matron team • Community midwifery • Community neuro rehabilitation • Community orthotics • Diabetes • District nursing • Expert patients programme • Health visiting • Infant parent service • Nutrition and dietetics service	• Orthopaedics assessment service • Orthoptics and optometry • Palliative care • Parenting team • Physiotherapy • Podiatry • Pulmonary rehabilitation • Safeguarding • School nursing • Swanbourne gardens • Tissue Viability • Wheelchair/ specialist equipment

This Patient Safety Incident Response Plan is relevant to all services provided by the Trust.

3. Defining our patient safety incident profile

As part of the Patient Safety Incident Response Plan the Trust has completed a review of its patient safety incident profile. This means that we have reviewed our patient safety data – both quantitative and qualitative, and engaged with our stakeholders to better understand what our patient safety priorities should be.

3.1. Data sources

Patient safety data has been collected from the following sources to support understanding of patient safety at the Trust:

Data Source	Timescale
Patient safety incident reporting	01/04/2018 – 31/03/2023
Complaints received	01/04/2018 – 31/03/2023
Claims received – including the litigation scorecard	01/04/2020 – 31/03/2023
Inquest outcomes – including prevention of future death notifications	01/04/2020 – 31/03/2023
Mortality Review outcomes – including learning from death reviews	01/04/2020 – 31/03/2023
Getting it Right First Time (GIRFT) outcomes	01/04/2020 – 31/03/2023
Risk Register Review – review of patient safety risks within the Trust risk register	May 2023

Each data source has been interrogated to understand themes and trends to support the agreement of patient safety priorities for the Trust.

3.2. Stakeholder engagement

Alongside the review of patient safety data we have sought to collaborate with our stakeholders to agree the patient safety priorities within this plan.

Stakeholder engagement	
Trust staff and team members	Regular PSIRF sessions have taken place across the Trust. In July these focused upon agreement of the local priorities for patient safety
Patients, families and carers	The Trust has engaged with the local Healthwatch and Community Champions Network to seek input into the Patient Safety Incident Response Plan
NHS Greater Manchester Integrated Care Board (ICB)	The Trust has engaged with key team members at the ICB in the creation of this plan.
Council of Governors	The Trust has engaged with the Council of Governors to seek input into the Patient Safety Incident Response Plan

4. Defining our patient safety improvement profile

As part of the Patient Safety Incident Response Plan the Trust has completed a review of its patient safety improvement profile. This means that we have reviewed all improvement and service transformation work across the organisation to better understand the totality of activity currently planned or taking place which will improve patient safety.

4.2. The Quality Strategy 2021-2024

Stockport NHS Foundation Trust has a Trust Quality Strategy 2021-24 with an ambition to:

Start Well – Improve the first 1,000 days of life

Live Well – Reduce avoidable harm

Age Well – Reduce avoidable harm

Die well with dignity – Improve the last 1,000 days of life

Stockport Quality Strategy Schemes	
Pressure Ulcers	Aims: • 5% reduction on acute care 22/23 reported figures – no more than 87 acquired pressure ulcer incidents reported • 10% reduction on community care 22/23 reported figures - no more than 137 pressure ulcer incidents reported • No more than 5% of all pressure ulcers reported as a result of a lapse in care • No category 3-4 pressure ulcers due to a lapse in care Oversight: All pressure ulcers will be reviewed using the organisations pressure ulcer proforma and reviewed at harm free care group where lesson learning and actions will be identified. Any acquired pressure ulcers requiring further escalation will be reviewed at incident review group and Patient Safety Incident Response Group (PSIRG).
Falls	Aims: • 5% reduction in moderate harm or above caused by falls • 10% reduction in lapses in care Oversight: All falls will be reviewed using the organisations falls proforma, and reviewed at harm free care group where lesson learning and actions will be identified. Any falls requiring further escalation will be reviewed at incident review group and PSIRG
Infection Prevention	Aim: • No more than 40 cases of clostridium difficile in line with national trajectories • Zero MRSA bacteraemia Oversight:

	All healthcare acquired infections are reviewed, and lesson learning identified via the healthcare acquired infection panel where lesson learning and actions are agreed. There is also additional oversight via the Infection Prevention and Control Group. Any healthcare infections requiring further escalation will be reviewed at incident review group and PSIRG.
Ward Accreditation Scheme StARs	Aim: • To maintain 50% of wards as green accreditation • To have no more than 25% of wars as red accredited Oversight: The ward accreditation programme is a continuous programme of review, learning and improvement linked to the CQC domains of safe, effective, caring, responsive and well led. Progress is reported to Quality Committee.

4.1. Transformation Schemes

The Stockport NHS Foundation Trust Service Transformation Team provides a proactive resource for continuous improvement to the Trust. The current transformation schemes include:

Stockport Transformation Schemes	
Digital Health Development	Aim: To conduct and evaluate a pilot of a Stockport Local Clinical Assessment Service (LCAS) and implement a virtual ward for Stockport locality.
Endoscopy Improvement Project	Aim: To ensure that utilisation of endoscopy sessions are fully maximised.
Frailty Programme	Aim: To support a standardised approach to identifying people living with frailty and develop a clear operating model and pathways depending on levels of severity.
Surgery Out of Hours	Aim: To improve the provision of out of hours medical staffing in the surgical division and effective flow of patients from the emergency department to surgical admissions unit.
Children's, Young People and Families	Aim: To improve pathways that our patients under the age of 18 access, including supporting their transition to adult services.
Cancer Improving Outcomes	Aim: To implement best timed pathways, supporting faster diagnosis. To implement personalised stratified follow up pathways.
Outpatients	Aim: To improve patient experience of their outpatient journey, enhancing the efficiency of Trust outpatient services.

Respiratory Outpatients	Aim: To improve efficiency of Respiratory outpatient service in light of high demand and limited services.
Pain Management	Aim: To develop the urgent community response to support admission avoidance, focusing on transforming the current advanced clinical practitioner model. To ensure a 'patient-led' patient journey through pain management services.
Elective Booking Admin' Review	Aim: To deliver a fully centralised elective booking and scheduling structure for surgical specialities across the Trust.
Theatres Efficiency and Productivity	Aim: To ensure theatre usage is maximised by reviewing the patient journey from pre-op' to post-op' care.
Ophthalmology and ENT Theatre Productivity Project	Aim: To optimise theatre utilisation for ophthalmology and oral surgery – working alongside the main theatres efficiency and productivity scheme.
Antenatal Pathway Review	Aim: To ensure safety of service users of the antenatal services and timely review for women on scan pathways.
District Nurse Redesign	Aim: To review and redesign the District Nurse team and processes to make efficiencies, contributing to improved patient care and staff engagement.
Advanced Practice Future Model	Aim: To develop the urgent community service (UCRS) to support admission avoidance.
Medicolegal Pathway Redesign	Aim: To improve processes to ensure the organisation meets compliance with the UK General Data Protection Regulations (GDPR) Subject Access Request timescales.
Rapid Diagnostic Centre	Aim: To develop a Rapid Diagnostic Pathway for patients with non-site specific cancer symptoms, supporting patient experience and performance against the faster diagnosis standards.

5. Our patient safety incident response plan: national requirements

5.1. Incidents requiring a response as set out by national requirements

The Trust is required to respond to certain patient safety incidents according to national requirements. This section of the Patient Safety Incident Response Plan sets out what these national requirements are and how our learning will inform improvement at the Trust.

Incident type	Required response	Anticipated improvement route
Deaths clinically assessed as thought more than likely than not due to problems in care (incidents meeting the learning from deaths criteria for PSII)	Locally-led Patient Safety Incident Investigation (PSII)	Create local organisational actions and where appropriate feed these into the quality strategy or transformation schemes
Death of a patient where the Mental Capacity Act 2005 applies where there is reason to think that the death may be linked to problems in care (incidents meetings the learning from deaths criteria)	Locally-led PSII	Create local organisational actions and where appropriate feed these into the quality strategy or transformation schemes and Trust Integrated Safeguarding as necessary
Incidents meeting the Never Event criteria 2018 or its replacement	Locally-led PSII	Create local organisational actions and where appropriate feed these into the quality strategy or transformation schemes
Maternity and neonatal incidents meeting Healthcare Safety Investigation Branch (HSIB/ HSSIB) criteria	Referral to HSIB for independent PSII	Respond to recommendations as required and feed actions into the Maternity Sustainability Plan
Child Deaths	Refer to Child Death Overview Panel for review Additional PSII may be required alongside panel review – to be agreed on individual basis	Create local organisational actions to be overseen by the Trust Integrated Safeguarding Group. Where appropriate feed these into the quality strategy or transformation schemes

Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR) Additional PSII may be required alongside panel review – to be agreed on individual basis.	Create local organisational actions to be overseen by the Trust Integrated Safeguarding Group and Mortality Review Group. Where appropriate feed these into the quality strategy or transformation schemes.
Safeguarding incidents in which: • babies, children or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/ violence • adults (over 18 years old) are in receipt of care and support needs from their local authority • the incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery, and human trafficking or domestic abuse/ violence	Refer to local authority safeguarding lead The Trust will contribute to any safeguarding review and inquiry as required to do so by the local safeguarding partnership (for children) and local safeguarding adult's board.	Create local organisational actions to be overseen by the Trust Integrated Safeguarding Group. Where appropriate feed these into the quality strategy or transformation schemes
Incidents in NHS screening programmes	Refer to local screening quality assurance service (SQAS) for consideration of locally led learning response required.	Respond to input from SQAS and where required create local organisational actions for improvement. Where appropriate feed these into the quality strategy or transformation schemes
Deaths in custody where health provision is delivered by the NHS	The Trust will fully support the Prison and Probation Ombudsman (PPO) or Independent Office for Police Conduct (IOPC) with any investigation they undertake.	Respond to recommendations as required and create local organisational actions where relevant
Reportable infections meeting the national definition (hospital-onset healthcare associated, community-onset healthcare associated)	Submission to national IPC reporting system within 48 hours	Create local organisational actions where appropriate, to be overseen at Infection Prevention and Control Group with reporting to Patient Safety Group

Incidents meeting the criteria for reporting to Medicines Healthcare products Regulatory Agency (MHRA) and Serious Hazards of Transfusion (SHOT) and local Quality Management Systems	Report to MHRA/ SHOT Investigation of all required incidents documented within the SHOT definitions 2023. All transfusion incidents will be managed in accordance with Blood Safety and Quality Regulations (BSQR) and Good Practice Guidance (GPG).	Create local organisational actions where appropriate, to be overseen at Transfusion Group with reporting to Patient Safety Group

6. Our patient safety incident response plan: local focus

6.1. Incidents identified as a priority for Stockport NHS Foundation Trust

The Trust has reviewed the data sources available to it and engaged with key stakeholders to identify local priorities for patient safety. This section of the Patient Safety Incident Response Plan sets out what these local priorities are and how our learning will inform improvement at the Trust.

It is acknowledged that the local priorities are a focused list of incident types where the Trust has decided to invest its resources to learn and improve. The priorities were reached based upon a review of patient safety data alongside consultation and engagement with stakeholders. It is important to note that all other patient safety incidents reported will continue to be reviewed and responded to within our risk management system. Where necessary teams will utilise appropriate incident response tools to enable learning and improvement across all patient safety areas.

Although the local priorities below have been agreed and will be the focus of resource until the plan is reviewed, it is recognised that the Trust may gain new insight or reason throughout the time of the plan that requires additional responses to be agreed and take place.

Incident type	Planned local response	Anticipated improvement route
Nutrition and hydration incidents where: • there are identified lapses in care related to the weighing of patients, calculation of malnutrition universal screening tool (MUST) and dietician referral that led to weight loss of more than 5% of body weight and that is significant for that individual • there are delays in tube feeding or providing medication via tube, to a patient for more than 2 days due to lapses in care.	PSII/ thematic analysis	All PSIIs will be approved at Patient Safety Incident Review Group (PSIRG) and action plan related to improvement will be led by the Nutrition and Hydration Steering Group which is reported to Patient Safety Group and Quality Committee.
Acquired pressure ulcer incidents where: • a grade 3 or 4 pressure ulcer is acquired where lapses in care are identified as having contributed to skin deterioration.	PSII	All PSIIs will be approved at PSIRG and action plan related to improvement will be monitored as part of the Quality Strategy and action plan to achieve reductions in acquired pressure ulcers. This is reported to Patient Safety Group and Quality Committee. Safeguarding processes will also apply

		where appropriate with assurance received at the Trust Integrated Safeguarding Group.
Delayed diagnosis of cancer in a patient where: • initial review of the incident identifies that the delay is due to an omission, and where the patient outcome and treatment options are materially impacted by the delay in diagnosis	PSII	All PSIIs will be approved at PSIRG and action plan related to improvement will be monitored at the Cancer Quality Improvement Group. This is reported to Patient Safety Group and Quality Committee.
Deterioration of patients on the waiting list where: • the patient has a significant event or irrecoverable deterioration and following review by the clinician this is confirmed as a result of the extended waiting time.	After Action Review (AAR)/ Thematic analysis	AARs will be approved at PSIRG and any action plan related to improvement will be monitored. The quarterly patient safety report submitted to Patient Safety Group and Quality Committee will include a section to review themes and trends of AARs and ongoing improvement activity.
Maternity and neo-natal related incidents, outside of the scope of Healthcare Safety Investigation Branch (HSIB/ HSSIB) criteria where: • following review the Trust consider considerable learning and improvement will be identified	Local response to be agreed on individual incident basis. Where a theme is identified then a thematic analysis may be suitable.	All responses will be approved at PSIRG and any action plan related to improvement will be monitored via the sustainable maternity improvement plan that is presented to Patient Safety Group and Quality Committee.

Further detail regarding local priorities and how learning will inform improvement will be set out in the 'Safety action development and monitoring improvement' and Safety Improvement Plans sections of the Trust's Patient safety incident response policy.

NHS Stockport NHS Foundation Trust

Meeting date	3 August 2023	x	Public		Confidential	Agenda item
Meeting	Board of Directors					
Title	Maternity Service Highlight Report					
Lead Director	Andrew Loughney, Medical Director Nic Firth, Chief Nurse		Author	Divisional Director of Midwifery & Nursing / Deputy Head of Midwifery/		

Recommendations made / Decisions requested.

The Board of Directors is asked review the Maternity Services Highlight Report and confirm current position against key workstreams the service is working towards.

This paper relates to the following Corporate Annual Objectives

x	1	Deliver personalised, safe and caring services
	2	Support the health and wellbeing needs of our community and colleagues
	3	Develop effective partnerships to address health and wellbeing inequalities
x	4	Develop a diverse, talented and motivated workforce to meet future service and user needs
	5	Drive service improvement through high quality research, innovation and transformation
	6	Use our resources efficiently and effectively
	7	Develop our estate and digital infrastructure to meet service and user needs

The paper relates to the following CQC domains

x	Safe	x	Effective
x	Caring	x	Responsive
x	Well-Led		Use of Resources

This paper relates to the following Board Assurance Framework risks

x	PR1.1	There is a risk that the Trust does not deliver high quality care to service users
	PR1.2	There is a risk that patient flow across the locality is not effective
	PR1.3	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan
	PR2.1	There is a risk that the Trust is unable to sufficiently engage and support our people's wellbeing

	PR2.2	There is a risk that the Trust's services do not fully support neighbourhood working
	PR3.1	There is a risk in implementing the new provider collaborative model to support delivery of Stockport ONE Health & Care (Locality) Board priorities
	PR3.2	There is a risk that the Trust does not deliver a joint clinical strategy with East Cheshire NHS Trust
	PR4.1	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit and retain the optimal number of staff, with appropriate skills and values
	PR4.2	There is a risk that the Trust's workforce is not reflective of the communities served
x	PR5.1	There is a risk that the Trust does not implement high quality transformation programmes
	PR5.2	There is a risk that the Trust does not implement high quality research & development programmes
	PR6.1	There is a risk that the Trust does not deliver the annual financial plan
	PR6.2	There is a risk that the Trust does not develop and agree with partners a multi-year financial recovery plan
	PR7.1	There is a risk that the Trust does not implement the Digital Strategy to ensure a resilient and responsive digital infrastructure
	PR7.2	There is a risk that the estate is not fit for purpose and/or meets national standards
	PR7.3	There is a risk that the Trust does not materially improve environmental sustainability
	PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus

Where issues are addressed in the paper-

	Section of paper where covered
Equality, diversity, and inclusion impacts	
Financial impacts if agreed/ not agreed	
Regulatory and legal compliance	
Sustainability (including environmental impacts)	

Executive Summary

The report incorporates an update on a number of the elements the service is currently working towards, including.

- CNST Year 4/5
- Saving Babies Lives Care Bundle V3 (SBLCBv3)
- Midwifery Continuity of Carer pathway (MCOC)
- Ockenden Reports (2020/2022)
- East Kent Report (2022)

- Three-year delivery plan for maternity and neonatal services (2023)
- Pregnancy Loss review (July 2023)

The update also includes an overview of Stockport's performance across GMEC using the Quality surveillance toolkit, ongoing work with the MVP, Midwifery staffing, Equality and Equity plan, Perinatal mental health and maternity and perinatal safety champions.

The update also includes the recent successes and achievements of teams and individuals within the service.

The Maternity service highlight report will be presented on a bi-monthly basis to Patient Safety Group, a quarterly basis to Quality Committee and bi-annually to Trust Board.

1. Purpose

1.1 The purpose of this paper is to provide an update on a number of elements the maternity service is working towards to ensure safe and personalised care is delivered to women, birthing people and families who use the service and provide assurance against the recommendations of regional and national drivers for safer maternity and neonatal care.

2. Updates

2.1 **Clinical Negligence Scheme for Trusts** (CNST)

- The trust achieved full compliance of all 10 safety standards for year 4.
- Year 5 submission is due to be submitted to NHSR on 1 February 2024

2.2 **Saving Babies Lives Care Bundle V3** (SBLCBv3)

- Released 1 June 2023.
- New element added - Management of Diabetes in pregnancy.
- 6 elements of care in total
- Implementation deadline – March 2024

2.3 **Midwifery Continuity of Carer** (MCoC)

- No national targets for reporting MCoC
- Th trust continues to work towards delivering MCoC to the most vulnerable families.

2.4 **Equality and Equity Plan 2022-2027**

- The service is working towards the 5 priorities of the plan to improve maternity outcomes for service users who face inequalities based on their circumstances.

2.5 **Perinatal Mental Health**

- Overview of the current service offer and collaborative working within GM.
- Personalised care plans for all women/Birthing people.

2.6 **Ockenden/East Kent/Three-year delivery plan**

- The trust is fully compliant with all actions from the interim Ockenden report and recommendations from the regional assurance visit.
- All the reports and plans are now incorporated in the Northwest Regional Maternity strategy to allow robust oversight and a single point of reporting.

2.7 **Northwest Regional Maternity strategy 2023-25**

- Developed by NHSE Northwest maternity team to support providers to deliver the Vision set out in;
    - Better births (2016)
    - Long Term Plan (2018)
    - Annual NHS planning guidance
    - Three-year delivery plan for maternity and neonatal services (2023), which brings together the improvements required following the 2022

reports on maternity services in Shrewsbury and Telford and the maternity and neonatal services in East Kent.

- Gap analysis in progress

2.8 **Perinatal Loss Review**

- Report published 22nd July 2023 setting out the vision for improving the care of people who experience pre 24 week baby loss. With a key focus on ensuring:
  - All trusts and organisations can offer a consistent and forward-thinking service
  - Excellent care is acknowledged and rewarded
  - Areas of concern are highlighted so that improvements can be made
  - The review looks at options to improve NHS gynaecology and maternity care practice for parents who experience a miscarriage, ectopic pregnancy, molar pregnancy or termination for medical reasons
- Following publication of the pregnancy loss review, The service will prioritise a review to evaluate our current position against the **20** immediate actions. This will be followed up with a review of the remaining **53** recommendations.

3. Midwifery Staffing

3.1 Overview of midwifery staffing WTE, vacancy and recruitment.

3.2 Current budgeted establishment in line with Birth Rate plus.

3.3 Vacancy of 20.81 WTE, with 13.03 WTE recruited to, due to commence in post September/October 2023.

3.4 Maternity Red flags (events related to reduced staffing levels) are reported through directorate governance meetings and monitored through division.

- During June 6 were reported via Datix.
- 4 were reported as a result of staffing below the recommended safe staffing levels.

4. Maternity Voices Partnership (MVP)

4.1 The trust has good engagement with the MVP including co-production of services, recruitment, and service user feedback action plans.

4.2 Quarterly meeting attended by all Maternity and Perinatal safety champions including Executive and Non-Executive

5. Maternity and Perinatal Safety Champions

5.1 The role of the safety champion is to ensure that women, birthing people, babies, and families receive the safest care possible by adopting best practice and personalised care.

5.2 Members of the team include representatives from Trust Board and Maternity. Obstetric and Neonatal services.

5.3 Bi-monthly meetings and walk rounds in place.

6. GMEC Maternity Quality Surveillance

6.1 Dataset displaying the Trust's safety and quality performance across GMEC using the Quality surveillance toolkit.

6.2 The dashboard also enables an overview of all GMEC providers performance against the same dataset providing an opportunity for providers to benchmark/learn from each other.

7. Successes and Achievements

7.1 The maternity team presented their work in reducing term admissions to the Neonatal unit at the National Maternity Safety Conference in Birmingham in September 2022

7.2 The trust was visited by Sascha Wells Munro OBE, Deputy Chief Midwifery Officer, NHSE on 30 November 2022 to present 3 Chief Midwifery awards to individual midwives and teams.

8. Recommendations

8.1 The Board is asked to note the contents of the report and the trusts progress against regional and national maternity reports.

Maternity Services Highlight Report

Trust Board – 3 August 2023

Maternity Update

NHS Stockport NHS Foundation Trust

The update incorporates a number of elements the service is currently working towards, including

- Maternity Incentive Scheme (MIS) CNST Year 4/5
- Saving Babies Lives Care Bundle V3 (SBLCBv3)
- Midwifery Continuity of Carer pathway (MCOC)
- Ockenden Reports (2020/2022)
- East Kent Report (2022)
- Three year delivery plan for maternity and neonatal services (2023)
- Pregnancy Loss review (July 2023)

The update also includes an overview of Stockport's performance across GMEC using the Quality surveillance toolkit and ongoing work with the MVP, Midwifery staffing, Equality and Equity plan, Perinatal Mental Health and Maternity and Perinatal Safety champions.

The update also includes the recent successes and achievements of teams and individuals within the service.

MIS CNST Year 4 and 5

NHS Stockport NHS Foundation Trust

Year 4

- Declaration submitted to Board and NHSR on 2 February 2023
- Full national results released 19 May 2023
- Stockport declared as **fully compliant** against all **10** safety actions.

Year 5

- Information published 31 May 2023
- Continue to incentivise the 10 maternity safety actions from year 4 with some further refinement
- Completed board declaration to be submitted to NHSR by **12 noon** on **1 February 2024**

Saving Babies Lives Care Bundle V3 (SBLCBv3)

NHS Stockport NHS Foundation Trust

Background

- The Saving Babies' Lives Care Bundle provides evidence based best practice, for providers and commissioners of maternity care across England to reduce perinatal mortality.
- Version 3 of the SBLCB was released on 1 June 2023, and builds on the SBLCBv1 (March 2016) and SBLCBv2 (March 2019)
- Stockport Maternity services successfully implemented all **5** elements of the SBLCBv2.
- Version 3 of the SBLCB builds on the achievements of previous iterations and includes a refresh of all existing elements.
- Each element in SBLCB v3 has been reviewed to include actions to improve equity, including for babies from Black, Asian and mixed ethnic groups and for those born to mothers living in the most deprived areas, in accordance with the NHS equity and equality guidance.
- Version 3 includes a new, additional element on the management of pre-existing diabetes in pregnancy based upon data from The National Pregnancy in Diabetes (NPID) Audit

Element 1	Reducing Smoking in pregnancy
Element 2	Risk assessment, prevention and surveillance of pregnancies at risk of Management fetal growth restriction
Element 3	Raising awareness of reduced fetal movement
Element 4	Effective fetal monitoring during labour
Element 5	Reducing preterm births
Element 6	Management of Diabetes in pregnancy

- As part of the Three Year Delivery Plan for Maternity and Neonatal Services, NHS Trusts are responsible for **implementing** SBLCBv3 by **March 2024**
- Integrated Care Boards (ICBs) are responsible for agreeing a local improvement trajectory with providers, along with overseeing, supporting, and challenging local delivery.

Midwifery Continuity of Carer (MCoC)

NHS Stockport NHS Foundation Trust

Stockport remains committed to the development of MCoC when workforce pressures allow. The plans will build on existing progress & identify the building blocks to delivering MCoC at full scale in the future.

IN THE ABSENCE OF NATIONAL MCOC TARGETS THE STOCKPORT OFFER :

- Established a model of AN and PN continuity for all women and families including named Midwife
- Low risk offer for intrapartum care utilising the birth centre for suitable women
- Established a successful home birth service led from community and utilising an on-call system.
- Enhanced MCOC offer to the most vulnerable families including young parents and asylum seekers
- Data continues to be collated on Euroking for all MCoC care and births.
- The current transformation towards Family Hubs in Stockport, provides an opportunity for further development of smaller community based MCoC teams. The teams will provide an enhanced offer to those most likely to benefit from coordinated and relational care.
- Early adopter sites have been identified in Adswood, Brinnington and Offerton to this effect and plans have begun within community teams to align to the family hubs footprints. This is to enable both increased efficiency and more joined up and integrated care around vulnerable families within the community.

Equity and Equality Plan 2022 – 2027 (GMEC/LMNS)

NHS Stockport NHS Foundation Trust

Aim of the plan

To improve maternity outcomes and experiences for those women and people using maternity and neonatal services in GMEC who face inequality based on their circumstances or protected characteristics, such as ethnicity, faith, belief, sexual orientation and disability.

- In response to national guidance the LMNS and GMEC developed The Maternity Equity & Equality Action Plan 2022-2027, we have commenced the process of benchmarking ourselves against the 5 priorities and inclusive recommendations:
  - Restore NHS services, following COVID pandemic
  - Mitigate against digital exclusion
  - Ensure datasets are complete and timely
  - Accelerate preventative programmes that engage those at greatest risk of poor health outcomes
  - Strengthen leadership

Progress to date

- June 2022 a Standing Operating Procedure (SOP) developed titled 'Reducing inequality in Black Asian and minority Ethnic communities during the perinatal period'
- The service collects data on a monthly basis through the maternity data set system which enables mapping in relation to local deprivation utilising postcodes
- Designated Cultural & Diversity Midwife in post who has attended cultural competency training and delivers (mandatory) training to the maternity workforce, which incorporates tackling unconscious bias, cultural sensitivity, and trauma informed care.

Perinatal Mental Health

NHS Stockport NHS Foundation Trust

Service offer

- Perinatal Mental Health Lead Midwife and Lead Obstetric Consultant supported by B6 midwife and B4 Midwifery Assistant
- Stockport NHS Foundation trust have adopted the GMEC Perinatal Mental Health Guideline
- A screening tool comprising of a series of questions known as PHQ4 (Patient health questionnaire) is a universal offer within the booking procedure to identify current maternal depression & anxiety.
- Partners of women booked with poor mental health are signposted to Dad Matters or Stockport Talking therapies for additional psychological support.
- Families are prioritised within Stockport talking therapies for psychological support in the perinatal period
- Stockport fall within cluster 1 of the development of the specialist Community MH services which ensures complex need is managed appropriate
- Women have personalised plans

Collaborative working

- Bi-monthly Partnership meetings with the ICB
- Monthly mandatory education day provides updates on perinatal Mental Health
- Active MVP that engages with the local community
- Bi-Monthly Joint infant parent health meeting

Ockenden/East Kent Reports/Three year delivery plan

NHS Stockport NHS Foundation Trust

Ockenden Interim report (2020)

- 7 Immediate and Essential actions (IEA's) issued to providers across England
- The trust is **fully compliant** with all IEA's

Regional Insights assurance visit (May 2022)

- To review compliance against the 7 IEA's
- Recommendations and points for consideration were provided in the feedback report, which the trust have made good progress against and are **fully complaint**.

Final Ockenden report (2022)

- 15 IEA'S
- Each IEA requires ownership from either the National team, Regional team and/or the Trust.

East Kent Report (2022)

- 4 Key areas for action

The first Safety Progress and Performance Special Interest Group established by the LMNS convened on the 7th March 2023 – The aim of this group is to share progress against Ockenden and Kirkup recommendations/IEA's

Three-year delivery plan (March 2023)

- Sets out how the NHS will make maternity and neonatal care safer, more personalised, and more equitable for women, babies, and families.
- Concentrates on 4 themes
  - Listening to and working with women and families, with compassion
  - Growing, retaining, and supporting our workforce
  - Developing and sustaining a culture of safety, learning, and support
  - Standards and structures that underpin safer, more personalised, and more equitable care.

All of the above are incorporated in the new regional maternity strategy 2023-2025.Described in the next slide

North West Regional Maternity Strategy 2023-25

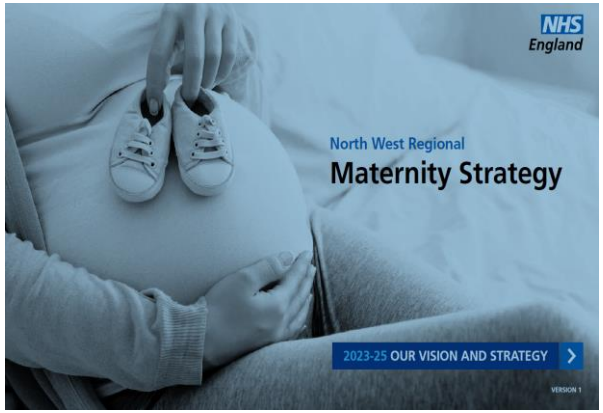
Stockport NHS Foundation Trust

Developed by the NHSE North West Maternity Team to support Local Maternity and Neonatal Systems (LMNS) and maternity providers to deliver the;

- Vision set out in better births (2016)
- Long Term Plan (2018)
- Annual NHS planning guidance
- Three-year delivery plan for maternity and neonatal services (2023), which brings together the improvements required following the 2022 reports on maternity services in Shrewsbury and Telford and the maternity and neonatal services in East Kent.

Aim

- To support all key stakeholders to work towards the 'North West being the safest, most personalised, and desirable place in England to give birth and work'
- The strategy is due to be launched and available on the NW maternity NHSE landing page in the coming weeks (NHS England — North West » North West Maternity Services)



Review to be undertaken by the Maternity Triumvirate and assess services against the strategy.
This will form a large part of the maternity update to Patient Safety Group, Quality Committee and Board.

Pregnancy Loss Review

NHS Stockport NHS Foundation Trust

Aim

The report was published 22nd July 2023 setting out the vision for improving the care of people who experience pre 24 week baby loss. With a key focus on ensuring:

- All trusts and organisations can offer a consistent and forward-thinking service
- Excellent care is acknowledged and rewarded
- Areas of concern are highlighted so that improvements can be made

The review looks at options to improve NHS gynaecology and maternity care practice for parents who experience a miscarriage, ectopic pregnancy, molar pregnancy or termination for medical reasons

Recommendations

The review has published 73 recommendations , which cover:

• Education, training and information	• Service provision
• Early pregnancy assessment units	• Gynaecology services
• Clinical care quality	• Bereavement care and support
• Primary and secondary care chaplaincy	• Patient records, IT and data
• The workplace	

Pregnancy Loss Review

NHS Stockport NHS Foundation Trust

Out of the 73 recommendations the government has identified 20 immediate actions that are to be implemented in the short term, which cover the following areas:

Sensitive handling and storage of pregnancy loss remains	Care for sporadic and recurrent miscarriage
Bereavement	NHS employees
Certificate of baby loss	Education, training and information
EPAUs	Research

Future Plan

Following publication of the pregnancy loss review, the division will prioritise a review to evaluate our current position against the 20 immediate actions. This will be followed up with a review of the remaining 53 recommendations.

Maternity Staffing Oversight

NHS Stockport NHS Foundation Trust

The maternity unit is currently staffed in line with NICE guidance for Safe Midwifery Staffing for Maternity Settings (NICE 2015) and the latest Birth Rate plus (BR+) midwifery staffing review (March 2023.)

Current position

	WTE Actual	Number of WTE Vacancies	Post WTE Recruited to TRAC
Registered Midwives	160.48 (Including B8 and above)	Vacancy 20.81 Maternity Leave 5.4	13.04 (11.44 due to start Sep/Oct 1.6 due to start August

Challenges

- Current registered vacancy inclusive of Inpatient and outpatient area's 20.81wte, in addition to this there is currently a gap of 5.4 wte on Maternity leave (due back April 24 – June 24). This equates to a total deficit of 26.21wte.

Actions

- Weekly planned roster scrutiny meetings/E.Roster training sessions
- Rolling advert for Band 5/6 midwives
- Planning recruitment event

Assurance

- All shift coordinators have supernumerary status.
- 98.4% of 180 eligible women received 1:1 care in labour in May– 1 lady fully dilated on arrival , 1 precipitate birth , 1 no reason documented on Euroking
- Maternity Red Flags monitored and reported through division
- Fully engaged with Maternity support workers framework working group
- Funding extended until 23/24 for Recruitment and Retention Midwife
- Engaged with the International Educated Midwifery (IEM) recruitment programme, three IEMs recruited in 1st wave. 1 commenced in post, 2nd awaiting pin number, 3rd awaiting OSCE
- The Trust has applied for further funding for 2 IEMs to be appointed to Stockport NHS Foundation Trust.

Maternity Red Flags

NHS Stockport NHS Foundation Trust

Maternity red flags are events that are immediate signs that something may require action to stop the situation getting worse.

Red flags are triggered by insufficient staffing levels resulting in the following:

- Delayed or cancelled time-critical activity
- Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing).
- Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication).
- Delay of more than 30 minutes in providing pain relief.
- Delay of 30 minutes or more between presentation and triage.
- Full clinical examination not carried out when presenting in labour.
- Delay of 2 hours or more between admission for induction and beginning of process.
- Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output).
- Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour.

Action includes escalation to the senior midwife in charge of the service, and the response may include allocating additional staff to the ward or unit.

Maternity red flags are monitored by the Maternity manager of the day and the shift coordinators out of hours.

During June 2023 there were 6 maternity red flags reported via datix

4 were reported as a result of **staffing** being below the recommendation of safe staffing, one was reported to be as a result of both acuity and staffing and one as a result of **acuity** alone.

Maternity Voices Partnership (MVP)

NHS Stockport NHS Foundation Trust

MVP Engagement

- New MVP Chair appointed April 2023
- Monthly 1:1 with Deputy HOM
- MVP Quarterly meetings represented by Exec and Non Exec Safety Champions, Maternity, Obstetric and Neonatal safety champions.
- First face to face MVP meeting April since COVID
- MVP Chair invited to Maternity and Perinatal safety champions meetings as standing agenda item and HSIB quarterly meetings
- Minutes or Patient Experience Group shared with MVP chair

Working in Collaboration

- Induction of labour survey – 1 year on – Complete Action plan to be presented in May (PEG)
- Inpatient welcome to ward leaflet/ antenatal aromatherapy leaflet – co produced
- Feedback Friday
- Maternity Infographic
- 15 Steps action plan ongoing – 15steps follow up walk round date to be confirmed

Maternity and Perinatal Safety Champions

NHS Stockport NHS Foundation Trust

Maternity and Perinatal Safety Champions walk round take place bi-monthly. Next one is due 6th July

- Andrew Loughney and/or Mary Moore
- All area's in Maternity visited excluding community
- Meet with various Midwives/Neonatal Nurses and support staff.

Discussions held regarding:

- Return of services/Maternity staff to EC and its impact
- Induction of Labour
- Staffing challenges
- Everyone welcomed the discussions
- Environmental improvements recognised

Greater Manchester and Eastern Cheshire Strategic Clinical Network

NHS Stockport

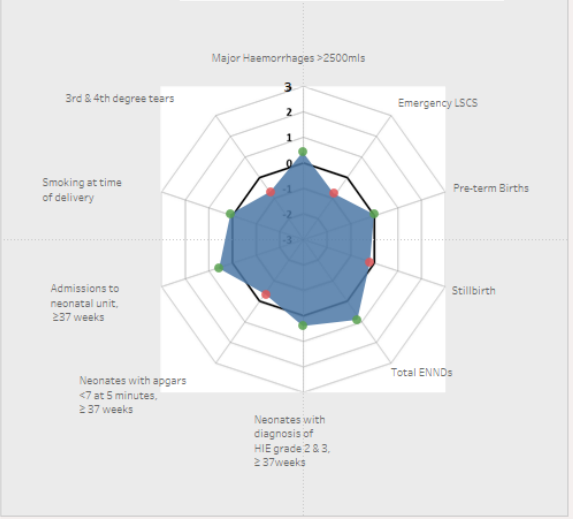
Maternity Quality Surveillance | Updated: 19/05/23 | Provider Choice: Stockport

NHS Greater Manchester and Eastern Cheshire Strategic Clinical Networks

Lastest 12 months | Apr, 2022 | to | Mar, 2023

Stillbirth (per 1,000)	4.607
Early Neonatal Deaths (per 1,000)	0.617
HIE (per 1,000)	1.027
Maternal Deaths (per 1,000)	0.000

Further Maternity data available here



GM Avg

	GM Avg	
Stillbirths		4.607
Total ENNDs		0.617
Maternal Deaths		0.000
Neonates with a diagnosis of HIE Grade 2 and ..		1.03
Apgars <7 at 5 minutes, ≥ 37 weeks		15.06
Major haemorrhages >2500mls		4.66
3rd & 4th degree tears		3.08
Admissions to neonatal unit, ≥37 weeks		4.72
Emergency LSCS		25.03
Pre-Term Births		9.85
Women smoking at time of delivery		8.26

Part of Greater Manchester Local Care Partnership

% Compliant:

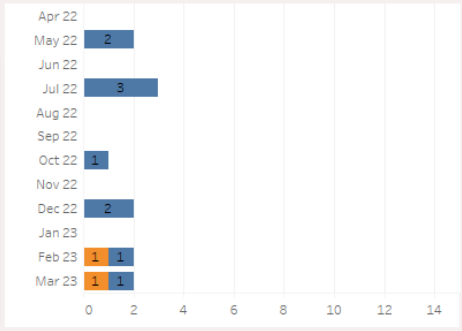
Element 1	100.0%	0.0%	0.0%
Element 2	100.0%	0.0%	0.0%
Element 3	100.0%	0.0%	0.0%
Element 4	100.0%	0.0%	0.0%
Element 5	100.0%	0.0%	0.0%

NHS Improvement

STEIS and Diverts
Total number of diverts
Total number of STEIS excluding diverts

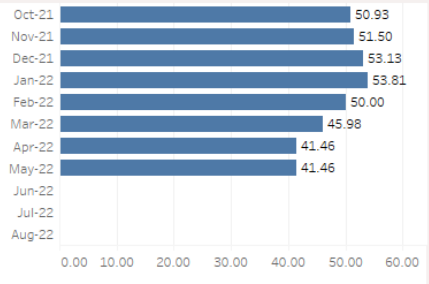
Total	
	10
	2

No. of StEIS/Divert INCIDENTS:



CONTINUITY OF CARE

%



CareQuality Commission: Requires Improvement

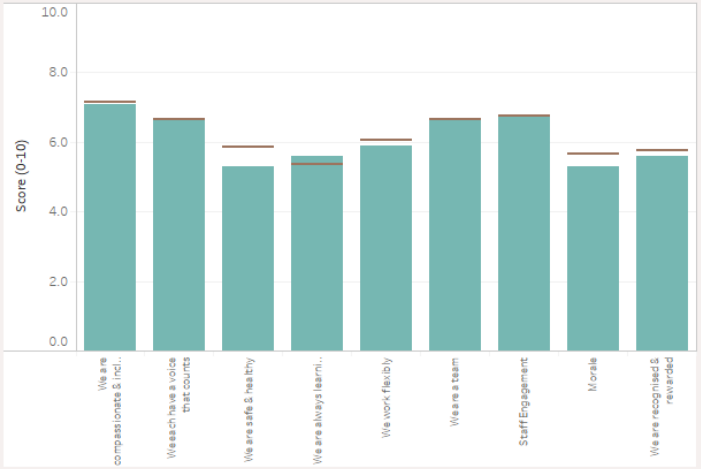
NHS Resolution

CNST MIS Status (Year 3): 10

SURVEYS

Breakdown | Your Org

Stockport NHS Foundation Trust: Nursing & Midwifery Registered Score (Breakdown) Vs Unweighted Organisation Average (Your Org)



	We are com passionate & inclu..	We each have a voice that counts	We are safe & healthy	We are always learning	We work flexibly	We are a team	Staff Engag ement	Morale	We are recognised & rewarded
Breakdown	7.1	6.7	5.3	5.6	5.9	6.7	6.8	5.3	5.6
Your Org	7.2	6.7	5.9	5.4	6.1	6.7	6.8	5.7	5.8
Responses	728	722	727	707	723	727	728	728	724

GMC National Training Survey (2022) Overall Satisfaction (published March 2023)

69%

RAGB Rating for CQC Maternity Survey
Amber (7-7.9)
Green (8-9)
red

GMEC CQC Maternity Survey

The Start of Your Care During Pregnancy	Antenatal Check-Ups	During Your Pregnancy	Your Labour and Birth	Staff Caring for You	Care in Hospital After Birth	Feeding Your Baby	Care at Home After Birth	Overall average
5.46	8.66	8.61	7.43	8.08	7.89	8.19	7.97	7.78

Successes and Achievements

NHS Stockport NHS Foundation Trust

The maternity team presented their work in reducing term admissions to the Neonatal unit at the National Maternity Safety Conference in Birmingham in September 2022.

Successes and Achievements

NHS Stockport NHS Foundation Trust

Chief Midwifery Officer Awards

The trust was visited by Sascha Wells Munro OBE, Deputy Chief Midwifery Officer, NHSE to present 3 awards to individual midwives and teams.

Kristy Franklin, Midwife, was awarded a **Gold** Chief Midwifery award in recognition for her work with refugees in Stockport.

Successes and Achievements

NHS Stockport NHS Foundation Trust

Chief Midwifery Officer Awards

Sharon Hyde, Divisional Director of Midwifery and Nursing was awarded a **Silver** award for her leadership skills in the trusts journey through the maternity Safety Support programme (MSSP) and successful exit from the programme.

Successes and Achievements

NHS Stockport NHS Foundation Trust

The **Maternity perinatal mental health team** were awarded a **Silver** award for their "walk into wellbeing" initiative to provide support to new parents during the pandemic and beyond.

NHS Stockport NHS Foundation Trust

Meeting date	3rd August 2023	X	Public		Confidential
Meeting	Board of Directors				
Title	Research, Development and Innovation (RD&I) Annual Report: Trust Performance and Strategic Update for 2022-23				
Lead Director	Dr Andrew Loughney, Medical Director and RD&I Executive Lead	Author	Wiesia Woodyatt, RD&I Manager		

Recommendations made / Decisions requested

The Board of Directors are asked to receive the annual report and confirm:
- Delivery of the joint RD&I Strategy with Tameside and Glossop Integrated Care NHS Foundation Trust (TGIC) throughout 2022-23 with the resource available
- Risks to delivery of the RD&I Strategy have been identified and managed appropriately.
- An appropriate direction of travel for future RD&I sustainability and growth across Stockport NHS Foundation Trust and TGIC.

This paper relates to the following Corporate Annual Objectives:

	1	Deliver personalised, safe and caring services
x	2	Support the health and wellbeing needs of our community and colleagues
x	3	Develop effective partnerships to address health and wellbeing inequalities
x	4	Develop a diverse, talented and motivated workforce to meet future service and user needs
x	5	Drive service improvement through high quality research, innovation and transformation
x	6	Use our resources efficiently and effectively
	7	Develop our estate and digital infrastructure to meet service and user needs

The paper relates to the following CQC domains

	Safe	x	Effective
	Caring		Responsive
x	Well-Led		Use of Resources

This paper relates to the following Board Assurance Framework risks

x	PR1.1	There is a risk that the Trust does not deliver high quality care to service users
	PR1.2	There is a risk that patient flow across the locality is not effective
	PR1.3	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan
	PR2.1	There is a risk that the Trust is unable to sufficiently engage and support our people's wellbeing
	PR2.2	There is a risk that the Trust's services do not fully support neighbourhood working
	PR3.1	There is a risk in implementing the new provider collaborative model to support delivery of priorities/objectives of the Stockport ONE Health & Care (Locality) Board

	PR3.2	There is a risk that the Trust does not deliver a joint clinical strategy with East Cheshire NHS Trust
	PR4.1	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit and retain the optimal number of staff, with appropriate skills and values
	PR4.2	There is a risk that the Trust's workforce is not reflective of the communities served
	PR5.1	There is a risk that the Trust does not implement high quality transformation programmes
x	PR5.2	There is a risk that the Trust does not implement high quality research & development programmes
	PR6.1	There is a risk that the Trust does not deliver the annual financial plan
	PR6.2	There is a risk that the Trust does not develop and agree with partners a multi-year financial recovery plan
	PR7.1	There is a risk that the Trust does not implement the Digital Strategy to ensure a resilient and responsive digital infrastructure
	PR7.2	There is a risk that the estate is not fit for purpose and/or meets national standards
	PR7.3	There is a risk that the Trust does not materially improve environmental sustainability
	PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus

Where issues are addressed in the paper

	Section of paper where covered
Equality, diversity and inclusion impacts	4.4 and Appendix 1
Financial impacts if agreed/ not agreed	Sections 3.1.2, 3.3 and 4.1
Regulatory and legal compliance	Section 3.1.1.2 and 5, 4.2
Sustainability (including environmental impacts)	Throughout paper.

Executive Summary

This report has been reviewed and confirmed by the Research, Development and Innovation Committee, Clinical Effectiveness Group and Quality Committee.

The purpose of this report is to inform the Board of Directors of the Trust's R&I performance for 2022-23, focussing on:

- Organisational changes including staffing, engagement and the risks/ implications of an under-resourced/ trained workforce.

- Key performance indicators (KPIs) mandated by the Department of Health and Social Care (DHSC) for research study set-up and delivery.

- KPIs from the National Institute for Health and Care Research (NIHR) Greater Manchester Clinical Research Network (GMCRN) and internally for research study set-up, recruitment and research participant experience.

- Annual financial summary focusing on:
    - Re-investment of RD&I generated income to expand the local research workforce and embed a research active culture throughout the organisation.
    - Income received to support the research delivery workforce from the NIHR.

- General assurances for research delivery conduct and risk mitigation.

- Progress update on the delivery of the RD&I joint strategy with TGIC and recommendations to ensure this is delivered, with a focus on protecting research time, acknowledging that with the Trust's significantly challenged financial position, this will rely on robust sources of research income and be balanced against operational demands.

1. Purpose

1.1 The purpose of this report is to provide an annual review for 2022-23 of Research, Development and Innovation (RD&I) activity at Stockport NHS Foundation Trust (SNHSFT), focusing on Key Performance Indicators (KPIs) for study set-up, delivery targets, participant recruitment and experience, finances, staffing and engagement. A summary is provided for the gaps currently identified in the RD&I service and the proposal for addressing these over the year ahead to minimise risk. There is also an update of the progress made on delivery of the joint RD&I strategy with Tameside and Glossop Integrated Care NHS Foundation Trust (TGIC), which was successfully launched in Oct-2022. The report's content has already been shared and confirmed with the Clinical Effectiveness Group (CEG), RD&I Committee (RD&I-C) and Quality Committee (QC). There is a request for these groups and the Board of Directors to confirm if they are assured that the RD&I team have delivered effectively throughout 2022-23 with the resource available, focused on relevant, high-quality, inclusive research to meet our population's needs, with a robust plan to sustain and improve this in the future across both Trusts.

2. Background and links to previous papers

2.1 The local, regional and global response to the COVID-19 pandemic has highlighted the critical importance of clinical research, increasing awareness and engagement from our staff and patients alike. The aim of the Department of Health and Social Care (DHSC), through the National Institute for Health and Care Research (NIHR) and through our joint RD&I strategy with TGIC, is to give the opportunity for our local population to access a diverse range of research studies that are of high quality, for direct patient benefit and that tackle health and care inequalities. It is well known that clinical research provides the evidence base to answer key questions that help us tackle health and care issues in our population. However, it can also make a real difference to clinical care outcomes, patient experience and organisational reputation. Embedding and maintaining a robust RD&I infrastructure and culture at SNHSFT is integral to delivering the Trust's higher level strategy for continued service improvement.

2.2 Research is enabled in the Trust predominantly through research active healthcare professionals and the delivery staff and service department (i.e. laboratories, pharmacy and radiology) funding support received from the NIHR, coupled with income generation from specific research projects. The NIHR supports the infrastructure for research delivery in the NHS. Support is offered regionally and SNHSFT is currently part of the Greater Manchester Clinical Research Network (GMCRN). From 01-Oct-2024, GMCRN will merge with the North West Coast network to create the North West Research Delivery Network, the largest geographical region of the new networks, encompassing a population of 7.0M and 33 NHS Trusts, with Manchester University NHS Foundation Trust acting as the regional host.

2.3 Throughout 2022-23, the prolonged impact from the COVID-19 pandemic has reinforced the importance of having a robust RD&I infrastructure in the Trust. To address the post-pandemic challenges across the UK clinical research delivery system, the DHSC has focused on identifying measures to strengthen the UK's research base, in a continued programme of 'Research Recovery, Resilience and Growth'. This included the 2022 Research Reset programme, which aimed to make research portfolio delivery achievable within planned timelines and sustainable within the resource and capability we currently have in the NHS. Significant work with funders and sponsors was undertaken nationally to review studies that were unlikely to be able to deliver their end points in a post-pandemic environment. Locally, this resulted in our research portfolio changing significantly from the previous year, which meant our workforce adapting quickly to changes in study status. The challenges of Research Reset have been intense locally, coupled with high levels of sickness in the local research delivery team and capacity issues in supporting departments. The service has therefore not been able to move as quickly as hoped to re-build across specialties. This report details these key challenges and difficulties, but also the many successes of 2022-23.

3. Matters under consideration

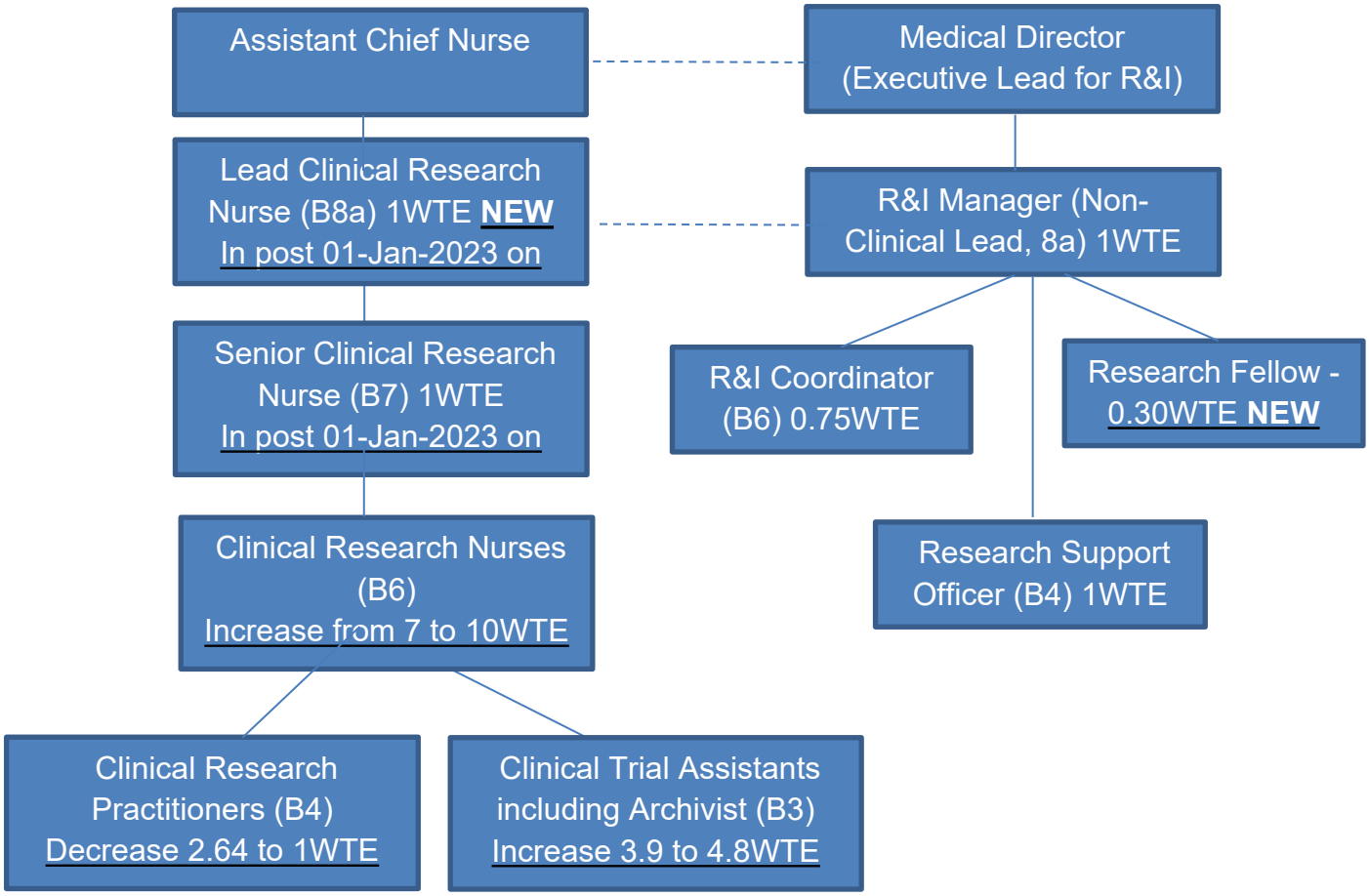
3.1 Organisation, staff funding and engagement

3.1.1 Organisational changes

3.1.1.1 2022-23 was a difficult year for the RD&I staffing structure. However, significant advances were made in the re-organisation of the leadership roles and research delivery team in the last quarter of the year, along with a gradual expansion of the staffing complement throughout the year due to re-investment of the income generated from COVID-19 vaccine work. By the end of 2022-23, all new and existing research delivery role vacancies had been appointed to (see summary on next page), with the hope that the revised structure will allow the continued re-build of a study portfolio varied in specialties, complexity and risk.

3.1.1.2 The key issues impacting service delivery in 2022-23 arose from the continued vacancy of the Lead Clinical Research Nurse post and high levels of long-term sickness in the latter half of the year. The expanded team vacancies therefore had to be staggered to be filled, slowing progress with study recruitment and the national Research Reset demands. There were also high sickness levels in the RD&I core governance team of 3 staff, which resulted in the R&I Manager covering this function solo for over a third of the year. This meant there was a prolonged lack of resource to expedite new study set-ups, fully re-implement research training, progress significantly with strategic delivery and pick work back up on the development of a new Quality Management System (QMS). The demands of the existing study portfolio and day-to-day running of the department had to be prioritised.

3.1.1.3 Assurances can be provided to the Trust with regard to these service challenges. The nursing leadership role was successfully filled internally to support career development, with the new Lead Clinical Research Nurse and Senior Clinical Research Nurse post holders starting from Jan-2023 in 'acting up' positions (substantive posts plan to be advertised in Aug/ Sep-2023). These roles have made a significant positive difference almost immediately, with a focus on appointing to other vacant clinical posts, re-defining work flows and also further re-structuring of the team (e.g. The Clinical Trial Assistant roles transitioned in Jan-2023 to be fully part of the research delivery team to focus on active clinical study support). Coupled with this, a new Archivist role was appointed to in the second half of the year, allowing a focus on the closure and off-site archiving of older studies, to help make way for new projects. Finally, part of the 2023-24 strategic work plan programme is complete a full review of the RD&I core governance team structures across SNHSFT and TGIC, to then propose and implement a revised, shared model to improve resilience in this area of the RD&I workforce.



3.1.1.4 Another key issue in 2022-23 was the capacity challenges from key service departments supporting research. These departments also faced the challenges of service reset post-pandemic with the need to balance these pressures with RD&I requests for a rapidly changing study portfolio.

- **Laboratories:** This department cited a 10% overall workload increase year on year, with no protected time in job plans to support research activity in the Trust (unlike pharmacy and radiology). This has meant increased pressure on laboratory staff to support research activity as an 'add on' to their usual roles (generally through an overtime model), which is not sustainable from a health and well-being perspective for these staff or for providing the optimal service for our patients. RD&I is an integral strand of the overarching Trust strategy for supporting continued service development throughout the organisation, so it needs to be robustly integrated through all departments.

  In the second half of 2022-23, discussions have increased with laboratory leads around re-investment of the ~£250,000 income generation from COVID vaccine study work, coupled with the recurrent ~£20,000 from NIHR GMCRN annual funding to provide a more robust RD&I support service that works for both laboratories and RD&I patients. The finalised proposal for short and longer team cover is expected in the first quarter of 2023-24 from the laboratory team. The RD&I department has also invested in a new refrigerated centrifuge and fridge/ freezer to help with laboratory research capacity. If studies allow, some samples are now being processed on Ward C2 (RD&I Department) by RD&I staff to help alleviate current pressures on laboratory equipment and staff.

- **Pharmacy:** This department experienced challenges with sickness amongst technician staff, resulting in limited back-up cover for study dispensing visits for the 0.5WTE Band 7 Clinical Trials Pharmacist. The linked Pharmacist also handed in their notice at the end of 2022-23. However, this change enabled the role to be re-defined, so the post has now been appointed to at a Band 8a level, due to start in Jul-2023 with technician support. There is a new satellite pharmacy room being constructed in the RD&I department on Ward C2, to help provide a more integrated research pharmacy service for our patients. Research documentation is also being standardised in the pharmacy team to provide improved contingency cover for the RD&I service when dedicated pharmacy staff are off.

- **Radiology:** Up to Autumn-2022, there was limited staff cover to support RD&I activity in radiology, with assigned staff covering multiple roles to support with vacancies and post-pandemic catch up in their area. However, the latter half of the year saw a re-focus with RD&I income being directly linked to a Research Radiology Lead role, which allows 3.5h protected time per week of a Radiographer's time to directly support research requests, along with some limited time for oversight from a Consultant Radiologist as a clinical radiation expert. This dedicated time has significantly improved the service support from radiology and has allowed us to expand our research portfolio to offer more studies with imaging requirements.

3.1.1.5 Lack of resource contingency has been a recurring theme in previous years in RD&I. However, the re-investment of income from COVID-19 projects has helped to overcome this in the shorter term (i.e. next 4-5 years). The longer term plan of service resource investment will require further scrutiny if the Trust is truly going to adopt a research active and supportive culture, underpinned by robust governance structures that can successfully demonstrate regulatory compliance and sustained income generation. There needs to be a significant mind set shift across the organisation that RD&I is not an 'add on' but an essential service to improve outcomes for our patients, as outlined by various DHSC papers.

3.1.2 **Staff funding**

3.1.2.1 At the end of 2021-22, there were 14.77 WTE active staff in the RD&I team, then 16.59 WTE at the end of 2022-23 with other vacancies out to advert/ filled, to take the team to 20.85 WTE by the end of the first quarter of 2023-24. These additional posts have predominantly been funded by non-recurrent COVID-19 income generation in research, with the hope that it will pump prime the service to expand across specialties. This non-recurrent income can sustain the current staff structure for 4-5 years if other external funding avenues aren't reduced. Securing both future commercial work and Trust investment will be the key to continuity of this revised structure.

3.1.2.2 RD&I staff funding is directly linked to achievement of participant recruitment targets set by the NIHR GMCRN for enrolment into studies which form part of their portfolio, as well as regular invoicing for specific study work to support Trust funded roles. The figures below demonstrate the NIHR GMCRN's commitment in supporting SNHSFT with the infrastructure needed to sustain the study portfolio.

2020-21: £456,149 was received from the NIHR (original allocation was £363,989, so £92,160 in non-recurrent funding was provided). This increase in non-recurrent funding was in recognition of SNHSFT's position as 'South Sector' GM lead for COVID-19 vaccine research.

2021-22: £429,691 was received from the NIHR (original allocation was £389,850, so £39,841 in non-recurrent funding was provided). This reflected more of a 'business as usual' distribution from the previous year, with extra non-recurrent funding secured specifically to focus on reset of the non-COVID-19 portfolio.

2022-23: £451,936 was received from the NIHR (original allocation was £404,336, so £47,600 in non-recurrent funding was provided). This funding level was similar to the previous year (to account for Agenda for Change cost of living increases), with again, additional non-recurrent funding to focus on reset of a study portfolio covering expanded specialties.

The original allocated funding amount covered some of the above research delivery staff salaries (7.43 WTE) along with contributions to the Trust infrastructure as a whole (i.e. pharmacy, radiology, laboratories, PAs: 4 x 0.25 to 0.5PA for research active clinicians, totaling 1.5 PAs) to support research. The original allocation reflects the equivalent WTE to that funded in the previous year. There are other research PAs covered by the Trust for other clinicians but these are minimal.

If participant recruitment targets are not achieved, there is a direct financial risk to the Trust. NIHR funding may not be renewed or funding may not be available from income generation in future financial years, which could result in redeployment or redundancy of RD&I staff. This hopefully is a low risk (we already have a 7 year track record of sourcing funding, with 4-5 years ahead already secured for non-NIHR funded staff), but it is still one to be highlighted. The staffing challenges outlined in 3.1.1 did have a significant impact on SNHSFT achieving its annual participant enrolment target in 2022-23, with 73.2% of its 1,630 target being met by the end of the year. However, the NIHR GMCRN acknowledged and understood the challenges of Research Reset in Trusts, so the 2023-24 funding allocation for research delivery staff reflected this with 8.7WTE assigned. For the financial year ahead, the 2023-24 recruitment target of 2,000 will need to be met as the funding purse for the new, merged North West Research Delivery Network is currently unknown. Our Trust needs to demonstrate a strong recruitment record so that this funding level is secured in future years to minimise risks around finances and staffing. Our RD&I strategy sees a focus on commercial portfolio re-growth, aligning with national mandates. Our research delivery team is focused on securing future vaccine work and other high recruiting studies to help mitigate these risks, but these will only be achievable with robust service department support.

3.1.2.3 The Trust infrastructure still requires further evaluation to ensure healthcare professionals have the time to truly embed research into clinical care and attract staff who wish to improve treatment options for our patients. Discussions are ongoing through the RD&I-C and with key stakeholders as we deliver on our 5 year strategic plan.

3.1.3 **Staff engagement**

3.1.3.1 Staff engagement in research has improved in 2022-23 and we have a fantastic baseline to build on for the year ahead. Our 2022-23 SNHSFT research portfolio demonstrated some of the ‘Research Reset’ we had hoped for post-pandemic. Recruitment started to pick up across more specialties, with clinicians and allied health care professionals contributing to activity. We have also seen an increase in more junior healthcare professionals stepping forward into the Associate Principal Investigator roles and allied healthcare professionals becoming Principal Investigators (e.g. in podiatry for diabetes and for stroke, physiotherapists and speech/ language therapists). Vaccine and other COVID-19 pressures also continued to ease throughout this year. In 2021-22, we saw recruitment

into 30 different studies across COVID-19, anaesthetics/ critical care, cancer, diabetes, gastroenterology, ophthalmology, rheumatology, reproductive health and trauma/ emergencies. Despite staffing issues, we did build on this in 2022-23 with recruitment across 40 different projects, with cardiology, haematology, paediatrics, renal disorders and stroke being added to the specialty list above. This pattern is commensurate with the national 'Research Reset' landscape and true testament to the dedication of the research delivery team here at SNHSFT.

3.1.3.2 The RD&I team has also approached research publicity from different angles in 2022-23 to start sending the key message to the wider organisation that clinical research is definitely part of everyday business. Some key examples are:

- Development, release and posting of research specialty newsletters to publicise the different projects available to our patients.
- Launch of the 5-year RD&I strategy with TGIC.
- Presentations at the Advanced Clinical Practitioner, Student Nurse, Junior Doctor and Practitioner forums to showcase research work.
- Regular posting on staff intranet news and RD&I microsite to publicise new studies opening, training/ seminar/ conference/ funding opportunities, as well as publications for studies we have supported locally.
- Support at Trust-wide events such as Stockport Pride and celebrating International Clinical Trials Day and other research events to raise the department's profile.
- Press releases on high profile studies and to celebrate successes.

3.1.3.3 The above summary is to provide assurance that the RD&I team has been committed to engaging participants and staff across our healthcare system to deliver the studies that best aligned with the needs of our population during another challenging year.

3.2 Key Performance Indicators (KPIs) for research

3.2.1 DHSC KPIs for research

3.2.1.1 Background: The DHSC wishes to see a dramatic and sustained improvement in the performance of providers of NHS services in initiating and delivering clinical research. The aim is to increase the number of patients who have the opportunity to participate in research and to enhance the nation's attractiveness as a host for research. The NIHR has enforced the transparency commitment for this exercise. Providers of NHS services have been required to publish outcomes against the DHSC benchmarks for recruiting their first patient into a clinical research study and delivery to time and to target for commercial clinical studies. SNHSFT's latest performance reports are always published on http://www.stockport.nhs.uk/services_895R. In 2022-23, all studies were reported on accurately, continuing the robust tracking systems which have

been in place since 2016-17. The types of studies required for inclusion in these reports are: 'Clinical trials of investigational medicinal products'; 'Clinical investigations or other studies of a medical device'; 'Combined trial of an investigational medicinal product and an investigational medical device' and 'Other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice'.

3.2.1.2 KPIs for study set-up: This section provides a summary of the study numbers reported on externally for 2022-23 for every study where the 'date site selected' fell within the previous 12 months. This date effectively triggers a clock from when a minimum document set is provided to the Trust for a study (so that local capacity and capability can be assessed) to recruiting the first participant locally. This includes commercially sponsored (pharmaceutical industry) and non-commercially sponsored studies (NHS/ University). The aim is to ensure that all reported studies are set-up efficiently, without delay, and if not, for minimal reasons for the delay to be attributable to the Trust. It is important to note that due to general NHS pressures, the last DHSC requested report was in the second quarter of 2022-23 so we have 6 months of data for 2022-23. We are currently awaiting a formal briefing of how performance reporting will change in the new world of 'Research Reset' post COVID-19. This is expected in Autumn-2023.

The detail below summarises the outcome of the 11 (in just 6 months, compared to 16 in the entirety of 2021-22) studies falling into the DHSC reporting categories in 2022-23, where delays are in reference to the duration from the site being selected to the first participant recruited. Generally, we saw more typical delay reasons (e.g. contracting, equipment and staffing availability etc) between sponsors and site as pandemic pressures continued to ease.

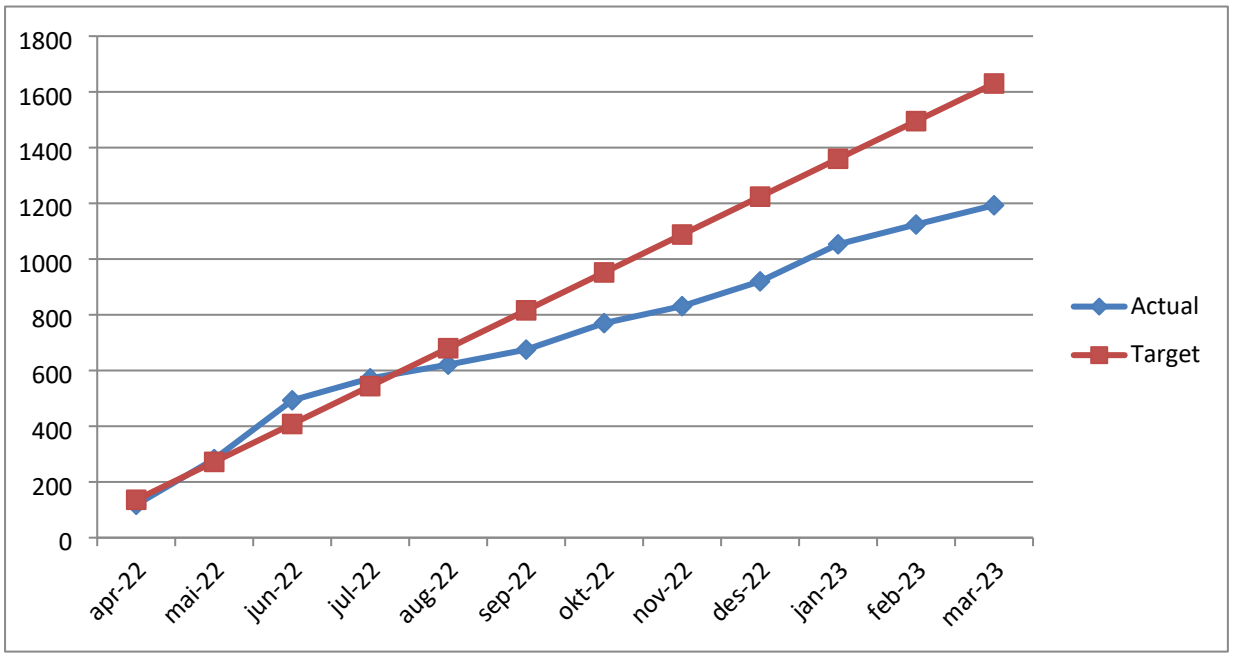
- 18.1% of studies experienced no delays (12.5% in previous year).
- 27.3% of studies experienced delays due to both sponsor and site (18.75% in previous year).
- 27.3% of studies experienced delays due to sponsors (12.5% in previous year).
- 27.3% of studies experienced delays due to site (43.75% in previous year).
- 0% of studies experienced delays outside sponsor and site control (12.5% in previous year), which reflects the decreased impact of COVID-19 implications on this metric.

3.2.1.3 KPIs for study delivery: This section provides a summary of the commercial contract clinical studies hosted by SNHSFT, which closed to recruitment in the previous 12 months. The metric measured is whether the pre-agreed numbers of participants have been recruited in the pre-agreed recruitment period for the study. Only 1 study fell into this category for the first half of 2022-23 reporting compared to 7 in the previous full reporting year. This ear, nose and throat study did not achieve its

recruitment target as it relied on endoscopy (aerosol generating procedure), so the pandemic halted recruitment and it never re-started. A significant portion of our commercial portfolio closed in 2022-23. This is a risk for continued income generation to support the RD&I team. However, we are trying to mitigate this by bidding for new commercial work and supporting the GM-wide bid to attract more vaccine work into the area, in which the SNHSFT team has significant expertise (linked to the recent DHSC deal signed with Moderna to secure a large vaccine study pipeline for the UK). Investments into the expanded staffing structure, RD&I department capability (i.e. new laboratory equipment, research pharmacy satellite room) and improved service department support is all critical to supporting future commercial work.

3.2.2 NIHR GMCRN KPIs for research study recruitment and set-up

3.2.2.1 Recruitment: In 2022-23, the number of patients enrolled into a clinical research study adopted by the NIHR was 1,193 (our target was 1,630). This reflects research studies that were approved by a research ethics committee (in conjunction with the Health Research Authority). This was an expected, significant decrease from the 2,389 enrolment of 2021-22, which still included high recruiting COVID-19 studies. We had hoped to achieve our target of 1,630 but due to the staffing challenges outlined in 3.1. and some high recruiting studies closing earlier than anticipated; this meant we finished the year at 73.2% achieved. The team performed really well despite the challenges. The now improved staffing contingency should mean the 2023-24 target of 2,000 is achievable.



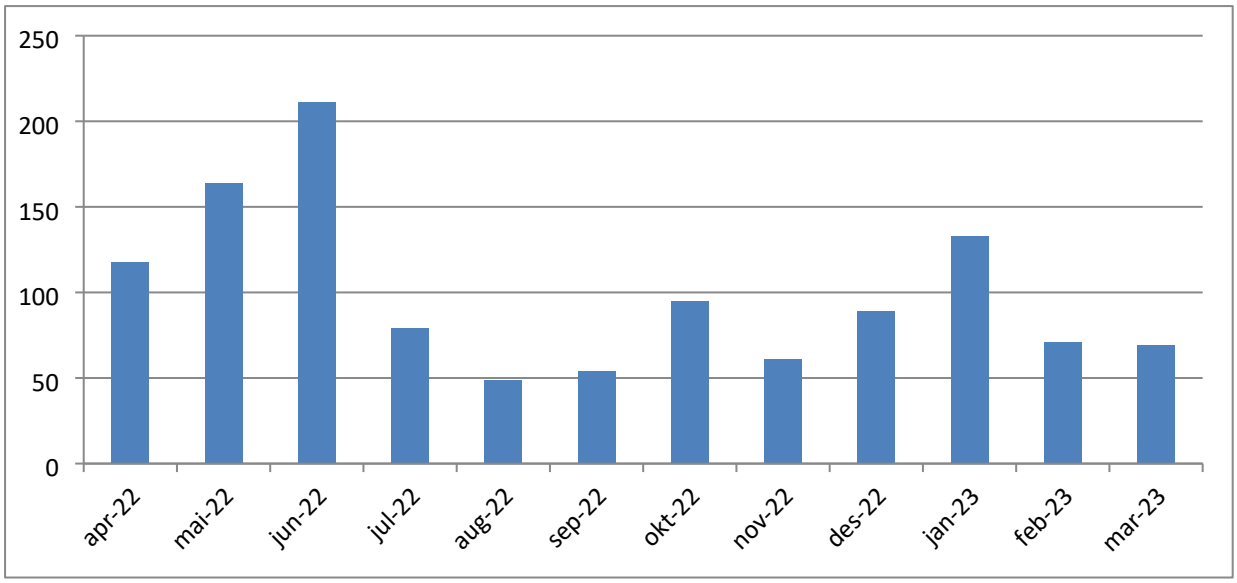
Despite not achieving our 2022-23 NIHR recruitment target, we did successfully open up to 5 more specialty areas than in 2021-22 (see 3.1.3.1) and we hope to build on this diversification into 2023-24. The summary below

demonstrates the areas of recruitment growth in 2022-23, with some areas decreasing as expected (e.g. critical care, health services, infectious disease, mental health, respiratory), because of the reduced COVID-19 study portfolio.

Specialty	**Number of Participants Recruited**		
	2021/22	**2022/23**	**Difference**
Anaesthesia	61	22	-39
Cancer	18	25	+7
Cardiovascular	0	227	+227
Children	0	72	+72
Critical Care	75	14	-61
Diabetes	9	14	+5
Ear, Nose, Throat	1	0	-1
Gastroenterology	7	62	+55
Haematology	0	30	+30
Health Services	26	0	-26
Infectious Disease	619	53	-566
Injuries, Trauma and Emergencies	6	7	+1
Mental Health	340	0	-340
Musculoskeletal	136	127	-9
Ophthalmology	5	14	+9
Renal Disorders	17	8	-9
Reproductive Health	1,067	464	-603
Respiratory	1	0	-1
Stroke	1	54	+53
Surgery	0	0	0
Totals	**2,389**	**1,193**	**-1,196**

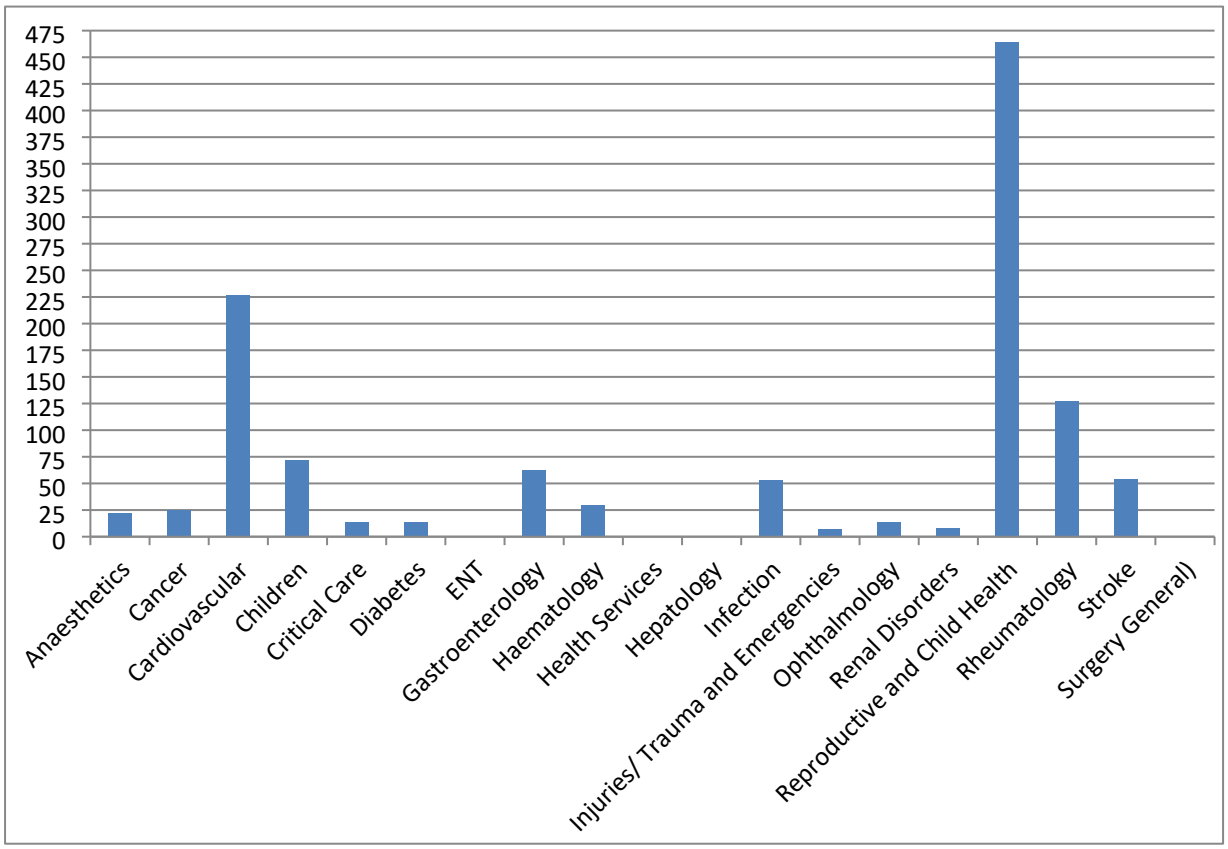
In GM, SNHSFT was the 8th highest recruiting Trust, with East Lancs, TGIC, Wigan, Wrightington and Leigh and Bolton ahead, but our performance being better then East Cheshire. This reflects a drop in position from 7th in previous years. However, it is important to note that the 2022-23 staffing challenges contributed to this and that our vaccine delivery work was significantly higher than other similar acute Trusts, with a large follow up schedule that continued in 2022-23. It is hoped that now these 2 key pressures are alleviated, our performance ranking will improve in 2023-24.

Month by month recruitment activity: 1,193 participants



The following chart shows the recruitment activity across different Trust specialisms:

Month by month activity across specialities



3.2.2.2 Study set-up: The DHSC KPIs referenced in 3.2.1.2 only cover a sub-section of the different types of study conducted at SNHSFT. There are also data collection, quantitative/ qualitative surveys, questionnaires, tissue only or basic scientific studies. In 2022-23, 30 studies were locally assessed and capacity and capability confirmed (compared to 17 in 2021-22). We had anticipated ~40 studies to have been assessed in 2022-23 but the RD&I governance team capacity issues reduced this workflow.

However, assurance can be provided that Research Reset post COVID-19 still occurred with 30 non-COVID projects opening and most of the delayed projects forming part of the 2023-24 portfolio. Assurance can be provided that SNHSFT aligned with the DHSC 2022 mandate of focused research recovery over a broader range of specialties for our local population.

3.2.3 **Participant research experience survey (PRES)**

3.2.3.1 A NIHR survey to capture the experience of participants in health research has run annually since 2015/16. It is carried out to help improve the experience of those taking part in research, giving a chance to feedback on what went well and what could be improved. From 2019/20, this survey was made a Higher Level Objective by the DHSC. The elevation of the PRES's profile is in a wider context of increasing appreciation of the importance of access to research being routinely promoted in health care provision.

3.2.3.2 In 2022/23, SNHSFT again received one of the highest response rates to the PRES in GM (233 surveys completed, where our NIHR target was 100). This provides assurance that our RD&I team are actively seeking feedback on how we are currently performing in this area and what we need to focus on in future to ensure exceptional experiences for our research participants. Key questions and responses are summarised below, which provide assurance of the overwhelmingly positive experience delivered to our surveyed participants during 2022-23. Strong themes identified were again the knowledge, professionalism and communication from the SNHSFT team.

3.2.3.3 The critique on how we can improve has also been reviewed and integrated into how we have run future studies. Key improvements made from 2022-23 feedback in the RD&I department include improved patient facilities on Ward C2 (e.g. water cooler installed, waiting area furniture updated with chairs to better support those with mobility issues); directional documents developed so our participants can more easily find the RD&I department and paediatrics; Relationship established with the travel office and security so that patients can park for free in 'out of hours' research clinics.

A recurring theme still stands on how results of research studies are shared. This is outside of SNHSFT's control for where we are one of many participating sites, but we have continued to report this back to study sponsors to ensure this is considered at appropriate study milestones. We have seen an improvement with this with more studies now issuing regular newsletters and posting journal article results on 'easy to access' websites. The changes in UK trials legislation and guidance should improve this further when these come in to force from later in 2023-24.

3.2.3.4 It is critical for SNHSFT to continue to request feedback from our participants and consider the recommendations of future PRES responses

in relation to the research participants' pathways, environment and motivation for being involved, to ensure we can mitigate any risks/ concerns identified. R&I staff are briefed at team meetings to ensure PRES surveys are not forgotten.

Questions: **Adults – 186 responses**	**Answer (%)**		
	Agree	**Neutral/ Too early to tell/ Forgotten**	**Disagree**
The information I received before taking part prepared me for my experience on the study	95.6	2.2	2.2
I feel I have been kept updated about the research study	90.9	8.1	1.0
I know how I will receive the results of the research study	90.3	1.1	8.6
I feel staff have valued my taking part in the research study	96.8	2.2	1.0
Research staff have always treated me with courtesy and respect	97.8	0.6	1.6
I would consider taking part in research again	95.7	2.7	1.6

Questions: **Children (12-15 years) – 4**	**Answer (%)**		
	Agree	**Neutral/ Too early to tell/ Forgotten**	**Disagree**
The information I got at the start of the research was easy to understand	100	0.0	0.0
I always knew what was happening during this research study	100	0.0	0.0
I know how I will receive the research results	100	0.0	0.0
I know who to talk to from the research team if I have any queries	100	0.0	0.0
The research team made me feel valued	100	0.0	0.0
The research team always treated me with kindness and respect	100	0.0	0.0
I would take part in research again	100	0.0	0.0

Questions: **Parents of Children (0-6 years) – 43**	**Answer (%)**		
	Agree	**Neutral/ Too early to tell/ Forgotten**	**Disagree**
The information that I received about the research when my child was invited to take part was easy for me to understand	97.7	2.3	0.0

I feel I have been kept updated about this research study	83.7	14.0	2.3
I know how I will receive the results of the research	86.0	7.0	7.0
I know how to contact someone from the research team if I have any questions or concerns	97.7	2.3	0.0
I feel research staff have valued my child taking part in this research study	97.7	2.3	0.0
Research staff always treated my child with courtesy and respect	97.7	2.3	0.0
I would consider my child taking part in research again	97.7	2.3	0.0

3.3 **Financial assessment (research income)**

3.3.1 During 2022-23, the measures first enacted in 2016-17 to ensure all RD&I invoicing was brought up to date (with clear funding distributions) have continued as much as possible, to minimise the financial risk to the Trust for lost income due to late or missed invoicing. Compared to 2021-22, 2022-23 saw the catch up on invoicing to clear the post-pandemic backlog, so we have entered into 2023-24 fully up to date. We also maintain clear tracking systems to support this for our wider study portfolio.

3.3.2 2022-23 RD&I income totalled £874,776.76 compared to £1,201,108.37 in 2021-22. 2022-23 continued to benefit from the income generated from commercially linked COVID vaccine and other urgent public health work, plus invoicing catch up on non-COVID projects. This was still a significant increase from pre-pandemic levels (i.e. 2019-20 saw £247,667.53). However, we have seen the income trajectory start to decrease since its peak in 2020-21, so the importance of securing future, regular commercial work is becoming increasingly important as our funding contingency based on the current team size only covers the next 4-5 years. 3.1 describes how this income has been re-invested into a staffing plan to expand the RD&I service at SNHSFT. This provides assurance of the current team funding sustainability for 4-5 years. It also provides a platform to allow further income generation due to increased capacity in the team to take on more commercial work. However, this is contingent on the rest of the Trust infrastructure supporting this and concerns have been highlighted in 3.1 around this.

4. Areas of risk

4.1 **Performance/ Business/ Financial:** Re-setting the service to our pre-pandemic 'business as usual' research portfolio, alongside general catch up from workload previously set aside to focus on urgent public health studies in the last few years has been challenging in 2022-23 due to resourcing. 3.1 clearly highlights the areas of our service that have

suffered due to this. The DHSC's continued approach to what we can continue to deliver from our pre-pandemic portfolio has helped to mitigate this risk. It has enabled our service to continue to conduct a pragmatic review of the whole research portfolio, closing off studies that are no longer suitable for our Trust. We can then focus on continuing to re-build a portfolio more fit for purpose for our population's benefit, based on our 5 year RD&I strategy and aligned to the DHSC focus of attracting more commercial work to the UK.

To further mitigate this, we also have an additional 4.26 WTE new research delivery staff who have joined the team in 2022-23, into 2023-24, as well as an Archivist from Oct-2022, who is clearing our study closure backlog. This has enabled the rest of the delivery team to focus on active studies. The Band 8a Lead Clinical Research Nurse and Band 7 Senior Clinical Research Nurse vacancies have also proven successful and we aim to go out to substantive advert in late Summer 2023. These posts are, and will continue to be instrumental in supporting the delivery of our joint RD&I strategy, managing performance, integrating research into the general nursing workforce and ensuring Trust values are continued to be demonstrated in the work of the department. However, R&I income generation can only support this post for up to 3 years in the first instance. Future funding from a Trust perspective (i.e. business case) will need to be considered for longer-term sustainability, particularly as the role contributes to the senior nursing professional cover rota and other Trust led requirements.

The set-up of new studies will continue to be staggered until the RD&I team reaches full complement and staff members are fully trained and competent, to ensure we maintain quality and don't overload staff.

Finally, the available support from key service departments (laboratories, pharmacy and radiology) is integral to the research portfolio expanding locally. 3.1.1.4 summarises the individual challenges in each of these areas. We are reliant on the mitigations and forward planning proposed in this section to ensure future research portfolio growth. Without this, there is a risk that our portfolio won't grow sufficiently to generate the income to sustain and build on the current RD&I team infrastructure. This links to Ambitions 3 and 4 of our key strategic themes of RD&I integration into service development and increasing research funding.

4.2 **Clinical/ Quality/ Reputational (Part 1):** This risk has continued to be rolled over from 2021-22 due to the capacity reasons outlined throughout this report. Although all our core RD&I staff are trained in Trust essentials, research legislation and regulations, with protocols provided for each study conducted, the lack of a fully developed Quality Management System (QMS) continues to be an organisational risk with reputational consequences if we were to be inspected by external regulatory authorities. It is also an important underpinning factor of our second strategic ambition to embed an inclusive research active culture within our Trust community. At SNHSFT, we currently don't sponsor any studies

which fall under the remit of the Medicines for Human Use Regulatory Authority, so the risk of inspection is low (it would only come from a hosted study if triggered due to recurrent safety issues at site or if the study drug was coming close to licensing and our site is randomly selected out of all participating sites). However, the lack of a fully established QMS means that it would not be prudent for our RD&I service to expand into study sponsorship until this is in place. This is a key strategic step for our Trust as 'home-grown' ideas and development of these locally is really important to our clinical staff. We need to have a robust framework in place to support this in the future. A shared Standard Operating Procedure (SOP) and policy matrix has been developed with TGIC colleagues in Jan-2023, with a view to expand this work programme to standardised job descriptions and induction programmes across the 2 sites. Due to the long-term sickness in the core RD&I governance team in 2022-23, this work programme is ~6 months behind schedule. However, when work does commence, there will be standardised processes across SNHSFT and TGIC, which will support a more cohesive work force across the 2 Trusts, working to the same quality standards.

4.3 **Clinical/ Quality and Reputational (Part 2):** This risk has also rolled over from 2022-23 and is a prominent theme in strategic direction discussions, with a direct impact on future University Hospital status if it is not addressed. The current Trust structure for clinician/ allied health care professional work plans, does not allow for planned, protected research time. Most research work is currently seen as an 'add on', incorporated into other SPA time or in their own time. There is very limited funding from the Trust or NIHR for protected research time. This then puts pressure on the acceptance of new studies into an area, limiting research portfolio growth, as staff don't have the time dedicated to supervise or act as a Principal Investigator for these studies for ongoing recruitment and follow up. The Trust infrastructure does require further evaluation at executive level to ensure healthcare professionals have the time to truly embed research into clinical care, so that it is an expectation to be research active in a standard care setting. Discussions have continued through the RD&I-C but need to be acted on at the appropriate level of authority to enact real change locally. Coupled with this, a recommendation from the RD&I C is for consideration to be given to Trust funding and support for dedicated clinical time to support operationalisation of key elements of the strategy, working hand in hand with the executive lead and RD&I service management team.

4.4 **General:** Our first ambition in our 5-year RD&I strategy is to focus on establishing a research portfolio that is of high quality, for direct patient benefit and tackles health and care inequalities. The health and care inequality focus is a newer strand for our Trust to focus on. Some assurance can be given from a regional perspective as healthcare inequality in research is also a key priority for the NIHR. In 2022-23, benchmarking work commenced where year of birth has been collected for all research participants recruited (where applicable) and this continues into 2023-24. There is regional analysis of this to help understand our

baseline in this area and where we have to focus on to reduce the inequality gap. From a national perspective, funding bid applications for new research projects continue to include a section on health and care inequality and how study design has been adapted to reduce this. Our strategic milestones delivery update provides information on what we plan to focus on with TGIC in the year ahead to provide better assurances that we are addressing this fully as inequalities are of course much more diverse than just age alone.

4.5 **Strategic update:** Finally, with the launch of our joint RD&I strategy in Oct-2022, this report holds Appendix 1, which provides a detailed summary of our key achievements in the first 6 months. As referenced throughout this report, we are behind where we would like to be due to resource issues, specifically in the areas of wider GM collaborations and QMS development. However, Sep-2023 will see our first joint Research Showcase Event with TGIC, with invited speakers from the wider GM region to help initiate these relationships. The review and organisational re-structure of the RD&I core governance roles across SNHSFT and TGIC is also critical to take place (with improved Trust investment). This will support a more resilient workforce in this area with scope for career development and role diversification, to successfully offer a joint quality/ sponsorship function. This will help safeguard business continuity in the future (through succession planning) and hopefully provide more resilience from staff long-term absences/ vacancies. Section 4.3 also highlights the recommendation for some dedicated clinician time to help enable the key strategic themes, supporting the executive infrastructure already in place.

5. Recommendations

5.1 The Board of Directors is asked to note the report and advise if there are any areas that they are not assured by or risks they feel haven't been appropriately considered and mitigated. Support from Board in the actions to mitigate the more serious risks is also requested, with a focus on the structural re-organisation of the core RD&I offices across both Trusts and protecting research time. It is acknowledged that this re-structure will be a challenge with the Trust's current financial position, relying on robust sources of research income and to be balanced against operational demands. Trust investment will be required, with Quality Committee Non-Executive Director acknowledgement that whilst the wider Trust circumstances are challenging, there are excellent opportunities for recruitment, retention and quality improvements by investment into RD&I expansion for our patient population.

Quality Metrics For Achievement: Oct-2022 – Mar-2023 Update

Metric	Measure	Achievement / Update (Oct-2022 – Mar-2023)
Ambition 1: High quality research of direct patient benefit, tackling health and care inequalities **Objective 1.1: Increase participation and diversity in NIHR studies**		
Growing number of NIHR studies with Trust participation, with particular emphasis on those presently known to have lower levels of access to RD&I projects due to personal characteristics or socioeconomic status.	Year on year increase in studies opened and offered to our participants across the 2 Trusts: - Benchmark data will be taken from Oct-2022. - Aim for 10% increase in Year 1 and Year 2 (then 5% increase thereafter). Focussed expansion in reproductive health (SNHSFT – GBS3), respiratory (both) and cancer (TGIC – Breast, SNHSFT – Urology, Both – Colorectal) to account for key healthcare inequality areas.	**Not started:** We will look to review this when we have a full year's data set for benchmarking (so Oct-2023) to allow the RD&I team to catch up after a challenging year of resourcing issues. The remaining 6 months of the first strategic year should provide us with more meaningful benchmarking metrics which we can then build upon. **Initiated:** There is a short-term plan (Jun – Sep- 2023) for ~25-30 new studies to be set up across >10 different specialities: Focussed expansion has started for key areas, with GBS-3 opening Jun-2023 and a re-focus onto the colorectal cancer screening study COLO-COHORT for Stockport.
An increased number of investigator-initiated research studies with industrial partners and academic institutions, adopted by the NIHR.	Years 1 and 2 will focus on developing and embedding the quality management system (QMS) and processes needed to be in place before sponsorship of new studies will be viable locally. The aim will be to have 1 research study set-up in this time frame to test the new systems, with either TGIC or SNHSFT acting as sponsor, and the other Trust as a site.	**Initiated:** TGIC and SNHSFT R&I leads met in Jan-2023 and a new QMS across both sites have been proposed with development over 2023, looking to extend to pharmacy departments as well for research activity. This work plan has been delayed due to staffing issues by around 6 months.
Increasing representative sample of participants completing the Participant Research Experience Survey (PRES) with evidence of improvements from feedback.	Year on year or PRES being offered to our participants across the 2 Trusts: - Benchmark data will be taken from Oct-2022. - Aim for 10% increase in Year 1 and Year 2 (then 5% increase thereafter). Quarterly reviews will be undertaken through the NIHR data platform for this and feedback acted upon each time. A report will be generated to confirm feedback,	**Initiated and compliant:** Latest report from NIHR for SNHSFT for 2022-23 shows achievement of our 100 target, with 233 surveys completed and a target of 150 set for 2023-24 (see 3.2.3 for full details of 2022-23 and actions taken from the participant feedback)

Metric	Measure	Achievement / Update (Oct-2022 – Mar-2023)
	achievements and improvements throughout the year.	
Ambition 1: High quality research of direct patient benefit, tackling health and care inequalities **Objective 1.2: Increase patient and public involvement in research studies**		
An increased proportion of patients recruited to research studies across all groups within our population, with diversity of participants partaking in studies matching local demographics.	Year 1 will be about setting the baseline of what this looks like across both Trusts. Implementation of either a NIHR e-form through RPEAK (the local portfolio management system for research) for capturing demographic data for each participant recruited from Jan-2023 or utilisation of TGIC's demographics form for the same purpose, with data collated centrally. Year 2 will then be about using the above data to develop a more targeted plan to increase research awareness across all our population groups.	**Initiated:** NIHR GMCRN confirmed in Jan-2023 that our local portfolio management system (LPMS) RPEAK will be adapted to include NHS numbers for all enrolled research participants from Apr-2023, which has now happened. This will mean we will have a full dataset as a benchmark from that point on with regard to our local age demographics. There is a GM-wide DPIA that will continue to add appropriate data sets to our LPMS to help benchmark our demographics splits. These measures will help support our Year 2 work plan to analyse our demographics split and the areas we need to target to ensure equity in research opportunities across our full population.
Number of Trust events with RD&I participation.	Years 1 and 2 will demonstrate evidence of at least 4 key events annually to showcase RD&I at both Trusts, through avenues such as patient stories at Trust board, International Clinical Trials Day, EDI events, annual research showcase, patient and public workshops etc.	**Initiated/ Planned:** To date, the following are scheduled: - SNHSFT/ TGIC team building afternoon 29/04/2023 to. - International Clinical Trials Day Activities around 20/05/2023. - SNHSFT presence at Stockport Pride in Jul-2023 to raise awareness of research opportunities available locally. - SNHSFT/ TGIC joint research showcase event, hosted at SNHSFT 29/09/2023, agenda being worked up across both organisations. - In Dec-2022, we also took a patient story to Trust Board, which was well received and told the story of one our research participants involved in a vaccine booster study, then joining the team as a Research Nurse.
Number of patient and public communications promoting research participation.	External and internal website content will be shared between both Trusts and refreshed for consistency in messaging, for showcasing of the strategy and for updated content to champion the research work delivered locally and regionally. There will be evidence of at least monthly	**Not started:** Work to share website content will commence from Jul-2023 when capacity allows across both SNHSFT and TGIC teams. **Initiated:** Since strategy launch, there has been a very regular stream of intranet news, R&I microsite updates and specialty specific newsletters being produced to showcase the RD&I activity

Metric	Measure	Achievement / Update (Oct-2022 – Mar-2023)
	communications shared through Trust channels – microsites, intranet news, weekly email bulletins, newsletter across both Trusts, to showcase the progress of research and this strategy.	at SNHSFT: https://intranet.stockport.nhs.uk/business/intranet/microsites/News.aspx?siteid=352 Work has also commenced to produce a quarterly RD&I newsletter, which we hope to launch from Jul-2023, capacity permitting.
Ambition 1: High quality research of direct patient benefit, tackling health and care inequalities **Objective 1.3: Improve clinical research facilities**		
Dedicated clinical research facilities within each Trust.	- For SNHSFT, Years 1-2 will see the clearing of the archived study backlog to free up space for study portfolio expansion on the unit and establishment of a satellite pharmacy on Ward C2 for clinical trials. - For TGIC, Years 1-2 will see reconfiguration of their expanded research area to create a more fit for purpose environment for clinical research.	**Initiated:** - For SNHSFT, the room to be used for the satellite pharmacy on Ward C2 has been cleared and the reconfiguration is booked in with Estates from Jun-2023. Approximately 30-35 studies are currently being worked on to close down fully and move off site for archive. We anticipate a significant volume to leave the department in Jun-Jul-2023. - For TGIC, their research dedicated space has now been extended and they are currently re-configuring to ensure the area is fit to support clinical research.
Shared facilities and infrastructure with other external partners (e.g. Higher Education Institutes, working with regional Clinical Research Facilities).	Years 1 and 2 will focus on developing collaborations with the GM Biomedical Research Centre, Health Innovation Manchester and developing the TGIC based MMU integrated clinical research facility to support objective 1.1.	**Initiated:** Collaboration work started at Feb-2023 R&I Committee with Lloyd Gregory, Academic Partnerships Director, Health Innovation Manchester (HInM) joining us to provide a background to HInM and possible, future collaborations. Both HInM and the GM Biomedical Research Centre representatives will be asked to collaborate and speak at our Research Showcase Day in Sep-2023 with a focus on how SNHSFT and TGIC-NHSFT can integrate more into the wider GM research community.
Ambition 1: High quality research of direct patient benefit, tackling health and care inequalities **Objective 1.4: Deliver NIHR targets**		
Improved metrics for study feasibility, set-up and delivering to time and target,	Year on year increase for improvements across the 2 Trusts: - Benchmark data will be taken from Oct-2022.	**Not started:** We will look to review this when we have a full year's data set in Oct-2023 as there hasn't been capacity in SNHSFT R&I office in last 6-9 months to collate the benchmarking data due to

Metric	Measure	Achievement / Update (Oct-2022 – Mar-2023)
with evidence to showcase our organisation and efficiencies.	- Aim for 10% increase in Year 1 and Year 2 (then 5% increase thereafter). Each quarter's performance data will be scrutinised and reported back on to see studies which achieved DHSC metrics vs those that didn't to learn from each data set for future improvements.	limited staffing capacity.
An increased portfolio of research studies which has tackled health and care inequalities.	See 1.1-1.2.	See 1.1-1.2.
Ambition 1: High quality research of direct patient benefit, tackling health and care inequalities **Objective 1.5: Support grant application development**		
Increased number of grant applications supported by RD&I team and an increased number of funding awards/ national leadership positions presented to local researchers.	Refer to 1.1 for QMS development to support this objective and building sponsorship functions across both Trusts. We will aim for 1-2 awards annually across both organisations, whether that is in a sponsorship or lead site function.	Refer to 1.1.
Ambition 2: Embed an inclusive research active culture within our community **Objective 2.1: Protected research time**		
Increased number of roles with protected research time from supporting funding.	Years 1 and 2 will see discussions being held at Clinical Director level to review key job descriptions/ plans and appraisal process to ensure each key area has some protected research time in for staff – These first two years will be about developing this process. Avenues to fund will be actively explored, costed and utilised (from service support applications, re-investment of research income into research PAs or equivalent – pump priming, active support for GMCRN research PA/ other funding bids etc). A process for active assessment will then be needed to ensure that funding continues to be directed to the right staff (likely Year 3 onwards but	**Initiated:** At SNHSFT, started with service departments, before moving to specialty areas. - Pharmacy have protected pharmacist and technician support already in place, using GMCRN service support income and have also re-invested commercial income into developing the satellite pharmacy on Ward C2. - Radiology have protected radiographer and consultant support now in place, again using some of the GMCRN service support income. - Discussions are underway with labs around embedding similar job role protected time to support as pharmacy/ imaging have done.

Metric	Measure	Achievement / Update (Oct-2022 – Mar-2023)
	assessment matrix to be developed in first 2 years).	
Ambition 2: Embed an inclusive research active culture within our community **Objective 2.2: Researcher career pathways**		
An increased proportion of staff being research-active across different groups.	Objective 2.1 will enable this, but Years 1 and 2 will focus on ensuring research awareness/ activity is embedded across all clinical job descriptions and is part of the junior doctor training programme. Research staff will also be requested to actively consider this and engage all AHPs in their specialty areas to support the different research projects coming through.	**Initiated:** - R&I team now deliver awareness training through the sim rotations for FY2s (first session Jan-2023) and looking to become a recurrent part of this training and other junior doctor training in future. - Initial discussions have taken place with the new lead nurse looking after ACPs to ensure we have a recurring slot on their forums to raise awareness for their participation, as research involvement is one of their core pillars. The R&I Manager and Lead Research Nurse are presenting at their Advanced Practice Conference in Jun-2023. - New studies at feasibility stage are now shared with relevant AHPs, modelling the success we have had with this approach in stroke, where we have OT, physio PIs etc. - Now have a regular slot at the TNA forum for students/ nursing associates/ practitioners and some specialty forums (e.g. maternity) to showcase research at Stockport.
Increased number of staff given academic mentorship, development and training opportunities.	Years 1 and 2 will see re-establishment of NIHR training courses being delivered face to face again across the 2 Trusts, with improved information on Trust microsites/ intranet about the wealth of courses and initiatives available on-line to support a research career.	**Initiated:** - 20/10/2022: PI Essentials on-line course co-facilitated by SNHSFT R&I Manager and NIHR staff for the local region. - 28/11/2022: GCP introduction training day ran at Stockport, with a focus on training TGIC/ SNHSFT new staff. - 17/02/2023: GCP refresher training day ran at TGIC by SNHSFT facilitators for TGIC research staff. - From Feb-2023, SNHSFT has started to share the latest training updates for research with all staff through the R&I microsite and intranet news pages. - Sep-2023 and Nov-2023: GCP refresher sessions scheduled at TGIC and SNHSFT respectively, facilitated by SNHSFT staff. **Not started:** Job descriptions across the 2 Trusts will be re-

Metric	Measure	Achievement / Update (Oct-2022 – Mar-2023)
	These years will also see the refresh and full development of delivery and sponsorship SOPs plus job descriptions, to ensure consistency of approach across the 2 Trusts. TGIC/ SNHSFT staff will also regionally lead the NW R&D Managers Forum, by ensuring regular events throughout the year to share best practice and develop the R&I workforce regionally.	reviewed when R&I office capacity allows, likely from Jul-2023. See 1.1 on SOP work. **Initiated:** TGIC RD&I Director is leading the development of the 2023 NW Forum content.
Ambition 2: Embed an inclusive research active culture within our community Objective 2.3: Increase understanding of RD&I role in clinical care		
Improved engagement of our research workforce (measured by the NHS Staff Satisfaction Survey and local recruitment and retention rates).	We will benchmark and review the survey results around staff satisfaction, ensuring these are acted on annually. Years 1 and 2 will see the first, annual joint research showcase day between TGIC and SNHSFT, open to all staff to celebrate research achievements, in collaboration with our regional partners. See objective 1.2 for details on communications updates.	**Initiated** 2022 staff survey results for SNHSFT RD&I team received in May-2023 so senior leadership team will review and ensure an action plan for 3 areas for improvement and also to highlight key successes. **Initiated:** Joint research showcase day planned for 29/09/2023.
Ambition 2: Embed an inclusive research active culture within our community Objective 2.4: Quicker uptake of new techniques and therapies		
Mechanisms developed so research outcomes are shared with senior clinical teams.	We will start the development of strong relationships with Health Innovation Manchester, the GM BRC etc to ensure the results of the research we deliver are made available for evidence-based translation into current practice.	**Initiated:** See 1.3 on HInM.
Ambition 2: Embed an inclusive research active culture within our community Objective 2.5: Data and resources to support research delivery		
Improved data systems and digital screening tools in place.	Years 1 and 2 will see our direct input into regional initiatives to improve the data/ digital tools we have to support research delivery, through attendance at NIHR digital champion events.	**Not started:** See 1.2 for further details on regional plans for demographic data benchmarking.

Metric	Measure	Achievement / Update (Oct-2022 – Mar-2023)
	For any EPR updates at the Trusts, we will ensure RD&I is actively represented to ensure new systems that are fit for research purpose, MHRA compliant and will enable research in our area.	**Initiated:** Meetings have been held with the transformation/ project leads for the new EPR for SNHSFT/ TGIC. MHRA compliance statements have nee shared and RD&I have been listed as a key stakeholder to input into the tender process, starting later in 2023.
Ambition 3: Integrate RD&I into clinical service development **Objective 3.1: Maximise RD&I potential for translational and applied health services**		
Increasing research activity among key specialisms.	We will complete a mapping exercise of what are strengths, weaknesses, opportunities and threats are across both Trusts, then align these with regional strategies (i.e. the BRC) so that we can actively support delivery of research in our strongest areas and pave the way to supporting with future regional bids.	**Not started:** Will be focussing on this as part of the SNHSFT/ TGIC team building afternoon on 29/04/2023.
Ambition 3: Integrate RD&I into clinical service development **Objective 3.2: Collaboration to improve health outcomes**		
Embedded joint working model across the two organisations with leadership infrastructure re-organisation to enable this.	Years 1 and 2 will see the review, update and any re-configurations to ensure we have the right R&I governance structure across the 2 Trusts to deliver this strategy. This will involve re-defining job descriptions, looking at shared roles across sites (e.g. archivist) and a business case to the joint TGIC/ SNHSFT board to hopefully fund/ support the changes recommended.	**Not started:** Will be focussing on this as part of the SNHSFT/ TGIC team building afternoon on 29/04/2023.
Robust university/ academic collaborations in place to support the University Hospital status application.	Foundations will be set for this by the other deliverables listed in this plan.	No further comments.
Ambition 4: Increase Research Funding **Objective 4.1: Maximise external income opportunities**		
Increase NIHR core funding.	Both sites will collaborate with the GMCRN/ other funding routes through the various annual bid processes to ensure stabilised funding (with some growth, possibly at B3-4 level) to support the increased research delivery portfolio expected.	**Initiated:** Confirmation received the SNHSFT 2023/24 funding has been matched for existing posts and there will be a small allowance of extra funding to support our research nurse team expansion across specialities as well. All vacancies in team have been appointed to.
Ambition 4: Increase Research Funding		

Metric	Measure	Achievement / Update (Oct-2022 – Mar-2023)
Objective 4.2: Fiscal transparency		
Annual reporting on research income, expenditure and performance management.	SNHSFT and TGIC will share their developed income generation and distribution models, to look for a consistent plan across both Trusts in how we generate, distribute and ensure transparency for research income. This will be implemented across Years 1-2.	**Initiated:** SNHSFT have shared their model as part of RD&I Committee minutes in Feb-2023 for TGIC review.
Ambition 4: Increase Research Funding **Objective 4.3: Increase research infrastructure funding**		
Sustainability of our research financial position, allowing year-on-year investment.	Years 1 and 2 will scope out SME collaborations to determine if we can secure projects that can be run across both sites, with income generation potential and be of benefit to our local population. Objective 3.2 also highlights the business case plan for hopefully improved Trust funding to realise this strategy in full.	**Not started:** We will look to review this from Jul-2023 as there has been limited capacity to initiate this across the 2 organisations during the winter pressure months.

TRUST SAFEGUARDING ANNUAL REPORT

2022-2023

Trust Board

Trust Safeguarding Annual Report 22/23

The purpose of the annual safeguarding report is to:

- Assure the Trust board that the Trust and its services are delivering the statutory obligations to safeguard individuals
- Assure service commissioners and regulators that the Trusts activity over the reporting year has continued to embed learning, seek service developments, and make improvements to the way in which the Trust safeguards people
- Appraise key stakeholders internally and externally about the work undertaken to safeguard people and how the safeguarding team support all colleagues in clinical and operational services
- Provide the public with an overview of safeguarding activity within the Trust and demonstrate that safeguarding is a key priority for the Trust and its services

SUCCESSES

NHS Stockport NHS Foundation Trust

- Profiling data questions are embedded within the assessment templates. We are now able to extract this data to provide a comprehensive overview of health needs for Looked after children living in Stockport.
- All face-to-face safeguarding children's training has been reviewed and will now incorporate the required LAC L3 competencies.
- Stockport has taken part in a pilot for the development of a national dataset for Looked after children.
- Maternity have firmly embedded ICON message to 97% of all women discharged from series and over 70% to both parents
- Relaunched the Learning disability information packs and delivered toolbox training across the Trust.
- Audit schedules have been developed to conduct a programme of audit and oversee the implementation of learning throughout the Trust.
- Produced new and updated a variety of safeguarding associated policies and procedures
- Safeguarding training videos were produced allowing staff to access at a glance bite size video films relating to safeguarding matters. The videos were launched during National Safeguarding Awareness week 2022 and are available on the Trust Intranet.
- Developed an effective electronic reporting system to support the development of an interactive safeguarding dashboard that illustrate safeguarding activity for adults at risk.
- Redesigned Safeguarding training methods for delivery
- Incorporated Safeguarding supervision for adult inpatient and community areas
- Received substantial assures from NHS Greater Manchester ICB Annual Assurance review
- Strengthened the governance and reporting of Trust Safeguarding activity

Key highlights of the report

NHS Stockport NHS Foundation Trust

- The think family approach to all safeguarding work underpins the key changes we have seen in the legislation of the Health and Care Act 2022 and the report highlights the collaborative working internally and externally
- We have continued to support Safeguarding Partnership and Board arrangements, leading on aspects of business plans and supporting the system to learn and adapt to changing locality need
- We have seen an increase in all aspects of safeguarding activity across services
- We have seen increased complexity with safeguarding cases often think family and frequently associated by previous trauma
- Adult safeguarding referrals have almost doubled in the last year along with DoLS activity
- Training has been a core priority for all teams, and we have seen increase in all aspects of safeguarding training
- Teams continue to review impact on services with audit plans, activity reports and key issue reports reported via matured governance arrangements

Summary and conclusions

- The Trust acknowledges that this year has continued to present the people of Stockport with significant challenges both in health and social care.
- This report highlights that although the challenges have been unprecedented the Trust continues to have safeguarding as core business and have continued to support the most at risk in society.
- The annual report provides assurance in how the Trust has delivered its statutory obligations to safeguard people, learn from incidents both local and national and set the ambitions for the next reporting year.

TRUST SAFEGUARDING PLAN

2023-2026

Trust Board

The structure to the plan

- Introduction to concept of the plan and the alignment to Trust strategy
- Sets the scene for safeguarding and the links with partnership safeguarding
- 5 core priorities for the Trust, these are the pillars of safeguarding for SFT

1. Develop an integrated approach to our safeguarding work (Think Family)
2. Develop the Trust's workforce to be confident and competent to safeguard people from harm and abuse
3. Ensure that we are complaint with statutory guidance and legalisation in the execution of our statutory duties
4. Be a learning organisation and embed lessons learned from safeguarding and other reviews
5. Improve the health outcomes for people where safeguarding concerns are evident.

The structure to the plan

- Created our Mission – to safeguard our community
- Created our Vision – to work collaboratively with people, providers and partners to safeguard the communities we serve.
- The plan then highlights 3 ambitions from each team to support the priorities:
- The plan will receive a refresh along with the annual report each year, so the ambitions reflect the changing landscape of safeguarding and is responsive to locality need
- Each of the teams have a detailed delivery plan and a highlight report to track the progress of these actions and improvements and this will be part of the TISG agenda and feature in KIR to QC
- The plan has been socialised with key stakeholders and received positive feedback and is welcomed to support the strategic direction for safeguarding at SFT

Safeguarding Team Ambitions for 23/24

NHS Stockport NHS Foundation Trust

Our Ambitions for 2023/24

Adults

- Improve the reporting and recording of safeguarding adult concerns to support in local decision making and provide thematic updates on areas of concern for the Trust
- Ensure that all safeguarding adult work incorporates the voice of the adult at risk and ensure that making safeguarding personal principles are included in all activity
- To improve in the use of quality assurance processes in reviewing safeguarding adult activity

Children

- Review the current infrastructure for safeguarding children's teams
- Complete a review of Safeguarding Supervision and highlight key success and make any necessary recommendations
- Support Stockport Family in its transition to Family Hub Models

Maternity

- Embed proactive responses when safeguarding concerns are raised during the pregnancy and beyond
- To process map and review how safeguarding concerns are managed within maternity services
- Support the review of safeguarding supervision and its interfaces with the safeguarding children team

Looked After Children

- Maintain a high standard for the completion of Initial Health Assessments for children who become looked after
- Support the ongoing work to reduce health inequalities for looked after children
- Incorporate and report level 3 training for looked after children into all safeguarding training

Summary

- The plan is a key document with tangible objectives that the Trust will focus on delivering across the next 3 years.
- The plan sets out the vision for safeguarding and how this is maintained as core business for the Trust, the Trust firmly believes that safeguarding is everyone's business
- The plan is built upon data that has been identified via national and local reporting and is mapped across the Safeguarding Partnership priorities to ensure we have a system wide approach safeguarding
- The delivery plan references the 5 key questions that are used in CQC inspections, and this remains a focus for the plan to be successful
- The monitoring of this plan will be through a highlight report that will be authored by the safeguarding teams and overseen by the Head of Safeguarding and Chief Nurse as executive lead for Safeguarding

NHS
Stockport
NHS Foundation Trust

Meeting date	3rd August 2023	x	Public		Confidential	Agenda item
Meeting	Board of Directors					
Title	Trust Safeguarding Annual Report 2022/23					
Lead Director	Nic Firth Chief Nurse		Author	Tom Parker-Evans Head of Safeguarding		

Recommendations made / Decisions requested

The Board of Directors is asked to:
- Review the Safeguarding Annual Report and endorse this report for publication
- Confirm the Trust has discharged its statutory duties for Safeguarding

This paper relates to the following Corporate Annual Objectives-

x	1	Deliver personalised, safe and caring services
x	2	Support the health and wellbeing needs of our community and colleagues
x	3	Develop effective partnerships to address health and wellbeing inequalities
x	4	Develop a diverse, talented and motivated workforce to meet future service and user needs
x	5	Drive service improvement through high quality research, innovation and transformation
x	6	Use our resources efficiently and effectively
	7	Develop our estate and digital infrastructure to meet service and user needs

The paper relates to the following CQC domains-

x	Safe		Effective
x	Caring		Responsive
x	Well-Led		Use of Resources

This paper relates to the following Board Assurance Framework risks

x	PR1.1	There is a risk that the Trust does not deliver high quality care to service users
	PR1.2	There is a risk that patient flow across the locality is not effective
	PR1.3	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan
	PR2.1	There is a risk that the Trust is unable to sufficiently engage and support our people's wellbeing
	PR2.2	There is a risk that the Trust's services do not fully support neighbourhood working
	PR3.1	There is a risk in implementing the new provider collaborative model to support delivery of Stockport ONE Health & Care (Locality) Board priorities

	PR3.2	There is a risk that the Trust does not deliver a joint clinical strategy with East Cheshire NHS Trust
	PR4.1	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit and retain the optimal number of staff, with appropriate skills and values
	PR4.2	There is a risk that the Trust's workforce is not reflective of the communities served
	PR5.1	There is a risk that the Trust does not implement high quality transformation programmes
	PR5.2	There is a risk that the Trust does not implement high quality research & development programmes
	PR6.1	There is a risk that the Trust does not deliver the annual financial plan
	PR6.2	There is a risk that the Trust does not develop and agree with partners a multi-year financial recovery plan
	PR7.1	There is a risk that the Trust does not implement the Digital Strategy to ensure a resilient and responsive digital infrastructure
	PR7.2	There is a risk that the estate is not fit for purpose and/or meets national standards
	PR7.3	There is a risk that the Trust does not materially improve environmental sustainability
	PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus

Where issues are addressed in the paper-

	Section of paper where covered
Equality, diversity and inclusion impacts	
Financial impacts if agreed/ not agreed	
Regulatory and legal compliance	All
Sustainability (including environmental impacts)	

Executive Summary

The Trust Safeguarding Annual Report highlights the overall activity for safeguarding across the organisation and how the Trust has discharged its statutory safeguarding duties effectively. The annual report highlights key successes for each of the safeguarding teams and supports the Trusts improvement journey for Safeguarding. It evidences how the Trust supports the local system approach to safeguarding and how as an NHS commissioned service it is externally assured by NHS Greater Manchester Integrated Care.

The report highlights the Trusts ambitions for the next financial year.

Stockport NHS Foundation Trust Integrated Safeguarding Annual Report 22/23

Abstract

Stockport NHS Foundation Trust firmly believes that a whole organisational approach is required to safeguard and promote the welfare of children, young people and adults at risk using Trust services.

As an organisation we emphasise that safeguarding is everyone's business and is a golden thread across all our work

Tom Parker-Evans

Head of Safeguarding

June 2023

Making a difference every day

FOREWORD

As Chief Nurse and Executive Lead for Safeguarding along with the Head of Safeguarding, we are delighted to present the Trusts Integrated Safeguarding Annual Report for the period of April 2022 to March 2023.

The report outlines the work which has been undertaken to support this growing and complex agenda and the work that has been completed with our partners both from within Stockport and across the wider Greater Manchester footprint. The report outlines the progress, challenges and successes experienced over the last reporting year.

All the Safeguarding teams continue to recover from the Covid 19 Pandemic and as part of the restoration work, the teams continue to excel and innovate in everyday practice.

We would both like to take this opportunity to thank all those who have contributed to the work completed over the last year. We look forward to addressing those challenges and developments for the forthcoming year and making Stockport a safer place to live and work.

Nic Firth
Chief Nurse/DIPC and
Executive Lead for Safeguarding

Tom Parker-Evans
Head of Safeguarding

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Introduction and purpose

As the Trust continues to move forward in the delivery of its Safeguarding strategy with particular emphasis placed on the protection of at-risk people in our care. It is necessary for us to reflect and identify learning from the period of 2022 - 2023. This annual report provides not only an update on activity in the protection of both children and adults, but also offers the level of assurance and compliance with both local and national standards, this report will focus on its core Safeguarding activity for Adults and Children.

The purpose of this report is to provide a declaration of assurance that the Trust is fulling its duties and responsibilities in relation to promoting the welfare of children, young people, adults, and their families who encounter Trust services.

This annual report will provide a key summary of the activity, developments, and achievements from the previous financial year.

Furthermore, the report will:

- Assure the Trust board that the Trust and its services are delivering the statutory obligations to safeguard individuals
- Assure service commissioners and regulators that the Trusts activity over the reporting year has continued to embed learning, seek service developments, and make improvements to the way in which the Trust safeguards people
- Appraise key stakeholders internally and externally about the work undertaken to safeguard people and how the safeguarding team support all colleagues in clinical and operational services
- Provide the public with an overview of safeguarding activity within the Trust and demonstrate that safeguarding is a key priority for the Trust and its services

What is Safeguarding?

The Care Quality Commission (CQC) state that Safeguarding means protecting people's health, wellbeing and human rights and enabling them to live free from harm, abuse and neglect. It is fundamental to high-quality health and social care (CQC, 2016)

- **Safeguarding children:**

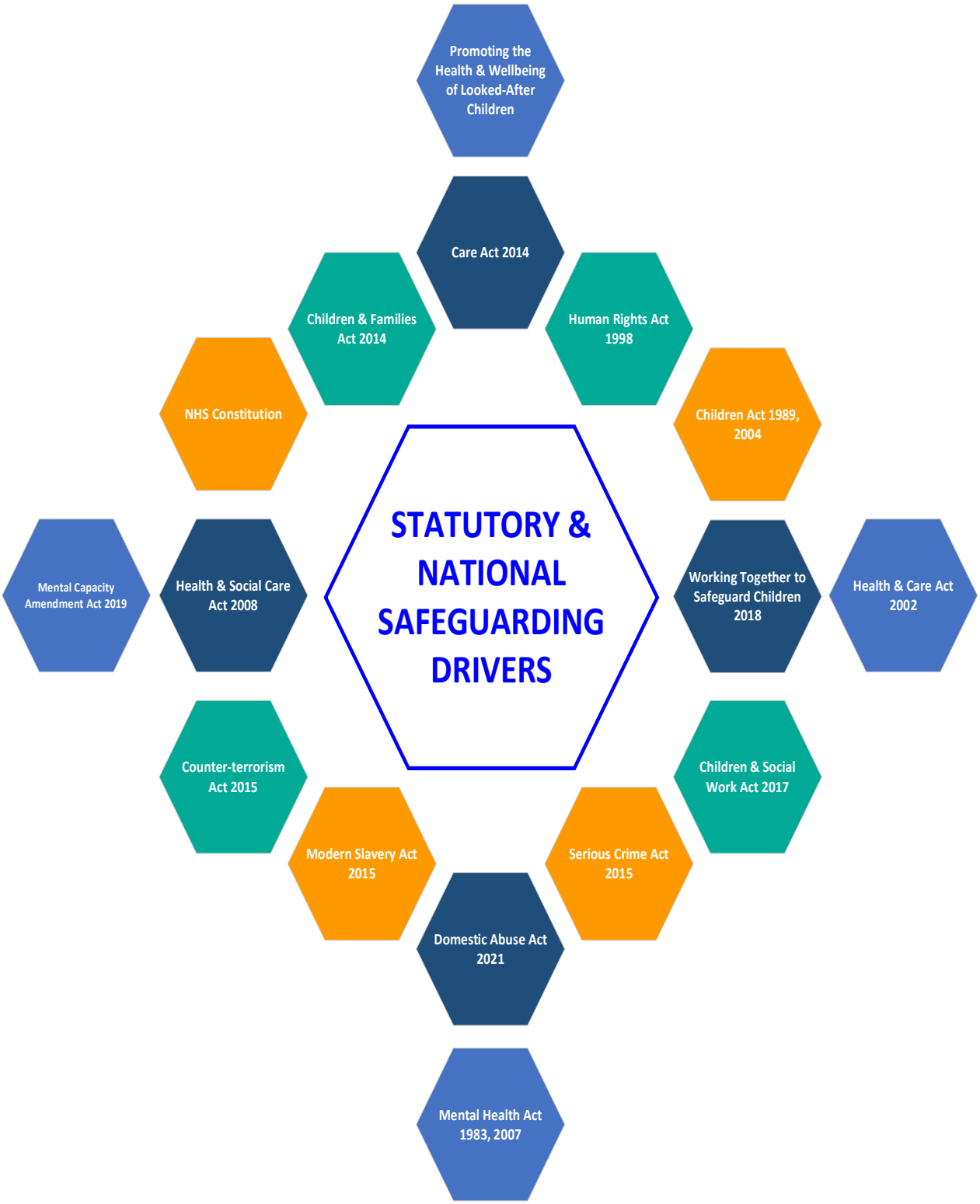
a child is defined within the Children Act 1989 as
"an individual who has not yet reached their 18th birthday".

- **Safeguarding Adults:** An adult is an individual aged over 18 years and over, the Care Act 2014 defines an adult at risk as:
  - An adult who has care and support needs (whether the needs are met or not)
  - Is experiencing or at risk of experiencing abuse or neglect and
  - As a result of those care and support needs is unable to protect themselves from either the risk of, of the experience of, abuse or neglect

Statutory and national drivers

Safeguarding adults and children is enshrined within UK law and is key to ensuring that all safeguarding practice is supported by legislation, statutory guidance, and regulations.

Key legislation and guidance for safeguarding are:



Key Achievements and Celebrating success

This reporting year has highlighted the significant contribution that everyone plays in safeguarding and how the Trust has embedded safeguarding practices. The safeguarding teams have worked alongside trust staff, patients, system partners and third sector organisations to deliver outstanding work to keep people safe and there have been some stand out moments over the year.

Below are some key achievements, these are not all of them and none of the achievements are possible without the dedicated teams in the Trust and the individuals who support the entire safeguarding agenda.

Reporting year of 22/23

- The LAC health team have seen a sustained increase in both admin and nursing activity.
- The LAC health team provide care and support to some of the most complex and vulnerable young people living in Stockport.
- Profiling data questions are embedded within the assessment templates. We are now able to extract this data to provide a comprehensive overview of health needs for Looked after children living in Stockport.
- All face to face safeguarding children's training has been reviewed and will now incorporate the required LAC L3 competencies making recording easier.
- Stockport has taken part in a pilot for the development of a national dataset for Looked after children.
- A gap analysis has been completed and benchmarked against available guidance and models of provision. This included recommendations to increase service provision for Looked after children with the drivers for change looking at improving quality, the recognition of increasing demand and reducing unwarranted variation.
- Midwifery and Health Visiting continue to undertake Early Help Assessments on families with identified unmet needs. By identifying and supporting these families early it reduces the need for more intensive intervention later.
- Nationally, the Baby's Cry, you can cope (ICON) message is seen as fundamental in helping reduce the numbers of Abusive Head Trauma seen in infants under one year of age. The Maternity Safeguarding team have delivered ICON training to all Midwives during the last year. This has resulted in the ICON message being delivered to over 97% of all women discharged from postnatal ward with more than 70% being delivered to both parents. With 70% of all AHT being caused by male care givers it is seen as best practice to deliver the message to both parents.
- Maternity Safeguarding team continued to strengthen the process of information sharing between the acute and community setting in particular post birth of baby. Safeguarding management plans are completed antenatally during the last trimester of pregnancy, in high risk cases, so that any discharge planning is proactive and shared fittingly with the family and all professionals involved.
- Maternity Safeguarding Team have continued to work closely with East Cheshire Maternity services to ensure safe and effective safeguarding of vulnerable women during the extended divert of inpatient services.
- Positive multiagency partnership working with partners to safeguard adults at risk and Children and young people

- Active participation at Stockport Safeguarding Partnership and Board and subgroup meetings.

- Introduced webinars on mental capacity assessments to guide staff to improve their understanding of the application of MCA and documentation.

- Strengthened the process to respond and act quickly to address the concerns, raised of patients with a learning disability and/or Autism whilst in hospital.

- Relaunched the Learning disability information packs and delivered toolbox training across the Trust.

- We maintained our Safeguarding Training compliance in level 1 and 2, where we achieved more than 90% target against a national goal of 85%.

- Built professional relationships with Healthwatch Stockport (HWS) and independent care providers to improve communication across the health economy to improve the patients experience when coming into hospital.

- The safeguarding team have developed and strengthened internal IT systems to help identify and flag adults at risk who may be exposed to, at risk of or experiencing domestic abuse, through the Multi-Agency Risk Assessment Committee (MARAC) information sharing process.

- A rolling programme of safeguarding adults level 3 training has been launched within the Trust with a trajectory of compliance that continues to increase.

- Audit schedules have been developed to conduct a programme of audit and oversee the implementation of learning throughout the Trust.

- Produced new and updated a variety of safeguarding associated policies and procedures

- Prepared and supported the transformation of CCGs to Integrated Care Boards ensuring safeguarding statutory functions remain central with good governance arrangements. Alongside this, we have strengthened safeguarding assurance in line with the assurance tool and framework.

- Safeguarding training videos were produced allowing staff to access at a glance bite size video films relating to safeguarding matters. The videos were launched during National Safeguarding Awareness week 2022 and are available on the Trust Intranet.

- The recruitment and appointment of the IDVA roles in situ with a 1.5 Full time Equivalent between both children and adults safeguarding services.

- Developed an effective electronic reporting system to support the development of an interactive safeguarding dashboard that illustrate safeguarding activity for adults at risk.

The Safeguarding adults team hosted a week of events to mark Adult Safeguarding week. The team participated in Anne Crafts social media campaign to share excellent work that was taking place within the hospital, but also to share the excellent work within the partnership. The Team developed a wide-reaching selection of training programmes to meet the needs of our patients and staff.

Adult Safeguarding Week 21st Nov – 27th November 2022

Monday: The team started the week with a talk from partner organisation, Stockport Homes, around Cuckooing and exploitation. We also launched our new safeguarding adult snapshot videos which are now available on the Trust Intranet.
Tuesday: The safeguarding team delivered a full day of level three training, to 67 senior members of the Trust, along with partners from the Integrated Care Board, Stockport Homes, and Stockport Safeguarding Board.
Wednesday: Our Freedom to Speak Up representative spoke to Trust staff about the importance of highlighting concerning practice, whistle blowing policy and how to create positive working environment.
Thursday: The Team delivered tailored training around domestic abuse in older adults.
Friday: The team produced and delivered a trouble shooting training package entitled How to Complete a Mental Capacity Assessment. This session is delivered monthly and allows the staff to embed their knowledge around the MCA and ask specific questions about cases they have worked. This gives staff more confidence in their practice. Announced the winners of the Safeguarding Ward Boards.

- **Ward AMU for patient focused category**
- **Ward C4 for most visual category**
- **M4 for staff engagement category**
- **D5 for most informative category**
- **B3 for students contributions**

Safeguarding structure / roles

Stockport NHS Foundation Trust employees several highly skilled safeguarding specialists in a variety of roles both statutory and non-statutory to support the Trust in discharging its safeguarding duties.

The Chief Nurse is the Executive Lead for Safeguarding, the Deputy Chief Nurse (DCN) and the Head of Safeguarding (HoS) provide both strategic and operational support for all aspects of safeguarding and the wider agenda covering mental health, learning disability, autism, dementia, and delirium. Alongside the DCN and HoS, the Divisional Nurse Director and Divisional Director of Midwifery and Nursing for Women's, Children's and Diagnostics support the safeguarding agenda with line management and professional support to named professionals.

The current safeguarding structure as of May 2023 can be found in Appendix 2 of this report.

Governance and reporting Structure

The Trust has an Integrated safeguarding group which is chaired by the Chief Nurse/Executive Lead for Safeguarding whereby assurance is sought from named professionals, divisional colleagues and partnership updates are provided, this reports to the Trust Quality Committee in the form of a key issues report to provide robust assurance through to the Board of Directors. The Trust group is supported by operational groups for adults, children, and public health nursing, all these groups have a term of reference, action plans and business cycles. Further details of the governance structure for Safeguarding can be found in appendix 3 of this report.

SNHSFT have reporting structures in place for safeguarding across the Trust and work has continued to progress this year to support a think family approach to all safeguarding work.

Safeguarding incident reporting is managed through internal systems and processes which specialist practitioners support with providing advice, guidance, and support to Trust staff. The Trust has a mechanism of reporting safeguarding incidents using the Trust intranet and the Do it online form for Adult Safeguarding and via telephone contact, heath information sharing forms for children's safeguarding along with targeted referrals in maternity services. Staff can also refer directly to social care through the Multi Agency Safeguarding Support Hub (MASSH) and via the Adult social care referral form. Incidents that relate to the possible abuse and or neglect whilst in hospital and or concerns regarding patient safety will be discussed at other Trust meetings which include managing safeguarding allegations against staff.

External Safeguarding Governance and Partnership working

SNHFT continue to work with external safeguarding partners across the borough of Stockport and Greater Manchester.
The Safeguarding teams participate in several multi-agency meetings to support safeguarding arrangements. The HoS and DCN represent the Trust at the Local Safeguarding Adult Board in Stockport and the HoS and Chief Nurse represent the Trust at the Executive meeting for the Local Safeguarding Children Partnership. Members of the safeguarding teams also attend subgroups of the respective boards and partnerships and these all share key information vie internal reporting mechanisms.

A representative from safeguarding attends the following strategic and operational multiagency safeguarding meetings:

Adult	Children's	Joint
Stockport Local Safeguarding Adult Board	Children's Practice Improvement Partnership	Stockport Joint Safeguarding Adults Partnership Board & Safeguarding Children Partnership Executive Meeting
Adults Practice improvement partnership	Children's Quality Assurance Partnership	Domestic Abuse Partnership Board
Adults Quality assurance partnership	FGM Task and Finish Group	Domestic Abuse Operational Meeting
Multiagency adults at risk system (MAARS)	Integrated Looked after Children Board	Channel Panel & Prevent steering group
Safeguarding adult review (SAR) consideration and panel	Rapid review & Child safeguarding practice review panel and process	Domestic Homicide Review Consideration Panel
Hate crime partnership	Child Death Overview Panel	Complex safeguarding subgroup
		Training & Workforce development

The Trust continues to provide assurance to NHS Greater Manchester Integrated Care Board (ICB) (Stockport Locality) via the Greater Manchester Safeguarding Assurance Framework document that is populated by the safeguarding team each quarter and then is reviewed and scrutinised by Designated Professional and commissioning colleagues to monitor the Trust in its ability to safeguard individuals. This quarterly report is produced into an action plan whereby the safeguarding team and key leads from the trust and ICB meet to discuss. In addition to this an annual self-assessment of commissioning standards is completed for all aspects of safeguarding and sent as assurance to the ICB, this provides robust assurance in that the Trust is delivering its statutory duties and this supports the section 11 audit that is required of all NHS Trust as directed by the Children Act 2004.

Looked after children (LAC)

The Trust is commissioned to provide a dedicated resource for Looked After Children which sit alongside universal services. Together these fulfil the aim of reducing inequalities and ensuring Looked After Children's health needs are met, in accordance with statutory guidance.

The vision across Stockport is that Looked After Children will access universal health services in the same way as other children and young people. Additional needs will be met through targeted interventions and specialist services. Furthermore, children and young people who are cared for by any Local Authority, but living in Stockport, will receive the same opportunities to access health services within the borough irrespective of their originating ICB. It should however be acknowledged that this can cause difficulties due to commissioning arrangements for these children within some services.

Stockport can and does provide care to Looked After Children from outside the Local Authority due in part to the high number of private residential provisions. Placements here from other local authorities have a significant impact on the whole health economy

Placements

In addition to Stockport's 152 mainstream foster carers there are 78 connected carers for Stockport children living in Stockport, in addition to this there are numerous different IFA (Independent Fostering Agency) carer's registered in Stockport. Stockport also has a large number of children who are looked after but continue to be placed at home with their parents.

The large number of children placed in Stockport by other areas are accommodated in a variety of settings, including private agency foster carers, residential homes, 16+ provision, therapeutic placements and specialist provisions. Currently Stockport has 53 homes providing approximately 233 places to children and young people.

Some of these placements provide accommodation for some of the most complex and vulnerable young people in Stockport, who access a variety of provision across the health economy. The Specialist Looked After Children's health team ensure that information is shared timely and appropriately to support access to services while here in Stockport.

Looked After Children placed here from outside the Greater Manchester (GM) area face further challenges as they are not provided with any on-going therapy they may require. The current commissioning arrangements would mean that following assessment it would be up to the placing ICB to find and commission something privately.

There are currently 400 children from other local authorities placed in Stockport with 256 moving into the area during the year. For Stockport Local authority there were 481 LAC at the end of Q4 with an additional 259 starting their journey into care over the year.

Children are placed in Stockport from across the country with currently 65 local authorities placing children locally.

- **Specialist LAC team activity**

The LAC team provides a specialist resource to address the health needs of children and young people who are looked after by Stockport Local Authority, and young people who are living in

Stockport who are looked after by other LAs. The delivery model for LAC is that services will primarily be delivered through existing primary and community services (such as health visitors, school nurses), with additional targeted support provided by the LAC nursing team for those children and young people who either do not fall within the remit of, or find it difficult to access, local services. The team coordinate health assessment requests and provide support and guidance to professionals completing assessments. They also provide quality assurance for health assessments completed both in and out of area.

Most Stockport children that are placed out of area remain within Greater Manchester (GM) meaning many of the children living on the borders of Stockport remain on Stockport caseloads. The Specialist LAC team is currently working with a caseload of 189 young people, in addition to this the team coordinates the health requests for those children placed out of area and provides clinical oversight for those children with additional complexities and risk.

Information including safeguarding information, placement moves and requests for this year's 701 health assessments comes through the Specialist LAC team, activity is captured through the quarterly activity reports and will need considering in terms of capacity, delivery and the commissioning of future service requirements.

- **Emotional Health and Wellbeing**

There is a significant challenge for looked after children to access appropriate mental health provision, with the reduction of tier 2 services, LAC young people are required to meet the threshold for tier 3 to receive specialist support. The health and wellbeing team commissioned by the LA are providing consultation to Social Workers and supporting carers and schools with interventions. There is hope in the future that they will be able to offer 1:1 work with young people. All children between the ages of 4-16years have an SDQ (strengths and difficulties questionnaire) completed to inform the health assessment. Health professionals completing the review health assessment (RHA) also complete an age-appropriate assessment of emotional well-being; this provides a basis for discussion, support and on-going referral.
Children placed locally from other authorities outside of GM experience further challenge with emotional health support as currently Stockport CAMHS do not provide therapeutic support for these children.

Considering LAC make up a small proportion of the child population (nationally 67 per 10,000 (0.67%)) they are significantly overrepresented in mental health presentations in ED (19%). Whilst there is recognition that following COVID 19 there has been an increase in demand in the general population, there needs to be consideration as to how services are experienced by young people and whether the provision is available and proportionate to need.

Key Performance Indicators (KPI) – Looked after children

- **Initial Health Assessments**

The Foundation Trust is commissioned to deliver 52 clinics a year which has been has the capacity required to meet the statutory requirement.

Q3 & Q4 has provided some additional challenges which has impacted on the trusts ability to meet the KPI set for IHA. Between 22/11/22 and 22/12/22 we received 34 requests for IHA including 5 UASC.

In January we received a further 20, February 13 and 31 in March. This included 9 UASC.
In Q4 we provided 15 clinics and 64 clinic slots in response to demand. This includes 10 UASC and 11 DNA's.

13% of children were seen within timescales.

With the recent demand we no longer have capacity within the weekly clinics we are commissioned to deliver.

Referrals continue to remain high. Clinic spaces are allocated into June meaning that children will not be seen within timescales. There are more requests pending with children who have come into care. We also have the unpredictability of the number of requests received by other areas placing children here.

The LAC health team will continue to monitor and report changes and challenges to performance. There needs to be consideration to the impact on service delivery if this increase is sustained. We will continue to prioritise IHA's to meet the needs of the children referred. Some additional clinics have been created but the impact of the quantity of referrals will continue to affect the next quarters performance.

Review Health Assessments

Review Health Assessments are completed by the caseload holder. In Stockport the Health Visitor completes the under 5's and the School Nurse would complete any 5-16's in mainstream education. Any 16-18 year olds or young people in specialist educational provision would be completed by the specialist Looked After Children's team.

The challenges in meeting these KPI's are now monitored within a LAC dashboard. This is providing greater oversight from managers and will feed into continuous service review.

The table below shows the comparison in completed assessments over the last 5 years.

Completed by	2018-2019	2019-2020	2020-2021	2021-2022	2022-2023
IHA	180	181	185	128	173
LAC team	68	105	84	102	105
School Nursing	209	222	276	299	269
Health Visiting	96	96	113	133	154

There continues to be an overall increase in LAC related activity for both IHA and RHA work, in association with increased activity the complexity of each child and or young person continues to present challenges which need further support.

Missing from Home

Looked After Children make up a significant proportion of all children that go missing in Stockport. Ensuring that they have a multiagency plan for support is key when considering their safeguarding needs. For Stockport children there is a weekly staying safe panel for which there is health input too. This is attended by the aspire nurse or a member of the specialist LAC team will attend when this isn't possible. A process is in place to ensure that the health professional is informed and future support can be planned appropriately.

For Out of area children living in Stockport a process has been developed, following learning from a Serious Case Review, to ensure that the health professional is also notified. This has now been extended to include all Stockport looked after children as well. The team ensure that the appropriate professional receives the notification so they can review and support appropriately. This has a had significant impact on the work of both the specialist LAC team alongside the wider health economy with 1,058 missing notifications processed over the year.

Children's Safeguarding

The Trust have a specialist children's safeguarding team which provide specialist advice, guidance and support to staff, patients, visitors, and other key agencies in the protection of children, unborn babies, and adults, they are supported by the adult safeguarding, maternity safeguarding and looked after children teams and work in collaboration to support the needs of individuals. These specialist teams attend internal and external strategy meetings, case conferences, section 47 meetings, and other key safeguarding meetings to ensure that any lessons learned are disseminated and embedded in Trust practice and people are continued to be safeguarded.

- **Health information Sharing Forms (HISF) & Children's Social Care Referrals**

To ensure there is a clear review of the referral activity within the organisation the Safeguarding Children's Team review all child safeguarding referrals that are completed within the acute Trust and ensure that this is communicated in a timely manner to community health colleagues. Additional actions may be required to be completed such as follow-up referrals, escalating immediate concerns and ensuring the right practitioners are in receipt of the right guidance and support.

In addition to this function is the need to provide an element of quality assurance oversight to ensure all appropriate tasks have been completed and any outstanding actions are escalated accordingly within the relevant division or governance structure. The table below provides a breakdown of the total number of Health Information Sharing Forms and direct referrals to Children's Social care (CSC) completed for the reporting year.

Health information Sharing Forms (HISF) & Children's Social Care Referrals.				
Month	**Total No. of HISF**	**HISF completed by the SGCT**	**Total No. of direct referrals to CSC**	**CSC ref completed by the SGCT**
April 2022	103	24	108	7
May 2022	140	25	154	16
June 2022	158	48	141	22
July 2022	117	34	128	26
August 2022	135	64	132	39
September 2022	106	49	151	20
October 2022	122	36	119	16
November 2022	96	16	147	16
December 2022	94	17	120	20
January 2023	108	25	126	24
February 2023	97	19	95	18
March 2023	119	20	147	22
Year End Totals	**1,395**	**377**	**1,568**	**279**

The referral activity has remained high across the Trust following the pandemic. The overall increase in activity is due to the developments in recognition and response within the key hot spot areas such as ED, the children's ward, and some of the adult services within the Integrated Care Division. Ensuring the safeguarding children's team provides direct support to the departments and wards has been pivotal in developing working relationships and guiding staff through the relevant processes.

It is noted however, that the Safeguarding Children Team complete a proportion of the referral activity and further work has been completed within the ED to ensure that the relevant actions are completed at the time the concern is raised when the patient presents. This will ensure the right detail regarding the incident is collated at the time and the patient is updated regarding the actions taken. From reviewing the data, it is noted that there has been a marked improvement during some of the months, but this continues to be an area of challenge.

The Public Health Nursing Team are reviewing ways of reporting, to ensure that details can be streamed from the community systems - EMIS electronic health record system to ensure activity can be secured. The detail in the table below evidences the referral activity within health visiting and school nursing services. It is recognised within Public Health Nursing Teams that concerns are often escalated through a Step-Up Process rather than a direct referral; work is underway to look at how this safeguarding activity can be captured.

Public Health Nursing Team - Children's Social Care Referrals.		
Month	**Health Visiting**	**School Nursing**
April 2022	0	0
May 2022	2	0
June 2022	2	0
July 2022	4	0
August 2022	3	0
September 2022	3	0
October 2022	5	0
November 2022	1	0
December 2022	0	1
January 2023	0	1
February 2023	0	0
March 2023	1	0

- **Mental Health Presentations**

The data below demonstrates the referral activity in relation to children and young people who have presented due to concerns for their mental health and emotional wellbeing, and adult presentations where there have been safeguarding children concerns identified.
Whilst the data demonstrates that there has been a reduction in the amount of presentations the complexity of these presentations continue to increase. The reduction of presentations also demonstrates that community support from external providers may be making a difference to acute presentations.

Month	CYP MH Presentations **2021 / 2022**	CYP MH Presentations 2022/ 2023	Adult MH presentations **2021 / 2022**	Adult MH presentations 2022/2023
April 2022	66	53	55	15
May 2022	74	68	53	24
June 2022	78	67	46	29
July 2022	58	44	37	30
August 2022	40	33	48	36
September 2022	65	46	40	20
October 2022	66	43	30	10
November 2022	77	47	42	24
December 2022	59	30	23	14
January 2023	80	61	30	12

February 2023	71	51	27	11
March 2023	85	86	28	24
Total	819	629	459	249

•The data includes all children and young people who have presented with a mental health / behavior related concern.
• The data provided includes the number of presentations to the ED whereby a health information sharing form / MASSH has been generated.
• The data is inclusive of the children / young people who may have re-presented to the ED on a number of occasions due to concerns for their MH.
• The data includes the adult related ED presentations where there are concerns for the patients MH and a MASSH / health information sharing form has been completed for the welfare of their children.
• The data includes adult's patients who have re-presented on more than one occasion due to concerns for their MH.
• Please note that all the ED attendance records for children and young people under the age 18 are reviewed by the Safeguarding Children Team / Pediatric Liaison Nurse role.

- **Paediatric Liaison Nurse Role**

The traditional Paediatric Liaison Nurse function is an established role within the organisation. The role currently ensures that there is an effective communication pathway between hospitals and community services which enables children and their families to receive appropriate care and support. Within the organisation the Paediatric Liaison Nurse is based on the hospital site and reviews in detail all Emergency Department attendances of children and young people up to the age of 17years.This is to identify any potential concerns and to ensure that the appropriate community professionals and services are notified of the child or young person's presentation within a timely manner to ensure the families are in receipt of early intervention services. Dependent on the need of the family further communications may be held with other multiagency partners such as children's social care, youth offending services, mental health services, and drug and alcohol services. The detail below captures the activity during April 2022 to March 2023, with the comparative data from the previous two years.

Emergency department Attendances 0 – 15yrs	**2022/2023**	**2021/2022**	**2021/ 2020**
April 2022	**1928**	**1801**	**595**
May 2022	**2278**	**2095**	**876**
June 2022	**2016**	**2079**	**1024**
July 2022	**2074**	**2431**	**1075**
August 2022	**1428**	**1623**	**1204**
September 2022	**1724**	**2136**	**1595**
October 2022	**2050**	**1744**	**1299**
November 2022	**2436**	**1643**	**1203**
December 2022	**2593**	**1416**	**1127**
January 2023	**1625**	**1394**	**867**
February 2023	**1733**	**1603**	**905**
March 2023	**2005**	**1436**	**1482**

- **Emergency department Attendances – 16–17-year-old**

Noted in the table below is a breakdown of the number of young people who have presented to the Emergency Department during April 2022 to March 2023. The information includes:

- The number of 16-17yr old attendances to the Emergency Department.
- The number of attendances that have resulted in the young person requiring admission.
- The total number of 16-17yr olds that require a direct admission to a ward.
- The total number of Children's Social Care referrals and health information sharing forms that have been generated as a result of the Emergency Department presentation.

Emergency department Attendances – 16-17yr olds.					
Month	**Total number of Attendees to ED**	**Total No. Admitted via ED**	**Total No. of direct ward Admissions**	**Total No. Health Info sharing forms.**	**Total No. of CSC referrals.**
April 2022	186	10	21	9	12
May 2022	203	24	12	12	17
June 2022	181	20	8	7	21
July 2022	178	14	9	14	20
August 2022	143	12	9	20	15
September 2022	180	21	8	25	2
October 2022	184	21	9	13	20
November 2022	216	24	2	18	21
December 2022	152	18	4	11	6
January 2023	174	24	0	22	10
February 2023	162	22	0	15	14
March 2023	199	34	0	8	19

- **Paediatric Medical Reports**

As part of a child protection enquiry a request for a child protection medical may be requested by Children Social Care and the Police as part of a Section 47 Investigation. This service is provided by Stockport Foundation Trust and the clinic is situated within the Treehouse Children Unit. Presented below is the data regarding the number of medicals completed during April 2022 to March 2023 with the comparative data from the previous year.

Paediatric Medical Reports (NAI)		
	2022/2023	2021/2022
April 2022	**9**	**7**
May 2022	**12**	**4**
June 2022	**1**	**7**
July 2022	**8**	**0**
August 2022	**13**	**5**
September 2022	**8**	**5**
October 2022	**8**	**5**
November 2022	**8**	**10**
December 2022	**1**	**11**
January 2023	**15**	**8**
February 2023	**11**	**8**
March 2023	**10**	**23**
End of Year Total	**104**	**93**

Where possible it is best practice to ensure sibling groups are seen together. This ensures that the children remain together as a sibling cohort, and it assists with continuity and the ability to reduce the need for multiple histories to be obtained if the children are reviewed by the same practitioner. This can however have a direct impact on the clinic capacity and workload within the department which can result in time slots being extended to accommodate.

- **Child Death Overview Panel**

Child Death Overview Panels (CDOPs) are a multi-disciplinary sub-group of Local Safeguarding Children Partnerships that work across Local Authority boundaries based on population numbers. CDOP reviews the deaths of all children aged from birth up to the age of 18 years old (excluding still births and planned terminations carried out under the law) who normally reside within the geographical boundaries of that CDOP area. There are 4 CDOPs across Greater Manchester, 3 of which function as a 'tri-partite' such as Stockport, Tameside and Trafford (STT). The table below details the Stockport child deaths during April 2022 to March 2023 within Stockport.

C.D.O.P			
Month	**Expected**	**Unexpected**	**Total**
April 2022	2	0	2
May 2022	0	2	2
June 2022	1	0	1
July 2022	0	0	0
August 2022	0	0	0
September 2022	0	0	0
October 2022	0	1	1
November 2022	0	3	3
December 2022	1	0	1
January 2023	0	1	1
February 2023	2	0	2
March 2023	1	1	2
End of Year Totals	**7**	**8**	**15**

- **Reporting a serious child safeguarding incident (working together-2018)**

Local authorities in England must notify the National Child Safeguarding Practice Review Panel within 5 working days of becoming aware of a serious incident. This is whereby a local authority in England knows or suspects that a child has been abused or neglected, the local authority must notify the Child Safeguarding Practice Review Panel if –

(a) the child dies or is seriously harmed in the local authority's area, or
(b) while normally resident in the local authority's area, the child dies or is seriously harmed outside England.

Safeguarding Partners must undertake a rapid review into all serious child safeguarding cases promptly and complete this within fifteen working days of becoming aware of the incident.

The table below demonstrates the number of agency check / rapid review responses submitted for children and young people who have died or have suffered significant / serious harm. The safeguarding children team have responded to all requests within the required time frame and submitted the evidence accordingly.

Child Safeguarding Practice Review / Learning Review Agency Report Submissions	
April 2022	**1**
May 2022	**1**
June 2022	**0**
July 2022	**0**
August 2022	**0**
September 2022	**0**
October 2022	3
November 2022	2
December 2022	2
January 2023	1
February 2023	1
March 2023	1

- **Overarching key themes from Child Safeguarding practice reviews Q1-Q4**

- **Multi-Agency Staying Safe Meetings**

The Multiagency Staying Safe Meeting is a process which incorporates the previously noted MASE (Multiagency Sexual Exploitation) function and children / young people missing from home. The meeting aims to review cases whereby the child / young person may be at risk of being harmed / sexually exploited. The meetings are now held weekly, and its primary purpose is to coordinate the care planning for young people at risk. It is a multi-agency forum to share information and alert those agencies that may not be immediately involved with the child but may come into contact with them. Identified leads representing each agency are present – for SNHSFT the representative is a Specialist School Nurse who works within the ASPIRE team. The Aspire nurse works closely with Stockport Family to ensure health are clearly represented as part of this process and that the data can be collated.

Currently there is a review of this panel's function from a Greater Manchester perspective with the focus on Child Sexual Exploitation (CSE), children Missing from Home (MFH) and Child Criminal Exploitation (CCE). The Aspire Nurse will contribute to this review and align with the other health representatives on a GM level to develop a quarterly report to explore activity, identify themes within the local area and from a GM perspective.

Safeguarding Children's Supervision

Safeguarding Children's supervision is offered widely across the Trust; acute and community services. The Trust Safeguarding Children Supervision Policy has been reviewed and incorporates amended ways of working to meet the needs of the service and demonstrate improvements within outcomes.

The compliance data has been separated below to include narrative surrounding the different cohorts of staff and their requirements.

- **Safeguarding Children Supervision in Health Visiting and School Nursing**

Safeguarding Children's supervision in health visiting and school nursing has continued with the revised model of provision, with the aim to spend longer on those cases that are presenting the most difficulties for practitioners. This enables quality reflection, learning and development which are transferrable to other cases within their caseload.

The current safeguarding supervision compliance for health visitors and school nurses are noted below:

Health Visitor and School Nurse Supervision 2022 – 2023												
	April 2022	**May 2022**	**June 2022**	**July 2022**	**August 2022**	**Sept 2022**	**Oct 2022**	**Nov 2022**	**Dec 2022**	**Jan 2023**	**Feb 2023**	**Mar 2023**
No of staff requiring supervision (HV & SN)	20 HV 3 SN	19 HV 3 SN	17 HV 10 SN	16 HV 7 SN	17 HV 3 SN	14 HV 2 SN	19 HV 11 SN	19 HV 9 SN	13 HV 3 SN	25 HV 4 SN	7 HV 10 SN	21 HV 8 SN
No of staff supervised within timescale	**18 HV** **3 SN**	11HHV 3 SN	13 HV 7 SN	16 HV 7 SN	17 HV 3 SN	14 HV 1 SN	16 HV 7 SN	15 HV 8 SN	7 HV 3 SN	14 HV 4 SN	8 HV 7 SN	11 HV 5 SN
No of staff supervised from prev mth	1 HV 0 SN	2 HV 0 SN	0	0	0	0	0	0	0	1 HV	1 HV	4 HV 1 SN
No of staff not supervised within timescale	7 HV 0 SN	7 HV 0 SN	3 SN 3 HV	0	0	0	0	0	1 HV	7 HV 2 sick, 1 retired, 1	7 HV 5 late replies book	7 HV 5 no response, 1 mat leave

										left, 3 no response, 1 A/L no return date	ed for March, 1 sick leave, 1 mat leave 3 SN did not reply to emails	, 3 sick. 3 SN – 1 supervision in feb, 1 sick, 1 Mat leave

Compliance remains high and of significant importance within the community provisions. To note, safeguarding supervision continued during the covid pandemic with amendments made to ensure that staff were seen prior to redeployment to ensure the caseloads had clear oversight.

The table presented below provides insight into the supervision and support activity which is delivered to a number of additional services across the organisation. This includes the detail of the total number of sessions completed across the community teams. The supervision sessions are completed in a variety of formats from individual sessions, to group sessions and supervision regarding the production of chronologies and support with court reports and guidance through the child death rapid review process. This activity and demand for support remains high with the number of sessions delivered in all quarters as illustrated below.

Month	Total Number of SG Supervision Sessions Delivered by the Vulnerable Childrens Team
April 2022	22
May 2022	16
June 2022	20
July 2022	23
August 2022	20
September 2022	15
October 2022	23
November 2022	23
December 2022	10
January 2023	18
February 2023	15
March 2023	16

- **Safeguarding Supervision within the Acute Services**

The provision of supervision within the acute setting has been reviewed and a robust model has been implemented. The information below is in relation to practitioners who have specialist nursing roles and therapy roles as well as the practitioners within the main unit areas within paediatrics, neonates and the children's ED department.

Specialist Nursing Roles

Acute Safeguarding Children Supervision Provision – Acute Specialist Nursing Roles. Supervision (compliance collated on staff receiving supervision sessions every 12-14 weeks)												
	Q1			**Q2**			**Q3**			**Q4**		
	April 2022	**May 2022**	**June 2022**	**July 2022**	**August 2022**	**Sept 2022**	**Oct 2022**	**Nov 2022**	**Dec 2022**	**Jan 2023**	**Feb 2023**	**Mar 2023**
Children's Learning Disability Team		**100 %**		100 %		100 %		**100 %**		100 %		100 %
Children's Diabetes Team		**100 %**		100 %		100 %		**100 %**			100 %	
Children's Respiratory Team	100 %	**100 %**		100 %		100 %		100 %		100 %		100 %
Children's Epilepsy Team	100 %	**100 %**		100 %	100 %	100 %			100 %			100 %

The monitoring and data collation regarding the specialist nursing groups remains on an individual compliance basis due to their case holding capacity. It is also noted that a number of the community teams hold dual roles and access supervision via the main community nursing forum.

Children Therapy Services.

Therapies Safeguarding Children Supervision Provision – Non- Case Holding Practitioners. Supervision (compliance collated on staff receiving supervision sessions every 12-16 weeks) Supervision is provided by Therapy Service Leads and Includes Paediatric Physiotherapy, Speech and Language Therapy and Orthoptist Department,												
	April 2022	**May 2022**	**June 2022**	**July 2022**	**August 2022**	**Sept 2022**	**Oct 2022**	**Nov 2022**	**Dec 2022**	**Jan 2023**	**Feb 2023**	**Mar 2023**
Therapy Services	56 %	**66 %**	45 %	46 %	42 %	67 %	72 %	75 %	90 %	86 %	94 %	82 %
Therapy Leads	100 %			100 %			100 %			100 %		

The delivery of safeguarding children's supervision is provided by the Therapy Team Leads in group format. A number of the team leads have completed a safeguarding supervision course to support this function. The team leads then receive supervision facilitated by the Safeguarding Children's Team to provide aerial oversight of case management.

Main Paediatric Service Departments.

Acute Safeguarding Children Supervision Provision – Non-Case Holding Practitioners. Supervision (compliance collated on staff receiving supervision sessions every 12-14 weeks)												
	Q1			Q2			Q3			Q4		
	April 2022	May 2022	June 2022	July 2022	August 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023
Children's CCNT			100 %		100 %			100 %	100 %			100 %
Treehouse and Outpatient Department.	100 %	100 %			100 %	100 %	100 %		100 %	100 %		100 %
Neonates	100 %		100 %			100 %	100 %		100 %			100 %
Children's ED	100 %			100 %		100 %		100 %		100 %		

The provision of safeguarding children's supervision to the acute staff is delivered in group format and the data collated demonstrates the sessions offered. This has been well received by the service leads and will be supported in the year ahead.

To assist with the delivery of this model there have been a number of practitioners within the Women and Children's Business Group who have completed a safeguarding supervision course to support the service provision. This aim is to enhance the team experience by having one of the safeguarding children's team support the implementation and development of the supervisor skills and enhance the application of theory to practice.

Spontaneous supervision continues to be provided on a daily basis supporting current / active case management, some of which is delivered in a coaching method whereby the specialist nurse works directly alongside the member of staff to guide them through the process as well as telephone advice that results in a reflection and staff actions with regards to the case. Due to the increase in visibility across the Trust and the developments in working within other areas, there has been a noted increase in this activity which has been extremely well received especially in adult service areas.

Maternity Safeguarding

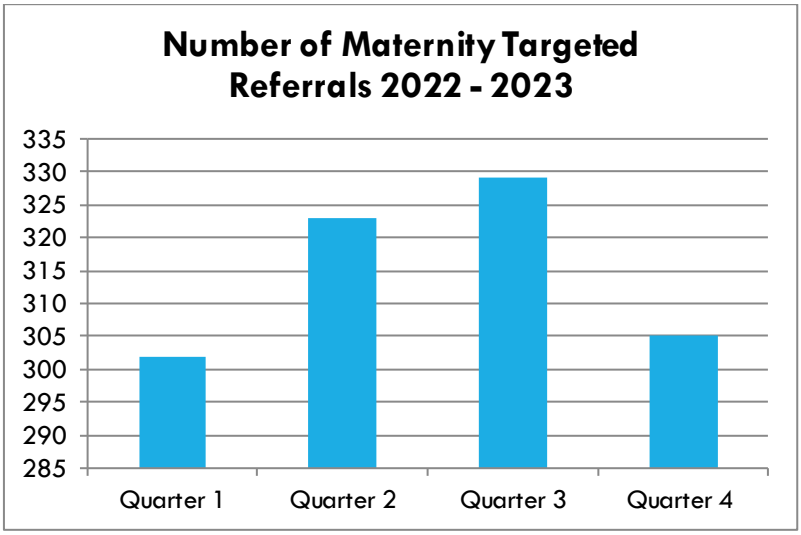
All staff working within Maternity Services at Stockport NHS Foundation Trust (SNHSFT) have a role in identifying risk and ensuring unborn babies, new-born babies and adults at risk are protected from harm and abuse. Maternity staff are likely to have significant contact with families who may require support and interventions in relation to safeguarding children and adults. As part of the on-going developments in demonstrating the trust response to the protection of these at-risk groups, key systems and processes have been implemented to enhance the safe provision and care delivery to the patients in our care.

Maternity services at SNHSFT provide antenatal, intrapartum, and postnatal care both within the acute environment of the acute Trust and across the Stockport footprint within children's centres and GP surgeries. In line with the choice agenda within maternity care, the organisation also provides antenatal and intrapartum care for out of area women who decided to access their antenatal and intrapartum care at SNHSFT.

Within Maternity services, there are clear reporting structures to enable staff to escalate identified safeguarding concerns to any of the safeguarding teams as part of a think family approach to safeguarding. Most referrals are submitted directly to the maternity safeguarding team via a targeted referral. Staff can also refer directly to Childrens and Adult social care as necessary to protect the most at risk.

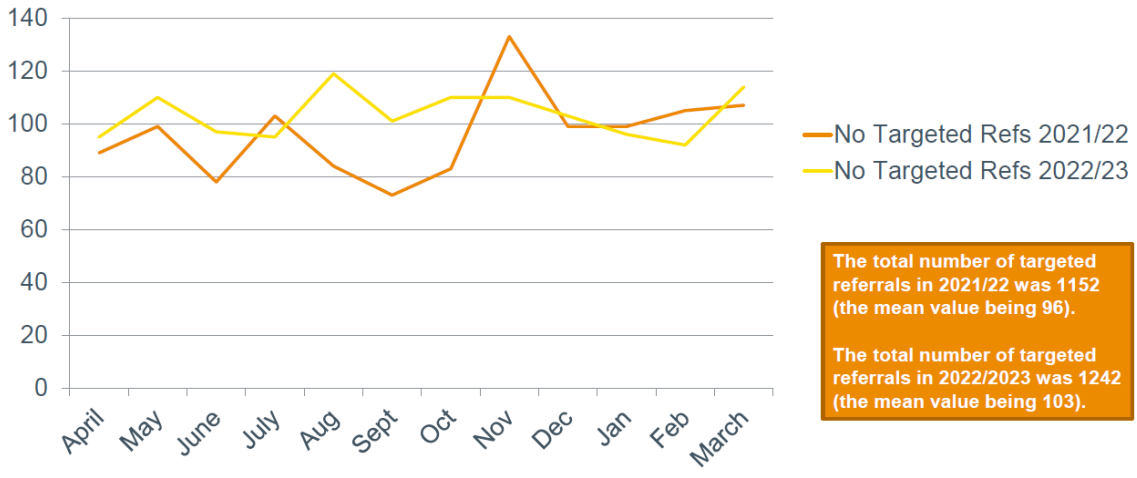
Robust screening for social risk indicators is embedded in all pathways of care, from the initial booking questionnaire up until handover of care to Health Visiting (HV) colleagues. At any point in the pregnancy and postpartum continuum an electronic targeted referral can be completed when a safeguarding concern has been identified or reported, which facilitates information sharing with partner agencies within health. All targeted referrals are received by the midwifery safeguarding team and are reviewed and a variety of follow up actions completed to ensure that the professionals involved with the child and family have the right information to inform risk assessments and safeguard the unborn child, children, young people and vulnerable adults that present to our organisation and access our services.

During the reporting period, the Maternity Safeguarding team have received 1246 maternity targeted referrals. This equates to 38.8% of women booked to deliver at Stockport NHS Trust had identifiable vulnerabilities or unmet needs. The most common indication for completing a maternity targeted referral was due to perinatal mental health issues.



Advantis CDS Maternity Safeguarding IT system went live in January 2021, the numbers of targeted referrals received over the past 24 months have been reasonably consistent with an upward trend, which would indicate that the process for identifying vulnerable women and families is well embedded and staff feel confident in using the IT system to alert practitioners to risk and unmet needs.

The chart below compares last year's Q1, Q2, Q3 and Q4 data to this reporting year's data. This year's Q4 data indicates slightly less targeted referrals being completed compared to last year in January and February but finishing the year end with a peak in March.



Numbers of targeted referrals are averaging > 100 per month which places increasing pressure on the maternity safeguarding team to triage them and action them to the appropriate professional in a timely manner. This in turn places pressure on the perinatal mental health midwives, IDVA service and the young person's midwife who need to triage them once they receive them from the safeguarding team.

Maternity Safeguarding Supervision

Safeguarding Supervision within Maternity is delivered differently depending on the area of the service the midwife practices. For the community based midwives who hold a caseload of families, they require safeguarding supervision every 3 months. For midwives working in the acute Trust, one safeguarding supervision update session is all that is required which is facilitated through the Public Health Study day.

There are currently 63 community based midwives requiring 4 sessions of safeguarding supervision per year. In order to facilitate these requirements, safeguarding supervision is currently offered either one-to-one with a member of the maternity safeguarding team or as group supervision. Group supervision is delivered by the Community Team leaders as well as the named Midwife for Safeguarding Children. Group supervision is most suited to those community based staff who do not case manage significant numbers of safeguarding families, whereas the one-to-one sessions are vital to those midwives who work with more vulnerable families or in areas of more social deprivation.

- **Year to Date Compliance**

Team	Compliance (Rolling 12 Months)	End of March 2023		
		No. Midwives	No. Midwives Compliant	% Compliant
Community	4 or above sessions	63	34	54%
Acute	1 or above sessions	168	117	70%
	Total	231	151	65.37%

- **Breakdown of Compliance by Quarter**

Team	Compliance	No. Midwives	Quarter 1		Quarter 2	
			No. MW Compliant	% Compliant	No. MW Compliant	% Compliant
Community	1 or above	63	47	75%	37	59%
Acute	1 or above	168	25	15%	27	16%
	Total	231	72	31.17%	64	27.71%

Team	Compliance	No. Midwives	Quarter 3		Quarter 4	
			No. MW Compliant	% Compliant	No. MW Compliant	% Compliant
Community	1 or above	63	44	70%	27	43%
Acute	1 or above	168	43	26%	39	23%
	Total	231	87	37.66%	66	28.57%

Female Genital Mutilation (FGM)

The safeguarding teams continue to support the Trusts mandatory recording and reporting of FGM data on a quarterly basis. The FGM enhanced dataset requires organisations to record collect and return detailed information about FGM within the patient population, as treated by the NHS in England. There have been a total of 17 reportable cases identified between April 2022 - March 2023.

The data collected is used to produce information that helps to:

- Improve how the NHS supports women and girls who have had or who are at risk of FGM
- Plan the local NHS services needed both now and in the future
- Help other organisations e.g. local authorities to develop plans to stop FGM happening in local communities.

A new on-line training session on FGM has become a mandatory requirement for all patients facing staff, and as part of the Level 3 safeguarding training offer, the Named Midwife continues to deliver face-to-face FGM training for the Trust.


Department of Health
NHS England
'Care, Protect, Prevent'
#EndFGM
FGM Mandatory reporting duty – What you need to do
Strengthening Safeguarding – from 31 October 2015
What does it mean for me?
Phone the police non-emergency crime number, 101, if a girl under 18 you treat
a) Tells you she has had FGM (female genital mutilation)
b) Has signs which appear to show she has had FGM.
When?
As soon as possible; normally by close of the next working day. Longer timeframes are allowed under exceptional circumstances but always discuss with your local safeguarding lead.
Can someone else do this?
No. This is a personal duty; the professional who identifies FGM/receives the disclosure must report.
Why?
FGM is child abuse and a crime. Health professionals have a responsibility to care for and protect girls.
What if I don't do this?
If you do not comply, your professional regulator may consider the circumstances under the existing 'Fitness to Practise' proceedings.
NSPCC FGM helpline: 0800 028 3550 fgmhelp@nspcc.org.uk
Quick guide for professionals: https://www.gov.uk/government/publications/fgm-mandatory-reporting-in-healthcare
CPHVA
unite the UNION
The Royal College of Midwives
Royal College of Nursing
Royal College of Obstetricians & Gynaecologists
RCPCH
Royal College of Paediatrics and Child Health

Adult Safeguarding

A significant part of the Trusts responsibility is contributing to statutory safeguarding enquiries and reviews. As such, the Adult Safeguarding Team has contributed positively to Section 42 Enquiries held under the auspices of the Care Act (2014) throughout the period of this report, furthermore the team support practitioners in providing specialist advice, guidance and support in risk and safety planning, complex care planning and training and educating staff.

The Trust continues to support Local Authorities in their statutory lead role for safeguarding adults and as such actively contribute to safeguarding enquiries (section 42, Care Act 2014) and other reviews. The Adult Safeguarding team continue to attend external strategy meetings, case conferences section 42 outcome meetings to ensure that any lessons learned are disseminated and embedded in Trust practice.

The Trust has a reporting system to enable all staff to escalate any safeguarding concerns to the Adult Safeguarding Team. The cause for concern form can be accessed electronically through the Adult Safeguarding microsite. All concerns are reviewed and where indicated patient records are reviewed to add additional information to support and inform the concern, to escalate immediate concerns and to ensure that the right practitioners are in receipt of the right guidance and support. All actions relating to safeguarding concerns are recorded on a database to support data analysis and reporting via the Trust Integrated Safeguarding Group.

- **Concerns raised by Trust staff during the reporting period 22-23**

Month	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2022/23	81	112	114	126	126	111	111	111	111	99	117	118	1337
2021/2022	77	80	66	41	47	52	87	84	77	67	68	81	827
2020/2021	45	79	94	71	55	57	62	73	80	74	16	82	833

The total number of referrals received in this reporting year has increased by 61% (510) compared to the previous period 2021/22. The increase tells us that there is greater awareness and understanding of how staff report a safeguarding cause for concern but also is line with trend analysis in local reporting in neighbouring Trusts.

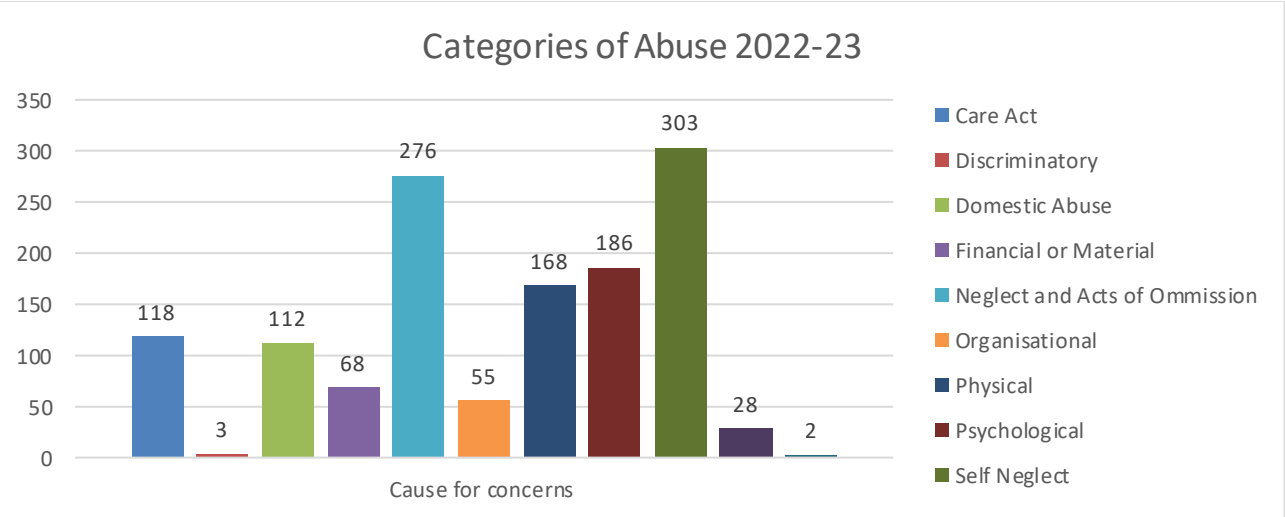
- **Referrals to Adult Social Care**

Month	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2022/23	61	103	109	67	115	84	94	70	77	33	115	82	1010
2021/2022	68	62	55	41	43	34	56	31	56	56	51	42	595
2020/2021	38	68	73	59	51	44	52	58	71	59	59	74	706

The referrals to the Local Authority have also increased by 70% (415) compared to the previous period 2020/21. This is a significant increase, based on the on the total amount or referrals received. Out of those referrals (327) 24% of referrals were screened and signposted to the most suitable agency for their consideration, or with no further action necessary.

The below graph highlights the cause for concern categories made by Trust staff in this reporting period.

The main reason for consultation within the safeguarding adult team is relating to categories related to issues of Self-neglect, Neglect and Psychological (See Table below). The team also ensure the completion of domestic abuse DASH forms and referrals to MARAC are completed timely for high-risk domestic abuse cases, this is in keeping with local and national reporting data.



Adult Safeguarding Supervision

Safeguarding supervision is the most influential and effective of safeguarding interventions taken by safeguarding professionals. The Adult Safeguarding Team continues to deliver monthly safeguarding supervision session with all Divisions. Safeguarding supervision is offered to all Band 7 and 8a staff either on a one-to-one basis or a group session.
These sessions have increased knowledge and awareness of safeguarding issues, escalations of safeguarding concerns and staff report they feel better supported and competent to deliver their safeguarding role. The provision is also promoted within the Safeguarding level 3 training, and we have seen people request peer supervision following attendance at the training.

Mental Capacity, Deprivation of Liberty (DoLS) and Liberty Protection Safeguards (LPS)

As part of the Trusts statutory obligation to ensure that there are effective arrangements in place to safeguard individuals this is embedded in the work the Trusts undertakes in Mental Capacity assessment and DoLS applications and authorisations. The Trust has systems and processes in place to monitor the effectiveness of MCA assessments and regularly reviews this to support learning and education to all staff members. The adult safeguarding team play a critical role in supporting the Trust in working within the regulations for DoLS and MCA. The team continue to work with Divisions in improving the standard of applications and authorisations that are sent to the relevant Local Authorities for further scrutiny and processing.

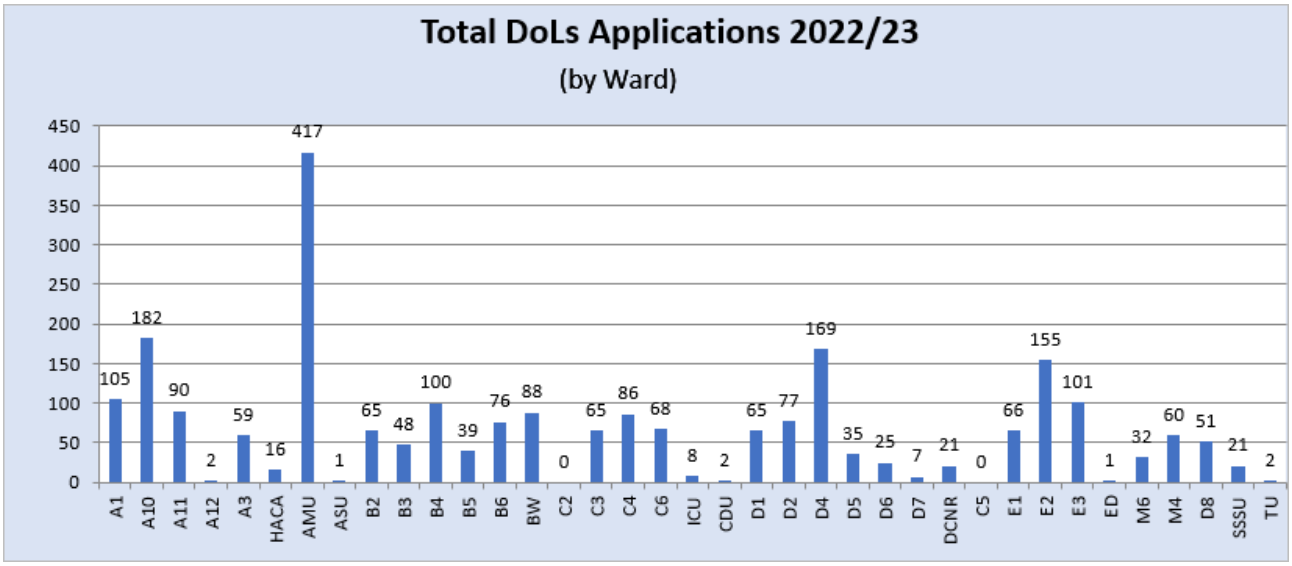
The team provide area specific guidance and training on capacity assessment and completion of DoLS authorisations and applications. The introduction of How to complete a Mental Capacity Assessment webinar to support staff in assessing capacity was rolled out across the Trust, with posters, pocket cards as well as on the intranet to raise awareness to provide clinical staff information on the implementation and statutory responsibilities for MCA.

- ### Deprivation of Liberty Authorisations / Applications April 2022 – March 202

Each DoLS authorisation and application is reviewed by the safeguarding adult's team prior to the safeguarding administrator sending to the appropriate DoLS supervisory office. An administrative and clinical review is undertaken prior to the submission of the DoLS application and or authorisation form. This ensures a relevant mental capacity assessment is documented accurate, appropriate, and comprehensive.

The Trust continues to provide care for patients under best interest arrangements due to the supervisory body having a back log of applications requiring a Best Interest Assessment this reflects the national position.

There were 2526 DoLS applications made during the year, an increase of 49% (837) from the previous year 2021/22. This is a significant increase and does reflect on the ease of Covid restrictions and the increase of staff awareness, particularly since the introduction of toolbox training.



The graph above shows the DoLS applications per clinical area varied over the year. The majority were received from the Acute Medical Unit (AMU). The team continue to support clinical areas in identifying, documenting mental capacity, reviewing applications and providing several toolbox training sessions to staff highlighting good practice examples.

The figures in the tables below illustrate the activity over the year and show significant trends of applications related to 'spikes' in admissions of vulnerable people related to the time of year being the winter months and high summer.

The tables below illustrate the number of applications on a month-by-month basis; overall there is a 496 increase in the number of applications made by Trust staff.

Quarter 1 2022-23	**Apr**	**May**	**Jun**	**Total**
DoLS applications	219	171	165	555
Quarter 2 2022-23	**Jul**	**Aug**	**Sep**	**Total**
DoLS applications	210	231	217	658
Quarter 3 2022-23	**Oct**	**Nov**	**Dec**	**Total**
DoLS applications	232	231	246	709
Quarter 4 2022-23	**Jan**	**Feb**	**Mar**	**Total**
DoLS applications	189	211	204	604

Quarter 1-4 2021-22	**1689**
Quarter 1-4 2022-23	**2526**
Increase of	**837 (49%)**

The Trust received formal notification from the Department of Health and Social Care to announce that the development and implementation of the Liberty Protection Safeguards which was due to

replace the DoLS framework back in 2020 is going to be delayed beyond this life of this current parliament and the Department is going to focus its efforts into government reforms for Adult Social Care (Adult social care system reform: next steps to put People at the Heart of Care).

Safeguarding Training compliance

Safeguarding training remains a key priority for all employees at Stockport NHS FT, there is a nationally set requirement for levels of safeguarding training as appropriate to individuals' roles and responsibilities. Key learning aims and outcomes for safeguarding training are refenced in relevant Intercollegiate documents for all staff. During the reporting year safeguarding training has continued through a variety of different platforms to aide staff and reporting of this in measured regularly through divisional performance reviews and Trust Integrated Safeguarding Group. Moreover, adult safeguarding level 3 remains below the allocated target however reference must be paid to the improvements that have been made. In addition, actions to continue to improve this picture are being worked through by relevant safeguarding teams and reported through internal and external governance and assurance routes. To support the work in educating staff work is being completed on the reporting and recording system that the Trust utilises to ensure that reporting is accurate.

The safeguarding teams acknowledge that whilst an improvement is required in safeguarding training, staff are committed to protecting people to keep them safe from harm and abuse and utilise specialist teams to support them in this.

- **Adult Safeguarding Training**

Adult Safeguarding Training	2022-2023			
	Q1	Q2	Q3	Q4
Level 1 (TARGET 85%)	95.54	96.72	95.41	95.50
Level 2 (TARGET: 85%)	94.06	92.40	90.22	92.41
Level 3 (TARGET: 85%)	56.02	61.97	71.37	78.16
Prevent WRAP 3 Training (TARGET: 95%)	91.60	91.11	87.70	92.20
Prevent Basic Awareness (TARGET: 95%)	94.51	94.53	94.82	95.09

Online training remains the main route to deliver Level 1 and 2 adult Safeguarding training. In house Level 3 adult Safeguarding face to face training was reinstated from October 2022 and delivery has continued with a rolling programme where staff can enrol onto. The sessions are well evaluated and target the audience feedback from the E portfolio Learning Pathway. Feedback on themes regarding "what went well" and "what could be better" at were asked of learners about the training. Participants gave ratings based on three questions regarding relevance, quality, and interaction. The overall average rating was 3.5 out 4.

Question text	Average rating
How relevant is the course content to you?	3.3/4
How well would you rate the overall quality of the course delivery?	3.4/4
Were you happy with the level of interaction and Q&A opportunities?	3.6/4

Learners also have the facility to provide optional feedback. All learners who gave top mark feedback stated that the course was interesting, they learned a lot and providing constructive feedback on what they would like to see differently in the future.

The Adult Safeguarding Intercollegiate guidance is used to inform the Trust training. While the compliance for 2022/23 is shown in the table above, the current activity demonstrates a strong level of compliance in level 1 and level 2 safeguarding training and a trajectory of compliance that continues to rise throughout the financial year to ensure practitioners are compliant with co mpleting 8 hours of competency to meet with safeguarding level 3.

- **Childrens Safeguarding Training**

The training compliance figures for Level 1 & 2 safeguarding children training remain above 90% and have continued to be monitored across the organisation. Level 3 safeguarding children training is offered to all clinical staff working with children/families who contribute to assessing, planning, intervening and evaluating the needs of a child/young person and their carers.

Particular focus has been placed to ensure level 3 practitioners have access to the required level of high quality training through a blended approach alongside the Stockport Safeguarding Children's Partnership multiagency programme and the safeguarding children team. The training provision from the safeguarding children team has been adapted to offer an 8 hour face to face safeguarding children level 3 full day which meets the competences outlined in the Intercollegiate document. The safeguarding children's team have also developed more frequent and shorter sessions to increase the current offer for staff who find it difficult to be released from clinical settings. Training has evaluated extremely well; attendees report that they felt more confident about their involvement in safeguarding children, have benefited from the knowledge of outside speakers and the importance of having up to date knowledge around the more recent learning from Child Safeguarding Practice Reviews

Level 3 compliance reporting has been reviewed with the learning and development team. A revised Do It Online submission form is being produced to provide professionals with the ability to save the training that has been undertaken and submit the form once 8 hours of training has been accrued. In response to feedback from practitioners, there will be separate adult and children Do It Online forms.

The Childrens team are working to create a full day of training in line with Intercollegiate guidance and these sessions will be uploaded onto the Trust ESR system, without the need to complete a Do It Online form. The revised Do It Online form and the 8-hour face to face sessions will assist with accurate and consistent reporting and will support managers in accessing this information readily as part of their staff assurance and monitoring processes.

Childrens Safeguarding Training	**2022-2023**			
	Q1	**Q2**	**Q3**	**Q4**
Level 1 (TARGET 85%)	**95.12**	**96.02**	**95.34**	**96.65**
Level 2 (TARGET: 85%)	**93.55**	**93.26**	**91.28**	**92.49**
Level 3 (TARGET: 85%)	**80.25**	**78.50**	**79.94**	**83.29**

Partnership working to improve outcomes for children and adults

The safeguarding teams contribute daily to support the functioning of the Multi-Agency Daily risk meeting. This function is shared with Greater Manchester Police to ensure health information is shared to inform assessment of high-risk domestic abuse cases. The team have supported, in health information requests and attend meetings when required.

Multi Agency Adults at Risk (MAARS)

The team attends the Multi Agency Adults at Risk (MAARS) Panel monthly, and the forum is intended to identify, risk assess and support adults who would not be eligible for statutory support under the Care Act 2014. The team provides all agencies working in Stockport with information and resources around the Multi-Agency Adults at Risk System (MAARS). In 2022-23, there were **3** referrals to MAARS for consideration and meetings are represented by the team to assist in sharing of information.

Prevent (anti-terrorism)

The Named Professional for Adult Safeguarding regularly attends Stockport's Channel panel. The Trust made no referrals to Channel panel throughout 2022/23 but was able to assist in sharing information, where we received **13** requests to provide information by the Channel panel at meetings with statutory and no statutory partners.

Multi-Agency Risk Assessment Conferences (MARAC)

A Multi Agency Risk Assessment Conference (MARAC) is a local, multi-agency victim-focused meeting where information is shared on the highest risk cases of domestic violence and abuse between different statutory and voluntary sector agencies. Within Stockport Borough this is held every 2 weeks and the organisation is represented by the Safeguarding Children Team, Adult Safeguarding and when required the Named Midwife who attend to gather information to support risk assessment and planning for practitioners who have case holding responsibilities.

It is important to note that each case is reviewed to ascertain if there are any children associated with the victim and / or alleged perpetrator so information can be shared to ensure that the child/ren are considered and included as part of the wider risk assessment. This is a key function which is currently undertaken by the two Safeguarding Children Team nurses whose base is currently at Central House.

Once the cases are heard at the panel, action plans are developed and communicated accordingly by the Safeguarding Children Team to the case holding professional and the relevant GP practice, so the practitioners involved with the family are clearly cited on the level of risk and the requirements to provide support to the child and family. This is also a key trigger for GP practices to review the GP coding / flagging system so appropriate safeguards can be put in place if the parent / child presents. It is important to note that there can be a large number of GP practices, practitioners and services involved in one incident which can be a challenge to ensure that the right teams are alerted.

In addition, due to the noted national increase in domestic abuse notifications there has been a need to review the data in relation to this activity. The final row of the table presented notes the domestic abuse notifications received by Greater Manchester Police (GMP). Each case is reviewed, and clarity secured regarding the case holding practitioners so the information can be shared effectively, and immediate support can be made available for the family. These figures remain high, and the team are currently reviewing the systems and processes in place to support this function.

Safeguarding Learning Reviews – Safeguarding Adult Reviews (SAR) / Domestic Homicide Review (DHR)

During the reporting year SNHSFT have contributed to several safeguarding reviews and learning events hosted by Stockport Safeguarding Board and Partnerships, the Trust is committed to

identifying learning and after each of these reviews take place, action plans are created to track key areas of work and improvements to practice. These are monitored through respective safeguarding groups in the Trust and form part of supervision, training and education, objective, and strategy planning.

There was 1 Information requests from the Stockport Safeguarding Adult Partnership to inform decision making for Safeguarding Adult Review under Section 44 of the Care Act 2014. This case was heard, however this did not met the criteria for a SAR.

One Stockport Safety Partnership received 4 information requests for consideration of a Domestic Homicide Review. There were 3 cases that had not met the criteria for a DHR, although 1 was progressed to DHR 17.

- **Safeguarding Adult Reviews (SARs)**

No SARs to report on and no action plans outstanding for the Trust

- **Domestic Homicide Reviews (DHRs)**

DHR 12 – Completed and awaiting Home Office sign-off before publication. Action plan is nearing completion by the Trust.

DHR 13 – Completed and awaiting Home Office sign-off before publication. Panel members agreed no action plan was required for this review.

DHR 17 – Completed and awaiting Home Office sign-off before publication. The action plan for this review has been prepared and shared with children and adult teams to progress on actions.

Conclusion

The Trust acknowledges that this year has continued to present the people of Stockport with significant challenges both in health and social care, the Trust Integrated Safeguarding Annual Report for 22/23 highlights that although the challenges have been unprecedented the Trust continues to have safeguarding as core business and have continued to support the most at risk in society. The annual report provides assurance in how the Trust has delivered its statutory obligations to safeguard people, learn from incidents both local and national and set the ambitions for the next reporting year.

Our Ambitions for 2023/24

Adults

- Improve the reporting and recording of safeguarding adult concerns to support in local decision making and provide thematic updates on areas of concern for the Trust
- Ensure that all safeguarding adult work incorporates the voice of the adult at risk and ensure that making safeguarding personal principles are included in all activity
- To improve in the use of quality assurance processes in reviewing safeguarding adult activity

Children

- Review the current infrastructure for safeguarding children's teams
- Complete a review of Safeguarding Supervision and highlight key success and make any necessary recommendations
- Support Stockport Family in its transition to Family Hub Models

Maternity

- Embed proactive responses when safeguarding concerns are raised during the pregnancy and beyond
- To process map and review how safeguarding concerns are managed within maternity services
- Support the review of safeguarding supervision and its interfaces with the safeguarding children team

Looked After Children

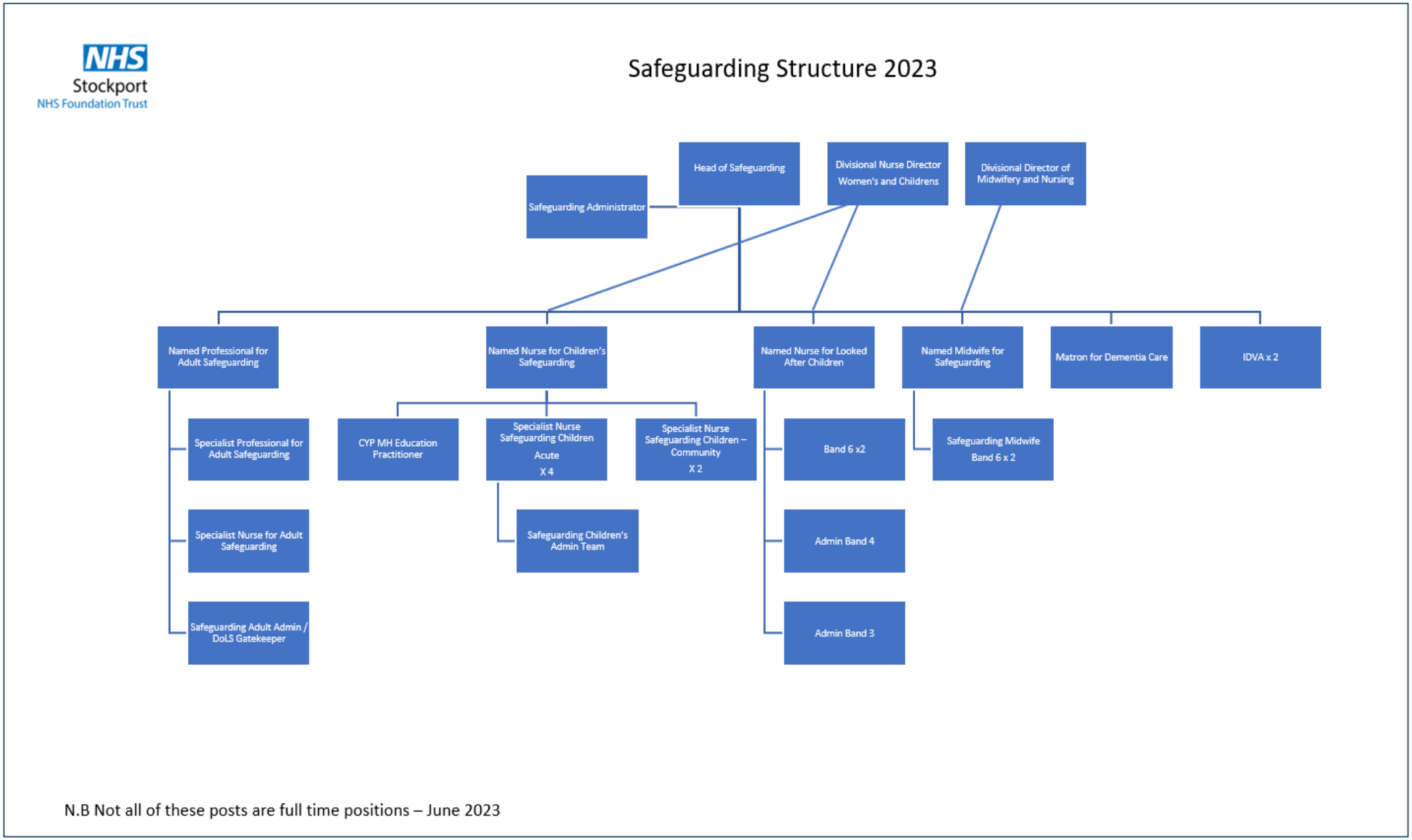
- Maintain a high standard for the completion of Initial Health Assessments for children who become looked after
- Support the ongoing work to reduce health inequalities for looked after children
- Incorporate and report level 3 training for looked after children into all safeguarding training

Appendix 1

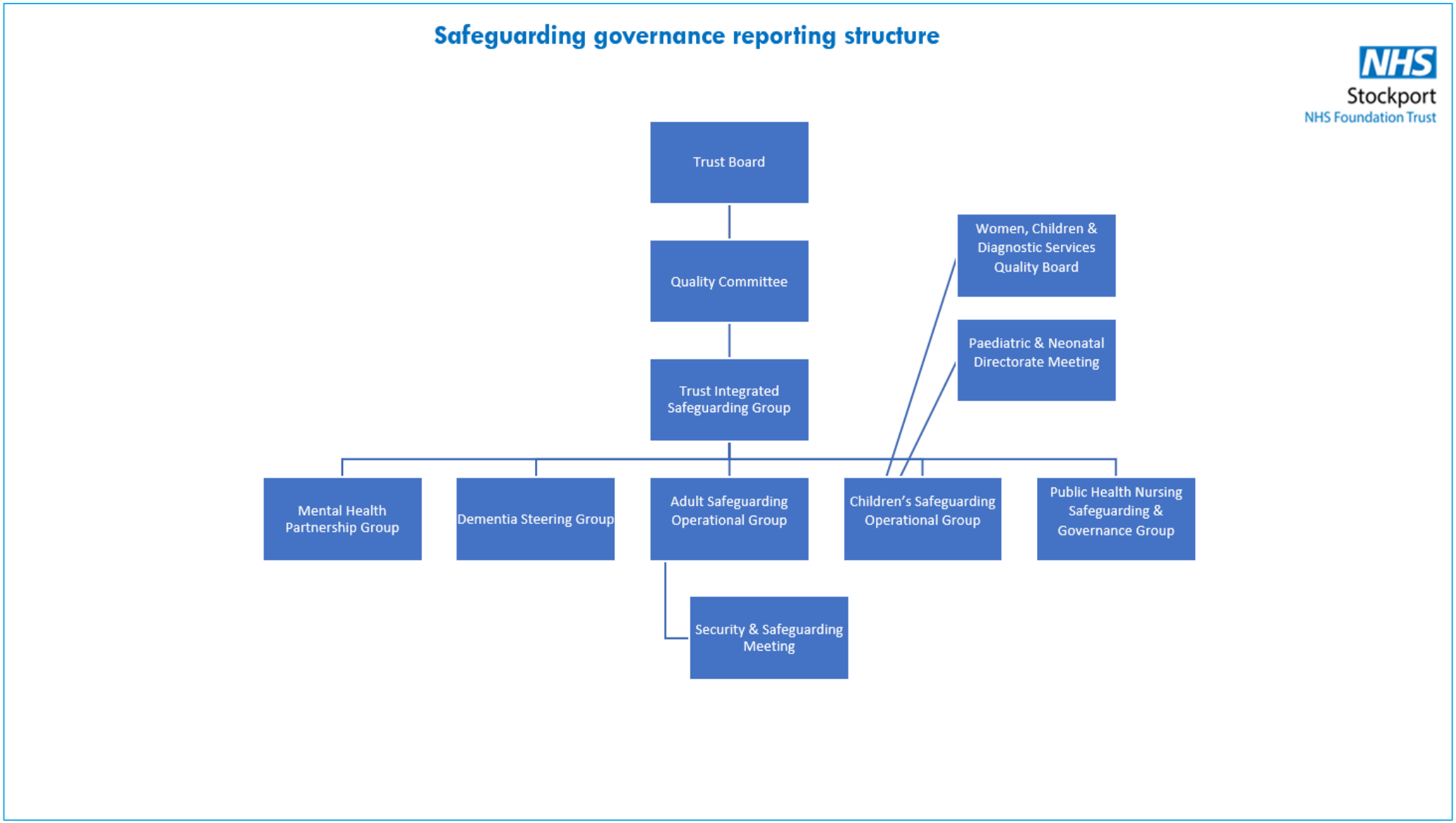
Safeguarding 2-year strategy annual update 22/23

AIM	HOW	UPDATE
Integrated Services	• Adopt the proposed Safeguarding Structure for the Trust	• Completed and the Trust has a fully established Safeguarding teams with integrated approaches to safeguarding
Training and Supervision	• Ensure Leadership and medical staffing is compliant with intercollegiate guidelines regarding Named Doctors. • Enhance current safeguarding supervision. • Establish training Strategy based on skill-based learning. • Establish Non-Violent Resistance Training (NVR)	• Consistent increase in safeguarding training in all levels • Safeguarding supervision has been successfully enhanced in all areas and update of safeguarding supervision in adult safeguarding has been a great success and further rollout to other practitioners is panned for forthcoming year • The Trust is working in partnership with Tameside and Glossop NHS FT to have an integrated Safeguarding training strategy, this is a key objective for the next year • The establishment of Non-violent resistance training has been completed in Children and young people and plans to review for adults next year
Policy Development	• Trust wide adoption of the Domestic Abuse Strategy. • Roll out suicide and self-harm toolkit. • Mental Capacity Act to be threaded through all training and practice. • Ensure all policies, SOP's and guidelines are in date and evidence based.	• Domestic Abuse is a core priority for the Trust and we continue to support the delivery of the Stockport Domestic Abuse strategy • Enhanced observation and therapeutic training continues • MCA toolbox sessions launched and level 3 day incorporates MCA session • Policy tracker now in place which monitors all safeguarding related policies
Safeguarding Report	• Demonstrate compliance in line with the NHS Assurance Framework. • Develop a refined reporting process and establish a safeguarding dashboard.	• The Trust has received substantial assurance from the NHS Greater Manchester ICB for Safeguarding Contractual standards • The Safeguarding teams continue to develop their reporting processes and this is aligned at Trust Integrated Safeguarding Group.
Multi-agency Working	• Partnership process mapping of Liberty Protection Safeguarding. • Implementation of Transitional Service developments from Child to Adult • Adopt the Homelessness Strategy into practice. • Develop Mental Health Strategy with Partner agencies. • Adopt the Modern Slavery Bill. • Commence the Comprehensive service review for Looked After Children.	• Due to the Governments publication that LPS is delayed beyond the life of this parliament no further partnership is continuing on LPS, this will be business as usual • The Trust contiunues to engage with complex Safeguarding Group to review transition and Stockport Partnerships identify this as a core priority for the next three years • The Trust works with Stockport Homes on delivering its Homelessness strategy and we have good partnership practice with colleagues • Mental health strategy and Modern-Day slavery statement are completed and in circulation • Due to ICB development, a review of LAC services is ongoing, Named Nurse for LAC has completed a review of their service

Appendix 2


NHS
Stockport
NHS Foundation Trust
Safeguarding Structure 2023
Head of Safeguarding
Divisional Nurse Director Women's and Childrens
Divisional Director of Midwifery and Nursing
Safeguarding Administrator
Named Professional for Adult Safeguarding
Named Nurse for Children's Safeguarding
Named Nurse for Looked After Children
Named Midwife for Safeguarding
Matron for Dementia Care
IDVA x 2
Specialist Professional for Adult Safeguarding
Specialist Nurse for Adult Safeguarding
Safeguarding Adult Admin / DoLS Gatekeeper
CYP MH Education Practitioner
Specialist Nurse Safeguarding Children Acute X 4
Specialist Nurse Safeguarding Children – Community X 2
Safeguarding Children's Admin Team
Band 6 x2
Admin Band 4
Admin Band 3
Safeguarding Midwife Band 6 x 2
N.B Not all of these posts are full time positions – June 2023

Appendix 3
Safeguarding governance reporting structure



NHS
Stockport
NHS Foundation Trust

Meeting date	3rd August 2023	x	Public		Confidential	Agenda item
Meeting	Board of Directors					
Title	Trust Safeguarding Plan 2023-2026					
Lead Director	Nic Firth Chief Nurse		Author	Tom Parker-Evans Head of Safeguarding		

Recommendations made / Decisions requested

The Board of Directors is asked to review the Trust Safeguarding Plan 2023-2026 and approve this document.

This paper relates to the following Corporate Annual Objectives-

x	1	Deliver personalised, safe and caring services
x	2	Support the health and wellbeing needs of our community and colleagues
x	3	Develop effective partnerships to address health and wellbeing inequalities
x	4	Develop a diverse, talented and motivated workforce to meet future service and user needs
	5	Drive service improvement through high quality research, innovation and transformation
x	6	Use our resources efficiently and effectively
	7	Develop our estate and digital infrastructure to meet service and user needs

The paper relates to the following CQC domains-

x	Safe		Effective
x	Caring		Responsive
x	Well-Led		Use of Resources

This paper relates to the following Board Assurance Framework risks

x	PR1.1	There is a risk that the Trust does not deliver high quality care to service users
	PR1.2	There is a risk that patient flow across the locality is not effective
	PR1.3	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan
	PR2.1	There is a risk that the Trust is unable to sufficiently engage and support our people's wellbeing
	PR2.2	There is a risk that the Trust's services do not fully support neighbourhood working
	PR3.1	There is a risk in implementing the new provider collaborative model to support delivery of Stockport ONE Health & Care (Locality) Board priorities

	PR3.2	There is a risk that the Trust does not deliver a joint clinical strategy with East Cheshire NHS Trust
	PR4.1	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit and retain the optimal number of staff, with appropriate skills and values
	PR4.2	There is a risk that the Trust's workforce is not reflective of the communities served
	PR5.1	There is a risk that the Trust does not implement high quality transformation programmes
	PR5.2	There is a risk that the Trust does not implement high quality research & development programmes
	PR6.1	There is a risk that the Trust does not deliver the annual financial plan
	PR6.2	There is a risk that the Trust does not develop and agree with partners a multi-year financial recovery plan
	PR7.1	There is a risk that the Trust does not implement the Digital Strategy to ensure a resilient and responsive digital infrastructure
	PR7.2	There is a risk that the estate is not fit for purpose and/or meets national standards
	PR7.3	There is a risk that the Trust does not materially improve environmental sustainability
	PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus

Where issues are addressed in the paper-

	Section of paper where covered
Equality, diversity and inclusion impacts	
Financial impacts if agreed/ not agreed	
Regulatory and legal compliance	All
Sustainability (including environmental impacts)	

Executive Summary

The Safeguarding Plan is the Trusts commitment to Safeguarding the welfare of children, young people, adults and families across Stockport and beyond and it sets out the strategic approach that is needed to strengthen the foundations of safeguarding practice at the Trust and sets out the priorities and ambitions for the next three years.

The plan is a working document that is underpinned by 5 core priorities for the Trust, along with key ambitions for each of the safeguarding services that will be refreshed each year. This approach allows for the Trust to recognise the changing landscape of safeguarding work, and work with the communities to deliver the right work at the right time.

The plan is supported using a delivery plan to highlight key actions that will be necessary to deliver the priorities and ambitions, and this will be monitored via the Trust Integrated Safeguarding Group and referenced in the Key Issues Report to Quality Committee.

Stockport
NHS Foundation Trust

Safeguarding Plan

2023 – 2026

Making a difference every day

Safeguarding Plan

2023 - 2026

Contents

Foreword

Stockport NHS Foundation Trust is committed to and adopts a whole organisational approach to safeguarding. We believe that to effectively safeguard everyone we need an integrated think family approach to our work. This plan is our commitment to delivering our ambitions of this think family approach and our associated safeguarding work streams.

As an organisation we emphasise that safeguarding is everyone's business and it's a golden thread across all our work. To ensure that this is delivered we will have safeguarding governance and practices embedded across all divisions both in the hospital and out in our communities that we serve.

The development of this plan has given us the opportunity to reflect on our previous successes and learn from when things have gone wrong in the past and how we can move forward and ensure that our care and services are effective in delivering our safeguarding work.

Our work to safeguard will be supported by our interagency relationships with locality colleagues in Greater Manchester Integrated Care Board and Safeguarding children and adults partnerships across Stockport and the wider community that supports the safe and effective safeguarding practice.

This plan will be monitored via regular assurance meetings known as the Trust Integrated Safeguarding Group and we remain committed as a Trust to ensure we have the highest standards of safeguarding practice.

All of the Safeguarding Teams wish to thank all of our dedicated staff, our supportive partners, the Executive Team and the Trust Board who continue to work so positively with us to make Stockport NHS FT a safer place to work and Stockport and beyond a safer place to live

Nicola Firth

Chief Nurse
DIPC and Executive Lead for Safeguarding

Context

About the Trust

Stockport NHS Foundation Trust aims to be a well-led organisation delivering safe, high-quality care for local people.

Our Vision

Our Strategic Plan for 2020-2025 sets out a clear vision - developed in collaboration with our staff and our patients - to continue to improve the quality and performance of our services, while achieving financial sustainability.

Our Mission

Making a DIFFERENCE every day

Our Values

- We care
- We respect
- We listen

Our Strategic Objectives

- A great place to work
- Always learning, continually improving
- Helping people live their best lives
- Investing for the future by using our resources well
- Working with others for our patients and communities

Alignment of plans

Our long-term Trust Strategy will be delivered through a range of medium-term business strategies, which set out the detail of how we will achieve our ambitions across our clinical divisions and enabling functions such as workforce, informatics and estates.

Each year, the Trust develops annual operational plans for our in-year priorities, which align to national policy and delivery of our strategic objectives. This hierarchy of plans is set out in the figure to the right.

This document sits among our business strategies, detailing our medium-term plans to deliver the Trust's vision.

Prior to this business plan development the Trust had a two strategy for Safeguarding and this plan aims to build on those foundations that were set and continue with the improvement journey. The Trust has reported on the achievements from that strategy in the annual reports for 21/22 and 22/23.

What is safeguarding?

Safeguarding is a range of activities aimed at upholding adults and children's right to be safe.

The Care Quality Commission (CQC) state that Safeguarding means protecting people's health, wellbeing and human rights and enabling them to live free from harm, abuse and neglect. It is fundamental to high-quality health and social care (CQC, 2016)

This plan sets out how Stockport NHS FT will work to safeguard all and promote a preventative think family approach to safeguarding people from harm and abuse and ensure that this practice is core business in all Trust activity.

National context

Safeguarding adults and children is enshrined within UK law and is key to ensuring that all safeguarding practice is supported by legislation, statutory guidance, and regulations.

Key legislation and guidance for safeguarding include:

- Care Act 2014
- Human Rights Act 1998
- Children Act 1989, 2004
- Working together to safeguard children 2018
- Children and Social Work Act 2017
- Serious Crime Act 2015
- Domestic Abuse Act 2021
- Modern Slavery Act 2015
- Counter-terrorism Act 2015
- Health and Social Care Act 2008
- NHS constitution
- Children and Families Act 2014
- Promoting the health and wellbeing of looked-after-children
- Mental Capacity Amendment Act 2019
- Mental Health Act 1983, 2007
- Health and Care Act 2022.

Introduction

The safety and welfare of children, young people, adults and families across Stockport and beyond is a core priority for the Trust. This document sets out the strategic approach that is needed to strengthen the foundations of safeguarding practice at the Trust and set out the priority and ambitions for the next three years.

Stockport borough has a resident population of Stockport is **291,775** (2018)

Stockport has the oldest age profile in Greater Manchester and the population continues to age. **19.9%** of people are aged 65 or over and this is likely to rise to **21%** by 2024.

Average life expectancy in Stockport is high, with women living on average **83.3** years and men **79.8**.

The number of Stockport residents grew by **3.6%** over the past decade and is predicted to rise to 306,300 by 2028.

While life expectancy in Stockport is above average, there is significant difference within our neighbourhoods, with men in Bramhall South living **11** years longer than those in Brinnington & Central. This variation is also seen in healthy life expectancy - in the most deprived areas the decline in health starts at age 55, compared to 71 in the most affluent areas

Stockport NHS Foundation Trust is a medium-sized hospital serving the populations of Stockport, High Peak and eastern Cheshire.

The Trust is an integrated provider of acute hospital and community services, employing around 5,500 people.

With around 700 inpatient beds and an annual budget of around £340 million, the trust supports over half a million patients each year, including:

105,000 A&E attendances

131,700 hospital admissions

350,000 outpatient appointments

3,000 births each year

470,650 community health contacts.

Safeguarding Adults

Stockport has a lower rate of adult safeguarding concerns (786 stated per 100,000 population) than the North West (971) and Greater Manchester (1226) average.

The majority of Section 42 enquiries were for adults in care homes.

Section 42 enquiries for Neglect and Acts of Omission were higher in Stockport (167.7 per 100,000) than the Greater Manchester (156.6) and North West average (137.9).

We have seen an increase of adults with multiple vulnerabilities presented at Multi Agency Adults at Risk System (MAARS) Panel - 15% of cases were referred by the Leaving Care Team.

Safeguarding Children

62,900 Children 0-17 live in Stockport:

- 5,908 MASSH Contacts a year
- 3,529 Children's Social Work assessments
- 3,442 Referrals to Children's Social Care
- 2008 Children in Need
- 450 Initial Child Protection Conferences
- 445 OLA Looked-After-Children
- 363 Children in Care
- 332 subject to a Child Protection Plan
- 216 referrals to the LADO
- 10 children living in a private fostering
- >10 Unaccompanied Asylum Seeking Children

This safeguarding plan sets out core priorities for safeguarding and how they aim to be delivered over the time set. A key component to effective safeguarding practice is based upon relationships and the Trust has key relationships with a number of internal and external stakeholders. The Trust will continue to work alongside the three statutory partners for safeguarding which include Stockport Local Authority, Greater Manchester Police and Greater Manchester Integrated Care. The Trust is also a key partner of both Safeguarding adults and children's partnership and this plan is linked to delivering system wide change for safeguarding whilst discharging the Trust statutory duties.

The plan is designed around core priorities in delivering our safeguarding work and they are:

- Develop an integrated approach to our safeguarding work (Think Family)
- Develop the Trust's workforce to be confident and competent to safeguard people from harm and abuse
- Ensure that we are complaint with statutory guidance and legalisation in the execution of our statutory duties
- Be a learning organisation and embed lessons learned from safeguarding and other reviews
- Improve the health outcomes for people where safeguarding concerns are evident.

This safeguarding plan outlines the Trusts vision and strategic direction for safeguarding practice over the next three years, it builds upon the existing arrangements that are in place and aims to strengthen and mature these to meet the needs of the patient population covered by Stockport NHS Foundation Trust.

Our Mission and Vision

The Trust has a clear mission and vision for safeguarding and a core set of priorities for 2023-2026, and this will be delivered by adopting this plan, and by doing that the Trust will create a safeguarding delivery plan that is linked to partnership work to deliver both internally and externally safe and effective safeguarding practice.

Our Mission

To safeguard our community

Our Vision

To work collaboratively with people, providers and partners to safeguard the communities we serve.

Delivering the Safeguarding Plan

To track and monitor the effective implementation of this plan, a detailed delivery plan will be part of this plan that will highlight how we aim to deliver against the priorities, the delivery plan will develop and change over time to fit with the changing landscape of safeguarding practice and the plan will be reviewed in accordance with any change to legislation, guidance or recommendations.

Safeguarding activity, risks, and concerns will be monitored through effective governance arrangements in place and will be regularly reviewed in Trust assurance meetings, the Trust will also publish an annual report each year highlighting success and areas of further development to meet our priorities.

Our Ambitions

The base of this plan is set on five core priorities to deliver effective safeguarding practice, in association with this, each year a refresh of this plan will be highlighted to represent the Trusts ambition for the following year and work that the Trusts safeguarding teams will undertake. This innovative approach allows for the Trust to recognise the changing landscape of safeguarding work and work with the communities to deliver the right work at the right time.

Trust Safeguarding

The Trust will continue to work in partnership with Stockport Council within an integrated Stockport Family system. We will support Local Authorities in their statutory lead role for safeguarding adults and children and as such actively contribute to safeguarding enquiries, and reviews, and work with partners to assess, plan and support care for children, families and adults who are within children and adults safeguarding arena. Overarching key areas of work include ensuring that the Trust has a workforce that is fit for purpose and that there is a training and education plan for all aspects of safeguarding training. A culture of “Think Family” is key to this plan.

In collaboration with all partners the safeguarding teams will be focusing on key ambitions to deliver our Trust Safeguarding Priorities, these ambitions include the following:

Adult Safeguarding

1. Improve the reporting and recording of safeguarding adult concerns to support in local decision making and provide thematic updates on areas of concern for the Trust
2. Ensure that all safeguarding adult work incorporates the voice of the adult at risk and ensure that making safeguarding personal priorities are included in all activity
3. To improve in the use of quality assurance processes in reviewing safeguarding adult activity

Childrens Safeguarding

1. Review the current infrastructure for safeguarding children’s teams.
2. Complete a review of Safeguarding Supervision and highlight key success and make any necessary recommendations
3. Support Stockport Family in its transition to Family Hub Models

Looked After Children

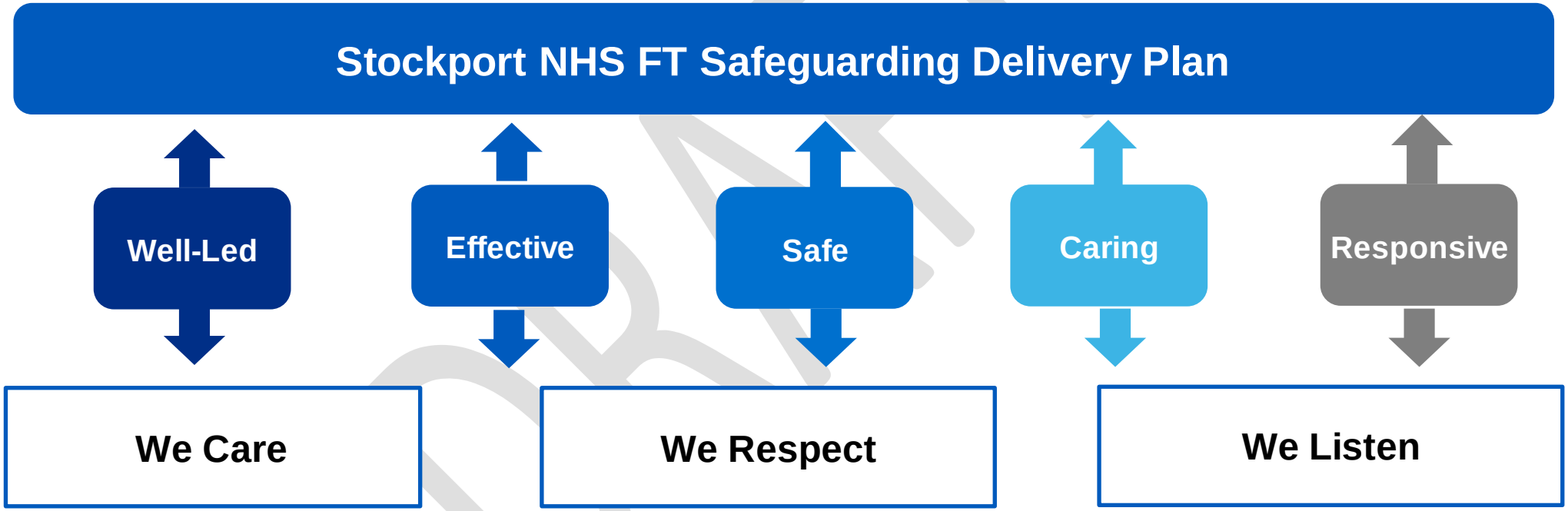
1. Maintain a high standard for the completion of Initial Health Assessments for children who become looked after
2. Support the ongoing work to reduce health inequalities for looked after children
3. Incorporate and report level 3 training for looked after children into all safeguarding training

Maternity Safeguarding

1. Embed proactive responses when safeguarding concerns are raised during the pregnancy and beyond
2. To process map and review how safeguarding concerns are managed within maternity services
3. Support the review of safeguarding supervision and its interfaces with the safeguarding children team

Delivery Plan

Our Safeguarding delivery Plan is linked to the key domains set out by the Care Quality Commission for measuring a good care service.



Core Priorities	Actions	Success Criteria How we will know that our actions have been achieved
Develop an integrated approach to our safeguarding work (Think Family)	• The Trust will review how safeguarding concerns and protection plans are documented in health records so there is evidence of making safeguarding personal and hearing the voice of the child/unborn • All Named professionals will have core objectives and ambitions for their services • Review current safeguarding infrastructures • To work with Stockport Family on the integration of Family hubs	• An audit of safeguarding reviews will highlight how effective document is • All safeguarding teams will have an annual work plan of activities with cross cutting themes • Creation of a workforce plan to ensure that there is sufficient capacity to meet the demand on safeguarding services • The Trust will be a key stakeholder in the family hub model and regular reporting via TISG will be evidenced
Develop our Trusts workforce to be confident and competent to safeguarding people from abuse	• The Trust will have a training needs analysis for all levels of safeguarding training and this will be regular reviewed in line with national, regional and local guidance and any legislative changes • There will a joint Safeguarding training strategy with colleagues at Tameside and Glossop NHS Integrated Care FT	• The training needs analysis will support divisions and the Trust reporting at TISG and will be used in performance review to assure the Trust. • Strategy document will be available for all staff
Ensure that we are complaint with statutory and legislation in the execution of our statutory duties	• The Trust will have a policy schedule document with all policies, SOPs and guidance, guidelines that are authored by the safeguarding teams. • Complete a review of safeguarding reporting governance structures for all safeguarding teams • Risk register will be regularly reviewed in line with Trust reporting • Key issue reports will be presented to Quality Committee and Trust Board for regular assurance / the Trust will submit data to the Stockport Local Safeguarding Children Partnership in relation to Section 11 of the Children Act.	• Th policy schedules will be reviewed at TISG • There will be a governance reporting diagram with lines of reporting responsibility • Safeguarding risks will be regularly monitored and updates provided via the TISG • The Quality Committee will be kept up to date with key issues and risk associated to safeguarding work streams

Core Priorities	Actions	Success Criteria How we will know that our actions have been achieved
Be a learning organisation and embed lessons learned from safeguarding and other reviews	• The Trust will review its current safeguarding reporting process and will support practitioners to reflect on their practice and seek supervision to allow learning and reflection • The Trust will have a clear process for embedding learning from local safeguarding reviews, patient safety incidents, national safeguarding reviews • A communication plan will be evident to support local updates	• Safeguarding supervision sessions will increase across all divisions and key areas • Actions plans will be monitored through the Safeguarding practice review group • Standardized staff and patient information board will be present in all areas
Improve the health outcomes for people where safeguarding concerns are evident	• The Trust will review the need for an integrated Acute Liaison learning disability and Autism Nurse • The Trust will provide comprehensive activity reports for reporting to TISG for assurance • The Trust will have a programme of planned audit for safeguarding • The Safeguarding teams will support in the delivery of the Stockport Accreditation and Recognition Scheme (StARS) programme	• Business case will be presented to Operational Management Group and Executive team • Compliance will be confirmed annual and quarterly safeguarding assurance meeting held with GM ICB • TISG will approve these audit plans and these will be discussed at each meeting • TISG will receive written assurance reports from the Trust Quality Team regarding StARS

Governance and Reporting Structure

The Trust has a Trust Integrated safeguarding group which is chaired by the Chief Nurse who is also the Executive Lead for Safeguarding whereby assurance is sought from named professionals, divisional colleagues and partnership updates are provided, this then reports to Trust Quality Committee in the form of a key issues report to provide robust assurance through to the Board of Directors. The Trust group is supported by operational groups for adults, children, and public health nursing, all these groups have a term of reference, action plans and business cycles.

SNHSFT have reporting structures in place for safeguarding across the Trust and work will be progressed for the duration of the plan to support a think family single point of access to raising concerns and sharing information.

Safeguarding incident reporting is managed through internal systems and processes which specialist practitioners support with providing advice, guidance, and support to Trust staff. The Trust has a mechanism of reporting safeguarding incidents using the Trust intranet and the Do it online form for Adult Safeguarding and via telephone contact, heath information sharing forms for children's safeguarding along with targeted referrals in maternity services. Staff can also refer directly to social care through the Multi Agency Safeguarding Support Hub (MASSH) and via the Adult social care referral form. Incidents that relate to the possible abuse and or neglect whilst in hospital and or concerns regarding patient safety will be discussed at other Trust meetings which include managing safeguarding allegations against staff.

External Safeguarding Governance and Partnership working

SNHFT will continue to work with external safeguarding partners across the borough of Stockport and Greater Manchester.

The Safeguarding teams participate in several multi-agency meetings to support safeguarding arrangements. The Head of Safeguarding (HoS) and Deputy Chief Nurse represent the Trust at the Local Safeguarding Adult Board in Stockport and the HoS and Chief Nurse represent the Trust at the Executive meeting for the Local Safeguarding Children Partnership.
Members of the safeguarding teams also attend subgroups of the respective boards and partnerships.

A representative from safeguarding attends the following strategic and operational multiagency safeguarding meetings:

Safeguarding Adults	Safeguarding Children	Joint Safeguarding
Stockport Local Safeguarding Adult Board	Children's Practice Improvement Partnership	Stockport Joint Safeguarding Adults Partnership Board & Safeguarding Children Partnership Executive Meeting
Adults Practice improvement partnership	Children's Quality Assurance Partnership	Domestic Abuse Partnership Board
Adults Quality assurance partnership	Child Death Overview Panel	Domestic Abuse Operational Meeting
Multiagency adults at risk system (MAARS)	Integrated Looked after Children Board	Channel Panel & Prevent Steering Group
Safeguarding adult review (SAR) consideration and panel	Rapid review & Child safeguarding practice review panel and process	Domestic Homicide Review Consideration Panel
Hate crime partnership		Complex safeguarding subgroup
		Training & Workforce development

The Trust will continue to provide assurance to Stockport locality via the Greater Manchester Safeguarding Assurance Framework document that is populated by the safeguarding team each quarter and then is reviewed and scrutinised by commissioning colleagues to monitor the Trust in its ability to safeguard individuals and discharge its statutory duties.

This quarterly report is produced into an action plan whereby the safeguarding team and key leads from the trust and ICB colleagues meet to discuss. In addition to this an annual self-assessment of commissioning standards is completed for all aspects of safeguarding and sent as assurance to the ICB, this provides robust assurance in that the Trust is delivering its statutory obligations and this supports the section 11 audit that is required of NHS Trust as directed by the Children Act 2004.

Conclusion

By implementing this plan, working with partner organisations and in accordance with safeguarding policies the Trust will be assured that it is discharging its statutory duties alongside promoting effective safeguarding practice in a system wide approach.

References

- *Adult Safeguarding: Roles and Competencies for Health Care Staff. The Intercollegiate Document January 2018*
- *Care Act* (2014) available at: http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted/data.htm
- *Children Act* (1989) available at: https://www.legislation.gov.uk/ukpga/1989/41/contents
- Department for Education (DfE) (2018) *Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children* (PDF).London: HM Government
- Francis R (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*. London: The Stationery Office.
- Keogh B (2013) *Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report*. London: NHS England.
- HM Government (2007) *Statutory guidance on making arrangements to safeguard and promote the welfare of children under Section 11 of the Children Act 2004.* DCSF Publications
- *Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff*. The Intercollegiate Document Fourth edition: January 2019.

NHS Stockport NHS Foundation Trust

Meeting date	3rd August 2023	X	Public		Confidential	Agenda item
Meeting	Board of Directors					
Title	People & Organisational Plan Update					
Lead Director	Director of People & OD		Authors	Deputy Director of People & OD and Deputy Director of OD		

Recommendations made / Decisions requested

The Board of Directors are requested to note the contents of this report.

This paper relates to the following Corporate Annual Objectives

	1	Deliver personalised, safe and caring services
x	2	Support the health and wellbeing needs of our community and colleagues
	3	Develop effective partnerships to address health and wellbeing inequalities
x	4	Develop a diverse, talented and motivated workforce to meet future service and user needs
	5	Drive service improvement through high quality research, innovation and transformation
	6	Use our resources efficiently and effectively
	7	Develop our estate and digital infrastructure to meet service and user needs

The paper relates to the following CQC domains

x	Safe	x	Effective
	Caring	x	Responsive
x	Well-Led		Use of Resources

This paper relates to the following Board Assurance Framework risks

	PR1.1	There is a risk that the Trust does not deliver high quality care to service users
	PR1.2	There is a risk that patient flow across the locality is not effective
	PR1.3	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan
x	PR2.1	There is a risk that the Trust is unable to sufficiently engage and support our people's wellbeing
	PR2.2	There is a risk that the Trust's services do not fully support neighbourhood working
	PR3.1	There is a risk in implementing the new provider collaborative model to support delivery of Stockport ONE Health & Care (Locality) Board priorities
	PR3.2	There is a risk that the Trust does not deliver a joint clinical strategy with East Cheshire NHS Trust

x	PR4.1	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit and retain the optimal number of staff, with appropriate skills and values
	PR4.2	There is a risk that the Trust's workforce is not reflective of the communities served
	PR5.1	There is a risk that the Trust does not implement high quality transformation programmes
	PR5.2	There is a risk that the Trust does not implement high quality research & development programmes
	PR6.1	There is a risk that the Trust does not deliver the annual financial plan
	PR6.2	There is a risk that the Trust does not develop and agree with partners a multi-year financial recovery plan
	PR7.1	There is a risk that the Trust does not implement the Digital Strategy to ensure a resilient and responsive digital infrastructure
	PR7.2	There is a risk that the estate is not fit for purpose and/or meets national standards
	PR7.3	There is a risk that the Trust does not materially improve environmental sustainability
	PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus

Where issues are addressed in the paper-

	Section of paper where covered
Equality, diversity, and inclusion impacts	All objectives
Financial impacts if agreed/ not agreed	N/A
Regulatory and legal compliance	N/A
Sustainability (including environmental impacts)	N/A

Executive Summary

The purpose of this report is to provide the Board of Directors with an update and oversight of the progress of delivery against priorities as detailed in the People & OD plan. The People Performance Committee received and approved the People & OD priorities in March 2023 and the Board of Directors approved the OD Plan in February 2023.

Our 2022 NHS national staff survey results, along with other employee feedback mechanisms have highlighted the need for us to enhance performance and culture and these are contained within the OD Plan.

Against a backdrop of industrial action, increasing operational demands on services, and emerging priorities, the majority of the actions that were planned to be delivered within the first six months have been completed or are in train.

The Board of Directors are requested to note the contents of this report.

1. Introduction

1.1 The purpose of this report is to provide the Board of Directors with an update and oversight of the progress of delivery against priorities as detailed in the People & OD plan. The People Performance Committee received and approved the People & OD priorities in March 2023 and the Board of Directors approved the OD Plan in February 2023.

2. Priorities

2.1 In March 2023, the People Performance Committee received and approved the People & OD 2023/24 priorities. Appendix 1 details our progress against the delivery plan.

2.2 Against a backdrop of industrial action, increasing operational demands on services, and emerging priorities, the majority of the actions that were planned to be delivered within the first six months have been completed or are in train.

3. Impact

3.1 We are on an improvement journey, with ambitious aims and objectives for our organisation, operating in a challenging multifaceted context, whilst acknowledging this it is important that we measure the impact of our plans against our people key performance indicators.

3.2 We can see the 'green shoots' of improvement and movement in a positive direction. We will continue to monitor our progress and ensure mitigations are in place should our performance change.

People Key Performance Indicators:

- ✓ Annualised (adjusted) Turnover Rate has reduced from 14.6% (June 22) to 13.8% (June 23).
- ✓ Early Leavers Rate (leaving within 12 months) has reduced from 28.21% (June 22) to 10.64% (June 23).
- ✓ Vacancy Rate remains stable 11.8% (June 22) to 11.3% (June 23).
- ✓ Sickness Absence Rate remains challenging, a decreasing trend from 6.1% (June 22) to 5.7% (June 23).

3.3 We are also seeing positive movement within our EDI statistics:

- ✓ Our BME staff group has increased from 20.6% (June 22) to 24% (June 23).
- ✓ More of our staff are declaring a disability, increasing from 4% (June 22) to 4.9% (June 23).
- ✓ WRES findings published from the 1 April 2022 and 31 March 2023 reporting period demonstrated that the relative likelihood of staff from ethnic minority groups entering a formal disciplinary process compared to white staff was 1.14. This figure was 0.77 in 2022.

4. Next Steps

4.1 Our 2022 NHS national staff survey results, along with other employee feedback highlighted the need for us to enhance performance and culture. In response to this we are implementing a range of sequenced activities with an emphasis on changing hearts, minds and skills. It is recognised that changing culture is a large scale undertaking that requires committed leadership, and often years of concerted and consistent effort.

4.2 Our initial focus is on designing and delivering interventions with the aim of strengthening leadership and management approaches, and improving working relationships and team effectiveness. This has included launching a new 'Introduction to Compassionate and Inclusive Leadership' one-day training course for current and aspiring managers. The initial sessions, involving around 30 individuals, have been very positively received. We have also delivered a senior leadership session that included a guest speaker on creating a kindness collaborative. This has provided a great bedrock for us to launch the Civility Saves Lives Programme in September 2023.

4.3 We have been surprised that the demand for OD consultancy support has been so high from the outset. In the main this has involved designing and delivering bespoke interventions for divisional leadership teams and departmental teams to bring about changes in performance, culture and ways of working. Anecdotal feedback suggests that the OD consultancy support provided to teams has been extremely helpful in terms of improving morale, relationships and team effectiveness.

4.4 In the short term we are measuring the impact of OD and leadership and management development interventions through attendee evaluations. Moving forward we will introduce post-intervention assessments and we will actively utilise the Divisional Performance Review meetings and Operational Management Group meetings to connect the OD programme into the needs of divisions. The OD Service is currently developing a robust approach for measuring the short term and long term impact of their work and this will be included in future update reports.

4.5 Following the publication of the NHS Long-Term Workforce Plan[1], which is the first comprehensive workforce plan for the NHS, putting staffing on a sustainable footing and improving patient care. It focuses on retaining existing talent and making the best use of new technology alongside the most ambitious recruitment drive in health service history.

4.6 We will be undertaking a review of the Long-Term Workforce Plan, against our local and system wide plans to identify areas where we are already making progress and areas for improvement. An update paper will be shared with our People, Engagement and Leadership Group and People Performance Committee over August and September 2023. This review will inform any amendments required to our priorities and focus for the remainder of 2023/24.

4.7 It is hoped that we will achieve improved scores in the 2023 NHS national staff survey which will further demonstrate the impact of the People & OD agenda.

5. Recommendations

5.1 The Board of Directors are requested to note the contents of this report.

[1] NHS England » NHS Long Term Workforce Plan

Appendix 1: People & OD Plan and Priorities – Q1/Q2 Progress Update

Priority	Programme of Work	Q1/Q2 Progress	Q3/Q4 Actions
Organisational Development Plan	• Culture & Development Programme for Board & Execs. • Civility Saves Lives (CSL) roll-out.	• Board & Exec Development Programme developed & communicated with Executive & Non-Executive Directors; future development sessions scheduled. • A small task & finish group has been established which is responsible for developing and implementing the CSL Programme.	• Work is underway to have the initial CSL sessions up and running from September onwards.
	• Leadership & Management Development.	• Senior Leadership event held; future sessions scheduled. Workshops for operational divisional triumvirates in development. • Refreshed & re-launched the managers briefing sessions on facilitating meaningful appraisal discussions. • Designed and launched a new 1-day 'Introduction to Compassionate & Inclusive Leadership' course aimed at first line and middle managers. • The OD Service has designed and facilitated several bespoke team effectiveness sessions. • Established pool of Lumina Spark facilitators.	• Develop and implement a robust approach for evaluating the impact of leadership & management development interventions.
	• Talent Management.	• Joined and contributing to the GM Talent Leadership & Culture Group which is shaping talent management solutions. • Met with the NHS national team to further explore the 'Scope for Growth' career conversation tool.	• Develop a proposed talent management approach/framework & supporting tool. • Implement the Scope for Growth tool initially for senior leaders.
Equality, Diversity & Inclusion	• Career progression opportunities for BME staff.	• Reverse Mentoring Scheme launched (initially with BME and disabled staff mentoring senior leaders).	• Facilitate listening sessions with BME staff to understand the barriers to career progression.
	• Review of recruitment process to reduce/remove barriers.	• Review of HCA application / recruitment stats has been undertaken - identified a high number of multiple applications from people who require visas and poor completion of application form / supporting evidence.	• Developing additional support for applicants to include advice document on the internet and face to face application 'clinic'.

		• Role Profiles developed & implemented for entry level roles (HCA / Admin / Porter / Domestic / Catering).	• Basic literacy and numeracy testing to be completed prior to application / interview to be implemented Q3. • Q3 - Developing Recruitment / EDI dashboard on People Analytics to enable quarterly review of all data & evaluation of impact/outcomes.
	• Review of disciplinary progress to reduce likelihood of BME staff entering formal process.	• Implementation of the conduct review panel complete. • Review and lessons learned from ET cases complete.	• Audit & review of impact of conduct panel – Q4. • Monitor impact through WRES.
	• Improving the way in which Staff Networks work.	• Review of staff networks completed & recommendations will be presented to Exec Team in August.	• Relaunch of Staff Networks, each with an assigned Board sponsor.
	• Disability – improvement of metrics & handling of reasonable adjustments.	• Promotion to increase awareness and use of disability passport. • Person centred approach adopted to ensure all adjustments are documented. • Quarterly case reviews to share learning in place.	• Audit to confirm usage of Disability Passport and propose improvements – Q4. • Continuation with lessons learned approach and engagement with the DAWN Staff Network. • Monitor impact through WDES.
	• Improved programme of widening participation.	• As reported at PPC in May 2023, we have made significant progress on increasing our numbers of work experience participants and placements.	• Continue to develop and promote opportunities for work experience. • Continue to develop & promote pre-employment opportunities building on our successes.
Place Based Programmes	• Attracting the local population, partnership working as part of the One Stockport Programme.	• Pharmacy pathway complete and attached to all related vacancies, pathways drafted for AHPs and generic nursing roles. • Career development pathways in place (tACP / TNA / RDNA / AHPA / Assistant Therapist Apprenticeships). • Supporting 'Care Leavers' in to work programme in development with first candidate identified. • We are supporting the increase in AHP placements for all HEIs with a revised model to support learners in practice. • TPEP NHS England project - expansion of Practice Placement within our ICS. Placements have been identified and learners	• Career development / aspirational workshops to be developed. • Review by One Stockport Group to expand the model to other areas within our locality, to other groups such as the over 50's and young people. • Identify placement areas and pathways within SMBC and wider Stockport locality; to support Cadets. • T Level opportunities also being explored across our sector for September 2023. • TPEP NHS England ACCEND pathway – supporting learner

		to be supported with an MDT placement model commencing in November.	pathways to support the Aspirant Cancer Care and Education and Development pathway pilot for Stockport ICS. • Cadet programme expansion to place based placements developed, placements to be offered across our sector including social care.
	• Understanding the demographics and make up of our staff by ward/area within Stockport.	• Achieved through our One Stockport Group with our partners, shaping the widening participation & community engagement actions.	• Continue to use demographic understandings to drive and shape our response to employment opportunities as an anchor institution.
	• Develop relationships and worth with Tameside colleague to further develop Cadet schemes, pre-employment courses, routes into employment.	• Cadet programme collaboration and sharing of learning in progress to expand the cadet programme for Sept 23. • Working in partnership with the Trafford College Group to support T level placements in all areas across our Trust.	• Continuation of programme expansion and opportunities for collaboration.
Collaboration	• Continue to look at opportunities to collaborate e.g. Knowledge & Library Services (KLS), Resus Faculty, etc.	• Established a joint KLS across Stockport and Tameside. • Established the Resus Faculty across Stockport and Tameside. • Our clinical skills teams, resus teams and AIM faculties are working collaboratively to support each site for the provision of training. • Continued collaboration with colleagues in GM to support ongoing projects (CPD portfolio is in design - expected November 23).	• Embedding the Resus Faculty across Stockport and Tameside. • Embedding the KLS Faculty across Stockport and Tameside. • Launching of CPD e-portfolio Trust wide.
	• Commence work with Payroll.	• Business case and options appraisal drafted.	• Business case approval.
	• Continue with Occupational Health collaboration programme of work.	• Collaboration arrangement in place, including joint appointments. • Joint procurement of improved G2 system and implementation underway.	• Hub and spoke model implemented by end of Q3. • G2 system migration and implementation completed.
	• Continue to engage with East Cheshire on Clinical Strategy.	• Participation, engagement, and support of the clinical pathway work continues. • Joint recruitment protocol developed and agreed.	

Medical Staffing/ Agency Expenditure	• Review opportunities for increased grip/control to reduce expenditure.	• Review of SAG terms of reference and attendees widened. • Deep Dives into sickness & agency expenditure • Review of e-Rostering Governance utlising the Levels of Attainment Standards.	
Sickness Absence	• Development and implementation of person-centred absence management and wellbeing policy & approach. • Reduce sickness absence.	• Policy drafted and being progressed through approval processes. • Review of associated paperwork & development of a toolkit for managers. • Training and development plan being designed for HR teams, OH, Trade Unions & Managers.	• Implementation of the policy. • Roll out of training plan.

NHS Stockport NHS Foundation Trust

Meeting date	3 August 2023	X	Public		Confidential	Agenda item
Meeting	Board of Directors					
Title	Board Assurance Framework 2023/24					
Lead Director	Karen James, Chief Executive		Author	Rebecca McCarthy, Company Secretary		

Recommendations made / Decisions requested

The Board of Directors is asked to:
- Review and approve the Board Assurance Framework 2023/24
- Review the Trust's current significant risk profile confirming alignment between operational and principal risks.

This paper relates to the following Corporate Annual Objectives

X	1	Deliver Personalised, Safe and Caring Services
	2	Support the health and wellbeing needs of our community and colleagues
	3	Develop effective partnerships to address health and wellbeing inequalities
	4	Develop a diverse, talented and motivated workforce to meet future service and user needs
	5	Drive service improvement through high quality research, innovation and transformation
	6	Use our resources efficiently and effectively
	7	Develop our Estate and Digital Infrastructure to meet service and user needs

The paper relates to the following CQC domains-

	Safe		Effective
	Caring		Responsive
X	Well-Led		Use of Resources

This paper is related to these BAF risks	All

Where issues are addressed in the paper-

	Section of paper where covered
Equality, diversity and inclusion impacts	N/A
Financial impacts if agreed/not agreed	N/A
Regulatory and legal compliance	All
Sustainability (including environmental impacts)	N/A

Executive Summary

The Trust maintains a Board Assurance Framework as a key tool to manage and mitigate strategic risk to the achievement of the corporate objectives that have been agreed by the Board. The Corporate Objectives 2023/24 were approved by the Board of Directors in June 2023, enabling development of the Board Assurance Framework (BAF).

To inform its development, a workshop took place to review the Board's risk appetite entering the financial year 2023/24, recognising that risk appetite changes over time as circumstances change, and therefore needs to be kept under consideration.

The principal risks for the opening BAF 2023/24 (Appendix 1) were developed via the relevant board assurance committees based on review of; principal risks 2022/23 year-end position, risk appetite, key controls and assurances, including any gaps, and required actions.

Principal risks have been prioritised as follows:

No.	Principal Risk	C	L	Opening position	Target Score
PR1.2	There is a risk that patient flow across the locality is not effective	4	4	16	8
PR4.1	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit and retain the optimal number of staff, with appropriate skills and values	4	4	16	8
PR2.1	There is a risk that the Trust is unable to sufficiently engage and support our people's wellbeing	4	4	16	8
PR6.1	There is a risk that the Trust does not deliver the annual financial plan	4	4	16	8
PR6.2	There is a risk that the Trust does not develop and agree with partners a multi-year financial recovery plan	4	4	16	6
PR7.2	There is a risk that the estate is not fit for purpose and does not meet national standards	4	4	16	8
PR7.4	There is a risk that there is no identified funding mechanism or insufficient funding to support strategic regeneration of the hospital campus	4	4	16	8
PR1.1	There is a risk that the Trust does not deliver high quality care to service users	4	3	12	8
PR1.3	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan	4	3	12	8
PR3.2	There is a risk that the Trust does not deliver a joint clinical strategy with East Cheshire NHS Trust	4	3	12	8
PR7.3	There is a risk that the Trust does not materially improve environmental sustainability	4	3	12	8
PR2.2	There is a risk that the Trust's services do not fully support neighbourhood working	3	3	9	6
PR3.1	There is a risk in implementing the new provider collaborative model to support delivery of Stockport ONE Health & Care (Locality) Board priorities	3	3	9	6

PR4.2	There is a risk that the Trust's workforce is not reflective of the communities served	3	3	9	6
PR7.1	There is a risk that the Trust fails to develop and implement a responsive and resilient Digital Strategy	3	3	9	6
PR5.1	There is a risk that the Trust does not implement high quality transformation programmes	3	2	6	6
PR5.2	There is a risk that the Trust does not implement high quality research & development programmes	3	2	6	6

In addition, the Trust's significant risks from the corporate risk register (as presented to Risk Management Committee in July 2023), are provided at Appendix 2 to ensure alignment between operational and principal risks. The significant risks relate to the following areas:

Risk Subtype	**No of Risks**	**Risks Identified**
Capacity and demand of services	3	- Patient flow / NCTR due to reduced access to community capacity (16) - 4 hr ED access target (16) - Access to Rapid Access Chest Pain Clinic (16)
Environment	2	- Pathology estate not fit for purpose (15) - Outpatient B environmental condition (15)
Compliance	1	- Breach of Regulatory Reform (Fire Safety) Order 2005 (16)
Quality Improvement	1	- Mortality on Ward E3 (15)
Staffing	1	- Employee Relations & Industrial Action (16)
Financial	1	- Risk of insufficient cash reserves (15)

1. Introduction

1.1 The Trust maintains a Board Assurance Framework as a key tool to manage and mitigate strategic risk to the achievement of the corporate objectives that have been agreed by the Board.

1.2 The Corporate Objectives 2023/24 were approved by the Board of Directors in June 2023, enabling development of the Board Assurance Framework (BAF).

2. Risk Appetite

2.1 To inform development of the BAF, a workshop took place to review the Board's risk appetite entering the financial year 2023/24, recognising that risk appetite changes over time as circumstances change, and therefore needs to be kept under consideration.

2.2 The current risk appetite for each risk element for 2023/24, was confirmed as:

Risk Element	2023-24	Statement
Finance / Value for Money	Risk Level: Cautious Risk Appetite: Moderate	We are prepared to accept the possibility of limited financial risk. However, VFM is our primary concern.
Compliance / Regulation	Risk Level: Cautious Risk Appetite: Moderate	We are prepared to accept the possibility of limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision.
Quality & Outcomes	Risk Level: Cautious Risk Appetite: Moderate	Our preference is for risk avoidance. However, if necessary, we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place.
Reputation	Risk Level: Cautious Risk Appetite: Moderate	We are prepared to accept the possibility of limited reputational risk if appropriate controls are in place to limit any fallout.
People	Risk Level: Open Risk Appetite: High	We are prepared to accept the possibility of some workforce risk, as a direct result from innovation as long as there is the potential for improved recruitment and retention, and developmental opportunities for staff.
Innovation	Risk Level: Seek Risk Appetite: Significant	We will pursue innovation – desire to 'break the mould' and challenge current working practices. New systems / technologies viewed as a key enabler of operational delivery.

3. Principal Risks 2023/24

3.1 The principal risks for the opening BAF 2023/24 (Appendix 1) were developed via the relevant board assurance committee. The committees confirmed that, in line with only minor revision to the Corporate Objectives for 2023/24, all principal risks from the BAF 2022/23 would be reflected in the BAF 2023/24. Subsequently, key controls and assurances in relation to each were reviewed, alongside any gaps and required mitigating actions.

4. Significant Risks – Corporate Register

4.1 In addition, the Trust's significant risks from the corporate risk register (as at 12 July 2023) (Appendix 2) is provided in the paper to ensure alignment and triangulation between operational and principal risks.

4.2 The Risk Management Committee has continued oversight and management of the significant risk register, alongside divisional and corporate risk registers, and horizon scanning of future risks. Board of Directors are asked to note that the risks relating to Ward E3 Mortality and the rapid access chest pain clinic are under further review, as requested by Risk Management Committee, with risk score anticipated to reduce based on current data sources.

4.3 The Risk Management Committee reports to the Audit Committee, as part of its responsibility to review of the establishment and maintenance of an effective system of integrated governance, risk management and internal control, and the effectiveness of the structures, processes and responsibilities for identifying and managing key risks facing the Trust.

4.4 Furthermore, at each Audit Committee meeting, the Chairs of Board level Committees provide update with a focus on:

- how significant risks identified by the Risk Management Committee are being addressed or monitored in their Board Committee
- any risks which are not appropriately reflected in the Risk Management Committee report
- emerging or potential risks and matters which may bring into question the adequacy of underlying assurance processes or have implications for other Committees
- effectiveness of controls in place to manage risks recorded on the Board Assurance Framework, with controls generally being applied consistently.

Stockport NHS Foundation Trust

Board Assurance Framework

2023/2024

Corporate Objectives 2023/24

1. Deliver personalised, safe and caring services
2. Support the health and wellbeing needs of our community and colleagues
3. Develop effective partnerships to address health and wellbeing inequalities
4. Develop a diverse, talented and motivated workforce to meet future service and user needs
5. Drive service improvement through high quality research, innovation and transformation
6. Use our resources efficiently and effectively
7. Develop our estate and digital Infrastructure to meet service and user needs

1. Key to Board Assurance Framework

CONSEQUENCE MARKERS		LIKELIHOOD MARKERS		
5	Multiple deaths caused by an event; ≥£5m loss; May result in Special Administration or Suspension of CQC Registration; Hospital closure; Total loss of public confidence	5	Very Likely	No effective control; or ≥1 in 5 chance within 12 months
4	Severe permanent harm or death caused by an event; £1m - £5m loss; Prolonged adverse publicity; Prolonged disruption to one or more Directorates; Extended service closure	4	Somewhat Likely	Weak control; or ≥1 in 10 chance within 12 months
3	Moderate harm – medical treatment required up to 1 year; £100k – £1m loss; Temporary disruption to one or more Directorates; Service closure	3	Possible	Limited effective control; or ≥1 in 100 chance within 12 months
2	Minor harm – first aid treatment required up to 1 month; £50k - £100K loss; or Temporary service restriction	2	Unlikely	Good control; or ≥1 in 1000 chance within 12 months
1	No harm; 0 - £50K loss; or No disruption – service continues without impact	1	Extremely Unlikely	Very good control; or ≤ 1 in 1000 chance (or less) within 12 months

Risk Matrix					
Impact	**Likelihood**				
	1 - Rare	2 - Unlikely	3 - Possible	4 - Likely	5 - Certain
1 - Negligible	**1**	**2**	**3**	**4**	**5**
2 - Minor	**2**	**4**	**6**	**8**	**10**
3 - Moderate	**3**	**6**	**9**	**12**	**15**
4 - Major	**4**	**8**	**12**	**16**	**20**
5 - Catastrophic	**5**	**10**	**15**	**20**	**25**

Gap Score Matrix (Difference between Target Score and Current Score)	
Gap score ≤0	Risk target achieved
Gap score 1 - 5	Tolerable
Gap score 6 - 9	Close monitoring
Gap score 10	Concern
Gap score > 10	Serious

2. Risk Appetite Framework

Risk Level ➡ **Key Elements** ⬇	**Avoid** Avoidance of risk is a key organisational objective.	**Minimal** Preference for very safe delivery options that have a low degree of inherent risk and may only have a limited reward potential.	**Cautious** Preference for safe delivery options that have a low degree of residual risk and may only have a limited reward potential.	**Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.	**Seek** Eager to be innovative and to choose options which may offer higher levels of reward, despite greater inherent risk.	**Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust and highly embedded.
Financial / Value for Money How will we use our resources	We have no appetite for decisions or actions that may result in financial loss.	We are only willing to accept the possibility of very limited financial risk.	We are prepared to accept the possibility of limited financial risk. However, VFM is our primary concern.	We are prepared to accept some financial risk as long as appropriate controls are in place. We have a holistic understanding of VFM with price not the overriding factor	We will invest for the best possible return and accept the possibility of increased financial risk.	We will consistently invest for the best possible return for stakeholders, recognising that the potential for substantial gain outweighs inherent risks.
Compliance / Regulatory How will we be perceived by our regulator	We have no appetite for decisions that may compromise compliance with statutory, regulatory of policy requirements.	We will avoid any decisions that may result in heightened regulatory challenge unless essential.	We are prepared to accept the possibility of limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some regulatory challenge as long as we can be reasonably confident, we would be able to challenge this successfully	We are willing to take decisions that will likely result in regulatory intervention if we can justify these and where the potential benefits outweigh the risks.	We are comfortable challenging regulatory practice. We have a significant appetite for challenging the status quo in order to improve outcomes for stakeholders.
Quality / Outcomes How will we deliver quality services	We have no appetite for decisions that may have an uncertain impact on quality outcomes.	We will avoid anything that may impact on quality outcomes unless essential. We will avoid innovation unless established and proven to be effective in a variety of settings.	Our preference is for risk avoidance. However, if necessary, we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place.	We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation.	We will pursue innovation wherever appropriate. We are willing to take decisions on quality where there may be higher inherent risks but the potential for significant longer-term gains.	We seek to lead the way and will prioritize new innovations, even in emerging fields. We consistently challenge current working practices in order to drive quality improvement.
Reputation How will we be perceived by the public and our partners	We have no appetite for decisions that could lead to additional scrutiny or attention on the organisation.	Our appetite for risk taking is limited to those events where there is no chance of significant repercussions.	We are prepared to accept the possibility of limited reputational risk if appropriate controls are in place to limit any fallout.	We are prepared to accept the possibility of some reputational risk as long as there is the potential for improved outcomes for our stakeholders.	We are willing to take decisions that are likely to bring scrutiny of the organisation. We outwardly promote new ideas and innovations where potential benefits outweigh the risks.	We are comfortable to take decisions that may expose the organisation to significant scrutiny or criticism as long as there is a commensurate opportunity for improved outcomes for our stakeholders.
People How will we be perceived by our workforce	We have no appetite for decisions that could have a negative impact on our workforce development, recruitment and retention. Sustainability is our primary interest.	We will avoid all risks relating to our workforce unless absolutely essential. Innovative approaches to workforce recruitment and retention are not a priority and will only be adopted if established and proven to be effective elsewhere.	We are prepared to take limited risks with regards to our workforce. Where attempting to innovate, we would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some workforce risk, as a direct result from innovation as long as there is the potential for improved recruitment and retention, and developmental opportunities for staff.	We will pursue workforce innovation. We are willing to take risks which may have implications for our workforce but could improve the skills and capabilities of our staff. We recognize that innovation is likely to be disruptive in the short term but with the possibility of long-term gains.	We seek to lead the way in terms of workforce innovation. We accept that innovation can be disruptive and are happy to use it as a catalyst to drive a positive change.
Innovation How will we transform services	We have no appetite for decisions to innovate, our aim is to maintain or protect, rather than to create or innovate. General avoidance of system / technology developments.	We will avoid innovations unless essential or commonplace elsewhere. Only essential systems / technology developments to protect current operations.	We tend to stick to the status quo, innovations generally in practice avoided unless really necessary. Systems / technology developments limited to improvements to protection of current operations.	We support innovation, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery.	We will pursue innovation – desire to 'break the mould' and challenge current working practices. New systems / technologies viewed as a key enabler of operational delivery.	Innovation is the priority – consistently 'breaking the mould' and challenging current working practices. Investment in new systems / technologies as catalyst for operational delivery.
Appetite	**None**	**Low**	**Moderate**	**High**	**Significant**	

3. Heat Map & Gap Analysis

Risk Matrix					
Impact	**Likelihood**				
	1 - Rare	2 - Unlikely	3 - Possible	4 - Likely	5 - Certain
1 - Negligible					
2 - Minor					
3 - Moderate		**5.1, 5.2**	**2.2, 3.1, 4.2, 7.1**		
4 - Major			**1.1, 1.3, 3.2, 7.3**	**1.2, 2.1, 4.1, 6.1, 6.2, 7.2, 7.4**	
5 - Catastrophic					

Gap Score Matrix (Difference between Target Score and Current Score)		
Gap score ≤0	Risk target achieved	**5.1, 5.2**
Gap score 1 - 5	Tolerable	**1.1, 1.3, 2.1, 2.2, 3.1, 3.2, 4.2, 7.1, 7.3**
Gap score 6 - 9	Close monitoring	**1.2, 4.1, 6.1, 6.2, 7.2, 7.4**
Gap score 10	Concern	
Gap score > 10	Serious	

4. Board Assurance Framework 2023/24

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score		
								Impact	Likelihood	Current	Q4 22/23	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 1 - Deliver personalised, safe and caring services																		
Principal Risk Number: PR1.1				**Risk Appetite: Moderate**														
There is a risk that the Trust delivers suboptimal quality of care to service users, which may lead to suboptimal patient safety, effectiveness and/or experience and failure to meet regulatory standards.	Quality Committee	Quality Committee Subgroups established to direct policies and procedures relating to: Patient Safety, Clinical Effectiveness, Patient Experience, Health & Safety, Integrated Safeguarding Divisional Quality Boards established. SFT Quality Strategy 2021-2024 - Established subgroup of Patient Safety Group - Quality Safety & Improvement Group SFT Patient, Carer, Family & Friends Experience Strategy 2022-2025 SFT Mental Health Plan 2022-2025 CQC Action Plans in place (2022) Established process for managing and learning from: - Incidents including Serious Incidents and patient flow associated harms - Duty of Candour - Complaints - Legal Claims Mechanisms in place to gather patient experience: - Family & Friends - Carers Opinion - Patient Stories - Walkabout Wednesday - Senior Nurse Walkarounds - Feedback Friday Clinical Audit & NICE Guidelines - Established clinical audit programme including national and local audit - Compliance Review Process – All NICE documents relevant to SFT portfolio - Established process for review of NICE Guidelines Learning from Deaths - Mortality Review Policy - Learning from Deaths Review process - Medical Examiner Team StARS - Ward assurance & accreditation process established. Also established for: Paediatrics, Maternity, Theatres, Community. Safe Staffing - Defined Nurse Establishments - Defined Medical Establishments - Medical Job Planning process in place - Medical Appraisal & Revalidation process in place including quality assessment	Impact of employee relations & industrial action issues Impact of continuing operational pressures	**Level 1 - Management:** Divisional Quality Boards (Monthly) – Quality & Safety Integrated Performance Report Divisional Clinical Audit Meeting (Quarterly) **Level 2 – Corporate** Quality Committee: - Quality IPR - Key Issues & Assurance Reports: o Patient Safety (Serious Incidents & Duty of Candour) o Clinical Effectiveness (Clinical Audit & NICE Compliance) o Patient Experience o Health & Safety o Integrated Safeguarding - CQC Report including CQC Action Plan Update, CQC Preparation (Quarterly) - StARS Position Statement & Key Themes (Quarterly) - Patient Safety Report (Quarterly) (Incidents, PALS/Complaints, Inquests, Claims) - Quality Strategy Progress Report (Biannually) - Maternity Services Report - Incorporates all improvement/action plans including: CNST, Saving Babies Lives, Continuity of Carer, Ockenden Report, Maternity Safety Support Programme (MSSP) - LMS Insight Report NHSE/I NW - Learning from Deaths Reports / Mortality Reviews (Quarterly) Board of Directors: - IPR - Safe Care Report including nurse establishments/E-roster (Quarterly) - Guardian of Safe Working / Freedom to Speak Up Report to Board (Bi-annually) - Quality Strategy (Annual) Annual Quality Accounts **Level 3 - Independent** Friends & Family Test National Patient Experience Surveys: - Adult Inpatient Survey - National Cancer Survey - Emergency Department Survey MIAA Internal Audits 2022-23: • Risk Management (Substantial) • Clinical Audit (Substantial) • StARS (Substantial) • Quality Spot Checks (Substantial)		Patient Safety Incident Response Framework – Plan	July 2023	4	3	12	12	12				4	2	8

4. Board Assurance Framework 2023/24

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score		
								Impact	Likelihood	Current	Q4 22/23	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 1 - Deliver personalised, safe and caring services																		
		Maternity Improvement/Sustainability Plan in place and Maternity Strategy. Trust & GM Command & Control Process established - Before, During and After Strike Action.																
Principal Risk Number: PR1.2				**Risk Appetite: Moderate**														
There is a risk that patient flow across the locality is not effective which may lead to patient harm, suboptimal user experience, and inability to achieve national access standards for urgent care and elective care	Finance & Performance Committee	Established models of emergency and urgent care in place in line with national standards Rapid emergency diagnostic pathway in place – General Surgery & Medical Rapid Ambulance Handover process in place. 'Programme of Flow' established and informed by Working Intelligently Group Reporting via Service Improvement Group Virtual Ward Weekly Trust Performance Meeting and twice weekly locality tactical meeting to seek support to mitigate risk – Attended by Nurse Director of the Day (Divisional Director) System wide Urgent & Emergency Care (UEC) Board in place (oversight of patient flow management plans). Urgent & Emergency Care Delivery Group established (biweekly), feeding into UEC Board. Trust and system escalation process in place, aligned to a single OPEL system – Including divert of resource from elective activity to support flow Winter Planning Debrief Process in place at GM, Locality and Trust – Informing Winter Plan 2023/24 Bed Modelling – 18 Month Plan Workforce models in place – Reflect demand and flexible to adapt to surges. Learning from Deaths process includes: - Delayed admission - Delayed discharge Patient Flow Associated Harms – Review via Quality Committee and process for future surveillance Robust phasing programme for building works as part of EUCC to ensure no loss of capacity.	Capacity constraints in domiciliary & bed-based care impacting on levels of patients with no criteria to reside High levels of delayed discharges for out of borough patients Significant increase in unfunded non-elective demand Lack of standardised 7-day services across medical & surgical specialties to support discharge of non-elective patients. Locality plan for intermediate bed base to be agreed for 2023/24. Managerial and operational capacity, including ICB, to support key workstreams.	**Level 1 – Management** Divisional Operations Boards (Monthly) – Performance Management Report - ED Attendance - Overall bed occupancy rate - Patients No Criteria to Reside - ED 4 Hour Target Performance - Ambulance Handover times - ED 12 hour waits - Time to triage Daily Bed meetings (x 4) System dashboard of acute, intermediate and domiciliary care capacity		Finalise recurrent Medical Staffing model	Q2 2023/24	4	4	16	16	16				4	2	8
				Level 2 – Corporate Divisional Performance Review (Monthly) including targeted 'Deep Dives' Finance & Performance Committee - Operational Performance Report (Monthly) - Themes from Performance Review Working Intelligently Programme - Elective Length of Stay Integrated Performance Report – Board (Bimonthly)		Locality agreement for community capacity	Q2 2023/24											
				Level 3 – Independent Urgent & Emergency Care Delivery Board NHSE – Activity Returns GM ICS reporting aligned to Tier 1 – Urgent Care														

4. Board Assurance Framework 2023/24

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score		
								Impact	Likelihood	Current	Q4 22/23	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 1 - Deliver personalised, safe and caring services																		
Principal Risk Number: PR1.3				**Risk Appetite: Moderate**														
There is a risk that the Trust does not have capacity to deliver elective, diagnostic and cancer care, including the clearance of surgical backlog caused by the Covid-19 pandemic, which may lead to suboptimal patient safety, outcomes and experience and inability to achieve national access standards	Finance & Performance Committee	Biweekly Trust Performance Meeting. Agreed Specialty Activity Plans & Budget Escalation process in place with Performance Team – 65+ week wait patients and any P2/cancer patients that are not dated. Clinical Prioritisation Group established & harm review process in place for patients waiting – including review of demographics of patients waiting to identify inequalities. Cancer Quality Improvement Board established chaired by Lead Cancer Clinician Established efficiency/transformation programmes: - Radiology - Theatres, Endoscopy & Diagnostics - Outpatient Transformation Booking & Scheduling centralisation Expansion of Endoscopy GM Mutual Aid agreed.	Workforce – Sickness Absence & Recruitment Impact of urgent care pressures on elective capacity Winter Planning 2023/24	**Level 1 – Management** Divisional Operations Boards (Monthly) Trust Performance Meeting: - Elective demand - Activity v Plan (Waits) - % Patients on PIFU - Levels Advice & Guidance - Theatre Utilisation - Outpatient Utilisation - Endoscopy Utilisation Activity Management Group – Data review of elective activity **Level 2 – Corporate** Divisional Performance Review (Monthly) including targeted 'Deep Dives' Finance & Performance Committee Operational Performance Report (Monthly) - 52+ week waits - 65+ week waits - Overall RTT waiting list size - Cancer 2ww - Cancer 62 day - Diagnostic waits Quality Committee - Waiting List Harms Review (3 x year) Integrated Performance Report (Operational Performance) – Board (Bimonthly) **Level 3 – Independent** SFT Tier 2 Elective Restoration Monitoring NHSE – Activity Returns	Limited availability of GM wide restoration performance data for benchmarking.			4	3	12	12	12				4	2	8

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score		
								Impact	Likelihood	Current	Q4 22/23	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 2 - Support the health and wellbeing needs of our communities and colleagues																		
Principal Risk Number: PR2.1				**Risk Appetite: High**														
There is a risk that the Trust is unable to sufficiently engage and support our people's wellbeing, leading to low morale, higher turnover & sickness absence and gaps in the workforce that may impact on delivery of high quality care.	People Performance Committee	Approved People Plan in line with national People Strategy objectives – Including enabling approaches to Workforce Transformation (Planning); Leadership Development; Health & Wellbeing; Coaching; Resourcing; Organisational Development; Equality, Diversity & Inclusion, Talent Management & Succession Planning Approved Organisational Development Plan 2023-2025 Approved People policies, procedures, guidelines and/or action cards in place (including. staff development; appraisal process; sickness and relationships at work policy) Influenza vaccination programmes Staff Wellbeing Programme established including staff psychology and wellbeing service and menopause service. Occupational Health Service – including Staff Counselling Service & Physio Fast Track Service Dying to Work Charter Values into Action programme established Award & Recognition including Staff Awards (Oct 2022), MADE Awards, Long Service Awards Wellbeing Guardian supported by Schwartz Rounds Freedom to Speak Up Guardian / Guardian of Safe Working Divisional Staff Survey Action Plans 2022 in place. Confirmed approach to flexible working. Industrial Action Planning Group in place	Embedded approach to Wellbeing Conversations Embedded system to learn from exit conversations Impact of employee relations & industrial action issues on morale and wellbeing Impact of continuing operational pressures	**Level 1 - Management:** People, Engagement & Leadership Group - People Plan – Workstream Reports Equality Diversity & inclusion Steering group - EDI Strategy Industrial Action Planning Group **Level 2 – Corporate** Performance Reviews – Workforce Metrics NHS People Plan Self-Assessment People Performance Committee - People Plan Update (bimonthly) - Workforce KPIs (bimonthly) - Freedom to Speak-up Report (Quarterly) - Freedom to Speak-up Guardian (Bi-annually) Integrated Performance Report (Workforce) - Board (Bimonthly) **Level 3 - Independent** CQC Well-led Mapping Report – Recognition of Staff Health & Wellbeing offer NHS National Staff Survey		Delivery Plan, including timescales and outcomes to support pledge for 'the wellbeing of our NHS people' to be developed in line with policies and guidance from the regional working group Implementation of collaborative Occupational Health function with T&G, including joint IT system.	July 2023 October 2023	4	4	16	16	16				4	2	8
Principal Risk Number: PR2.2				**Risk Appetite: Moderate**														
There is a risk that the Trust's services do not fully support neighbourhood working leading to suboptimal improvement in population health	Finance & Performance Committee	Operational & Winter Planning processes established with system arrangements. Capacity & demand modelling for community services Established joint community Health & Well Being programmes e.g. Waiting Well, Active Hospitals, Stop Smoking CURE project.	Unfunded growth in demand for community services Capacity & demand modelling for community services to support appropriate deployment of resources	**Level 1 – Management** Divisional Quality & Operations Boards (Monthly) Performance Management Report - Integrated Care Division - Women, Children & Diagnostics Adult's: Neighbourhood Leadership Group (Monthly) Children's:	Community Services Dashboard ICS Acute Flow Dashboard	Align Trust community services & workforce to PCNs Integration of Community Services Dashboard to IPR Locality Neighbourhood Working Programme	Ongoing Q2 2023/24 Q3 2023/24	3	3	9	9	9				3	2	6

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score		
								Impact	Likelihood	Current	Q4 22/23	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 2 - Support the health and wellbeing needs of our communities and colleagues																		
		Integrated service models established including: Adults: District Nursing Teams – Work across 7 PCNs with GPs, Social Care, VCSE Children's: Stockport Family – Health, Social Care & Education Adult's: Neighbourhood Leadership Group established with multi partner representation. Children's: Joint oversight groups established with multi partner representation (SEND, Public Health, Safeguarding, Mental Health) Trust represented on the One Stockport Health & Care Board (Locality Board) for Stockport via the CEO and Director of Strategy & Partnerships. Locality Provider Partnership (led by SFT) operational with defined workstreams and focus on population health. ONE Stockport Health and Care Plan & Delivery Plan/Outcomes developed with focus on reducing inequalities and improving population health outcomes ICS employed Locality Deputy Place Lead in post	Alignment of Community Services to PCNs – Potential change to PCN geographical footprints Managerial and operational capacity, including ICB, to support key workstreams	- Joint Public Health Oversight Group - SEND Joint Commissioning Group - CYP mental health & Well-being Partnership Board - Joint Safeguarding Board **Level 2 – Corporate** Divisional Performance Review (Monthly) including targeted 'Deep Dives' Locality Provider Partnership (Monthly) Locality Board (Monthly) **Level 3 – Independent** Children's – SEND Inspection Ofsted Report – 'Good' SALT – External multiagency review – Pathways & capacity and demand													

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score		
								Impact	Likelihood	Current	Q4 22/23	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 3 - Develop effective partnerships to address health and wellbeing inequalities																		
Principal Risk Number: PR3.1				**Risk Appetite: Significant**														
There is a risk in implementing the Provider Collaborative model to support delivery of priorities/objectives of the Stockport's ONE Health & Care (Locality) Board leading to a delay in delivery of models of care which support improvements in population health and operational recovery following the pandemic	Finance & Performance Committee	Locality ICS arrangements developed and approved by partners. CEO and Chair members of Stockport Health & Wellbeing Board ONE Stockport Health and Care (Locality Board) operational. Membership includes CEO, Director of Strategy & Partnerships & Chief Finance Officer ONE Stockport Plan and ONE Stockport Health and Care Plan. Stockport Provider Partnership operational, chaired by SFT CEO Provider Partnership identified key workstreams for 2023/24 based on population health metrics. Operational & Winter planning processes well established with system arrangements as a focus Recovery Objectives published in Planning Guidance 2023/34 in Trust Plan 2023/24	Controls not yet designed for the management of the One Stockport Health & Care Plan	**Level 1 – Management**				3	3	9	9	9				3	2	6
				Level 2 – Corporate Executive Team / Finance & Performance Committee oversight of key strategic matters Trust Board Reports as required and CEO Report including key strategic developments - ICS - Stockport One Health & Care Plan Joint system meetings on ONE Stockport plan Locality Provider Partnership (Monthly) Locality Board (Monthly) ICS Executive Meeting (Monthly)	Robust neighbourhood data to enable Provider Partnership to measure improvement in population health outcomes	A review of the effectiveness of locality arrangements including the Locality Board and Provider Partnership to be undertaken.	Q2 2023/24											
				Level 3 – Independent Health & Wellbeing Board														
Principal Risk Number: PR3.2				**Risk Appetite: Significant**														
There is a risk that the Trust does not deliver a joint Clinical Strategy with East Cheshire NHS Trust (ECT), leading to suboptimal pathways of care and/or limited-service resilience across the footprint of both Trusts	Finance & Performance Committee	Established Board to Board meetings with ECT. Established ECT & SFT programme governance arrangements with clinical and support workstreams identified: Joint Programme Board in place (Monthly). Approved SFT & ECT Case for Change in June 2022. Case for Change presented to NHSE and ICB. Work programme in place for 2023/24 including development of transformation workstreams and services to be considered as part of the OBC. Stakeholder engagement plan in place including ICBs, LA, Healthwatch, DPHs, VCSE and NHSE regulators.	Failure to gain key stakeholder support for Joint Clinical Strategy and Case for Change. Currently no long term funding strategy for the programme of work and no funding identified for 2023/24 financial year	**Level 1 – Management** Joint Programme Board and Clinical Advisory Groups Programme Governance Meeting				4	3	12	12	12				4	2	8
				Level 2 – Corporate Executive Team oversight of key strategic matters. Trust Board & ECT/SFT Board to Board Reports		Produce Models of Care and Pre-Consultation Business Case Plan for and commence implementation of service changes where no formal further process is required.	Q2 2023/24 Q3 2023/24											
				Level 3 – Independent Oversight and challenge by NHSE and other health care partners on Joint Clinical Strategy Case for Change and models of care development		Present Models of Care to NHSE and ICB	Q2 – Q3 2023/24											

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score		
								Impact	Likelihood	Current	Q4 22/23	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 4 - Develop a diverse, capable and motivated workforce to meet future service and user needs																		
Principal Risk Number: 4.1				**Risk Appetite: High**														
There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit & retain the optimal number of staff, with appropriate skills and values, which may lead to suboptimal staff and patient experience.	People Performance Committee	Approved People Plan in line with national People Strategy objectives – Including enabling approaches to Workforce Transformation (Planning); Leadership Development; Health & Wellbeing; Coaching; Resourcing; Organisational Development; Equality, Diversity & Inclusion, Talent Management & Succession planning E-rostering and Job Planning in place to support staff deployment Recruitment & Retention Implementation Plan in place, supported by Attract, Develop & Retain Group. Medical Workforce Group established. Defined safe medical and nurse staffing levels for all wards and departments. Safe Staffing Standard Operating Procedure deployed. Temporary staffing and approval processes with defined authorisation levels Bank & Agency Usage Deep Dive Undertaken. Mandatory Training Requirements set. Realignment of Role Essential Training Requirements Range of leadership and management development training sessions available. Local/ Regional/National Education partnerships Alternative development pipelines in place – Degree Apprenticeships, Medical Support Workers, Cadet Programme commenced. Workforce Strategy & Divisional Workforce Plans	Embedded system for identifying and managing talent not yet available Restrictions on staff capacity to attend and participate in mandatory/statutory training. Bank and agency staff costs not reducing. Escalation areas remaining open – staffing additional areas required.	**Level 1 - Management** People, Engagement & Leadership Group - People Plan – Workstream Reports Educational Governance Group - Exception reports for Mandatory & Role Essential Training, Attendance Equality, Diversity & Inclusion Steering Group - Staff Networks				4	4	16	16	16				4	2	8
				Level 2 – Corporate People Performance Committee – - Workforce Integrated Performance Report (Sickness Absence / Substantive Staff /Recruitment Pipeline / Appraisal, Turnover, Flexible Working Requests, Bank & Agency) - Safe Staffing Report (Quarterly) - Annual Nurse Establishments - Annual Medical Job Planning) - Annual Medical Revalidation Report Bank & Agency Usage – Review via Exec Team (Monthly)		Launch refreshed leadership & management development offer Launch & deliver a Medical Leadership Programme Develop and implement phase one of a talent management and succession planning approach Bank and agency staff Utilisation - Deep Dive Actions	July 2023 July 2023 September 2023 Q1 2023/24										
				Level 3 - Independent NHS National Staff Survey GMC Survey Health Education Visits Model Hospital and comparative benchmarking data Confirm and Challenge by NHSEI NW Regional Team												
Principal Risk Number: 4.2				**Risk Appetite: High**														
There is a risk that the Trust's workforce is not reflective of the communities served and staff with a protected characteristic having a suboptimal staff experience (career progression, turnover) which may lead to a poorer patient experience.	People Performance Committee	Approved People Plan in line with national People Strategy objectives – Including Equality, Diversity & Inclusion, Talent Management & Succession planning Equality, Diversity & Inclusion Strategy & Implementation Plan Staff Networks (BAME / Disability / Carer/ LGBTQ+)	Career Development Programmes for staff with protected characteristics Development of Staff Network Chairs and the Staff Networks	**Level 1 - Management** WRES / WDES Steering Group - Oversight of WRES / WDES Annual Report and Action Plan Equality, Diversity & Inclusion Steering Group - Oversight of the EDI Action Plan		Staff Network review taking place	September 2023	3	3	9	9	9				3	2	6
				Level 2 – Corporate Performance Review (Monthly) including targeted 'Deep Dives'	EDI metrics to be built into People Analytics Dashboard.	Civility Saves Lives Programme - Phase 1	September 2023											

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score		
								Impact	Likelihood	Current	Q4 22/23	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 4 - Develop a diverse, capable and motivated workforce to meet future service and user needs																		
		Senior medical leadership roles – Interview panel includes representation from staff with protected characteristics Hate Crime Reduction Policy in place (Red/Yellow card) Dying to Work Charter Accessible Scheme		People Performance Committee - EDI Report (Biannually) - WRES and WDES Report - Gender Pay Gap report to Board - Annual EDI Report **Level 3 - Independent** NHS National Staff Survey		~~Delivery~~ implementation ~~to be agreed~~												

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score		
								Impact	Likelihood	Current	Q4 22/23	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 5 – Drive service improvement through high quality research, innovation and transformation																		
Principal Risk Number: 5.1								**Risk Appetite: Significant**										
There is a risk that the Trust does not implement high quality transformation programmes which may lead to suboptimal service improvements.	Quality Committee	Director of Transformation working across SFT and Tameside & Glossop (utilising experience and knowledge of system-wide transformation programmes across other localities) Trust Transformation Programmes identified through a formal process of prioritisation linked to corporate objectives (Aims, KPIs, Milestones) Standardised governance & assurance in place for Transformation Programmes - Service Improvement Group (SIG) chaired by the Chief Executive. Senior Responsible Officer, Clinical & Operational Lead in place for each Transformation Programme Transformation Team supporting Stockport Provider Partnership identified key priority workstreams	Capacity of operational teams to implement change due to operational pressures	**Level 1 – Management** Transformation - Programme Boards Provider Partnership Key Priority Areas – Programme Boards				3	2	6	6	6				3	2	6
				Level 2 – Corporate Service Improvement Group – Monthly Transformation Programme Report & Quarterly Deep Dive: Review KPIs/Milestones Stockport Provider Partnership (Monthly) - Priority Workstreams Board Report: Transformation Programme (Biannually)														
				Level 3 - Independent														
Principal Risk Number: 5.2								**Risk Appetite: Significant**										
There is a risk that the Trust does not implement high quality research & development programmes which may lead to suboptimal service improvements	Quality Committee	SFT Research Team established. Joint Clinical Research, Development & Innovation Strategy 2022-2027 (SFT & T&G) & governance meetings in place to review work programme (as derived from strategy) Annual research programme in place.	Capacity of operational teams to implement change due to operational pressures	**Level 1 – Management** Clinical Effectiveness Group - Research & Innovation Progress Report - Annual Research & Innovation Report		Review of the RD&I governance team structures across SFT & T&G and implement revision to support improved workforce resilience.	2023/24	3	2	6	6	6				3	2	6
				Level 2 – Corporate Quality Committee: - Clinical Effectiveness Group Key Issues & Assurance Report - Annual Research & Innovation Report 2022-23														
				Level 3 - Independent DHSC KPIs for Research NIHR GMCRN KPIs for Research Participant research experience survey (PRES)														

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score		
								Impact	Likelihood	Current	Q4 22/23	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 6 – Use our resources efficiently and effectively																		
Principal Risk Number: 6.1				**Risk Appetite: Moderate**														
There is a risk that the Trust does not deliver the 2023/24 financial plan leading to increased regulatory intervention	Finance & Performance Committee	Annual financial plan 2023/24 approved – Confirmed deficit as part of GM control total Indicative SFT Capital Plan 2023/24 set. Annual cash plan 2023/24 in place – Cash support if required from GM Approved Opening Budgets 2023/24 including requirement for recurrent and non-recurrent CIP Established STEP Programme (CIP) and oversight of delivery. Working Intelligently Group established – Data Analysis & Benchmarking – Workplan in place, informing STEP Programme Divisional Performance Review process - including financial escalation actions based on control totals for divisions. SFT Finance Improvement Group established, chaired by Chief Executive Delivery of budget holder training and enhancements to financial reporting SFI's & Scheme of Delegation in place including authorisation limits – Revised & Board approved – December 2022 GM Financial Recovery Committee established – Chief Finance Officer member as Chair of GM DoFs GM PMO – Established to oversee implementation of PWC Diagnostic Review – Delivery of System Savings Executive Driver Group (Finance & Performance Recovery Exec Group) – Including GM Finance representatives, and Chairs of professional Director Groups (Nursing, Medical Operations), GM PMO and PWC Stockport System Finance Recovery Group established (Monthly)	Implementation of recurrent CIP Plan Financial impact of industrial action Lack of clarity on mechanism for accessing cash support. Lack of clarity on Elective Recovery Fund (ERF) – Trust not currently at activity levels compared to 2019/20. Resource gap impacting coding activity in line with 'flex and freeze' requirements.	**Level 1 – Management** Division Operation Board - Finance Metrics Divisional CIP Meetings Finance Training Group – Training Materials Cash Action Group (Monthly) - Cash flow monitoring Financial Position Review Group (Monthly) **Level 2 – Corporate** CIP Oversight Group - Monthly chaired by Director of Operations. Division level reporting for all schemes and tracking of savings Financial Improvement Group (Monthly) Activity Management Group (Monthly) Finance & Performance Committee Finance Report (Monthly) CPMG – Capital Position Divisional Performance Review (Monthly) including Financial Position/CIP Integrated Performance Report (Finance) - Board (Bimonthly) Stockport System Financial Recovery Group (Monthly) **Level 3 - Independent** **External** Internal Audit Reports - Key Financial Systems (Substantial) 2021/22 - HFMA Financial Sustainability Review - Confirmation of Self-Assessment. - Provenance of Data (High) **GM ICS** Monthly Provider Finance Return including detailed commentary on financial position and reconciliation of workforce, productivity/finance and performance data. GM PMO – Reporting on workstreams identified in PWC Diagnostic Review – Delivery of System Savings **NHSE**	Regular benchmarking data to support monitoring of service delivery, productivity & efficiency Visibility of performance against income block and non-block	Review of CIP opportunities (including outcome of PWC Diagnostic Review) Financial Year-End Forecast Review (to inform NHS England declaration process on delivery of financial plan)	Ongoing September 2023	4	4	16	12	16				4	2	8

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score		
								Impact	Likelihood	Current	Q4 22/23	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 6 – Use our resources efficiently and effectively																		
				NHSE - North West Region oversight and triangulation of finance, activity and workforce data. Monthly Finance Return – Detailed commentary on financial position and Oversight of GM ICS based on the GM NHS SOF Rating 3													
Principal Risk Number: 6.2								**Risk Appetite: Moderate**										
There is a risk that the Trust does not develop and agree with partners a multi-year financial recovery plan, optimising opportunities for financial recovery through system working, leading to lack of financial sustainability.	Finance & Performance Committee	GM ICS financial planning/position processes established including GM DoFs Planning Group. Board review of high-level actions required in order to avoid submitting a deficit plan (June 2023) GM Financial Recovery Committee established - Chief Finance Officer member as Chair of GM DoFs. Locality financial planning/position processes in place including monthly meeting Local Authority Treasurer & Trust CFO. Stockport System Financial Recovery Group established – Chief Finance Officer, Director of Finance & Director of Operations. Prioritisation of investments linked to planning priorities. Drivers of financial deficit review including benchmarking data and levels of efficiency & two-year financial forward view – Deficit & Opportunities to address – Review via Finance & Performance Committee (Jan 23) Established Trust planning processes - Triangulates activity, workforce and cost.	Underlying financial deficit Lack of certainty regarding system funding beyond 2023/24 including reductions due to convergence factor. Requirement for increased % CIP (recurrent/non-recurrent) GM Financial Risk Framework to be agreed Elective Recovery Fund (ERF) remains unclear) – Trust not at activity levels compared to 2019/20. Growth in demand not recognised.	**Level 1 - Management**				4	4	16	16	16				4	2	8
				Level 2 – Corporate CIP Oversight Group - Monthly chaired by Director of Operations. Division level reporting for all schemes and tracking of savings Finance & Performance Committee - Finance Report (Monthly) Financial Improvement Group (Monthly) Stockport System Financial Recovery Group (Monthly)		Review of CIP Opportunities (including outcome of PWC Diagnostic Review)	Ongoing										
				Level 3 - Independent Provider Director of Finance GM Meeting **GM ICS** Monthly Provider Finance Return including detailed commentary on financial position and reconciliation of workforce, productivity/finance and performance data. GM PMO – Reporting on workstreams identified in PWC Diagnostic Review – Delivery of System Savings **NHSE** NHSE - North West Region oversight and triangulation of finance, activity and workforce data. Monthly Finance Return – Detailed commentary on financial position and Oversight of GM ICS based on the GM NHS SOF Rating 3		GM Financial Risk Framework to be agreed	September 2023										

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score		
								Impact	Likelihood	Current	Q4 22/23	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 7 - Develop our estate & digital infrastructure to meet service and user needs																		
Principal Risk Number: 7.1				**Risk Appetite: Significant**														
There is a risk that the Trust does not implement the Digital Strategy designed to ensure a resilient and responsive digital infrastructure which may lead to inability to support improvements in quality of care and compromise of data/information.	Finance & Performance Committee	Digital Strategy 2021-2026 Capital plan in place for funding of Digital Strategy and receipt of capital funding for core elements of the Digital Strategy Robust project management infrastructure in place Information Governance Assurance Framework (IGAF) & NHIS Cyber Security Strategy Anti-virus updates & spam and malware email notifications Network accounts checked after period of inactivity – Disabled if not used Major incident plan in place Digital & Informatics Group established Terms of Reference & Work Plan approved by F&P Committee. Bimonthly reporting.		**Level 1 – Management** Digital & Informatics Group Digital Risk Register – Quarterly review via Risk Management Committee				3	3	9	9	9				3	2	6
				Level 2 – Corporate Finance & Performance Committee - Digital & Informatics Group established Bimonthly - Digital Strategy Progress Report - Capital Programmes Management Group – (Monthly): Including digital capital Board of Directors - Biannual Digital Strategy Progress Report		Completion of MIAA audit (and agreed recommendations) relating to legacy systems and asset control	Q2 2023/24											
				Level 3 - Independent Business Continuity Confirm and Challenge NHSE ISO 27001 Information Security Management Certification – Achieved November 2022 DCB 1596 Secure Email Standard Accreditation – Achieved February 2023. Internal Audit Report: Data Security and Protection (DSP) Toolkit – Moderate Assurance, MIAA, June 2023. Data Security and Protection Toolkit self-assessment submission June 2023 – Standards Met.		Completion of Data Protection & Security Toolkit (DSPT) Assessment 2023 upon new release due August 2023.	Q4 2023/24											
Principal Risk Number: 7.2				**Risk Appetite: Moderate**														
There is a risk that the estate is not fit for purpose and/or meets national standards due to increasing maintenance requirements, which may lead to inefficient utilisation of the estate to support high quality of care and increased health & safety incidents.	Finance & Performance Committee	Approved Capital Programme including backlog maintenance Robust process in place for identification and stratification of estates related risks and backlog maintenance 6-facet survey completion and review – Action Plan in place Premises Assurance Model (PAM) Action Plan in place Estates & Facilities Performance Dashboard (Compliance & Performance Metrics) Site Development Strategy in place. Project Board and Senior Responsible Officer identified for major capital developments	Insufficient financial resources to enable optimum levels of estates maintenance investment Inability to deliver required upgrades due to access limitations related to clinical activity pressures	**Level 1 – Management** Capital Programme Management Group - Compliance with agreed delivery programme - Confirmation of spend against approved budget Health & Safety Group - Compliance with regulatory standards Health & Safety Incidents				4	4	16	12	16				4	2	8
				Level 2 – Corporate Quality Committee - Health & Safety Group Key Issues Report Finance & Performance Committee - Capital Programme Management Group Key Issues Report		Develop site development strategy delivery plan to reduce maintenance costs aligned to Project Hazel	October 2023											
				Level 3 - Independent Estates Return Information Collection (ERIC) Model Hospital Data Set														

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score		
								Impact	Likelihood	Current	Q4 22/23	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 7 - Develop our estate & digital infrastructure to meet service and user needs																		
		Trust Head of Operational Estates and Compliance appointed as National E&F compliance lead for HEFMA (NHS Health Estates and Facilities Management Association)		Estates & Facilities Compliance Review (MIAA 2020/21) – Substantial Assurance														
Principal Risk Number: 7.3					**Risk Appetite: Moderate**													
There is a risk that the Trust does not materially improve environmental sustainability which may lead to suboptimal support to locality ambitions and the NHS commitment to carbon reduction.	Finance & Performance Committee	Approved Green Plan in place. Green Plan Committee established and Green Plan Work Plan in place monitored by the committee. Approved Capital Programme 2022/23 Robust identification and stratification of sustainability-related risks. 6-facet survey completion and review of information Trust Sustainability Manager in post Mechanisms in place to explore and develop sustainability approach across Stockport locality.	Insufficient financial resources to enable optimum levels of investment to deliver sustainability improvements	**Level 1 – Management** Capital Programme Management Group - Compliance with agreed delivery programme - Confirmation of spend against approved budget Green Plan Committee - Monitoring of Green Plan delivery - Development of sustainability opportunities				4	3	12	8	12				4	2	8
				Level 2 – Corporate Annual Sustainability Report Finance & Performance Committee Estates Progress Report including Sustainability (Biannually)														
				Level 3 - Independent Estates Return Information Collection (ERIC)														
Principal Risk Number: 7.4					**Risk Appetite: Moderate**													
There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus which may lead to an adverse long-term impact on the Trust's capability to deliver modern and effective care.	Finance & Performance Committee	Strategic Regeneration Framework Prospectus completed New Hospital Building Programme Expression of Interest submitted – Project Hazel Established governance structure to develop Outline Business Case Project Hazel Business Case ~~in~~ produced and approved by Board of Directors. Site Development Strategy to support and inform immediate site development and maintenance aspirations New Hospital Project Board established, chaired by SFT Chief executive. including representation from key external partners. Estates Strategy Steering Group (ESSG) established, reporting to Finance & Performance Committee.	Insufficient financial resources to enable optimum levels of investment to deliver regeneration ambitions including Project Hazel. DHSC has confirmed that the Trust has been unsuccessful in securing necessary support from the New Hospital Building Programme. New Hospital Building Outline Business Case	**Level 1 - Management**				4	4	16	12	16				4	2	8
				Level 2 – Corporate Strategic Regeneration Framework Prospectus and Expression of Interest – Reviewed by Board		Consideration of resources for development of New Hospital Strategic Outline Business Case (OBC)	Q2 2023/24											
				Level 3 - Independent														

Appendix 2 – Stockport NHS Foundation Trust Significant Risk Register (as at July 2023)

Risk ID	Business Group	Risk Title	Consequence	Likelihood	Rating	Target Rating	Change since last report
130	Emergency Department and Clinical Decision Unit	There is a risk the Trust does not meet the 4 hour access standard and this leads to delays in treatment and potential patient harm.	4	4	16	10	↔
2133	Integrated Care	There is a risk that patient flow may be compromised by the reduced access to community capacity and therefore rising NCTR.	4	4	16	6	↔
1004	Corporate – Estates and Facilities	There is a risk that the Trust is in breach of the Regulatory Reform (Fire Safety) Order 2005.	4	4	16	4	↔
2337	Medicine	There is risk of rapid access chest pain patients coming to harm as a result of delays in booking first appointments.	4	4	16	8	↔
1711	Corporate – Workforce	There is a risk of deterioration in employee relations and industrial action.	4	4	16	4	↔
2452	Clinical Support Services	There is a risk of the pathology estate not being fit for purpose or safe.	3	5	15	3	↔
2234	Medicine	There is a risk of increased mortality on Ward E3.	5	3	15	10	↔
101	Corporate - Finance	There is a risk that the Trust has insufficient cash reserves to operate.	5	3	15	5	↔
2465	Clinical Support Services	There is a risk to outpatient appointment delivery and patient and staff health and wellbeing due to environmental condition in OPB.	3	5	15	6	↔

NHS Stockport NHS Foundation Trust

Meeting date	3rd August 2023	X	Public		Confidential	Agenda item
Meeting	Board of Directors					
Title	Board Committee Assurance – Key Issues Reports					
Lead Director	Committee Chairs	Authors	Soile Curtis, Deputy Company Secretary Rebecca McCarthy, Trust Secretary			

Recommendations made / Decisions requested:

The Board of Directors is asked to:

- Review the key issues and assurances provided via the Board Committees
- Receive the Local Maternity and Neonatal Systems (LMNS) Submission as reviewed and confirmed by Quality Committee.

This paper relates to the following Corporate Annual Objectives

x	1	Deliver safe accessible and personalised services for those we care for
	2	Support the health and wellbeing needs of our communities and staff
	3	Develop effective partnerships to address health and wellbeing inequalities
	4	Drive service improvement, through high quality research, innovation and transformation
	5	Develop a diverse, capable and motivated workforce to meet future service and user needs
	6	Use our resources in an efficient and effective manner
	7	Develop our Estate and Digital infrastructure to meet service and user needs

The paper relates to the following CQC domains

x	Safe	x	Effective
x	Caring	x	Responsive
x	Well-Led	x	Use of Resources

This paper relates to the following Board Assurance Framework risks

x	PR1.1	There is a risk that the Trust does not deliver high quality care to service users
x	PR1.2	There is a risk that patient flow across the locality is not effective
x	PR1.3	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan
x	PR2.1	There is a risk that the Trust is unable to sufficiently engage and support our people's wellbeing
x	PR2.2	There is a risk that the Trust's services do not fully support neighbourhood working

x	PR3.1	There is a risk in implementing the new provider collaborative model to support delivery of Stockport ONE Health & Care (Locality) Board priorities
x	PR3.2	There is a risk that the Trust does not deliver a joint clinical strategy with East Cheshire NHS Trust
x	PR4.1	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit and retain the optimal number of staff, with appropriate skills and values
x	PR4.2	There is a risk that the Trust's workforce is not reflective of the communities served
x	PR5.1	There is a risk that the Trust does not implement high quality transformation programmes
x	PR5.2	There is a risk that the Trust does not implement high quality research & development programmes
x	PR6.1	There is a risk that the Trust does not deliver the annual financial plan
x	PR6.2	There is a risk that the Trust does not develop and agree with partners a multi-year financial recovery plan
x	PR7.1	There is a risk that the Trust does not implement the Digital Strategy to ensure a resilient and responsive digital infrastructure
x	PR7.2	There is a risk that the estate is not fit for purpose and/or meets national standards
x	PR7.3	There is a risk that the Trust does not materially improve environmental sustainability
x	PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus

Where issues are addressed in the paper-

	Section of paper where covered
Equality, diversity and inclusion impacts	N/A
Financial impacts if agreed/ not agreed	N/A
Regulatory and legal compliance	All
Sustainability (including environmental impacts)	N/A

Executive Summary

The Board of Directors has established the following Committees:

- People Performance
- Finance & Performance
- Quality
- Audit Committee

The Committees have no executive powers, other than those specifically delegated within their Terms of Reference, but they can make recommendations to the Board of Directors for approval. The Committees are to report to the Board of Directors by means of a Key Issues Report summarising business conducted by the Committee together with key actions and/or risks.

A summary is provided for the Board of Directors of the key matters and decisions from the meetings of the Finance & Performance Committee, People Performance Committee, Quality Committee and Audit Committee held during June and/or July 2023.

NHS Stockport NHS Foundation Trust

KEY ISSUES AND ASSURANCE REPORT
Finance & Performance Committee
15 June 2023

The Finance & Performance Committee draws the following matters to the Board of Director's attention -

Issue	Committee Update	Assurance received	Action	Timescale
Operational Performance Report	The Director of Operations presented the Operational Performance Report, including performance at the end of May 2023 against the strategic core operating standards, benchmarking of performance against the four key standards (A&E 4-hour standard, Cancer 62-day standard, 18-week Referral to Treatment (RTT) standard, and Diagnostic 6-week wait standard), and Productivity, Efficiency & Transformation. The Director of Operations highlighted the continued operational pressures and described action to improve performance. It was noted that the significant drivers of the performance continued to be the challenges around flow and no criteria to reside (NCTR), particularly for out of area patients.	The Committee reviewed and noted the Operational Performance Report for Month 2. The Committee heard that the Trust continued to perform below the national target against all of the core operating standards, however it was acknowledged that the Trust's performance compared favourably against GM peers. It was noted that cancer performance was extremely challenged due to the compounded impact of industrial action, significantly affecting elective capacity, with limited opportunity for recovery in May due to the bank holidays. The Committee heard, however, that the Trust continued to perform strongly against the 2-week wait standard, achieving 97.6% against the 93% standard in May. It was noted that the wider cancer transformation programme continued and the Director of Operations was pleased to report that GM Cancer Alliance had highlighted Stockport as an area of good practice for cohesive working across different organisations, consequently adopting the Trust's Quality Assurance process across GM. It was noted that diagnostic performance was on trajectory, however Echocardiology remained the	The Director of Operations agreed to establish the financial cost of out of area NCTRs and report back to the Committee.	July 2023

Issue	Committee Update	Assurance received	Action	Timescale
		biggest area of challenge. The sixth treatment room was now operational, which was having a positive impact on capacity. It was noted that the Trust benchmarked well in GM around endoscopy productivity.		
Performance Review Framework	The Director of Operations presented a Performance Review Framework. She highlighted the approach to operational performance assurance framework, providing a connection from Board to Ward and maintaining a line of sight to key organisational risks. She noted the key domains covered by the framework and briefed the Committee on the change in approach in 2023/24.	The Committee received and noted the Performance Review Framework report and noted strong assurance for the framework in place.		
Finance Report	The Chief Finance Officer provided an update on financial performance for Month 2 2023/24. The overall Trust position at Month 2 was adverse to plan by £1.2m, with a planned year-end deficit of £31.5m, which was in line with the annual plan for 2023/24. It was noted that the key reasons for the variance to plan in month related to strike action, pay award, open escalation wards, impact of inflation, enhanced staffing levels to support the high level of ED attendances and cover for vacancies and sickness absence.	The Committee reviewed and noted the financial position for Month 2. It was noted that the Stockport Trust Efficiency Programme (STEP) plan for 2023/24 was £26.2m (£10.3m recurrent) and that the delivery of the plan was £2.2m behind target. The Committee noted that the outcome of the PWC financial diagnostic review would inform any learnings in this area and the Committee would be kept updated regarding the approach for the STEP internal audit. The Committee has limited assurance that the CIP/ STEP (particularly the recurrent element) will be achieved. The Committee heard that the forecast was set to balance at this stage of the financial year, but the Chief Finance Officer highlighted the risk of non-delivery of activity in accordance with the Elective Recovery Fund (ERF) and briefed the Committee on the GM position and the negative system variance to plan.		

Issue	Committee Update	Assurance received	Action	Timescale
		It was noted that the Trust had maintained sufficient cash to operate during May, but the Committee acknowledged risks in this area, including the uncertainty around cash support. The Committee noted that capital plan for 2023/24 was £62.7m but subject to confirmation. At month 2 expenditure was behind plan by £2.1m. The Committee noted system-wide challenges around the capital envelope.		
Procurement Update – inc. Contracts for Recommendation to Board	The Chief Finance Officer presented a report detailing procurement processes in progress over £750k.	The Committee noted the report and recommended the award of the Microsoft Office 365 tender to the Board of Directors for approval.	Microsoft Office 365 tender recommended to the Board of Directors for approval.	June 2023
Pharmacy Shop Board Report	The Associate Director of Financial Services presented a report providing an update on the 2022/23 financial performance of the Trust's wholly owned subsidiary 'Stepping Hill Healthcare Enterprises Ltd'.	The Committee received and noted the report, including the estimated 2022/23 financial results as reported in the Group Consolidated Accounts, anticipated 2023/24 financial performance and associated risks to performance.		
Community Diagnostic Centre Business Case	The Director of Strategy & Partnerships presented a report setting out the case for development of a joint Community Diagnostic Centre (CDC) across Stockport and Tameside, with an aim to address growth in demand for diagnostic activity, support earlier diagnosis and tackle health inequalities. The Committee noted the full breakdown of finances, risk and benefits, procurement process followed, and successful bidder award.	The Committee noted the report endorsed the governance arrangements for the Community Diagnostic Centre business case. The Committee noted that a further report would be presented to the Board of Directors in August 2023.	A report to be presented to the Board of Directors.	August 2023
Estates & Facilities Assurance Report	The Director of Estates & Facilities and the Associate Director of Estates & Facilities presented an Estates & Facilities Assurance Report.	The Committee received and noted the report and heard that an Estates Strategy Steering Group was being established to monitor the delivery of the Estates Strategy.		

Issue	Committee Update	Assurance received	Action	Timescale
Standing Committees	• **Capital Programme Management Group (CPMG)** • **Digital & Informatics Group**	The Committee received and noted the Key Issues and Assurance Reports.		

NHS Stockport NHS Foundation Trust

KEY ISSUES AND ASSURANCE REPORT
Finance & Performance Committee
20 July 2023

The Finance & Performance Committee draws the following matters to the Board of Director's attention -

Issue	Committee Update	Assurance received	Action	Timescale
Finance Report	The Director of Finance provided an update on financial performance for Month 3 2023/24. The overall Trust position at Month 3 was adverse to plan by £0.9m, with a planned year-end deficit of £31.5m, which was in line with the annual plan for 2023/24. It was noted that the key reasons for the variance to plan in month related to strike action, pay award, open escalation wards, undelivered cost improvements, impact of inflation, enhanced staffing levels to support the high level of ED attendances and cover for vacancies and sickness absence.	The Committee reviewed and noted the financial position for Month 3. It was noted that the Stockport Trust Efficiency Programme (STEP) plan for 2023/24 was £26.2m (£10.3m recurrent) and that the delivery of the plan was £1.1m behind target. The Committee heard that the forecast was set to balance at this stage of the financial year, but that the Board would need to consider if the risks presented meant that the financial plan could not be delivered, given the change in circumstances since the setting of the annual plan. The Director of Finance highlighted the risk of non-delivery of activity in accordance with the Elective Recovery Fund (ERF) and briefed the Committee on the GM position and the negative system variance to plan. It was noted that the Trust had maintained sufficient cash to operate during June, but the Committee acknowledged risks in this area and heard that the Trust would require revenue support in 2023/24. The Committee also noted additional costs associated to any additional borrowing if GM was unable to provide cash support. The Committee noted that capital plan for 2023/24		

Issue	Committee Update	Assurance received	Action	Timescale
		was £62.7m but subject to confirmation. At month 3 expenditure was behind plan by £3.3m. The Committee noted system-wide challenges around the capital envelope.		
Contract Income 2023/24	The Associate Director of Finance presented a report which summarised the basis of contract income for 2023/24 and risks to the income position.	The Committee noted associated risks to the contract income, particularly in relation to ERF and out of area income. The Committee acknowledged difficulties around forecasting due to the number of unknown variables, including ongoing industrial action.		
Operational Performance Report	The Director of Operations presented the Operational Performance Report, including performance against the strategic core operating standards, benchmarking of performance against the four key standards (A&E 4-hour standard, Cancer 62-day standard, 18-week Referral to Treatment (RTT) standard, and Diagnostic 6-week wait standard), and Productivity, Efficiency & Transformation programmes. The Director of Operations highlighted the continued operational pressures and described action to improve performance. It was noted that the significant drivers of the performance continued to be the challenges around flow and no criteria to reside (NCTR), particularly for out of area patients. It was noted that the internal Programme of Flow work was having a positive impact on performance.	The Committee reviewed and noted the Operational Performance Report. The Committee heard that the Trust continued to perform below the national target against all of the core operating standards, however it was acknowledged that the Trust's performance compared favourably against GM peers. It was noted that the metrics had been impacted by the BMA industrial action resulting in significant elective cancellations and the Committee also noted the consequent impact on staff having to cover for colleagues. It was noted that cancer and Referral to Treatment (RTT) performance was extremely challenged due to the impact of industrial action, due to reduced elective capacity. However good performance was noted around the 2-week wait standard. It was noted that diagnostic performance was on trajectory, however Echocardiology remained the biggest area of challenge and was unlikely to be resolved until the Community Diagnostic Centre		

Issue	Committee Update	Assurance received	Action	Timescale
		was in place. It was noted that the Trust benchmarked well in GM around endoscopy productivity.		
Charging for Out of Area Discharge Delays	The Director of Operations presented a report outlining theoretical income value which could be secured if the Trust was able to recharge Derbyshire and Cheshire for delayed discharges, and a summary of the potential annualised impact and costs being incurred to support these patients.	The Committee received and noted the report and recognised the need to keep highlighting the issue with GM at every available opportunity with a clear narrative on the drivers of our financial deficit.		
Costing Submission 2022/23 Pre-Submission Planning Report	The Associate Director of Finance presented a report seeking confirmation from the Committee that the processes and systems in place are sufficient to provide assurance on the plan to complete the mandated costing submissions for 2022/23.	The Committee received and noted the report and confirmed the process in place as sufficient to provide assurance to the Board on the plan to complete the mandated costing submissions for 2022/23.		
Procurement Update – inc. Contracts for Recommendation to Board	The Director of Finance presented a report detailing procurement processes in progress over £750k.	The Committee noted the report and recommended the award of the Blood Sciences Managed Service tender to the Board of Directors for approval.	Blood Sciences Managed Service tender recommended to the Board of Directors for approval.	August 2023
Board Assurance Framework 2023/24: Draft Principal Risks Review	The Committee received a report detailing the draft principal risks for 2023/24 assigned to the Committee. The Committee also noted confirmation of the aligned significant risks from the Corporate Risk Register, which were included for review to ensure alignment with the draft principal risks.	The Committee noted that the principal risks had been developed based on review of key controls and assurances in relation to each, any gaps and required actions. It was noted that the current risk appetite for each risk element had been confirmed at the Board risk appetite workshop and had been applied to the draft principal risks.	The Committee reviewed and approved the finance & performance related principal risks to be included within the Board Assurance Framework 2023/24 to be presented to the Board of Directors for approval in August 2023.	August 2023
Standing Committees	• **Capital Programme Management Group (CPMG)** The Committee received and noted the CPMG Key Issues and Assurance Report.	The Committee heard that the GM ICS capital plan was still under review as it was currently over committed. It was noted that further reductions were anticipated across GM and the Committee acknowledged risks in this area.		

Issue	Committee Update	Assurance received	Action	Timescale
	• **Estates Strategy Steering Group** The Committee approved the newly established Estates Strategy Steering Group Terms of Reference, subject to a minor amendment.	It was noted that a review was being undertaken to ensure capital related risks were appropriately included on the Trust's risk register.		

NHS Stockport NHS Foundation Trust

KEY ISSUES AND ASSURANCE REPORT
People Performance Committee
13 July 2023

The People Performance Committee (PPC) draws the following matters to the Trust Board's attention

Issue	Committee Update	Assurance received	Action	Timescale
People Integrated Performance Report	The Committee considered the People Integrated Performance Report and received an update on the following key performance indicators: attendance, appraisals, mandatory training, turnover, vacancies, time to hire, and agency expenditure.	The Committee confirmed performance in relation to attendance, vacancies and time to hire was within target, with all other metrics were below target. Albeit training was below performance, an improving trajectory for mandatory training, role specific training, children's resus and safeguarding training (adults and children) was noted. Regarding turnover, a deep dive was being undertaken to understand reasons for staff leaving, particularly Allied Health Professionals. The Committee heard that the decline in medical appraisals had related to a recording issue, which had now been resolved.	The Chief Finance Officer agreed to liaise with the Director of People & OD to review the financial impact of staff turnover, to support appropriate allocation of resources.	
Agency Expenditure	The Committee considered a report providing an overview of the Trust's position against the agency rules and costs of usage, along with the initiatives in place aimed at reducing the usage of bank and agency workers.	The Committee noted agency usage remained at above target primarily due to vacancies, open escalation beds and industrial action. The Committee noted controls in place to ensure agency workers were only engaged where essential to ensure safe staffing levels, and at the most competitive rates,		

Issue	Committee Update	Assurance received	Action	Timescale
		including additional scrutiny of agency requests through the revised Staffing Approval Group. The Committee noted recent reduction in agency spend, albeit acknowledged the risk to the position due to further industrial action.		
Organisational Development Plan Update	The Committee considered a report providing a progress against the four priority areas of the Organisational Development (OD) Plan 2023-25, since it was approved by the Board in February 2023. Priority Areas: • Leadership and Working Relationships • Talent Management • Innovation • OD Consultancy	The Committee noted solid progress in delivery of action plan with majority of actions complete or in train. Committee acknowledged the impact of development interventions currently measures through attendee evaluations, with further development of a more robust approach for measuring both the short term and long term impact of our work.	PPC Chair, Director of People & OD and Trust Secretary to further consider the evidence-based reporting approach, to enable the assurance to be provided to the Board.	
Staff Survey Update	The Committee received an update on actions taken in response to feedback from the 2022 Staff Survey and planning underway for the 2023 Staff Survey, due to launch in September 2023.	The Committee recognised the Staff Survey results were key to demonstrating impact of several 'people' workstreams and interventions, including OD Plan and EDI Strategy. The Committee highlighted the importance of communications to reassure staff that the responses were confidential and able to highlight tangible changes made in response to feedback.		

Issue	Committee Update	Assurance received	Action	Timescale
Health & Wellbeing	The Committee received an update on the Trust's Health & Wellbeing offer aligned to the People Plan.	The Committee noted the range of supportive interventions and services in place to support colleagues during the past 12 months, and priorities for the year ahead. PPC Chair highlighted importance of appropriate rest areas for staff, following a walkabout in Outpatients B, aligned to supporting health and wellbeing. The Chief Finance Officer to explore potential funding in the current significantly challenging financial context.		
Violence Prevention & Reduction Standard	The Committee received an update on progress made in relation to the violence prevention and reduction standards, including each section of the standards.	The Committee heard that the Trust had a newly appointed Health & Safety Manager who would oversee this work. It was noted that progress would be monitored via the Health & Safety Joint Consultative Group, with the group also reporting to the Quality Committee on a quarterly basis. The Committee requested a further report including additional data analysis to better understand issues specific to SFT, including identification of 'hot spot' areas and breakdown via staff protected characteristics.	Update report to be considered at the next meeting.	September 2023
Wellbeing Guardian Report	The Committee received a verbal update from the Wellbeing Guardian (Non-Executive Director).	The Committee heard that wellbeing was being prioritised throughout the organisation and formed part of departmental meetings.		

Issue	Committee Update	Assurance received	Action	Timescale
	The Committee received a report detailing how the Wellbeing Guardian would support the Wellbeing Guardian principles, which had been reviewed and interpreted to reflect the requirements of Stockport NHS Foundation Trust (Appendix 1)	The Committee noted that the principles were embedded within the reporting schedule of the PPC.	PPC supported the review of the Wellbeing Guardian Principles, including how the principles would be implemented and supported to meet the needs of Stockport NHS Foundation Trust (Appendix 1)	
Guardian of Safe Working	The Committee received the Guardian of Safe Working Report.	The Committee confirmed there had been no immediate safety concerns raised during the reporting period, and acknowledged the ongoing focus required to support trainees and raise the profile of exception reporting. The Committee thanked the Guardian of Safe Working for all his efforts in overseeing the safety of trainee doctors' working.		
Resourcing Report	The Committee received an update on progress during 2022/23, and the current programmes of work supporting the resourcing agenda aligned to Our People Plan with the aim of recruiting and retaining people and ensuring a sufficient workforce.	The Committee confirmed the activity that had taken place to support recruitment and retention to address workforce gaps, including alternative recruitment pipelines 2023/24 priorities for resourcing.		
Board Assurance Framework 2023/24: Draft Principal Risk Review	The Committee received a report detailing the three draft principal risks for 2023/24 assigned to the Committee. The Committee also noted confirmation of the aligned significant risks from the Corporate	The Committee noted that the three principal risks had been developed based on review of key controls and assurances in relation to each, any gaps and required actions. It was noted that the current risk appetite for each risk element had been confirmed	The Committee reviewed and approved the people related principal risks to be included within the Board Assurance Framework 2023/24 to be presented to the Board of Directors for approval in August 2023.	August 2023

Issue	Committee Update	Assurance received	Action	Timescale
	Risk Register, which were included to ensure alignment with the draft principal risks.	at the Board risk appetite workshop and had been applied to the draft principal risks. The Committee also noted triangulation with the Board walkabouts, which supported the proposed risk scores.		
Key Issues Reports	The Committee received and noted the following key issues reports: • Equality, Diversity & Inclusion Group • Educational Governance Group			
The Committee requested further focus on evidence based assurance, and themed data analysis, within the reports to support in effective allocation of resources and ensure trajectories for improvement were clarified. The People Performance Committee Chair, the Director of People & OD and Trust Secretary agreed to meet before the next meeting to discuss.				

Appendix 1

NHS England Health & Wellbeing Guardian Principles

The NHS England nine board principles outline how our wellbeing guardian provides support and the table below explains what #TeamStockport are doing in support of these going forward:

Principle	What we are doing already	Gaps/ Further action
Principle one: The health and wellbeing of our NHS people and those learning and working in the NHS should not be compromised by the work they do for the NHS.	We have a number of measures in place to reduce any adverse impacts to a minimum and to offer appropriate support.	
Principle two: Where an individual or team is exposed to a distressing clinical event, board time should be made available to assure the board and the wellbeing guardian that the wellbeing impact on those NHS staff and learners has been checked.	This in place already through regular updates at Board meetings & via People Performance Committee on Health and Wellbeing and our OH & psychological support initiatives. We have our Staff Psychological & Wellbeing Service (SPAWs) which is providing trauma-based treatment, training for managers and staff bereavement groups. It is acknowledged that the nature of our services will mean that from time-to-time staff will experience events that may be distressing on an individual basis, and we have appropriate mechanisms in place for reporting, responding to and supporting staff with such incidents. However, there will also be events which the Trust deems to be a significant distressing clinical event where a significant number of staff will be affected, for example, the Arena bombing, ED assault, a staff member is unwell and come into our care, staff death (non-suicidal).	

Principle three: Regular assurance will be provided to the wellbeing guardian to ensure that wellness induction (previously wellbeing 'check-in') is being provided to all new NHS people on appointment and to all learners on placement in the NHS, as outlined in the 2019 NHS Staff and Learners' Mental Wellbeing Review's recommendations.	Health and Wellbeing is covered at corporate induction and already included in the appraisal process, with the message to be strengthened again this year. Corporate induction has recently been transitioned to face-to-face from February 2023 and will continue to emphasise the offer available to colleagues.	Wellbeing conversation toolkit in launched, along with refresh of communications and evaluation will be undertaken through the Health & Wellbeing Steering Group
Principle four: The wellbeing guardian will receive assurance that all our NHS people and those learning in the NHS have ready access to a self-referral, proactive and confidential occupational health service that promotes and protects wellbeing.	Occupational Health Service is in place, with self-referral option and access to counselling services, fast-track physio and SPAWs service. Assurance is provided through Health & Wellbeing updates at People Performance Committee.	
Principle five: The death by suicide of any member of our NHS people or a learner working in an NHS organisation will be independently examined and the findings reported through the board to the wellbeing guardian.	A review of the circumstances to understand the facts and lessons learned to inform the organisational response to prevent and/or respond to further incidences of this nature.	A flowchart to describe the approach and action to be taken in such circumstances has been developed. This will be implemented in conjunction with the NHS Confederation postvention toolkit
Principle six: The NHS will ensure that all our NHS people and learners have an environment that is both safe and supportive of their mental and psychological wellbeing, as well as their physical wellbeing.	Already in place with extensive support introduced during the pandemic and longer-term impacts recognised. As per principle one – several measures in place to reduce any adverse impacts to a minimum and to offer appropriate support. Such support mechanisms and signposting to local and national campaigns and support is available via the monthly Health & Wellbeing Newsletter, microsite on the intranet, team brief and regular communication mechanisms.	Further work is being prioritised to increase our understanding of the lived experience of our colleagues to ensure an inclusive and supportive culture for all. This will be emphasised and delivered though our OD plan/staff networks.

Principle seven: The NHS will ensure that the cultural and spiritual needs of our NHS people and those learning in the NHS are protected, and equitable and appropriate wellbeing support for overseas NHS people and learners working in the NHS.	This is in place, with our Chaplaincy service and our staff networks and will be promoted throughout the year. This is further detailed through our EDI Strategy delivery arrangements, supported by our staff networks. Overseas NHS people working with us are provided with dedicated pastoral care arrangements and extended induction arrangements as appropriate.	
Principle eight: The NHS will ensure the wellbeing and make the necessary adjustments for the nine groups protected under the Equality Act 2010 (including consideration for how intersectionality may impact wellbeing).	This is in place, and our staff network groups will consider how intersectionality may impact wellbeing. Our reasonable adjustment policy is in place and managers and staff are supported to ensure that this is utilised appropriately and with flexibility. This is also being addressed through our EDI Strategy and is captured via the Staff Survey, WDES and associated action plans.	The development and move towards our person-centred approach to the management of sickness absence in line with the NW Wellbeing Pledge is underway and will further enhance the support available to staff and managers in this area.
Principle Nine: The wellbeing guardian will provide suitable challenge to the board to be assured that the organisation is working with system leaders and regulators, to ensure that wellbeing is given the same weight as other aspects in organisational performance assessment.	This is in place and will develop further as the role embeds. The Wellbeing Guardian attends the People Performance Committee and meets quarterly with the Director of People, Deputy Director of People & OD and triangulates this information by attending the Staff Networks and walk rounds.	

KEY ISSUES AND ASSURANCE REPORT *Quality Committee* *June & July 2023*				
The Quality Committee draws the following matters to the Board of Director's attention-				
Issue	**Committee Update**	**Assurance received**	**Action**	**Timescale**
Patient Story June & July 2023	The Committee heard a patient story, the objective of which was to remind us why we are here and the values we have.	Positive assurance on: • Positive assurance on listening to patients and using feedback to improve services. • Positive assurance on how we treat patients with dementia.		
Action Log June & July 2023	All outstanding actions for current period were reviewed, with updates on progress, completion or on the agenda.	Positive assurance that actions are being undertaken and progressed. Quality Committee discussed Action 11/23 and determined this action would be closed on the Quality Committee action log, for consideration by the Board of Directors regarding feedback from the range of board 'engagement' taking place to understand themes.	Update action log Board of Directors to consider engagement activity, feedback and themes.	23/24 Sept 2023
Board Assurance Framework – Principal Risks July 2023/24	The Trust Secretary presented the quality related draft principal risks to be incorporated in the Board Assurance Framework 2023/24.	The Committee confirmed that all principal risks from 2022/23 had been reviewed and incorporated within the principal risks for 2023/24. Further assurance and supporting data was being sought for the significant operational risks under review. Agreed that this would be considered via the Health & Safety JCG and Risk Management Committee.	Health & Safety JCG and Risk Management Committee to update via KIR	October 2023

End of Life Care June & July 2023	The Medical Director presented a summary of the end of life care deep dive.	Positive assurance in respect of end of life care feedback from families. Fundamentals of care require continued focus as highlighted in complaints themes. Positive assurance of further development of the StARS accreditation scheme. Care of the dying standard to provide assurance regarding end of life care and initial development of the SWAN model. Work in progress locality wide to record and improve the experience for patients dying in the right/preferred place with the right level of care.	Progress would be reported via the Patient Safety Group.	Monthly
CQC Update **June 2023**	The Deputy Director of Governance provided an update on CQC enquiries and engagement, Insight Reporting, LEAPs towards outstanding and an update on the ED Inspection Plan	Positive assurance was received regarding the systems and processes in place to provide assurance against CQC metrics Limited assurance was received in relation to aspects of the ED Inspection Action Plan.	Monthly update through Patient Safety Group. CQC Update report	July
Learning from Deaths (LFD)Quarterly Report July 2023	The Medical Director presented this quarterly report.	Positive assurance regarding the process undertaken and number of deaths reviewed in line with the policy. Key themes: • For surgical patients in ED who have had a CT scan, the quality of care is being negatively impacted by delays in the reporting of scans. • Earlier discussions about ceilings of care for patients nearing the end of life would help avoid unnecessary interventions. • Renewed focus on nutrition and	Further training in Acute and Community settings on recognising EOL Associate Medical Director to explore best practise in other GM Trusts	Ongoing Oct 2023 (revised from July 2023)

		hydration is required on the hospital's wards. Limited assurance on our improvement of HSMR as SFT remain an outlier as the only GM Trust to remain red in June 2023		
Maternity Services **Local Maternity and Neonatal Systems (LMNS) submission** **June 2023**	The Divisional Director of Midwifery & Nursing presented a report incorporating an update on a number of the elements the service was working towards, including: CNST Year 4/5 - Stockport declared as fully compliant against all 10 safety actions for Year 4. Saving Babies Lives Care Bundle V3 (SBLCBv3) – Successfully implemented all 5 elements of the SBLCBv2. Work towards 6 elements of BLCBv3 by March 2024. Midwifery Continuity of Carer pathway (MCOC) Ockenden Reports (2020/2022) - Trust is compliant with all 7 Immediate and Essential actions (IEA's). East Kent Report (2022) Three-year delivery plan for maternity and neonatal services (2023)	Positive assurance was received regarding compliance position and action being taken to support continued improvement. Positive assurance was taken from the LMNS position against the recommendations.	LMNS Report would be appended to the Quality Committee Key Issues Report provided to the Board of Directors on 3rd August 2023.	August 2023
Patient Family, Carer Experience Report **June 2023**	Quality Committee reviewed the report and actions being taken to drive improvements in patient, carer & family experience.	Limited assurance was received in relation to the patient experience improvement and metrics.	Non-Executive Directors to consider metrics and further assurance	July / Aug 2023

Annual Infection Prevention Control Report 2022/23 **June 2023**	The Quality Committee receive and reviewed the Annual Infection Prevention Control Report 2022/23 and HCAI thresholds for 2023/24.	Number of IPC metrics not achieved during 2022/23, actions in place to drive improvement and targets for 2023/24.		
StARS Q1 Progress Report July 2023	The Deputy Chief Nurse presented the StARS quarterly report including confirmation of assessments completed and current assessment ratings.	Positive assurance on review of accreditation standards and that the process is fit for purpose. Newly introduced StARS assessments provided limited assurance for Maternity Services recognising the standards monitored were out with those of the national safety reporting which provided positive assurance. There were no significant safety concerns. Improving assurance for medicines management in both acute and community although remaining a key theme. Also triangulating with EoLC theme. Positive assurance on increasing maturity of the system and analysis of data and triangulation of the StARS metrics with performance information. The committee were updated on the introduction of 'Blue Star' Accreditations to recognise continued and embedded improvement	Continue with roll out and reporting	

Patient Engagement Update **July 2023**	The Chief Nurse presented a report in response to a query from the Quality Committee about the Trust's current approach to patient engagement and involvement.	The contextual content of the report was well received. Further, and ongoing assurance, was required to confirm reporting arrangements of patient engagement activities provided adequate assurance that the Trust was comprehensively delivering on its responsibilities.	The Chief Nurse to confirm and consider capacity for, the development of a patient engagement repository with the Director of Communications & Corporate Affairs	TBC
Integrated Performance Report – Quality & Safety June & July 2023	The IPR Report was presented, reviewed, and noted. Assurance was reviewed and agreed, and further actions and focus agreed.	The Committee identified that the IPR triangulates with assurances on performance identified throughout the meeting, with remaining metrics considered by exception. This reporting period did not include Hospital Standard Mortality Rate (although presented in the EoLC deep dive). SFT continue to remain outside the control limit. The only GM Trust in the Red zone. Limited continued assurance on Sepsis antibiotic administration standard which continues to deteriorate. Further request to seek learning from other organisations Positive assurance on response time to complaints (100% in some divisions) Division of Surgery remain an outlier. *C-Difficile* trajectory above target a GM collaborative initiative established for quality improvement on this metric.	IPR Escalated to Board as part of Trust IPR Associate Medical Director to explore best practise in other GM Trusts	June 2023 Oct 2023 (Revised)

Annual Research and Development and Innovation Report **June 2023**	Quality Committee reviewed and confirmed the Annual Research, Development & Innovation Report 2022/23	Positive assurance		
Clinical Audit Annual Report June 2023	The Quality Committee reviewed and confirmed the Clinical Audit Forward Programme for 2023/24, noting key issues in relation to the programme would be provided via the Clinical Effectiveness Group Key Issues Report to Quality Committee.	Positive assurance		
Patient Safety Incident Response Plan	The Deputy Director of Quality Governance confirmed that at the end of September 2023 the Trust would transition from the Serious Incident Framework (SIF 2015) to the Patient Safety Incident Response Framework (PSIRF), in relation to management of patient safety incidents.	Positive assurance of engagement with key stakeholders including governors in the development of the plan. Positive assurance on significant progress ahead of national PSIRF replacing the SI Framework in October 2023. Assurance of an iterative approach to the plan during its implementation		
Safeguarding	The Head of Safeguarding presented the Annual Report and the Safeguarding Plan 2023 – 2026	Positive assurance on activity and improvement across a wide range of Safeguarding initiatives both for SFT and across the wider Stockport and GM Partners. Positive assurance on workforce.	Safeguarding Report 2022/23 to be presented to the Board of Directors in August 2023 prior to publication.	Aug 2023
Annual PALS & Complaints Report 2022/23	The Deputy Director of Quality Governance presented the This report provides a summary of activity within the PALS & Complaints Team 2022-2023.	Assurance on triangulation of formal complaints, incidents and inquests form part of any complaint investigation.	Standardisation of compliments narrative and complaints data, to	TBC

		Negative assurance with an increase in formal and informal complaints in year.	establish learning from both.	
Key Issues Reports June & July 2023	The following Key Issues Reports were presented to the committee: • Patient Safety Group Key Issues Report – Medical Director • Patient Experience Group Key Issues Report – Deputy Chief Nurse • Trust Integrated Safeguarding Group (TISG) Key Issues & Assurance Report Head of safeguarding	Quality Committee reviewed and confirmed the reports. Items of limited assurance and risk have been covered by exception within other Quality Committee reports.		

Stockport NHS Foundation Trust

Meeting date	27 June 2023	x	Public		Confidential	Agenda item
Meeting	Quality Committee					
Title	Local Maternity and Neonatal System (LMNS) safety assurance return.					
Lead Director	Andrew Loughney, Medical Director Nic Firth, Chief Nurse		Author	Divisional Director of Midwifery & Nursing / Deputy Head of Midwifery/ Business Planning Manager		

Recommendations made / Decisions requested

Quality Committee will receive the quarterly safety assurance return as required to be submitted to the LMNS.

The Quality Committee is asked to review and confirm update on progress.

This paper relates to the following Corporate Annual Objectives-

x	1	Deliver safe accessible and personalised services for those we care for
	2	Support the health and wellbeing needs of our communities and staff
	3	Develop effective partnerships to address health and wellbeing inequalities
x	4	Drive service improvement, through high quality research, innovation and transformation
	5	Develop a diverse, capable and motivated workforce to meet future service and user needs
	6	Use our resources in an efficient and effective manner
	7	Develop our Estate and Digital infrastructure to meet service and user needs

The paper relates to the following CQC domains-

x	Safe	x	Effective
x	Caring	x	Responsive
x	Well-Led		Use of Resources

This paper is related to these BAF risks	x	**PR1.1**	There is a risk that the Trust does not deliver high quality of care to service users, which may lead to suboptimal patient safety, effectiveness and/or experience and failure to meet regulatory standards
		PR1.2	There is a risk that patient flow across the locality is not effective which may lead to potential harm, suboptimal user experience, and inability to achieve national standards for urgent and elective care
		PR1.3	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan which may lead to suboptimal patient safety, outcomes and user experience and inability to achieve national standards for planned care
		PR2.1	There is a risk that the Trust fails to sufficiently engage and support our people, which may lead to low morale, higher turnover & sickness absence and gaps in the workforce that may impact on delivery of high-quality care
		PR2.2	There is a risk that the Trust's community services do not fully support neighbourhood working which may lead

			to suboptimal improvement in neighbourhood population health
		PR3.1	There is a risk in approving and implementing a new Provider Collaborative model to support delivery of priorities/objectives of the Stockport's ONE Health & Care (Locality) Board which may lead to a delay in delivery of models of care which support improvements in population health and operational recovery following the pandemic
		PR3.2	There is a risk that the Trust does not deliver a joint Clinical Strategy with East Cheshire NHS Trust (ECT), which may lead to suboptimal pathways of care and/or limited service resilience across the footprint of both Trusts
		PR4.1	There is a risk that the Trust does not implement high quality research & transformation programmes which may lead to suboptimal service improvements
		PR5.1	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit the optimal number of staff, with appropriate skills and values, which may lead to suboptimal staff and patient experience
		PR5.2	There is a risk that the Trust fails to have a workforce that is reflective of the communities served which may lead to staff with a protected characteristic having a suboptimal staff experience (career progression, turnover) and a poorer patient experience
		PR6.1	There is a risk that the Trust does not deliver the 2022/23 financial plan which may lead to a poor use of resources and increased regulatory intervention
		PR6.2	There is a risk that the Trust does not develop and agree with partners a multi-year financial recovery plan, optimising opportunities for financial recovery through system working, which may lead to a lack of financial sustainability
		PR7.1	There is a risk that the Trust does not implement the Digital Strategy designed to ensure a resilient and responsive digital infrastructure which may lead to inability to support improvements in quality of care and compromise of data/information
		PR7.2	There is a risk that the estate is not fit for purpose and/or meets national standards which may lead to inefficient utilisation of the estate to support high quality of care and increased health & safety incidents
		PR7.3	There is a risk that the Trust does not materially improve environmental sustainability which may lead to suboptimal support to locality ambitions and the NHS commitment to carbon reduction
		PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus which may lead to an adverse long term impact on the Trust's capability to deliver modern and effective care

Where issues are addressed in the paper-

	Section of paper where covered
Equality, diversity and inclusion impacts	
Financial impacts if agreed/ not agreed	
Regulatory and legal compliance	
Sustainability (including environmental impacts)	

Executive Summary

The trust is required to update the LMNS on progress with Ockenden, East Kent and the single plan recommendations.

The LMNS has a responsibility to improve oversight and safety assurance across Maternity Services in in Greater Manchester and East Cheshire (GMEC), as recommended by the National Quality Board on Systems Group and the revised Perinatal Quality Surveillance Model, to ensure that safer outcomes for pregnant women/Birthing people and babies are achieved.

The system has introduced a quarterly Safety Progress and Performance Special Interest Group (SPP SIG) to demonstrate that these principles are implemented into the LMNS governance structure.

Annex A Is the Ockenden - Kirkup return 2023 demonstrating the Trusts level of implementation to date.

The return will be presented on a quarterly basis to Quality Committee and Board of Directors as required.

1. Purpose

1.1 The purpose of this paper is to give an overview of the requirements of the LMNS from the Trust in providing assurance against the progress of Ockenden, East Kent and the proposed single plan.

2. Background and Links to Previous Papers

2.1 The Local Maternity and Neonatal System (LMNS) has a responsibility to improve oversight and safety assurance across Maternity Services in Greater Manchester and East Cheshire (GMEC), as recommended by the National Quality Board on Systems Group and the revised Perinatal Quality Surveillance Model, to ensure that safer outcomes for pregnant women/Birthing people and babies are achieved.

2.2 The LMNS as a result has developed a Safety Progress and Performance Special Interest Group (SPP) where Trusts are required to provide a quarterly update on progress against recommendations and actions from the national reports.

2.3 This paper links with the information provided in the quarterly maternity services update report to Quality Committee, which includes progress and actions in relation to the national reports.

3. Matters under consideration.

3.1 This is the second quarterly data return where the trust will share progress with the LMNS against the Ockenden and Kirkup recommendations and immediate and essential actions.

3.2 The trust has declared full compliance against the recommendations in the Kirkup report, apart from full compliance against questions 28;

- Ensure that staff undertaking incident investigations have received appropriate education and training to undertake this effectively
    - All consultants to have completed RCA training.
    - Develop a local record of staff who have completed RCA training and the investigations undertaken (including dates)

- The trust had previously declared full compliance with this question. It has been acknowledged that as Trusts are moving towards the Patient Safety Incidence Response Framework (PSIRF) for responding to patient safety incidents, this question is no longer relevant. Consultants will complete PSIRF training and a local record of staff who have completed PSIRF training will be developed to monitor compliance.

3.3 The trust has declared **full compliance** against **43** of the **48** questions relating to the 7 immediate and essential actions from the initial Ockenden report (Appendix A has the full breakdown of all questions).

The remaining **5** questions are currently **partially compliant.** A summary of these questions with associated actions is outlined in the table below.

IEA	Question	Evidence Required	RAG Rating	Action/Info
IEA4 Managing Complex Pregnancy	**Q28.** All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.	Submission of an audit plan to regularly audit compliance		Currently undertaking Audits adhoc. Robust audit plan due for completion and implementation end of May 2023
IEA5 Risk assess throughout pregnancy	**Q30.** All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional **Q31** Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture. **Q33** A risk assessment at every contact. Include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance.	Personal and support plans are in place and an ongoing audit of 1% of records that demonstrate compliance of the above		Currently undertaking Audits adhoc. Robust audit plan due for completion and implementation end of May 2023
	Q42. Women's choices following a shared and informed decision-making process must be respected	An Audit of 5% of notes demonstrating compliance		Currently undertaking Audits adhoc. Robust audit plan due for completion and implementation end of May 2023

4. Recommendations

4.1 Quality Committee is asked to note the contents of the report and the trusts progress against national maternity reports.

Completion Guidance:		
Please complete each tab demonstrating your level of implementation at the time of reporting		
Tab:		
1	**Submission Overiew**	Please complete in full
2	**Ockenden return**	This mirrors earlier returns and requires updating on progress up to the date of competion - Please report on your percentage of compliance. It will RAG rate automatically.
3	**Kirkup return**	Please note some recommendations have been greyed out – these do not require completion as they are superseded by information in the Ockenden recommendations.
4	**Kirkup recommendations**	Details the Kirkup recommendations as a helpful reminder – this doesn't require any completion.

Internal trust governance

	Confirmation of / or planned Public Trust Board update on progress against the Ockenden action plan	Date of Public Board update	Executive sign off of this return		
	Yes/No	please insert date	**Date**	**Name**	**Role**
Stockport NHS FT	Y	06/04/2023	02/03/2023	Nicola Firth	Chief Nurse
Stockport NHS FT	Y		22/05/2023	Nicola Firth	Chief Nurse
Insert Trust Name					
Insert Trust Name					

Submission dates	**Meeting Dates**
Monday 27th February 2023	Tuesday 7th March 2023
Wednesday 19th April 2023	Wednesday 26th April 2023
Wednesday 19th July 2023	Wednesday 26th July 2023
Thursday 19th October 2023	Wednesday 25th October 2023
Wednesday 24th January 2024	Friday 19th January 2024

Ockenden Initial report recommendations

IEA	Question	Action	Evidence Required	GMEC August 2021 Submission - STOCKPORT NHS FOUNDATION TRUST	GMEC March 2022 - STOCKPORT NHS FOUNDATION TRUST	Isight Visit Date of insight visit to populate	Self Report with % of compliance Report to LMNS by 27th February 2023	Details of action to be taken if partially or not compliant	Self Report with % of compliance Report to LMNS by 19th April 2023	Details of action to be taken if partially or not compliant	Initial Self Report with % of compliance Report to LMNS by 19th July 2023	Details of action to be taken if partially or not compliant
IEA1 Enhanced Safety	Q1	Are maternity dashboards a formal item on LMNS agendas at least every 3 months?	Dashboard to be shared as evidence.	100%	100%		100%		100%			
			Minutes and agendas to identify regular review and use of common data dashboards and the response / actions taken.	100%	100%		100%		100%			
			SOP required which demonstrates how the trust reports this both internally and externally through the LMS.	100%	100%		100%		100%			
			Submission of minutes and organogram, that shows how this takes place.	100%	100%		100%		100%			
		Maternity Dashboard to LMS every 3 months Total		**100%**	**100%**		100%		100%			
	Q2	External clinical specialist opinion for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death	Audit to demonstrate this takes place.	0%	100%		100%		100%			
			Policy or SOP which is in place for involving external clinical specialists in reviews.	100%	100%		100%		100%			
		External clinical specialist opinion for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death Total		**50%**	**100%**		100%		100%			
	Q3	Maternity SI's to Trust Board & LMS every 3 months	Individual SI's, overall summary of case, key learning, recommendations made, and actions taken to address with clear timescales for completion	100%	100%		100%		100%			
			Submission of private trust board minutes as a minimum every three months with highlighted areas where SI's discussed	100%	100%		100%		100%			
			Submit SOP	0%	100%		100%		100%			
		Maternity SI's to Trust Board & LMS every 3 months Total		**67%**	**100%**		100%		100%			
	Q4	Using the National Perinatal Mortality Review Tool to review perinatal deaths	Audit of 100% of PMRT completed demonstrating meeting the required standard including parents notified as a minimum and external review.	100%	100%		60%		100%			
			Local PMRT report. PMRT trust board report. Submission of a SOP that describes how parents and women are involved in the PMRT process as per the PMRT guidance.	100%	100%		100%		100%			
		Using the National Perinatal Mortality Review Tool to review perinatal deaths Total		**100%**	**100%**		60%		100%			
	Q5	Submitting data to the Maternity Services Dataset to the required standard	Evidence of a plan for implementing the full MSDS requirements with clear timescales aligned to NHSR requirements within MIS.	100%	100%		100%		100%			
		Submitting data to the Maternity Services Dataset to the required standard Total		**100%**	**100%**		100%		100%			
	Q6	Reported 100% of qualifying cases to HSIB / NHS Resolution's Early Notification scheme	Audit showing compliance of 100% reporting to both HSIB and NHSR Early Notification Scheme.	100%	100%		100%		100%			
		Reported 100% of qualifying cases to HSIB / NHS Resolution's Early Notification scheme Total		**100%**	**100%**		100%		100%			
	Q7	Plan to implement the Perinatal Clinical Quality Surveillance Model	Full evidence of full implementation of the perinatal surveillance framework by June 2021.	100%	100%		100%		100%			
			LMS SOP and minutes that describe how this is embedded in the ICS governance structure and signed off by the ICS.	100%	100%		100%		100%			
			Submit SOP and minutes and organogram of organisations involved that will support the above from the trust, signed of via the trust governance structure.	0%	100%		100%		100%			
		Plan to implement the Perinatal Clinical Quality Surveillance Model Total		**67%**	**100%**		100%		100%			
	Q8	**Same as Q3**										
IEA1 Total				**81%**								
	Q9	**N/A**										
	Q10	**N/A**										
	Q11	Non-executive director who has oversight of maternity services, (Is there an allocated Non-Executive at Board level who works collaboratively with the maternity safety champions?)	Evidence of how all voices are represented:	100%	100%		100%		100%			
			Evidence of link in to MVP; any other mechanisms	100%	100%		100%		100%			
			Evidence of NED sitting at trust board meetings, minutes of trust board where NED has contributed	100%	100%		100%		100%			
			Evidence of ward to board and board to ward activities e.g. NED walk arounds and subsequent actions	100%	100%		100%		100%			
			Name of NED and date of appointment	100%	100%		100%		100%			
			NED JD	100%	100%		100%		100%			
		Non-executive director who has oversight of maternity services Total		**100%**	100%		100%		100%			

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IEA2 Listening to Women and Families	Q12	Same as Q4										
	Q13	Demonstrate mechanism for gathering service user feedback, and work with service users through Maternity Voices Partnership to coproduce local maternity services	Clear co-produced plan, with MVP's that demonstrate that co production and co-design of service improvements, changes and developments will be in place and will be embedded by December 2021.	100%	100%		100%		100%			
			Evidence of service user feedback being used to support improvement in maternity services (E.G you said, we did, FFT, 15 Steps)	100%	100%		100%		100%			
			Please upload your CNST evidence of co-production. If utilised then upload completed templates for providers to successfully achieve maternity safety action 7. CNST templates to be signed off by the MVP.	100%	100%		100%		100%			
		Demonstrate mechanism for gathering service user feedback, and work with service users through Maternity Voices Partnership to coproduce local maternity services Total		**100%**	100%		100%		100%			
	Q14	Trust safety champions (Midwifery and Obstetrician) meeting bimonthly with Board level champions	Action log and actions taken.	100%	100%		100%		100%			
			Log of attendees and core membership.	100%	100%		100%		100%			
			Minutes of the meeting and minutes of the LMS meeting where this is discussed.	100%	100%		100%		100%			
			SOP that includes role descriptors for all key members who attend by-monthly safety meetings.	0%	100%		100%		100%			
		Trust safety champions meeting bimonthly with Board level champions Total		**75%**	**100%**		100%		100%			
	Q15	Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services.	Clear co produced plan, with MVP's that demonstrate that co-production and co-design of all service improvements, changes and developments will be in place and will be embedded by December 2021.	100%	100%		100%		100%			
		Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services. Total		**100%**	**100%**		100%		100%			
	Q16	Non-executive director support the Board maternity safety champion	Evidence of participation and collaboration between ED, NED and Maternity Safety Champion, e.g. evidence of raising issues at trust board, minutes of trust board and evidence of actions taken	0%	100%		100%		100%			
			Name of ED and date of appointment	100%	100%		100%		100%			
			Role descriptors	100%	100%		100%		100%			
		Non-executive director support the Board maternity safety champion Total		**67%**	**100%**		100%		100%			
IEA2 Total				**88%**	**100%**							
	Q17	Multidisciplinary training and working occurs. Evidence must be externally validated through the LMNS, 3 times a year via TNA Template.	A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	100%	100%		100%		100%			
			LMNS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data.	0%	50%		100%		100%			
			Submit evidence of training sessions being attended, with clear evidence that all MDT members are represented for each session.	100%	100%		100%		100%			
			Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements.	100%	100%		100%		100%			
			Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place.	100%	100%		100%		100%			
		Multidisciplinary training and working occurs. Evidence must be externally validated through the LMS, 3 times a year. Total		**80%**	**100%**		100%		100%			
	Q18	Twice daily consultant-led and present multidisciplinary ward rounds on the labour ward.	Evidence of scheduled MDT ward rounds taking place since December, twice a day, day & night. 7 days a week (e.g. audit of compliance with SOP)	100%	75%		75%		100%			
			SOP created for consultant led ward rounds.	0%	100%		100%		100%			
		Twice daily consultant-led and present multidisciplinary ward rounds on the labour ward. Total		**50%**	**75%**		75%		100%			
		External funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only	Confirmation from Directors of Finance	0%	100%		100%		100%			
			Evidence from Budget statements.	100%	100%		100%		100%			
			Evidence of funding received and spent.	100%	100%		100%		100%			

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IEA3 Staff Training and working together	Q19		Evidence that additional external funding has been spent on funding including staff can attend training in work time.	100%	100%		100%		100%			
			MTP spend reports to LMS	0%	100%		100%		100%			
		External funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only Total		**60%**	**100%**		100%		100%			
	Q20	**N/A**							100%			
	Q21	90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session	A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	100%	100%		100%		100%			
			Attendance records - summarised	100%	100%		100%		100%			
			LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data. Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place.	0%	50%		100%		100%			
		90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session Total		**67%**	**100%**		100%		100%			
	Q22	Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.	Evidence of scheduled MDT ward rounds taking place since December 2020 twice a day, day & night; 7 days a week (E.G audit of compliance with SOP)	100%	75%		75%		100%			
		Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week. Total		**100%**	**75%**		75%		100%			
	Q23	Is MDT schedule for training in place?	A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	100%	100%		100%		100%			
			LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation described as checking the accuracy of the data.	0%	50%		100%		100%			
		The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place Total		**50%**	**100%**		100%		100%			
IEA3 Total				**67%**					100%			
IEA4 Managing Complex Pregnancy	Q24	Links with the tertiary level Maternal Medicine Centre & agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre	Audit that demonstrates referral against criteria has been implemented that there is a named consultant lead, and early specialist involvement and that a Management plan that has been agreed between the women and clinicians	0%	100%		100%		100%			
			SOP that clearly demonstrates the current maternal medicine pathways that includes: agreed criteria for referral to the maternal medicine centre pathway.	100%	100%		100%		100%			
		Links with the tertiary level Maternal Medicine Centre & agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre Total		**50%**	**100%**		100%		100%			
	Q25	Women with complex pregnancies must have a named consultant lead	Audit of 1% of notes, where all women have complex pregnancies to demonstrate the woman has a named consultant lead	100%	100%		100%		100%			
			SOP that states that both women with complex pregnancies who require referral to maternal medicine networks and women with complex pregnancies but who do not require referral to maternal medicine network must have a named consultant lead.	100%	100%		100%		100%			
		Women with complex pregnancies must have a named consultant lead Total		**100%**	**100%**		100%		100%			
	Q26	Complex pregnancies have early specialist involvement and management plans agreed	Audit of 1% of notes, where women have complex pregnancies to ensure women have early specialist involvement and management plans are developed by the clinical team in consultation with the woman.	100%	100%		100%		100%			
			SOP that identifies where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the teams.	100%	100%		100%		100%			
		Complex pregnancies have early specialist involvement and management plans agreed Total		**100%**	**100%**		100%		100%			
	Q27	Compliance with all five elements of the Saving Babies' Lives care bundle Version 2	Audits for each element.	100%	100%		100%		100%			
			Guidelines with evidence for each pathway	100%	100%		100%		100%			

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			SOP's	100%	100%		100%		100%			
		Compliance with all five elements of the Saving Babies' Lives care bundle Version 2 Total		**100%**	**100%**		100%		100%			
	Q28	All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.	SOP that states women with complex pregnancies must have a named consultant lead.	100%	100%		100%		100%			
			Submission of an audit plan to regularly audit compliance	100%	100%		50%		50%	**Currently undertaking Audits adhoc. Robust audit plan due for completion and implemenation end of May 2023**		
		All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place. Total		**100%**	**100%**		50%		50%			
	Q29	Do you have agreed maternal medicine specialist centre?	Agreed pathways	100%	100%		100%		100%			
			Criteria for referrals to MMC	100%	100%		100%		100%			
			The maternity services involved in the establishment of maternal medicine networks evidenced by notes of meetings, agendas, action logs.	100%	100%		100%		100%			
		Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres Total		**100%**	**100%**		100%		100%			
IEA4 Total				**93%**	**100%**							
	Q30	All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional	How this is achieved within the organisation.	100%	100%		100%		100%			
			Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above.	100%	100%		50%		50%	**Currently undertaking Audits adhoc. Robust audit plan due for completion and implemenation end of May 2023**		
			Review and discussed and documented intended place of birth at every visit.	100%	100%		100%		100%			
			SOP that includes definition of antenatal risk assessment as per NICE guidance.	0%	100%		100%		100%			
			What is being risk assessed.	0%	100%		100%		100%			
		All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional Total		**60%**	**100%**		75%		80%			
IEA5 Risk assess throughout pregnancy	Q31	Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.	Evidence of referral to birth options clinics	100%	100%		100%		100%			
			Out with guidance pathway.	100%	100%		100%		100%			
			Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above.	100%	100%		50%		50%	**Currently undertaking Audits adhoc. Robust audit plan due for completion and implemenation end of May 2023**		
			SOP that includes review of intended place of birth.	0%	100%		100%		100%			
		Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture. Total		**75%**	**100%**		75%		75%			
	Q32	**Same as Q27**										
	Q33	A risk assessment at every contact. Include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance.	Example submission of a Personalised Care and Support Plan (It is important that we recognise that PCSP will be variable in how they are presented from each trust)	100%	100%		100%		100%			
			How this is achieved in the organisation	100%	100%		100%		100%			
			Personal Care and Support plans are in place and an ongoing audit of 5% of records that demonstrates compliance of the above.	100%	100%		50%		50%	**Currently undertaking Audits adhoc. Robust audit plan due for completion and implemenation end of May 2023**		
			Review and discussed and documented intended place of birth at every visit.	100%	100%		100%		100%			
			SOP to describe risk assessment being undertaken at every contact.	0%	100%		100%		100%			
			What is being risk assessed.	0%	100%		100%		100%			
		A risk assessment at every contact. Include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance. Total		**67%**	**100%**		83%		83%			
IEA5 Total				**67%**	**100%**							
	Q34	Appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring	Copies of rotas / off duties to demonstrate they are given dedicated time.	0%	100%		100%		100%			
			Examples of what the leads do with the dedicated time E.G attendance at external fetal wellbeing event, involvement with training, meeting minutes and action logs.	100%	100%		100%		100%			

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IEA6 Monitoring Fetal Wellbeing			Incident investigations and reviews	100%	100%		100%		100%			
			Name of dedicated Lead Midwife and Lead Obstetrician	100%	100%		100%		100%			
		Appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring Total		**75%**	**100%**		100%		100%			
	Q35	The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on elements of fetal health	Consolidating existing knowledge of monitoring fetal wellbeing	100%	100%		100%		100%			
			Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported e.g clinical supervision	0%	100%		100%		100%			
			Improving the practice & raising the profile of fetal wellbeing monitoring	0%	100%		100%		100%			
			Interface with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.	0%	100%		100%		100%			
			Job Description which has in the criteria as a minimum for both roles and confirmation that roles are in post	100%	100%		100%		100%			
			Keeping abreast of developments in the field	0%	100%		100%		100%			
			Lead on the review of cases of adverse outcome involving poor FHR interpretation and practice.	100%	100%		100%		100%			
			Plan and run regular departmental fetal heart rate (FHR) monitoring meetings and training.	0%	100%		100%		100%			
		The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on elements of fetal health Total		**38%**	100%		100%		100%			
	Q36	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	Audits for each element	100%	100%		100%		100%			
			Guidelines with evidence for each pathway	100%	100%		100%		100%			
			SOP's	100%	100%		100%		100%			
		Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2? Total		**100%**	100%		100%		100%			
	Q37	Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?	A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	100%	100%		100%		100%			
			Attendance records - summarised	100%	100%		100%		100%			
			Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements.	100%	100%		100%		100%			
		Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019? Total		**100%**	100%		100%		100%			
	Q38	**Same as 35**										
IEA6 Total				**67%**	**100%**							
	Q39	Trusts ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery	Information on maternal choice including choice for caesarean delivery.	100%	**100%**		100%		100%			
			Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites.	100%	**100%**		100%		100%			
		Trusts ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery Total		**100%**	**100%**		100%		100%			
	Q40	Do you have Do you have accessible information to enable accurate evidence based information including all care AN, Intrapartum & PN?	Demonstration of the information service users can access for evidence based information in all formats	100%	**100%**		100%		100%			
			Demonstration of the information service users can access for evidence based information in all	100%	**100%**		100%		100%			
			MVP review of information	100%	**100%**		100%		100%			
		Do you have Do you have accessible information to enable accurate evidence based information including all care AN, Intrapartum & PN?		**100%**	**100%**		100%		100%			

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	Q41	Women must be enabled to participate equally in all decision-making processes	An audit of 1% of notes demonstrating compliance.						50%	Currently undertaking Audits adhoc. Robust audit plan due for completion and implemenation end of May 2023		
			CQC survey and associated action plans						100%			
			SOP which shows how women are enabled to participate equally in all decision making processes and to make informed choices about their care, and where that is recorded.						25%	SOP in development		
		Women must be enabled to participate equally in all decision-making processes Total							50%			
	Q42	Women's choices following a shared and informed decision-making process must be respected	An audit of 5% of notes demonstrating compliance, this should include women who have specifically requested a care pathway which may differ from that recommended by the clinician during the antenatal period, and also a selection of women who request a caesarean section during labour or induction.	0%	100%		50%		50%	Currently undertaking Audits adhoc. Robust audit plan due for completion and implemenation end of May 2023		
			SOP to demonstrate how women's choices are respected and how this is evidenced following a shared and informed decision-making process, and where that is recorded.	100%	100%		100%		100%			
		Women's choices following a shared and informed decision-making process must be respected Total		**50%**	**100%**		50%		50%			
	Q43	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?	Clear co produced plan, with MVP's that demonstrate that co production and co-design of all service improvements, changes and developments will be in place and will be embedded by December 2021.	100%	100%		100%		100%			
			Evidence of service user feedback being used to support improvement in maternity services (E.G you said, we did, FFT, 15 Steps)	100%	100%		100%		100%	IOL survry		
			Please upload your CNST evidence of co-production. If utilised then upload completed templates for providers to successfully achieve maternity safety action 7. CNST templates to be signed off by the MVP.	100%	100%		100%		100%			
		Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services? Total		**100%**	**100%**		100%		100%			
	Q44	Pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website.	Co-produced action plan to address gaps identified	100%	100%		100%		100%			
			Gap analysis of website against Chelsea & Westminster conducted by the MVP	100%	100%		100%		100%			
			Information on maternal choice including choice for caesarean delivery.	100%	100%		100%		100%			
			Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites.	100%	100%		100%		100%			
		Pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. Total		**100%**	**100%**		100%		100%			
IEA7 Total				**93%**	**100%**				100%			
	Q45	Demonstrate an effective system of clinical workforce planning to the required standard	Consider evidence of workforce planning at LMS/ICS level given this is the direction of travel of the people plan	100%	100%		100%		100%			
			Evidence of reviews 6 monthly for all staff groups and evidence considered at board level.	100%	100%		100%		100%			
			Most recent BR+ report and board minutes agreeing to fund.	100%	100%		100%		100%			
		Demonstrate an effective system of clinical workforce planning to the required standard Total		**100%**	**100%**		100%		100%			
	Q46	Demonstrate an effective system of midwifery workforce planning to the required standard?	Most recent BR+ report and board minutes agreeing to fund.	100%	100%		100%		100%			
		Demonstrate an effective system of midwifery workforce planning to the required standard? Total		**100%**	**100%**		100%		100%			
	Q47	Director/Head of Midwifery is responsible and accountable to an executive director	HoM/DoM Job Description with explicit signposting to responsibility and accountability to an executive director	100%	100%		100%		100%			
		Director/Head of Midwifery is responsible and accountable to an executive director Total		**100%**	**100%**		100%		100%			
WF		Describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care:	Action plan where manifesto is not met	100%	100%		75%		100%			
			Gap analysis completed against the RCM strengthening midwifery leadership: a manifesto for better maternity care	100%	100%		75%		100%			

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	Q48		1. A Director of Midwifery in every trust and health board, and more Heads of Midwifery across the service						100%	Divisional Director of Midwifery in post with a Deputy Head of Midwifery.		
			2. A lead midwife at a senior level in all parts of the NHS, both nationally and regionally						100%			
			3. More Consultant midwives						0%	Currently no Consultant Midwife		
			4. Specialist midwives in every trust and health board						100%			
			5. Strengthening and supporting sustainable midwifery leadership in education and research						100%			
			6. A commitment to fund ongoing midwifery leadership development						100%			
			7. Professional input into the appointment of midwife leaders						100%			
	Q49	**Describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care. Total**		**100%**	**100%**		75%					
		Providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate.	Audit to demonstrate all guidelines are in date.	100%	100%		100%		100%			
			Evidence of risk assessment where guidance is not implemented.	0%	100%		100%		100%			
			SOP in place for all guidelines with a demonstrable process for ongoing review.	0%	100%		100%		100%			
		Providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Total		**33%**	**100%**		100%		100%			
WF Total				**80%**	**100%**				92%			

Kirkup report recommendations
Regional Update

Key :

RAG Rate : Green = Complete.
Amber = Partial compiant
Red = Not compliant

Those that are greyed out are superseded by Ockenden and do not need completing on this tab.

Kirkup Action no.	Relating to Kirkup Recommendation (see Kirkup Recommendations tab for further information)	Action	Suggested documents that may support Trust assurance.	GMEC STOCKPORT NHS FOUNDATION TRUST	Report to LMNS by 27th February 2023	Report to LMNS by 19th April 2023	Report to LMNS by 19th July 2023
6	R2	Obtain feedback from midwives and nurses who have recently completed a preceptorship programme to identify any improvements that can be made to the programme	Utilise PMA feedback	Green	Green	Green	
7		Review the skills of Band 6 midwives to identify and address any training needs to ensure a competent and motivated workforce	Develop a robust support package for new band 6 midwives	Green	Green	Green	
	R2, R3		Completion of the Mentoring module	Green	Green	Green	
			Suturing competency	Green	Green	Green	
			IV therapy competency	Green	Green	Green	
			Care of women choosing epidural anaesthesia.	Green	Green	Green	
8		Review the current induction and orientation process for midwives and nurses joining the organisation at Band 6 to ensure they are competent and confident to provide care	Practice educator reports and feedback	Green	Green	Green	
11	R2	Review the provision of maternal AIMS courses and ensure that all places are allocated appropriately and staff attend the session.	Practice educator meeting notes, discussion with DoMS/HoMs	Green	Green	Green	
12	R2	Review the educational opportunities available for staff working in postnatal areas to increase their understanding of the compromised neonate, including consideration of bespoke educational sessions and HEI courses e.g. Care of the compromised baby module at University of Salford	Practice educator reports and feedback	Green	Green	Green	
13	R2	Improve staff knowledge, response time and escalation processes in relation to a woman's deteriorating condition	Incident review and feedback, related lessons learnt, training opportunities	Green	Green	Green	
14	R2	Implement a process for cascading learning points generated from incidents or risk management in each clinical area e.g. email to staff, noticeboard, themed week / message of the week, core huddles, NICU news	Weekly Safety Huddles, Hot Topics, Governance Boards, Monthly Governance updates	Green	Green	Green	
17	R3	Review the support provided when staff are allocated to a new clinical area and what supernumerary actually means in order to manage staff expectations		Green	Green	Green	
18	R3	Offer opportunities to other heads of service for staff from other trusts to broaden their experience by secondment or supernumerary status					
19	R5	Develop a list of current MDT meetings and events and share with staff across the directorate					
20	R8	Develop and implement a recruitment and retention strategy specifically for the obstetric directorate	Employment of a Recruitment and Retention Midwife	Green	Green	Green	
21		Review the current midwifery staffing establishment to ensure appropriate staffing levels in all clinical areas					
22		Ensure that all staff who leave are offered an exit interview with a senior member of staff and use the information gained from these interviews to inform changes aimed at improving retention		Green	Green	Green	
23		Provide Staff Forum meetings where staff are encouraged to attend and discuss concerns	Ward Meetings, Professional Midwifery Advocates drop in sessions and clinical supervision	Green	Green	Green	
24	Only applicable to multi-site trusts.	Improve working relationships between the different sites located geographically apart but under the same organization.					
25	R9	Reiterate to all staff via email and team meetings the roles and responsibilities of the consultant obstetrician carrying the hot week bleep.					
26	R11, R12	Ensure that staff receive education during their induction regarding the incident reporting process including the process for reporting incidents, the incidents that should be reported and the rationale for learning from incidents.		Green	Green	Green	
27	R11, R12	Including a review of the processes for disseminating and learning from incidents					
28		Ensure that staff undertaking incident investigations have received appropriate education and training to undertake this effectively	All consultants to have completed RCA training	Green	Amber	Amber	
			Identified midwives to have completed RCA training	Green	Green	Green	
			Staff who have completed RCA training undertake an investigation within 1 year and regularly thereafter in order to maintain their skills	Green	Green	Green	
			Develop a local record of staff who have completed RCA training and the investigations undertaken (including dates)	Green	Amber	Amber	
29	R12	Ensure that the details regarding staff debriefing and support are completed on the Trust incident reporting system for all level 4 and 5 incidents					
30	R12	Ensure that all Serious Incidents (SI's)are fedback to the staff					
31	R12	Identify ways of improving attendance of midwives at SI's feedback sessions					
32	R13	Maternity Services Liaison Committee involvement in complaints	Collation of complaints reports				
33	R14	Review the current obstetric clinical lead structure					
34	R15	Review past SI's and map common themes	Thematic reviews				
35	R23	Ensure that maternal deaths, late and intrapartum stillbirths and unexpected neonatal deaths are reported, reviewed and an investigation undertaken where appropriate	Maternal deaths, stillbirths and early neonatal deaths reports				
36	R26	Ensure that all staff are aware of how to raise concerns	Whistle blowing staff policy	Green	Green	Green	
37	R31	Provide evidence of how we deal with complaints		Green	Green	Green	
38	R31	Educate staff regarding the process for local resolution and support staff to undertake this process in their clinical area	Identifying situations where local resolution is required	Green	Green	Green	
39	R32	Develop a plan to maintain a supervision system beyond the decommissioning of the LSAs once national recommendations have been agreed.	Implementation of the A-AQUIP model				
40	R38	Ensure that all perinatal deaths are recorded appropriately	Sending the completed form to the Deputy Director of Nursing/ Head of Midwifery and the Divisional Clinical Effectiveness Manager				
41	R39	Ensure that Confidential Enquiry reports are reviewed following publication and that an action plan is developed and monitored to ensure that high standards of care are maintained	MBRRACE action plan	Green	Green	Green	

Recommendations from the published Kirkup report

1	The University Hospitals of Morecambe Bay NHS Foundation Trust should formally admit the extent and nature of the problems that have previously occurred, and should apologise to those patients and relatives affected, not only for the avoidable damage caused but also for the length of time it has taken to bring them to light and the previous failures to act. This should begin immediately with the response to this Report.
2	The University Hospitals of Morecambe Bay NHS Foundation Trust should review the skills, knowledge, competencies and professional duties of care of all obstetric, paediatric, midwifery and neonatal nursing staff, and other staff caring for critically ill patients in anaesthetics and intensive and high dependency care, against all relevant guidance from professional and regulatory bodies. This review will be completed by June 2015, and identify requirements for additional training, development and, where necessary, a period of experience elsewhere if applicable
3	The University Hospitals of Morecambe Bay NHS Foundation Trust should draw up plans to deliver the training and development of staff identified as a result of the review of maternity, neonatal and other staff, and should identify opportunities to broaden staff experience in other units, including by secondment and by supernumerary practice. These should be in place in time for June 2015.
4	Following completion of additional training or experience where necessary, the University Hospitals of Morecambe Bay NHS Foundation Trust should identify requirements for continuing professional development of staff and link this explicitly with professional requirements including revalidation. This should be completed by September 2015.
5	The University Hospitals of Morecambe Bay NHS Foundation Trust should identify and develop measures that will promote effective multidisciplinary team-working, in particular between paediatricians, obstetricians, midwives and neonatal staff. These measures should include, but not be limited to, joint training sessions, clinical, policy and management meetings and staff development activities. Attendance at designated events must be compulsory within terms of employment. These measures should be identified by April 2015 and begun by June 2015.
6	The University Hospitals of Morecambe Bay NHS Foundation Trust should draw up a protocol for risk assessment in maternity services, setting out clearly: who should be offered the option of delivery at Furness General Hospital and who should not; who will carry out this assessment against which criteria; and how this will be discussed with pregnant women and families. The protocol should involve all relevant staff groups, including midwives, paediatricians, obstetricians and those in the receiving units within the region. The Trust should ensure that individual decisions on delivery are clearly recorded as part of the plan of care, including what risk factors may trigger escalation of care, and that all Trust staff are aware that they should not vary decisions without a documented risk assessment. This should be completed by June 2015.
7	The University Hospitals of Morecambe Bay NHS Foundation Trust should audit the operation of maternity and paediatric services, to ensure that they follow risk assessment protocols on place of delivery, transfers and management of care, and that effective multidisciplinary care operates without inflexible demarcations between professional groups. This should be in place by September 2015.
8	The University Hospitals of Morecambe Bay NHS Foundation Trust should identify a recruitment and retention strategy aimed at achieving a balanced and sustainable workforce with the requisite skills and experience. This should include, but not be limited to, seeking links with one or more other centre(s) to encourage development of specialist and/or academic practice whilst offering opportunities in generalist practice in the Trust; in addition, opportunities for flexible working to maximise the advantages of close proximity to South Lakeland should be sought. Development of the strategy should be completed by January 2016.
9	The University Hospitals of Morecambe Bay NHS Foundation Trust should identify an approach to developing better joint working between its main hospital sites, including the development and operation of common policies, systems and standards. Whilst we do not believe that the introduction of extensive split-site responsibilities for clinical staff will do much other than lead to time wasted in travelling, we do consider that, as part of this approach, flexibility should be built into working responsibilities to provide temporary solutions to short-term staffing problems. This approach should be begun by September 2015.
10	The University Hospitals of Morecambe Bay NHS Foundation Trust should seek to forge links with a partner Trust, so that both can benefit from opportunities for learning, mentoring, secondment, staff development and sharing approaches to problems. This arrangement is promoted and sometimes facilitated by Monitor as 'buddying' and we endorse the approach under these circumstances. This could involve the same centre identified as part of the recruitment and retention strategy. If a suitable partner is forthcoming, this arrangement should be begun by September 2015.
11	The University Hospitals of Morecambe Bay NHS Foundation Trust should identify and implement a programme to raise awareness of incident reporting, including requirements, benefits and processes. The Trust should also review its policy of openness and honesty in line with the duty of candour of professional staff, and incorporate into the programme compliance with the refreshed policy.
12	The University Hospitals of Morecambe Bay NHS Foundation Trust should review the structures, processes and staff involved in investigating incidents, carrying out root cause analyses, reporting results and disseminating learning from incidents, identifying any residual conflicts of interest and requirements for additional training. The Trust should ensure that robust documentation is used, based on a recognised system, and that Board reports include details of how services have been improved in response. The review should include the provision of appropriate arrangements for staff debriefing and support following a serious incident. This should be begun with maternity units by April 2015 and rolled out across the Trust by April 2016.
13	The University Hospitals of Morecambe Bay NHS Foundation Trust should review the structures, processes and staff involved in responding to complaints, and introduce measures to promote the use of complaints as a source of improvement and reduce defensive 'closed' responses to complainants. The Trust should increase public and patient involvement in resolving complaints, in the case of maternity services through the Maternity Services Liaison Committee. This should be completed, and the improvements demonstrated at an open Board meeting, by December 2015.
14	The University Hospitals of Morecambe Bay NHS Foundation Trust should review arrangements for clinical leadership in obstetrics, paediatrics and midwifery, to ensure that the right people are in place with appropriate skills and support. The Trust has implemented change at executive level, but this needs to be carried through to the levels below. All staff with defined responsibilities for clinical leadership should show evidence of attendance at appropriate training and development events. This review should be commenced by April 2015.
15	The University Hospitals of Morecambe Bay NHS Foundation Trust should continue to prioritise the work commenced in response to the review of governance systems already carried out, including clinical governance, so that the Board has adequate assurance of the quality of care provided by the Trust's services. This work is already underway with the facilitation of Monitor, and we would not seek to vary or add to it, which would serve only to detract from implementation. We do, however, recommend that a full audit of implementation be undertaken before this is signed off as completed.
16	As part of the governance systems work, we consider that the University Hospitals of Morecambe Bay NHS Foundation Trust should ensure that middle managers, senior managers and non-executives have the requisite clarity over roles and responsibilities in relation to quality, and it should provide appropriate guidance and where necessary training. This should be completed by December 2015.
17 & 18	The University Hospitals of Morecambe Bay NHS Foundation Trust should identify options, with a view to implementation as soon as practicable, to improve the physical environment of the delivery suite at Furness General Hospital, including particularly access to operating theatres, an improved ability to observe and respond to all women in labour and en suite facilities; arrangements for post-operative care of women also need to be reviewed. Plans should be in place by December 2015 and completed by December 2017. 18. All of the previous recommendations should be implemented with the involvement of Clinical Commissioning Groups, and where necessary, the Care Quality Commission and Monitor. In the particular circumstances surrounding the University Hospitals of Morecambe Bay NHS Foundation Trust, NHS England should oversee the process, provide the necessary support, and ensure that all parties remain committed to the outcome, through an agreed plan with the Care Quality Commission, Monitor and the Clinical Commissioning Groups.
Recommendations for the wider NHS	
19	In light of the evidence we have heard during the Investigation, we consider that the professional regulatory bodies should review the findings of this Report in detail with a view to investigating further the conduct of registrants involved in the care of patients during the time period of this Investigation. Action: the General Medical Council, the Nursing and Midwifery Council.
20	There should be a national review of the provision of maternity care and paediatrics in challenging circumstances, including areas that are rural, difficult to recruit to, or isolated. This should identify the requirements to sustain safe services under these conditions. In conjunction, a national protocol should be drawn up that defines the types of unit required in different settings and the levels of care that it is appropriate to offer in them. Action: NHS England, the Care Quality Commission, the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives, the Royal College of Paediatrics and Child Health, the National Institute for Health and Care Excellence.

21	The challenge of providing healthcare in areas that are rural, difficult to recruit to or isolated is not restricted to maternity care and paediatrics. We recommend that NHS England consider the wisdom of extending the review of requirements to sustain safe provision to other services. This is an area lacking in good-quality research yet it affects many regions of England, Wales and Scotland. This should be seen as providing an opportunity to develop and promote a positive way of working in remote and rural environments. Action: NHS England.
22	We believe that the educational opportunities afforded by smaller units, particularly in delivering a broad range of care with a high personal level of responsibility, have been insufficiently recognised and exploited. We recommend that a review be carried out of the opportunities and challenges to assist such units in promoting services and the benefits to larger units of linking with them. Action: Health Education England, the Royal College of Obstetricians and Gynaecologists, the Royal College of Paediatrics and Child Health, the Royal College of Midwives.
23	Clear standards should be drawn up for incident reporting and investigation in maternity services. These should include the mandatory reporting and investigation as serious incidents of maternal deaths, late and intrapartum stillbirths and unexpected neonatal deaths. We believe that there is a strong case to include a requirement that
24	We commend the introduction of the duty of candour for all NHS professionals. This should be extended to include the involvement of patients and relatives in the investigation of serious incidents, both to provide evidence that may otherwise be lacking and to receive personal feedback on the results. Action: the Care Quality Commission, NHS England.
25	We recommend that a duty should be placed on all NHS Boards to report openly the findings of any external investigation into clinical services, governance or other aspects of the operation of the Trust, including prompt notification of relevant external bodies such as the Care Quality Commission and Monitor. The Care Quality Commission should develop a system to disseminate learning from investigations to other Trusts. Action: the Department of Health, the Care Quality Commission
26	We commend the introduction of a clear national policy on whistleblowing. As well as protecting the interests of whistleblowers, we recommend that this is implemented in a way that ensures that a systematic and proportionate response is made by Trusts to concerns identified. Action: the Department of Health.
27	Professional regulatory bodies should clarify and reinforce the duty of professional staff to report concerns about clinical services, particularly where these relate to patient safety, and the mechanism to do so. Failure to report concerns should be regarded as a lapse from professional standards. Action: the General Medical Council, the Nursing
28	Clear national standards should be drawn up setting out the professional duties and expectations of clinical leads at all levels, including, but not limited to, clinical directors, clinical leads, heads of service, medical directors, nurse directors. Trusts should provide evidence to the Care Quality Commission, as part of their processes, of appropriate policies and training to ensure that standards are met. Action: NHS England, the Care Quality Commission, the General Medical Council, the Nursing and Midwifery Council, all Trusts.
29	Clear national standards should be drawn up setting out the responsibilities for clinical quality of other managers, including executive directors, middle managers and non-executives. All Trusts should provide evidence to the Care Quality Commission, as part of their processes, of appropriate policies and training to ensure that standards are met. Action: NHS England, the Care Quality Commission, all Trusts.
30	A national protocol should be drawn up setting out the duties of all Trusts and their staff in relation to inquests. This should include, but not be limited to, the avoidance of attempts to 'fend off' inquests, a mandatory requirement not to coach staff or provide 'model answers', the need to avoid collusion between staff on lines to take, and the inappropriateness of relying on coronial processes or expert opinions provided to coroners to substitute for incident investigation. Action: NHS England, the Care Quality Commission.
31	The NHS complaints system in the University Hospitals of Morecambe Bay NHS Foundation Trust failed relatives at almost every turn. Although it was not within our remit to examine the operation of the NHS complaints system nationally, both the nature of the failures and persistent comment from elsewhere lead us to suppose that this is not unique to this Trust. We believe that a fundamental review of the NHS complaints system is required, with particular reference to strengthening local resolution and improving its timeliness, introducing external scrutiny of local resolution and reducing reliance on the Parliamentary and Health Service Ombudsman to intervene in unresolved complaints. Action: the Department of Health, NHS England, the Care Quality Commission, the Parliamentary and Health Service Ombudsman.
32	The Local Supervising Authority system for midwives was ineffectual at detecting manifest problems at the University Hospitals of Morecambe Bay NHS Foundation Trust, not only in individual failures of care but also with the systems to investigate them. As with complaints, our remit was not to examine the operation of the system nationally; however, the nature of the failures and the recent King's Fund review (*Midwifery regulation in the United Kingdom*) lead us to suppose that this is not unique to this Trust, although there were specific problems there that exacerbated the more systematic concern. We believe that an urgent response is required to the King's Fund findings, with effective reform of the system. Action: the Department of Health, NHS England, the Nursing and Midwifery Council.
33	We considered carefully the effectiveness of separating organisationally the regulation of quality by the Care Quality Commission from the regulation of finance and performance by Monitor, given the close inter-relationship between Trust decisions in each area. However, we were persuaded that there is more to be gained than lost by keeping regulation separated in this way, not least that decisions on safety are not perceived to be biased by their financial implications. The close links, however, require a carefully coordinated approach, and we recommend that the organisations draw up a memorandum of understanding specifying roles, relationships and communication. Action: Monitor, the Care Quality Commission, the Department of Health.
34	The relationship between the investigation of individual complaints and the investigation of the systemic problems that they exemplify gave us cause for concern, in particular the breakdown in communication between the Care Quality Commission and the Parliamentary and Health Service Ombudsman over necessary action and follow-up. We recommend that a memorandum of understanding be drawn up clearly specifying roles, responsibilities, communication and follow-up, including explicitly agreed actions where issues overlap. Action: the Care Quality Commission, the Parliamentary and Health Service Ombudsman.
35	The division of responsibilities between the Care Quality Commission and other parts of the NHS for oversight of service quality and the implementation of measures to correct patient safety failures was not clear, and we are concerned that potential ambiguity persists. We recommend that NHS England draw up a protocol that clearly sets out the responsibilities for all parts of the oversight system, including itself, in conjunction with the other relevant bodies; the starting point should be that one body, the Care Quality Commission, takes prime responsibility. Action: the Care Quality Commission, NHS England, Monitor, the Department of Health.
36	The cumulative impact of new policies and processes, particularly the perceived pressure to achieve Foundation Trust status, together with organisational reconfiguration, placed significant pressure on the management capacity of the University Hospitals of Morecambe Bay NHS Foundation Trust to deliver against changing requirements whilst maintaining day-to-day needs, including safeguarding patient safety. Whilst we do not absolve Trusts from responsibility for prioritising limited capability safely and effectively, we recommend that the Department of Health should review how it carries out impact assessments of new policies to identify the risks as well as the resources and time required. Action: the Department of Health.
37	Organisational change that alters or transfers responsibilities and accountability carries significant risk, which can be mitigated only if well managed. We recommend that an explicit protocol be drawn up setting out how such processes will be managed in future. This must include systems to secure retention of both electronic and paper documents against future need, as well as ensuring a clearly defined transition of responsibilities and accountability. Action: the Department of Health.
38	Mortality recording of perinatal deaths is not sufficiently systematic, with failures to record properly at individual unit level and to account routinely for neonatal deaths of transferred babies by place of birth. This is of added significance when maternity units rely inappropriately on headline mortality figures to reassure others that all is well. We recommend that recording systems are reviewed and plans brought forward to improve systematic recording and tracking of perinatal deaths. This should build on the work of national audits such as MBRRACE-UK, and include the provision of comparative information to Trusts. Action: NHS England.
39	There is no mechanism to scrutinise perinatal deaths or maternal deaths independently, to identify patient safety concerns and to provide early warning of adverse trends. This shortcoming has been clearly identified in relation to adult deaths by Dame Janet Smith in her review of the Shipman deaths, but is in our view no less applicable to maternal and perinatal deaths, and should have raised concerns in the University Hospitals of Morecambe Bay NHS Foundation Trust before they eventually became evident. Legislative preparations have already been made to implement a system based on medical examiners, as effectively used in other countries, and pilot schemes have apparently proved effective. We cannot understand why this has not already been implemented in full, and recommend that steps are taken to do so without delay. Action: the Department of Health.
40	Given that the systematic review of deaths by medical examiners should be in place, as above, we recommend that this system be extended to stillbirths as well as neonatal deaths, thereby ensuring that appropriate recommendations are made to coroners concerning the occasional need for inquests in individual cases, including deaths following neonatal transfer. Action: the Department of Health
41	We were concerned by the ad hoc nature and variable quality of the numerous external reviews of services that were carried out at the University Hospitals of Morecambe Bay NHS Foundation Trust. We recommend that systematic guidance be drawn up setting out an appropriate framework for external reviews and professional responsibilities in undertaking them. Action: the Academy of Medical Royal Colleges, the Royal College of Nursing, the Royal College of Midwives.
42	We further recommend that all external reviews of suspected service failures be registered with the Care Quality Commission and Monitor, and that the Care Quality Commission develops a system to collate learning from reviews and disseminate it to other Trusts. Action: the Care Quality Commission, Monitor.
43	We strongly endorse the emphasis placed on the quality of NHS services that began with the Darzi review, *High Quality Care for All* , and gathered importance with the response to the events at the Mid Staffordshire NHS Foundation Trust. Our findings confirm that this was necessary and must not be lost. We are concerned that the scale of recent NHS reconfiguration could result in new organisations and post-holders losing the focus on this priority. We recommend that the importance of putting quality first is re-emphasised and local arrangements reviewed to identify any need for personal or organisational development, including amongst clinical leadership in commissioning organisations. Action: NHS England, the Department of Health.

44	This Investigation was hampered at the outset by the lack of an established framework covering such matters as access to documents, the duty of staff and former staff to cooperate, and the legal basis for handling evidence. These obstacles were overcome, but the need to do this from scratch each time an investigation of this format is set up is unnecessarily time-consuming. We believe that this is an effective investigation format that is capable of getting to the bottom of significant service and organisational problems without the need for a much more expensive, time-consuming and disruptive public inquiry. This being so, we believe that there is considerable merit in establishing a proper framework, if necessary statutory, on which future investigations could be promptly established. This would include setting out the arrangements necessary to maintain independence and work effectively and efficiently, as well as clarifying responsibilities of current

NHS Stockport NHS Foundation Trust

KEY ISSUES AND ASSURANCE REPORT
Audit Committee
18th July 2023

The Audit Committee draws the following matters to the Board of Director's attention -

Issue	Committee Update	Assurance received	Action	Timescale
Audit Committee Annual Report 2022-23	• Audit Committee Annual Review 2022-23 • Audit Committee Terms of Reference • Audit Committee 2023-24 Work Plan • Report of Audit Committee Effectiveness Review	The Committee were assured that its terms of reference had been reviewed and updated as required on an annual basis. The Committee were assured of proposed changes to the quoracy of future meetings to include the attendance of any non-executive member of the Board. The Committee discussed its self-assessment of the effectiveness of the Committee and confirmed positive outcome, including confirmation that clinical audit was overseen via Quality Committee. The Committee approved the 2023-24 Annual Work Plan.	The Committee approved the Audit Committee Annual Report 2022-23 to be presented to the Board of Director.	August 2023
Internal Audit Progress Report	The Committee received a report of: • Internal Audit Progress Report • Internal Audit Reports • Follow up Tracker	The Committee received assurance that two reviews had now been finalised, one issued as draft has now been finalised that the 2022-23 programme of work is now complete. The Committee received moderate assurance on: • Sickness Absence • Data Security and Protection Toolkit Assessment Summary	People Performance Committee to have oversight of HR actions.	

NHS Stockport NHS Foundation Trust

KEY ISSUES AND ASSURANCE REPORT
Audit Committee
18th July 2023

The Audit Committee draws the following matters to the Board of Director's attention -

Issue	Committee Update	Assurance received	Action	Timescale
Internal Audit Progress Report continued	The Committee received a report of: • 2023/24 Internal Audit Plan • Anti-Fraud Progress Report • Anti-Fraud Annual Report 2023/24	The Committee received an update report on two reviews that had previously received limited assurance: • Legacy Systems Review (Sep 22) • IT Asset Management Review (Jan 23) The Committee noted that work on the 2023-24 programme was already in progress. The Committee agreed to amend the 2023/24 Internal Plan to pause the CIP Review and review in September 2023 following GM ICS and Finance and Performance Committee discussions. The MIAA counter fraud report was received and progress against work plan noted and approved. The Committee were informed that Government Counter Fraud Standard Return for the Trust was successfully submitted and that the Trust had achieved a 'Green' rating.	MIAA have assigned follow up actions to the IT Auditor Audit Committee to review the CIP Review inclusion in the 2023/24 Work Plan.	September 2023

NHS Stockport NHS Foundation Trust

KEY ISSUES AND ASSURANCE REPORT
Audit Committee
18th July 2023

The Audit Committee draws the following matters to the Board of Director's attention -

Issue	Committee Update	Assurance received	Action	Timescale
	• Anti-Fraud Progress Report • Anti-Fraud Annual Report 2023/24	The MIAA counter fraud report was received and progress against work plan noted and approved. The Committee received assurance that Counter Fraud lead was working with the Company Secretary to provide awareness sessions to staff on reporting conflicts of interest. The Committee received continued assurance that the Trust is vigilant to fraud attempts. No financial losses had been incurred by the Trust from the Fraud Prevention Check notices issued in this reporting period.		
External Audit Progress Report.	The Committee received: • External Auditor Report (Final)	The Committee noted the final version of the external auditor report including: - Unqualified opinion on the financial statements - Completion of the Value for Money work reported a significant weakness in relation to financial sustainability, based on submission of a deficit financial plan for 2023/24. The Committee confirmed this was a balanced report and was consistent with the audit report opinions of other Trusts. The Committee confirmed that that this formally concluded the audit, and Mazars would issue the Audit Report Certificate for	The Committee approved the External Auditor report for 2022/23. July 2023	July 2023

NHS Stockport NHS Foundation Trust

KEY ISSUES AND ASSURANCE REPORT
Audit Committee
18th July 2023

The Audit Committee draws the following matters to the Board of Director's attention -

Issue	Committee Update	Assurance received	Action	Timescale
		inclusion in the Parliamentary and NHSE final submission of the Annual Accounts and Report for 2022/23.		
Losses and Special Payments Annual Review	The Committee received a report from on the annual Losses and Special Payments reported in the financial statements for 2022/2023	The Committee was updated on the significant losses and special payments reported. The Committee received assurance from MIAA benchmarking that the Trust levels of losses and special payments sat within the lower ranges of reported amount sin these areas.	The Committee approved the Losses and Special Payments report for 2022/23.	
Risk Management Committee Summary Report	The Committee received: • a report on the work of the Risk Committee • a list of significant risks at June 2023.	The Committee noted the report of the work of the Risk Management Committee. The Committee were assured that deep dive of key risks had been undertaken and that mitigation plans were having an impact on risk scores.		
Trust Committee updates	The Committee received verbal reports from the Chairs of key Board Committees.	The Committee noted the key risks identified in other Board Committees from the Finance and Performance, People Performance and Quality Committees.		

NHS
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Audit Committee Annual Review 2022/23

1. INTRODUCTION

1.1 Audit Committee considered and confirmed the Annual Review, including the Terms of Reference and Work Plan at its meeting on 18th July 2023. The review is recommended to the Board of Directors for approval.

2. BACKGROUND

2.1 Section 8.1 of the current Terms of Reference requires that the Terms of Reference of the Audit Committee shall be reviewed by the Board of Directors annually. The Terms of Reference were last reviewed and approved by the Board of Directors on 4 August 2022 and are therefore now due for review. In addition, section 8.2 requires the Committee to review its effectiveness and performance on an annual basis and report the outcome to the Board of Directors.

3. COMPLIANCE WITH TERMS OF REFERENCE

3.1 The Audit Committee has a well-established workplan which sets out its annual cycle of work and reporting. This is kept under regular review and updated to consider matters relevant to the responsibilities of Audit Committee.

The Audit Committee also works with the Board's other assurance committees and will receive matters for its consideration and refer matters to other committees for assurance purposes.

Appendix 1 details key matters considered at the Audit Committee during 2022/23. In addition, the Committee also requested the following deep dives / presentations, which were considered at meetings during 2022/23:

- Update on IT Continuity Planning and Unsupported Systems
- Follow up from Data Security and Protection Toolkit Review
- Maternity Roofing Scheme – Waiver

The Committee also has a follow up system to ensure agreed recommendations are implemented in timely manner.

3.2 <u>Internal Audit & Counter Fraud</u>

The Internal Audit Work Plan 2022/23 was approved by Audit Committee at the start of 2022/23 and delivered by Mersey Internal Audit Agency (MIAA), subject to any adjustments agreed by the Committee.

The Committee reviewed in detail the findings of Internal Audit reports, and responsible managers were asked for a specific written response to these reports and/or to attend the Audit Committee where further assurances regarding recommendations/actions to be taken were identified, notably in response to audits with limited assurances.

Each year, the Audit Committee receives and considers the annual Counter Fraud plan, with regular progress reports and updates and the annual Counter Fraud report provided to Committee.

The Committee has reviewed the performance of the internal audit & counter fraud function in 2022/23 and considers that this is satisfactory.

3.3 External Audit

Mazars LLP are the Trust's external auditors – having taken over this contract from the 2019/20 financial year.

The Committee reviewed the audit for 2022/23 as it progressed including final audit reports and management letters.

3.4 Review of Annual Report and Accounts for 2022/23

The Committee considered the draft Annual Report and Accounts, including Annual Governance Statement (AGS) at its meeting in May 2023. The final Annual Report and Accounts were reviewed and recommended for approval to the Board of Directors in June 2023.

4. Committee Effectiveness

An annual assessment has been completed by members of Audit Committee and regular attendees.

The assessment included two parts; a checklist focused on committee administration and processes; the second on how well the Committee operates over several categories.

The checklist focused on Committee administration and processes was completed by the Committee's secretary and distributed to Audit Committee members and regular attendees. The checklist was designed to elicit a simple yes or no answer to each question. There was a single 'no' answer with regards to the Audit Committee receiving regular Clinical Audit report. The assessment confirmed that Audit Committee will receive update from Quality Committee on this matter as required.

The outcome of the second part of the assessment is presented in Appendix 2. The outcome of the self-assessment was positive with members and regular attendees confirming the work plan was followed and appropriate challenge was made.

5. Attendance

Attendance at 2022/23 Audit Committee meetings is provided in Appendix 3. The Committee met on six occasions in 2022/23 (+ two year-end meetings in May and June 2023), and all meetings were quorate.

6. Terms of Reference

A review of the draft Terms of Reference was conducted by the Trust Secretary and Chair of Audit Committee. The revised Terms of Reference are included at Appendix 4 of the report for approval. The key changes relate to:

- Update to job titles of regular attendees
- Removal of review of Quality Accounts as no longer subject to audit (Quality Accounts are reviewed by Quality Committee prior to recommendation of approval to Board)

- Membership: In addition to the regularly attending membership (Chair of audit Committee & Chair of Board Assurance Committees), recognition that all statutory non-executive directors, except for the Chair of the Trust, are authorised to attend as members of the Audit Committee, to ensure quoracy at meetings.

7. Work Plan 2023/24

A review of the work plan was conducted by the Trust Secretary and Chair of Audit Committee (Appendix 5).

Committee members are asked to note that the 'year-end' meeting dates will be determined in line with NHS England (NHSE) financial accounting and reporting year-end requirements 2023/24. Any subsequent change to meetings in 2024 will be communicated to members & attendees as soon as possible.

AUDIT COMMITTEE 2022/23

Topic	26 May 2022	21 Jun 2022	14 Jul 2022	22 Sep 2022	24 Nov 2022	9 Feb 2023	23 May 2023	27 Jun 2023
Audit Committee Work Plan 2022/23	✓		✓	✓	✓	✓	✓	
Audit Committee Annual Review 2021/22			✓					
Internal Audit Progress Report	✓		✓	✓	✓	✓	✓	
Review of Internal Audit Plan	✓		✓	✓	✓	✓	✓	
Internal Audit Charter							✓	
Anti-Fraud Progress Report	✓		✓	✓	✓	✓	✓	
Anti-Fraud Annual Report	✓						✓	
Anti-Fraud Plan 2023/24						✓		
Internal Audit Annual Report	✓						✓	
Head of Internal Audit Opinion	✓	✓					✓	✓
Next Steps – Internal Audit Contract					✓			
External Audit Progress Report	✓			✓	✓	✓		
External Governance Reports: • **External Audit Opinion** • **ISA260 Report from External Audit**		✓						✓
External Audit Strategy Memorandum							✓	
External Auditor's Annual Report			✓					
Review of Annual Governance Declarations/Self-Certifications	✓						✓	
Annual Report	✓	✓					✓	✓
Annual Governance Statement	✓	✓					✓	✓
Key Accounting Issues Report	✓						✓	
Annual Accounts	✓	✓					✓	✓

Topic	26 May 2022	21 Jun 2022	14 Jul 2022	22 Sep 2022	24 Nov 2022	9 Feb 2023	23 May 2023	27 Jun 2023
Management Representation Letter: Financial Accounts		✓						✓
Review of Going Concern basis of preparation	✓						✓	
Declaration of Interests Annual Review	✓						✓	
Review of Waivers	✓				✓		✓	
Review of Accounting Policies							✓	
Review of Losses and Special Payments			✓					
Board Assurance Framework Review				✓				
To review arrangements by which staff can raise issues				✓				
Review the operation of and proposed changes to Standing Orders, Scheme of Reservation & Delegation and Standing Financial Instructions					✓			
Policy for the Approval of Non-Audit and Additional Services by the Trust's External Auditors						✓		
Risk Management Committee Key Issues Report	✓		✓	✓	✓		✓	
Feedback from Board Committees	✓		✓	✓	✓	✓	✓	
Informal Review of Meeting Effectiveness	✓		✓	✓	✓	✓	✓	

Appendix 2: Outcome of Audit Committee Review & Self-Assessment

Statement	Strongly agree	Agree	Disagree	Strongly disagree	Unable to answer	Comments/Action
Theme 1 – committee focus						
The committee has set itself a series of objectives it wants to achieve this year.	1 / 1	2 / 3				
The committee has made a conscious decision about how it wants to operate in terms of the level of information it would like to receive for each of the items on its cycle of business.	1 / 1	2 / 3				
Committee members contribute regularly across the range of issues discussed.	1 / 3	2 / 1				
The committee is fully aware of the key sources of assurance and who provides them in support of the controls mitigating the key risks to the organisation.	1 / 2	2 / 2				
The committee clearly understands and receives assurances from third parties the organisation uses to manage/operate key functions – for example, financial services operated by NHS Shared Business Services, other NHS bodies, commissioning support units or private contractors.	1	3 / 3				
Equal prominence is given to both quality and financial assurance.	1	3 / 3				
Theme 2 – committee team working						
The committee has the right balance of experience, knowledge and skills to fulfil the role described in the *NHS Audit Committee Handbook*.	1	3 / 3				
The committee has structured is agenda to cover, quality, data quality, performance targets and financial control.		2 / 4	1			
The committee ensures that the relevant executive director/manager attends meetings to enable it to secure the required level of understanding of the reports and information it receives (i.e. the right executive lead is there to discuss risk and internal matters in their area of responsibility rather than the committee having to rely on the DoF to act as conduit to the executive team).		3 / 4				
Management fully briefs the committee via the assurance framework in relation to the key risks and assurances received and any gaps in control/assurance in a timely fashion thereby eradicating the potential for 'surprises'.	1 / 1	1 / 3			1	.
Other committees provide timely and clear information in support of the committee thereby eradicating the potential for 'surprises'.	1 / 2	1 / 2			1	
I feel sufficiently comfortable within the committee environment to be able to express my views, doubts and opinions.	2	1 / 2			1	
I understand the messages being given by the organisation's assurance advisors (external audit/internal audit/counter fraud specialists).	1 / 2	2 / 2				
Internal audit contributes to the debate across the range of the agenda and not just on the papers they present.	1 / 1	1 / 3			1	
Members hold their assurance providers to account for late or missing assurances.	2	2 / 2			1	
When a decision has been made or action agreed I feel confident that it will be implemented as agreed and in line with the timescale set down.	2	2 / 2			1	
Theme 3 – committee effectiveness						
The quality of committee papers received allows me to perform my role	1 / 1	2 / 3				

Statement	Strongly agree	Agree	Disagree	Strongly disagree	Unable to answer	Comments/Action
effectively.						
Members provide real and genuine challenge – they do not just seek clarification and/or reassurance.	1 / 2	1 / 2			1	
Debate is allowed to flow and conclusions reached without being cut short or stifled due to time constraints etc.	2	1 / 2			1	
Each agenda item is 'closed off' appropriately so that I am clear what the conclusion is; who is doing what, when and how etc and how it is being monitored.	2	1 / 2			1	
At the end of each meeting we discuss the outcomes and reflect back on decision's made and what worked well, not so well etc.		2 / 4			1	
The committee provides a written summary report of its meetings to the Board.	1 / 1	2 / 3				
The Board challenges and understands the reporting from this committee.	1	1 / 3			1 / 1	
There is a formal appraisal of the committee's effectiveness each year which is evidence based and takes into account my views and external views.	1	2 / 4				
Theme 4 – committee engagement						
The committee actively challenges both management and other assurance providers during the year to gain a clear understanding of their findings.	1	2 / 3			1	
The committee is clear about the complementary relationship it has with other Board committees that play a role in relation to clinical governance, quality and risk management.	1 / 2	1 / 2			1	
The committee receives clear and timely reports from other Board committees which set out the assurances they have received and their impact (either positive or not) on the organisation's assurance framework.	1	2 / 3			1	
I can provide two examples of where we as a committee have focused on improvements to the system of internal control as a result of assurance gaps identified.	1 / 2	1 / 2			1	
Theme 4 – committee leadership						
The committee Chair has a positive impact on the performance of the committee.	2	2 / 2				
Committee meetings are chaired effectively and with clarity of purpose and outcome.	2	1 / 2			1	
The committee Chair is visible within the organisation and is considered approachable.		3			2 / 1	
The committee Chair allows debate to flow freely and does not assert his/her own views too strongly.	2	1 / 2			1	
The committee Chair provides clear and concise information to the Board on the activities of the committee and the implications of all identified gaps in assurance/control.	1	1 / 3			1	
Green = Response from Members / Blue = Response from Regular Attendees						

Appendix 3: Audit Committee 2022/23 Attendance Register

Member	Name	26 May 2022	21 Jun 2022	14 Jul 2022	22 Sep 2022	24 Nov 2022	9 Feb 2023	23 May 2023	27 Jun 2023
Core Members									
Chair of Audit Committee, Non-Executive Director	David Hopewell	Y	Y	Y	A	Y	Y	Y	Y
Chair of F&P Committee/Non-Executive Director	Tony Bell	Y	Y	Y	Y	A	Y	Y	A
Chair of People Performance Committee/Non-Executive Director	Catherine Barber-Brown / Louise Sell / Beatrice Fraenkel	A	Y	A	A	Y	Y	A	A
Chair of Quality Committee/Non-Executive Director	Mary Moore	Y	Y	Y	Y	A	Y	Y	A
Non-Executive Director	Marisa Logan-Ward								Y
Non-Executive Director	Louise Sell								Y
Regular Attendees									
Chief Executive	Karen James	Y	Y	Y	Y	Y	A	Y	Y
Chief Finance Officer	John Graham	Y	Y	Y	A	Y	Y	Y	Y
Associate Director of Financial Services	Lisa Byers	Y	Y	Y	Y	Y	Y	Y	Y
Director of Communications & Corporate Affairs	Caroline Parnell	A	Y	Y	Y	Y	A	A	A
Trust Secretary	Rebecca McCarthy	A	Y	Y	Y	Y	Y	Y	Y
MIAA	Representative from Internal Audit	Y	N/A	Y	Y	Y	Y	Y	N/A
MIAA	Counter-Fraud Specialist	Y	N/A	A	A	Y	Y	Y	N/A
Mazars	Representative from External Audit	Y	Y	Y	Y	Y	Y	Y	Y
Director of Finance	Kay Wiss	Y	Y		A (D)			Y	Y
Was Meeting Quorate (Y/N)		**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**
Key									
Y	= Present								
A	= Apologies								
A (D)	= Attended as Deputy								

NHS Stockport NHS Foundation Trust

AUDIT COMMITTEE

TERMS OF REFERENCE

1. CONSTITUTION

1.1. The Board of Directors hereby resolves to appoint a Committee, to be known as the Audit Committee (the Committee).

1.2 It shall have terms of reference and powers delegated by the Board of Directors and is subject to such conditions, such as reporting to the Board of Directors, in accordance with any legislation, regulation or direction issued by the Trust.

1.3 The Audit Committee will provide report to the Council of Governors identifying any matters in respect of which it considers that action of improvement is needed and recommendation as to the action to be taken.

2. PURPOSE OF THE COMMITTEE

The overarching purpose of Audit Committee is to:

2.1 review the establishment and maintenance of an effective system of governance, and internal control, including risk management, across the whole of the organisation's activities (both clinical and non-clinical);

2.2 ensure there is an effective internal audit function established which provides appropriate independent assurance to the Committee;

2.3 review the findings of the External Auditor, as appointed by the Council of Governors, as part of its delegated authority from the Board of Directors and consider the implications and management's responses to their work;

2.4 review and approve for audit the annual report (including Annual Governance Statement), annual accounts and financial statements as part of its delegated responsibility from the Board.

3. COMPOSITION & CONDUCT OF THE COMMITTEE

3.1 Membership

3.1.1 Membership will comprise:

- A non-executive director who should have relevant financial experience and should be appointed Chair of the Committee by the Board.
- In addition to the Chair, at least three non-executive directors, to include the Chair of each of the Trust's Board assurance committees.

3.1.2 All statutory non-executive directors, except for the Chair, are authorised to attend as members of the Audit Committee.

3.1.3 The Chair of the Foundation Trust shall neither chair nor be a member of the Committee but can attend meetings by invitation of the Chair of the Committee.

3.1.4 There is an expectation that the membership will attend all Committee meetings during the financial year. Individual attendance levels will be monitored by the Chair of the Committee who will take appropriate measures should attendance be less than 75%.

3.1.5 The following shall attend the Committee meetings on a regular basis:

- Chief Executive
- Chief Finance Officer
- Director of Finance
- Associate Director of Finance (Financial Services)
- Company Secretary
- A representative of the Internal Auditors
- A representative of the External Auditors
- Counter-Fraud Lead

3.1.5 Executive Directors and/or senior leaders shall be invited to attend those meetings in which the Audit Committee will consider areas of risk or operation that are their responsibility.

3.2. Chair

3.2.1 The Chair of the Committee will be a Non-Executive Director with relevant financial experience.

3.2.2 Another Non-Executive Director will deputise as the Chair of the Committee in the Chair's absence.

3.3 Quorum

3.3.1 A quorum will consist of at least two independent non-executive directors.

3.3.2 Members withdrawing from the meeting owing to a conflict of interest shall no longer count towards a quorum.

3.3.3 However, at the discretion of the Chair, matters and decisions deemed urgent may proceed within the absence of a quorum with any actions from that meeting being confirmed at the next full meeting.

3.4 Notice of meeting

3.4.1 Before each meeting, a notice of the meeting specifying the business proposed to be transacted and supporting papers for the business expected shall be sent by electronic mail to the usual place of business of each member, to be available at least five clear days before the meeting.

3.4.2 The Chair of the Committee may, at their discretion, allow additional agenda items and papers to be circulated after the notice of the meeting.

3.5 Frequency of meetings

3.5.1 Meetings shall be held at least five times per year, with additional meetings where necessary.

3.5.2 The External Auditor and Internal Auditor shall have the opportunity at least once per year to meet with the Audit Committee without executive directors present.

3.5.3 The Chair may at times convene additional meetings of the Committee to consider business that requires urgent attention.

3.6. Administration

3.6.1 The Trust Secretary will ensure appropriate administrative arrangements are in place and that minutes are recorded, confirmed and appropriately archived from each meeting.

4. DELEGATED AUTHORITY

The Audit Committee is authorised by the Board of Directors to:

4.1 Investigate any matter within these terms of reference.

4.2 Seek information from any Director, officer, or employee; and all Directors, officers and employees are directed to extend the fullest co-operation to the Committee in the discharge of its functions.

4.3 Within the procedures approved by the Board, obtain outside legal or other independent professional advice. The Committee is authorised by the Board of Directors to request the attendance of individuals and authorities from outside the Foundation Trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions.

5. RESPONSIBILITIES

5.1 Integrated governance, risk management and internal control

5.1.1 To review provision of an effective system of integrated governance, including systems for risk management and clinical audit, and internal control aligned to the overall governance agenda.

5.1.2 To maintain oversight of the Trust's risk management structures, processes and responsibilities, including the production and issue of any risk and control-related disclosure statements.

5.1.3 To review processes to ensure appropriate information flows to the Audit Committee from executive management and other Board Committees in relation to the Trust's overall internal control and risk management.

5.1.4 To review the adequacy of underlying assurance processes that indicate the degree of achievement of corporate objectives and the effectiveness of the management of principal risks. In respect of the controls in place to manage risks recorded on the Board Assurance Framework, each Board Committee (through its Chair) shall report regularly to the Audit Committee.

5.1.5 To review the adequacy of arrangements by which staff can raise issues in confidence about possible improprieties in matters of financial reporting and control and related matters or any other matters of concern.

5.1.6 To review the adequacy of the policies and procedures in respect of all local Counter-Fraud services work.

5.1.7 To review the adequacy of policies and procedures for ensuring compliance with relevant regulatory, legal and code of conduct requirements.

5.2 Internal Audit & Counter Fraud

5.2.1 To review and approve the internal audit strategy and programme, ensuring that it is consistent with the needs and priorities of the organisation.

5.2.2 To oversee on an on-going basis the effective operation of internal audit in respect of:
- Adequate resourcing;
- Co-ordination with external audit;
- Meeting relevant internal audit standards;
- Providing adequate independence assurances;
- Having appropriate standing within the Foundation Trust; and
- Meeting the internal audit needs of the Foundation Trust.

5.2.3 To consider the findings of internal audit investigations and management's response and their implications and monitor progress on the implementation of recommendations.

5.2.4 To evaluate performance of the internal audit service against relevant key performance indicators on an annual basis.

5.2.5 Receive the Head of Internal Audit Opinion

5.2.6 To oversee the conduct of a market testing exercise for the appointment of an internal auditor at least once every five years and, based on the outcome, make a recommendation to the Board of Directors for award of contract.

5.2.7 To review and approve the Trust's annual Counter-Fraud workplan, ensuring that it is consistent with the needs of the organisation.

5.2.8 To satisfy itself that the organisation has adequate arrangements in place for anti-fraud, bribery and corruption that meets the NHS Counter Fraud Authority's (NHS CFA) standards. In doing so, the Audit Committee will refer any suspicious of fraud, bribery and corruption to the NHS CFA via its Counter-Fraud Specialist.

5.3 External Audit

5.3.1 To oversee, in liaison with the Council of Governors, the conduct of a market testing exercise for the appointment of an external auditor at least once every five years and, based on the outcome, make a recommendation to the Council of Governors for award of contract.

5.3.2 To assess the external auditor's work and fees in line with the contract award, and based on this assessment, make the recommendation to the Council of Governors with respect to the re-appointment or removal of the auditor. This assessment should include the review and monitoring of the external auditor's independence and objectivity and effectiveness of the audit process in light of relevant professional and regulatory standards.

5.3.3 To discuss with the external auditor, before the audit commences, the nature and scope of the audit, and ensure co-ordination, as appropriate, with other external auditors in the local health economy.

5.3.4 To review all external audit reports, including the 'auditor's annual report', together with the

management response, and to monitor progress on the implementation of recommendations.

5.3.5 To develop and implement a policy on the engagement of the external auditor to supply non-audit services.

5.3.6 To consider the provision of the external audit service, the cost of the audit and any questions of resignation and dismissal of the auditors.

5.3.7 To ensure mechanisms are in place to engage with the external auditor out with the Audit Committee as maybe required.

5.4 Annual Report & Accounts

5.4.1 To review and approve for audit the Annual Accounts, before they are presented to the Board of Directors, in order to determine their completeness, objectivity, integrity and accuracy. This review will cover but is not limited to:

- The meaning and significance of the figures, notes and significant changes;
- Areas where judgment has been exercised;
- Adherence to accounting policies and practices;
- Explanation of estimates or provisions having material effect;
- The schedule of losses and special payments;
- Any unadjusted statements; and
- Any reservations and disagreements between the external auditors and management which have not been satisfactorily resolved.

5.4.2 To review and approve for audit the Annual Report and Annual Governance Statement, before they are presented to the Board of Directors, to determine completeness, objectivity, integrity and accuracy.

5.4.3 To review accounting and reporting systems on a cyclical basis for reporting to the Board of Directors, including in respect of budgetary control.

5.5 Scheme of Reservation & Delegation, Standing Financial Instructions and Standards of Business Conduct

5.5.1 To review on behalf of the Board of Directors the operation of, and proposed changes to, the Standing Orders, Scheme of Reservation & Delegation and Standing Financial Instructions.

5.5.2 To examine the circumstances of any significant departure from the requirements of any of the foregoing, and whether those departures relate to a failing, an overruling or a suspension.

5.5.3 To monitor the implementation of policy of the Standards of Business Conduct and Codes of Conduct, on behalf of the Board of Directors.

5.6 Other

5.6.1 To examine any other matter referred to the Audit Committee by the Board of Directors and to initiate investigation as determined by the Audit Committee.

5.6.2 To review each year the accounting policies of the Foundation Trust and make appropriate recommendations to the Board of Directors.

5.6.3 Review and approve the Annual Report, Work Plans and Terms of Reference of any group/committee that reports directly to the Committee.

5.6.4 To consider the outcomes of significant reviews carried out by other bodies which include but are not limited to regulators and inspectors within the health and social care sector and professional bodies with responsibilities that relate to staff performance and functions.

6. RELATIONSHIP WITH THE BOARD OF DIRECTORS

6.1 The Committee will report to the Board of Directors by means of a Key Issues Report summarising business conducted by the Committee together with key actions and/or risks.

6.2 The Key Issues Report will be forwarded to the Board of Directors following each Committee meeting.

7. RELATIONSHIP WITH OTHER GROUPS

7.1 The Committee will receive reports, in the form of Key Issues Reports, from the following:
- Risk Management Committee

8. REVIEW

8.1 The Committee will review its terms of reference and membership annually and recommend any changes to the Board of Directors for approval.

8.2 The Committee will review the effectiveness and performance of the Committee on an annual basis and report the outcome to the Board of Directors.

Appendix 5: Audit Committee Work Plan 2023/24

			2023									2024					
	Items		**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**
		Lead	**Q1**			**Q2**			**Q3**			**Q4**			**Q1**		
General																	
1.	Review the operation of, and proposed changes to, the **Standing Orders, Scheme of Reservation & Delegation and Standing Financial Instructions**	Director of Finance								•							
2.	Board Assurance Framework review	Trust Secretary						•							•	•	
3.	To review arrangements by which staff can raise issues	Director of People & OD						•									
4.	Review of **waivers**	Director of Finance		•						•					•	•	
Internal Audit																	
5.	Oversee the conduct of a **market testing exercise for the appointment of an internal auditor** at least once every five years and, based on the outcome, make a recommendation to the Board of Directors for award of contract **** Current Internal Audit contract term is 1 April 2023 – 31 March 2026 (with a two-year extension option)***																
6.	**Approval of the internal audit plan and counter fraud plan** based on risk assessments	Internal Audit											• *Draft*		• *Final*	• *Final*	
7.	**Review of internal audit plan** to ensure it remains consistent with Trust priorities	Internal Audit		•		•		•		•			•		•	•	
8.	**Review of internal audit reports issued since last meeting** and major audit issues arising from audits in progress	Internal Audit		•		•		•		•			•		•	•	
9.	**Review of internal audit follow up report** including follow up of outstanding recommendations and ongoing review of key governance processes	Internal Audit		•		•		•		•			•		•	•	
10.	**Review of Local Counter Fraud specialist activities** through consideration of progress reports.	Local Counter Fraud Specialist (LCFS)		•		•		•		•			•		•	•	
11.	**Counter Fraud Annual Report**	LCFS		•											•	•	
12.	Emerging Issues (with urgent and emergent issues reported outside of formal timetable as required)	Internal Audit / LCFS		•		•		•		•			•		•	•	

			2023									2024					
	Items		**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**
		Lead	**Q1**			**Q2**			**Q3**			**Q4**			**Q1**		
External Audit																	
13.	Oversee, in liaison with the Council of Governors, the conduct of a **market testing exercise for the appointment of an external auditor** at least once every five years and, based on the outcome, make a recommendation to the Council of Governors for award of contract **** To commence in Sept 2023, Ext Audit contract term ends on 31 March 2024***							•									
14.	**Assess the external auditor's work and fees** and make recommendation to the Council of Governors re re-appointment or removal of the auditor ****Presented to CoG in Feb 2022***																
15.	**Approval of the external audit plan**, based on risk assessments, and the proposed fee for the next year	External Audit											•				
16.	**External Audit Update Report** including review of outstanding implementation of recommendations with significant / fundamental status as required	External Audit		•		•		•		•			•		•	•	
17.	Policy on the engagement of the External Auditor to supply non-audit services **** Next due for review in Feb 2026***	Trust Secretary / Deputy Dir of Finance															
18.	Emerging Issues (with urgent and emergent issues reported outside of formal timetable as required)	External Audit		•	•	•		•		•			•		•	•	
19.	Private discussions with Internal and External Audit (if required)	Chair		•		•		•		•			•		•	•	
Year End Matters																	
20.	Review of **Accounting Policies**	Director of Finance											• *Draft*		•	•	
21.	Review of **annual accounts progress** and **agreement of final accounts process and timetable**	Director of Finance		•											•	•	
22.	**Annual Report and Accounts** review and recommendation to the Board	Director of Finance / Trust Secretary		• *Draft*	• *Final*										• *Draft*	• *Draft*	• *Final*
23.	**Review of Going Concern basis of preparation**	Director of Finance		•											•	•	
24.	Review **Annual Governance Statement** (AGS) **and related disclosure statements** and make	Chief Executive /		• *Draft*	• *Final*										• *Draft*	• *Draft*	• *Final*

			2023									2024					
	Items		**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**
		Lead	**Q1**			**Q2**			**Q3**			**Q4**			**Q1**		
	recommendation to the Board	Trust Secretary															
25.	Receipt of **Annual Internal Audit Annual Report and Head of Internal Audit Opinion**	Internal Audit		•											•	•	
26.	**Audit Completion Report including Auditor's Report**	External Audit			•												•
27.	**Audit Annual Report**	External Audit				•											
28.	**Management Representation letter: Financial Accounts**	Director of Finance			•												•
29.	Review of **losses and special payments**	Director of Finance				•											
30.	Review **Declaration of Interests Annual Report**	Trust Secretary		•											•	•	
Board Committees																	
31.	Reports from Board Committee Chairs	Committee Chairs		•		•		•		•			•		•	•	
Subgroups																	
32.	**Risk Management Committee** Key Issues Report	Chief Executive		•		•		•		•			•		•	•	
Committee Business																	
33.	**Annual Review of Audit Committee, inc. review of Terms of Reference, Work Plan and Formal Committee Evaluation**	Chair				•									•	•	
34.	Informal Review of Committee Effectiveness	Led by Chair		•	•	•		•		•			•		•	•	•

NB. Subject to NHSE financial accounting and reporting requirements for 2023/24, year-end meetings will take place in April/May/June 2024 and the work plan will be followed accordingly.