Public Board meeting

Thu 04 April 2024, 09:30 - 12:35

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

All

09:30 - 09:35
5 min

3. Patient Story (Verbal)

Information

09:35 - 09:40
5 min

4. Minutes of Previous Meeting - held on 1 February 2024 (Paper)

Decision *Marisa Logan-Ward*

04 - Public Board Minutes - 1 Feb 2024.pdf (11 pages)

09:40 - 09:40
0 min

5. Action Log (Paper)

Information *Marisa Logan-Ward*

05 - Public Board Action Log - April 2024.pdf (1 pages)

09:40 - 09:50
10 min

6. Chair's Report (Paper)

Discussion *Marisa Logan-Ward*

06 - Chairs Report - April 2024.pdf (4 pages)

09:50 - 10:00
10 min

7. Chief Executive's Report (Paper)

Discussion *Karen James*

07 - Chief Executive Report - April 2024.pdf (7 pages)

PERFORMANCE

10:00 - 10:20
20 min

8. Integrated Performance Report (Paper)

Discussion *Karen James / Executive Directors*

- **Quality**
- **Operational Performance**
- **Workforce**
- **Finance**

08a - Integrated Performance Report - Front Sheet April 2024.pdf (2 pages)
08b - Integrated Performance Report (Feb 2024 Data) - Final.pdf (24 pages)

10:20 - 10:35
15 min

9. Finance Report - Financial Position Month 11 (Paper)

Discussion *John Graham*

09a - Financial Position Report Month 11 2023-24 - Front Sheet.pdf (3 pages)
09b - Financial Position 2023-24 M11.pdf (12 pages)

PEOPLE

10:35 - 10:45
10 min

10. Freedom to Speak Up Report including Annual Self-Assessment and Reflection Tool (Paper)

Discussion *Caroline Parnell / Nadia Walsh*

10a - Freedom to Speak Up Report - April 24.pdf (10 pages)
10b - Freedom to Speak Up Self Assessment - Front Sheet - April 24.pdf (3 pages)
10c - Freedom to Speak Up Self Assessment.pdf (30 pages)

10:45 - 11:00
15 min

11. NHS Staff Survey 2023 (Paper)

Discussion *Amanda Bromley*

11 - NHS Staff Survey.pdf (15 pages)

11:00 - 11:10
10 min

12. Safer Staffing Report (Paper)

Discussion *Nicola Firth / Andrew Loughney*

12a - Safe Staffing Report - April 2024.pdf (2 pages)
12b - Safe Staffing Report - April 2024.pdf (26 pages)

11:10 - 11:20
10 min

COMFORT BREAK

STRATEGY

11:20 - 11:30
10 min

13. Corporate Objectives 2024/25 (Paper)

Decision *Karen James*

13 - Corporate Objectives 2024-25.pdf (4 pages)

GOVERNANCE

11:30 - 11:40
10 min

14. Board Assurance Framework - Q4 2023/24 (Paper)

Decision *Karen James*

- 14a - Board Assurance Framework Q4 2023-24 - Front Sheet.pdf (5 pages)
- 14b - Appendix 1 - Board Assurance Framework Q4 2023-24.pdf (19 pages)
- 14c - Appendix 2 - Significant Risk Register - March 2024.pdf (2 pages)

11:40 - 11:50
10 min

15. Standing Financial Instructions and Scheme of Reservation & Delegation (Paper)

Decision *John Graham*

- 15a - SFIs and Scheme of Reservation & Delegation - Front Sheet.pdf (6 pages)
- 15b - Appendix 1 - SFT Standing Financial Instructions DRAFT - February 2024.pdf (96 pages)
- 15c - Appendix 2 - SFT SoRD DRAFT - February 2024.pdf (45 pages)

11:50 - 12:00
10 min

16. Annual Review of NHS Provider Trust Code of Governance (Paper)

Discussion *Rebecca McCarthy*

- 16 - Annual Review of Provider Trust Code of Governance - April 2024.pdf (27 pages)

12:00 - 12:05
5 min

17. Annual Trust Seal Report (Paper)

Information *Rebecca McCarthy*

- 17 - Use of Common Seal 2023-24.pdf (3 pages)

STANDING COMMITTEE REPORTS

12:05 - 12:15
10 min

18. Board Committees Annual Review: Including Terms of Reference and Work Plans for Approval (Paper)

Decision *Rebecca McCarthy*

- 18a - Board Committees Annual Review 2023-24.pdf (3 pages)
- 18b - Finance & Performance Committee Annual Review 2023-24.pdf (17 pages)
- 18c - People Performance Committee Annual Review 2023-24.pdf (15 pages)
- 18d - Quality Committee Annual Review 2023-24.pdf (19 pages)

12:15 - 12:25
10 min

19. Board Committees - Key Issues Reports (Paper)

- 19a - Board Standing Committees Key Issues Reports - Front Sheet.pdf (2 pages)

19.1. People Performance Committee

Information *Beatrice Fraenkel*

- 19b - People Performance Committee - Key Issues Report - March 2024.pdf (4 pages)

19.2. Finance & Performance Committee

Information *Anthony Bell*

- 19c - Finance & Performance Committee - Key Issues Report - Feb 2024.pdf (2 pages)
- 19d - Finance & Performance Committee - Key Issues Report - March 2024.pdf (3 pages)

19.3. Quality Committee

Information *Mary Moore*

- 19e - Quality Committee Key Issues Report - February & March 2024.pdf (4 pages)
- 19e.1 - Maternity Services Highlight Report - March 2024.pdf (4 pages)
- 19e.2 - Maternity Service Highlight Report - March 2024.pdf (35 pages)
- 19e.3 - LMNS Safety Assurance Return - March 2024.pdf (4 pages)
- 19e.4 - STOCKPORT Ockenden-Kirkup Return April 2024.pdf (9 pages)

19.4. Audit Committee

Information *David Hopewell*

- 19f - Audit Committee Key Issues Report 20th February 2024.pdf (3 pages)

CLOSING MATTERS

12:25 - 12:25
0 min

20. Any Other Business

DATE, TIME & VENUE OF NEXT MEETING

12:25 - 12:25
0 min

21. Thursday, 6 June 2024, 9.30am, Pinewood House Education Centre

12:25 - 12:25
0 min

22. 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".

NHS Stockport NHS Foundation Trust

STOCKPORT NHS FOUNDATION TRUST
Minutes of a meeting of the Board of Directors held in public
Held on Thursday 1 February 2024, at 9.30am in Pinewood House Education Centre, Stepping Hill Hospital

Members Present:

Dr Marisa Logan-Ward	Interim Chair
Mr Anthony Bell	Non-Executive Director
Mrs Amanda Bromley	Director of People & Organisational Development
Mrs Nicola Firth	Chief Nurse
Mrs Beatrice Fraenkel	Non-Executive Director
Mr John Graham	Chief Finance Officer / Deputy Chief Executive
Mrs Karen James	Chief Executive
Dr Andrew Loughney	Medical Director
Mrs Jackie McShane	Director of Operations
Dr Louise Sell	Non-Executive Director

In attendance:

Mrs Soile Curtis	Deputy Trust Secretary
Mrs Rebecca McCarthy	Trust Secretary

Observing:

Mrs Sue Alting	Lead Governor
Mr Paul Buckley	Incumbent Director of Strategy & Partnerships
Dr Rebecca Dooley	Member of the public
Mrs Mary Moore	Non-Executive Director
Ms Gemma Sayer	Business Development Executive, System C

Apologies:

Dr Samira Anane	Non-Executive Director
Mr David Hopewell	Non-Executive Director
Mrs Mary Moore	Non-Executive Director
Mrs Caroline Parnell	Director of Communications & Corporate Affairs*

** indicates a non-voting member*

Quoracy:
To be quorate the meeting requires:
At least six voting Directors including not less than two Executive Directors (one of whom must be the Chief Executive, or another Executive Director nominated by the Chief Executive), and not less than two Non-Executive Directors (one of whom must be the Chair or the Deputy Chair of the Board of Directors)

Quorate: Yes

REF No/Yr.	ITEM	ACTION OWNER
01/24	**Apologies for Absence** The Interim Chair welcomed everyone to the meeting. Apologies for absence were noted as above.	
02/24	**Declarations of Interest** There were no declarations of interest.	

03/24	**Patient Story** The Board of Directors watched a video about the Trust's Neonatal Unit, which highlighted developments undertaken by the Neonatal Unit team that had led to the achievement of green FiCare accreditation, and the consequent improvements to the patient and carer experience. FiCare is a model that supports and educates parents and carers to become an integral part of their baby's care in partnership with the Neonatal Team, from the moment a baby is admitted to the Neonatal Unit. The Board also heard about the positive experience from a parent whose son had been cared for on the Neonatal Unit. In response to a question from the Interim Chair querying support available to parents and babies following discharge from the Neonatal Unit, the Board heard that a formal support network was in place and that parents often joined volunteer networks supporting other parents going through similar experiences. Mrs Beatrice Fraenkel, Non-Executive Director, queried if the support responded to everyone's individual circumstances, taking into account e.g. culture mix, language and mental health needs. The Medical Director advised that the service was not designed to emphasise any specific culture but was designed around the baby. The Chief Nurse confirmed that the Trust employed a Mental Health midwife, and a number of specialist midwives ensured relevant assurance from a Black, Asian and Minority Ethnic (BAME) perspective. **The Board of Directors received and noted the Patient Story.**	
04/24	**Minutes of Previous Meeting** The minutes of the previous meeting held on 7 December 2023 were agreed as a true and accurate record.	
05/24	**Action Log** The action log was reviewed and annotated accordingly.	
06/24	**Clinical Negligence Scheme for Trusts (CNST) Year 5 Maternity Incentive Scheme – Board Declaration** The Chief Nurse presented a report detailing the position of the Trust's maternity service in relation to the 10 Safety Actions required as part of the CNST Year 5 maternity incentive national scheme. The Chief Nurse confirmed that, on review of the standards and in line with the submission requirements of the Board Assurance Framework, the Trust would be compliant with ten out of ten safety actions. She added that the submission was subject to the approval of action plans in relation to safety actions 4 and 5, included within the report. The Board heard that the Quality Committee had considered the report and recommended it to the Board for approval. The Chief Nurse provided an overview of the evidence for Safety Actions 1-10, including: - Narrative relating to Safety Action 4a – Obstetric and Medical Workforce compensatory rest - Action Plan Safety Action 4a – Obstetric and medical Workforce	

	compensatory rest - Action Plan Safety Action 4c – Neonatal Medical Workforce - Action Plan Safety Action 5 – One to one care in labour - CNST Year 5 Action Plan and Evidence - CNST Year 5 Board declaration documentation The Chief Nurse confirmed that the submission of the Trust Board declaration form of compliance for CNST was due on 1 February 2024. She advised that following review of the CNST Year 5 Maternity Incentive Scheme submission and Board declaration form, alongside Quality Committee recommendation of approval, the Chief Executive had confirmed she was fully assured and in agreement with the compliance submission and that her signature be applied to the Board declaration form. Furthermore, the Chief Executive had ensured that the Accountable Officer for the Integrated Care System is apprised of the Maternity Incentive Scheme safety actions' evidence and Board declaration form requirements. Dr Louise Sell, Non-Executive Director, briefed the Board on a discussion held at Quality Committee about the associated action plan, noting that a business case had been agreed in principle for additional medical workforce. **The Board of Directors:** • **Received assurance that action plans are in place against safety action 4 and 5.** • **Approved that the evidence provided meets the necessary sub requirements to be able to submit the Trust Board declaration.** • **Approved the submission of the Trust Board declaration form, to be signed by the Chief Executive, for the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS), noting compliance is demonstrated with ten out of ten safety actions. There are two safety actions that require action plans as part of the submission, which do not impact on achieving full compliance with the ten safety actions.**	
07/24	**Chair's Report** The Interim Chair presented a report reflecting on recent activities within the Trust and the wider health and care system. The Board of Directors received an update on external partnerships, Trust activities and strengthening Board oversight. The Interim Chair paid tribute and expressed thanks to Prof. Tony Warne for his chairmanship, and the Board of Directors wished him the very best for the future and in his new role as Chair of Greater Manchester Mental Health NHS Foundation Trust. **The Board of Directors received and noted the Chair's Report.**	
08/24	**Chief Executive's Report** The Chief Executive presented a report providing an update on local and national strategic and operational developments, including: • Industrial Action • NHS GM Integrated Care - Finance Update • NHS GM Integrated Care – 2024/25 Planning Update • Operational Pressures	

	• Outpatients B Update • Handover of Rapid Assessment Unit • Visit from Leader of Liberal Democrats • Awards Furthermore, the Medical Director provided an update on the national measles outbreak and associated mitigating actions to ensure robust processes. In response to a question from Mrs Beatrice Fraenkel, Non-Executive Director, about the Board's role in health prevention and interventions, the Medical Director and Chief Executive provided an overview of collaborative working with Locality Board and Health & Wellbeing Board in this area. In response to a question from Mr Tony Bell, Non-Executive Director, the Chief Executive and Director of Operations provided an update on the Trust's tiering status as part of the national elective recovery programme, including from a GM perspective. Dr Louise Sell, Non-Executive Director, advised that the Quality Committee had requested that the Finance & Performance Committee consider trajectory and action required to improve performance of cancer standards. In response to a further question from Mr Tony Bell, Non-Executive Director, the Chief Executive highlighted challenges relating to planning, given the national guidance was still awaited. **The Board of Directors received and noted the Chief Executive's Report.**	
09/24	**Integrated Performance Report** The Chief Executive introduced the Integrated Performance Report (IPR), which included exception reports for areas of most significant note. **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), outpatient efficiency, and theatre efficiency metrics due to under-achievement in month. The Director of Operations reported that current performance against the ED 4-hour standard continued to benchmark well across Greater Manchester (GM), with Stockport ranking second for type-1 performance at 63.21% year to date. The Board noted, however, the impact of the significant numbers of ED attendances. The Board heard that 12-hour waits had increased and robust processes for managing, reviewing, and providing assurance for assessment of harm relating to the delays were fully embedded within the service. The Director of Operations highlighted the challenges of accessing timely care home beds, which continued to impact the Trust's ability to discharge or transfer patients with 'no criteria to reside' (NCTR) in a timely manner. It was noted, however, that the NCTR position had improved in month. The Director of Operations advised that diagnostic performance had been	

challenged by industrial action, repeat/return procedures, long-term sickness and annual leave over the festive period.

The Director of Operations reported that cancer performance had continued to improve, and welcomed support received from the national team and Cancer Alliance in this area.

In response to a question from the Interim Chair about the risk relating to histology backlogs, the Director of Operations and Medical Director briefed the Board on mitigating actions, including outsourcing work, and confirmed that this was included on the Trust's Significant Risk Register.

Quality
The Chief Nurse and Medical Director presented the quality section of the IPR and highlighted challenges and mitigation actions regarding sepsis, infection prevention & control, incidents and pressure ulcers due to under-achievement in month.

The Medical Director advised that the Trust was performing well against the timely recognition of sepsis metric and achieving performance above target levels. He noted, however, that antibiotic administration within the necessary timescales continued to be challenging, highlighting key themes in this area.

The Chief Nurse advised that infection rates for C.diff and E.coli continued to be significantly higher than associated thresholds. She noted that C.diff themes from the avoidable cases were linked with antibiotic appropriateness, course length, and course numbers which appeared to have increased following the Covid pandemic.

The Chief Nurse reported that hospital acquired category-2 pressure ulcers remained within target threshold, however December had seen most cases this year to date. The Board heard about mitigating actions, both in the hospital and the community.

People
The Director of People & Organisational Development (OD) presented the people section of the IPR and highlighted performance and mitigating actions around sickness absence, workforce turnover, appraisal and mandatory training rates due to under-performance in month.

The Director of People & OD reported that sickness absence was above target for December, however noted an improved position compared to December 2022. She briefed the Board on mitigating actions, including targeted support and promotion of health & wellbeing support.

The Board heard that whilst workforce turnover was still above the target, performance continued on an improved trajectory. It was noted that mandatory training compliance was also showing significant improvements.

In response to a question from Mrs Beatrice Fraenkel, Non-Executive Director, querying impact of vacancies on the service, the Board received an overview of associated actions, noting weekly vacancy reviews undertaken by the staffing review group, and positive substantive appointments made in a number of areas.

	Mr Tony Bell, Non-Executive Director, highlighted challenges in relation to staff turnover, sickness absence and cost of cover, in the context of increased demand. In response to a question from Dr Louise Sell, Non-Executive Director, the Director of People & OD briefed the Board on mitigating actions taken by the Trust to address staff turnover. She noted positive inroads in this area, albeit acknowledging continued challenges, including regarding the Trust's age profile and higher-paid opportunities provided by neighbouring trusts. **The Board of Directors received and noted the Integrated Performance Report.**	
10/24	**Finance Report – Financial Position Month 9** The Chief Finance Officer presented a report providing an update on financial performance for Month 9 2023/24, summarising key extracts from a report presented to the Finance & Performance Committee. The Board heard that the Trust had a deficit of £24.6m at Month 9 2023/24, which was an adverse variance of £1m to plan. The Chief Finance Officer highlighted the following key risks to delivery of the financial plan: • Derbyshire Integrated Care Board (ICB) contract issues • Industrial action • ERF • Capital • Depreciation funding • Outpatients B closure The Chief Finance Officer reported that, subject to known risks as agreed within the GM ICB, the Trust was forecasting to: - deliver its financial plan for 2023/24 - deliver its capital plan for 2023/24 - deliver its savings plan for 2023/24 with a requirement for increased recurrent delivery - require cash borrowing in March 2024, which was subject to national approval. The Chief Finance Officer stated that the Trust had strengthened its financial governance with a series of grip and control actions to support delivery of the financial plan for 2023/24. In response to a question from Mrs Beatrice Fraenkel, Non-Executive Director, about economies of scale, the Chief Finance Officer stated that the Trust was actively engaging with the system in this area, and stressed the importance of quality provision. In response to a question from the Interim Chair, the Chief Finance Officer confirmed that the Board would continue to receive a summary version of the Finance Report that was provided to the Finance & Performance Committee. Board members welcomed the level of detail provided in the report. **The Board of Directors received and noted the Finance Report.**	

11/24	**Wellbeing Guardian Report** The Board received a verbal update from the Wellbeing Guardian (Non-Executive Director/Interim Chair). She highlighted the continued focus on health and wellbeing across the organisation and noted in particular the importance of the Staff Psychology and Wellbeing Support (SPAWS) service in supporting staff in this area. The Board heard that further opportunities for health and wellbeing partnership working would be explored. In response to a comment from the Wellbeing Guardian, the Board of Directors recognised the impact of operational pressures on staff's health and wellbeing. **The Board received and noted the verbal update from the Wellbeing Guardian.**	
12/24	**Integrated People & Organisational Development Plan Progress Report** The Director of People & Organisational Development (OD) presented a report providing a 6-monthly progress update against the OD Plan 2023-25. She briefed the Board on the content of the report, which had also been considered by the People Performance Committee, highlighting progress made against the following four priority areas aimed at improving organisational culture and performance: • Leadership and working relationships • Talent management • Innovation • OD consultancy The Director of People & OD confirmed that Equality, Diversity & Inclusion (EDI) remained a golden thread throughout the OD work programme and a number of actions within the plan were helping the Trust to achieve the ambitions set out in the EDI Strategy. The Board noted good progress with the delivery of the action plan, but acknowledged the adverse impact of ongoing industrial action, increased operational demands and emerging priorities, which had delayed some planned events and activities and actions relating to talent management, succession planning and career progression. The Board heard that a more robust evaluation approach was currently in development, which would measure the impact of OD intervention on participants' behaviour and achievement of team objectives. In response to a comment from Mrs Beatrice Fraenkel, Non-Executive Director, about the need to reflect on the changing nature of CQC inspections, the Chief Executive advised that GM had agreed to be a pilot for the new CQC inspection regime and the Board would be kept updated on progress in this area. In response to a further comment from Mrs Fraenkel about the impact of the new national EDI framework, the Director of People & OD confirmed that the Trust had undertaken a gap analysis in this area, with any gaps incorporated into the EDI action plan.	

	In response to a question from the Interim Chair, the Director of People & OD briefed the Board on actions taken to improve the effectiveness of staff networks, including attendance at meetings. In response to a question from Dr Louise Sell, Non-Executive Director, about the risk findings of BAME colleagues entering disciplinary process, the Director of People & OD noted positive movement in this area, but acknowledged further work was required to ensure the Trust's processes did not have unintended discriminatory elements to them. **The Board of Directors received and noted the Integrated People & Organisational Development Plan Progress Report.**	
13/24	**Annual Nursing & Midwifery Establishment Review** The Chief Nurse presented the Annual Strategic Staffing Report, which had also been considered by the People Performance Committee, and provided assurances and risks associated with safer nursing and midwifery staffing and the actions in progress to mitigate the risks associated with patient safety and quality, based on patients' needs, acuity, dependency and risks. She briefed the Board on the content of the report and advised that the underlying nurse staffing position had remained consistent with a reduction in nursing and midwifery vacancies and a levelling out in turnover. The Board heard that systems were in progress to provide assurance that safer nursing and midwifery staffing across the organisation was a priority to maintain patient quality and safety, and that the Safer Nurse Care Tool (SNCT) enabled triangulation between patient acuity, the number of patients and the nursing staffing levels. Dr Louise Sell, Non-Executive Director, noted that the report provided assurance regarding our own staffing levels but that it would be helpful for future iterations to include assurance about staff employed by partner organisation/s providing mental health liaison in the Trust, which was critical to service delivery. The Chief Nurse acknowledged the comment and agreed to liaise with Pennine Care to understand how they assess their staffing levels. **The Board received and noted the Annual Nursing & Midwifery Establishments Report.**	
14/24	**Safe Care (Staffing) Report** The Chief Nurse and Medical Director presented a report providing assurances and risks associated with safe staffing, alongside actions to mitigate the risks to patient safety and quality, based on patients' needs, acuity, dependency and risks. The Board acknowledged the ongoing high levels of operational demand within the acute and community services, which was having an impact on patient and staff experience. It was noted that demands within the Emergency Department remained significant, impacted by large numbers of patients who no longer require a hospital bed, and that this demand and consequent adverse impact on patient flow was being operationally managed by senior teams and on-call colleagues with continual dynamic risk assessments	

	conducted. The Board also acknowledged the impact and associated challenges of the industrial action. The Interim Chair requested the inclusion of information on healthcare scientists group in future reports, and it was noted that this was being progressed through an action included on the People Performance Committee action log. **The Board received and noted the Safe Care (Staffing) Report.**	
15/24	**Emergency Preparedness, Resilience and Response (EPRR) Update – NHS England Core Standards** The Chief Finance Officer presented a report describing the NHS England (NHSE) Core Standards Assessment process and the Trust's findings following a self-assessment. The report also highlighted the regional position regarding NHSE Core Standards and the Trust's plan to ensure continued improvement of emergency preparedness. The Board heard that the Trust had completed the Core Standards Self-Assessment and, as reported to the Board of Directors in December 2023, an improvement plan was developed to ensure the Trust achieves full compliance by March 2024. The Chief Finance Officer advised that this assessment was not accepted by regional colleagues, with request for both assessments to be presented to the Boad of Directors. He stated that the Trust's response did not reconcile with the regional team assessment and the Trust remained committed to implementing key actions to achieve full compliance by March 2024. In response to a question from Mrs Beatrice Fraenkel, Non-Executive Director, regarding emergency planning testing, the Chief Finance Officer noted priorities going forward to test emergency planning in conjunction with system colleagues. **The Board of Directors received and noted the EPRR Update – NHS England Core Standards, including the outcome of the Trust EPRR Self-Assessment and the assessment of the regional team, and confirmed the improvement plans in place.**	
16/24	**Board Assurance Framework 2023/24 – Quarter 3** The Chief Executive presented the Board Assurance Framework (BAF) 2023/24 as at the end of Quarter 3, noting that all BAF risks were regularly reviewed by relevant Board Committees. She briefed the Board on the report and the principal risks and associated mitigations. Furthermore, a gap analysis between current and target risk score was provided. The Board heard that operational performance, finance, workforce, and estates related risks remained as the Trust's most significant scoring risks. The Chief Executive noted that the risk profile had remained stubborn since the start of the year with several key gaps in control being out with the Trust's scope of control, and actions required to mitigate were both complex and required partner/system working. In response to a comment from Mr Tony Bell, Non-Executive Director, the	

	Chief Executive acknowledged that there would be merit in aligning risks GM-wide with a longer term risk management approach, once there was further clarity of a longer term financial plan. In response to questions from Mrs Beatrice Fraenkel, Non-Executive Director, and the Interim Chair about the Integrated Care System (ICS) risk register, the Chief Executive advised that the risk register was discussed at their Board, noting that the process was an evolving one. **The Board of Directors reviewed and approved the Board Assurance Framework 2023/24 as at Quarter 3, including action proposed to mitigate risks.**	
17/24	**Board of Directors Standards of Business Conduct:** • **Non-Executive Director Independence** • **Board of Directors Declarations of Interest** • **Annual Fit & Proper Person Review, including approval of Fit & Proper Persons Policy** The Trust Secretary presented the Standards of Business Conduct reports providing detail regarding the independence of Non-Executive Directors in line with the NHS FT Code of Governance (Provision B.1.2); declared interests of all Board members; new Fit & Proper Persons Policy and the Board's compliance with the new Fit & Proper Person Framework, following an annual assessment of compliance completed in January 2024. **The Board of Directors:** • **Reviewed independence declarations and confirmed that it considered the Interim Chair and all Non-Executive Directors to be independent.** • **Reviewed and confirmed the interests declared by the Board of Directors.** • **Reviewed and approved the Fit & Proper Persons Policy.** • **Endorsed the Interim Chair's annual assessment of the Fit & Proper Person requirements for the Board of Directors.**	
18/24	**Board Committees – Key Issues Reports** **Finance & Performance Committee** The Chair of Finance & Performance Committee (Mr Tony Bell, Non-Executive Director) presented the key issues report from Finance & Performance Committee meeting held on 18 January 2024. He briefed the Board on the content of the report and detailed key financial and operational issues and associated key risks considered. **The Board of Directors reviewed and confirmed the Finance & Performance Committee Key Issues Report, including actions taken.** **People Performance Committee** The Chair of People Performance Committee (Mrs Beatrice Fraenkel, Non-Executive Director) presented the key issues report from the People	

	Performance Committee meeting held on 11 January 2024. She briefed the Board on the content of the report and detailed key people related issues considered. In response to a comment about the time allocation for the Freedom to Speak Up Guardian, the Director of People & OD confirmed that this would be kept under review as part of the annual Freedom to Speak Up Self-Assessment Tool. **The Board of Directors reviewed and confirmed the People Performance Committee Key Issues Report, including actions taken.** **Quality Committee** The Acting Chair of Quality Committee (Dr Louise Sell, Non-Executive Director) presented the key issues report from the Quality Committee meeting held on 23 January 2024. She briefed the Board on the content of the report and detailed key quality related issues considered at the meeting. **The Board of Directors reviewed and confirmed the Quality Committee Key Issues Report, including actions taken.**	
19/24	**Any Other Business** There was no other business.	
20/24	**Date and Time of Next Meeting** Thursday, 4 April 2024, 9.30am, Pinewood House Education Centre.	
21/24	**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".*	

Signed:_____Date:_____

BOARD OF DIRECTORS PUBLIC MEETING ACTION TRACKER

Action Log Ref No/Yr.	Meeting Date	Minute Ref	Item	Action	Responsible	Status
01/22	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. **Update October 2023** – Further review of toolkit and action plan agreed to be presented to PPC in March 2024 – Confirmed on PPC Work Plan. The Board agreed to keep the action open as the toolkit would require Board sign off once it had been through PPC. **Update April 2024** – Toolkit on agenda.	Director of People & OD / Director of Communications & Corporate Affairs	April 2024

On agenda
Not due
Overdue
Closed

Closed actions will be removed from the Action Log once confirmed by the Committee/Group.

NHS
Stockport
NHS Foundation Trust

Meeting date	4th April 2024	**Public**	X	**Agenda No.**	6
Meeting	Board of Directors				
Report Title	Chair's Report				
Presented by	Dr Marisa Logan-Ward, Interim Chair	**Author**	Dr Marisa Logan-Ward, Interim Chair		

Paper For:	**Information**	X	**Assurance**		**Decision**	
Recommendation:	The Board of Directors is asked to note the content of the report.					

This paper relates to the following Annual Corporate 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
	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
	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

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	
Financial impacts if agreed/not agreed	
Regulatory and legal compliance	
Sustainability (including environmental impacts)	

Executive Summary

This report advises the Trust Board of the Interim 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 Interim Chair's reflections on her recent activities.

2. External Partnerships

I attended the Stockport Health and Wellbeing Board which included:

- A progress update on the outcomes of the ONE Stockport Active Communities Strategy (Stockport Moving Together)
- Presentation of first combined LeDeR annual report as an Integrated Care Board (ICB) for 2022/23.
- Report on Better Care Fund (BCF) which provided an update on the overall financial performance of the BCF as of 31 December 2023 (Quarter 3).
- The report of the Deputy Place Lead which provided an update on the differing roles and responsibilities between the Health and Wellbeing Board and the One Stockport Health & Care Board and why both continue to be necessary. The report was requested by the Adult Social Care & Health Scrutiny Committee.

3. Trust Activities

As part of the financial turnaround programme of NHS Greater Manchester ICB, supported by PwC, I have attended the monthly Stockport's Finance and Recovery Meetings with executive colleagues. The requirements of the programme remain a significant challenge, but focus remains on delivering high quality and safe care to our patients.

In February I visited Outpatients A and talked to staff who have been directly and indirectly affected by the closure of Outpatients B in December. The closure of the building is having a huge impact on both patients and staff. Teams are coming together to adapt to the new arrangements and are committed to providing high quality outpatient services in difficult circumstances.

In March I spent a morning visiting theatres and had an opportunity to talk to orthopaedic surgeons, anaesthetists, operating department practitioners and scrub practitioners about our surgical services. It was impressive to see what goes into preparing for a day of operations and ensuring high-quality care whilst maximising the utilisation of theatres, which we know is vital to help address the backlogs.

A real highlight for me has been attending a special exhibition at Stockport War Memorial Art Gallery featuring the pandemic experiences of several of our staff alongside their portraits. You will hear more about this in the Chief Executives Report.

4. Strengthening Board Oversight

Our board development session on 7th March focussed on population health and health prevention. We were joined by Stockport Council's Director of Public Health and Public Health Consultant who delivered an insightful presentation on health inequalities followed by board discussion on the role of the acute Trust in addressing population health and inequalities. We look forward to a follow up session later in the year and working together with partners on the forthcoming Health Inequalities Board Assurance Toolkit and assess maturity levels as an anchor institution.

I am on-track to conclude both Chief Executive and Non-Executive Director appraisals by the end of April. These will be reported to the Council of Governors in June.

5. Other activities:

I have continued to undertake a range of other activities, including: -

- Attending the Clinical Directors Forum
- Interview panel member – Consultant Urologist recruitment.
- Regular discussions with Non-Executive Directors, Executive Directors, Chief Executive, and the Deputy Chief Executive
- Meeting with the Lead Governor
- Meeting with Stockport Council Cabinet Member for Health & Social Care
- Meeting with Freedom to Speak Up Guardian
- Meeting with Trust Lead Nurse for Health Prevention.
- Board sub-committee member: Quality, People Performance and Charitable Funds.
- Chaired the meeting of the Council of Governors.

NHS Stockport NHS Foundation Trust

Meeting date	4th April 2024	**Public**	X	**Agenda No.**	7
Meeting	Board of Directors				
Report Title	Chief Executive's Report				
Presented by	Karen James, Chief Executive	Author	Caroline Parnell, Director of Communications & Corporate Affairs		

Paper For:	**Information**	X	**Assurance**		**Decision**	
Recommendation:	The Board of Directors is asked to note the content of the report.					

This paper relates to the following Annual Corporate 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
	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
	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
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

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	
Financial impacts if agreed/not agreed	
Regulatory and legal compliance	
Sustainability (including environmental impacts)	

Executive Summary

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

- Spring budget
- Industrial action
- Mental health service developments
- Operational pressures
- Estate issues
- Covid memorial exhibition
- National Joint Registry
- NHS Communicate Award
- Learning of the Year
- Auditor of the Year

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 Spring Budget

Jeremy Hunt, the Chancellor of the Exchequer, delivered his spring budget on 6 March, and it included a number of changes that will impact on health and care systems.
He announced a £2.5bn revenue funding increase for the NHS in 2024-25, a £3.4bn increase in capital funding for NHS technological and digital transformation over three years from 2025-26, and £35m over three years from 2024-25 to improve maternity safety.

The Chancellor said the revenue funding increase will protect current funding levels in real time and support the NHS to continue to reduce waiting times and improve performance.
The £3.4bn of capital funding will be split across three areas:

- £1bn to transform the use of data to reduce time spent on administrative tasks eg pilots to test the ability of AI to automate back office functions.
- £2bn to update IT systems eg to ensure all trusts have electronic patient records.
- £430m to transform access for patients eg making the NHS app the front door for patents to access NHS services and manage their care.

The Government estimates this funding will unlock £35bn in productivity savings from 2025-26, and NHS England has committed the NHS to 1.9% average productivity growth from 2025-26 to 2029-30, rising to two per cent over the final two years. NHS England will start reporting on productivity measures from the second half of 2024-25.

The additional investment in maternity care of £35m over three years from 2024-25 will fund a number of measures, including the roll out of the avoiding brain injuries in childbirth programme and the Maternity and Neonatal Voice Partnerships.

The Government will also work with NHS England on reducing the cost of agency staffing, including stopping the use of off-framework agency staff from July 2024.

2.2 Industrial action

Since the last Board meeting, “junior” doctors have taken further industrial as part of the long running dispute between health unions and the Government.

We must pay tribute to our colleagues and teams for all the work they did to safely maintain services during the latest round of strikes that took place between 24 and 29 February 2024.
The British Medical Association (BMA) has balloted its “junior” members on extending its mandate for further industrial action, including for the first time support to take action short of striking.

With regards to the dispute between consultants and the Government, following constructive talks and after the rejection of an initial offer, and amended offer was agreed between the Government, BMA and the Hospital Consultants and Specialists Association (HCSE) at the

beginning of March. This offer, which the unions are recommending to their members, is currently the subject of a ballot, which closes on 3 April 2024.

The improved offer has a clear focus on reform and includes reducing the number of pay points to shorten the time it takes to reach the top of the pay scale, and the introduction of new pay progression elements that would link pay progression to evidence of skills, competencies and experience. To enable the reforms the unions agreed to end Local Clinical Excellence Awards.

However, the BMA has announced that its speciality doctors, associate specialists and specialist doctor members have voted against the Government's pay offer by a majority of 62.3 per cent. The BMA has said that it wants to continue talks with the Government with the hope of reaching an improved offer, and it has not made a call for further industrial action by this group of clinicians, although it does have an active mandate to take further action if necessary.

3. REGIONAL NEWS

3.1 Mental health service developments

Pennine Care NHS Foundation Trust is on track to open a new £2.4m six bedded psychiatric intensive care unit (PICU) for female patients. Woodbank is due to open later this spring at Stepping Hill Hospital as part of the Trust's drive to improve local services.

A new assertive outreach pathway team has also recently been established in Stockport to work with local community mental health teams in supporting people with severe mental illness, as well as secondary conditions such as drug and alcohol addiction.

4. TRUST NEWS

4.1 Operational pressures

Our teams continue to be under significant operational pressure, and this is particularly apparent in our urgent and emergency care services.

Demand is 1.5% ahead of plan and in recent weeks the team has consistently cared for more than 300 patients a day, and up to 364 patients on one day. Many patients are acutely ill or have complex conditions that require hospital admission, and our bed occupancy rates have remained high at over 96%.

The demand, coupled with difficulties discharging patients from wards once they no longer need hospital care, means that our performance against the national four hour A&E standard is around 55% and we are not meeting the improvement trajectory set for the year end. We do not want patients waiting long periods of time in A&E, and we know that for 2024-25 the performance of urgent and emergency care services will be a particular area of focus for improvement across the NHS.

We have instigated daily urgent care reviews to try to identify any actions that could improve the prompt flow of patients through the hospital, and we have seen some improvement in the

use of the transfer unit freeing up beds earlier in the day. We are also planning a deep dive focusing on how we can improve the way we manage type three cases.

On a positive note we know from the latest data that our teams have achieved a significant reduction in the number of people re-admitted to hospital, and that has steadily reduced since 2020-21.

We have also seen significant reductions in the number of people waiting more than 78 and 65 weeks for treatment, and positive improvements in performance against the diagnostic standards.

4.2 Estate issues

Our ageing estate, particularly on the hospital site, has had an impact on the performance of our services in recent weeks.

The closure of Outpatients B continues to impact on a number of our services. Most have been found temporary homes, but the impact means that currently we are only delivering around 51% of the outpatient appointments we expected to provide.

A small number of services, including ophthalmology, are still to be found temporary homes due to the need to accommodate large pieces of equipment that are not easy to move. Our estates team is prioritising efforts to find alternative accommodation for those services as well as permanent homes for the others as we move forward with the demolition of Outpatients B.

Accommodating services that have had to move out of the department has taken a huge effort from lots of different teams, and we appreciate all the work they are doing to be able to continue to care for patients.

However, this was not the only issue that our ageing estate has caused in recent weeks. We have also suffered unexpected and unrelated ceiling collapses in our critical care unit and radiology department caused by leaks from the heating system.

The critical care unit had to be evacuated but no patients suffered harm thanks to the prompt actions of our staff, and the estates team worked hard to repair the damage so the unit could re-open. The leak in the radiology department did cause the cancellation of some appointments, but again our teams worked hard to re-open the department as soon as possible.

Both incidents meant we had to rapidly implement business continuity plans, which were successful in containing and managing the issues, however estates problems are more frequently impacting on our services and feature on our risk register.

The age of our estate was one of the reasons for our unsuccessful application to the Government's New Hospitals Fund, and while we still have ambitions to build a new hospital for the people of Stockport we also have to be realistic about the amount of capital funding that is likely to be available in 2024-25 to maintain the current hospital buildings. That will mean that we are likely to experience more business continuity issues as the result of our ageing buildings.

4.3 Covid Memorial Exhibition

A special exhibition featuring the pandemic experiences of a number of our staff alongside their portraits is currently on display at Stockport War Memorial Art Gallery.

Local artists have captured the portraits of clinical and non-clinical colleagues, who worked in hospital and community services during the Covid-19 pandemic. They are on show alongside very personal insights into the challenges they faced and the impact that Covid-19 had on them and the people they cared for.

The project, which was organised by the Trust's communications team, was funded by Stockport Metropolitan Borough Council as part of its Covid Community Commemoration Project.

The exhibition, which is on show at the art gallery until 11 April 2023 before the artworks go on permanent display at our hospital, has attracted significant media local and national media attention.

4.4 National Joint Registry

The Trust was named as a gold standard quality data provider by the National Joint Registry (NJR) in recognition of the organisation's commitment to patient safety in joint replacement surgery.

Only trusts that are 100% compliant with NJR standards receive the gold standard and we were one of just four organisations in Greater Manchester to receive the accolade.

4.5 NHS Communicate Award

A project to support colleagues experiencing the menopause has won a national NHS communications award.

The project topped the Communications Team Health and Wellbeing Category of the recent NHS Communicate Awards 2024, that celebrates the best NHS communications projects across the country.

The award recognised the work of the Trust's communications team in promoting the range of support available to colleagues, including a specialist Staff Facebook group, regular menopause blog, and promotion of a monthly menopause café and menopause focused Schwartz round where staff came together to share experiences.

4.6 Learner of the Year

Rachel Donnelly, a recently qualified school nurse, has been shortlisted in the Learner of the Year category of the Student Nursing Times Awards.

She completed a postgraduate apprenticeship with Manchester Metropolitan University to qualify as a specialist community public health nurse with a particular passion for improving school nursing support and reducing health inequalities for LGBTQ+ young people.

She has been shortlisted for the national award in recognition of a school nursing toolkit she developed following focus groups with young LGBTQ+ to identify their needs. Rachel has already received the national School Student Nurse of the Year award from the School and Public Health Nurse Association. The winners of the Student Nursing Times Awards will be announced at a ceremony in London on 26 April 2024.

4.7 Auditor of the Year

Sarah Irvine, our cleanliness monitoring officer, was shortlisted in the Auditor of the Year category of the My Cleaning Awards, which celebrate the best in healthcare cleaning standards across the UK and Ireland.

Responsible for auditing cleaning standards across our hospital Sarah was praised for her positive motivational style helping to maintain high standards of cleaning and morale within the domestics' team.

NHS
Stockport
NHS Foundation Trust

Meeting date	4th April 2024	**Public**	X	**Agenda No.**	8
Meeting	Board of Directors				
Report Title	Integrated Performance Report				
Director Lead	Chief Executive	**Author**	Peter Nuttall, Director of Informatics		

Paper For:	**Information**	X	**Assurance**	X	**Decision**	
Recommendation:	The Board of Directors is asked to review and discuss performance against the reported metrics including any mitigating actions to improve performance that are described in the exception reports.					

This paper relates to the following Annual Corporate 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
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
	PR4.2	There is a risk that the Trust's workforce is not reflective of the communities served
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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
	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	Highlight section and Finance exception report
Regulatory and legal compliance	All sections
Sustainability (including environmental impacts)	

Executive Summary

This report provides an overview of the Trust's performance across a range of Quality, Operational, Workforce and Financial metrics. The report includes a scorecard that incorporates metrics from the Single Oversight Framework, as well as other high priority metrics.

The scorecard details the in-month and year- to- date performance for each metric along with an indicative forecast for next month and summary indicator of performance trend.

Exception reports are included for each metric group that is not currently achieving target thresholds and includes metric descriptions, in-month performance and target thresholds, as well SPC charts clearly showing performance trends. Exception reports also include detailed narrative from the relevant services detailing key issues affecting performance, and mitigating actions of note.

Please see introduction page of the report, which includes summary highlights for each section.

BUSINESS INTELLIGENCE

NHS Stockport NHS Foundation Trust

Integrated Performance Report

Reporting period

February 2024

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 Sepsis, Infection Prevention Control, Incidents, Pressure Ulcers and Complaints due to under-achievement in month.

- The Trust is performing well against the Timely Recognition of Sepsis metric and achieving well above target levels, as has been the case for the past six months. Antibiotic administration within timescales continues to be challenging. Key themes include fails occurring out of hours (5 out of 7), delayed prescribing (4 out of 7) and delay in administration (3 out of 7). Sepsis6 compliance continues to be poor and was only completed in 1 out of 7 incidents.

- Reported infection rates for C.diff, E.coli and MRSA continue to be significantly higher than the thresholds set by the UKHSA.

- All pressure ulcers indicators are not achieving target levels. However, level-2 hospital acquired ulcers are within trajectory to meet reduction targets. Work is underway to convert the purpose built pressure ulcer risk assessment tool into digital version and increased training with AHPs and ulcer prevention training is being delivered at a consistently higher rate than last year. There was one category 3 hospital acquired pressure ulcer in February and this has been investigated and areas that we can learn from identified. Category 2, community acquired pressure ulcers are a concern at 14 (target: 9) and performing outside of expected levels to hit 10% reduction target. Category 3&4, community acquired ulcers have been investigated. The main concern is around patient decision making.

- Written complaints received hasn't achieved target for 2 months consecutively now. Communication has been identified as one of the top two reasons for complaints in both formal written and informal complaints.

Operations Highlights

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

- ED has seen a significant increase in attends year-on-year (7%). This has placed increased pressure on ED and thus seen deterioration in both 4-hour and 12-hour performance, however, there are a number of actions taking place to improve this performance going forward.

- NCtR patients has risen in month to 91. Out-of-area patients continues to impact this whilst we struggle to discharge or transfer these patients. As of January 2024 there has been a reduction in commissioned community D2A beds. This is being rectified but is currently causing delays.

- Imaging and Endoscopy have both recovered from the issues seen across the festive period and are now compliant. ECG remains an area of issue but there is a recovery plan in place and WL is expected to recover a further 50 breaches by end of March with continued improvement over the coming weeks.

- Cancer performance has continued to improve across all standards. 28-day and 2WW are now both ahead of their targets. Task group for lung pathway is to be implemented to further improve the 62-day standard.

- RTT is continuing to show significant improvement. Issues remain in 18-week incomplete pathways but the trust is working towards zero 65+ and 78+ week waiters by the end of April 2024.

Workforce Highlights

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

- Sickness Absence is above target for February at 6.28%. This is a decrease from January however is considerably higher than February 2023 (5.66%). Rolling 12-month absence is now below target. Seasonal illness remains the 2nd highest reason for absence after anxiety/stress. The flu vaccination program is continuing to be offered and promoted and there has been an appointment of a staff MSK physio. Departmental managers are also focussing on preventative measures such as team stress risk assessments.

- Agency costs % achieved target in December and January but didn't meet target for the first time in 3 months in February 2024. Agency spend was £1.1M which represents almost double the spend in February 2023. Discussions are taking place with providers with the objective of reducing agency commission rates.

- Workforce turnover is continuing to improve towards the target of 12.5%. The 13.1% achieved in February is still not achieving target but is a 2% improvement year-on-year and also the lowest seen since August 2021. Voluntary resignation was the most common reason for leaving over the past 12 months, followed by relocation and work-life balance.

- Mandatory training achieved target for the first time in a number of years in January 2024 however February dipped back under the 95% target. The main reasoning for the deterioration in performance is poor attendance at mandatory sessions whilst junior doctor industrial action was taking place.

Finance 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 11 the Trust position is £2.4m adverse to plan – a deficit of £31.3m. This is a deterioration of £0.8m in month.

- The drivers of the movement from plan are the impact of industrial action by junior doctors and consultants, the ERF estimated penalty from April 2023 to February 2024, risks around contract income 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 11 is £23.9m; and at this point the delivery against the target is break-even.

- The Trust has maintained sufficient cash to operate during February.

- The Capital plan for 2023-24 is £62.7m, the latest expenditure forecast is £47.3m. At month 11 expenditure is behind plan by £16.1m, however internally funded estates schemes are progressing and should be delivered in March.

Integrated Performance Report
Scorecard

BUSINESS INTELLIGENCE

NHS Stockport NHS Foundation Trust

	Reporting Period	Target 23/24	Actual YTD	6-mth Trend	Actual Month	Current Period	1-mth Forecast
Quality Scorecard							
Mortality: SHMI	Dec-22 to Nov-23	≤ 100		↑	92	●	●
Sepsis: Timely recognition	Mar-23 to Feb-24	≥ 90%		→	97.5%	●	●
Sepsis: Antibiotic administration	Mar-23 to Feb-24	≥ 90%		→	75.4%	▲	▲
C.diff infection rate	Mar-23 to Feb-24	≤ 17.63		→	57.88	▲	▲
Covid-19 infection rate	Mar-23 to Feb-24	≤ 4.27		↑	1.16	●	●
MRSA infection rate	Mar-23 to Feb-24	≤ 0		→	2.69	▲	▲
E. coli infection rate	Mar-23 to Feb-24	≤ 20.27		↑	111.72	▲	▲
Medication incident rate	Sep-23 to Feb-24	≤ 4.64		↓	5.88	▲	▲
Patient safety incident rate	Sep-23 to Feb-24	≤ 69.24		↓	84.15	▲	▲
STEIS reportable incidents	Feb-24	≤ 4	46	↗	4	●	●
Stroke: Overall SSNAP Level	Sep-23	≥ C		→	A	●	●
Falls rate	Feb-24	≤ 3.51	3.02	→	2.6	●	●
Falls due to lapses in care	Feb-24	≤ 425	243	→	16	●	●
Falls causing moderate+ harm	Feb-24	≤ 22	4	→	0	●	●
Pressure Ulcers: Hospital, Cat 2	Feb-24	≤ 79	62	↘	7	▲	●
Pressure Ulcers: Hospital, Cat 3&4	Feb-24	≤ 8	11	→	1	▲	▲
Pressure Ulcers: Community, Cat 2	Feb-24	≤ 114	130	↘	14	▲	▲
Pressure Ulcers: Community, Cat 3&4	Feb-24	≤ 38	40	→	4	▲	▲
Complaints: Written Complaints Rate	Feb-24	≤ 7.9	7.87	↘	10.04	▲	▲
Complaints: Timely response	Feb-24	≥ 95%	94.2%	→	97%	●	●
Early Neonatal Deaths	Feb-24	≤ 0	3	→	0	●	●
Registrable Stillbirths	Feb-24	≤ 0	3	↗	0	●	●
Registrable Stillbirth Rate	Feb-24	≤ 0	1.15	↗	0	●	●
Smoking In Pregnancy	Feb-24	≤ 10%	6%	↗	4.4%	●	●
Maternity Diverts	Feb-24	≤ 0	11	↗	0	●	●

	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	Feb-24	≥ 76%	62.1%	↘	55.7%	▲	▲
Patients in department over 12 hrs	Feb-24	≤ 2%	9.9%	↓	15.5%	▲	▲
No criteria to reside (NCTR)	Feb-24	≤ 73	976	→	91	▲	▲
Discharge ready	Feb-24		80.4%	→	79.6%		
Delayed discharges	Feb-24		4.1%	↘	5.3%		
Diagnostics: 6 Week Standard	Feb-24	≤ 5%	14.4%	→	18.5%	▲	▲
62-day standard	Feb-24	≥ 85%	56.2%	↗	61.2%	▲	▲
28-day standard (FDS)	Feb-24	≥ 75%	67%	↑	82.5%	●	●
14-day standard (2WW)	Feb-24	≥ 93%	96.8%	↗	98.5%	●	●
Incomplete pathways 18-week %	Feb-24	≥ 92%		→	50.3%	▲	▲
52-week breaches	Feb-24	≤ 3791		↑	3059	●	●
65-week breaches	Feb-24	≤ 0		↑	953	▲	▲
Activity vs. Plan: Elective	Feb-24	≥ 100%	101.7%	→	96.3%	▲	▲
Activity vs. Plan: Outpatient	Feb-24	≥ 100%	98.6%	↘	91%	▲	▲
Activity vs. Plan: ED Attendances	Feb-24	≤ 100%	101.6%	→	106.1%	▲	▲
Outpatient DNA rate	Feb-24	≤ 6.3%	7.7%	↗	7.2%	▲	▲
Outpatient clinic utilisation	Feb-24	≥ 90%	89.3%	↘	86.5%	▲	▲
Patient initiated follow up (PIFU)	Feb-24	≥ 4.87%	3.8%	→	4.5%	▲	▲
Capped Touch Time Utilisation	Feb-24	≥ 85%	73.7%	↑	79.1%	▲	▲
Average cases per 4-hour session	Feb-24	≥ 2.8	2.84	→	2.7	▲	▲
Workforce Scorecard							
Substantive Staff-in-Post	Feb-24	≥ 90%	92.1%	↑	93.8%	●	●
Sickness Absence: Monthly Rate	Feb-24	≤ 6%	5.9%	↘	6.3%	▲	▲
Workforce Turnover	Feb-24	≤ 12.5%	14.2%	↑	13.1%	▲	▲
Staff Retention Rate	Feb-24		98.9%	↗	99.2%		
Appraisal Rate: Overall	Feb-24	≥ 95%	89.7%	→	88.6%	▲	△
Mandatory Training	Feb-24	≥ 95%	94.3%	↗	94.8%	▲	▲
Agency Costs %	Feb-24	≤ 3.7%	4.9%	↗	3.8%	▲	▲
Finance Scorecard							
Capital Expenditure	Feb-24	≤ 10%		↘	-32.8%	●	●
Cash Balance	Feb-24			→	20.9		
CIP Cumulative Achievement	Feb-24	≥ 0%		↗	0%	●	●
Financial Controls: I&E Position	Feb-24	≤ 0%		↗	8.3%	▲	▲

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

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%	97.5%	→	● ● ● ● ● ●	●
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%	75.4%	→	▲ ▲ ▲ ▲ ▲ ▲	▲

Performance is based on an audit sample of patients, and 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.

Timely Recognition.
- 100% timely recognition in February.
- 12 month rolling figure 97.5%, ahead of trust target of 95%
- 99 records included in audit - 99 compliant.

- NICE Guidance published Jan 31st. For GAP analysis Adult acute next Steering Group on 07/03/24.
- Continue trial AQ audit.

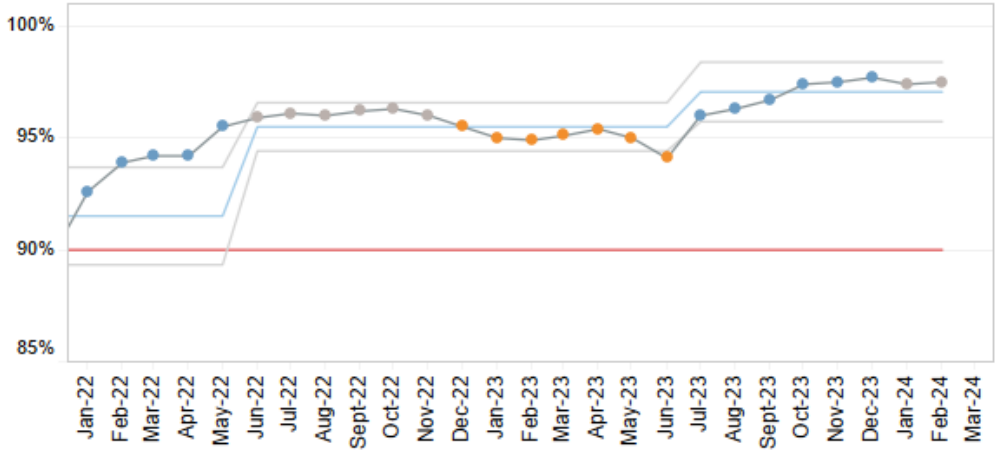
Antibiotic Administration
- February compliance 77%.
- 12 months rolling figure now 75.4% below trust target of 95%
- 24/31 patients screened for sepsis received antibiotics in accordance with trust guidelines.
- 7 Fails - 5 occurred Out of Hours.
- 4 Red Flag Fails, 3 Amber Flag Fails.
- 6 fails within Medicine and 1 within Surgery.
- Average delay in receiving antibiotics - 66 min. Average time from prescription to administration 44 min.
- Themes: Delay in administration in 3/7 fails - in one case this was due to unavailability antibiotics on ward. Delayed prescribing a factor in 4/7 fails.
- Poor compliance Sepsis6 - completed by clinician in 1/7 incidents.

Background Strike action 24/2/24-28/2/24 and Opal3/4

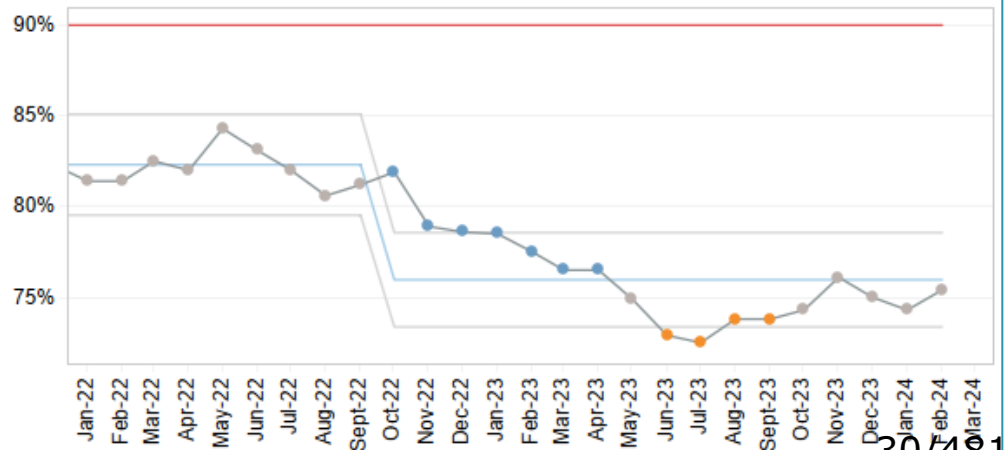
McCarthy,Rebecca 28/03/2024 17:31:14

Narrative provided by	Emily Abdy
Executive Lead	Nicola Firth

Performance for Sepsis: Timely recognition



Performance for Sepsis: Antibiotic administration



Quality **Infection Prevention Control** C.Diff & COVID-19

		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	57.88	→	▲ ▲ ▲ ▲ ▲ ▲	▲
Covid-19 infection rate	The number of Covid-19 infections per 1,000 bed days.	<= 4.27	1.16	↑	● ● ● ● ● ●	●

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 3 HOHA and 2 COHA cases in February totalling 73 YTD. The Trust is over the projected threshold of 36.6 for the end of February and over the 2023-24 threshold of 40 cases for the year.

70 cases have been presented to the HCAI Panel. 9 Cases have been deemed Avoidable and 61 Cases deemed Unavoidable. 3 cases await panel review in March.

The latest National figures (December 2023) rates Stockport fifth out of the seven GM Trusts which is an increase from the previous month.

COVID-19

The Trust had 23 new COVID-19 positive cases in February of which 5 were nosocomial. This is a decrease of 8 positive cases and 5 HOC case numbers on the previous month.

The Trust currently has a HOC rate of 22% which is a decrease of 10% from last month.

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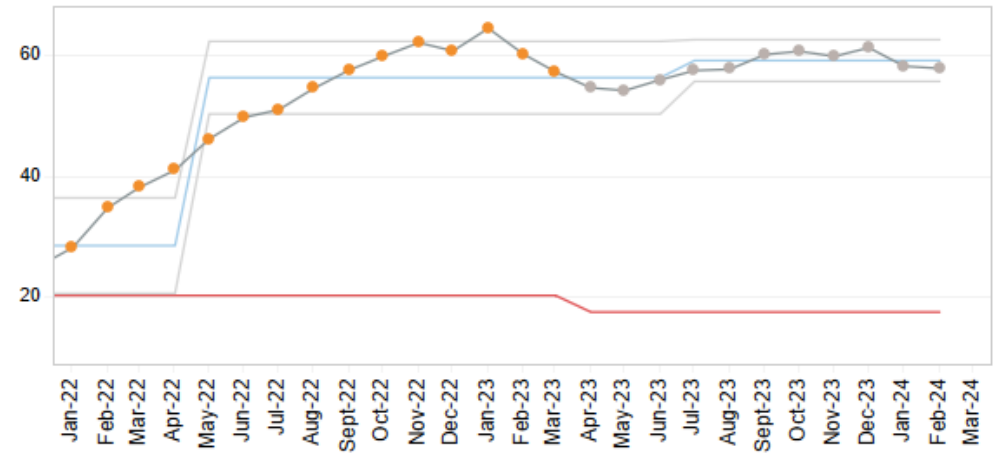
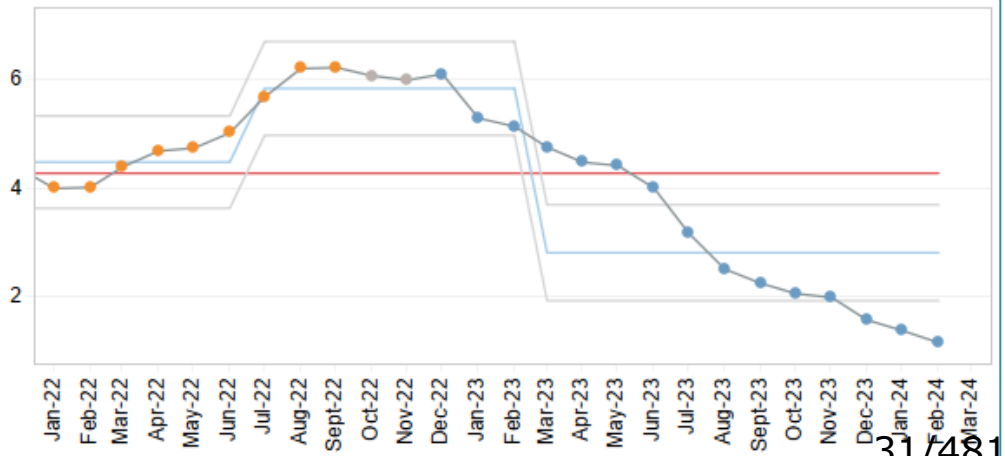
Performance for C.diff infection rate



Performance for Covid-19 infection rate



Narrative provided by	Nesta Featherstone
Executive Lead	Nicola Firth

Quality **Infection Prevention Control** E.Coli & MRSA

		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	111.72	↑	▲ ▲ ▲ ▲ ▲ ▲	▲
MRSA infection rate	The number of hospital-onset Methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemia infections per 100,000 bed days.	<= 0	2.69	→	▲ ▲ ▲ ▲ ▲ ▲	▲

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

There were 6 HOHA and 1 COHA cases in February totalling 66 cases YTD. The Trust is over the projected threshold of 42.2 for the end of February and over the 2023-24 threshold of 46 cases for the year.

The latest National figures (December 2023) rates Stockport fourth out of the seven GM Trusts which is the same as the previous month.

MRSA

The Trust has had 1 case of MRSA in February against a zero-tolerance threshold set by the UKHSA.

This case has been reviewed by HCAI Panel and deemed indeterminate. Discussions resulted in several learning outcomes which the division is addressing within their action plan.

The latest National figures (December 2023) rates Stockport second out of the seven GM Trusts which is the same as the previous month.

McCarthy,Rebecca
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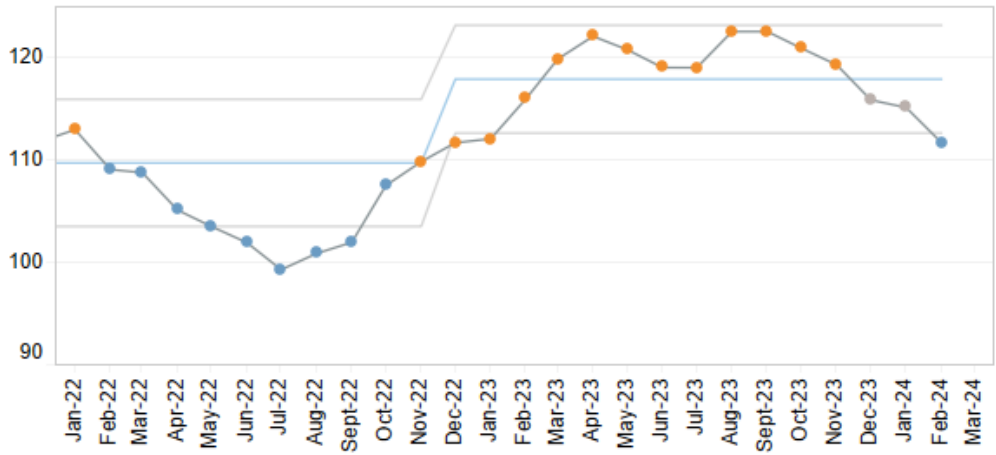
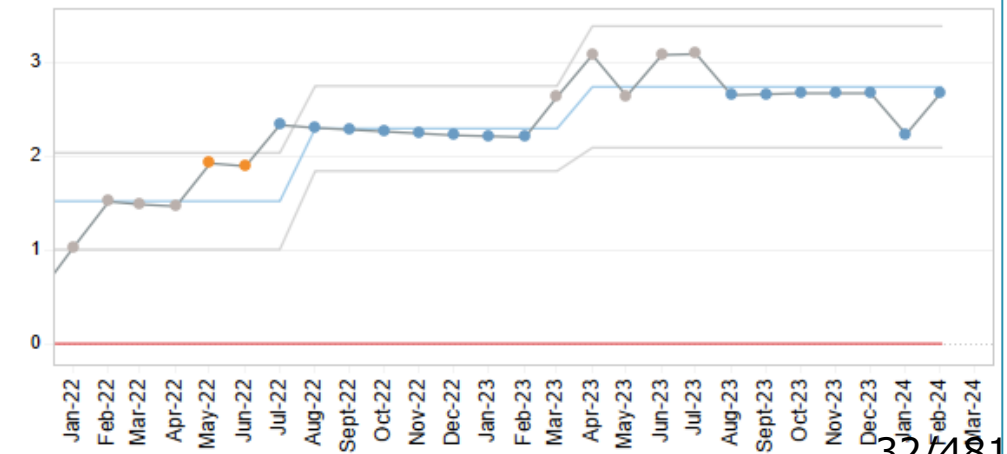
Performance for E. coli infection rate



Performance for MRSA infection rate



Narrative provided by	Nesta Featherstone
Executive Lead	Nicola Firth

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Quality **Incidents**

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
Medication incident rate	The number of medication incidents, calculated as an incidence rate for every 1000 bed days. This average is calculated using a rolling 6 months of data.	<= 4.64	5.88	↓	▲ ▲ ▲ ▲ ▲ ▲	▲
Patient safety incident rate	The number of patient safety incidents, calculated as an incidence rate for every 1000 bed days. This average is calculated using a rolling 6 months of data.	<= 69.24	84.15	↓	▲ ▲ ▲ ▲ ▲ ▲	▲
STEIS reportable incidents	The total number of STEIS reportable incidents. Target/benchmark based on the median performance for 2021/22 financial year.	<= 4	4	↗	▲ ▲ ● ● ● ●	●

Medication Incident Rate
There are no issues related to medication incidents to report.

Medication incidents are reviewed at Incident Review Group on a weekly basis.

Patient Safety Incident Rate
There are no issues related to patient incidents to report.

The Incident Review Group meets on a weekly basis to review incidents with a focus on those where harm has been attributed, as well as other topics of interest.

Pressure ulcer incidents are reviewed at the Pre Harm Free Care Panel on a weekly basis.
Patient falls incidents are reviewed at the Falls Review Panel on a weekly basis.
Security & Safeguarding Meeting takes place to review Security related incidents.

STEIS Reportable
There were 4 serious incidents declared and submitted to StEIS in February 2023:
- Wrong Site Surgery (Never Event) – incision made to tonsil during bilateral grommet insertion
- Delayed treatment - for a urology patient requiring transfer from Tameside Hospital
- Category 3 Foot Pressure Ulcer
- Category 3 Spinal Pressure Ulcer

All incidents are undergoing patient safety incident investigation.

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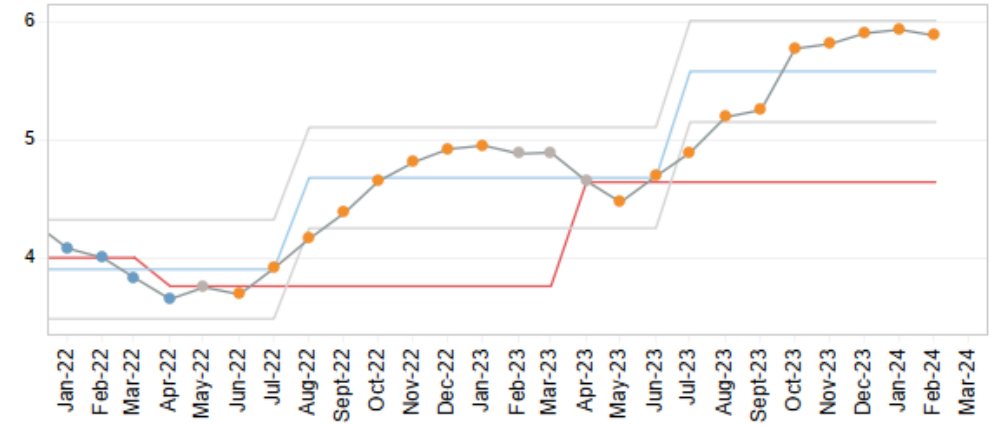
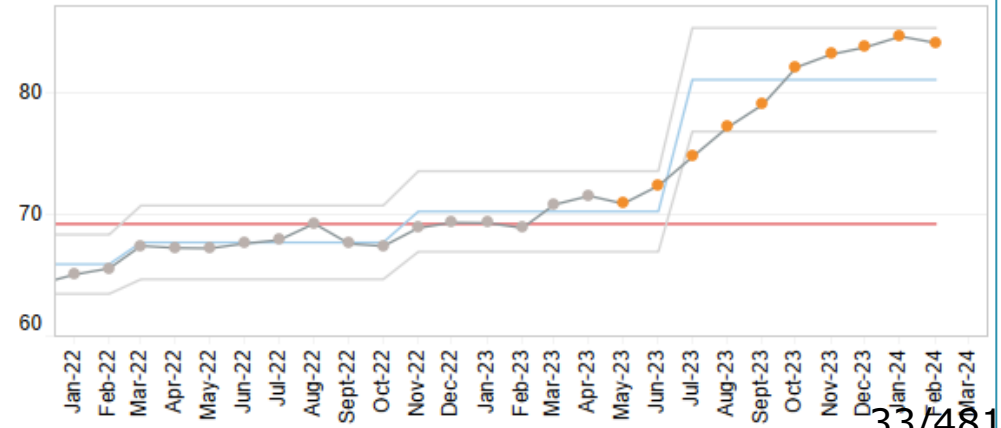
Performance for Medication incident rate



Performance for Patient safety incident rate



Signed off by	Natalie Davies
Executive Lead	Nicola Firth

Quality **Pressure Ulcers** Hospital

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
Hospital, Category 2	Total number of category 2 pressure ulcers in a hospital setting - includes device-related pressure ulcers.	<= 6	7	↘	● ● ▲ ▲ ▲ ▲	●
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	→	● ● ● ▲ ▲ ▲	▲
Community, Cat 2	Total number of category 2 pressure ulcers in a community setting.	<= 9	14	↘	▲ ● ▲ ▲ ▲ ▲	▲
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	→	▲ ▲ ● ● ● ▲	▲

Category 2
The Trust has set a target to reduce the overall number of hospital acquired pressure ulcers by 5% for year April 2023- April 24.

This month (February data) we have had 7 category 2 pressure ulcers reported: 2 of which were as a result of a medical device. This has continued a higher trend in reporting over the last 2 months, but the overall performance still remains within trajectory for the reduction target.

The main work streams in progress now are developing the purpose built pressure ulcer risk assessment tool into digital version (using patient track) and reviewing the training provision and role-specific requirements. Increased engagement and training has taken place with allied health professionals (physios, OT, social workers and discharge co-coordinators) with further sessions planned.

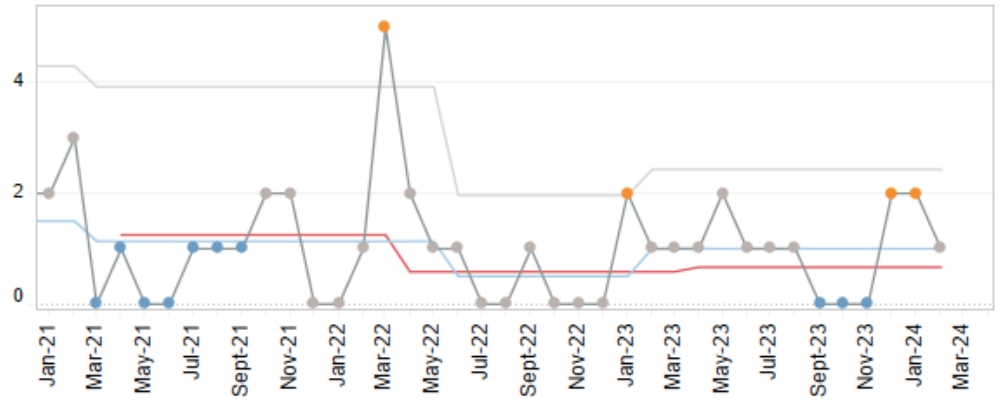
Additional tool box training sessions are being developed with the CPF teams across all divisions to promote pressure ulcer prevention awareness.

Attendance at the pressure ulcer prevention training session delivered monthly remains consistently better than last year. There have been more people trained up to this point of the year than last year in total Additional training sessions have been held within integrated care to increase the skills and knowledge of our HCAs in skin care and pressure ulcer prevention.

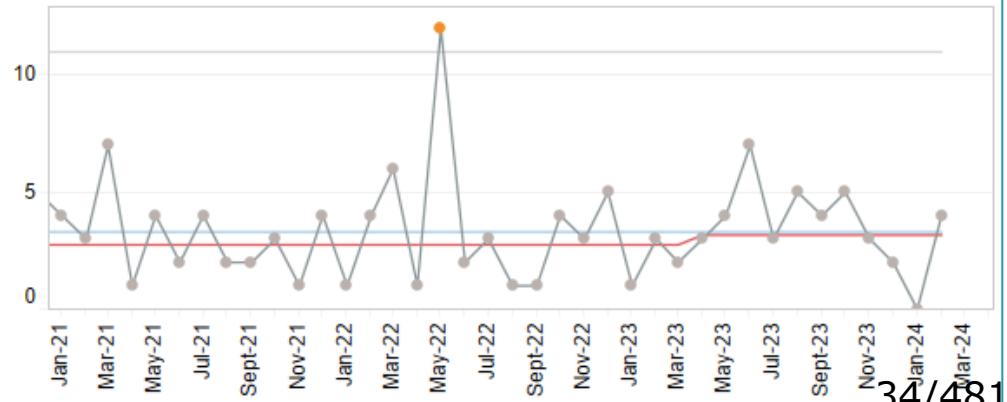
Category 3&4
The Trust is aiming to achieve no hospital acquired Category 3 or 4 pressure ulcers as a result of a lapse in care. This month (February data) there has been 1 Category 3 pressure ulcer.

The incident has been investigated and reviewed with the serious incident review group, both incidents have identified areas for learning and further investigation is required.

Performance for Pressure Ulcers: Hospital, Cat 3&4



Performance for Pressure Ulcers: Community, Cat 3&4



Signed off by	Lisa Gough
Executive Lead	Nicola Firth

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Quality **Pressure Ulcers** Community

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
Hospital, Category 2	Total number of category 2 pressure ulcers in a hospital setting - includes device-related pressure ulcers.	<= 6	7	↘	● ● ▲ ▲ ▲ ▲	●
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	→	● ● ● ▲ ▲ ▲	▲
Community, Cat 2	Total number of category 2 pressure ulcers in a community setting.	<= 9	14	↘	▲ ● ▲ ▲ ▲ ▲	▲
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	→	▲ ▲ ● ● ● ▲	▲

Category 2
The Trust has set a target to reduce the overall number of community acquired pressure ulcers by 10% for year April 2023- March 24.

This month (February data) we have had 14 category 2 pressure ulcers reported. The community is currently over trajectory to meet the reduction target. This number of incidents has not significantly changed in the last months.

Trend analysis is ongoing in the community and there are minimal incidents that identify missed opportunities or lapses in care.

Category 3&4
The Trust is aiming to achieve no Category 3 or 4 pressure ulcers as a result of a lapse in care.

This month (February data) there have been 4 Category 3 or 4 ulcers in the community.

A thematic review of all category 3 or 4 pressure ulcers occurring in community patients over the last 9 months has been undertaken, the primary theme has shown decision making by the patient as the main factor. Work streams are in development to help our community nurses in their communication with patients and providing information to patients to help them make informed decisions.

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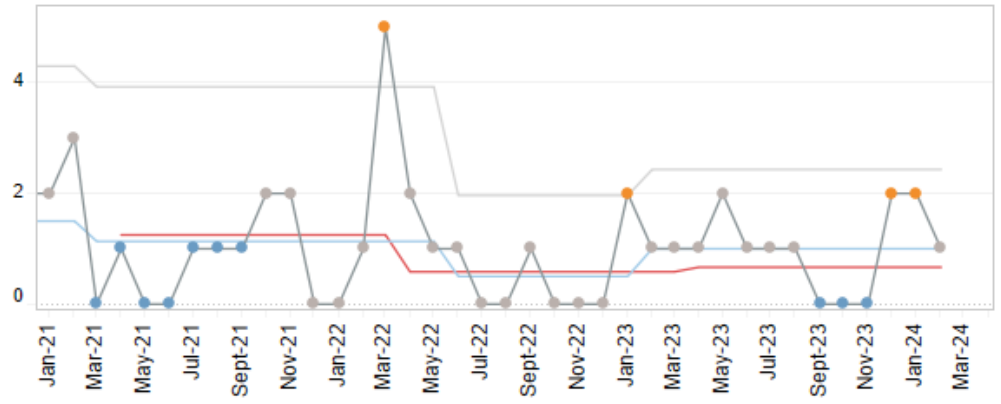
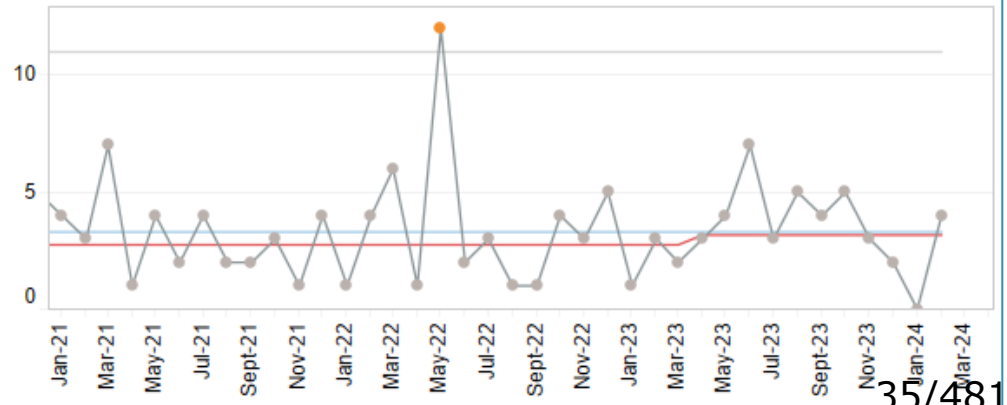
Performance for Pressure Ulcers: Hospital, Cat 3&4



Performance for Pressure Ulcers: Community, Cat 3&4



Signed off by	Lisa Gough
Executive Lead	Nicola Firth

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Quality **Complaints**

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
Timely response	The total number of formal complaints responded to within agreed timescales, as a percentage of all formal complaints responded to.	>= 95%	97%	→	● ● ● ● ● ●	●
Written Complaints Rate	Number of formal written complaints received, calculated as an incidence rate for every 1000 whole time equivalent staff in post.	<= 7.9	10.05	↘	● ▲ ● ● ▲ ▲	▲

Timely Response
32 of the 33 responses sent in February 2024 were sent within the agreed timeframe, resulting in a 96.9% response rate. This is a good achievement considering the continued pressures at the Trust and on the availability of clinical staff to undertake administrative work due to leave and industrial action.

When it is apparent that there will be a delay with the response, we will liaise with the complainant to provide an explanation and where necessary, agree a new timescale.

Written Complaints Rate
55 formal complaints were received in February 2024 - Clinical Support Services = 3, Integrated Care = 5, Medicine = 12, Emergency Department = 6, Surgery = 20, Women & Children = 8, Corporate = 1, Estates & Facilities = 0

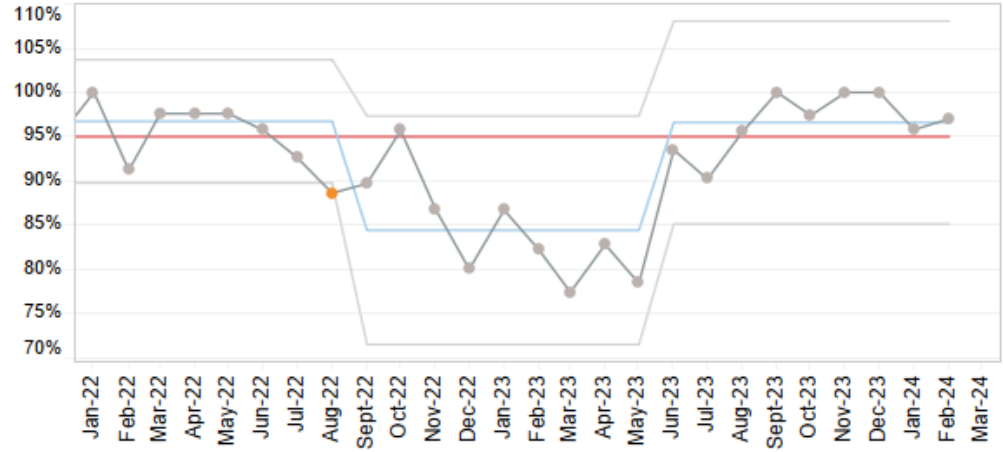
Top five themes for formal complaints in February 2024 was as follows:

1.Communication
2. Clinical treatment
3. Patient care
4. Staff values & behaviours
5. Admissions & discharges

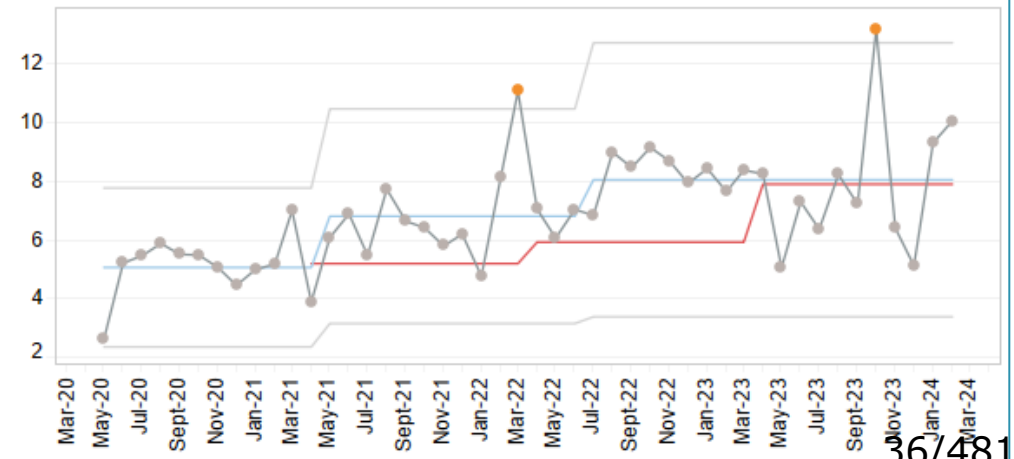
Top five themes for informal concerns in February 2024 was as follows:

1. Appointments
2. Communication
3. Access to treatment or drugs
4. Admin procedures & record management
5. Property (lost/missing)

Performance for Complaints: Timely response



Performance for Complaints: Written Complaints Rate



Signed off by	Natalie Davies
Executive Lead	Nicola Firth

Operational Perf. **Emergency Department**

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
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%	55.7%			
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%	15.5%			

February - Summary

- February 2024 performance against the UEC 4hr standard saw a decrease to 55.7%
- None of the caveats in the operational planning to delivery of the 76% standard were delivered, thus performance is compromised.
- Daily attendances increased to 310 per day compared to 305 in January. The same month last year saw a daily average of 285,so year on year a 7% increase in demand has occurred.
- Admissions to hospital remained static an average of 85 per day, a 27% conversion rate.
- A decrease in 12 hour waits in occurred and robust processes for managing, reviewing and providing assurance for assessment of harm in respect to 12hr breaches are fully embedded within the service.

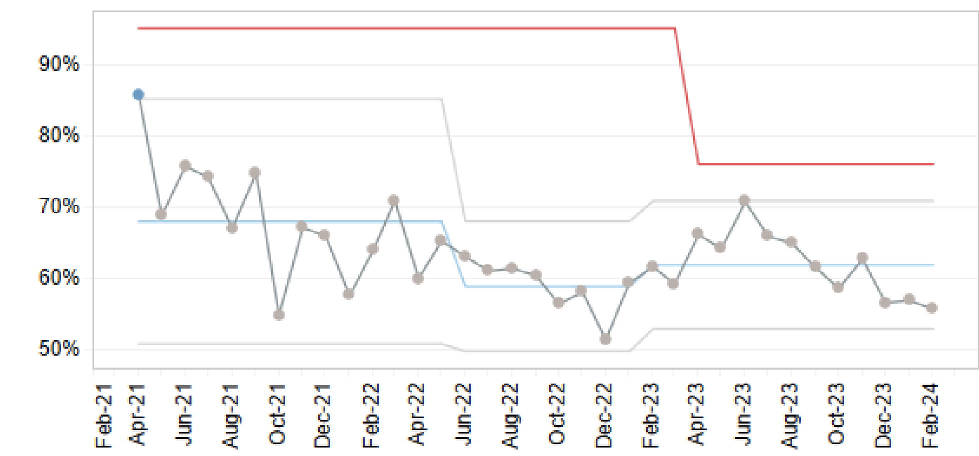
Key Actions - ED

- Weekly Trust ED Performance meetings to enable flow from each service to improve ED performance
- Review of the ED workforce model considered by Executive Team. Further work required.
- Partnership collaboration continues with Pennine Care, with weekly and monthly meetings ongoing to discuss and resolve service challenges.
- E-triage transformation piece of work continues to focus on front door streaming and decongestion of department with aim of soft launch in March 2024
- Admission Avoidance project to commence March 2024
- Focus on zero tolerance for UTC & Minors streams

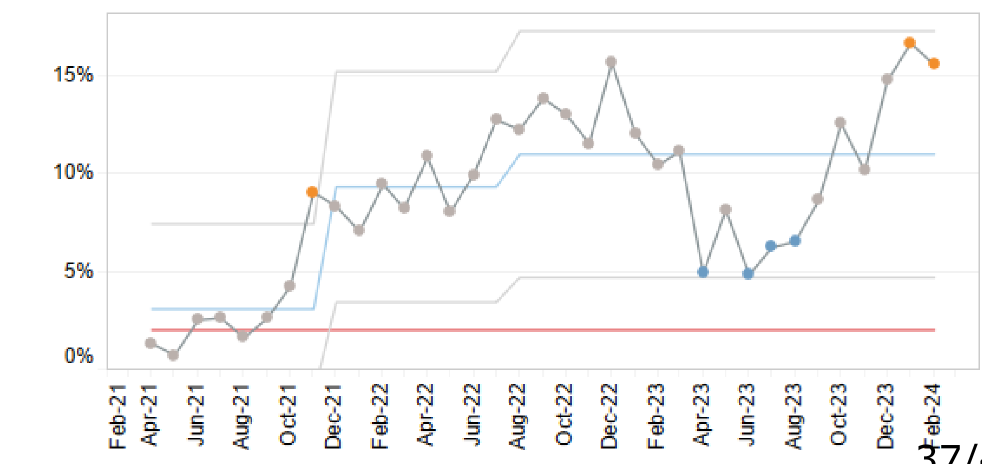
Key Actions – Programme of Flow

- MDT provision increased to support demand during 'Winter Pressures'
- Digitalisation – To progress the embedding of technology to support efficient and effective patient safety and flow, with a particular focus on wards and Patient Flow team.
- Discharge Policy – to share the discharge policy with all teams to support improved patient experience, reduce LOS and ensure our teams have the tools to support safe and effective discharge

Performance for 4hr Standard



Performance for Patients in department over 12 hrs



Signed off by	Catherine Cotton
Executive Lead	Jackie McShane

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Operational Perf. **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	91	→	▲ ▲ ● ● ▲ ▲	▲
Discharge ready	The number of patients discharged from hospital on the same day as their discharge ready date, as a percentage of all patients patient discharges.		79.6%	→		
Delayed discharges	The number of patients discharged from hospital 7 days or more after their discharge ready date, as a percentage of all patients patient discharges.		5.3%	↘		

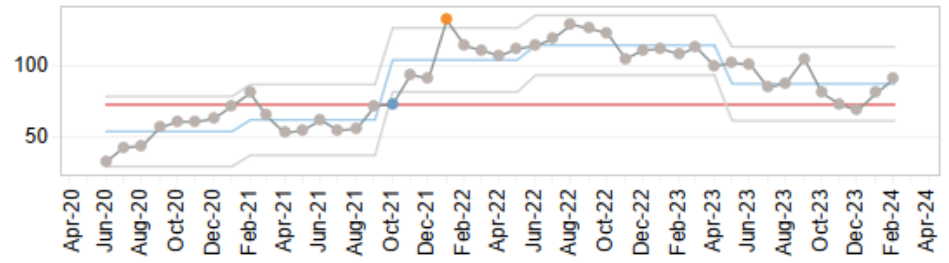
February - Summary

- The number of patients with no criteria to reside (NCtR) has risen in month. Work continues to embed and improve operational system and processes across the wards and within the Discharge to Assess services especially across Pathway 1 and 2.
- **Out-of-area patients** remains high with other localities struggling to access community capacity in their local area, adversely impacting on the ability of the trust to discharge / transfer non-Stockport residents.
- From Jan '24 there have been ten less **commissioned community D2A beds.** The locality has agreed to meet the deficit in community bed numbers by spot purchasing care home beds. However this is causing delays
- As of 31.01.24 provision of care packages (Pathway 1) from a Private Provider has been decommissioned.

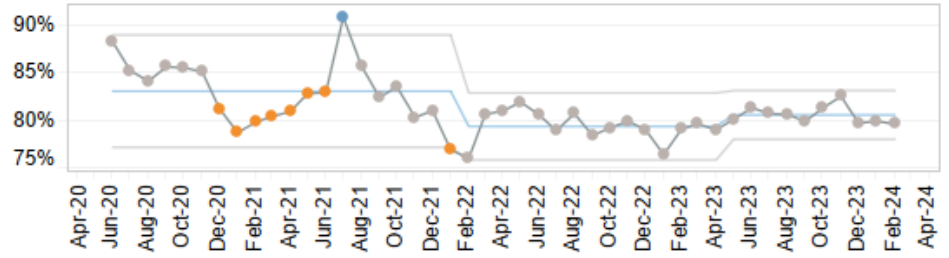
Key Actions

- Work continues to embed and improve operational system and processes across the Acute wards as part of our Patient Flow transformational workstream the Discharge to Assess services especially across Pathway 1 and 2.
- The electronic Transfer of Care referral form is now live on Advantis which will support timely referral on line to the Transfer of Care Hub and facilitate information sharing with providers, and reducing delays and duplicate information requests.
- Weekly meetings with out of area partners to support improved flow out of the Acute setting and escalation processes are in place.
- Escalation of Derbyshire delays to GM ICB due to lack of engagement
- Impact of spot purchase provision to be evaluated in January-24.

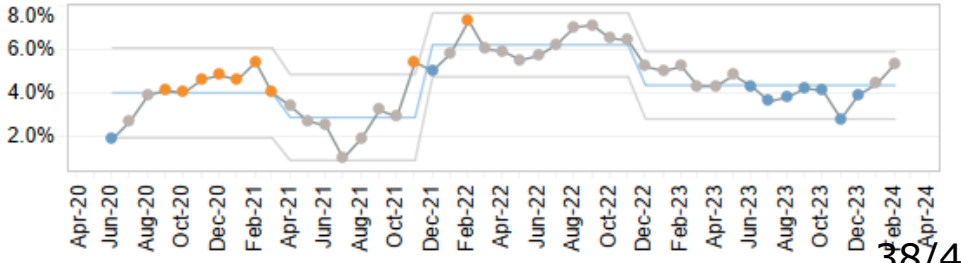
Performance for No criteria to reside (NCTR)



Performance for Discharge ready



Performance for Delayed discharges



Signed off by	Margaret Malkin
Executive Lead	Jackie McShane

Operational Perf. **Diagnostics**

	Target	Actual	6-month trend	Previous Performance	1-month Forecast
Diagnostics: 6 Week Standard — The percentage of patients referred for diagnostic tests who have been waiting for more than 6 weeks.	<= 5%	18.5%	→	▲ ▲ ▲ ▲ ▲ ▲	▲

February - Summary

Endoscopy

The Endoscopy backlog has decreased from 8 to 4 patients waiting over 6 weeks. The service is now compliant with the national diagnostic standards

ECG

February un-validated position is 712 breaches which is a **decrease of 51** breaches compared to January 24. the CDC provided an additional 70 slots for February and 177 patients were seen in WLI slots across the month. Predicted breaches for March month end will see a **decrease of 50** breaches compared to February and a grand total of 662 breaches.

Imaging

The Radiology backlog has recovered, and all modalities are expected to remain compliant.

Key Actions

- CDC to continue to support ECG capacity
- Recovery plan for CT and NOUS in place and planned to recover by end of January 2023.
- MR – current position due to focus on Cancer referral access.

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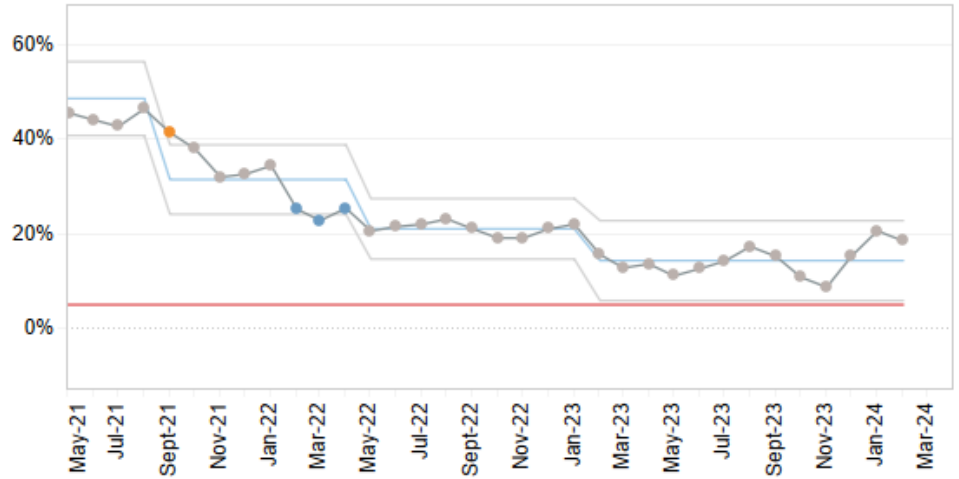
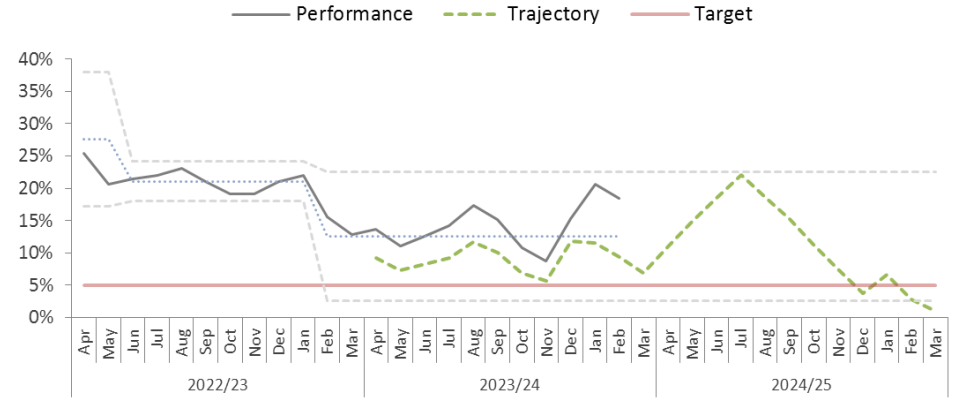
Performance for Diagnostics: 6 Week Standard



Diagnostic Backlog



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

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NHS Stockport NHS Foundation Trust

Operational Perf. **Cancer**

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
62-day standard	The percentage of patients on any type of cancer pathway that have received their first treatment within 62 days of upgrade or GP referral. Includes two-we..	>= 85%	61.2%			
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%	82.5%			
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%	98.5%			

February - Summary

- Cancer performance has showed significant improvement in month across all standards.
- The final 62 day performance for January is 67.8%, which is at trajectory. February to date is currently below trajectory with performance adversely affected by Industrial action following the Christmas period.
- 28 day FDS performance is 73.4 % for January, with the latest position for February at 82.5%. The Trust is forecasting to achieve the FDS for the first time this month.
- The 63+ backlog remains at a reduced rate, achieving planning target in month.
- The Trust continues to be supported by both the National Team and the regional Cancer Alliance in terms of identifying mutual aid and referral optimisation through the Tier 1 process.
- Histopathology has now recruited 2 new Consultants and an Associate Specialist to ease capacity pressures
- The Trust successfully recruited a locum Urologist which has supported improved performance.

Key Actions

- Focus on cancer referrals for the MR service
- Continuing outsourcing of histopathology to alleviate increase demand pressures
- Recruitment of a 2nd Head & Neck Radiologist continues following the recent withdrawal of a candidate
- A task and finish group will be initiated to look at the lung pathway to improve 62 day performance.
- A Transformation Manager for Cancer will commence in April, funded by the Cancer Alliance for 18 months. This post will lead on improvement projects across a breadth of cancer initiatives to improve access and quality of care for patients.

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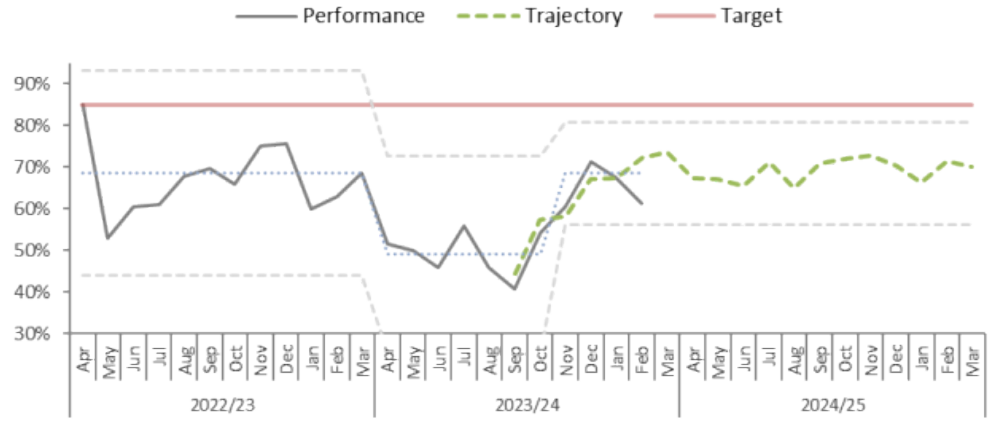
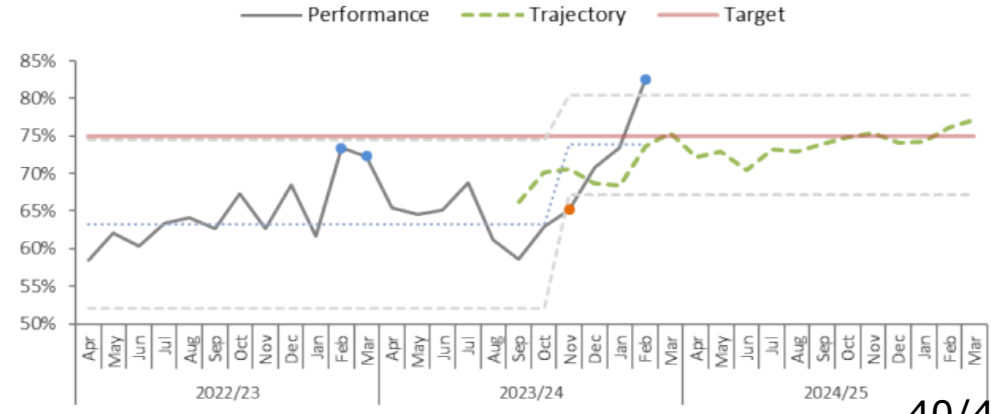
Performance for 62-day standard



Performance for 28-day standard (FDS)



Signed off by	Jo Pemrick
Executive Lead	Jackie McShane

Operational Perf. **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%	50.3%	→	▲ ▲ ▲ ▲ ▲ ▲	▲
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.	<= 3791	3062	↑	▲ ▲ ● ● ● ●	●
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	956	↑	▲ ▲ ▲ ▲ ▲ ▲	▲

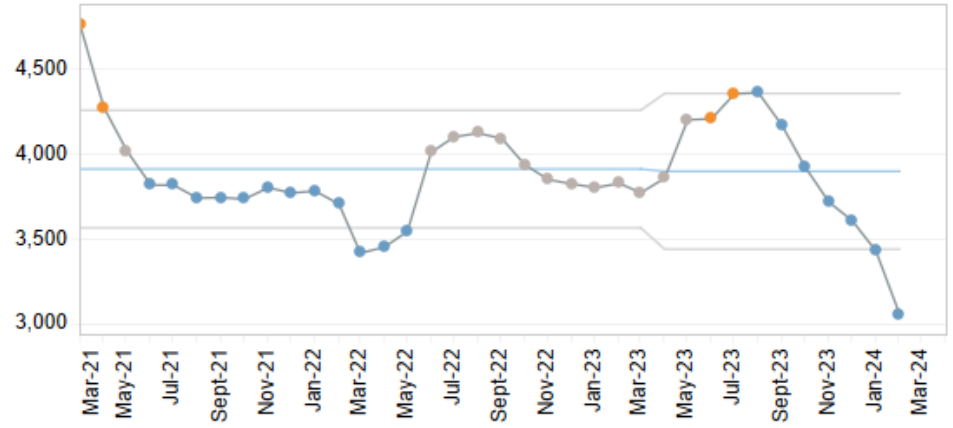
February - Summary

- The number of patients waiting 78+ & 65+ weeks to commence treatment decreased in month despite further BMA industrial action & the trust achieved the 78+ trajectory for February.
- The trust continues to seek mutual aid, independent sector support & the use of digital waiting list validation to further support the position.
- The Trust had 1 patient at 104+ weeks at the end of the month due to complexities in the patient pathway, however this patient has now been treated & we predict no further 104+ patients. This was an improvement on previous months.
- The closure of Outpatients B has had a significant impact on some specialties where alternative outpatient accommodation has not been readily available on site, with Ophthalmology only able to deliver 24% of the outpatient activity that was planned for January & 37% in February. Orthodontics unable to deliver any outpatient activity at all since the closure of Outpatients B at the end of November. Independent sector capacity support is now in place for Ophthalmology with the support from GM ICB.
- The current trajectory is that all 78 week waiters will be treated by the end of March and there will be a residual of 850 65 week waiters. All of whom will be treated in April-24

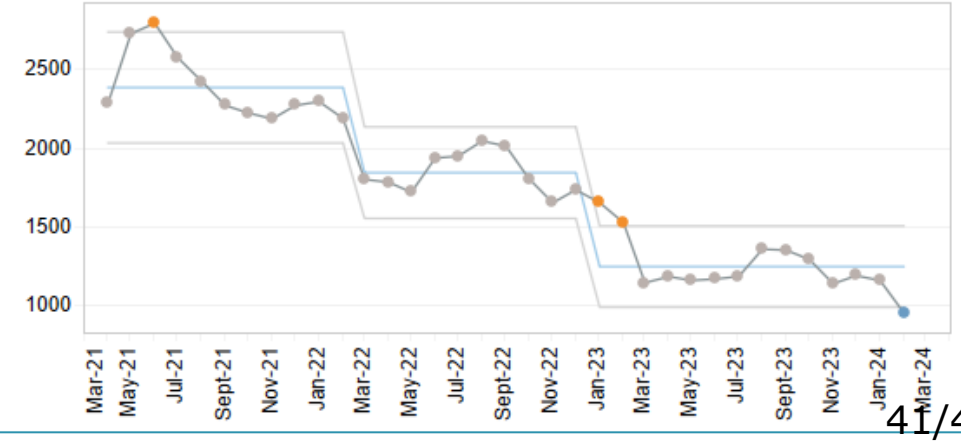
Key Actions

- Focus on providing additional capacity, prioritise long waiters and validate the waiting lists against the access policy.
- Work continues to try and meet the challenge of reducing to zero patients waiting over 78 & 65 weeks by the end of March 2024. The Trust is working collaboratively with other Greater Manchester Trusts to facilitate mutual aid opportunities where possible, however this has been very limited in our most challenged specialities.
- Extra activity performed during February has aided an improved position for our long waiters & further extra activity is planned in March for our under pressure specialties. Also, in February we received GM mutual aid for 12 Urology & 14 Oral Surgery long waiting patients and the trust is currently forecasting zero 78+ week wait patients by the end of March 2024 except for patients who remain due to choice or complexity.

Performance for 52-week breaches



Performance for 65-week breaches



Signed off by	Dan Riley
Executive Lead	Jackie McShane

Operational Perf. **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%	7.2%	↗	● ▲ ● ● ▲ ▲	▲
Outpatient clinic utilisation	The number of outpatient appointment slots booked, as a percentage of all outpatient appointment slots planned. Excludes cancelled clinic templates.	>= 90%	86.5%	↘	▲ ▲ ▲ ▲ ▲ ▲	▲
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.	>= 4.87%	4.5%	→	▲ ▲ ▲ ▲ ▲ ▲	▲

February - Summary
DNA rate has fallen to 7.17% which benchmarks as the second best performance in GM.

Clinic Utilisation
Overall utilisation is at 87%. Once exclusion have been removed overall utilisation improves to 92%.

The centralised booking team performance was maintained at 94% overall. In month Paediatrics was moved into this team. Non central booking team clinics were at 91% overall.

PIFU
Performance for the last two months has continued to show improvement and is now at 4.5%. Whilst this is a big improvement vs December 2023 (3.7%), it is still behind the trajectory of 4.8% to be in line with meeting the 5% target for March 2024. Stockport continues to be ranked 1st in GM for PIFU.

Key Actions
- DNA's - Ongoing review of the nudge texts is ongoing. A review with Booking team to see if we can try look at other ways to improve this position
- Clinic utilisation – continued focus with speciality teams as art of rust performance and GIRFT Further Faster. Further centralisation of teams will also take pace in Q2 2024/25
- PIFU - Specialties continue engaging with the GIRFT Further Faster initiative and is helping teams look at opportunities to increase the use of PIFU in their specialities and this work can be seen in the improving position in the data above. This is being led by the Medical Director

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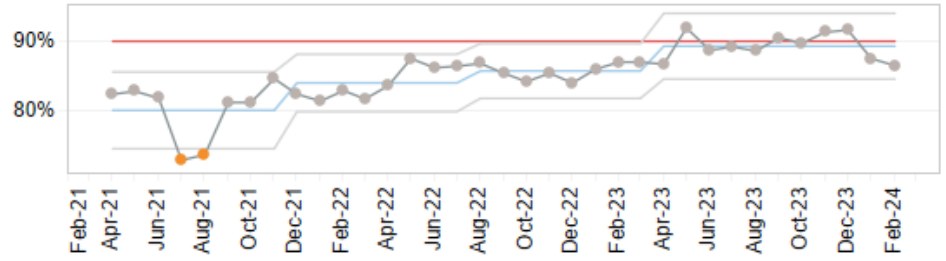
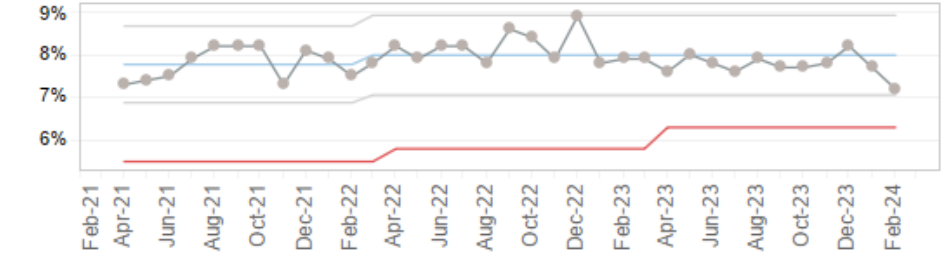
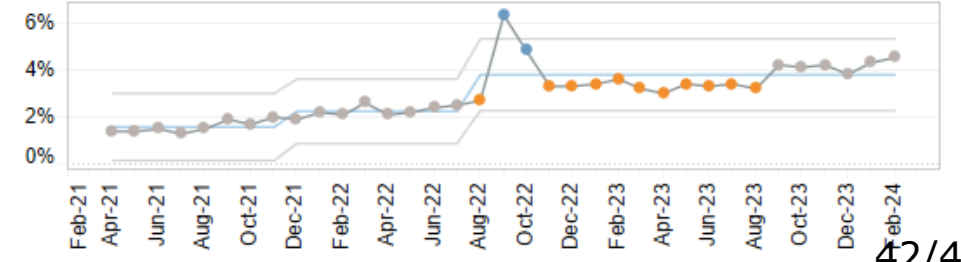
Performance for Outpatient clinic utilisation



Performance for Outpatient DNA rate



Performance for Patient initiated follow up (PIFU)



Signed off by	Mike Allison
Executive Lead	Jackie McShane

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Operational Perf. **Theatres**

		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 measur..	>= 85%	79.1%	↑	▲ ▲ ▲ ▲ ▲ ▲	▲
Average cases per 4-hour session	The total number of completed cases, calculated as a rate per 4-hour session equivalent. Excludes emergency and trauma sessions, and includes activity from ..	>= 2.8	2.7	→	● ● ▲ ▲ ● ▲	▲

February - Summary

Capped Touch-Time Utilisation

- Capped Touch-time Theatre Utilisation (CTTU) performance continues to improve
- In Q4 2023/24 the Trust benchmarked as the 4th worst in the country for CTTU. The most recent data has the Trust performing as the best in GM and performing in the highest quartile. :
  - General Surgery is the best nationally at 97%. Urology, Oral Surgery & Gynaecology are in Quartile 4, performing better than peers and the national median. T&O is in Quartile 3, performing better than peers

Average Cases per 4-hour Session

- Performance against this measure is consistently above peer and national averages.
- The latest Model Health data refresh on 11/02/24 shows the Trust ACPL (as a 4hr session) is 2.7, higher than Peer (2.1) and National (2.3) medians.

Day Case Rate

- Performance against this measure is consistently good
- The latest Model Health data refresh on 11/02/24 shows the Trust average is 83.8%, higher than Peer (83.1%) and National (81.0%) medians.

Key Actions

- Daily performance flash reporting was implemented in January 24 and is reviewed daily. Meetings are place chaired by the Director of Operations. This is now an embedded process.
- Engagement session with surgeons, anaesthetists and theatre teams completed in December-23 and will continue in Q4 to drive knowledge and impact positively on performance.

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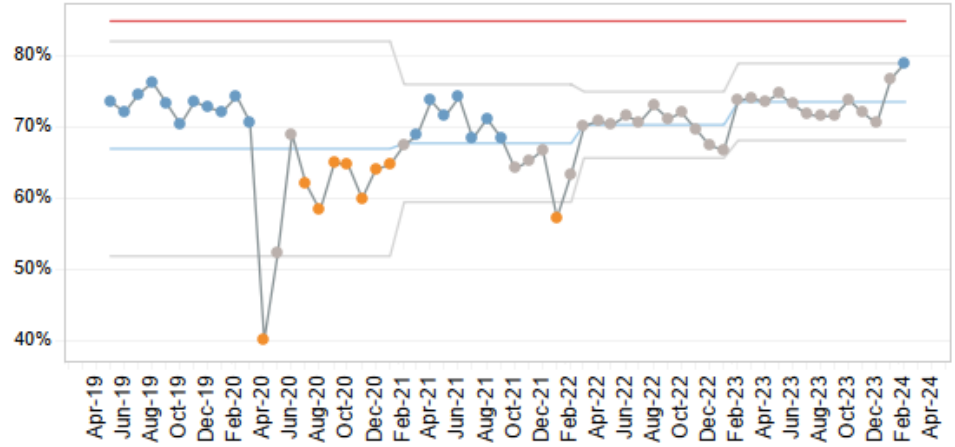
Performance for Capped Touch Time Utilisation



Benchmarking data sourced from Model Hospital, showing performance for week ending 11/02/2024

Signed off by	Karen Hatchell
Executive Lead	Jackie McShane

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%	6.3%	↘	● ▲ ● ▲ ▲ ▲	▲

The in-month sickness rate in February 2024 has decreased to 6.28% from 6.45% in January. Our rolling 12-month absence figure is 5.91%, below our 6% target.

After anxiety/Stress related illnesses, our highest reason for absence is the seasonal sickness of cough, cold and flu which is expected at this time of year (2,078 days lost). MSK has increased to the third highest reason for sickness with 923 days lost in February.

We continue to actively promote all health and well-being support mechanisms and are working with departmental managers focussing on preventive measures such as team risk stress assessments. We continue to offer and promote Flu Vaccination. The Staff MSK Physio who has joined the Wellbeing & Occupational Heath Team in February is a welcome support and teams in the Trust are already referring staff to this service. The Menopause clinic is well attended, and promotion of this service continues

The Deputy Director of People & OD continues to have an oversight of attendance, meeting monthly with divisions to address complex cases, ensuring staff are receiving appropriate support and all cases are being managed effectively.

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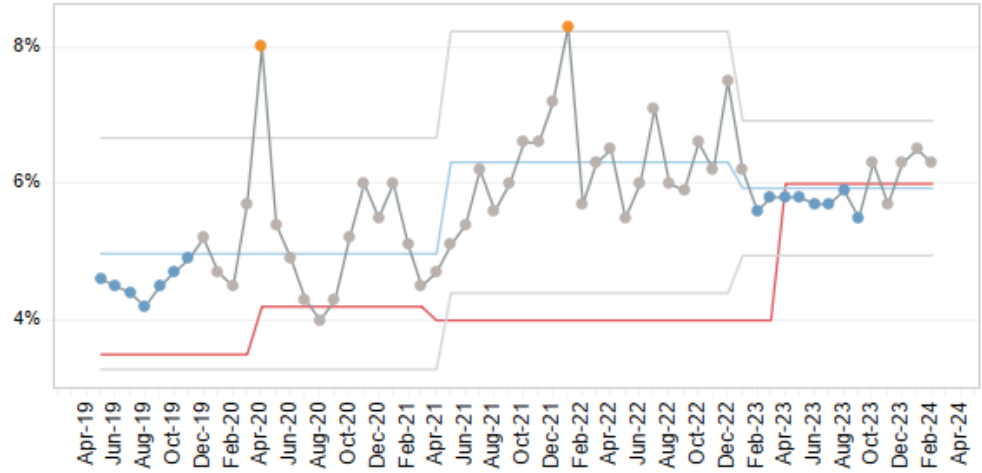
Performance for Sickness Absence: Monthly Rate



Signed off by	Ian Henry
Executive Lead	Amanda Bromley

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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%	3.8%			

In February 2024, 3.9% of the total pay bill related to agency usage, above the target of 3.7% following an increase of 0.3% since January 2024. Whilst this has been a small increase, our trajectory remains close to the target, at 0.2% above in month 11. Bank usage accounted for 75% of our overall temporary pay bill, against the GM target of 75%.

In month, the Price Cap Compliance was 45.32%, which is lower than the 60% North West target, however, is an improvement compared to 37.14% reported in February 2023. We did not use any off-framework agencies during the month.

The total bank and agency spend in December was £4.3M which represents 15.58% of the total pay bill within the month. The bank and agency spend is £130K lower than January. Agency spend in February was £1.1M, which is £494K higher compared to February 2023. We continue to see an improving trajectory in relation to our nursing and midwifery agency expenditure, which has been on a downward trajectory since March 2023. Reducing from £309k in month 10 to £285k in Month 11.

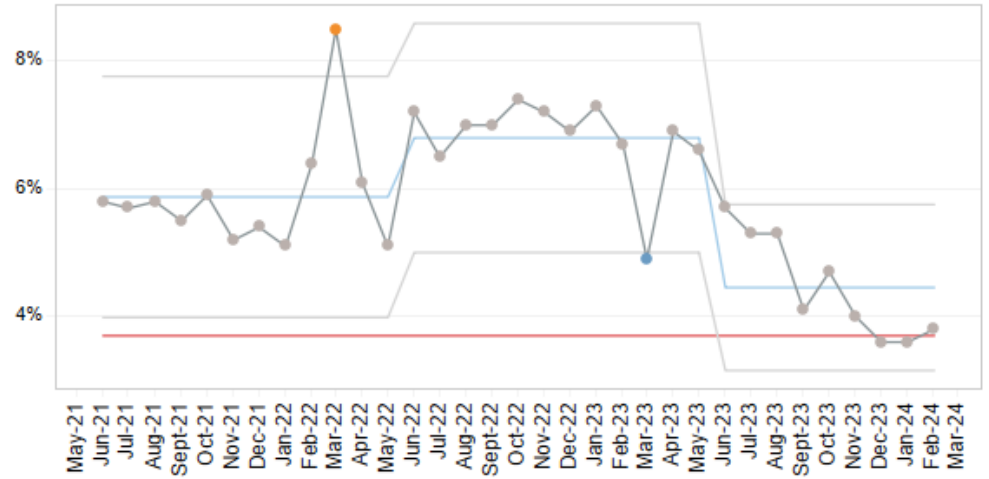
The highest divisional spend for agency usage is within Medicine (£386 an increase of £41k) and Surgery and Critical Care (£300 an increase of £53k).

We continue to experience significant, operational challenges particularly in elective and non-elective care, as the number of patients attending our services has increased; flow through the hospital remains difficult, and consequently additional, escalation beds remain open. This picture ultimately impacts on the number of temporary workers required to safely staff our services.

Actions to Reduce Agency Spend

- A process has been agreed to attract unregistered NHSP workers into permanent roles. Details will be displayed on wards from April and will allow for a fast-tracked interview process in an effort to reduce vacancies.
- Review and reduction of nursing and midwifery cascade arrangements. Benchmarking exercise into nursing and midwifery bank rates across GM has been completed, our rates are within the average levels paid within the system.
- Discussions took place in March between Stockport, Tameside, Liaison, and our framework provider (Health Trust Europe) to facilitate a collaboration with other GM organisations to agree common commission rates that will also facilitate a reduction in workers' pay.
- Continued scrutiny at the Staffing Approval Group to challenge agency requests.

Performance for Agency Costs %



Signed off by	Ian Henry
Executive Lead	Amanda Bromley

Workforce **Turnover**

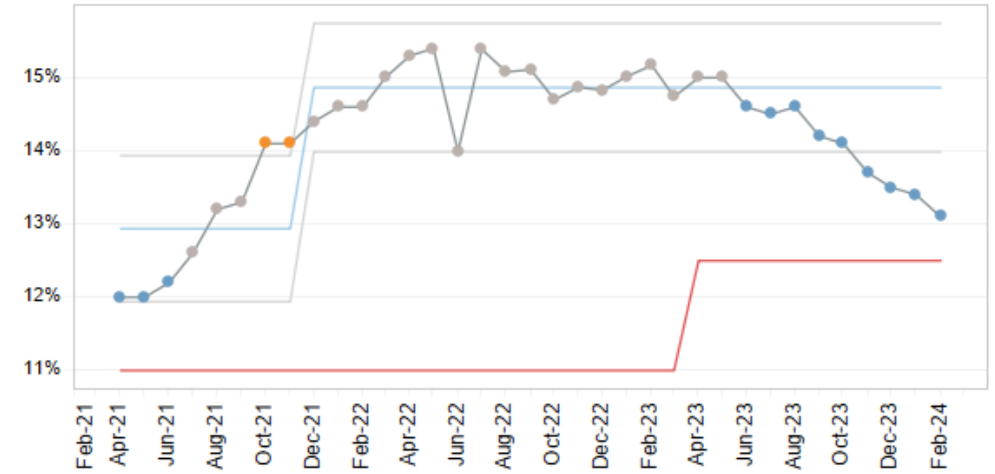
		Target	Actual	6-month trend	Previous Performance	1-month Forecast
Workforce Turnover	The percentage of employees leaving the Trust and being replaced by new employees.	<= 12.5%	13.1%	↑	▲ ▲ ▲ ▲ ▲ ▲	▲

The annualised turnover rate to February 2024 was 13.1%. The figure has continued to fall and is at its lowest rate since August 2021.

The Emergency Department has the highest turnover rate of 17.04%, followed by Integrated Care (16.11%). Corporate Services has the lowest turnover rate (9.51%).

The top known leaving reasons for the 12 months to December was Voluntary Resignation:
– Relocation - 24.22%
– Work Life Balance - 22.30%
– Promotion - 14.18%

Performance for Workforce Turnover



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Signed off by	Ian Henry
Executive Lead	Amanda Bromley

Workforce **Appraisal Rate**

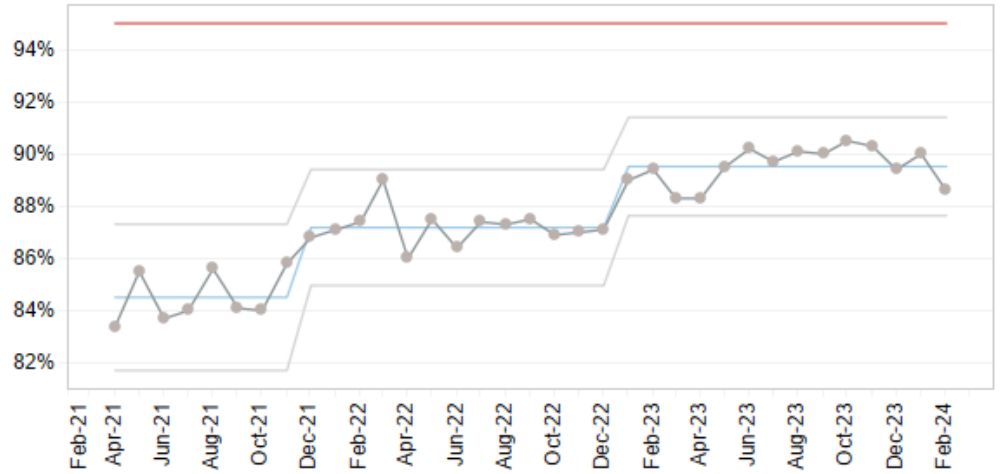
		Target	Actual	6-month trend	Previous Performance	1-month Forecast
Appraisal Rate: Overall	The percentage of overall staff that have been appraised within the last 15 months. Includes both medical staff and non-medical staff.	>= 95%	88.6%	→	▲ ▲ ▲ ▲ ▲ ▲	▲

Appraisal compliance currently stands at 88.6%, a reduction from last month.

The Learning & Education team are undertaking a deep dive into the performance appraisal training to see if there is any correlation between low compliance and number of people trained.

A revised and refreshed approach to appraisals is scheduled to launch from April and it is anticipated that this will assist in the appraisal experience and see an improvement in our performance.

Performance for Appraisal Rate: Overall



McCarthy Rebecca
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Signed off by	Joanne Martin
Executive Lead	Amanda Bromley

Workforce **Mandatory Training**

	Target	Actual	6-month trend	Previous Performance	1-month Forecast
Mandatory Training	>= 95%	94.8%			

The percentage of statutory & mandatory training modules showing as compliant.

Mandatory training has seen a slight decrease from 95.05% to 94.98% and is now just 0.2% below target. This is owing to poor attendance at mandatory sessions during junior doctors' industrial action and operational pressures. There has also been a focus on completion of mandatory eLearning packages to improve compliance which will continue in order to support divisions in achieving their trajectories. The Learning and Education team are taking proactive actions and contacting managers and colleagues directly.

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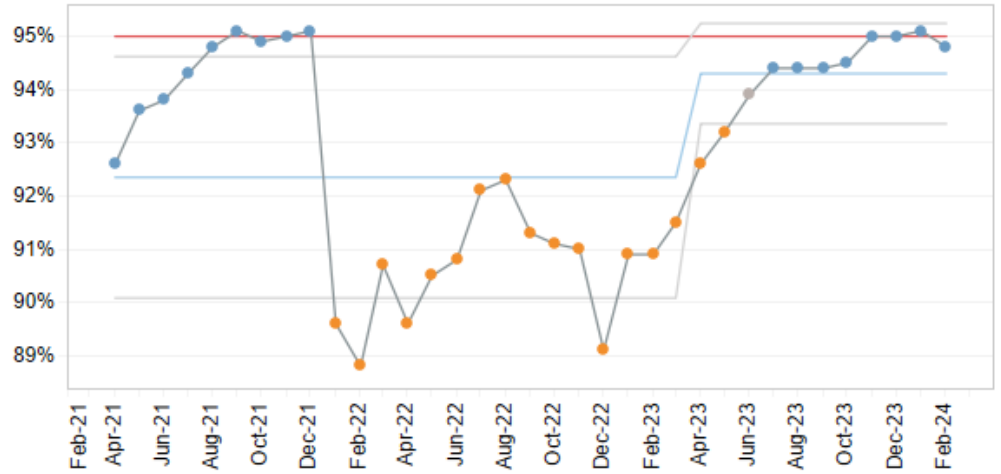
Performance for Mandatory Training



Signed off by	Joanne Martin
Executive Lead	Amanda Bromley

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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%	-32.8%	↘	● ● ● ● ● ●	●
Cash Balance	The amount of cash balance in Trust accounts. Figures displayed are millions per month.		20.9	→		
CIP Cumulative Achievement	The value of the actual CIP achievement, displayed as a percentage variance from the planned CIP achievement.	>= 0%	0%	↗	● ● ● ● ● ●	●
Financial Controls: I&E Position	The actual financial position, displayed as a percentage variance from the planned financial position.	<= 0%	8.3%	↗	▲ ▲ ▲ ▲ ▲ ▲	▲

Risks

There is a forecast £1.1m-£1.4m pressure from pay award 2023-24 costs for both the Agenda for Change staff and the medical staff above national funding allocations.

The cost of industrial action was not included in the planning process. The gross cost of the industrial action to date is £3.4m the pressure to month 8 of £2.1m has been covered by a share of the GM allocation. The system deficit assumes the latest cost of industrial action will be funded.

The ERF position remains uncertain, but we are assuming an adverse impact to date and the rest of the financial year. The impact at month 11 is £1.1m with a forecast penalty of circa £1.3m in the year end forecast.

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.

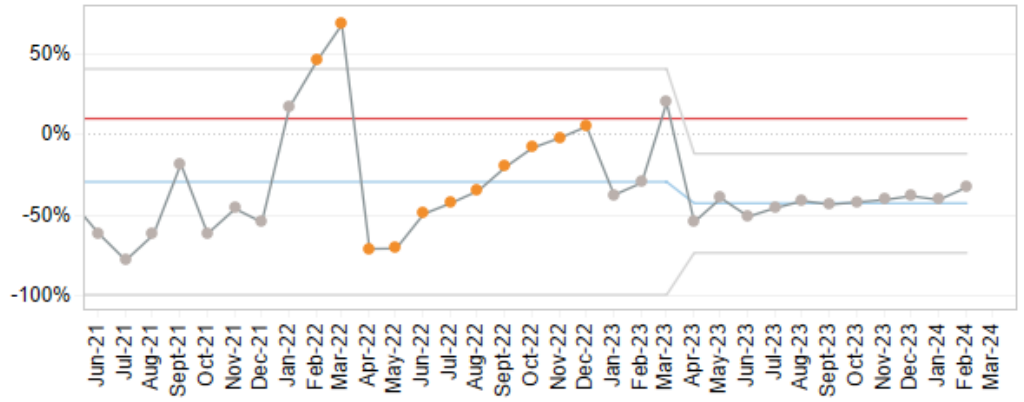
Escalation Capacity – alongside planned escalation capacity, additional beds over and above this level are open increasing the financial pressure.

Cashflow – based on the planned deficit of £31.5m the Trust will require revenue support in 2023-24. This has been received in March 2024.

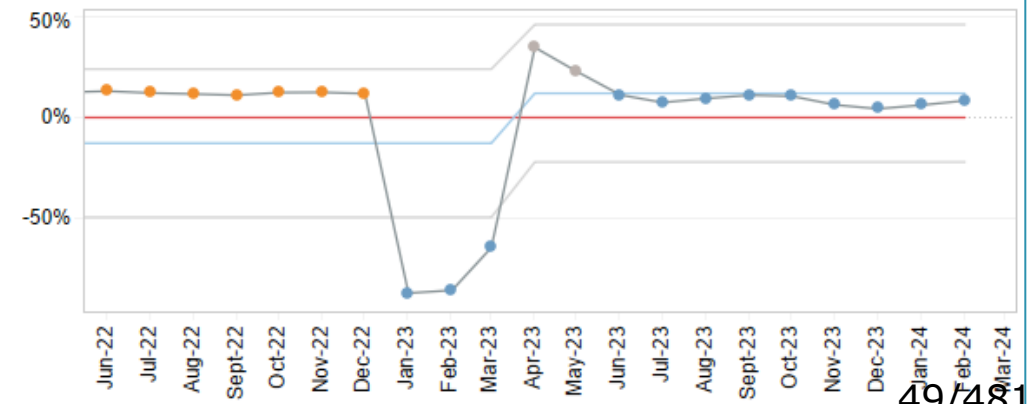
There is an increasing cost of acuity in the Trust for enhanced care for patients. This also particularly links to the number of no criteria to reside patients who have complex needs and for whom CHC external placements cannot be found.

Outpatients B – due to the business continuity incident of the closure of Out Patients B on the 23/11/23 - the cost impact is still being assessed on both capital and revenue but an impairment is highly likely to be transacted in 2023-24 and the accounting treatment is being clarified.

Performance for Capital Expenditure



Performance for Financial Controls: I&E Position



Signed off by	Kay Wiss
Executive Lead	John Graham

NHS
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Meeting date	4th April 2024	**Public**	**X**	**Agenda No.**	9
Meeting	Board of Directors				
Report Title	Financial Position Month 11 2023/24				
Director Lead	John Graham Chief Finance Officer	**Author**	Kay Wiss Director of Finance		

Paper For:	**Information**		**Assurance**	**X**	**Decision**	
Recommendation:	The Board of Directors is asked to receive the Financial Position Report for Month 11 2023/24, to update on the current financial position in support of the Integrated Performance Report and give assurance on the delivery of the financial plan for 2023/24.					

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
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		Effective
	Caring		Responsive
X	Well-Led	X	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
	PR2.1	There is a risk that the Trust is unable to sufficiently engage and support our people's wellbeing
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	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
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X	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	Whole paper
Regulatory and legal compliance	Whole paper
Sustainability (including environmental impacts)	n/a

Executive Summary

The Trust has a deficit of £31.3m at Month 11 (February) 2023-24, which is an adverse variance of £2.4m to plan. A detailed finance paper was presented to the Finance & Performance Committee on the 21st March 2024 and this paper is the summarised key extracts from that paper.

The paper seeks to give assurance that, subject to known risks as agreed within the GM ICB, that the Trust will:

- deliver its financial plan for 2023/24
- deliver its capital plan for 2023/24
- deliver its savings plan for 2023/24 with a requirement for increased recurrent delivery
- require cash borrowing in March 2024 which is subject to national approval

In order to deliver the financial plan for 2023/24 the financial governance in place has been strengthened with a series of grip and control actions, at a high-level these include review of all vacancies, focussed action on reduction in agency costs and reconciliation of budgeted posts.

NHS
Stockport
NHS Foundation Trust

Board of Directors

4th April 2024

Financial Performance Month 11

John Graham
Chief Finance Officer

Contents

Stockport NHS Foundation Trust

1. Overall Financial Position M11 2023-24

NHS Stockport NHS Foundation Trust

Income & expenditure Position	In-Month			Year to date			Forecast		
	Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m
Total Income	**34.9**	**35.2**	**0.2**	**385.7**	**386.5**	**0.9**	**420.6**	**425.0**	**4.4**
Substantive Staff	(22.9)	(23.3)	(0.4)	(252.8)	(252.1)	0.7	(275.4)	(272.3)	3.1
Bank Staff	(2.2)	(3.2)	(1.0)	(26.2)	(32.8)	(6.6)	(28.5)	(35.5)	(7.0)
Agency Staff	(1.7)	(1.1)	0.5	(18.7)	(14.7)	4.0	(20.4)	(16.7)	3.7
Pay Costs	(26.8)	(27.6)	(0.8)	(297.7)	(299.7)	(1.9)	(324.3)	(324.5)	(0.2)
Drugs	(1.9)	(2.0)	(0.1)	(21.3)	(21.6)	(0.4)	(23.2)	(23.6)	(0.4)
Clinical Supplies & Services	(2.3)	(2.5)	(0.2)	(23.4)	(25.9)	(2.5)	(25.6)	(28.3)	(2.7)
Other Non Pay Costs	(4.2)	(4.9)	(0.7)	(48.9)	(48.8)	0.1	(53.3)	(56.8)	(3.4)
Below the Line	(2.3)	(1.5)	0.8	(23.6)	(22.2)	1.4	(25.9)	(24.3)	1.6
Total Expenditure	**(37.4)**	**(38.4)**	**(1.0)**	**(414.8)**	**(418.1)**	**(3.3)**	**(452.3)**	**(457.4)**	**(5.1)**
TRUST SURPLUS / (DEFICIT)	**(2.5)**	**(3.3)**	**(0.8)**	**(29.2)**	**(31.6)**	**(2.4)**	**(31.8)**	**(32.5)**	**(0.7)**
Pharmacy Shop	-	-	-	-	-	-	-	-	-
Remove capital donations/grants/peppercorn lease I&E impact	0.0	0.0	(0.0)	0.3	0.3	0.0	0.3	0.3	(0.0)
Adjusted financial performance surplus/(deficit) for the purposes of system achievement	**(2.5)**	**(3.3)**	**(0.8)**	**(28.9)**	**(31.3)**	**(2.4)**	**(31.5)**	**(32.2)**	**(0.7)**

1. Overall Financial Position

NHS Stockport NHS Foundation Trust

The February 2024 (M11) financial position is a deficit of £31.3 which is £2.4m adverse to plan to date. This is a deterioration of £0.8m in month which relates to industrial action costs in month and the on-going depreciation income shortfall.

The key reasons for the variance to plan year to date are:

- (£1.0m) shortfall in GM funding allocation for depreciation to date
- (£1.0m) pay award 2023-24 costs not fully funded
- (£1.1m) elective recovery fund (ERF) estimated penalty
- (£0.9m) net position of cost of industrial action after funding in month 8
- £1.6m other budget underspends and non-contract income above plan

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 as well as patients with dementia and other continuing healthcare needs.

1. Overall Financial Position – YEAR END FORECAST

NHS Stockport NHS Foundation Trust

The year-end forecast has been agreed as part of the GM turnaround process. Since the report at Month 9 there has been clarification on how Trusts are to report their financial position and forecast; adjustments are then actioned at system level

Planned deficit 2023/24	**-31.461**
Agreed GM Improvement (PWC balance sheet)	0.298
Agreed further GM stretch	0.023
Agreed forecast January 2024	-31.14
Strike impact adjustment December '23 & January '24 *(including cover costs and loss of income)*	-1.697
Forecast submitted M09	**-32.837**
GM depreciation shortfall	-1.13
Revenue to Capital transfer	0.25
Offset OPD B revenue impact	-0.15
Forecast submitted M10	**-33.867**
GM notified strike income	1.697
Forecast submitted M11	**-32.170**

Depreciation shortfall to be reported as acceptable change to forecast
Revenue to capital agreed improvement less cost of revenue of OPB

Please note the Trust has been requested to take out all negative balances from ERF
This excludes the impairment for Out Patients B

2. Divisional Financial Position

Stockport NHS Foundation Trust

Division	In-Month			Year to date			Forecast		
	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Actual	Variance
Medicine	(5.8)	(5.9)	(0.1)	(63.8)	(66.2)	(2.5)	(69.4)	(72.2)	(2.9)
Emergency Department	(1.6)	(1.8)	(0.1)	(18.3)	(19.4)	(1.0)	(19.9)	(21.1)	(1.2)
Surgery	(6.6)	(7.1)	(0.5)	(73.6)	(76.5)	(3.0)	(80.2)	(83.7)	(3.4)
Women & Children	(3.6)	(3.5)	0.0	(40.9)	(38.7)	2.2	(44.5)	(42.4)	2.2
Integrated Care	(5.0)	(5.0)	(0.0)	(53.8)	(54.3)	(0.5)	(58.5)	(59.3)	(0.9)
Clinical Support Services	(3.6)	(3.6)	(0.0)	(38.0)	(39.0)	(1.0)	(41.4)	(42.8)	(1.3)
Estates & Facilities	(2.3)	(2.0)	0.3	(25.2)	(24.6)	0.6	(27.5)	(27.1)	0.4
Corporate	(2.7)	(2.4)	0.2	(30.4)	(28.6)	1.8	(33.0)	(31.4)	1.6
Pharmacy Trading Units	0.0	(0.1)	(0.1)	0.4	(0.2)	(0.6)	0.4	(0.3)	(0.7)
Divisional Total	**(31.3)**	**(31.5)**	**(0.3)**	**(343.5)**	**(347.6)**	**(4.1)**	**(374.0)**	**(380.3)**	**(6.3)**
Clinical income	31.8	31.2	(0.6)	353.7	351.0	(2.7)	385.7	386.4	0.7
General Trust	(3.0)	(2.9)	0.1	(39.4)	(35.0)	4.3	(43.5)	(38.6)	4.9
Total	**(2.5)**	**(3.3)**	**(0.8)**	**(29.2)**	**(31.6)**	**(2.4)**	**(31.8)**	**(32.5)**	**(0.7)**

The combined divisional position is £4.1m adverse year to date.

Top 5 variances within the divisions following the agreed non-recurrent monthly budget allocation are:

- Escalation capacity above funded levels £1.8m
- Other ward pressures covering sickness, vacancies and supernumerary staff £2.5m
- Waiting list initiatives (WLIs) to deliver activity £1.6m across all specialities (partially linked to 65 week wait funding received)
- Medical staffing costs (excluding escalation) £1.5m
- Undelivered STEP £0.5m

2. Divisional Financial Position

NHS Stockport NHS Foundation Trust

STAFF AND WTE RECONCILIATION

Staff Group	ACTUAL WTE M01 23/24	ACTUAL WTE M03 23/24	ACTUAL WTE M06 23/24	ACTUAL WTE M09 23/24	ACTUAL WTE M10 23/24
Registered nursing, midwifery and health visiting staff	1,617.4	1,634.5	1,610.8	1,689.5	1,705.2
Healthcare scientists and scientific, therapeutic and technical staff	653.4	642.7	647.3	660.8	655.1
Support to clinical staff	1,143.3	1,097.9	1,083.9	1,100.4	1,096.5
Medical & dental	566.8	588.2	588.9	605.0	600.7
Other	1,358.6	1,369.8	1,388.2	1,393.8	1,398.4
Substantive	**5,339.4**	**5,333.1**	**5,319.0**	**5,449.6**	**5,455.9**
Registered nursing, midwifery and health visiting staff	159.2	155.4	175.8	163.4	199.9
Healthcare scientists and scientific, therapeutic and technical staff	0.1	0.1	-	0.1	0.1
Support to clinical staff	228.7	224.0	245.1	236.2	246.0
Medical & dental	52.5	49.7	43.2	43.0	54.9
Other	74.1	66.3	69.2	58.2	59.4
Bank	**514.5**	**495.4**	**533.3**	**500.9**	**560.3**
Registered nursing, midwifery and health visiting staff	123.0	101.0	71.7	54.7	55.6
Healthcare scientists and scientific, therapeutic and technical staff	43.9	48.1	22.8	20.3	22.9
Support to clinical staff	3.1	0.4	-	-	-
Medical & dental	47.5	49.7	39.8	31.0	33.6
Other	0.6	3.2	4.2	3.8	3.4
Agency	**218.1**	**202.4**	**138.5**	**109.7**	**115.5**
TOTAL	**6,072.0**	**6,030.9**	**5,990.8**	**6,060.1**	**6,131.6**

There has been a slight increase in the number of substantive staff in month, but the biggest increase is across bank staff. This is because of increased sickness levels for nursing & support staff and cover for industrial action for medical staff.

3. STEP (Stockport Trust Efficiency Programme)

NHS Stockport NHS Foundation Trust

FULL YEAR 2023/24 STEP by Division £000s	Annual Target	Recurrent	Non-Recurrent	Total Delivered & Idntified in	Gap in Year	% Identified
Medicine	2,414	290	1,328	1,617	(797)	67%
Surgery	1,926	194	1,355	1,549	(377)	80%
Women & Childrens	1,192	38	1,304	1,343	151	113%
Integrated Care	1,935	470	1,348	1,818	(117)	94%
Clinical Support Services	1,318	87	659	747	(571)	57%
Estates & Facilities	627	123	712	835	208	133%
Corporate	888	212	1,058	1,269	381	143%
Sub-total for Divisions	*10,300*	*1,414*	*7,764*	*9,177*	*(1,123)*	*89%*
Technical	15,900	7,529	9,194	16,722	822	105%
TOTAL	**26,200**	**8,943**	**16,957**	**25,900**	**(300)**	**99%**

YEAR TO DATE (M11) 2023/24 STEP by Division £000s	Year to Date Target	Recurrent	Non-Recurrent	Total Delivered Year to Date	Gap Year to Date	% Identified
Medicine	2,213	266	1,233	1,499	(714)	68%
Surgery	1,765	172	1,350	1,521	(244)	86%
Women & Childrens	1,093	35	1,297	1,332	240	122%
Integrated Care	1,774	430	1,343	1,774	0	100%
Clinical Support Services	1,208	80	659	739	(469)	61%
Estates & Facilities	575	113	706	819	244	142%
Corporate	814	194	1,054	1,248	434	153%
Sub-total for Divisions	*9,441*	*1,290*	*7,642*	*8,933*	*(508)*	*95%*
Technical	14,481	6,875	8,116	14,991	510	104%
TOTAL	**23,922**	**8,165**	**15,758**	**23,924**	**2**	**100%**

IN MONTH (M11) 2023/24 STEP by Division £000s	In Month Target	Recurrent	Non-Recurrent	Total Delivered in Month	Gap in Month	% Identified
Medicine	201	25	146	171	(30)	85%
Surgery	160	22	64	86	(75)	53%
Women & Childrens	99	3	7	10	(89)	10%
Integrated Care	161	40	121	161	0	100%
Clinical Support Services	110	7	-	7	(103)	7%
Estates & Facilities	52	33	6	38	(14)	73%
Corporate	74	18	215	232	158	314%
Sub-total for Divisions	*858*	*148*	*558*	*706*	*(152)*	*82%*
Technical	1,452	651	953	1,604	151	110%
TOTAL	**2,310**	**799**	**1,511**	**2,310**	**(1)**	**100%**

The Trust STEP target for 2023-24 is £26.2m. This is split £10.3m recurrently allocated to Divisions, and £15.9m non-recurrent.

The top table shows the divisional progress on identification of schemes towards the target; the target of £26.2m has been identified of which £9.0m is recurrent.

The middle table shows the total delivered to date of £23.9m which is in line with plan.

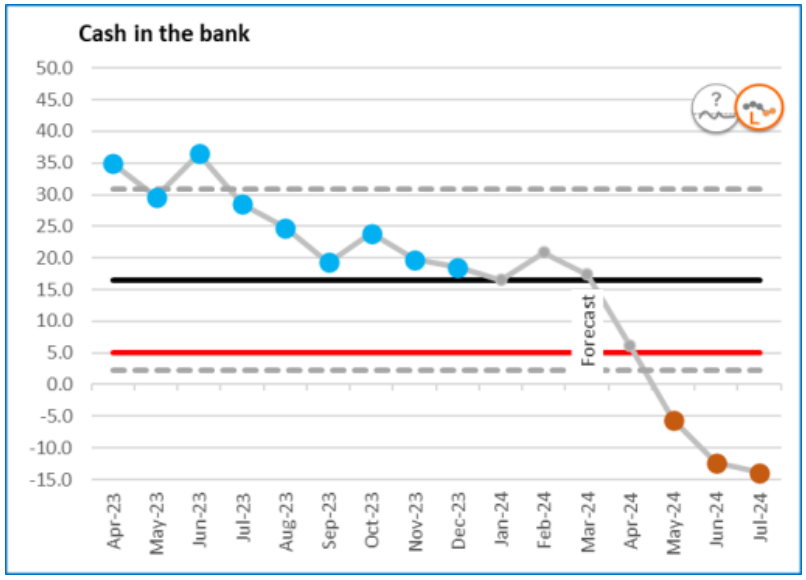
Non-recurrent vacancy factor continues to be transacted to gain consistency with other GM Trusts as part of the turnaround work. Some areas of the Trust have declared a vacancy factor as recurrent in previous years, as there is certainty of turnover. The recurrent nature of this will be considered as part of planning for 2024/25.

The divisions are currently working on the STEP plans for 2024-25 and 2025-26.

4. Cash

a. Cash Position

Stockport NHS Foundation Trust



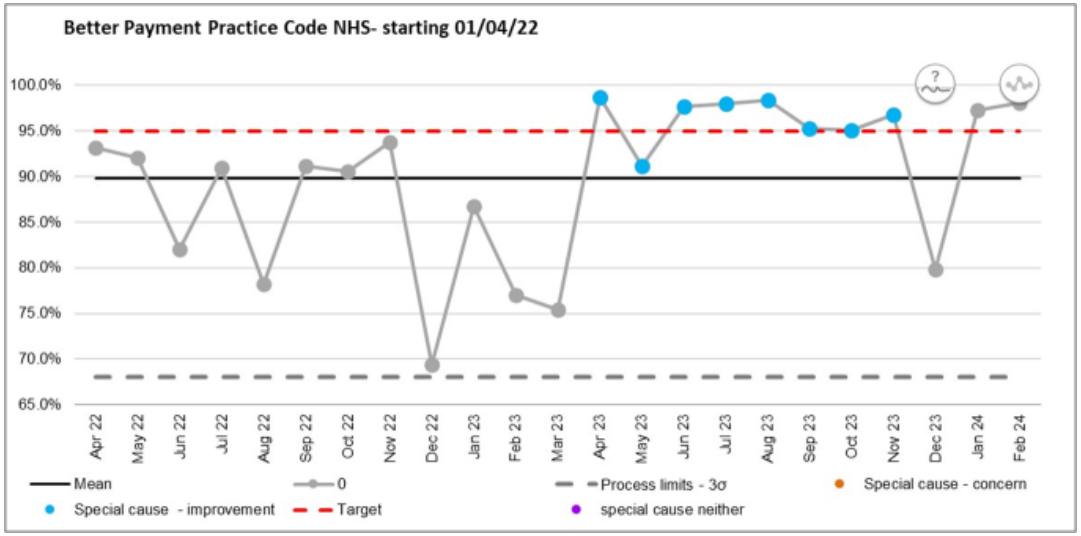
- Cash as the end of February was £20.9m.
- This was an increase of £4.4m from January largely due to receipt in February of £14.5m of capital PDC funding.
- The Cashflow Monitoring group will continue to closely monitor the cash position.

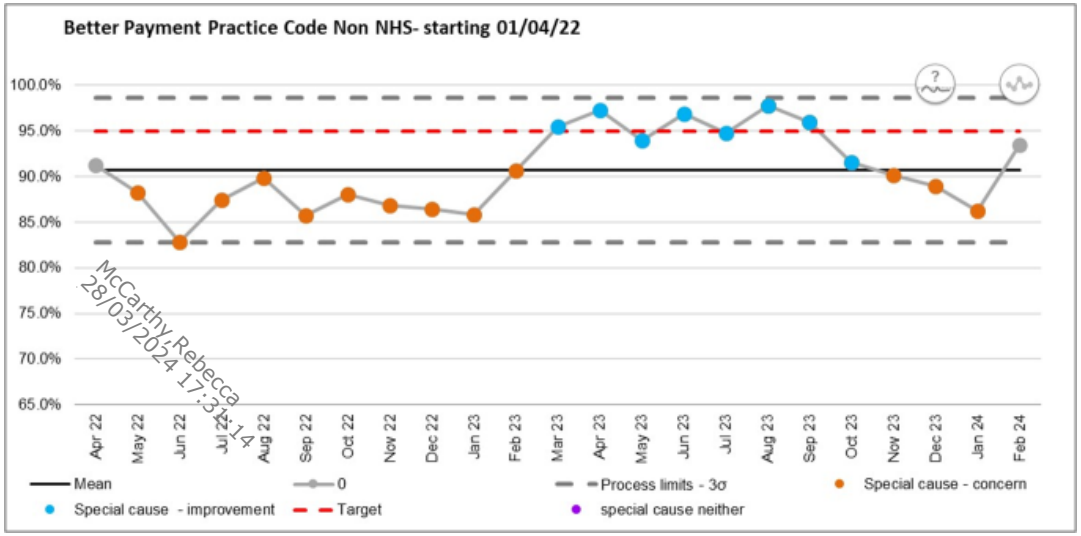
£5m of revenue support PDC has been received in March. The forecast year end cash balance for March and into Quarter 1 2024/5 will be influenced by the timing of capital cashflows. A request is to be submitted in March for further cash support in Quarter 1.

The cash risk has been reduced to a score of 10 as the application for revenue support has been approved. However cash support will be required in 2024-25 and this has been highlighted as part of the planning process.

4. Cash

b. Better Payment Practice Code





The Better Payment Practice Codes (BPPC) sets the target for 95% of all valid invoices to be paid within the agreed timeframe.

Performance against the standard is reported for both NHS and non-NHS invoices, as shown in the charts.

Performance against the standard has improved in 2023-24 from 2022-23 levels for both NHS and non-NHS invoices. Performance will continue to be closely monitored to ensure targets are met.

5. Capital

Stockport NHS Foundation Trust

Description	Month 11 Budget	Month 11 Actual	Month 11 Variance	Year To Date M11 Budget	Year To Date M11 Actual	Year To Date M11 Variance	Forecast Budget	Forecast Actual	Forecast Variance
Estates	6.1	4.1	(2.0)	31.9	20.8	(11.1)	39.0	35.6	(3.4)
Equipment	0.3	0.2	(0.1)	1.5	0.9	(0.6)	1.8	2.2	0.4
IFRS16	-	0.3	0.3	2.5	1.8	(0.7)	12.4	5.6	(6.8)
IT	2.8	0.5	(2.3)	6.6	2.9	(3.7)	9.5	3.9	(5.6)
Total	**9.2**	**5.1**	**(4.1)**	**42.5**	**26.4**	**(16.1)**	**62.7**	**47.3**	**(15.4)**

The £47.3m forecast shown is as per the latest NHSE return including £29.6m PDC.

- Emergency & Urgent Care Campus (EUC) - £16.5m
- Targeted Investment Fund (TIF) - £5.2m
- Aseptics - £5.0m
- RAAC - £1.3m
- Frontline Digitisation - £1.0m

- The internal programme had been reduced by £7.2m, however there has since been an additional £3.8m granted following a reallocation of capital within GM
- Just over half of the spend to month 11 relates to the Emergency Campus Development.
- Internally funded Estates schemes are progressing with a number of contractors now on site and should see spend delivered in the final month of the year.
- The IT variance is in relation to the Network Cab Scheme approved beyond the original plan.
- IFRS16 variances relate to changes made in the latest NHSE return, including removal of Cherry Tree lease, blood science contract and updating of 23/24 property rentals
- The Year-to-Date variance relating to IFRS16 is due to final confirmation of 23/24 rent figures.

6. Risks to Delivery of Plan

NHS Stockport NHS Foundation Trust

The Trust can give a high level of assurance that the financial plan for 2023/24 will be delivered as per the forecast agreed within the GM ICS. A series of risks to the financial position have been shared as part of the improvement work in the GM ICS and there is agreement on how these should be treated.

The Finance & Performance Committee have been briefed on the full range of risks on the 21st March 2024 and have discussed the actions in place.

Other internal risks to highlight are:

- There is an increasing cost of acuity in the Trust for enhanced care for patients. This also particularly links to the number of no criteria to reside patients who have complex needs and for whom CHC external placements cannot be found.

- Further unforeseen estate issues – the recent ceiling collapse in radiology B and leak in critical care highlight the risk on the condition of the Trust's estate. Due to timing it is not clear if there is a revenue impact in 23/24.

Meeting date	4th April 2024	**Public**	X	**Agenda No.**	10
Meeting	Board of Directors				
Report Title	Freedom to Speak Up - Update				
Director Lead	Caroline Parnell - Director of Communications and Corporate Affairs	**Author**	Nadia Walsh – Freedom to Speak Up Guardian		

Paper For:	**Information**		**Assurance**	X	**Decision**	
Recommendation:	The Board of Directors is asked to note the contents of the report and the actions being taken to progress the Freedom to Speak Up agenda.					

This paper relates to the following Annual Corporate 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	x	Effective
x	Caring	x	Responsive
x	Well-Led	x	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
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	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
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	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

This report provides a comprehensive update on the Trust's Freedom to Speak Up (FTSU) agenda, with a focus on the activities of the Freedom to Speak Up Guardian (FTSUG). The Guardian has engaged in various initiatives, including walkabouts, regional meetings, and visits, fostering open communication. Notably, a successful awareness campaign during Freedom to Speak Up Month resulted in increased reporting and awareness. The implementation of the Freedom to Speak Up Champions programme, training, and ongoing communication with guardians have been key accomplishments.

In terms of case contacts, a significant rise in concerns was observed during this reporting period, with all issues being addressed promptly. The report outlines positive outcomes for patient safety concerns and those raised by the Bluebell community department. However, there were instances of delayed responses, requiring escalation.

In total 31 concerns were raised with 21 needing Guardian support and seven with an element of patient safety as a concern all which have been reported and addressed.

Themes and trends highlight concerns about communication within the community and inappropriate behaviour from some managers, impacting staff's willingness to report which is a trust wide concern. A connection between staff wellbeing and the freedom to speak up is observed, emphasizing the need for psychological safety. Mental health and wellbeing support for Guardians and a revision of the reflection and planning tool are recommended.

Challenges include service inequality, balancing case work with visibility, and ethical considerations regarding focus shifts. Consistency in relationship-building and addressing capacity challenges are crucial

for the sustained success of the initiative.

1. **Introduction**

The purpose of this report is to provide the Board of Directors with an update on the Trust position in relation to the Freedom to Speak Up (FTSU) agenda and assurance on the approach and activities of the Freedom to Speak Up Guardian (FTSUG).

2. **Overview of FTSU Role Activities**

Walkabouts, Visits and Regional Meetings: The Guardian conducted three walkabouts within the trust to engage with staff members and identify potential issues. They also attended two regional meetings to share best practices and conducted eight visits to departments and teams to encourage open communication and identify potential concerns.

Safeguarding: One safeguarding concern was raised by the guardian in relation to patient safety.

Freedom to Speak up Month: An impactful awareness campaign was conducted during Freedom to Speak Up Month during October. Leveraging various channels, including email newsletters, intranet, and social media, the goal was to raise awareness and encourage active participation in the initiative. The awareness campaign resulted in a notable increase in staff contacting the Freedom to Speak Up Guardian and whilst anecdotal, this is evidence of increasing awareness of the Freedom to Speak up Guardian.

A significant achievement during the month was the marked increase in reporting of concerns compared to the previous month. Concerns increased from nine in September to 14 in October 2023. The combination of visibility and awareness initiatives contributed to a greater willingness among staff to voice their concerns.

Freedom to Speak up Champions: During the reporting period, a champion training program was implemented for members of staff who expressed an interest in becoming a Freedom to Speak up Champion. The training aimed to equip champions with the necessary skills and knowledge to effectively support and promote Freedom to Speak Up within their respective teams and departments.

To ensure this, the guardian ran a 1.5-hour information session which included a presentation and a question-and-answer session. They also designed and distributed information packs for the Champions, including relevant material, created certificates and obtained a quote for Champion pin badges for which the guardian is actively seek funding for.

Currently, there are two dedicated champions within the organisation and a further two awaiting training. The Champions are distributed across the hospital site and the community.

Due to a sharp increase in cases during the reporting period, the promotion of the champion role did not reach the desired trust-wide audience. To address this, the plan is to undertake an additional recruitment campaign for additional champions in the future.

NGO Guidance and Webinars: the guardian has kept abreast of the latest updates via the latest NGO guidance, and has participated in relevant webinars to enhance knowledge and skills. They have applied the insights gained from external resources to improve FTSU

processes. An example of this would be a webinar on Freedom to speak up champions and how to implement this within the organisation.

Contact with Guardians: Maintained regular communication with other guardians to exchange insights, share updates, and address challenges. Facilitated information exchange to ensure a cohesive approach to FTSU

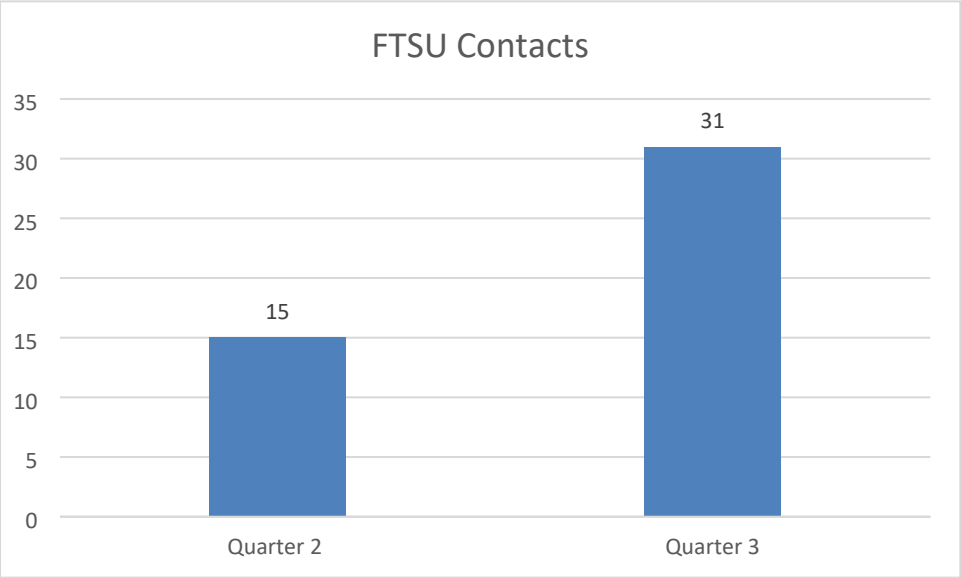
Equality and Monitoring Forms: Actively pursued completion of equality and monitoring forms by staff who raised concerns. Ensured comprehensive data collection for monitoring and evaluation purposes. This has been challenging in terms of uptake from staff who have raised concerns.

Feedback Loops: Closed feedback loops by providing updates on the resolution of reported concerns. Gathered feedback from staff and utilized it for continuous improvement.

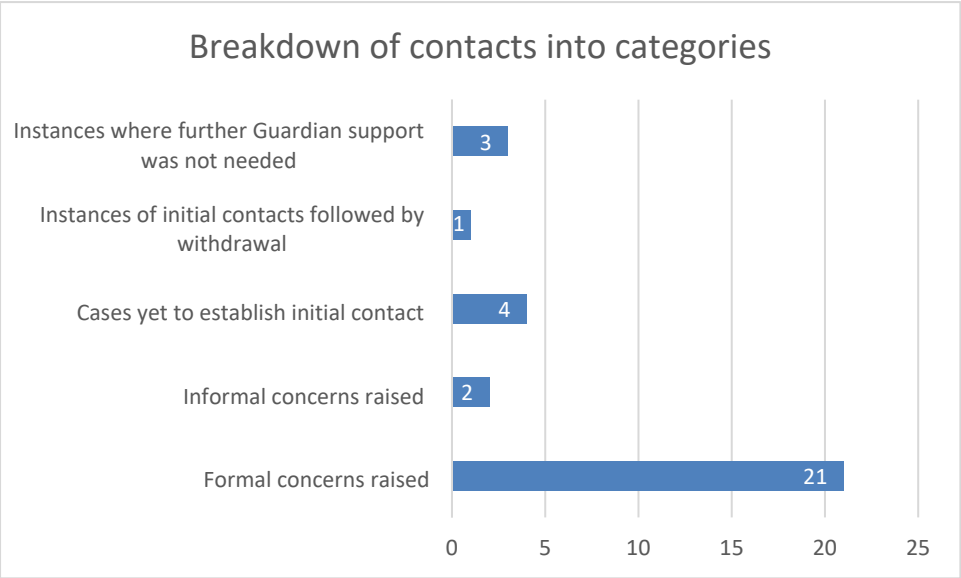
Other Tasks: Undertook meticulous data collection and record-keeping for reported concerns. Managed diaries efficiently to coordinate appointments and visits

3. **Case contacts**

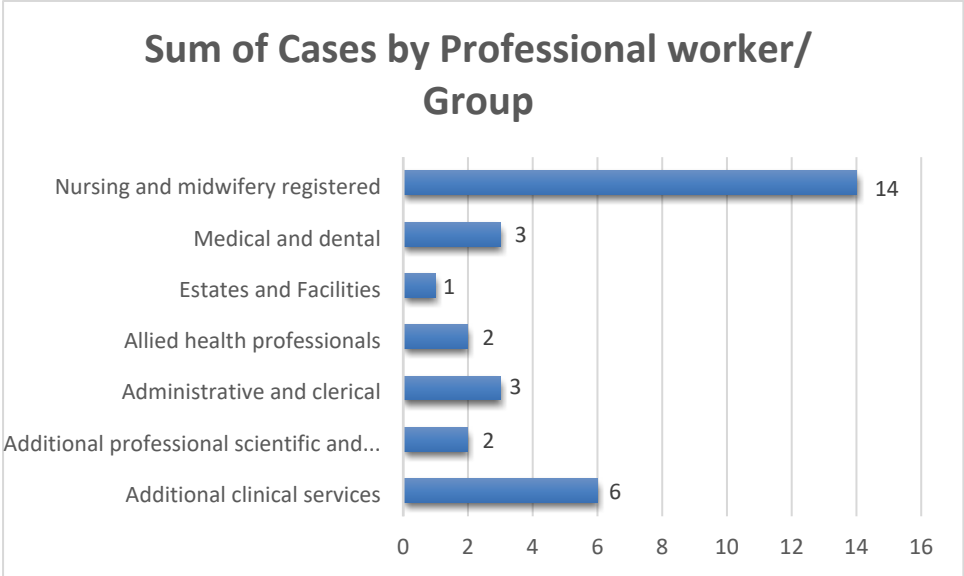
The table below details the number of Freedom to Speak up contacts received and illustrates a notable increase in contacts compared to Quarter two, with a significant rise of 167%—from 15 contacts in Quarter two to 31 contacts in Quarter three. It should be noted that this quarter included the National Freedom to Speak up Month where considerable awareness was raised.



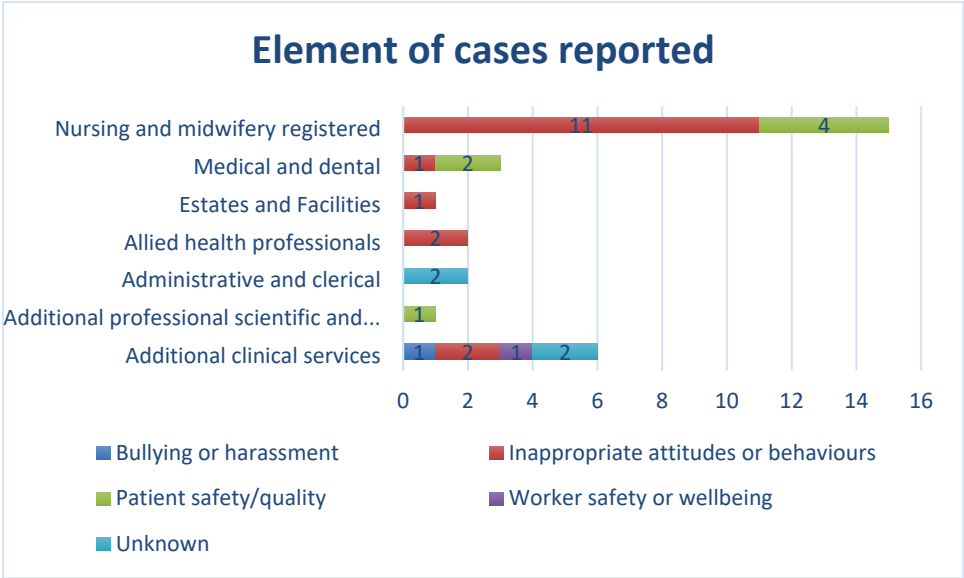
This has been broken down further into specific contact categories.



The sum of cases by professional/worker groups have been highlighted below for a clearer understanding of the distribution across different segments.



Additionally, the breakdown of cases based on the reporting element has been incorporated below.



All issues raised were responded to within four days.

As of the current reporting period, of the 21 concerns that where officially raised, five remain open awaiting further investigation, feedback, or support. One case has been open since June 2023 and is currently in the process of appealing a grievance decision, and two staff members feel they have faced detriment as a direct result of speaking up.

Five concerns were raised by the staff working at one of our community based in relation to allegations of inappropriate attitudes and behaviours regarding a member of the management team. The concerns were raised and dealt with swiftly by the Matron resulting in a positive speaking out experience for the staff members who raised the concerns.

All patient safety concerns raised have been reported and addressed. The four concerns raised by the Nursing and Midwifery team were all from the same department and were addressed promptly.

A member of the medical team reached out to the speak up guardian for further support with regards to a patient safety concern. A safeguarding form was completed by the guardian as a result.

This experience prompted the guardian to reflect on the awareness among staff regarding the distinction between incident reporting and safeguarding. My concern lies in ensuring that staff members are not only proficient in reporting incidents but also confident in recognizing when a situation warrants a safeguarding concern. It underscores the importance of fostering a culture where staff feel empowered to raise concerns of this nature, emphasizing the critical nuances between incident reporting and safeguarding for the overall enhancement of patient safety and well-being. A subsequent meeting was held with the Safeguarding lead in view of learning and reflection.

Overall, the interactions between all involved parties have been positive, reflecting effective communication and collaboration. However there have been instances where response times were slower than expected and needed to be escalated further by the guardian to get a response.

4. Themes and trends

The data analysis is somewhat constrained by the limited size of the data pool; nevertheless, it reveals an emerging theme within our community setting. A prominent concern is the observed lack of communication within various community teams, signalling potential challenges in fostering effective communication channels.

Inappropriate attitudes and behaviour

There appears to be an issue of inappropriate behaviour towards staff from some managers with some staff feeling able to report it but others not as they fear suffering a detriment if they do. It is noteworthy to add that nine instances of inappropriate attitudes and behaviours were from teams based within the community.

The trust appears to be aware of the issues relating to inappropriate attitudes and behaviours, given their proactive approach in conducting staff training on compassionate leadership and initiatives like Civility Saves Lives.

This issue acts as a significant barrier to speaking up, as there is a perceived detriment and fear associated with doing so. Ongoing support and intervention are crucial for effectively navigating these challenges.

Link to Wellbeing and Speaking up

An observance emerges regarding the intrinsic connection between staff wellbeing and the inclination to speak up. In environments prioritizing wellbeing, there's a notable tendency for individuals to feel psychologically secure, fostering openness in expressing concerns. Conversely, compromised wellbeing, whether due to perceived repercussions, trust issues, or concerns about managerial relationships, often correlates with a diminished willingness to voice thoughts.

This observation underscores the significance of recognizing and addressing the delicate balance between staff wellbeing and the freedom to speak up. Strengthening psychological safety becomes pivotal, not only for promoting open communication but also as a fundamental element contributing to the overall health of our organizational culture. This observation requires further thought to work towards a remedy.

Mental Health and Wellbeing support

In recognition of the unique challenges associated with the Freedom to Speak Up role, there is currently no formal requirement for supervision or emotional support for the guardian. However, the NGO is proactively taking steps to strengthen emotional support for guardians, recognizing the emotional impact it can have on mental health and wellbeing. To further bolster this support, the NGO has recommended that leaders actively utilize the reflection and planning tool, ensuring that emotional well-being remains a priority for guardians.

Supervision and emotional support for the guardian were briefly touched upon in a one-on-one meeting with the Chief Executive. Following that, a meeting with the SPAWS team has

been scheduled. This meeting aims to explore collaborative opportunities for peer support between the guardian and SPAWS, which has been welcomed.

6. Reflection and planning

The guardian, executive and non-executive leads for Freedom to Speak up have revised the reflection and planning tool to obtain a detailed plan of action for the months ahead.

7. Role Challenges

Incorporating the challenges faced in the role is paramount for providing a comprehensive and transparent view of the Freedom to Speak Up Guardian's responsibilities. These challenges not only highlight the complexities inherent in the role but also shed light on the external factors that may impact the effective execution of duties.

By openly discussing these obstacles, the report not only showcases the dedication to overcoming hurdles but also underscores the commitment to organizational growth and the overall success of the Freedom to Speak Up initiative. Additionally, acknowledging challenges ensures the trust is well-informed about the dynamic nature of the role, promoting a shared understanding of the efforts required for sustained progress. It is noteworthy that the challenges observed below have been discussed with the executive and non-executive Lead for Freedom to Speak Up.

Service Inequality

There have been instances where Stockport NHS Foundation Trust required a heightened level of attention due to an increased influx of cases, leading to a temporary shift in focus. Regrettably, this has inadvertently resulted in Tameside and Glossop Integrated Care NHS Foundation Trust receiving a diminished level of service during such periods.

Balancing Case Work and Visibility

Maintaining the recommended 50-50 split between case work and visibility becomes a formidable task when urgent case work demands precedence. The essential nature of responding promptly to reported concerns often takes precedence over maintaining consistent visibility in the community. This imbalance poses a challenge in fostering sustained relationships and visibility.

Ethical Considerations

The practice of shifting focus based on case urgency raises ethical considerations. It prompts reflection on whether the potential detrimental effects of this approach, including service inequalities, align with the ethical standards expected in the role and align with the values of the Trust. It's crucial to explore the ramifications of prioritizing cases over maintaining consistent visibility and relationship-building.

Consistency in Relationship-Building Cycle

Recognizing the importance of consistency, the cyclical nature of building relationships and maintaining visibility must be acknowledged. The current challenges in balancing case work and visibility can disrupt the organic growth of the service. It is imperative to establish a

consistent and predictable cycle that ensures sustained relationships while addressing immediate concerns. Uptake and Case Work

The challenges expressed pose a tangible barrier to the quality of service provided and any advancement of the Speak Up initiative. Addressing these capacity challenges is crucial for ensuring the sustained success of the Freedom to Speak Up initiative.

8. Resources

The Guardian currently works part-time – two days a week at both Stockport and Tameside & Glossop Integrated Care NHS Foundation Trust. The time commitment for the role is considered on an annual basis as part of the yearly review of the Trust's FSU arrangements.

Currently In the absence of the Guardian, staff raise concerns with the Director of Communication and Corporate Affairs, who is the executive lead for FSU and an experienced former Guardian,

9. Recommendations

The Board is recommended to note the contents of the report and the actions being taken to progress the Freedom to Speak Up agenda.

NHS
Stockport
NHS Foundation Trust

Meeting date	4th April 2024	**Public**	X	**Agenda No.**	10
Meeting	Board of Directors				
Report Title	Freedom to Speak Up annual self assessment planning and reflection tool				
Director Lead	Caroline Parnell - Director of Communications and Corporate Affairs	**Author**	Nadia Walsh – Freedom to Speak Up Guardian Caroline Parnell – FSU Executive Lead Beatrice Fraenkel – FSU Non-Executive Lead		

Paper For:	**Information**		**Assurance**		**Decision**	
Recommendation:	The Board of Directors is asked to note the content of the annual self-assessment and endorse the forward plan.					

This paper relates to the following Annual Corporate 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	x	Effective
x	Caring	x	Responsive
x	Well-Led	x	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
	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

Each year the National Office of the Freedom to Speak Guardian recommends that NHS organisations undertake a self reflection exercise, assessing themselves against a number of statements set out in a reflection and planning tool.

This is the second year that the Trust's Freedom to Speak Up Guardian, Executive and Non-Executive Director lead have completed the tool, which includes a plan for improvements during the coming year. The previous iteration of the toolkit was presented to the People Performance Committee and the Board of Directors for approval, and they subsequently received regular updates on progress in delivering the annual improvement plan.

The attached toolkit, which was presented to the People Performance Committee on 14 March 2024, highlights improvements made over the last year, including the review of the Freedom to Speak Up policy, the appointment of Nadia Walsh as the Trust's new Guardian, the introduction of role specific training, and

recruitment of two volunteer Freedom to Speak Champions.

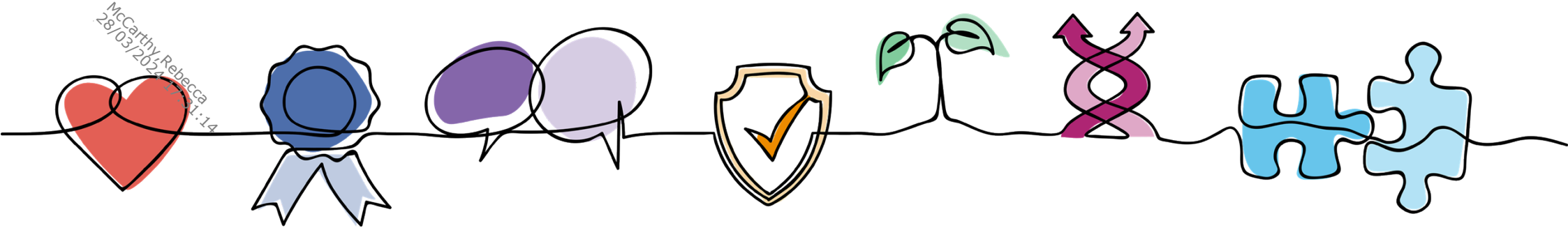
It also acknowledges the increase in issues raised with the Guardian, and identifies areas for improvement during 2024-25. These include the need to improve the triangulation of data in relation to the various ways that colleagues raise concerns, and the development of a wider Speaking Up strategy to include the organisation's vision for the speaking up agenda and ways of evaluating the impact of measures to reduce barriers to speaking up and ensure colleagues do not suffer detriment as a result of highlighting issues.

National Guardian
Freedom to Speak Up

NHS

Freedom to Speak up

A reflection and planning tool



Introduction

The senior lead for FTSU in the organisation should take responsibility for completing this reflection tool, at least every 2 years.

This improvement tool is designed to help you identify strengths in yourself, your leadership team and your organisation – and any gaps that need work. It should be used alongside Freedom to speak up: A guide for leaders in the NHS and organisations delivering NHS services, which provides full information about the areas addressed in the statements, as well as recommendations for further reading.

Completing this improvement tool will demonstrate to your senior leadership team, your board or any oversight organisation the progress you have made developing your Freedom to Speak Up arrangements.

You may find that not every section in this tool is relevant to your organisation at this time. For this reason, the tool is provided in Word format to allow you to adapt it to your current needs, retaining the elements that are most useful to you.

If you have any questions about how to use the tool, please contact the national FTSU Team using england.ftsu-enquiries@nhs.net

The self-reflection tool is set out in three stages, set out below.

Stage 1

This section sets out statements for reflection under the eight principles outlined in the guide. They are designed for people in your organisation's board, senior leadership team or – in the case of some primary care organisations – the owner.

You may want to review your position against each of the principles or you may prefer to focus on one or two.

Stage 2

This stage involves summarising the high-level actions you will take over the next 6–24 months to develop your Freedom to Speak Up arrangements. This will help the guardian and the senior lead for Freedom to Speak Up carry out more detailed planning.

Stage 3

Summarise the high-level actions you need to take to share and promote your strengths. This will enable othersin your organisation and the wider system to learn from you.

Stage 1: Review your Freedom to Speak Up arrangements against the guide

What to do

- Using the scoring below, mark the statements to indicate the current situation.

  1 = significant concern or risk which requires addressing within weeks

  2 = concern or risk which warrants discussion to evaluate and consider options

  3 = generally applying this well, but aware of room for improvement or gaps in knowledge/approach

  4 = an evidenced strength (e.g., through data, feedback) and a strength to build on

  5 = confident that we are operating at best practice regionally or nationally (e.g., peers come to use for advice)

- Summarise evidence to support your score.
- Enter any high-level actions for improvement (you will bring these together in Stage 2).
- Make a note of any areas you score 5s in and how you can promote this good practice (you will bring these together in Stage 3).

Principle 1: Value speaking up

For a speaking-up culture to develop across the organisation, a commitment to speaking up must come from the top.

Statements for the senior lead responsible for Freedom to Speak Up to reflect on	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	4
I have led a review of our speaking-up arrangements at least every two years	3
I am assured that our guardian(s) was recruited through fair and open competition	5
I am assured that our guardian(s) has sufficient ringfenced time to fulfil all aspects of the guardian job description	3
I am regularly briefed by our guardian(s)	5
I provide effective support to our guardian(s)	4

Enter summarised commentary to support your score.

- The Director of Communications & Corporate Affairs is the senior lead and was previously a guardian in another organisation so understands the role
- The Trust has reviewed FSU arrangements annually, has updated its FSU policy but a review of all speaking up arrangements is outstanding along with the development of the Trust's Speaking Up /strategy.
- The Guardian has raised concerns about a recent increase in cases at Stockport and how this impacts on the equity of the split role. However there has always been an understanding between the two organisations that there will be times when the needs of one Trust will be higher than the other.
- The Guardian is also concerned that the current level of cases makes it impossible for them to implement improvements

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1. Review wider speaking up arrangements as part of the development of a broader Speaking Up strategy
2. Keep FSUG arrangements/time commitment under review

Statements for the non-executive director lead responsible for Freedom to Speak Up to reflect on	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	3
I am confident that the board displays behaviours that help, rather than hinder, speaking up	2
I effectively monitor progress in board-level engagement with the speaking-up agenda	2
I challenge the board to develop and improve its speaking-up arrangements	2
I am confident that our guardian(s) is recruited through an open selection process	5
I am assured that our guardian(s) has sufficient ringfenced time to fulfil all aspects of the guardian job description	2
I am involved in overseeing investigations that relate to the board	NA
I provide effective support to our guardian(s)	4

Enter summarised evidence to support your score.

- While the guardian regularly reports to the Board in public due to the confidential nature of the cases it is not possible for Board members to have detailed discussions.
- Through Board activities eg walkabouts, there is more that Board members can do to encourage speaking up.
- The Board and PPC receives information via the NHS Staff Survey on colleagues views of speaking up, but via the triangulation of data and a speaking up strategy that includes metrics we could improve the information we have about our current arrangements and where further work is required.
- The guardian has raised concerns about their caseload in their dual role and their ability to deliver on national guidance around a 50/50 split between managing cases and raising awareness. The Trust would benefit from examining the way the role is currently operating and options for how resources could be used to the best effect.

• The guardian is positive about the support they receive from the non-executive director lead.
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1 Development of a speaking up strategy to include a vision and metrics for evaluating effectiveness of delivery.
2 Examine the way the Guardian's role is currently operation and options for how resources could be used to the best effect.

Principle 2: Role-model speaking up and set a healthy Freedom to Speak up culture

Role-modelling by leaders is essential to set the cultural tone of the organisation.

Statements for senior leaders	Score 1–5 or yes/no
The whole leadership team has bought into Freedom to Speak Up	3
We regularly and clearly articulate our vision for speaking up	2
We can evidence how we demonstrate that we welcome speaking up	2
We can evidence how we have communicated that we will not accept detriment	3
We are confident that we have clear processes for identifying and addressing detriment	3
We can evidence feedback from staff that shows we are role-modelling the behaviours that encourage people to speak up	2
We regular discuss speaking-up matters in detail	3

Enter summarised evidence to support your score.

- All Board members have previously made public statements about their commitment during Speaking Up month.
- Executive and Non-Executive Directors now have access to the national training package for Boards.
- We have a FSU policy but a wider Speaking Up strategy is required and this would include a vision's for what the organisation wants to achieve in relation to speaking up and how we would measure success at delivering the Trust's speaking up aspirations.
- The guardian presents regular reports to the People Performance Committee and public Board meetings, however speaking up matters are not discussed in detail at Board due to the confidential nature of some of the issues.
- CEO has made positive statements about not accepting detriment. These need to be regularly repeated, echoed and role modelled by senior leaders.

High-level actions needed to bring about improvement (focus on scores 1 ,2 and 3)	
1. Develop a wider Speaking Up strategy to include vision for speaking up.	
2. Incorporate awareness of the strategy and vision into the FSU communications plans along with regularly sharing evidence of the positive impact of speaking up.	
Statements for the person responsible for organisational development	**Score 1–5 or yes/no**
I am knowledgeable about Freedom to Speak Up	4
We have included creating a speaking-up culture (separate from the Freedom to Speak Up guardian process) in our wider culture improvement plans	4
We have adapted our organisational culture so that it becomes a just and learning culture for our workers	3
We support our guardian(s) to make effective links with our staff networks	4
We use Freedom to Speak Up intelligence and data to influence our speaking-up culture	2

Enter summarised evidence to support your score.

- The Deputy Director of Organisational Development was the strategic lead for embedding the FTSU process and had line management responsibility for the FTSU guardian at a previous trust.
- The Trust's OD plan has a focus on improving our organisation culture where staff feel psychologically safe to speak up and we have a just and learning culture
- The guardian has an open invite to attend staff networks.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1. Continue to implement the OD plan

2. Build on the Civility Saves Lives programme exploring work around just culture and compassionate leadership

Statements about how much time the guardian(s) has to carry out their role	Score 1–5 or yes/no
We have considered all relevant intelligence and data when making our decision about the amount of ringfenced time our guardian(s) has, so that they are able to follow the National Guardian's Office guidance and universal job description and to attend network events	3
We have reviewed the ringfenced time our Guardian has in light of any significant events	3
The whole senior team or board has been in discussions about the amount of ringfenced time needed for our guardian(s)	2
We are confident that we have appropriate financial investment in place for the speaking-up programme and for recruiting guardians	2

Enter summarised evidence to support your score.

- The guardian is able to attend network events and we adopted the universal job description. Due to the current number of cases the guardian does not always feel able to follow national guidance in relation to a 50/50 split between case work and raising awareness.
- Last year we benchmarked time available against other organisations in the region and considered the time commitment when appointing the current guardian. A recent survey of the North West FTSU Guardians network about ring fenced time found that with organisations with more than 250 workers the median amount of ring fenced time was one day per 1,300 workers.
- The time commitment was considered by the Board as part of the previous self assessment process. The guardian has recently raised concerns about the current number of cases and the time allocated to fulfil all aspects of the dual role.
- There is currently only sufficient funding for a guardian two days a week and we do not anticipate funding being available in 2024-25.
- The guardian has raised concern about the recent increase in cases and their ability to manage the caseload as well as implement improvements across the dual role. Discussions have taken place with the guardian about the supported needed to deliver, including the possibility of splitting out the two trusts.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1. Further discussion required between the guardian and the FSU leads for both Tameside & Stockport about required resources to then feed into a Board level discussion about the time commitment for the guardian.
2.

Principle 3: Make sure workers know how to speak up and feel safe and encouraged to do so

Regular, clear and inspiring communication is an essential part of making a speaking-up culture a reality.

Statements about your speaking-up policy	Score 1–5 or yes/no
Our organisation's speaking-up policy reflects the 2022 update	4
We can evidence that our staff know how to find the speaking-up policy	4

Enter summarised evidence to support your score.

- The FSU policy was updated in line of the most recent national guidance.
- The overall Speaking Up policy requires a review and the development of a broad speaking up strategy is outstanding.
- Policies are available on the intranet and training/induction requires staff access to the policy. The increase in referrals would suggest that staff are aware of how to access the policy and contact the guardian.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1. Develop overarching Speaking Up strategy
2. Use NHS Staff Survey feedback to understand how staff feel about raising concerns.

Statements about how speaking up is promoted	Score 1–5 or yes/no
We have used clear and effective communications to publicise our guardian(s)	4
We have an annual plan to raise the profile of Freedom to Speak Up	3
We tell positive stories about speaking up and the changes it can bring	2
We measure the effectiveness of our communications strategy for Freedom to Speak Up	3

Enter summarised evidence to support your score.

- We had a successful communications plan to introduce the new guardian to the Trust
- We need to do more to identify positive speaking up stories to share with the organisation via an updated communications plan.
- Incorporate metrics in the communications plan to evaluate impact.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1. Develop 2 year communication plan, including identifying positive stories about the impact of speaking up and metrics to evaluate impact.
2

Principle 4: When someone speaks up, thank them, listen and follow up

Speaking up is not easy, so when someone does speak up, they must feel appreciated, heard and involved.

Statements about training	Score 1–5 or yes/no*
We have mandated the National Guardian's Office and Health Education England training	4
Freedom to Speak Up features in the corporate induction as well as local team-based inductions	4
Our HR and OD teams measure the impact of speaking-up training	2

Enter summarised evidence to support your score.

- Training is not mandatory but role specific training has been rolled out, attendance is monitored and reported to Board.
- The guardian presents at corporate induction sessions.
- The trust measures the percentage of staff who have completed specific training, and there is further work required around measuring the impact of the training.
- The latest NHS Staff Survey will measure improvement around the awareness of raising concerns and confidence in raising concerns.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1 Identify ways of measuring the impact of speaking up training
2 Continue to monitor via the NHS Staff Survey

Statements about support for managers within teams or directorates	Score 1–5 or yes/no
We support our managers to understand that speaking up is a valuable learning opportunity and not something to be feared	3
All managers and senior leaders have received training on Freedom to Speak Up	3
We have enabled managers to respond to speaking-up matters in a timely way	3
We are confident that our managers are learning from speaking up and adapting their environments to ensure a safe speaking-up culture	2

Enter summarised evidence to support your score.

- We have rolled out role specific training, including specifically for managers.
- We have updated the FSU policy to include timescales for managers to respond to speaking up issues. This is not always followed.
- We have examples of managers learning from speaking up and making changes in their specific areas, but acknowledge there is more to do to foster a speaking up culture in all parts of the organisation.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. Incorporate awareness raising of the training into the communications plan.
2. Build into leadership development programmes, compassionate culture and the importance of FTSU and raising concerns.

Principle 5: Use speaking up as an opportunity to learn and improve

The ultimate aim of speaking up is to improve patient safety and the working environment for all NHS workers.

Statements about triangulation	Score 1–5 or yes/no
We have supported our guardian(s) to effectively identify potential areas of concern and to follow up on them	3
We use triangulated data to inform our overall cultural and safety improvement programmes	3

Enter summarised evidence to support your score.

- The guardian is supported by the senior lead and non-executive lead for FSU to identify and follow up areas of concern.
- They guardian meets regularly with the CEO and Chair.
- The Trust collects a range of data but further work is needed to triangulate all the information the organisation has to inform improvements

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1 Improve how the Trust triangulates data to inform improvements via discussions with HR and governance teams.
2

Statements about learning for improvement	Score 1–5 or yes/no
We regularly identify good practice from others – for example, through self-assessment or gap analysis	3
We use this information to add to our Freedom to Speak Up improvement plan	2
We share the good practice we have generated both internally and externally to enable others to learn	3

Enter summarised evidence to support your score.

- The guardian is part of the regional and national network and shares relevant information from those groups in reports to PPC and Board
- That information informs the work of the guardian, but a speaking up improvement plan needs to be developed, linked to a speaking up strategy and OD plan to foster a positive speaking up culture.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1. Communications plan to include sharing lessons from FSU investigations within the Trust and from other organisations.
2. Guardian to meet regularly with the OD team to ensure feedback and themes are built into the OD plan and associated programmes.

Principle 6: Support guardians to fulfil their role in a way that meets workers' needs and National Guardian's Office requirements

Statements about how our guardian(s) was appointed	Score 1–5 or yes/no
Our guardian(s) was appointed in a fair and transparent way	5
Our guardian(s) has been trained and registered with the National Guardian Office	5
Enter summarised evidence to support your score. • Appointment process in line with national guidance, using universal job description and advertised widely.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements about the way we support our guardian(s)	Score 1–5 or yes/no
Our guardian(s) has performance and development objectives in place	4
Our guardian(s) receives sufficient one-to-one support from the senior lead and other relevant executives or senior leaders	4
Our guardian(s) has access to a confidential source of emotional support or supervision	4
There is an effective plan in place to cover the guardian's absence	3
Our guardian(s) provides data quarterly to the National Guardian's Office	5

Enter summarised evidence to support your score.

- The guardian has regular 1-1s with the senior lead and non-executive lead to provide support and identify areas for improvement.
- The guardian has sought helpful support internally from the SPAWs team and has been offered supervision support subject to formal agreement.
- The guardian can also access the regional network for support and the national office is currently focusing on the mental health and wellbeing of guardians, recommending that it is considered as part of the annual self assessment process.
- The senior lead covers for the guardian when they are on leave and 2 champions are now in place to signpost staff with concerns as well as deal with low level cases.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1. Options for supervision to be explored.
2

Statements about our speaking up process	Score 1–5 or yes/no
Our speaking-up case-handling procedures are documented	4
We have engaged with managers and other key stakeholders on the role they play in handling speaking-up cases	3
We are assured that confidentiality is maintained effectively	3
We ensure that speaking-up cases are progressed in a timely manner within the teams or directorates we are responsible for	3
We are confident that if people speak up within the teams or directorates we are responsible for, they will have a consistently positive experience	3

Enter summarised evidence to support your score.

- The updated FSU policy sets out a clear process and timescales for investigating concerns, although not all managers are acting in line with the timescales.
- The role specific training for managers helps them to understand the role they play.
- Feedback from the guardian is that not everyone who speaks up has a consistently positive experience.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1. Senior leaders to continue to articulate their expectations around the importance of speaking up and expectations that people who speak up will have a positive experience
2

Principle 7: Identify and tackle barriers to speaking up

However strong an organisation's speaking-up culture, there will always be some barriers to speaking up, whether organisation wide or in small pockets. Finding and addressing them is an ongoing process.

Statements about barriers	Score 1–5 or yes/no
We have identified the barriers that exist for people in our organisation	2
We know who isn't speaking up and why	3
We are confident that our Freedom to Speak Up champions are clear on their role	4
We have evaluated the impact of actions taken to reduce barriers?	1

Enter summarised evidence to support your score.

- The Trust knows from the NHS staff survey and other data the backgrounds of people who are less likely to raise concerns, but no firm data on why and further work is needed to address barriers.
- We have recruited two champions in the last year who have had training on their role.
- We are implementing an OD plan that builds on the work we are doing to create an inclusive and compassionate culture, and includes working with the guardian to address themes around the speaking up culture…

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. Review actions to reduce barriers to speaking up.
2. Delivery of EDI strategy and OD plan and associated programmes to help improve speaking up culture.

Statements about detriment	Score 1–5 or yes/no
We have carried out work to understand what detriment for speaking up looks and feels like	N
We monitor whether workers feel they have suffered detriment after they have spoken up	Y
We are confident that we have a robust process in place for looking into instances where a worker has felt they have suffered detriment	3
Our non-executive director for Freedom to Speak Up is involved in overseeing how allegations of detriment are reviewed	

Enter summarised evidence to support your score.

- The guardian asks staff if they have suffered detriment as a result of speaking up.
- The People & OD team reviews elements as part of their business as usual to learn from cases and inform improvements.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1. Implement a more formal approach to identifying detriment as part of our cultural development work.
2 Communications plan to include CEO and other senior leader regularly reiterating that detriment will not be tolerated

Principle 8: Continually improve our speaking up culture

Building a speaking-up culture requires continuous improvement. Two key documents will help you plan and assess your progress: the improvement strategy and the improvement and delivery plan.

Statements about your speaking-up strategy	Score 1–5 or yes/no
We can evidence that we have a comprehensive and up-to-date strategy to improve the speaking-up culture	2
We are confident that the Freedom to Speak Up improvement strategy fits with our organisation's overall cultural improvement strategy and that it supports the delivery of related strategies	3
We routinely evaluate the Freedom To Speak Up strategy, using a range of qualitative and quantitative measures, and provide updates to our organisation	2
Our improvement plan is up to date and on track	2
Enter summarised evidence to support your score. • We have an updated FSU policy but a wider speaking up strategy is required, including a vision for where the organisation wants to go with the agenda and ways of evaluating its impact.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1. Develop a speaking up strategy	
2. Use this assessment to inform an improvement plan.	

Statements about evaluating speaking-up arrangements	Score 1–5 or yes/no
We have a plan in place to measure whether there is an improvement in how safe and confident people feel to speak up	2
Our plan follows a recognised 'plan, do, study, act' or other quality improvement approach	2
Our speaking-up arrangements have been evaluated within the last two years	3

Enter summarised evidence to support your score

- Our FSU arrangements have been reviewed annually.
- We have an OD Plan that focuses on leadership development and Civility Saves Lives.
- Effectiveness of speaking up arrangements measured via the NHS Staff Survey.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1. Development of a speaking up strategy, incorporating FSU, and metrics to evaluate impact.
2

Statements about assurance	Score 1–5 or yes/no
We have supported our guardian(s) to structure their report in a way that provides us with the assurance we need	3
We have we evaluated the content of our guardian report against the suggestions in the guide	4
Our guardian(s) provides us with a report in person at least twice a year	4
We receive a variety of assurance that relates to speaking up	3
We seek and receive assurance from the relevant executives/senior leaders that speaking up results in learning and improvement	3

Enter summarised evidence to support your score.

- The guardian produces a regular report for PPC and and twice a year for Board, which are continually developing to meet members' stated assurance and information needs, and it is in line with the national guidance.
- PPC receives other information in relation to speaking up eg Guardian of Safe Working, and relevant exec leads provide assurance to PPC about actions in relation to areas of concern.
- Currently neither Board or its assurance committees receives a regular report that triangulates data from all aspects of the speaking up agenda.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1 Continue to develop the FSU report to meet assurance needs and changing national guidance.

2 Consider PPC/Board requirements in relation to whole speaking up agenda and how the Trust can improve triangulation of HR and governance information.

Stage 2: Summarise your high-level development actions for the next 6 – 24 months

Development areas to address in the next 6–12 months	Target date	Action owner
1. Review wider speaking up arrangements as part of the development of a broader Speaking Up strategy	June 2023	Lisa Gammick Nadia Walsh
2. Further discussion required between the guardian and the FSU leads for both Tameside & Stockport about how dual roles is currently operations and options for how resources could be used to best effect, to then feed into a Board level discussion about the time commitment for the guardian.	End April 2023	Amanda Bromley Caroline Parnell
3. Develop two communications plan to incorporate awareness of the speaking strategy and vision along with regularly sharing evidence of the positive impact of speaking up, raising awareness of FSU training, and measuring effectiveness of the plan.	June 2023	Nadia Walsh
4. Identify ways of measuring the impact of speaking up training	January 2024	Nadia Walsh
5. Build into leadership development programmes, compassionate culture and the importance of FTSU and raising concerns.	January 2024	Lisa Gammick
6. Explore how the Trust can improve the way it triangulates data to inform improvements via discussions with HR and governance teams.	September 2024	Amanda Bromley

7. Use data from latest NHS Staff Survey to identify staffs' view of speaking up and identify barriers to inform the development of actions to encourage more staff to feel comfortable in raising concerns.	September 2024	Lisa Gammick Nadia Walsh
8. Implement a more formal approach to identifying detriment as part of our cultural development work.	January 2024	Lisa Gammick Nadia Walsh

Development areas to address in the next 12–24 months	Target date	Action owner
1		
2		
3		
4		
5		
6		
7		
8		

Stage 3: Summary of areas of strength to share and promote

High-level actions needed to share and promote areas of strength (focus on scores 4 and 5)	Target date	Action owner
1.		
2		
3		
4		
5		
6		
7		
8		

Meeting date	4th April 2024	**Public**	X	**Agenda No.**	11
Meeting	Board of Directors				
Report Title	2023 NHS Staff Survey Results				
Director Lead	Amanda Bromley, Director of People and OD	**Authors**	Lisa Gammack, Deputy Director of Organisational Development and Stuart McKenna, Assistant Director of HR (Inclusion and Colleague Experience)		

Paper For:	**Information**	X	**Assurance**	X	**Decision**	
Recommendation:	The Board of Directors is asked to note the contents of this report and support the priority areas for action.					

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
√	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
√	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 2023 NHS national staff survey was open from 25 September until 24 November 2023.

The Trust's full workforce (excluding bank staff) was invited to take part in the survey – a total of 6,114 staff. 2,642 staff completed the survey compared to 2,481 the previous year.

The Trust achieved an overall response rate of 43.49% which was 1.12% higher than last year's response rate (42.37%). Response rates varied across each division within the Trust. The Corporate Nursing Team achieved the most improved response rate increasing from 44% to 70%. The Allied Health Professionals staff group achieved the most improved response rate (+8%).

For the third consecutive year, the staff survey questions have been mapped to the elements and themes within the NHS People Promise. Each element and sub-theme of the People Promise is scored out of a possible 10. Significance testing by the National Survey Co-ordination Centre has demonstrated that the following changes in the People Promise Scores were significant changes/not significant changes).

We have improved scores for all 9 People Promise elements/themes, all of which were statistically significant:

- We are compassionate and inclusive
- We are recognised and rewarded
- We each have a voice that counts
- We are safe and healthy
- We are always learning
- We work flexibly
- We are a team
- Theme - staff engagement
- Theme – morale

There were 65 questions (68%) where the scores showed significant improvement from the previous year. There were no questions were there were significant decline since the previous survey. There were 3 new questions in the survey, which therefore had no historical comparison.

The national embargo on the staff survey results was lifted on 7th March 2024.

The Organisational Development Service continues to work with the Communications Team to implement our communication plan which will help to celebrate and translate our results both internally and externally. This provides a further opportunity to demonstrate to our employees that we listen and act upon their feedback and we continue to be fully committed to being a great place to learn, train and work.

The Trust's employee engagement journey continues to grow and it is acknowledged that 2023 was a very challenging year with significant operational pressures, financial challenges, on-going industrial action, staffing issues and cost of living rises.

The Trust has achieved an impressive set of survey results which evidences the hard work, commitment and investment that the Executive Management Team, divisions/directorates, staff side representatives and staff network members have contributed to making our Trust a great place to work. As ever, there is always room for improvement and whilst there are some clear areas of focus relating to burnout and quality of appraisals we will ensure we are clear on our priorities and will continue to co-create a more compassionate and inclusive culture with colleagues.

We will continue to deliver our People and OD Plan and Workforce Equality, Diversity and Inclusion Strategy that addresses the areas our employees have identified as requiring improvement. Based on the findings of the 2023 NHS national staff survey our key priorities over the next 12 months include:

- **Improving culture and behaviours** – we will review our values and behaviours, as part of our continued approach to improving our leadership and management development offer and do more to enhance our speak-up culture.
- **Strengthening relationships** – we will continue to develop and implement tools and interventions that help strengthen the relationship between employees and their immediate line manager. This will include a new appraisal and 121 toolkit and continuing to provide team building support.
- **Career progression** – we will design and implement targeted interventions that support career progression linked to our EDI agenda plus introduce a talent management and succession planning approach.
- **Accelerating our EDI improvement journey** – through our refreshed Workforce EDI Strategy and consolidated EDI action plan we will continue to deliver key actions aimed at achieving our EDI performance targets and create a more inclusive workplace.

In addition, we will analyse the results by staff group, EDI, and health & wellbeing data to ensure any themes are picked up on. We will review the qualitative narrative comments which prove to be a rich source of information about staff and can often highlight areas where further focus is required. Our action plans will be cognisant of these and the Trust's Workforce Race Equality Standard (WRES) and Workforce

Disability Equality Standard (WDES) to inform any reprioritisation of actions.

1. Introduction

1.1 The 2023 NHS national staff survey was open from 25 September until 24 November 2023.

1.2 The Trust's full workforce (excluding bank staff) was invited to take part in the survey – a total of 6114 staff. 2642 staff completed the survey compared to 2481 the previous year. This equated to an overall response rate of 43.49% which was 1.12% higher than last year (42.37%) and 1.74% lower than the average response rate for our national comparator group.

1.3 This report summarises the Trust's 2023 survey results including national benchmarking data.

2. Response Rates

2.1 Response rates varied across each division within the Trust. The Corporate Nursing Team achieved the most improved response rate increasing from 44% to 70%. The table below summarises the response rates across each division/directorate over the last three years.

Division / Directorate	2021	2022	2023	Difference compared to last year
Chief Executive's Department	65%	85%	68%	-17%
Finance and Procurement	91%	92%	95%	+3%
People & OD	71%	67%	73%	+6%
IT & Information services	79%	68%	65%	-3%
Corporate Nursing	46%	44%	70%	+26%
Performance & Transformation	80%	60%	70%	+10%
Research & Innovation	79%	94%	87%	-7%
Clinical Support Services	Not available	48%	52%	+4%
Estates and Facilities	32%	41%	42%	+1%
Integrated Care	37%	41%	45%	+4%
Medicine, Urgent Care	44%	36%	32%	-4%
Surgery	41%	36%	34%	-2%
Women's, Children's & Diagnostics	45%	42%	34%	-6%
Overall	**43%**	**42%**	**43%**	**+1%**

2.2 The table below provides a breakdown of response rates by staff group, over the last three years.

Staff Group	2021	2022	2023	Difference compared to last year
Administrative & Clerical	Not available	64%	64%	No change
Healthcare Scientists		51%	51%	No change
Add Prof Scientific & Technic		29%	28%	-1%
Allied Health Professionals		46%	54%	+8%
Estates and Ancillary		35%	36%	+1%
Nursing & Midwifery Registered		40%	39%	-1%
Medical & Dental		36%	37%	+1%
Additional Clinical Services		29%	28%	-1%
Overall		**42%**	**43%**	**-1%**

3. Our NHS People Promise Scores

3.1 For the third consecutive year, the survey questions have been mapped to the elements and themes within the NHS People Promise. Each element and sub-theme of the People Promise is scored on a 0-10 scale.

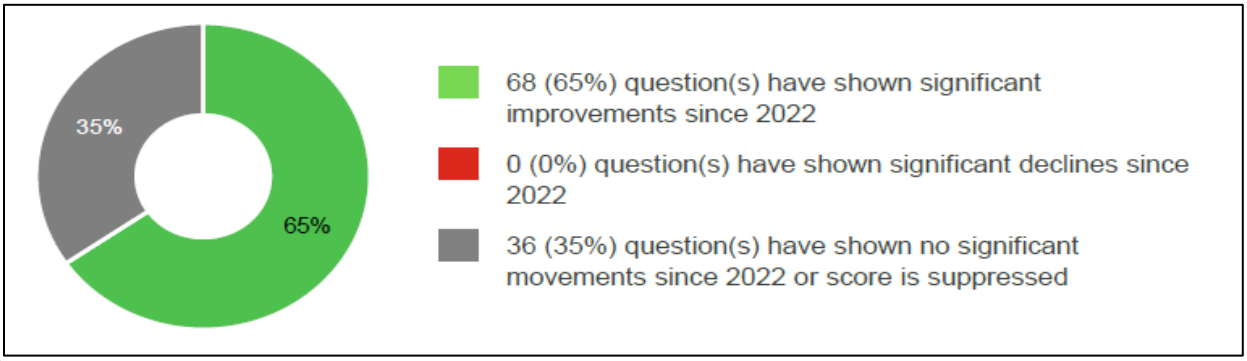
3.2 The table below shows our People Promise scores over the last three years. In 2022 we improved our scores on 3 of the 9 elements/sub-themes with only one of those scores being statistically significantly higher as determined by the National Co-ordination Centre. This year, we have achieved improved scores on all 9 elements/sub-themes and they are all statistically significantly higher, plus our scores are better than the average score for our national comparator group on all 9 elements/sub-themes. This is an impressive set of results achieved against a backdrop of increased operational pressures, national pay disputes, industrial action and cost of living rises.

People Promise Element / Theme	2021	2022	2023	Statistically significant change compared to last year?	2023 comparator group's average score	Difference to comparator group
We are compassionate & inclusive	7.3	7.22 ↓	**7.41** ↑	Significantly higher	7.24	+0.17
We are recognised & rewarded	5.8	5.78 ↓	**6.08** ↑	Significantly higher	5.94	+0.14
We each have a voice that counts	6.7	6.66 ↓	**6.81** ↑	Significantly higher	6.70	+0.11
We are safe & healthy	5.9	5.83 ↓	**6.15** ↑	Significantly higher	6.06	+0.09
We are always learning	5.3	5.39 ↑	**5.72** ↑	Significantly higher	5.61	+0.11
We work flexibly	5.9	6.08 ↑	**6.33** ↑	Significantly higher	6.20	+0.13
We are a team	6.7	6.71 ↑	**6.93** ↑	Significantly higher	6.75	+0.18
Theme - staff engagement	6.8	6.74 ↓	**6.94** ↑	Significantly higher	6.91	+0.03
Theme – morale	5.7	5.66 ↓	**5.96** ↑	Significantly higher	5.91	+0.05

3.3 The Trust's benchmark report which was published by the National Co-ordination Centre on the 7th March 2024 can be found here: cms.nhsstaffsurveys.com/app/reports/2023/RWJ-benchmark-2023.pdf

4. Our Question Scores

4.1 It is a positive picture when we compare our results for each of the 104 survey questions, compared to last year's scores. The diagram below summarises the number and percentage of questions that have significantly improved, declined, and remained the same.



4.2 **Appendix one** shows those survey questions where there has been statistically significant difference in the responses compared to last year.

4.3 The table below shows the 10 top question scores. Any questions where a lower score is better are shaded in orange. As negative measures are reported for these questions they may not appear to be in ranking order.

	Question	Score
1	In the last 12 months, I have personally experienced physical violence at work from managers.	0.6%
2	In the last 12 months, I have personally experienced physical violence at work from other colleagues.	1.2%
3	Experienced discrimination on grounds of sexual orientation.	2.9%
4	In the last 12 months, I have personally been the target of unwanted behaviour of a sexual nature in the workplace from a manager / team leader or other colleagues.	3.3%
5	Experienced discrimination on grounds of religion.	4.1%
6	In the last 12 months, I have personally experienced discrimination at work from a manager / team leader or other colleagues.	6.6%
7	In the last 12 months, I have personally experienced discrimination at work from patients / service users, their relatives or other members of the public.	6.9%
8	In the last 12 months, I have personally been the target of unwanted behaviour of a sexual nature in the workplace from patients / service users, their relatives or other members of the public.	7.3%
9	In the last 12 months, I have personally experienced harassment, bullying or abuse at work from managers.	8.7%
10	I am trusted to do my job.	91.1%

4.4 The table below shows the bottom 10 scored questions. Any questions where a lower score is better are shaded in orange. As negative measures are reported for these questions they may not appear to be in ranking order.

	Question	Score
1	I often / always feel worn out at the end of my working day / shift.	40.4%
2	My work often / always frustrates me.	35.1%
3	I never / rarely have unrealistic time pressures.	31.80%
4	I often / always find my work emotionally exhausting.	31.5%
5	The appraisal / review helped me to improve how I do my job.	26.8%
6	There are enough staff at this organisation for me to do my job properly.	30.0%
7	I am satisfied with my level of pay.	31.1%
8	I often / always feel burnt out because of my work.	29.6%
9	I do not have enough energy for family and friends during leisure time.	29.8%
10	The appraisal / review left me feeling that my work is valued by my organisation.	35.3%

4.5 It is evident from the question scores above that some staff are feeling fatigued and suffering with burn out which will impact of individual's mental health and wellbeing and ultimately employee attendance and performance. Further analysis will be carried out to understand hotspot areas and ensure that the Trust's health and wellbeing support is accessible and where targeted interventions may be required. We will also triangulate the survey results with attendance and retention data.

4.6 The analysis of the bottom 10 scored questions has highlighted that the quality of appraisals is an area requiring improvement. As part of the Trust's Organisational Development Plan 2023-25, work is underway to implement a refreshed appraisal process with a supporting toolkit and training for line managers. We are working towards the new approach being in place in spring 2024 subject to approval.

4.7 It is very positive to see that our Staff Friends and Family Test results have significantly improved compared to last year and they are above the average score for our comparator group.

Question	Trust Score					Comparator Group Average Score
	2019	2020	2021	2022	2023	2023
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation	61.68%	60.25% ↓	59.80% ↓	56.75% ↓	63.37% ↑	63.32%
I would recommend my organisation as a place to work	55.01%	54.91% ↓	55.41% ↑	53.36% ↓	60.78% ↑	60.52%

4.8 The 2023 survey included three new questions – below are the key findings.

Question	Description	Comparator Group Average Score	Trust Score
Q17a) In the last 12 months, how many times have you been the target of unwanted behaviour of a sexual nature in the workplace from patients / service users, their relatives, or other members of the public?	% of staff that said they had experienced at least one incident	7.73%	7.21%
Q17b) In the last 12 months, how many times have you been the target of unwanted behaviour of a sexual nature in the workplace from staff / colleagues?	% of staff that said they had experienced at least one incident	3.82%	3.25%
Q22) I can eat nutritious and affordable food while I am working.	% of staff that selected 'often/always'	53.77%	54.72%

4.9 The above findings show that 7.21% of respondents (189 people) that answered question 17a have experienced unwanted behaviour of a sexual nature in the workplace from patients/service users and 3.25% (85 people) from staff/colleagues (question 17b). The work we are currently doing to implement the Sexual Safety in the Workplace Charter will help to address this issue.

4.10 It is also concerning that 45.28% of respondents (1192 people) that answered question 22 feel they cannot often or always eat nutritious and affordable food while they are working. The Trust's new Health and Wellbeing Plan 2023-24 aims to take targeted steps to help our staff to eat well.

5. Greater Manchester Position

5.1 The table below shows the People Promise scores, plus Staff Engagement and Morale scores for each comparable Trust within the Greater Manchester footprint. The highest score for each theme is highlighted in green.

Trust	We are compassionate & inclusive	We are recognised & rewarded	We each have a voice that counts	We are safe & healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Bolton NHS FT	7.37	6.06	6.79	No result*	5.66	6.13	6.93	6.92	5.91
Manchester	7.16	5.86	6.62	No	5.48	5.89	6.67	6.76	5.77

University NHS FT				result*					
Northern Care Alliance	7.23	5.90	6.68	No result*	5.52	6.36	6.71	6.76	5.87
Stockport NHS FT	7.41	6.08	6.81	6.15	5.72	6.33	6.93	6.94	5.96
Tameside & Glossop IC NHS FT	7.17	5.97	6.59	No result*	5.57	6.20	6.69	6.76	5.87
Wrightington, Wigan & Leigh NHS FT	7.29	6.02	6.76	No result*	5.38	6.37	6.77	6.92	6.17
Overall Acute & Acute and Community Benchmark	7.24	5.94	6.70	6.06	5.61	6.20	6.75	6.91	5.91

***** *The National Survey Co-ordination Centre has not yet published the scores for the 'We are Safe and Healthy' theme because they are resolving a data quality issue. Individual Trusts have received their scores for this specific theme).*

5.2 The GM position shows that our Trust has achieved the highest score in 6 of the 9 People Promise themes/elements. In addition, our overall scores are consistently above the average scores for our national benchmarking group.

6. Next Steps

6.1 Divisional Senior Leadership Teams and Directors of Corporate Services received their division's/directorate's detailed survey results on 7th March 2024. The People and OD Directorate is supporting divisions to maximise their results to help improve staff experience and retention.

6.2 The Trust's results will be cascaded within the organisation as follows:

Operational Management Group	14 April
Health & Wellbeing Steering Group	16 April
EDI Steering Group	23 April
People Leadership & Engagement Group	1 May
Educational Governance Group	24 May
Staff Partnership Forum	TBC

6.3 The Organisational Development Service is continuing to work with the Communications Team to implement our communication plan which will help to celebrate and translate our results both internally and externally. This provides a further opportunity to demonstrate to our employees that we listen and act upon their feedback and we continue to be fully committed to being a great place to learn, train and work.

7. Steps Taken to Improve Staff Experience

7.1 The following provides a summary of some of the activities undertaken by the Trust, based on staff feedback:

- Launched the Trust's Civility Saves Lives Programme which aims to raise awareness of the power of civility in healthcare and grow a culture of kindness.
- Launched and started delivering an Organisational Development Plan that includes a range of activities aimed at making our Trust a great place to learn, develop and work.
- Enhanced our leadership and management development offer through the introduction of new courses and individual coaching and mentoring support. This has included the 'Introduction to Compassionate & Inclusive Leadership' course which runs on a monthly basis.

- Launched and started delivering an Organisational Development Plan that includes a range of activities aimed at making our Trust a great place to learn, develop and work.
- Implemented a Staff Health and Wellbeing Plan which outlines a range of activities over the next 12 months, aligned to the NHS Health and Wellbeing Framework.
- Executive Directors have continued to host “Big Conversations” with teams across the organisation to listen to staff achievements and concerns.
- Launched the Staff Menopause Group and Staff Neurodiversity Network.
- Continued to deliver the Staff Psychology & Wellbeing Service plus support and advice on a range of matters through our Employee Assistance Programme.
- Launched training courses focusing on workplace adjustments and undertaking equality impact assessments.
- Bespoke OD support to help strengthen divisional leadership teams and establish better ways of working has been provided across a number of areas.

8. Key Priorities 2024-25

8.1 We will continue to deliver our People and OD Plan and Workforce Equality, Diversity and Inclusion Strategy that addresses the areas our employees have identified as requiring improvement. Based on the findings of the 2023 NHS national staff survey our key priorities over the next 12 months include:

- **Improving culture and behaviours** – we will review our values and behaviours, as part of our continued approach to improving our leadership and management development offer and do more to enhance our speak-up culture.
- **Strengthening relationships** – we will continue to develop and implement tools and interventions that help strengthen the relationship between employees and their immediate line manager. This will include a new appraisal and 121 toolkit and continuing to provide team building support.
- **Career progression** – we will design and implement targeted interventions that support career progression linked to our EDI agenda plus introduce a talent management and succession planning approach.
- **Accelerating our EDI improvement journey** – through our refreshed Workforce EDI Strategy and consolidated EDI action plan we will continue to deliver key actions aimed at achieving our EDI performance targets and create a more inclusive workplace.

8.2 In addition, we will analyse the results by staff group, EDI, and health & wellbeing data to ensure any themes are picked up on. We will review the qualitative narrative comments which prove to be a rich source of information about staff and can often highlight areas where further focus is required. Our action plans will be cognisant of these and the Trust’s Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) to inform any reprioritisation of actions.

9. Conclusion

9.1 The Trust’s employee engagement journey continues to grow and it is acknowledged that 2023 was a very challenging year with significant operational pressures, financial challenges, industrial action, staffing issues and cost of living rises. The NHS staff survey is a snapshot in time and it is important that these results are viewed amongst the context within divisions and teams where the richness of the data can truly be understood. Regularly listening to our employees with

authenticity, and understanding what is working well and where improvements are required helps us to ensure that we are focusing on the things that matter the most to our workforce.

9.2 The Trust has achieved an impressive set of survey results which evidences the hard work, commitment and investment that the Executive Management Team, divisions/directorates, staff side representatives and staff network members have contributed to making our Trust a great place to work. As ever, there is always room for improvement and whilst there are some clear areas of focus relating to burnout and quality of appraisals we will ensure we are clear on our priorities and will continue to co-create a more compassionate and inclusive culture with colleagues.

10. Recommendation

10.1 The Board of Directors is asked to note the contents of this report and support the priority areas for action.

Appendix 1: Significantly changed question results compared to 2022

Significantly better scores:

Question		2022	2023	Difference
2a	I look forward to going to work.	49.7%	54.3%	+4.5%
2b	I am enthusiastic about my job.	66.5%	69.6%	+3.1%
3c	There are frequent opportunities for me to show initiative in my role.	72.1%	74.8%	+2.7%
3d	I am able to make suggestions to improve the work of my team / department.	70.8%	75.0%	+4.2%
3e	I am involved in deciding on changes introduced that affect my work area / team / department.	49.9%	53.4%	+3.5%
3f	I am able to make improvements happen in my area of work.	54.1%	58.3%	+4.2%
3g	I am able to meet all the conflicting demands on my time at work.	42.2%	45.6%	+3.4%
3h	I have adequate materials, supplies and equipment to do my work.	48.2%	51.9%	+3.6%
3i	There are enough staff at this organisation for me to do my job properly.	22.0%	30.0%	+8.0%

4a	I am satisfied with the recognition I get for good work.	49.6%	54.6%		+5.0%
4b	I am satisfied with the extent to which my organisation values my work.	39.9%	44.6%		+4.7%
4c	I am satisfied with my level of pay.	25.2%	31.1%		+5.9%
4d	I am satisfied with the opportunities for flexible working patterns.	53.0%	56.5%		+3.5%
5a	I never / rarely have unrealistic time pressures.	20.3%	24.4%		+4.2%
5c	Relationships at work are never / rarely strained.	46.3%	50.1%		+3.8%
6b	My organisation is committed to helping me balance my work and home life.	43.9%	50.1%		+6.2%
6c	I achieve a good balance between my work life and my home life.	53.3%	58.0%		+4.7%
7b	The team I work in often meets to discuss the team's effectiveness.	61.0%	64.8%		+3.8%
7c	I receive the respect I deserve from my colleagues at work.	73.0%	75.7%		+2.7%
7f	My team has enough freedom in how to do its work.	56.3%	60.0%		+3.7%
7g	In my team disagreements are dealt with constructively.	57.3%	60.5%		+3.2%
7h	I feel valued by my team.	71.4%	74.3%		+3.0%
8a	Teams within this organisation work well together to achieve their objectives.	52.9%	56.6%		+3.8%
8b	The people I work with are understanding and kind to one another.	74.4%	77.0%		+2.5%
9a	My immediate manager encourages me at work.	70.5%	75.1%		+4.6%

9b	My immediate manager gives me clear feedback on my work.	63.5%	68.5%	+5.0%
9c	My immediate manager asks for my opinion before making decisions that affect my work.	56.7%	61.3%	+4.7%
9d	My immediate manager takes a positive interest in my health and well-being.	67.6%	71.5%	+3.9%
9e	My immediate manager values my work.	71.8%	75.2%	+3.4%
9f	My immediate manager works together with me to come to an understanding of problems.	66.2%	71.5%	+5.3%
9g	My immediate manager is interested in listening to me when I describe challenges I face.	70.0%	73.5%	+3.5%
9h	My immediate manager cares about my concerns.	68.3%	72.7%	+4.4%
9i	My immediate manager takes effective action to help me with any problems I face.	64.2%	70.2%	+6.0%
10b	I work additional PAID hours for this organisation, over and above my contracted hours.	38.4%	35.0%	-3.5%
10c	I work additional UNPAID hours for this organisation, over and above my contracted hours.	59.5%	53.4%	-6.0%
11a	My organisation takes positive action on health and well-being.	53.6%	59.7%	+6.1%
11b	In the last 12 months, I have experienced musculoskeletal problems (MSK) as a result of work activities.	30.3%	27.7%	-2.5%
11c	During the last 12 months, I have felt unwell as a result of work related stress.	46.5%	40.7%	-5.8%
11e	I have felt pressure from my manager to come to work.	23.1%	19.5%	-3.6%
12a	I often / always find my work emotionally exhausting.	37.0%	31.5%	-5.5%
12b	I often / always feel burnt out because of my work.	34.5%	29.6%	-4.9%

12c	My work often / always frustrates me.	41.7%	35.1%	-6.6%
12d	I am often / always exhausted at the thought of another day / shift at work.	30.9%	25.7%	-5.1%
12e	I often / always feel worn out at the end of my working day / shift.	46.2%	40.4%	-5.8%
12f	I often / always feel that every working hour is tiring for me.	21.4%	18.0%	-3.5%
14a	In the last 12 months, I have personally experienced harassment, bullying or abuse at work from patients / service users, their relatives or other members of the public.	28.3%	22.6%	-5.7%
14b	In the last 12 months, I have personally experienced harassment, bullying or abuse at work from managers.	12.4%	8.7%	-3.7%
14c	In the last 12 months, I have personally experienced harassment, bullying or abuse at work from other colleagues.	18.6%	13.1%	-5.4%
16b	In the last 12 months, I have personally experienced discrimination at work from a manager / team leader or other colleagues.	8.4%	6.6%	-1.8%
19a	My organisation, treats staff who are involved in an error, near miss or incident fairly.	57.4%	60.5%	+3.1%
19c	When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again.	67.3%	70.2%	+2.9%
20a	I would feel secure raising concerns about unsafe clinical practice.	71.1%	74.0%	+3.0%
20b	I am confident that my organisation would address my concern.	55.9%	58.7%	+2.8%
23b	The appraisal / review helped me to improve how I do my job.	22.3%	26.8%	+4.6%
23c	The appraisal / review helped me agree clear objectives for my work.	32.3%	38.7%	+6.4%
23d	The appraisal / review left me feeling that my work is valued by my organisation.	29.6%	35.3%	+5.7%
24b	There are opportunities for me to develop my career in this organisation.	50.2%	53.6%	+3.3%

24c	I have opportunities to improve my knowledge and skills.	67.0%	70.3%	+3.3%
24d	I feel supported to develop my potential.	51.3%	57.3%	+6.0%
24e	I am able to access the right learning and development opportunities when I need to.	56.4%	61.0%	+4.6%
25a	Care of patients / service users is my organisation's top priority.	70.1%	73.0%	+3.0%
25c	I would recommend my organisation as a place to work.	53.4%	60.8%	+7.4%
25d	If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.	56.7%	63.4%	+6.7%
25e	I feel safe to speak up about anything that concerns me in this organisation.	60.3%	63.9%	+3.6%
25f	If I spoke up about something that concerned me I am confident my organisation would address my concern.	47.2%	52.3%	+5.1%
26a	I often think about leaving this organisation.	31.4%	26.7%	-4.7%
26b	I will probably look for a job at a new organisation in the next 12 months.	21.9%	19.1%	-2.8%

NHS Stockport NHS Foundation Trust

Meeting date	4th April 2024	**Public**	X	**Agenda No.**	12.
Meeting	Board of Directors				
Report Title	Safe Staffing Report				
Director Lead	Nic Firth, Chief Nurse Dr Andrew Loughney, Medical Director	**Author**	Helen Howard, Deputy Chief Nurse		

Paper For:	**Information**		**Assurance**	X	**Decision**	
Recommendation:	The Board of Directors are asked to receive the report and confirm action taking place to support safe staffing.					

This paper relates to the following Annual Corporate 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
	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		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
X	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
X	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
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
	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

This paper provides the assurances and risks associated with safe staffing and the actions in progress to mitigate the risks associated with patient safety and quality, based on patients' needs, acuity, dependency and risks, and trusts should monitor it from ward to board.

The Trust is assessed on the compliance with the 'triangulated approach' to deciding staffing requirements described in National Quality Boards' guidance. This combines evidence-based tools, professional judgement and outcomes to ensure the right staff with the right skills are in the right place at the right time.

We continue to experience high levels of operational demand within the acute and community services which we are aware is having an impact on patient experience and staff experience. The demands within the Emergency Department remain significant, impacted on by large numbers of patients who do not require a hospital bed any longer. This demand is operationally managed by our senior teams and on call colleagues with a continual dynamic risk assessments being carried out.

Safe Staffing Report – March 2024

Report of: Helen Howard
Deputy Chief Nurse

Contents

NHS Stockport NHS Foundation Trust

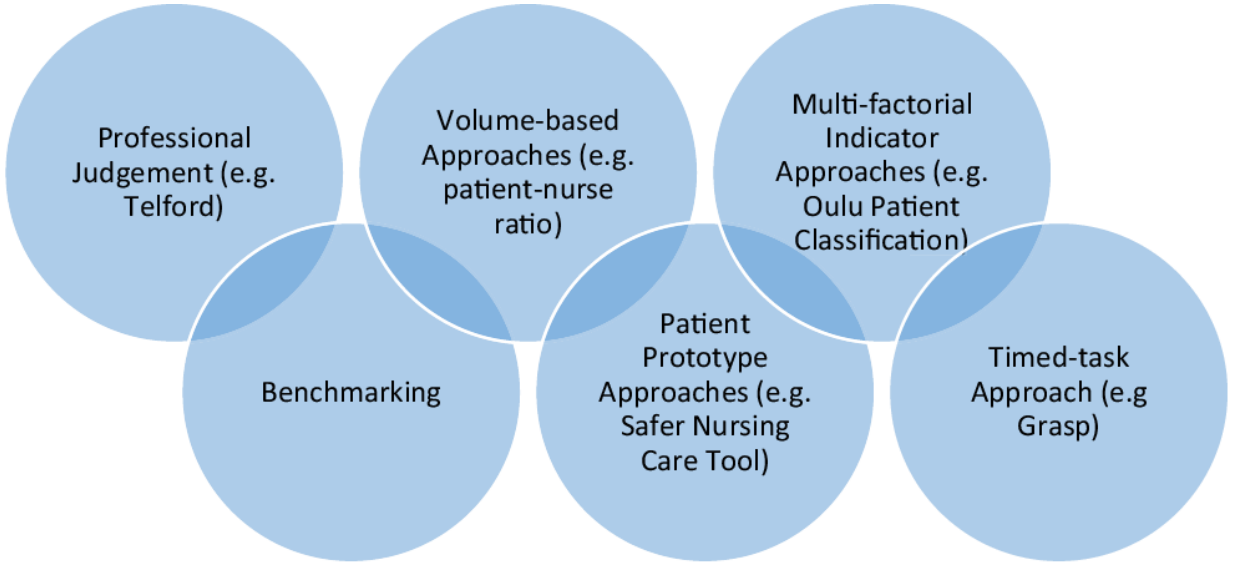
1. Introduction

NHS Stockport NHS Foundation Trust

The safe staffing report provides the People Performance Committee with an update on the following:

- Staffing assurances
- Current challenges regarding staffing levels and risk mitigations the actions being taken to mitigate risks identified
- Evidence-based decision-making on safe and effective staffing is a requirement for all NHS organisations.

The Committee are asked to note the contents of the paper, current performance and actions being taken to drive improvement.



1. Introduction

Stockport NHS Foundation Trust

Safe staffing is a fundamental part of getting care & support right for individuals. It is essential that there is the right number of skilled staff with the correct skills set to meet the needs of the service. Evidence based decision making on safe & effective staffing is a requirement for all NHS organisations. We continue to focus on patient safety & patient experience, in relation to safer staffing utilising a triangulated approach. Used in conjunction with Nurse Sensitive Indicators (NSI) such as patient falls & pressure ulcer incidence, which can be linked to staffing and support benchmarking activities. This will assist in facilitating consistent nurse-to patient ratios in line with agreed standards across similar care settings in England.

Safer Nursing Care Tool (SNCT)

The SNCT is a NICE endorsed evidence based tool and can be used in the following settings:

- adult inpatient wards in acute hospitals (updated 2023)
- adult acute assessment units (updated 2023)
- children and young people's inpatient wards in acute hospitals
- mental health inpatient wards
- emergency departments

Primarily used by the nursing workforce, the development of this tool has been led by a core group of experienced professional leaders & leading academics. This tool supports the Chief Nurse in determining optimal nurse staffing levels, assisting staff in measuring patient acuity and/or dependency to inform decision making on staffing and workforce.

SNCT can also deliver evidence based workforce plans to support existing services or to develop new services.

2. Healthroster

NHS Stockport NHS Foundation Trust

The Trust uses SNCT at the daily staffing meetings to review staffing levels in conjunction with acuity levels of patients. Processes for improving the Key Performance Indicator (KPI) are :

- Clinical Support Services (CSS) have now joined the rostering KPIs working towards the Trust standards
- Roster challenge has now commenced for CSS and Crisis Response
- Ward Manager Tile – enables the Trust to utilise Safecare fully, showing when the Ward Manager is working outside the clinical numbers, therefore not counting toward CHPPD
- Unused hours – aim for all to be within a maximum of one shift length over or under
- Supernumerary tiles have been added to the ward demand templates & used for new starters. An audit is taking place for the previous 3 months to ensure these are being used correctly
- Further work to be carried out to ensure all bank requests are made via Healthroster and not directly to NHSP. All NHSP requests need to be requested as soon as rosters are built to enable maximum bank fill. The 2 tier approval process needs to embedded into the roster build process
- Estates & Facilities (E&F) have completed 3 months of roster challenge & the Rostering Team are supporting for a further 3 months via roster challenge forms. CSS have not approved their roster 12 weeks before it is due to start which is the Trust expectation. ED have changed the roster several time since approval. This due to sickness and site pressures.

Roster period : 29 January – 25 February 2024								Roster period : 1 – 28 January 2024	
Business Division	Annual Leave %	Roster Approval (Full) Lead Time Days	Total Unavailability %	% Changed Since Approval	Unused hours (4 week period)	Over contracted hours (4 week period)	Total Hours balance	Additional Duties in hours (Total Hours)	Safecare % compliance across 3 Census periods (average)
ED	12.8%	53	22.1%	55%	398.3	653.8	255.6	997.5	n/a
IC	17.1%	64.50	25.1%	30.5%	1,235.5	571.5	664.1	2,881	50.71%
Medicine	14.4%	59.95	24.9%	31.4%	865.2	1,423.2	558	5,877	55.40%
S&CC	17.5%	65.41	28.2%	32.2%	1,568	1,095.6	472.4	5,214.27	50%
W&C	18.8%	59.35	34.8%	26.4%	978.6	714	264.6	343	47%
CSS	10.9%	13.45	14.10%	0.01%	856.5	908.29	51.79	545	n/a
Total					5,902	5,366	2,266	15,857.77	50.78%

Data provided by the Rostering Team

3. Vacancies

NHS Stockport NHS Foundation Trust

Registered Nurses & Midwives	FTE Actual	Variance FTE	Post Recruited to in TRAC FTE & awaiting start dates
Clinical Support Services	58.93	-10.41	1
Emergency Department	115.61	2.30	1
Integrated Care	355.21	-33.31	21
Medicine & Urgent Care	351.08	-39.79	13
Surgery & GI	442.41	-38.20	16
Women, Children & Diagnostics	402.55	-32.33	17
Grand Total	1819.23	-160.40	104

The data above covers the positions of registered nurses (RNs) and registered midwives (RMs), nursing associates (NAs) and staff awaiting PINs in January 2024.

The process for recruiting students is being reviewed in collaboration with the Deputy Chief Nurse, Head of Learning & Education, Divisional Nursing Directors (DNDs), Divisional Midwifery Director (DMDs) and Workforce; resulting in the publication of a new SOP outlining how the Trust will ensure that students are supported throughout the interview and appointment, recruitment process and induction to the Trust. This process will be led by the Pastoral Care Lead.

Obtaining accurate information on the number of vacancies within the Trust remains difficult, this has been an ongoing issue, as data is provided from a number of sources & figures do not correlate. A piece of work is currently being undertaken to ensure that this issue does not continue. Those involved are Finance, Workforce & HR (from Trac & ESR).

4. NHS Professionals

NHS Stockport NHS Foundation Trust

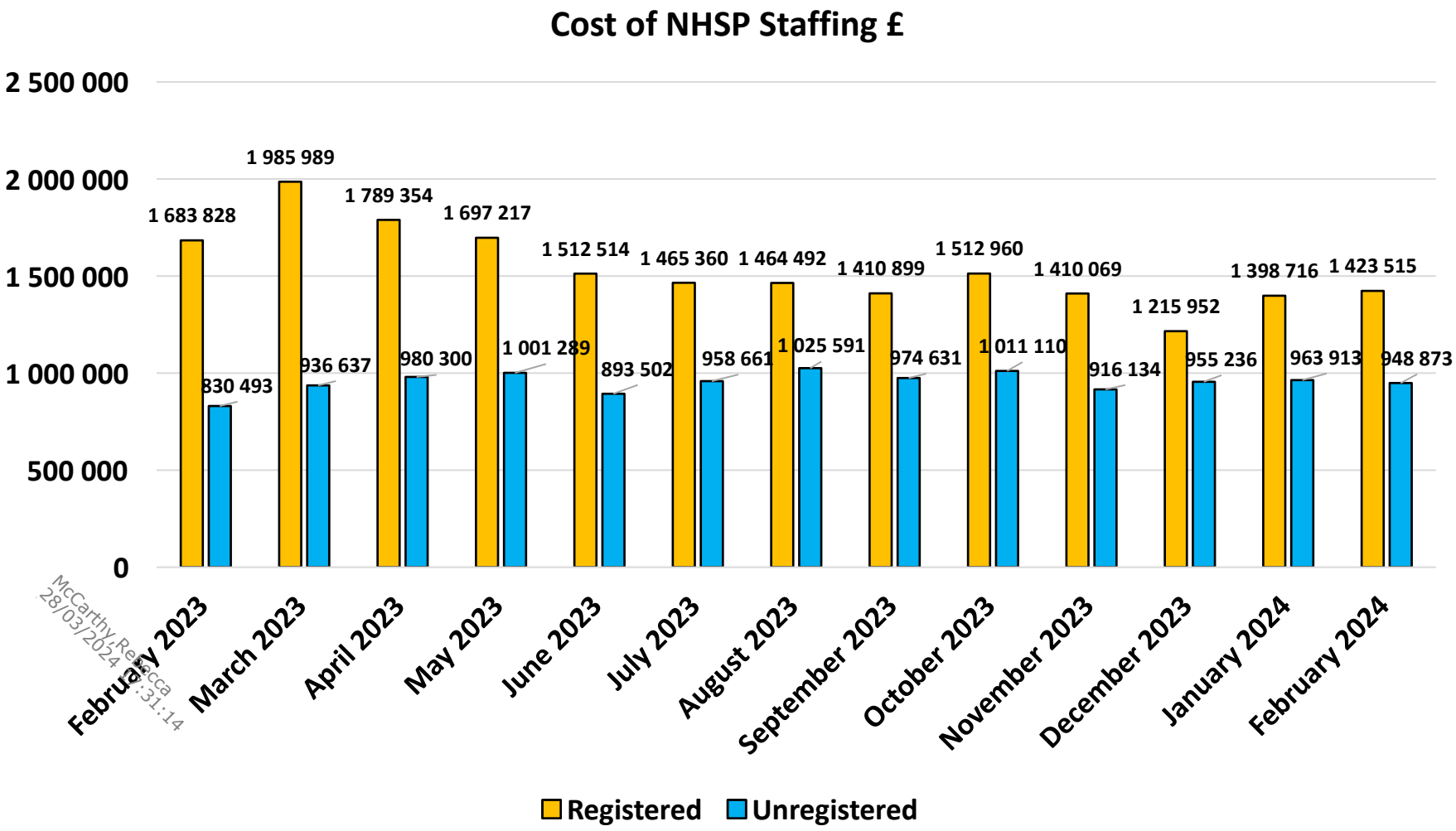
The continued focus is on the reduction of using bank and agency staff and has seen a decrease in agency usage to 9.5%. This is the first time the Trust has been under 10% and is testament to the focused attention of the Corporate and Divisional teams.

NHSP bank pick up on Saturday night and Sunday long days is between 93% - 100%, due to popularity the lead time has now been reduced to 24 hours for Saturday nights and Sunday long days. For the less popular shifts the agencies can see the view shifts 3 days in advance.

5. Nursing & Midwifery Temporary Staffing

NHS Stockport NHS Foundation Trust

The table below illustrates the 'month on month' cost to the Trust of NHSP bank RNs, RMs and non-registered staff.



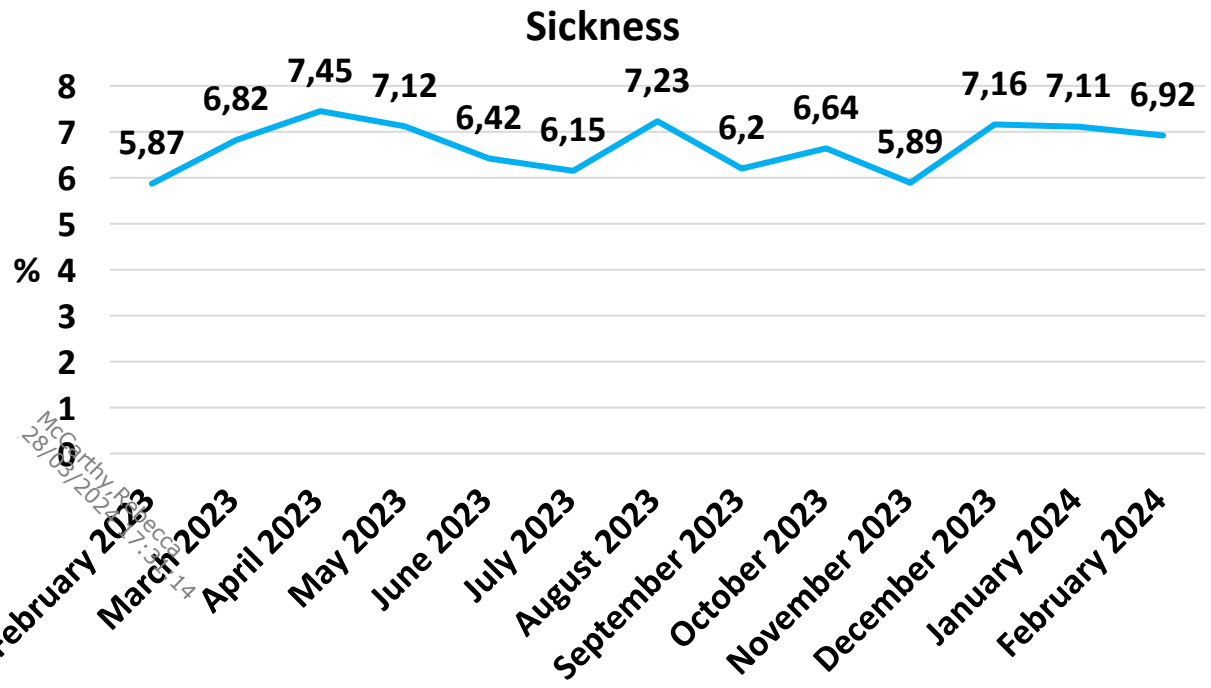
Data provided by People Analytics

6. Nursing & Midwifery Absences

NHS Stockport NHS Foundation Trust

The chart below illustrates the absence rates for registered nurses, registered midwifes, AHPs and students.

An absence from work can be the result of many factors for example short-term sickness due to colds/virus, long term condition, carers leave and it is recognised that the highest absence rates are during school holidays. 'Looking after our people' **NHS People Plan**.



Sickness %		
Role	Dec 2023	Jan 2024
AHPs	4.40%	4.22%
RNs & RMs	6.72%	6.63%
Students	0.22%	0.15%

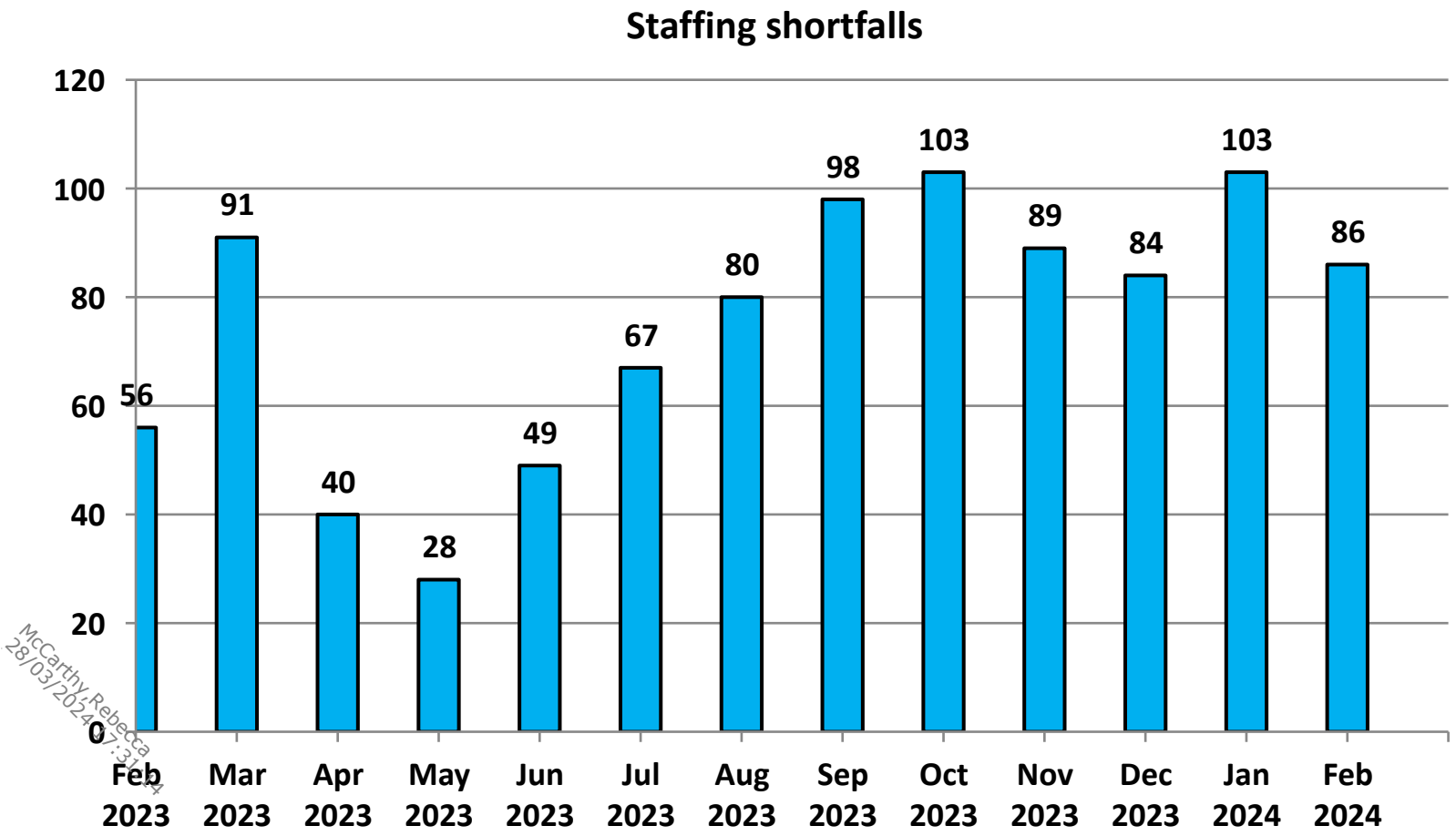
- The main reason for reported absence is Anxiety, Stress and Depression
- Managers work closely with Occupational Health in exploring alternative working patterns to ensure staff have a healthy work/life balance
- Support provided by the Trust's confidential Staff Psychology and Wellbeing Service (SPAWS)
- Professional Nurse Advocates (PNAs) provide coaching

Data provided by People Analytics & Workforce

7. Nursing & Midwifery Risk Highlights

NHS Stockport NHS Foundation Trust

The graph illustrates the 'month on month' number of staffing shortfalls recorded by Trust staff on Datix.

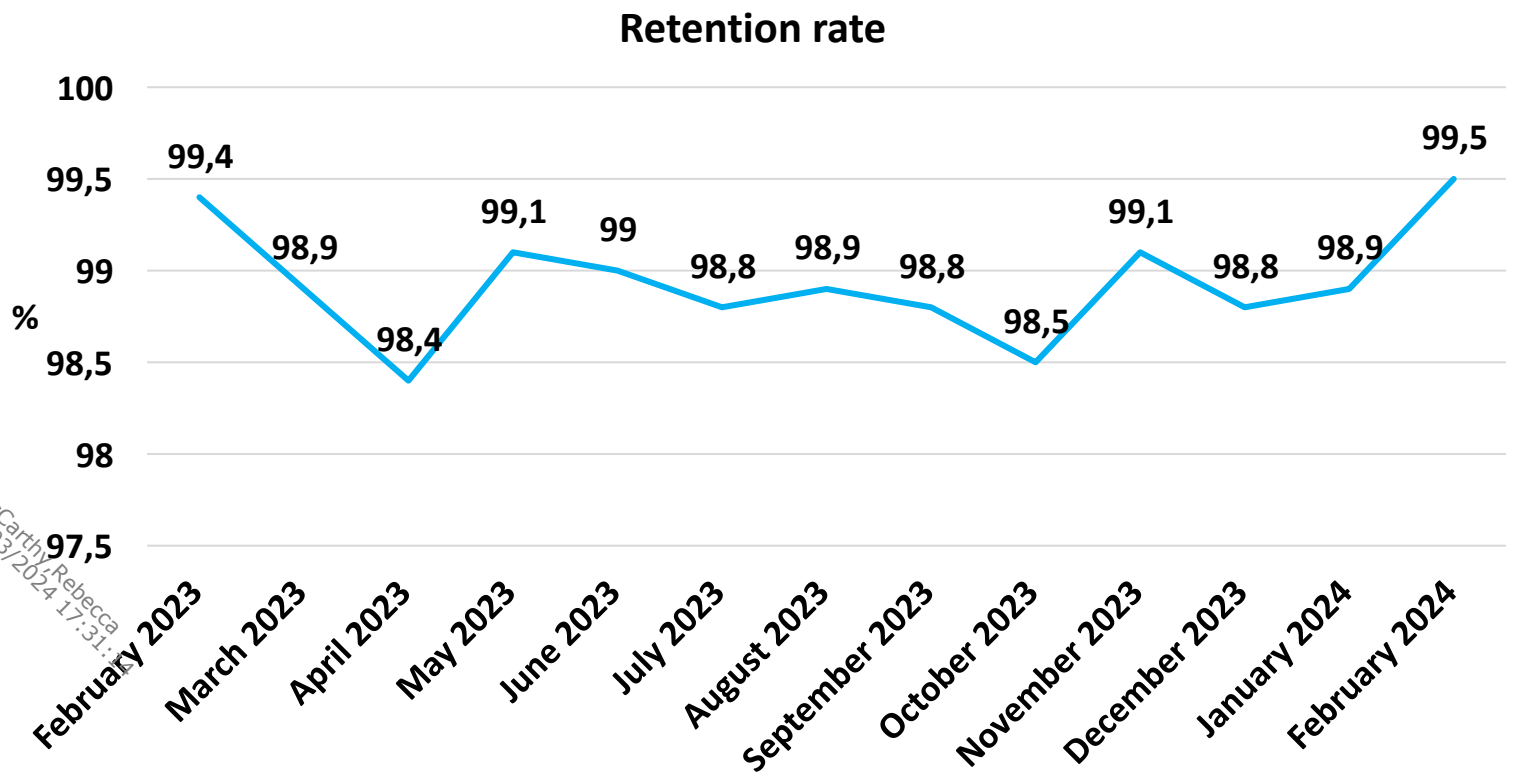


Data provided by Datix

8. Nursing & Midwifery Retention

The chart below illustrates the Trust's staff retention rate for the last 12 months.

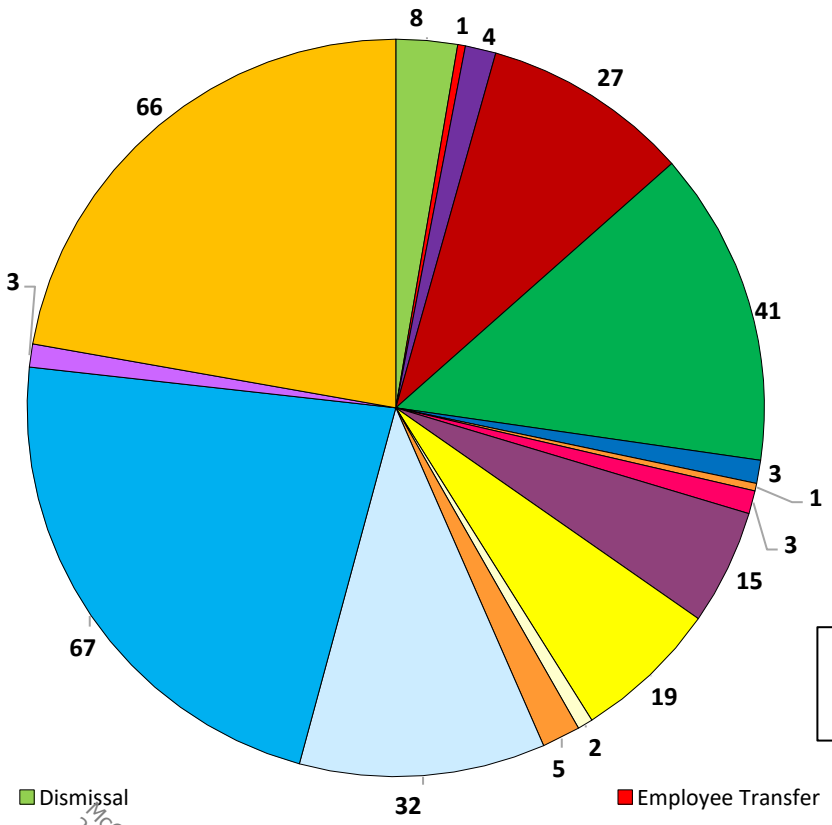
Retention figures are expected to improve with the recruitment of the Pastoral Care Lead who will be focusing on supporting the Trust's new starters from interview throughout the recruitment process and their initiation on the wards; supporting internationally educated nurses, working as HCAs through the OSCE process. In addition, the role will also include managing the Grow & Retain our Workforce (GROW) pathway which enables RNs to transfer internally. All which contribute to improving retention.



Data provided by People Analytics

9. Nursing & Midwifery – Reasons for Leaving

Stockport NHS Foundation Trust



- PNAs continue to have a positive impact on supporting staff and increase in retention. The popularity of the PNA programme continues to increase but unfortunately funding has now ceased & there the Trust will be unable to reach the NW expectation of 1 PNA to 25 Nurses
- The Pastoral Care Lead post has gone back out to advert. Following the AFC review it had been banded at 5 with a fixed term 18 month contract. The role has been created to provide emotional and practical support for new starters, internationally educated nurses and HCAs.

Number of leavers by reason
January 2023 – January 2024

Data provided by People Analytics

10. Nursing & Midwifery Recruitment

NHS Stockport NHS Foundation Trust

- The focus is now on the Internationally Educated Nurses (IENs) who are currently employed as HCAs in the Trust and to support them through the Objective Structured Clinical Examination (OSCE) process. Ten HCAs will be supported through the OSCE with training provided by the OSCE Team.

- Midwifery now have 4 Internationally Educated Midwives (IEMs) working at the Trust and awaiting confirmation of a start date of another IEM

- The Emergency Department and CDU held an event on 2nd March 2024 to recruit nursing staff in preparation for the opening of the new Acute Care Campus. They recruited 3 Band 6 RNs, 4 Band 5 RNs, 1 Band 3 HCA. CDU recruited 2 Band 2 HCAs.

- The Theatres Department are holding a recruitment event on 6th April which will include the opportunity to visit the operating theatres and anaesthetic rooms. They will be recruiting RGNs, ODPs and Theatre Assistants

- The Division of Medicine are holding a recruitment event on the 27th April 2024 for RNs and HCAs

10. Nursing & Midwifery Student Engagement

NHS Stockport NHS Foundation Trust

- To ensure that the nursing students experience a smooth recruitment process, from interview through to starting at the Trust and period of supernumerary; HR, Practice Education Facilitators and Recruitment and Retention Team have finalised a working policy

- At the request of the Senior Lecturer, University of Salford, in April the Workforce Matron & Matron for Medicine will present a "Meet the Matrons" Q&A session to 3rd year nursing students. This will be an opportunity for students to ask questions and find out about career opportunities at the Trust in a more informal environment

A selection of comments received from the students at a previous sessions :

"I enjoyed the session. Very positive individuals, having them ask us questions too - was good. They were encouraging, it was good to have the opportunity to ask questions & raise a few concerns."

"I really enjoyed the session. As a student given the opportunity of asking questions from matrons and getting some answers was helpful and inspiring too. Thank you to the team who delivered the message."

"Good session, valid and great to get the discussions going. Thought provoking. Good to hear so many students had got job offers – positive."

11. Training Pathways

NHS Stockport NHS Foundation Trust

Multi-professional Cadet Programme

This initiative has been put in place in order to support future NHS workforce demand.

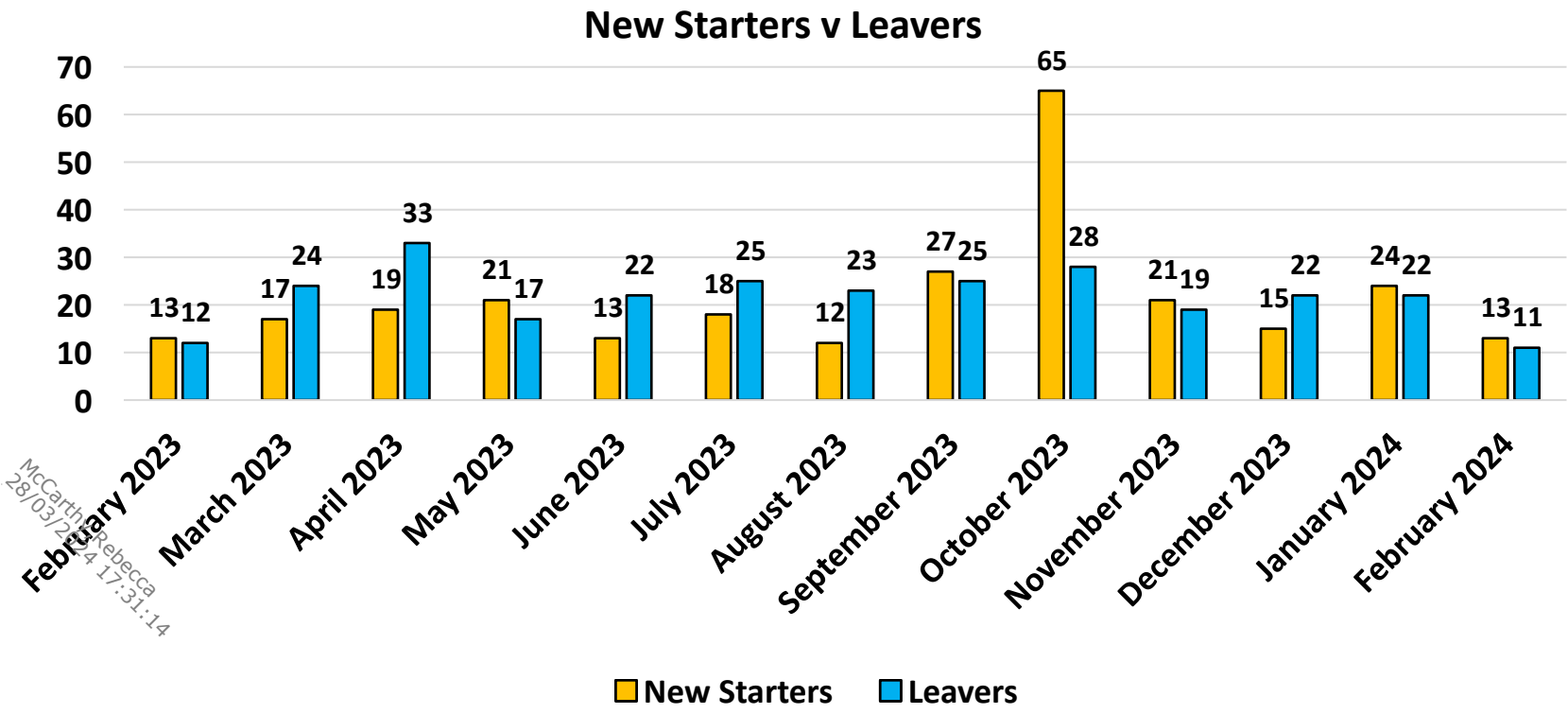
- In light of the large reduction in Student Nurse applications, the programme aims to recruit local young people and support them into careers in the NHS by offering a wide range of placement opportunities (across all professions)
- The Trust currently collaborates with The Trafford Group College (Stockport), Macclesfield College, Manchester College and the UCEN Manchester
- There are currently 84 cadets on programme who are studying on the National BTEC Level 3 programme, or the new industry T-Level qualification. These learners are between 16-19 years old
- It is anticipated that the number will increase to 120 by September 2024
- Cadets will be encouraged to either access HEI (guaranteed interviews at Universities of Salford and Bolton with agreement to complete 3 years training at Stockport NHS Foundation Trust), or access other roles within the Trust such as a HCA or administrator where they can continue to progress via apprenticeship routes
- UCEN students are adult learners studying a BSc in Health and Social Care; they will be actively looking to be recruited into HCA roles. On completion of a degree they can access the MSc Adult Nursing Programme (2 years) at the University of Bolton and be recruited into RN positions at SHH

Information provided by PEFs

12. Nursing & Midwifery Starters & Leavers

In October 2023 due to a summer of successful recruitment events coinciding with the end of the academic year there was a high intake of newly qualified nurses joining the Trust which is reflected in the chart below.

As a result of winter pressures and holidays during December 2023 fewer people apply for a new job. Statistically more people apply for new jobs in the new year, and it is recognised as 'New Job, New Start', therefore resulting in an increase in starters.



Data provided by People Analytics

13. Allied Health Professionals – Radiology

Stockport NHS Foundation Trust

Further continuation of the recruitment strategy has seen further vacant posts filled. In relation to allotted establishment this equates to full establishment in the Band 5 cohort.

The Band 5 cohort was briefly over established, only dipping below establishment upon the appointment of several internal promotions. Of note, our plan to fortify the Nuclear Medicine staffing to mitigate the staffing risk ahead of the current team reaching retirement age is going particularly well.

Trainees

The two trainee appointments are undertaking the relevant qualification and will be up and running within 12 months. Both candidates bring other useful skills to the role and have been pivotal in the introduction of a Radiographer led Ultrasound Guided Cannulation Service that will be accessible to all Radiology specialities, not just Nuclear Medicine.

International Recruits

Our new international recruits have been a great success and have been signed off. All are making really good progress and have integrated well into the team. We have also recruited a number of newly qualified Radiographers, the last joining in September 2023. All recruits are now working autonomously within numbers.

Locums Support

The use of locums has been reduced and continues to be reviewed regularly. They are now only used during cores hours to reduce the spend from enhancements. The exception is CT, but this is due to an unforeseen terminal illness presenting within the team suddenly.

13. Allied Health Professionals – Radiology

NHS Stockport NHS Foundation Trust

A long overdue review of our allotted establishment has revealed a shortfall in staffing. The cause is multi-faceted and includes an increase in assets minus the staffing associated with the running of them, and a general increase in activity since the inception of the original establishment calculation.

Some specialities have seen an upwards of 150% increases since the last review in 2012. Work has been done with the help of Finance and the new calculation shows the service is missing approximately 6.5 WTEs Band 6s. Long term this will threaten further retraction of locum support given our priority of maintaining our services and offering responsive throughputs.

Overall staffing levels in Radiology are the best they have been for over a decade, although there is a clear requirement for an increase to our establishment if our reliance on agency is to be resolved.

- Full establishment at Band 5
- Close to establishment at Band 6 (two WTEs currently out to advert)
- Nuclear Medicine future workforce planning progressing
- Ongoing work in building the case for increased establishments to match 150% increase in activity
- Overall reduction in Band 5 / 6 locum cover with the remainder in place to cover both long-term sickness or additional essential assets (from 5.3 to 2.8)
- Full revocation of locum support requires establishment increase

Data provided by CSS

14. Allied Health Professionals

Stockport NHS Foundation Trust

Significant effort continues in relation to timely & effective recruitment strategies and, as of January 2024, we saw 8.79 WTE vacancies against a substantive WTE of 290.1 (circa 3%). This result is a huge credit to the teams.

Job Planning / Capacity and Demand Analysis

- The job planning template for AHPs in Integrated Therapies is now complete in draft form and is being sense checked within the service areas. It has been modified from previous work completed to account for variations in SPA demands here at Stockport, and to account for the significant community/domiciliary workforce where travel needs to be accounted for.
- The aim is to get job plans agreed and signed off for all clinical staff by Q1 2024, and this then feeds into the capacity/demand project.

Agency Trajectory and Temporary Staffing

- Whilst work has been ongoing to reduce agency expenditure, our pressure points are in Speech and Language Therapy and Dietetics.
- The use of SLT and Dietetics agency staff has been essential to maintain safe staffing levels and ensure that patients in our care are not at risk due to unacceptably low staffing levels.
- We recruited 4 Orthotists onto NHSP, which is incredibly unusable locally and nationally, all of whom are interested in permanent posts should they become available. Onboarding is ongoing and this will support us to mitigate the risk faced with 50% of our orthotics workforce (only 2 staff members in this team) currently on long term sickness.

Data provided by Integrated Therapies & Boroughwide Services

14. Allied Health Professionals

NHS Stockport NHS Foundation Trust

Working with HEIs

- As highlighted in the last report, we were able to present at the University of Salford to support their 'Into Employment' final year module, focusing on preparing students more thoroughly for their transition into employment and setting out some clear expectations from employers to help them manage their beliefs and outlooks, and succeed in their early careers. It proved to be an effective opportunity to promote Stockport as an employer and as a great place to work.

Student Recruitment

- AHPs are now following the same process as nursing, providing a QR code for well-performing students to register their interest in upcoming jobs in Stockport. We are hopeful this will be a more proactive way of securing high quality new graduates who have had experience in the Trust and want to work with us.

Exit Interviews and Feedback

- Reviewing exit interview feedback for our workforce has highlighted the lack of consistent and useful information. We are currently reviewing the process for gaining useful information to help shape our future workforce strategy/strategies. We do, however, recognise, that the majority of our staff leave to other regional Trusts for promotional opportunities ort to seek speciality exposure which Stockport cannot offer. Exploring opportunities to collaborate with local HEIs and/or other Trusts to open up new experiences is on the agenda for 2024/2025.

15. Midwifery Update

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.)

Challenges

- Current registered vacancy inclusive of Inpatient and Outpatient areas 4.11 WTE, in addition to this there is currently a gap of 13.24 WTE on maternity leave (2.2 WTE due back April–June 2024). This equates to a total deficit of 17.35 WTE

Actions

- Weekly planned roster scrutiny meetings/E-Roster training sessions - continues
- Rolling advert for Band 5/6 midwives
- Plan to recruit to student midwives due to complete training Sept/Oct 2024

Current Maternity position		
WTE Actual	**Number of WTE Vacancies**	**Post WTE Recruited to TRAC**
160.48 (including Band 8 & above)	**4.11 (13.24 on Maternity Leave)**	**2.6 accepted & awaiting start dates**

Assurance

- All shift co-ordinators have supernumerary status
- January showed we achieved 98.3% one to one care in labour
- Maternity Red Flags monitored and reported through division
- Fully engaged with Maternity Support Workers Framework Working Group
- Recurrent funding confirmed for Recruitment and Retention Midwife, Band 6 Preceptor Midwife and Band 3 Maternity Support Worker Retention post – job descriptions under review
- Engaged with the International Educated Midwifery (IEM) recruitment programme. Three commenced in post, 1 IEM arrived on 28th December 2023 and awaiting arrival date of an additional IEM

Data provided by the Division of Women & Children's

15. Midwifery Update

NHS Stockport NHS Foundation Trust

Maternity Red Flags

Maternity red flag events are events that are immediate signs that something may require action to stop the situation getting worse. 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 co-ordinators out of hours. 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.

16. Medical Staffing

Stockport NHS Foundation Trust

The Tiers below describe the directly employed Medical Workforce within the Trust:

Tier 3: ***Expert clinical decision makers*** These are clinicians with overall responsibility for patient care. In the Medical Workforce these are our Consultants.

Tier 2: ***Senior clinical decision makers*** These are clinicians capable of making a prompt clinical diagnosis and deciding the need for specific investigations and treatment. For the medical grades this is largely SAS Doctors and Senior Clinical Fellows.

Tier 1: ***Competent clinical decision makers*** These are clinicians capable of making an initial assessment of a patient. For the medical grades this is largely Foundation Doctors and Junior Clinical Fellows.

Medical Staff	FTE Budgeted	FTE Actual	Variance FTE
Tier 3	238.78	227.46	-11.32
Tier 2	77.64	66.76	-10.88
Tier 1	119.62	153.98	34.36
Total	**436.04**	**448.20**	**12.16**

N.B. The Trust is also a host employer on behalf of the Lead Employer, St Helens and Knowsley NHS Trust, for specialty, core and general practice trainees and we host a further 165 trainee doctors working at the Trust across our specialties.

16. Medical Staffing

Stockport NHS Foundation Trust

Consultant Recruitment

Medical Staffing continue to work with divisions to target recruitment campaigns in advance of situations when Doctors in training are set to become eligible to work as Consultants. This has seen recent success since the last report with the appointment of Consultants in Anaesthetics and Critical Care with a record of 5 appointments in one afternoon, also in Microbiology and Radiology.

We are actively working with divisions regarding the recruitment of Consultants in Urology, General Medicine, DMOP and Stroke.

In 2023 Diabetes recruited a Specialist Doctor who can work autonomously, and Trauma and Orthopaedics are also now recruiting to this role. Appointees to the role often work autonomously and this provides another option for the Trust in the recruitment of senior Doctors, especially in areas where it can be difficult to recruit Consultants.

Medical Workforce Group

Andrew Loughney, Medical Director, has added the topic of 'Senior Medical Recruitment' to the Annual Workplan so that the group can monitor and support this, and in particular seek to assist with those difficult to fill specialties and ensure that all options are being explored.

17. Good news

- Creation of GROW microsite providing information about the internal transfer pathway for nursing staff

- ED & CDU held a recruitment event on Saturday 2nd March focusing on recruiting staff for the new build Emergency and Urgent Care Campus. They recruited 3 Band 6 RNs, 4 Band 5 RNs, 1 Band 3 HCA. CDU recruited 2 Band 2 HCAs.

- The Trust is regularly hosting recruitment events – The Theatres Department on the 6th April and Division of Medicine on the 27th April

- The efficient working partnership between the Trust and NHSP has now resulted in successfully reducing bank and agency usage to an all time low of 9.5%

- Currently in the process of recruiting for the role of Pastoral Care Lead, a role that will involve supporting new Band 5 registered nurses through the interview and recruitment process; during their corporate and clinical inductions, supernumerary period and precetorship programme

18. Going forward

- Shortlisting of applicants for the role of the Recruitment of a Pastoral Care Lead (Band 5 18 month permanent fixed term). After AFC panel the role was banded as 5. The role will involve supporting all new nursing starters joining the Trust, the career development of Internationally Educated Nurses (IENs) working as HCAs
- Liaising with the ward managers to co-ordinate a corporate welcome to nursing staff joining the Trust
- Identification of a role with the skillset to promote recruitment campaigns and the Trust as an employer of choice
- Introduction and promotion of retention initiative the GROW pathway
- Ward allocation for nursing students qualifying in January-April 2024
- Formalise the pathway for IENs working as HCAs to qualify as Band 5 registered nurses
- Promoting events on social media platforms
- Contacting individuals who had registered an interest in attending the events
- Manage #supportteamstockport Facebook page & @stockportnursing twitter account

NHS Stockport NHS Foundation Trust

Meeting date	4th April 2024	**Public**	X	**Agenda No.**	13.
Meeting	Board of Directors				
Report Title	Annual Corporate Objectives 2024-25				
Director Lead	Karen James, Chief Executive	**Author**	Andy Bailey, Deputy Director of Strategy & Partnerships		

Paper For:	**Information**		**Assurance**		**Decision**	x
Recommendation:	The Board is asked to receive the report and approve the Corporate Objectives 2024/25.					

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
✓	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
✓	PR2.1	There is a risk that the Trust is unable to sufficiently engage and support our people's wellbeing
✓	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
✓	PR5.1	There is a risk that the Trust does not implement high quality transformation programmes
✓	PR6.1	There is a risk that the Trust does not deliver the annual financial 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

Where issues are addressed in the paper

	Section of paper where covered
Equality, diversity and inclusion impacts	Objectives 1-4
Financial impacts if agreed/not agreed	Objective 6
Regulatory and legal compliance	Objective 1
Sustainability (including environmental impacts)	Objective 7

Executive Summary

The attached paper proposes a continuation of the current Trust Objectives for 2024/25.

Detailed outcomes measures are in development, linked to each Executive Director's portfolio.

A final report on delivery of the 2023/24 outcome measures will follow to the Public Board in June.

1. Purpose

1.1 The purpose of this report is to propose a continuation of the Trust's Corporate Objectives into 2024/25.

2. Introduction / Background

2.1 Each year, the Trust sets a range of Corporate Objectives, prioritising the key pieces of work for the year ahead to enable the Trust to meet its statutory obligations and deliver its Strategic Plan.

2.2 In 2023/24, the corporate objectives were to:

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

2.3 Board members will recall receiving a mid-year update on progress in delivering these objectives in December 2023.

2.4 A year-end position will be brought back to the Board's public meeting in June 2024.

3. Proposed Objectives for 2024/25

3.1 In light of national, system, and locality requirements, these priorities remain valid. As such, it is proposed that the 2023/24 corporate objectives are rolled over in 2024/25. If agreed by the Board, detailed outcomes measures will be developed and aligned to Executive Directors' portfolios.

4. Recommendations

4.1 The Board is asked to **approve** the corporate objectives set out over the page for 2024/25.

Our Objectives for 2024/25

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

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.

NHS Stockport NHS Foundation Trust

Meeting date	4th April 2024	**Public**	X	**Agenda No.**	14.
Meeting	Board of Directors				
Report Title	Board Assurance Framework 2023/24 – Quarter 4				
Director Lead	Karen James, Chief Executive	**Author**	Rebecca McCarthy, Trust Secretary		

Paper For:	**Information**		**Assurance**		**Decision**	X
Recommendation:	The Board of Directors is asked to review and approve the Board Assurance Framework 2023/24 as at Q4, including action proposed to mitigate risks.					

This paper relates to the following Annual Corporate 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
X	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
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	PR 4.2
Financial impacts if agreed/not agreed	PR 6.1 & 6.2
Regulatory and legal compliance	All
Sustainability (including environmental impacts)	PR 7.3

Executive Summary

The Trust maintains a Board Assurance Framework (BAF) as a key tool to manage and mitigate strategic risk to the achievement of the corporate objectives that have been agreed by the Board.

All principal risks within the Board Assurance Framework 2023/24 have been assigned to a relevant Board Committee for oversight, with review of risks taking place during March 2024. In reviewing the principal risks and determining risk score, consideration was given to the key controls and assurances, any gaps and required actions.

At the end of Q4 2023/24, there has been an increase to the score for the principal risk related to the current estate (Risk 7.2) and securing funding for the strategic regeneration of the hospital campus (Risk 7.4), from 16 to 20. These are the highest scoring risks on the Board Assurance Framework at present, recognising the escalating business continuity incidents being managed due to an ageing estate, challenging capital in 2023/24 and anticipation of significantly constrained capital in 2024/25.

Other significant risks continue to be delivery of the annual financial position and future financial sustainability; delivery of operational access standards and restoration of services; and workforce

challenges.

The potential impact of the financial and operational pressures, alongside industrial action, on quality of care is fully acknowledged. Principal Risk 1.1, relating to quality of care, receives scrutiny at Quality Committee in the context of these significant financial, operational and workforce related risks. Principal Risk 1.1 outlines the key controls and assurances considered by Quality Committee throughout the year, that support the Trust in understanding the effects of current financial and operational pressures on quality of care. Based on assurances considered by Quality Committee, it is proposed the risk score remains at 12.

The risks are prioritised as set out in table below and presented in full in the Board Assurance Framework 2023/24 (Appendix 1) as at the end of Q4.

No.	Principal Risk	C	L	Q1	Q2	Q3	Q4	Target Score
PR7.2	There is a risk that the estate is not fit for purpose and does not meet national standards	4	4	16	16	16	20 ↑	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	16	16	20 ↑	8
PR1.2	There is a risk that patient flow across the locality is not effective	4	4	16	16	16	16	8
PR1.3	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan	4	4	12	16	16	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	16	16	16	8
PR6.1	There is a risk that the Trust does not deliver the annual financial plan	4	4	16	16	16	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	16	16	16	6
PR1.1	There is a risk that the Trust does not deliver high quality care to service users	4	3	12	12	12	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	12	12	12	8
PR2.1	There is a risk that the Trust is unable to sufficiently engage and support our people's wellbeing	4	4	16	12	12	12	8
PR7.3	There is a risk that the Trust does not materially improve environmental sustainability	3	4	12	12	12	12	8
PR2.2	There is a risk that the Trust's services do not fully support neighbourhood working	3	3	9	9	9	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	9	9	9	6

PR4.2	There is a risk that the Trust's workforce is not reflective of the communities served	3	3	9	9	9	9	6
PR5.1	There is a risk that the Trust does not implement high quality transformation programmes	3	2	6	6	9 ↑	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	9	9	9	6
PR5.2	There is a risk that the Trust does not implement high quality research & development programmes	3	2	6	6	6	6	6

In addition, the Trust's significant risks from the corporate risk register (as presented to Risk Management Committee in March 2024), are provided at Appendix 2 to ensure there is alignment between operational and principal risks. The significant risks relate to the following areas:

Risk Subtype	No of relevant significant risks	Risks Identified
Capacity and demand of services	5	2677 – Risk to patient harm due to impact of closure of OPB on orthodontics Service (16) 2667 – Risk of patient harm due to loss of OP and diagnostic facilities for ophthalmology (16) 2715 – Risk of children not being assessed for their continence needs in a timely way (15) 2304 – Patient delays transferring from ambulance to ED (16) 2713 – Capacity and demand in ED leading to overcrowding (16)
Environment	4	2452 – Pathology estate not fit for purpose (15) 2247 – Electrical capacity (15) 2596 – Cooling in Beech House Data Centre (16) 2196 – Dangerous & obstructive car parking on SHH site (15)
Staffing	3	1711 – Employee relations/ possible strike action (16) 2690 – Risk to patient treatment as new ED HASU cannot open with current staffing levels. (20) 1288 - Risk that failure to achieve turnaround time targets in cell' path' will impact care for cancer patients (20)
Financial	1	2609 – Financial risk of providing care and support to vulnerable asylum seeking families (15)
Compliance (with standards/ mandatory or legislative)	1	1004 – Breach of Regulatory Reform (Fire Safety) Order 2005 (16)
Infection Prevention and Control	1	288 – Provision of robust service for VAD insertion (15)

Following Risk Management Committee in March, a review of the operational estates risks relating to backlog maintenance and specific buildings are to be undertaken. This acknowledges the increasing

business continuity incidents being managed, and significantly constrained capital as mentioned above, alongside impact of both patients and staff wellbeing.

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		**5.2**	**2.2, 3.1, 4.2, 5.1, 7.1**		
4 - Major			**1.1, 3.2, 7.3**	**1.2, 1.3, 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	**5.2**
Gap score 1 - 5	Tolerable	**1.1, 1.3, 2.1, 2.2, 3.1, 3.2, 4.2, 5.1, 7.1, 7.3**
Gap score 6 - 9	Close monitoring	**1.2, 4.1, 6.1, 6.2**
Gap score 10	Concern	**7.2, 7.4**
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	Q 2	Q 3	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) Board approved Patient Safety Incident Response Plan, Aug 2023 PSIRF Policy (March 2023) Review 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 locally prioritised audit based on risk assessment. - 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 - Freedom to Speak Up process established. New governance system for end of life care established, including internal group reporting to Stockport End of Life Care forum.	Impact of employee relations & industrial action issues Impact of continuing operational pressures Poor quality of estate including closure of Outpatients B and additional estate failures. Ineffective system for control of clinic outcome i.e., patient discharge v's clinical follow up required.	**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 Reports: - Patient Safety (Serious Incidents & Duty of Candour including review of harms from each industrial action) - Clinical Effectiveness (Clinical Audit & NICE Compliance) - Patient Experience - Health & Safety - Integrated Safeguarding - CQC Report including CQC Action Plan Update, CQC Preparation (Quarterly) - CQC Inspection – Maternity Services – High Level Feedback (Report Pending) - 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) - LMNS 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) and Annual Nursing Establishments Review - Guardian of Safe Working / Freedom to Speak Up Report to Board (Bi-annually) - Quality Strategy (Annual) Annual Quality Accounts **Level 3 - Independent** GM Clinical Quality & Effectiveness Group provide high level surveillance for harm. Friends & Family Test National Patient Experience Surveys: - Adult Inpatient Survey - National Cancer Survey - Emergency Department Survey	Indirect or subtle harm from operational pressures may be difficult to identify.	Full implementation of Patient Safety Incident Response Framework & Plan Patient Follow Up - Task and Finish Group to reconcile patient list and determine further action	March 2024 June 2024	4	3	12	12	12	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	Q 2	Q 3	Q4	Impact	Likelihood	Target
Objective 1 - Deliver personalised, safe and caring services																		
		External Visits & Accreditations Register Learning from Industrial Action Reviews established. StARS – Ward and Community 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 Maternity Improvement/Sustainability Plan in place and Maternity Strategy. Executive & Non-Executive Maternity Safety Champions in place, visits & meetings schedule. Trust & GM Command & Control Process established - Before, During and After Strike Action. Established Quality Impact Assessment in place for CIP – Sign off by Medical Director, Chief Nurse and Director of People & OD, Director of Operations QIA process part of all Business Cases – All Business Cases reviewed by Exec Team		MIAA Internal Audits 2022-23: • Risk Management (Substantial) • Clinical Audit (Substantial) • StARS (Substantial) • Quality Spot Checks (Substantial) GMC Medical Trainees Survey												
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 weekly locality tactical meeting to seek support to mitigate risk – Attended by Divisional Director. Weekly – Locality Patient Flow meeting established. System wide Urgent & Emergency Care (UEC) Board in place (oversight of patient	Capacity constraints in domiciliary & bed-based care impacting on levels of patients with no criteria to reside (NCTR). High levels of delayed discharges for out of borough patients. Lack of response from Derbyshire ICB. Significant increase in unfunded non-elective demand due to levels of patients with NCTR. Lack of standardised 7-day services across medical & surgical specialties to support discharge of non-elective patients.	**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 **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		Finalise recurrent Medical Staffing model	Q4 2023/24	4	4	16	16	16	16	16	16	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	Q 2	Q 3	Q4	Impact	Likelihood	Target
Objective 1 - Deliver personalised, safe and caring services																		
		flow management plans). Urgent & Emergency Care Delivery Group established (biweekly), feeding into UEC Board. Locality Action Plan in place following recommendations from ECIST Trust and system escalation process in place, aligned to a single OPEL system – Including divert of resource from elective activity to support flow. 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. Robust phasing programme for building works as part of EUCC to ensure no loss of capacity.	Locality Plan for Q4 2023/24 not agreed with Trust – Reduction in capacity for Pathway 1 and Pathway 2. Impact to be monitored.	Integrated Performance Report – Board (Bimonthly) **Level 3 – Independent** Urgent & Emergency Care Delivery Board NHSE – Activity Returns GM ICS reporting aligned to Tier 1 – Urgent Care		Escalation of Derbyshire delayed to discharge to GM SCC (Strategic Control Centre) – Awaiting Action Plan	Q4 2023/24											
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. 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 Authorisation (through Exec Management Team) to expand elective capacity through insourcing.	Workforce – Sickness Absence & Recruitment Impact of urgent care pressures on elective capacity Delivery of national access standards predicated on availability of GM mutual aid – Insufficient. Current independent sector providers unwilling to takeover care for long waiting patients. Change to commission of independent sector for 2024/25, however reduces capacity for 2023/24. Significant increase in referrals for elective care, including from out of area.	**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)				4	4	16	12	12	16	16	16	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	Q 2	Q 3	Q4	Impact	Likelihood	Target
Objective 1 - Deliver personalised, safe and caring services																		
		Roll out of GIRFT Further Faster Recommendations by Specialty Locality Action Plan in place following recommendations from ECIST	Cumulative impact of industrial action (Consultants & Juniors) having significant adverse impact on unbooked and cancelled appointments.	Integrated Performance Report (Operational Performance) – Board (Bimonthly) **Level 3 – Independent** SFT Tier 1 Elective Restoration Monitoring NHSE – Activity Returns GM productivity ranking – Benchmarked 4th in GM based on comparison to national peers.														

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 Health and Wellbeing Plan 2024. Approved People policies, procedures, guidelines and/or action cards in place (including. staff development; appraisal process; sickness and relationships at work policy) Vaccination programmes for both Influenza, Covid and MMR established. Comprehensive staff wellbeing programme established including staff psychology and wellbeing service and staff menopause service. Collaborative Occupational Health Service with T&G – including Staff Counselling Service & Physio Fast Track Service Dying to Work Charter Big Conversation programme established. Process to improve response rate of 'reason for leaving' in place. 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 Regular deep dive review of temporary staffing and sickness absence led by Deputy Director of People & OD established.	Embedded approach to Wellbeing Conversations Impact of employee relations & industrial action issues on morale and wellbeing Impact of continuing operational & external/internal financial pressures	**Level 1 - Management:** People, Engagement & Leadership Group - People Plan – Workstream Reports - Health & Wellbeing Plan 2024 – 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 MIAA Staff Wellbeing Review, February 2024 – Substantial Assurance.		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 G2 eOPAS IT system for integrated OH service with T&G.	Mar 2024 (Awaiting regional guidance) Mar 2024	4	3	12	16	16	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: PR2.2				**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. 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 Chief Finance Officer ~~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.	Unfunded growth in demand for community services Capacity & demand modelling for community services to support appropriate deployment of resources. Alignment of Community Services to PCNs – Potential change to PCN geographical footprints	**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: - 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	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 Q4 2023/24 Q4 2023/24	3	3	9	9	9	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 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 Board (Locality Board) operational. Membership includes CEO & Chief Finance Officer ONE Stockport One Future Plan and ONE Stockport Health and Care Plan. Stockport Provider Partnership operational, chaired by SFT CEO Provider Partnership identified key workstreams based on population health metrics. 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	9	9	9	3	2	6
				Level 2 – Corporate Executive Team / Finance & Performance Committee oversight of key strategic matters Trust Board Reports (6 monthly) and as required and CEO Report including key strategic developments - ICS - Stockport One Health & Care Plan Joint system meetings on ONE Stockport One Future 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	Neighbourhood profiles to be produced by Local Authority / GM BI	Q4 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 on the ambitions of the 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	Programme Board paused. Executive meetings taking place regarding sustainable services across ECT and SFT. Approved SFT & ECT Case for Change in June 2022. Case for Change presented to NHSE and ICB. Work programme has been completed for 2023/24 including development of transformation workstreams and services to be considered as part of the OBC. Case for change in General Surgical and T&O pathways documented including high level costs. Stakeholder engagement plan in place including ICBs, LA, Healthwatch, DPHs, VCSE and NHSE regulators. NHSE Regulators and ICB Commissioners engaged in plans.	Failure to gain key stakeholder support for Joint Clinical Strategy and Case for Change. Currently no funding strategy for the programme of work for 2024/25 financial year. No current capital or recurrent funding identified from commissioners to support proposed service change in 2023/24 and 2024/25	**Level 1 – Management** Joint Programme Board and Clinical Advisory Groups Programme Governance Meeting				4	3	12	12	12	12	12	12	4	2	8
				Level 2 – Corporate Executive Team oversight of key strategic matters. Trust Board & ECT/SFT Board to Board Reports	Joint Programme Board and Clinical Advisory Groups paused.	Identify funding for General Surgical & T&O pathways. Determine if wider Pre-Consultation Business Case is required.	Q1 2024/25 Q2 2024/25										
				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.		Paper detailing requirements for General Surgical & T&O to be presented to Cheshire & Merseyside ICB Confirm stakeholder engagement requirements for change in General Surgical & T&O Pathways and conduct engagement.	Q4 2023/24 Q1 2024/25										

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. E-Rostering Workforce Group established. 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 with enhancements of leadership and development offer continuing as identified within OD Plan. Local/ Regional/National Education partnerships Alternative development pipelines in place – Degree Apprenticeships, Medical Support Workers, Cadet Programme commenced. Workforce Strategy & Divisional Workforce Plans Phase One – Talent Management & Succession planning - Executive Team succession plan complete.	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 above target. 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 **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) **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		Develop and implement phase two – talent management approach for the wider senior leadership team and managers Introduce a refreshed 121/Appraisal process	Q1 2024/25 Q1 2024/25 (To align with the timing of the refresh of the Trust's Values & Behaviours)	4	4	16	16	16	16	16	16	4	2	8
Principal Risk Number: 4.2				**Risk Appetite: High**														
There is a risk that the Trust's workforce is not reflective of the communities served	People Performance Committee	Approved People Plan in line with national People Strategy objectives – Including Equality, Diversity & Inclusion, Talent Management & Succession planning	Career Development Programmes for staff with protected characteristics	Level 1 - Management WRES / WDES Steering Group - Oversight of WRES / WDES Annual Report and Action Plan				3	3	9	9	9	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 4 - Develop a diverse, capable and motivated workforce to meet future service and user needs																		
and staff with a protected characteristic having a suboptimal staff experience (career progression, turnover) which may lead to a poorer patient experience.		Equality, Diversity & Inclusion Strategy & Implementation Plan Staff Networks (BAME / Disability / Carer/ LGBTQ+ and Neurodiversity) Completed review of staff networks and relaunched under agreed improvement arrangements. 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 Civility Saves Lives Programme - Phase 1 Launched.	Development of Staff Network Chairs and the Staff Networks	Equality, Diversity & Inclusion Steering Group - Oversight of the EDI Action Plan EDI metrics for applicants included in People Analytics dashboard															
				Level 2 – Corporate Performance Review (Monthly) including targeted 'Deep Dives' People Performance Committee - EDI Report (Biannually) - WRES and WDES Report - Gender Pay Gap report to Board - Annual EDI Report	EDI metrics to be built into People Analytics Dashboard.	Inclusion of the wider EDI metrics in People Analytics dashboard to be scoped	July 2024											
				Level 3 - Independent NHS National Staff Survey														

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 (service improvement) programmes, as identified through Trust and locality prioritisation, 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 Trust transformation programmes - Service Improvement Group (SIG) chaired by the Chief Executive. External resource in place to support Trust identified improvement programmes. Senior Responsible Officer, Clinical & Operational Lead in place for each Trust transformation programme Transformation Team supporting Stockport Provider Partnership (SPP). SPP identified key priority workstreams (Diabetes, Frailty, Cardiovascular & Alcohol Related Harm) for pathway redesign.	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	3	6	6	6	6	9	9	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 Review Board Report: Transformation Programme (Biannually)	Stockport Provider Partnership priority workstreams at various stages of implementation.													
				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. Review of the RD&I team structures and joint governance structures commenced. Input of RD&I to development of Cancer Strategy		**Level 1 – Management** Clinical Effectiveness Group - Research & Innovation Progress Report - Annual Research & Innovation Report		Review RD&I financial provision by Finance Teams, ensuring financial assurance reporting is standardised across Trusts Review to determine if can establish a single service across the two Trusts.	Q1 2024/25 Q4 2024/25	3	2	6	6	6	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. GM Productivity/Benchmarking data to support monitoring of service delivery, productivity & efficiency 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 Mandated Support & Turnaround Director appointed. 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 further industrial action post November 2023 Financial impact of Outpatients B Lack of clarity on mechanism for accessing cash support within GM Lack of clarity on Elective Recovery Fund (ERF) – Trust not currently at activity levels compared to 2019/20. Derbyshire ICB planning expectation on savings, resulting in reduction in income. GM ICS – Change in planning assumptions relating to depreciation, resulting in reduction in income. Finance workforce capacity to support regulatory submissions.	**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**	Visibility of performance against income block and non-block.	Ongoing actions from each GM Finance Recovery Meeting including actions from GM ICB Discussion with NHS England on accounting treatment of impairments of Outpatients B	End March 2024 End March 2024	4	4	16	12	16	16	16	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. PwC commissioned to support initial planning exercise 2024/25. Established Trust planning processes - Triangulates activity, workforce and cost. GM Financial Recovery Committee established - Chief Finance Officer member as Chair of GM DoFs. GM Mandated Support & Turnaround Director appointed. 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) Board review of high-level actions required in order to avoid submitting a deficit plan (June 2023) Refresh of drivers of deficit and loss making services presented to FPRM (Jan 24) 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. GM Productivity/Benchmarking data to support monitoring of service delivery, productivity & efficiency	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. Detailed planning guidance 2024/25 not yet released. Working with series of interim GM principles.	**Level 1 - Management**				4	4	16	16	16	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)		Ongoing actions from each GM Finance Recovery Meeting GM Planning Process for 2024/25 including alignment to contract value Future Funding Flows Group (GM DoFs) – Review of alignment of work undertaken and contract funding. Stockport Locality review of contracts with particular focus on community services.	Timelines for each action determined at each meeting 21st March (Draft Plan Submission) Ongoing 2024/25									
				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													

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	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		Actions from MIAA audit relating to legacy systems and asset control.	Q4 2023/24											
				Level 3 - Independent Business Continuity Confirm and Challenge NHSE ISO 27001 Information Security Management Certification – Achieved November 2023. DCB 1596 Secure Email Standard Accreditation – Achieved February 2024. 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.		Development of action plan for Data Protection & Security Toolkit (DSPT) Assessment 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. McCarthy Rebecca 28/03/2024 17:31:44	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 in place. Premises Assurance Model (PAM) Action Plan in place Estates & Facilities Performance Dashboard (Compliance & Performance Metrics) Site Development Strategy in place. Joint working arrangements with SMBC established to develop potentially community based solutions to support short to medium term development strategy.	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 Delivery/Transition plan to address highest risk capital stock and decompression of site. New 6 facet update survey currently being commissioned in accordance with planned activity.	**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	5	16	12	16	16	16	20	4	2	8
				Level 2 – Corporate Quality Committee - Health & Safety Group Key Issues Report Finance & Performance Committee - Capital Programme Management Group Key Issues Report		Additional structural surveys for all Category D assets (to be undertaken by Marston and Grundy Structural Engineers).	Develop site development strategy delivery plan to reduce maintenance costs aligned to Project Hazel Review outcome of additional structural surveys of Category D buildings. Board review of outcome of structural surveys and review of backlog maintenance	February 2024 (Progress Report) March 2024 May 2024										

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																		
		Project Board and Senior Responsible Officer identified for major capital developments		**Level 3 - Independent** Estates Return Information Collection (ERIC) Model Hospital Data Set 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 Mechanisms in place to explore and develop sustainability approach across Stockport locality. Joint appointment of Sustainability Manager between Stockport and Tameside (To commence January 2024)	Insufficient financial resources to enable optimum levels of investment to deliver sustainability improvements. Decarbonisation Plan	**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				3	4	12	8	12	12	12	12	4	2	8
				Level 2 – Corporate Annual Sustainability Report Finance & Performance Committee Estates Progress Report including Sustainability (Biannually)		Decarbonisation Plan	Q4 2023/24											
				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. Joint working arrangements with SMBC established to explore strategic regeneration of the hospital campus.	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	5	16	12	16	16	16	20	4	2	8
				Level 2 – Corporate Strategic Regeneration Framework Prospectus and Expression of Interest – Reviewed by Board		Review of funding approach with partners	Q4 2023/24											
				Level 3 - Independent														

Appendix 2 – Stockport NHS Foundation Trust Significant Risk Register (as at March 2024)

Risk ID	Business Group	Risk Title	Consequence	Likelihood	Rating	Target Rating	Change since last report
1004	Corporate – Estates and Facilities	The Trust is in breach of the Regulatory Reform (Fire Safety) Order 2005	4	4	16	4	↔
1711	Corporate – Workforce	Deterioration in employee relations and possible industrial action	4	4	16	4	↔
2596	Corporate – IT	There is a risk of total failure of the cooling in the Beech House Data Centre	4	4	16	8	↔
2677	Medicine	Risk to patient harm due to impact of closure of OPB on orthodontics Service	4	4	16	8	↔
2667	Medicine	Risk of patient harm due to loss of OP and diagnostic facilities for ophthalmology	4	4	16	8	↔
2452	Clinical Support Services	The risk of the pathology estate not being fit for purpose or safe	3	5	15	3	↔
2609	Women and Children	There is a financial risk to the Division of providing required care and support to vulnerable asylum seeking families	3	5	15	2	↔
2247	Estates and Facilities	There is a risk that electrical capacity could prevent future electrical schemes and electrical purchases	3	5	15	3	↔
288	Corporate – Nursing	There is a risk of there being an inability to provide a robust service for the insertion of VADs	3	5	15	6	↔
2715	Women and Children	Risk of children not being assessed for their continence needs in a timely way	3	5	15	6	↔
1288	Clinical Support Services	Risk that failure to achieve turnaround time targets in cell' path' will impact care for cancer patients	4	5 (↑)	20	6	↑
2690*	Medicine & ED	Risk to patient treatment as new ED HASU cannot open with current staffing levels.	5	4	20	8	NEW

2304	Medicine & ED	There is a risk of harm when patients cannot be transferred from ambulances to ED resulting in delays in diagnostics & treatment	4	4	16	8	NEW
2713	Medicine & ED	There is a risk of patient harm due to capacity not meeting demand resulting in overcrowding in ED	4	4	16	8	NEW
2196	Estates and Facilities	Dangerous & obstructive car parking occurring across the SHH Site	3	5	15	6	NEW

NHS Stockport NHS Foundation Trust

Meeting date	4th April 2024	**Public**	X	**Agenda No.**	15.
Meeting	Board of Directors				
Report Title	Standing Financial Instructions and Scheme of Reservation & Delegation				
Director Lead	John Graham, Chief Finance Officer	**Author**	Kay Wiss, Director of Finance Rebecca McCarthy, Company Secretary		

Paper For:	**Information**		**Assurance**		**Decision**	X
Recommendation:	Following recommendation by Audit Committee, the Board of Directors is asked to review and approve the Standing Financial Instructions and Scheme of Reservation & Delegation.					

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
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		Effective
	Caring		Responsive
X	Well-Led	X	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
	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
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
	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	All
Regulatory and legal compliance	All
Sustainability (including environmental impacts)	N/A

Executive Summary

The Standing Financial Instructions detail the financial responsibilities, policies and procedures to be adopted by the Trust. The Scheme of Reservation & Delegation specifically sets out the roles and responsibilities for decision making.

Collectively these documents cover all aspects of financial management and control. In effect, they set the business rules which directors and employees (including employees of third parties contracted to the Trust) must follow when acting on behalf of the Board.

Standing Financial Instructions (SFIs)
Audit Committee reviewed the revised SFIs at its meeting in February 2024. Key changes to the revised document largely reflected change to the NHS landscape and ensure references to statutory bodies and/or organisations and codes of practice are current, alongside internal changes to job titles/positions. In addition, updated reference to the Staffing Approval Group, in line with current responsibilities and the procurement section in line with latest procurement regulation and guidance.

Scheme of Reservation & Delegation (SoRD)
Audit Committee reviewed the revised SoRD at its meeting in February 2024. Key changes to the revised document were the inclusion of the Reservation of Powers for the Council of Governance and Delegation of Powers to Committees. This is in line with best practice and supports compliance with the code of

governance for provider trusts (2022). In addition, the revised document reflects the operation and further decision-making role of the Staffing Approval Group, and business case approval process. There are no proposed changes to the levels of expenditure authorisation for budget holders.

With respect to the Annual Report & Accounts and Charity Annual Report & Accounts, the document has been updated enabling the Board to receive the annual report and accounts and ensure appropriation delegation for approval to the Audit Committee / Charitable Funds Committee respectively.

1. Purpose

1.1 The Standing Financial Instructions (SFIs) detail the financial responsibilities, policies and procedures to be adopted by the Trust. They are designed to ensure that the Trusts financial transactions are carried out in accordance with the law and government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness.

1.2 The Scheme of Reservation and Delegation (SoRD) details who is responsible for what decision making in the organisation and is a key financial governance document.

1.3 Collectively these documents must comprehensively cover all aspects of financial management and control. In effect, they set the business rules which directors and employees (including employees of third parties contracted to the Trust) must follow when acting on behalf of the Board.

1.4 This paper presents the outcome of the review of the documents, for approval by the Board.

2. Background & Links to Previous Papers

2.1 The SFIs were last reviewed and approved by the Board of Directors in June 2021, revision at this time were largely reflective of changes to national policy.

2.1 The previous update to the SoRD was extensive, due to both internal changes and the changing NHS landscape. This review took place in 2022/23; the final version was approved by the Board of Directors in December 2022.

Key changes at this time reflected revision to the internal divisional and executive structure, alongside changes to levels of expenditure post covid. In response to recommendations from internal audit, procurement expenditure levels and full tender thresholds were clarified, and subsequent amendments made to the waiver form.

Changes in the NHS landscape and the joint working across Greater Manchester (GM) and other partners meant that a new section was included for the transfer of services between providers.

In addition, key areas of approval on pay were updated, reflecting national focus on sustainability and keeping control of costs. To give clarity and affirm financial governance over approval of financial staffing decisions the temporary staffing approval group was confirmed as the “Staffing Approval Group” and reflected in the section on Workforce and Pay.

3. SFIs and SoRD Review 2023/24

3.1 A management review of the SFIs and SoRD was undertaken by the Director of Finance, Trust Secretary and the Deputy Director of Strategy and Partnerships. Other Executive Directors and their deputies were consulted on specific points, where required, and the revised documents considered by the Executive Team.

The revised documents, highlighting tracked changes, were subsequently reviewed by Audit Committee at its meeting on 20th February 2024.

3.2 **Standing Financial Instructions** - The revised SFI's are attached as Appendix 1, including a table of key amendments.

3.3 Within the current review, key changes largely reflect changes to the NHS landscape, and internal changes to job titles/positions.

3.4 Reference to the Staffing Approval Group has been updated reflecting the groups' role to authorise and monitor requested changes to the Trust's staffing levels and establishment figures.

3.5 Furthermore, update to the procurement section supports practice in line with latest procurement regulation and guidance.

3.6 References to statutory bodies/organisations and codes of practice have been updated also to make current.

3.7 **Scheme of Reservation & Delegation** – The revised SoRD is attached as Appendix 2, including table of key amendments.

3.8 A key change is the inclusion of the Reservation of Powers for the Council of Governance, reflecting the statutory duties of governors. In addition, a section on Delegation of Powers to Committees is included. Both sections are in line with best practice and support compliance with the code of governance for provider trusts (2022).

3.9 In addition, the role of the Staffing Approval Group in decision making on workforce/pay related matters has also been updated. Audit Committee sought clarification on the changes to the approval for pay for waiting list initiatives and unusual pay items over £2,500, previously requiring approval of Audit Committee. It was confirmed that this had been included in the original SoRD, with only one instance when happened. With the establishment of the Staffing Approval Group, attended by all Executive Directors, it was considered an operational matter of detail, with all approvals documented through the Staffing Approval Group and the Director of Finance would be required to formally authorise.

3.10 With respect to the Annual Report & Accounts and Charity Annual Report & Accounts, the document has been updated enabling the Board to receive the annual report and accounts and ensure appropriation delegation for approval to the Audit Committee / Charitable Funds Committee respectively.

3.11 The business case approval process has been updated to reflect current arrangements.

3.12 There are no changes to proposed to levels of expenditure authorisation for budget holders.

4. Implementation

4.1 Subject to approval by the Board of Directors, updates in the Standing Financial Instructions and SoRD will be distributed to all budget holders as part of regular updates and training sessions.

Stockport
NHS Foundation Trust

STANDING FINANCIAL INSTRUCTIONS

This document is for the use of Stockport NHS Foundation Trust employees only

FOREWORD

1. References to the "Board" in these Standing Financial Instructions (SFIs) apply to the Board of Directors of Stockport NHS Foundation Trust.

2. These Standing Financial Instructions (SFIs) are issued in accordance with the Financial Directions issued by the Secretary of State – under the provisions of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) – for the regulation of the conduct of the Trust in relation to all financial matters. They shall have effect as if incorporated in the Standing Orders (SOs) of the Trust.

3. The Code of Accountability for NHS Boards (published by the Department of Health in April 1994, EL(94)40 and updated in April 2023) requires Boards to draw up standing orders, a schedule of decisions reserved to the board and standing financial instructions. The code also requires Boards to ensure that there are management arrangements in place to enable responsibility to be clearly delegated to senior executives. Additionally, Boards are required to draw up locally generated rules and instructions, including financial procedural notes, for use within their organisation.

4. Collectively these must comprehensively cover all aspects of financial management and control. In effect, they set the business rules which directors and employees (including employees of third parties contracted to the Trust) must follow when taking action on behalf of the Board.

5. The purpose of this document is to provide clarity about the financial framework in which the Trust provides patient services. Once SFIs have been adopted by the Board of Directors they become mandatory on all directors and employees of the organisation.

CONTENTS

1. INTRODUCTION

1.1 General

1.1.1 These Standing Financial Instructions are issued in accordance with financial provisions of The National Health Service Act 2006, and The Health and Social Care Act 2012, as amended by The Health and Care Act 2022 for the regulation of the conduct of foundation trusts in relation to all financial matters. They shall have effect as if incorporated in the Trust's Standing Orders

1.1.2 Stockport NHS Foundation Trust ("the Trust") became a Public Benefit Corporation on the 1st April 2004, following authorisation by Monitor, Monitor), the independent regulator of NHS Foundation Trusts at that time. NHS England has now replaced Monitor as the independent regulator. The Terms of Authorisation for the Foundation Trust that require compliance with the principles of best practice applicable to corporate governance within the NHS / Health Sector with any relevant code of practice and guidance issued by NHS Improvement.

1.1.3 These Standing Financial Instructions (SFIs) are issued for the regulation of the conduct of its members and officers in relation to all financial matters with which they are concerned. They are issued in accordance with the Code of Accountability which requires that each NHS Foundation Trust shall give, and may vary or revoke, Standing Financial Instructions for the regulation of the conduct of its members and officers in relation to all financial matters with which they are concerned.

1.1.4 The NHS Oversight Framework details how NHS England oversees and supports all NHS Trusts; Additional financial guidance is included in Code of Audit Practice, NHS Foundation Trust Annual Reporting Manual and the Department of Health and Social Care Group Accounting Manual (DH GAM). These documents as well as other relevant guidance may be updated, replaced or superseded from time to time.

1.1.5 These Standing Financial Instructions (SFIs) detail the financial responsibilities, policies and procedures to be adopted by the Trust. They are designed to ensure that its financial transactions are carried out in accordance with the law and Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with Schedule of Decisions reserved to the Board and the Scheme of Delegation adopted by the Trust (collectively called the "Scheme of Reservation & Delegation" (SoRD)).

1.1.6 These SFIs identify the financial responsibilities which apply to everyone working for the Trust and its constituent organisations including Trading Units.

They do not provide detailed procedural advice. These statements should therefore be read in conjunction with the detailed departmental and have financial procedure notes and all financial procedures must be approved by the Chief Finance Officer

1.1.7 Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Chief Finance Officer MUST BE SOUGHT BEFORE TAKING ACTION. The user of these SFIs should also be familiar with and comply with the provisions of the Trust's Constitution.

IT SHOULD BE NOTED THAT THE FAILURE TO COMPLY WITH THE SFIS, CONSTITUTION AND SORD IS A DISCIPLINARY MATTER WHICH COULD RESULT IN DISMISSAL.

1.2 Terminology

1.2.1 Any expression to which a meaning is given in Health Service Acts, or in the Financial Directions made under the Acts, shall have the same meaning in these instructions; and

	Definition
the 2022 Act	*The Health and Care Act 2022*
the 2012 Act	*The Health and Social Care Act 2012*
the 2006 Act	*Means the National Health Service Act 2006;*
the 2003 Act	the Health and Social Care (Community Health and Standards) Act 2003;
the 1977 Act	*the National Health Service Act 1977;*
Accounting Officer	is the Officer responsible and accountable for funds entrusted to the Foundation Trust in accordance with the NHS Foundation Trust Accounting Officer Memorandum. They are responsible for ensuring the proper stewardship of public funds and assets. The National Health Service Act 2006 designates the Chief Executive of the NHS Foundation Trust as the Accounting Officer.
Agenda Item	an item from a Governor(s) or Board member (notice of which has been given) about a matter over which the Council/Board has powers or duties or which affects the services provided by the Foundation Trust
authorisation	means an authorisation given by the Independent Regulator.
the Board of Directors	means the Board of Directors as constituted in accordance with the Constitution;

	Definition
The Council of Governors	means the Council of Governors as constituted in accordance with the Constitution
Budget Holder	Means the officer with delegated authority to manage income and expenditure for a specific area of the organisation; and budget manager means the officer who has daily operational responsibility for the management of the budget
Budget	Means a resource, expressed in financial or manpower terms, proposed by the Board, for the purpose of carrying out, for a specific period, any or all of the functions of the Foundation Trust
The Chair	means the Chairman of the Foundation Trust, or, in relation to the function of presiding at or chairing a meeting where another person is carrying out that role as required by the Constitution, such person;
Chief Executive	The chief officer (and accounting officer) of the Foundation Trust
Chief Finance Officer	means the Chief Financial Officer of the Trust advising the Board on financial matters.
Committee	a committee or sub-committee created and appointed by the Foundation Trust.
CONCODE	Is a code of procedure for building and engineering contracts for the NHS
Constitution	Constitution of Stockport NHS Foundation Trust, describes the type of organisation, its primary purpose, governance arrangements and membership.
Contracting and Procuring	the systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.
Corporate Trustee	means a corporation that has been appointed to act as trustee of a charity. A corporation is a collection of persons, which, in the eyes of the law, has its own legal existence (and rights and duties) separate from those of the persons who form it from time to time. The Board is the corporate trustee for the Stockport NHS Charity.
Deputy Chair	the Deputy Chairman of the trust
Director	*means a member of the Board of Directors;*
Estate code	Is written guidance from the Department of Health on property transactions and is considered best practice
Executive director	an executive director of the trust

	Definition
financial auditor	*means the person appointed to carry out the functions set out in the 2006 Act (referred to as the auditor);*
Financial year	*means* *(a) the period beginning with the date on which the Trust is authorised and ending with the next 31st March; and* *(b) each successive period of twelve months beginning with 1st April;*
the Foundation Trust	Means Stockport NHS Foundation Trust;
Funds held on Trust	Means those funds which the Foundation Trust holds at its date of incorporation, received on distribution by statutory instrument, or chooses subsequently to accept under powers derived under the NHS 2006 Act
Foundation Trust Contract	Agreement between the Foundation Trust, Clinical Commissioning Groups and other bodies for the provision and commissioning of health services.
governor	a governor on the Council of Governors and being either an elected governor or an appointed governor
member	means a member of the Trust;
membership	membership of the trust through being a member of one of the constituencies
members' meetings	a meeting of the members and being either an Annual Members' Meeting or a Special Members' Meeting
Monitor	the independent regulator (Monitor) for the purposes of the 2006 Act; Replaced by NHS Improvement from 1.4.2019
Motion	A formal proposition to be discussed and voted on during the course of a meeting
NHS England	means the body responsible for overseeing foundation trusts, NHS trusts, independent providers and commissioning organisations
Nominated Officer	an officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.
non-executive directors	a Director who is not an officer of the Foundation Trust and is not treated as an officer by virtue of the constitution
Officer	Means an employee of the Foundation Trust.
partner	means, in relation to another person, a member of the same household living together as a family unit;
Protected Property	Means the property identified in the terms of authorisation as being protected. This will generally be property that is required

	Definition
	for the purposes of providing the mandatory goods and services and mandatory education and training
Secretary	*Means the secretary of the foundation trust or any other person appointed to perform the duties of the secretary, including a joint, assistant or deputy secretary;*
Service Agreement	In the context of provision of services, means an agreement in the form of a legally binding contract between organisations for the treatment of patients by the Trust in return for agreed levels of payment.
Standing Financial Instructions	(SFIs) regulate the conduct of the Trusts financial matters
Standing Orders	(SOs) incorporate the Constitution and regulate the business conduct of the Foundation Trust
Terms of Authorisation	Means the authorisation document issued by monitor, conferring Foundation Trust status on the organisation

All references to the masculine gender will be deemed to apply equally to the feminine gender when used with these instructions.

1.2.2 Wherever the title Chief Executive, Chief Finance Officer, or other nominated employee is used in these instructions, it shall be deemed to include such other directors or employees who have been duly authorised to represent them.

1.2.3 Wherever the term “employee” is used, and where the context permits, it shall be deemed to include employees of third parties contracted to the Trust when acting on behalf of the Trust.

1.3 RESPONSIBILITIES AND DELEGATION

1.3.1 The Trust shall at all times remain a going concern.

Trust Board of Directors

1.3.2 The Board of Directors exercises financial supervision and control by:

a) formulating the financial strategy;
b) requiring the submission and approval of budgets;

c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money) and by ensuring appropriate audit provision.
d) defining specific responsibilities placed on directors and employees as indicated in the Scheme of Delegation document ; and
e) developing strong cash and treasury management policies and procedures.

1.3.3 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the 'Reservation of Powers to the Board of Directors' document, published within the Scheme of Delegation document.

1.3.4 The Board will delegate responsibility for the performance of its functions in accordance with the Scheme of Delegation document adopted by the Trust.

The Chief Executive and Director of Finance

1.3.5 The Chief Executive and Chief Finance Officer will, as far as possible, delegate their detailed responsibilities as permitted by its Constitution but they remain accountable for financial control.

1.3.6 Within the SFIs, it is acknowledged that the Chief Executive is ultimately accountable to the Board and as the accountable officer to NHS England for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities, is responsible to the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

1.3.7 The general and specific responsibilities of the Chief Executive as the Accounting Officer for the Trust are outlined in more detail in the NHS Foundation Trust Accounting Officer Memorandum published by NHS England.

1.3.8 It is a duty of the Chief Executive to ensure that Members of the Board, employees and all new appointees are notified of, and put in a position to understand their responsibilities within, these SFIs. All staff shall be responsible for ensuring conformity with the Standing Financial Instructions and financial procedures of the Foundation Trust.

Chief Finance Officer

1.3.8 The Chief Finance Officer is responsible for:

a) the SFIs and for keeping them appropriate and up to date
b) implementing the Trust's financial policies and for coordinating any corrective action necessary to further these policies (the SFIs themselves do not provide detailed procedural advice. These statements should therefore be read in conjunction with the detailed departmental and financial procedure notes);
c) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal check are prepared, documented, and maintained to supplement these instructions;
d) ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time
e) without prejudice, to any other functions of directors and employees of the Trust, the duties of the Chief Finance Officer include:

i. the provision of financial advice to the Trust and its directors and employees;
ii. the design, implementation and supervision of systems of internal financial control; and
iii. the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its work including its statutory duties.

Board of Directors and Employees

1.3.9 All directors of the Board and employees, individually and collectively, are responsible for:

a) the security of the property of the Trust;
b) avoiding loss;
c) exercising economy, efficiency and effectiveness (i.e. value for money) in the use of resources; and
d) conforming to the requirements of NHS England, the Terms of Authorisation, the Constitution, Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.
e) notifying the Chief Finance Officer of any known instances of non-compliance with Standing Financial Instructions.

Contractors and their employees

1.3.10 Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall

be covered by these instructions. It is the responsibility of the appropriate Director to ensure that such persons are made aware of this.

1.3.11 For any and all directors and employees who carry out a financial function, the form in which financial records are kept and the manner in which directors and employees discharge their duties must be to the satisfaction of the Chief Finance Officer.

1.4 Escalation for non-compliance

1.4.1 Any instance of non-compliance with Standing Financial Instructions must be notified to the Chief Finance Officer as soon as it has been identified.

1.4.2 The Chief Finance Officer will investigate all significant instances and report the detailed circumstances of each to Audit Committee at its next meeting.

1.4.3 The Chief Finance Officer will determine what disciplinary or other action, if any, is necessary, having sought appropriate advice from the Director of People and Organisational Development.

1.4.4 If the Chief Finance Officer is suspected of breaching Standing Financial Instructions, then this should be notified to the Chief Executive who will similarly take action identified above.

1.4.5 Any potential breaches of Standing Financial Instructions by executive directors will be escalated to the Chair of the Audit Committee, who will advise on further actions to be instigated in accordance with the approved Governance and Compliance Framework. Any such breaches not involving the Chief Finance Officer will also be reported to the Chief Finance Officer.

2. AUDIT

2.1 AUDIT COMMITTEE

2.1.1 In accordance with the Constitution, the Board of Directors shall formally establish an Audit Committee of non-executive directors, consistent with 'Code of governance for NHS provider Trusts', with clearly defined Terms of Reference and following guidance from the NHS Audit Committee Handbook and Foundation Trust Governance requirements.

2.1.2 The Audit Committee's primary role is to conclude upon the adequacy and effective operation of the Trust's overall control system. In performing that

role the Committee's work will predominantly focus upon the framework of risks, controls and related assurances that underpin the delivery of the Trust's objectives.

2.1.3 The Audit Committee will review the adequacy of:

a) the integrity of the financial statements and any formal announcements relating to the Trust's financial performance, reviewing significant financial reporting judgements contained therein.
b) the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.
c) all risk and control related disclosure statements;
d) the underlying assurance processes;
e) the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements;
f) the policies and procedures for all work relating to fraud and corruption;
g) the Trust's internal financial controls;

Additionally, the Audit Committee will be responsible for:

h) monitoring compliance with Standing Orders and Standing Financial Instructions.
i) reviewing the appropriateness of waiving quotation and tender requirements in accordance with Section 11.5 and Appendix 8.
j) reviewing schedules of losses and compensations and making recommendations to the Board.

2.1.4 The Audit Committee may also review arrangements by which staff of the Trust may raise concerns about possible improprieties in matters of financial reporting and control, clinical quality or patient safety. All such concerns are to be treated in confidence and the Committee should ensure that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow up action.

2.1.5 The Board of Directors shall satisfy itself that at least one member of the Audit Committee has recent and relevant financial experience.

2.1.6 Where the Audit Committee considers that there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the committee wishes to raise, the Chair of the Audit Committee should raise the matter at a full meeting of the Board. Exceptionally, the matter should be referred to the Chief Finance Officer in the first instance and may need to be referred to NHS England.

2.1.7 It is the responsibility of the Chief Finance Officer to ensure an adequate Internal Audit and Counter Fraud service is provided and the Audit Committee shall be involved in the selection process when an Internal Audit service provider is changed.

2.1.8 It is the responsibility of the Council of Governors to appoint, and where necessary remove the Financial Auditor. The Audit Committee will ensure an adequate Financial Audit service is provided and make recommendations to the Council of Governors, in relation to the appointment, re-appointment and removal of the Financial Auditor, and remuneration and Terms of Engagement of the Financial Auditor.

2.1.9 Similarly, the Audit Committee shall report to the Council of Governors, identifying any matters in respect of which it considers that action or improvement is needed and making recommendations as to the steps to be taken in accordance with 'Code of governance for NHS provider Trusts'.

2.2 FRAUD, CORRUPTION AND BRIBERY

2.2.1 In line with their responsibilities, the Chief Executive and the Chief Finance Officer shall monitor and ensure compliance with the Government Functional Standard (GovS 013: Counter Fraud) Management of Counter Fraud, Bribery and Corruption Activity issued by the Counter Fraud Centre of Expertise, part of the Cabinet Office) and NHS Standard Contract Service Condition 24 to put in place and maintain appropriate anti-fraud, bribery and corruption arrangements and in accordance with all best practice guidance published by the NHS Counter Fraud Authority.

The Chief Executive is the executive board member responsible for countering fraud, bribery and corruption in the Trust.

2.2.2 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist (LCFS), to conduct the full range of anti-fraud, bribery and corruption work on behalf of the Trust as specified in the NHS Counter Fraud Authority anti-crime standards.

2.2.3 The Local Counter Fraud Specialist shall report to the Trust's Chief Finance Officer and shall work with the staff in the NHS Counter Fraud Authority, in accordance with the NHS Counter Fraud Authority anti-crime standards, the anti-fraud manual and the NHS Counter Fraud Authority's Investigation Case File Toolkit.

2.2.4 If it is considered that evidence of offences exists and that a prosecution is desirable, the LCFS will consult with the CFO to obtain the necessary authority and agree the appropriate route for pursuing any action e.g. referral to the police or NHS Counter Fraud Authority.

2.2.5 The Local Counter Fraud Specialist will provide a written report, at least annually, on anti-fraud, bribery and corruption work within the Trust to the Audit Committee.

2.2.6 The LCFS will ensure that measures to mitigate identified risks are included in an organisational work plan which ensures that an appropriate level of resource is available to the level of any risks identified. This work plan shall be agreed with the Audit Committee at the beginning of each financial year, with progress against the plan being reported back to the Audit Committee.

2.2.7 In accordance with the Raising Concerns Policy, the Trust shall have a whistle-blowing mechanism to report any suspected or actual fraud, bribery or corruption matters and internally publicise this, together with the national fraud and corruption reporting line provided by the NHS Counter Fraud Authority.

2.2.8 The Trust will report annually on how it has met the standards set by the NHS Counter Fraud Authority in relation to anti-fraud, bribery and corruption work and the CFO shall sign-off the annual self-review and authorise its submission to the NHS Counter Fraud Authority. The CFO shall sign-off the annual qualitative assessment (in years when this assessment is required) and submit to the relevant authority.

2.2.9 The Trust's Local Anti-Fraud, Bribery and Corruption policy applies to all staff and must be read in conjunction with these SFI's.

2.3 CHIEF FINANCE OFFICER

2.3.1 The Chief Finance Officer is responsible for:

a) ensuring that there are arrangements to review, evaluate and report on the effectiveness of internal financial control, including the establishment of an effective Internal Audit function and the coordination of other assurance arrangements;
b) ensuring that the Internal Audit service to the Trust is adequate and meets the NHS England's mandatory internal audit standards;
c) deciding at what stage to involve the Police in cases of fraud, misappropriation, and other irregularities;

d) ensuring that an annual Internal Audit report is prepared for the consideration of the Audit Committee and the Board. The report must cover:

i. a clear statement on the effectiveness of internal controls in accordance with current assurance framework guidance issued by the Department of Health and Social Care, including for example compliance with control criteria and standards. This opinion provides assurance to the Accounting Officer, especially when preparing the "Statement of Internal Control" and also provides assurances to the Audit Committee;
ii. any major internal control weaknesses discovered,
iii. progress on the implementation of Internal Audit recommendations
iv. progress against plan over the previous year
v. a strategic audit plan covering the coming three years, and
vi. a detailed plan for the coming year.

2.3.2 The Chief Finance Officer or designated auditors is entitled without necessarily giving prior notice (although this will usually be given unless circumstances warrant otherwise) to require and receive:

a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;
b) access at all reasonable times to any land, premises, members of the Board of Directors or employees of the Trust;
c) the production of any cash, stores or other property of the Trust under a member of the Board and an employee's control; and
d) explanations concerning any matter under investigation.

2.4 ROLE OF INTERNAL AUDIT

2.4.1 The NHS Foundation Trust Accounting Officer Memorandum requires the Foundation Trust to have an internal audit function. Internal Audit provides an independent and objective opinion to the Chief Executive, Audit Committee and Board on the degree to which risk management, control and governance support the achievement of the Trust's agreed objectives.

2.4.2 Internal Audit will review, appraise and report upon:

a) the extent of compliance with, and the financial effect of compliance with, relevant established policies, plans and procedures;
b) the adequacy and application of financial and other related management controls;

c) the suitability of financial and other related management data;
d) the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:
   i. fraud and other offences,
   ii. waste, extravagance and inefficient administration,
   iii. poor value for money or other causes, and
   iv. risk of all kinds.
e) The efficient and effective use of resources
f) The adequacy of follow up actions by the Trust to internal audit reports
g) Any investigations / project work agreed with and under the terms of reference agreed with the Chief Finance Officer and the Chair of the Audit Committee

2.4.2 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Chief Finance Officer must be notified immediately. In the case of alleged or suspected fraud, the Local Counter Fraud Service (LCFS) must be notified.

2.4.3 The Head of Internal Audit will normally attend Audit Committee meetings and will have a right of access to all Audit Committee members and the Chair and Chief Executive of the Trust.

2.4.4 The Head of Internal Audit shall be accountable to the Chief Finance Officer for the fulfilment of the service level agreement/contract.

2.4.5 The reporting system for Internal Audit shall be agreed between the Chief Finance Officer, the Audit Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the NHS Internal Audit Standards. The reporting system shall be reviewed every three years. Where, in exceptional circumstances, the use of normal reporting channels is thought to limit the objectivity of the audit, the Head of Internal Audit shall have access to report direct to the Chairman or a non-executive member of the Foundation Trust's Audit Committee.

2.4.6 Managers in receipt of audit reports referred to them, have a duty to take appropriate remedial action within the agreed timescales specified within the report. The Chief Finance Officer shall identify a formal review process to monitor the extent of compliance with audit recommendations. Where appropriate, when remedial action has failed to take place by the Manager within a reasonable period, the matter shall be reported to the Chief Finance Officer.

2.5 Financial Audit (may be referred to as External Audit)

2.5.1 Duties

The Foundation Trust is to have a financial auditor and is to provide the financial auditor with every facility and all information which they may reasonably require for the purposes of their functions.

The financial auditor is to carry out their duties in accordance with the Health and Social Care Act 2012 and in accordance with any directions given by NHS England on standards, procedures and techniques to be adopted.

In auditing the accounts the financial auditor must, by examination of the accounts and otherwise, satisfy themselves that the Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

The Foundation Trust is required to include a statement on internal control within the financial statements. The financial auditors have a responsibility to:

- consider the completeness of the disclosures in meeting the relevant requirements; and
- Identify any inconsistencies between the disclosures and the information that they are aware of from their work on the financial statements and other work.

2.5.2 Appointment of Financial Auditor

The financial auditor is appointed by the Council of Governors with advice from the Audit Committee.

The Code of Audit Practice sets out what local auditors of relevant public bodies are required to do to fulfil their statutory responsibilities under the Local Audit and Accountability Act 2014. Schedule 6 of the Act extends this requirement to include NHS foundation trusts. The financial auditor must comply with the code of practice.
A person may only be appointed as the financial auditor if they (or in the case of a firm of each of its members) are a member of one or more of the bodies referred to in the 2012 Act.

The Council of Governors at a General Meeting shall appoint or remove the Foundation Trust's financial auditor.

The Board of Directors may resolve that external auditors be appointed to review and publish a report on any other aspect of the Foundation Trust's performance. Any such auditors are to be appointed by the Council of Governors.

2.5.3 Undertaking Work

Prior approval must be sought from the Audit Committee and the Council of Governors should also be notified, for each discrete piece of additional audit work awarded to the financial auditors; this is work over and above the audit plan approved at the start of the year.

The auditor may provide the Foundation Trust with services which are outside of the scope as defined in the code (additional services). The Foundation Trust shall apply their policy for considering and approving any additional services to be provided by the auditor, with a report in retrospect to the Council of Governors.

2.5.4 Liaison with Internal Audit

It is expected that the financial auditors will liaise with the internal audit function in order to obtain a sufficient understanding of internal audit activities to assist in planning the audit and developing an effective audit approach. The auditors may also wish to place reliance upon certain aspects of the work of internal audit in satisfying their statutory responsibilities as set out in the 2012 Act and the Audit Code. In particular the financial auditor may wish to consider the work of internal audit when undertaking their procedures in relation to the statement on internal control.

2.5.5 Access to Documents

The Auditors of the Foundation Trust have a right of access at all reasonable times to every document relating to the Foundation Trust which appears to them necessary for the purpose of their functions.

2.5.6 Public Interest Report

In the event of the External Auditor issuing a Public Interest report the Foundation Trust shall:

- Send the public interest report to the Council of Governors, the Board of Directors and NHS England:
- At once if it is an immediate report, or
- Not later than 14 days after conclusion of the audit

- Forward a report to NHS England within 30 days (or such shorter period as NHSE may specify) of the report being issued. The report shall include details of the Foundation Trust's response to the issues raised within the Public Interest report.

2.6 SECURITY MANAGEMENT

2.6.1 In line with their responsibilities, the Chief Executive will monitor and ensure compliance with Directions issued by the Secretary of State and NHS England to put in place and maintain appropriate security management arrangements, having regards to the NHS Counter Fraud Authority's standards.

2.6.2 The Foundation Trust shall promote and protect the security of people engaged in activities for the purposes of the health service functions of that body, its property and its information in accordance with the requirements of the 'Foundation Trust Contract', having regard to any other reasonable guidance or advice issued by the NHS Counter Fraud Authority.

2.6.3 The Foundation Trust shall nominate and appoint a local security management specialist (LSMS) as specified in the NHS Counter Fraud Authority anti-crime standards.

2.6.4 The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Security Management Director (SMD) who is the Director of Estates and Facilities and also to the appointed LSMS.

2.6.5 The Trust shall nominate a Non-Executive Director to be responsible to the Board for NHS Security Management.

3. BUSINESS PLANNING, BUDGETS, BUDGETARY CONTROL AND MONITORING

3.1 PREPARATION AND APPROVAL OF BUSINESS PLANS AND BUDGETS

3.1.1 In accordance with the annual planning cycle, the Chief Executive will compile and submit to the Board of Directors the annual "Operational Plan" which takes into account financial targets and forecast limits of available resources. The Trust Operational Plan will contain:

a) a statement of the significant assumptions on which the plan is based;

b) details of major changes in workload, delivery of services or resources required to achieve the plan;
c) the financial plan for the year
d) other contents and details as determined by NHS England.

3.1.2 The annual Operational Plan must be submitted to NHS England in accordance with their requirements set out in the planning guidance. The period of time over which the plans are to be submitted will vary according to the planning guidance.

3.1.3 Prior to the start of the financial year the Chief Finance Officer will, on behalf of the Chief Executive, prepare and submit an annual financial plan that takes into account financial targets and forecast limits of available resources for approval by the Board of Directors.

Such budgets will:

a) be in accordance with the objectives set out in the Trust Operational Plan;
b) accord with demand, workload and capacity plans;
c) be produced following discussion with appropriate budget holders
d) identify potential risk
e) Have due consideration of the impact on the quality and safety of patient care;
f) be prepared within the limits of available funds;
g) be based on reasonable and realistic assumptions; and
h) enable the Foundation Trust to comply with the whole regulatory framework

3.1.4 The Trust Operational Plan, which will include the annual budget, will be submitted to the Council of Governors in a general meeting.

3.1.5 The local Integrated Care System will be responsible for reviewing the Trust's financial plan as part of its co-ordinating role in compiling a system wide plan for submission to NHS England.

3.1.6 The Chief Finance Officer shall monitor financial performance against budget and the Operational Plan, periodically review them, and report to the Board. Any significant variances should be reported by the Chief Finance Officer to the Trust Board as soon as they come to light and the Board shall be advised of action to be taken in respect of such variances.

3.1.7 All budget holders must provide information as required by the Chief Finance Officer to enable budgets to be compiled.

3.1.8 The Chief Finance Officer has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage their budgets successfully.

3.2 OPERATING PLAN AND BUDGET SETTING PROCESS

3.2.1 The Chief Finance Officer will submit to the Board of Directors a paper outlining the annual budget setting process for the year. This will include a baseline formed from a set of clearly defined assumptions.

3.2.2 Each Division and Director will be asked to submit a list of Service Developments and cost pressures for consideration in budget setting, as part of the Strategic Review process. Only approved service developments will be incorporated into delegated budgets. Service developments will require business cases which will then require approval as per the Trust Approval process.

3.2.3 The Chief Executive, Chief Finance Officer and Director of Strategy and Partnerships will set an annual process for approving service development business cases to be incorporated into the budget and Operational Plan.

3.2.4 Each Division and Director will be asked to provide assumptions for the setting of the Trust's Income and Activity Plan. These will be considered alongside external factors including Commissioner plans in order to set the Trust's income budget.

3.2.5 The Chief Finance Officer will set a Cost Improvement Programme (CIP) savings target, delegated to each budget holder.

3.2.6 The Chief Finance Officer may set reserves to cover unknown cost pressures at the planning stage, which may then subsequently be delegated in-year.

3.3 IN-YEAR ADJUSTMENTS TO BUDGETS

3.3.1 The Chief Finance Officer may authorise budget virements in the following circumstances:
a) To reflect an in-year business case approved by the relevant committee;
b) To distribute reserves set to cover cost pressures that were unknown at the planning stage;
c) To reflect where the distribution of income and expenditure has materially changed from the original plan, where this is net neutral. For example, to

reflect the reality of CIP delivery where this changes materially from the original planning assumption.

3.3.2 Budget virements for in-year business cases can only be allocated on an overall neutral basis, to ensure the budget remains balanced to the Operational Plan. Additional expenditure will require funding via additional income assumptions, release of reserves or additional savings in another part of the budget.

3.3.3 With the exception of budget transfers and virements there will be no changes to budgets in year unless duly authorised via the approval of a business case. Only expenditure that has already been budgeted for can be committed by budget holders and in accordance with their delegated spending limits.

3.4 BUDGETARY DELEGATION

3.4.1 The Chief Executive, through the Chief Finance Officer, may delegate the management of a budget to permit the performance of a defined range of activities. This delegation will be in accordance with the financial plan and the Scheme of Delegation, both approved by the Board. This delegation must be in writing and be accompanied as appropriate by a clear definition of:

a) the amount of the budget;
b) the purpose(s) of each budget heading;
c) individual and group responsibilities;
d) achievement of planned levels of service; and
e) the provision of regular reports.

3.4.2 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.

3.4.3 The Chief Finance Officer is responsible for maintaining the lists of authorised signatories and their delegated transactional financial limits. Managers are responsible for advising the Chief Finance Officer of all changes in accordance with agreed procedures.

3.4.4 Except where otherwise approved by the Chief Executive, taking account of advice from the Chief Finance Officer, budgets shall only be use for the purpose for which they were provided.

3.4.4 Any budgeted funds not required for their designated purpose(s) will revert to the immediate control of the Chief Finance Officer, subject to guidance on budgetary control in the Trust.

3.4.5 Non-recurring budgets should not be used to finance recurring expenditure without the prior written authority of the Chief Finance Officer or the Chief Executive.

3.4.6 Budget holders are expected to sign their acceptance of their annual expenditure budget.

3.5 BUDGETARY CONTROL, FORECASTING AND REPORTING

3.5.1 The Chief Finance Officer will devise and maintain a system of budgetary delegation and control. This will include:

a) monthly financial reports to the Board and the Finance & Performance Committee in a form approved by the Board and the Finance & Performance Committee containing:

   (i) monthly income and expenditure to date showing trends and forecast year-end position;
   (ii) movements in working capital and cash;
   (iii) capital project spend, commitments and projected outturn against plan;
   (iv) explanations of any material variances from plan, including variances from planned cost improvement programmes;
   (v) details of any corrective action where necessary; and
   (vi) the Chief Executive's and/or Chief Finance Officer's view of whether such actions are sufficient to correct the situation.

b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;
c) investigation and reporting of variances from financial, activity and workforce budgets;
d) monitoring of management action to correct variances;
e) arrangements for the authorisation of budget transfers virements; and
f) advising the Chief Executive and Foundation Trust Board of Directors of the consequences of changes in policy, pay awards and other events and trends affecting budgets and shall advise on the economic and financial impact of future plans and projects; and
g) review of the bases and assumptions used to prepare the budgets.

3.5.2 In the performance of these duties the Chief Finance Officer will have access to all budget holders and budget managers on budgetary matters and shall be provided with such financial and statistical information as is necessary.

3.5.3 Each Budget Holder is responsible for ensuring that:

a) any planned or known overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Board;
b) officers shall not exceed the budget limit set;
c) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement; and
d) no permanent employees are appointed without the approval of the Chief Executive other than those provided for in the budgeted establishment as approved by the Board.
e) Permanent employees are appointed in accordance with agreed procedures and numbers provided for in the budgeted establishment as approved by the Board.
f) Their use of temporary staff complies with Trust policies.

3.5.4 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Operational Plan and to ensure compliance with NHS England's Use of Resources regime and requirement's of other monitoring organisations.

3.6 CAPITAL EXPENDITURE

3.6.1 The general rules applying to delegation and reporting shall also apply to capital expenditure. Accounting for fixed assets must comply with the NHS Foundation Trust Annual Reporting Manual. The particular applications relating to capital are contained in Chapter 11.

3.7 MONITORING RETURNS

3.7.1 The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to NHS England and any requisite monitoring organisations within specified timescales.

3.7.2 The performance figures reported to NHS England should reflect the same figures report to the Board of Directors, though not necessarily in the same format. A reporting hierarchy will be maintained in order to ensure transparency of reporting throughout the Trust.

4 ANNUAL REPORT, ACCOUNTS AND ANNUAL QUALITY REPORT

4.1 Annual Accounts

4.1.1 The Foundation Trust is to keep accounts in such form as NHS England may direct with the approval of HM Treasury. The accounts are to be audited by the Trust's financial auditor in accordance with appropriate international auditing standards.

4.1.2 The following documents will be made available to the Comptroller and Auditor General for examination at his request:

a) the accounts;
b) any records relating to them; and
c) any report of the financial auditor on them.

4.1.3 The Chief Finance Officer, on behalf of the Trust, will prepare annual accounts in accordance with International Financial Reporting Standards, as adjusted from time to time with accounting policies and guidance issued by the Department of Health & Social Care in its annually updated Group Accounting Manual, together with the Trust's own accounting policies and generally accepted accounting practice, as appropriate is to prepare in respect of each financial year annual accounts in such form as NHS Improvement may direct with the approval of the Treasury.

4.1.4 In preparing its annual accounts, the Foundation Trust is to comply with current guidelines and directions given by NHS England as to their technical accounting content and information/data shown therein, before submission to NHS England in accordance with the prescribed timetable.

4.1.5 The annual accounts, any report of the financial auditor on them, and the annual report are to be reviewed by the Audit Committee and approved by the Board of Directors.

4.2 Annual Report

4.2.1 The Foundation Trust is to prepare an annual report in the format prescribed by NHS England and in accordance with the NHS Foundation Trust Annual Reporting Manual and send them to NHS England.

4.2.2 The Foundation Trust is to comply with any decision made by NHS England on:

a) the form of the reports;
b) when the reports are to be sent;
c) the periods to which the reports are to relate.

4.3 Annual Governance Statement

4.3.1 The annual report should include an Annual Governance Statement in accordance with the relevant requirements.

4.4 Publication of reports

4.4.1 The Annual Report and Accounts must be published and presented to the Council of Governors at a General Meeting and made available to the public for public inspection at the Trust's headquarters and on the Trust's website. Any summary financial statements published are in addition to, and not instead of, the full annual accounts.

4.4.2 The Trust shall:

a) lay a copy of the annual accounts, and any report of the financial auditor on them, before Parliament; and
b) send copies of those documents to NHS England.

4.4.3 Responsibility for complying with the requirements relating to the form, preparation and presentation of the accounts shall be delegated to the Chief Executive.

5 GOVERNMENT BANKING SERVICE BANK ACCOUNTS

5.1 General

5.1.1 The Chief Finance Officer is responsible for managing the Foundation Trust's banking arrangements and for advising the Foundation Trust on the provision of banking services and operation of accounts. This advice will take into account guidance and directions issued from time to time by NHS England.

5.1.2 The Audit Committee of the Board of Directors will review banking arrangement periodically.

5.1.3 The Audit Committee will make recommendations to the Board of Directors for approvals regarding the opening of any bank account in the name of the Trust.

5.2 Government Banking Service (GBS) Bank Accounts

5.2.1 In line with public sector practice the Trust's principal bankers are those commercial banks working in partnership with the GBS, referred to in 5,2,2

(a) below. However, these SFIs will apply to any other accounts opened in the name of the Trust or its subsidiaries form time to time.

5.2.2 The Chief Finance Officer is responsible for:

a) GBS bank accounts and any other non GBS bank accounts held for banking and merchant services;
b) establishing separate bank accounts for the Trust's non-exchequer funds as appropriate;
c) ensuring payments made from bank/GBS/RBS accounts do not exceed the amount credited to the account except where arrangements have been made;
d) reporting to the Board of Directors any arrangements made with the Trust's bankers for accounts to be overdrawn (together with the remedial action taken); monitoring compliance with NHS England or DH guidance on the level of cleared funds
e) ensuring covenants attached to bank borrowings are adhered to; and
f) ensuring all accounts are held in the name of the Trust.

5.2.3 No officer other than the Chief Finance Officer shall open any account in the name of the Trust or for the purpose of furthering Trust activities.

5.3 Banking Procedures

5.3.1 The Chief Finance Officer will prepare detailed instructions on the operation of bank which must include:

a) the conditions under which each bank account is to be operated;
b) the limit to be applied to any overdraft; and
c) those members of staff with mandated authority to carry out transactions (by signing transfer authorities or cheques or other orders) in accordance with the authorisation framework of these GBS bank accounts.

5.3.2 The Chief Finance Officer will advise the Foundation Trust's bankers in writing of the conditions under which each account will be operated, including any alterations as approved.

5.3.3 All funds shall be held in the name of the Trust. No employee other than the Chief Finance Officere shall open any bank account in the Trust's name.

5.3.4 Manually produced cheques shall be signed by the authorised officer(s) in accordance with the bank mandate.

5.3.5 All cheques shall be treated as controlled stationery, in the charge of a duly designated officer controlling their issue.

5.4 Review and Market Testing

5.4.1 The Chief Finance Officer will review the banking arrangements of the Trust at regular intervals, to ensure that they reflect best practice and represent best value for money.

5.5 Electronic Transfer of Funds

5.5.1 All electronic transfers of funds must only be made under secure arrangements approved by the Chief Finance Officer.

6 INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

6.1 Income Systems

6.1.1 The Chief Finance Officer is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, and collection and coding of all monies due.

6.1.2 All such systems shall incorporate, where practicable, in full the principles of internal check and separation of duties.

6.1.3 The Chief Finance Officer is also responsible for the prompt banking of all monies received.

6.2 Fees and Charges (including for private use of Trust assets)

6.2.1 The Trust shall follow guidance issued by the Department of Health and Social Care for the pricing of its patient related services with commissioners, supplemented by any additional guidance provided by NHS England. The Chief Finance Officer may agree alternative payment mechanisms with Commissioners.

6.2.2 The Chief Finance Officer is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health and Social Care or by Statute.

6.2.3 Independent professional advice on matters of valuation shall be taken as necessary.

6.2.4 Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered the guidance in the Trust's policy on Standards of Business Conduct and Conflict of Interest must be followed.

6.2.5 All employees must inform the Finance Department promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

6.2.6 Any employee wishing to use Trust assets for private use must comply with the Trust's policies, including those of the telephone and loan of equipment.

6.3 Private Health Care and Charging for Accommodation

6.3.1 The Trust is required to have a private patient policy in place which covers the charges and arrangements in place for private patients.

6.3.2 Prior approval of any private patient new schemes must be sought from the Chief Finance Officer before commencement in order to ensure that income can be appropriately charged and collected.

6.3.3 The Foundation Trust may, in the case of patients being provided with goods and services for the purposes of the health service, make accommodation or further services available for patients who give undertakings (or for whom undertakings are given) to pay any charges imposed by the NHS foundation trust in respect of the accommodation or services. This may only be exercised where it does not to any significant extent interfere with the performance by the NHS foundation trust of its functions.

6.4 Debt Recovery

6.4.1 The Chief Finance Officer is responsible for establishing the debt management policy and ensuring appropriate recovery action on all outstanding debts, including a formal follow up procedure for all debtor accounts. This will include the use of external debt recovery services, where appropriate.

6.4.2 Income not received should be dealt with in accordance with the losses and special payments procedures.

6.4.3 Overpayments should be detected (or preferably prevented) and recovery action initiated.

6.5 Security of Cash, Cheques and other Negotiable Instruments

6.5.1 The Chief Finance Officer is responsible for:

a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable (No form of receipt which has not been specifically authorised by the Chief Finance Officer should be issued);
b) ordering and securely controlling any such stationery;
c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes and the procedures for keys and for coin operated machines; and
d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust and for the banking of cash.
e) authorising the use of charitable giving platforms such as Just Giving and ensuring that there is appropriate oversight and monitoring.

6.5.2 Trust monies shall not under any circumstances be used for the encashment of private cheques or loans.

6.5.3 Staff shall be informed in writing on appointment of their responsibilities and duties for the collection, handling or disbursement of cash, cheques etc.

6.5.4 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements previously approved by the Chief Finance Officer.

6.5.5 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or in locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss and signed “declarations of indemnity” must be obtained from the organisation or individuals, absolving the Trust from responsibility for any loss.

6.5.6 Any loss or shortfall of cash, cheques or other negotiable instruments shall be reported in accordance with the procedure for losses and special payments. Any significant trends should be reported to the Chief Finance Officer and Internal Audit via the incident reporting system. Where there is prima facie evidence of fraud or corruption this should follow the form of the Trust’s Fraud, Bribery and Corruption Response Plan and the guidance provided by NHS Counter Fraud Authority. Where there is no evidence of fraud, bribery or corruption the loss should be dealt with in line with the Trust’s Losses and Special Payments Procedures.

7 CONTRACTS FOR THE PROVISION OF SERVICES

7.1 Service Contracts

7.1.1 The Chief Executive, as the accountable officer, is responsible for negotiating the Service and Financial Framework for the provision of services to patients in accordance with the Operational Plan, and for establishing the arrangements for providing non contracted activity.

7.1.2 In discharging this responsibility, the Chief Executive should take into account the advice of the Chief Finance Officer to ensure that the Trust is able to deliver:

a) the standards of service quality expected;
b) the requirements within the service specifications;
c) reliable information on activity levels and the costs of running the services;
d) the performance metrics; and
e) the planned activity levels contained within the Operational Plan

7.1.3 The Chief Executive shall nominate officers with power to negotiate for the provision of healthcare services with commissioners of healthcare.

7.1.4 The Chief Executive, as the accountable officer, will need to ensure that regular reports are provided to the Board of Directors detailing actual and forecast income.

7.1.5 Contract prices shall be in accordance with the National Tariff and guidance as applicable and for those services excluded from the tariff will be subject to negotiation with contracting commissioners as to the most appropriate currency.

7.2 Tendering

7.2.1 Where the Trust participates in a tendering exercise (whether in competition with others or not) for a health related service, approval must be sought according to the delegated authority limits.

7.2.2 No tender must be submitted without sign off from the relevant authorised executive director. For absolute clarity, no Trust employee should sign a tender or contract unless they have authority and the total contract value is within their financial limits. All tender decisions will be reported to the Finance & Performance Committee.

7.2.3 The contract value should be calculated by aggregating the estimated total annual value of the goods, service or works and multiplying this by the number of years that the contract is to run. If the contract does not specify the contract length, then four years shall be taken as the multiplier.

7.2.4 Staff who participate in a tendering exercise must notify the Deputy Director of Strategy and Partnerships and follow the Tender Opportunities Process Standard Operating Procedure.

7.2.5 The financial elements of the tender bid must have been agreed by the Director of Finance.

7.3 Service Level Agreements

7.3.1 Where the Trust receives or provides a service to another NHS Trust usually for the provision of staff or facilities, then a service level agreement must be put in place.

7.3.2 The Service Level Agreement must be completed either in accordance with the Trust's standard template and signed in accordance with the scheme of delegation.

7.3.3 All Service Level Agreements shall be reviewed on behalf of the Chief Finance Officer by the Finance Contracts Team prior to signing.

8.0 TERMS OF SERVICE, ALLOWANCES AND PAYMENT OF DIRECTORS, MEMBERS OF THE BOARD OF DIRECTORS AND EMPLOYEES

8.1 Remuneration Committee

8.1.1 In accordance with the Constitution, the Board shall establish a Remuneration Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition and the arrangements for reporting.

8.1.2 The Remuneration Committee will:

a) advise the Board about appropriate remuneration and terms of service for the Chief Executive and other executive directors (and other senior employees), including:

(i) all aspects of salary (including any performance related elements/bonuses);

(ii) provisions for other benefits including pensions and expenses; and

(iii) arrangements for termination of employment and other contractual terms;

b) make such recommendations to the Board on the remuneration and terms of service of executive directors (and other senior employees who have opted not to move to agenda for change conditions) to ensure that they are fairly rewarded for their individual contribution to the Trust - having proper regard to the Trust's financial circumstances and performance and to the provisions of any national arrangements for such staff, where appropriate;
c) monitor and evaluate the performance of individual executive directors (and other senior employees); and
d) advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments, taking account of such national guidance as is appropriate.

8.1.3 The Remuneration Committee shall report in writing to the Board the basis for its recommendations. The Board shall use these reports as the basis for its decisions but remains accountable for taking decisions on the remuneration and terms of service of executive directors. Minutes of the Board's meetings should record such decisions.

8.1.4 The Board will approve proposals presented by the Chief Executive for the setting of remuneration and conditions of service for those employees not covered by the Remuneration Committee.

8.1.5 The Council of Governors, at the General Meeting, will decide the remuneration and allowances, and the other terms and conditions of office of the Non-executive Directors. The Nominations Committee will support the Council of Governors through making recommendations to this effect.

8.1.6 Any Trust Board posts and designated Senior Manager posts will be subject to the requirements of the Fit and Proper Persons Test which is administered by the Corporate Governance and Workforce Teams.

8.1.7 The annual check exercise for the Fit and Proper Persons Test will be undertaken by the Corporate Governance and Workforce Teams.

8.1.8 Appointments to senior management or Director posts above the salary of the Prime Minister (c.£150k) must be referred to NHS England and onward ratification by the Secretary of State.

8.2 Funded Establishment

8.2.1 The workforce plans incorporated within the annual budget will form the funded establishment. The establishment of the Foundation Trust will be

identified and monitored by the Chief Finance Officer under delegation from the Chief Executive.

8.2.2 The funded establishment of any department may not be varied without the approval of the Chief Executive or individual nominated within the relevant section of the Scheme of Delegation. The Chief Finance Officer is responsible for ensuring there are procedures in place for verifying that funding is available for posts prior to advertisement. In exceptional circumstances posts which are advertised without confirmed funding, must be authorised by the Chief Finance Officer but no offers of contracts can be made prior to approval of funding.

8.2.3 In order to ensure control of the Trust's workforce costs a Staffing Approval Group shall be in place which has defined Terms of Reference and the remit of which is detailed within the Scheme of Reservation and Delegation.

8.3 Staff Appointments

8.3.1 An Employee or Director to whom a staff budget or part of a staff budget is delegated may engage employees or hire agency staff subject to any approval that may be required by the Staffing Approval Group and provided the post is within the limit of his approved budget and affordable staffing limit. He/she may also regrade employees after consultation with their Human Resources Business Partner and job evaluation has taken place in accordance with Trust policy.

8.3.2 The Trust's primary mechanism of engagement is for workers to be placed on payroll either through permanent employment or fixed term contracts. Where a requirement for temporary resourcing appears (or a specific short term skills shortage) alternative forms of resourcing may be used including Bank and Agency. The use of bank must be in line with the Trust's procedures for booking temporary staff. Agency bookings should be in line with the Trust procedures, ensuring required sign off is obtained and that NSH and Tax regulation are complied with. Any off-payroll engagements must be approved by the Director of Finance prior to contract signature.

8.3.3 All contracts of employment including recruitment, promotions and terminations will be transacted via ESR (Electronic Staff Record) via the Trust's online HR forms on the Trust intranet.

8.3.4 All staff employed by the Trust will be issued a contract of employment. All agency staff engaged should be via an approved framework agency and through the Trust's agreed suppliers. Any individuals directly engaged, who sit outside of these 2 categories, should have a suitable contractual

agreement in place. Engagement of agencies should also be in line with prevailing NHS England requirements and rules.

8.3.5 A termination of employment form must be submitted by the employee's line manager through the Trust's Online Leaver form on the Trust intranet.

8.3.6 Any appointments should follow the Trust Recruitment Policy found on the HR microsite on the intranet.

8.3.7 As a general principle the Trust will seek to avoid the requirement to make staff redundant. The Trust will therefore always seek to deploy staff where appropriate.

8.3.8 In the event that redundancy cannot be avoided the Trust shall:

i) Develop selection criteria based upon the agreed Trust Organisational Change Policy which includes affordability, and
ii) Complete the Trust redundancy approval form and submit to the HR Business Partner

8.3.9 The Trust must seek approval from NHS England before commissioning Management Consultants above a cap of £50k.

8.4 Processing of Payroll

8.4.1 The Director of People & OD is responsible for maintaining a list of managers who may appoint and dismiss staff in accordance with the Trust's Personnel Policy and Procedures.

8.4.2 The Director of People & OD is responsible for:

a) specifying timetables for submission of properly authorised time records and other notifications;
b) the final determination of pay and allowances, including verification that the rate of pay and relevant conditions of service are in accordance with current agreements;
c) making payment on agreed dates; and
d) agreeing the method(s) of payment.

8.4.3 The Director of People & OD in conjunction with the Chief Finance Officer will issue instructions regarding:

a) verification and documentation of data;

b) the timetables for receipt and preparation of payroll data and the payment of employees and allowances;
c) the maintenance of subsidiary records for superannuation, income tax, national insurance and other authorised deductions from pay;
d) security and confidentiality of payroll information;
e) checks to be applied to the completed payroll before and after payment;
f) authority to release payroll data under the provisions of the Data Protection Act;
g) methods of payment available to various categories of employee;
h) procedures for payment by cheque, bank credit or cash to employees;
i) procedures for the recall of cheques and bank credits;
j) pay advances and their recovery;
k) maintenance of regular and independent reconciliation of payroll control accounts;
l) separation of duties between the preparation of records and the handling of cash and other types of payment;
m) a system to ensure the recovery from leavers of sums of money and property due by them to the Trust;
n) the payment of pay awards and arrears;
o) procedures for the change of employee bank account details by staff;
p) the secure operation of the system for payments by BACS.

8.4.4 Appropriately nominated managers have delegated responsibility for:
a) processing an authorised copy of the contract/appointment form and such other documentation as may be required immediately upon an employee commencing duty;
b) submitting time records and other notifications in accordance with agreed timetables;
c) completing time records and other notifications in accordance with the Chief Finance Officer's instructions and in the form prescribed by him/her;
d) submitting authorised staff change forms in the prescribed form immediately upon knowing the effective date of a variation to an employee's contract;
e) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's resignation, termination or retirement. Where an employee fails to report for duty in circumstances that suggest that he/she has left without notice, the Payroll Department must be informed immediately; and
f) taking responsibility for managing staff costs within the available resources and engaging staff in accordance with Trust policies and procedures.

8.4.5 Regardless of the arrangements for providing the payroll service, the Chief Finance Officer shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, where appropriate, adequate

internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

8.4.6 The Scheme of Reservation and Delegation details the time periods for the submission and authorisation of claims for pay.

8.5 Contract of Employment

8.5.1 The Board shall delegate responsibility to the Director of People & OD for:

a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment and Health & Safety legislation;
b) dealing with variations to, or termination of, contracts of employment; and
c) the provision of appropriate terms and conditions of employment.

9 NON-PAY EXPENDITURE

9.1 Delegation of Authority

9.1.1 The Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers.

9.1.2 The Chief Executive will set out:

a) the list of managers who are authorised to place requisitions for the supply of goods and services. This should be updated and reviewed on an ongoing basis and annually by the Procurement Department or by officers in those departments that are responsible for their own procurement.

   Where the authorisation system is computerised the list will be maintained within the computerised system and the 'signature' will be in the form of electronic authorisation in accordance with the access and authority controls maintained within the computerised system; and

b) the maximum value of each requisition and the authority limits for authorisation above that level.

9.1.3 The Board will ratify decisions made by the Chief Executive or Chief Finance Officer relating to specific contracts of a capital or revenue nature (other than for healthcare provision) amounting to or exceeding (or likely to amount to or exceed) the "full competitive upper threshold" as directed in the Public Contracts Regulations.

9.1.4 However, to ensure rapid decision making, if the contract is a renewal and is above the competitive threshold and if the recommendation is to accept the lowest compliant bid the Chief Finance Officer can approve acceptance of the tenders. The decision is to be subsequently reported to the Audit Committee. If the contract is for an unplanned or not previously authorised project it must be approved by the Board of Directors.

9.1.5 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

9.1.6 The Trust has a Procurement Policy in place which provides more detailed guidance on the procurement of goods and services.

9.2 Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services

9.2.1 The requisitioner, in choosing the item to be supplied (or the service to be performed), shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's Head of Procurement shall be sought as appropriate. Where this advice is not acceptable to the requisitioner, the Chief Finance Officer shall be consulted and may approve procurement contrary to the advice received, as long as the Trust complies with statutory requirements.

9.2.2 Once the item to be supplied or service to be performed has been identified the requisitioner should raise a requisition or instruct a nominated person to do this on their behalf. In line with best practice, most goods or services will be ordered through the Procurement Department (via web-based requisitioning) following a requisition raised by an authorised signatory.

9.2.3 The Trust operates a “No Purchase Order No Pay” policy. All orders require a Purchase Order prior to being placed. The Chief Finance Officer will maintain and monitor a list of minimal exemptions which will be contained as a schedule within the policy.

9.2.3 The Chief Finance Officer shall be responsible for the prompt payment of accounts and claims in accordance with the Better Payment Practice policy. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

9.2.4 The Chief Finance Officer will:

a. advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained, and once approved, the thresholds should be incorporated into the Trust's Scheme of Delegation and regularly reviewed.
b. prepare procedural instructions [where not already provided in the Scheme of Delegation or procedure notes for budget holders] on the obtaining of goods, works and services, incorporating these thresholds;
c. be responsible for the prompt payment of all properly authorised accounts and claims;
d. be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall incorporate:

(i) a list of directors/employees (including specimens of their signatures) authorised to approve expenditure. Where the authorisation system is computerised the list will be maintained within the computerised system and the 'signature' will be in the form of electronic authorisation in accordance with the access and authority controls maintained within the computerised system;

(ii) Certification that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct; Certification of accounts may either be through goods received notes or by electronic personal certification by authorised officers. Goods and services should not be receipted in advance of possession.

- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;

- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality and price and the charges for the use of vehicles, plant and machinery have been examined:

    - where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;

- where an officer certifying accounts relies upon other officers to do preliminary checking he/she shall, wherever possible, ensure that those who check delivery or execution of work act independently of those who have placed orders and negotiated prices and terms and that such checks are evidenced;

- in the case of contract for building and engineering works which require payment to be made on account during process of the works the Chief Finance Officer shall make payment on receipt of a certificate from the appropriate technical consultant or authorised officer. Without prejudice to the responsibility of any consultant or authorised officer appointed to a particular building or engineering contract a contractors account shall be subjected to such financial examination by the Director of Finance and such general examination by the authorised officer as may be considered necessary before the person responsible to the Trust for the contract issues the final certificate;

- the account is arithmetically correct; and

- the account is in order for payment;

(iii) A timetable and system for submission to the Chief Finance Officer of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment;

(iv) Instructions to employees regarding the handling and payment of accounts within the Finance Department, including procedures for the secure operation of the system for payments by BACS; and

(v) adequate separation of duties;

e. be responsible for ensuring that payment for goods and services is only made once the goods and services are received, (except as below).

9.2.5 Prepayments outside of normal commercial arrangements, for example fully comprehensive maintenance contracts, rental, insurance are only permitted where exceptional circumstances apply. In all such instances, the advice of both the Director of Finance and the Head of Procurement should be sought before entering into any contractual arrangements. Prepayments are only permitted where the financial advantages outweigh the disadvantages:

a. the intention is not to circumvent cash limits;
b. the appropriate Officer in conjunction with the Procurement Department must provide to the Chief Finance Officer, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments;
c. the Chief Finance Officer will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the Public Contracts Regulations full competitive upper threshold where the contract is above a stipulated financial threshold); and
d. the budget holder is responsible for ensuring that all items due under a prepayment contract are received and he/she must immediately inform the appropriate Director or Chief Executive if problems are encountered.

9.3 OFFICIAL ORDERS

9.3.1 The Trust has a number of official ordering systems. These systems including those provided through electronic media must incorporate adequate controls and be in a form approved by the Chief Finance Officer.

Official orders must:

a. be consecutively numbered or in the case of purchasing cards and other official ordering systems be appropriately controlled;
b. be in a form approved by the Chief Finance Officer;
c. state the Trust's terms and conditions of trade; and
d. only be issued to, and used by, those duly authorised by the Chief Executive.

9.3.2 Managers must ensure that they comply fully with the guidance and limits specified by the Chief Finance Officer and that:

a. all contracts [other than for a simple purchase permitted within the Scheme of Delegation] or leases, tenancy agreements and other commitments which may result in a liability are notified to the Chief Finance Officer in advance of any commitment being made;
b. all requisitions must be approved in line with the Trust Authorisation Hierarchy
c. contracts above specified thresholds are advertised and awarded in accordance with Public Contract Regulations where consultancy advice is being obtained, the procurement of such advice must be in accordance

with guidance issued by the Department of Health and Social Care and/or, where applicable, NHS England;
no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, or their family, personal friends or associates, in accordance with the Trust Standards of Business Conduct

d. no requisition/order is placed for any item or items for which there is no budget provision unless authorised in advance by the Chief Finance Officer on behalf of the Chief Executive;
e. subject to 9.3.3 below, all goods, services, or works are ordered on an official order except works and services executed in accordance with a contract and purchases from petty cash;
f. verbal orders must only be issued very exceptionally - by an employee designated by the Chief Executive -and only in cases of emergency or urgent necessity (e.g. Estates where it is necessary to occasionally place verbal orders to achieve response times on rectifying reported faults). These must be confirmed promptly by an official order and clearly marked "Confirmation Order";
g. orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;
h. goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;
i. changes to the list of directors/employees authorised to certify invoices are notified to the Chief Finance Officer;
j. purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Chief Finance Officer;
k. petty cash records are maintained in a form as determined by the Chief Finance Officer

9.3.3 An alternative means of procurement is by use of a Trust Purchasing Card and these are for regular transactions where a card payment is required to secure a booking, service or pay for small items in advance. The Chief Finance is responsible for designing and maintaining procedures regarding the use and control of purchasing cards. The Purchasing Card holders are required to follow Trust Purchasing Card procedures and will be required to sign a declaration agreeing to the procedures. An independent reconciliation of the Purchasing Card transactions will be performed on a monthly basis.

9.3.4 Under no circumstances should goods be ordered through the Trust for personal or private use.

9.3.5 These Standing Financial Instructions apply equally to goods and services relating to charitable funds.

9.4 PETTY CASH

9.4.1 Reimbursement from the petty cash account will be made upon the production of a receipt for the goods in question. The receipt will need to be signed by the budget holder whose budget is being charged with the expenditure.

9.4.2 The maximum payment from petty cash for any reason is £100 (including charitable fund monies).

9.4.3 Requests for cash above £100 can be made in advance for specific events (such as activity days) by the budget holder to the Finance Department. Receipts are required for all items purchased.

9.5 BUILDING AND ENGINEERING TRANSACTIONS

9.5.1 The Director of Estates and Facilities shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within CONCODE and ESTATECODE. The technical audit of these contracts shall be the responsibility of the relevant Director.

10 EXTERNAL BORROWING, PUBLIC DIVIDEND CAPITAL AND CASH INVESTMENTS

10.1 External Borrowing

10.1.1 The Trust may borrow money for the purposes of, or in connection with, its strategic objectives and its operational functions.

10.1.2 The total amount of the Trust's borrowing must be affordable within NHS England's Single Oversight Framework for Trusts.

10.1.3 Any application for a loan, revenue support or overdraft facility must be approved by the Board of Directors in accordance with the requirements of NHS England. Any application for a loan, revenue support or overdraft will only be made by the Chief Finance Officer or by an employee so delegated by him/her.

10.1.4 All applications for revenue support or short term borrowing should be kept to the minimum period of time possible, consistent with the overall cash

position and comply with the latest guidance from the Department of Health and Social Care

10.1.5 All long-term borrowing must be consistent with the plans outlined in the current Trust Operational Plan approved by the Board.

10.1.6 The Chief Finance Officer must prepare detailed procedure instructions concerning applications for revenue support, loans and overdrafts.

10.2 Public Dividend Capital

10.2.1 On authorisation as a Foundation Trust the Public Dividend Capital held immediately prior to authorisation continues to be held on the same conditions (Initial Public Dividend Capital).

10.2.2 Additional Public Dividend Capital may be made available on such terms the Secretary of State (with the consent of the Treasury) decides.

10.2.3 Draw down of Public Dividend Capital should be authorised in accordance with the mandate held by the Department of Health and Social Care Capital and Cash Funding Team, and is subject to approval by the Secretary of State.

10.2.4 The Foundation Trust shall be required to pay six monthly to the Department of Health a dividend on its Public Dividend Capital at a rate to be determined from time to time, by the Secretary of State.

10.2.5 The Chief Finance Officer will advise the Board concerning the Trust's ability to pay interest on, and repay, both the Public Dividend Capital and any proposed new borrowing, within the limits set by NHS England. The Chief Finance Officer is also responsible for reporting periodically to the Board concerning the Public Dividend Capital and all loans and overdrafts.

10.3 Investment of Temporary Cash Surpluses

10.3.1 The Trust may invest money for the purposes of its strategic objectives and operational functions.

10.3.2 The Audit Committee shall set the investment policy) (setting out acceptable risks and unacceptable risks) and oversee all investment transactions by the Trust. The Treasury Management Policy shall set out the guidelines and shall be approved by the Finance and Performance Committee.

10.3.3 Investments may be made in forming / or acquiring an interest in bodies corporate where authorised by the Board of Directors.

10.3.4 Temporary cash surpluses must be held only in investments permitted by NHS England and meeting the criteria approved by the Treasury Management Policy. The Treasury Management Policy will be refreshed and approved by the Finance and Performance Committee on an annual basis.

10.3.5 Investments should only be made in accordance with the approved Treasury Management Policy.

10.3.6 The Chief Finance Officer is responsible for advising the Board of Directors on investments and shall report periodically to the Board of Directors concerning the performance of investments held, to the Board via the Audit Committee

10.3.7 The Chief Finance Officerill prepare detailed procedural instructions on investment operations and on the records to be maintained. The Chief Finance Officer a senior finance manager with specific delegated powers) will authorise all investment transactions and ensure compliance with the Treasury Management Policy at all times.

11 CAPITAL AND ASSET MANAGEMENT

11.1 Capital Investment

11.1.1 The Chief Executive shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon the business plans.

11.1.2 The Capital Programme Management Group (CPMG), chaired by the Chief Finance Officer, is responsible for managing and monitoring the development and delivery of the Trust capital programme ensuring there is a multi-disciplinary approach taken to planning and delivery.

11.1.3 CPMG have oversight of:

- All aspects of capital planning for the Trust, ensuring plans are prepared annually for approval by the Executive Team, Finance & Performance Committee and Trust Board
- Management of the allocated capital budget (including external capital awards), ensuring schemes are prioritised based on a risk based approach, taking into account; quality, safety and operational performance
- Resolving issues where possible and escalating others, via recommendations to the Executive Team

11.1.4 The relevant Director of a project is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and within budget.

11.1.5 The relevant Director shall ensure that capital investment is not undertaken without confirmation of purchaser(s) support and the availability of resources to finance all revenue consequences, including capital charges.

11.1.6 The Chief Executive shall (in accordance with the limits outlined in the Scheme of Delegation):
(a)
(i) Ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities;
(ii) Be responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;
(iii) Ensure that the capital investment is not undertaken without appropriate confirmation of the availability of resources to finance all revenue consequences, including depreciation and PDC dividend implications; and

b. that the Chief Finance Officer has certified professionally to the costs and revenue consequences detailed in the business case.

11.1.7 For capital schemes where the contracts stipulate stage payments, the Chief Finance Officer will issue procedures for their management, incorporating best financial practice. The Chief Finance Officer shall assess on an annual basis the requirement for the operation of the Construction Industry Tax Deduction Scheme in accordance with HMRC guidance.

11.1.8 The Chief Finance Officer shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

11.1.9 The approval of a capital programme shall not constitute approval for expenditure on any scheme. The Chief Executive shall issue to the manager responsible for any scheme:

a. specific authority to commit expenditure;
b. authority to proceed to tender; and
c. approval to accept a successful tender

11.2 ASSET REGISTERS

11.2.1 The Chief Executive is responsible for the maintenance of the register of assets, taking account of the advice of the Chief Finance Officer concerning the form of any register and the method of updating, and arranging for a rolling

programme for checking of assets against the asset register to be conducted over a 5 year period.

11.2.2 The Foundation Trust shall maintain an asset register recording fixed assets. As a minimum, the minimum data set to be held within these registers shall be in accordance to able the Trust to comply with International Financial Reporting Standards (IFRS).

11.2.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

a. properly authorised and approved agreements, architect's certificates, suppliers' invoices and other documentary evidence in respect of purchases from third parties;
b. stores requisitions and wages records for own materials and labour including appropriate overheads; and
c. lease agreements in respect of assets held under a finance lease and capitalised.

11.2.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

11.2.5 The Chief Finance Officer shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

11.2.6 The value of land and buildings shall be indexed to current values in accordance with best practice in order that the Trust complies with International Financial Reporting Standards (IFRS).

11.2.7 The value of each asset shall be depreciated using methods and rates so as to comply with best practice in order that the Trust complies with IFRS.

11.2.8 The Chief Finance Officer shall calculate estimated capital charges annually and submit details of these in accordance with the requirements of the Department of Health & Social Care, NHS England or other monitoring organisation as applicable.

11.2.9 As required by Condition 9 (4) of the Terms of Authorisation the Foundation Trust must make the Asset Register available for inspection by the public. The Foundation Trust may charge a reasonable fee for access to this information.

11.4 Security of Assets

11.4.1 The overall control of fixed assets is the responsibility of the Chief Executive, advised by the Chief Finance Officer.

11.4.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Chief Finance Officer. These procedures shall make provision for:

a. recording managerial responsibility for each asset;
b. identification of additions and disposals;
c. identification of all repairs and maintenance expenses;
d. physical security of assets;
e. periodic verification of the existence of, condition of and title to assets recorded;
f. identification and reporting of all costs associated with the retention of an asset; and
g. reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

11.4.3 All discrepancies revealed by physical verification of assets to the fixed asset register shall be notified to the appropriate manager who shall inform the Chief Finance Officer, who shall decide what further action shall be taken.

11.4.4 Whilst each employee has a responsibility for the security of property of the Trust, it is the responsibility of Directors and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with written instructions.

11.4.5 Any damage to Trust premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by directors and employees in accordance with the procedure for reporting losses and the requirements of insurance arrangements.

11.4.6 Where practical, assets should be marked as Trust property.

12 INVENTORY AND RECEIPT OF GOODS

12.1 Stocks and Stores

12.1.1 Stocks are defined as those goods normally utilised in day to day activity, but which at a given point in time have not been used or consumed. There are three broad types of store:-

a) Controlled stores - specific areas designated for the holding and control of goods;
b) wards & departments - goods required for immediate usage to support operational services;
c) manufactured Items - where goods and consumables are being made or processes are being applied which add to the raw material cost of the goods.

12.1.2 Such stocks should
a) be kept to a minimum;
b) for controlled stores and other significant stores (as determined by the Chief Finance Officer) should be subjected to an annual stocktake or perpetual inventory procedures; and
c) valued at the lower of cost and net realisable value.

12.1.3 Subject to the responsibility of the Chief Finance Officer for the systems of control, overall responsibility for the control of stores shall be delegated to appropriate managers by the Chief Executive. The day -to- day responsibility may be delegated by him/her to departmental employees and stores managers/storekeepers, subject to such delegation being entered in a record available to the Chief Finance Officer. The control of Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical manager; the control of fuel oil and diesel the responsibility of the Director of Estates.

12.1.4 The responsibility for security arrangements and the custody of keys for all stores and locations shall be clearly defined in writing by the designated managers/pharmaceutical manager.

12.1.5 Wherever practicable, stocks should be marked as NHS property.

12.1.6 The Chief Finance Officer shall set out procedures and systems to regulate the stores, including records for receipt of goods, issues, returns to stores, losses and materials management.

12.1.7 Stocktaking arrangements shall be agreed with the Chief Finance Officer and there shall be a physical check covering all items in store at least once a year.

12.1.8 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Chief Finance Officer.

12.1.9 The designated managers/ pharmaceutical manager shall be responsible for a system approved by the Chief Finance Officer for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated managers shall report to the Chief Finance Officer any evidence of significant overstocking and of any negligence or malpractice (see also 13, Disposals and Condemnations, Losses and Special Payments).Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

12.2 Receipt of Goods

12.2.1 All goods received shall be checked as regards quantity and/or weight and inspected as to quality and specification.

12.2.2 A delivery note shall be obtained from the supplier at the time of delivery and shall be signed by the person receiving the goods. Instructions shall be issued to staff covering the procedures to be adopted in those cases where a delivery note is not available.

12.2.3 All goods received shall be entered onto an appropriate goods received/stock record (whether a computer or manual system) on the day of receipt.

12.2.4 If goods received are unsatisfactory, the records shall be marked accordingly. Further, where the goods received are found to be unsatisfactory or short on delivery, they shall only be accepted on the authority of the designated officer and the supplier shall be notified immediately.

12.2.5 For goods supplied via the NHS Supply Chain central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note to satisfy themselves that the goods have been received.

12.2.6 The Finance Department will make payment on receipt of an invoice.

12.3 Issue of Stocks

12.3.1 The issue of stocks shall be supplied by an authorised requisition note and a receipt for the stock issued shall be returned to the designated officer. Where

a ‘topping up’ system is used, a record shall be maintained as approved by the Chief Finance Officer. Regular comparisons shall be made of the quantities issued to wards/departments etc., and explanations recorded of significant variations. All transfers and returns shall be recorded on forms/systems provided for the purpose and approved by the Chief Finance Officer.

13 DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

13.1 Disposals and Condemnations

13.1.1 The Chief Finance Officer must prepare detailed procedures for the disposal of assets including condemnations and ensure that these are notified to managers.

13.1.2 When it is decided to dispose of a Foundation Trust asset, the head of department or authorised deputy will:
a) Establish whether it is needed or could be utilised elsewhere in the Trust;
b) Determine and advise the Finance Department of the estimated market value of the item, taking account of professional advice where appropriate. The highest possible disposal value will be realised, taking into account potential risks and reputational impacts.

13.1.3 The Trust may not dispose of any assets which could affect the delivery of Commissioner Requested Services without the authorisation of NHS England.

13.1.4 All unserviceable articles shall be:

a. condemned or otherwise disposed of by an employee authorised for that purpose by the Chief Finance Officer;
b. recorded by the Condemning Officer in a form approved by the Chief Finance Officer which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Chief Finance Officer.

13.1.5 The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Chief Finance Officer who will take the appropriate action.

13.1.6 Disposals of assets must be approved by the Chief Finance Officer.

13.1.7 Where assets are no longer needed to fulfil the Trust's obligations to provide commissioner requested services then the disposal of these assets must be approved at the Board of Directors.

13.2 Losses and Special Payments

13.2.1 The Chief Finance Officer must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.

13.2.2 The Chief Finance Officer must also prepare a "Fraud Response Plan" that sets out the action to be taken by both persons detecting a suspected fraud and those persons responsible for investigating it. (The documents are available on the Trust's Counter Fraud microsite.

13.2.2 Any employee or officer discovering or suspecting a loss of any kind must act immediately accordingly to the Trust's Anti-Fraud, Bribery and Corruption Policy.

13.2.3 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial the Chief Finance Officer must immediately notify the Chief Executive in cases where the loss may be material or where the incident may lead to adverse publicity.

13.2.4 For losses apparently caused through inefficient operation of administrative controls or financial control systems or any other losses the Chief Executive or Chief Finance Officer shall review the reasons for the loss and take action to amend the relevant systems and/or such other action as appropriate.

13.2.5 Approval of the writing-off of all losses and special payments in accordance with the Scheme of Delegation.

13.2.6 The Chief Finance Officer shall be authorised to take any necessary steps to safeguard the Foundation Trust's interests in bankruptcies and company liquidations.

13.2.7 For any loss, the Chief Finance Officer should consider whether any insurance claim can be made.

13.2.8 The Chief Finance Officer shall maintain a Losses and Special Payments Register in which write-off action is recorded against each item in the register and regular reports of this will be presented at Audit Committee.

13.3 Insurance

13.3.1 The Trust Secretary shall ensure that insurance arrangements are maintained and are reviewed periodically by the Board of Directors.

13.4 Compensation Claims

13.4.1 The Foundation Trust is committed to effective and timely investigation and response to any claim which includes allegations of clinical negligence, employee and other compensation claims. The Foundation Trust will follow the requirements and note the recommendations of the Department of Health, and NHS Resolution (NHSR) in the management of claims. Where appropriate external insurance has been contracted this will be within the above mentioned requirements and recommendations. Every member of staff is expected to co-operate fully, as required, in assessment and management of each claim.

13.4.2 The Foundation Trust will seek to reduce the incidence and adverse impact of clinical negligence, employee and other litigation by:-

a. adopting prudent risk management strategies including continuous review.
b. implementing in full the NHS Complaints Procedure, thus providing an alternative remedy for some potential litigants.
c. adopting a systematic approach to claims handling in line with the best
d. current and cost effective practice.
e. following guidance issued by the NHS Resolution relating to clinical negligence.
f. implementing an effective system of Clinical Governance
g. complying with CQC registration requirements

13.4.3 The Medical Director and the Chief Nurse are responsible for clinical negligence: for managing the claims process and informing the Board of Directors (through the Quality Committee) of any major developments on claims related issues.

14 INFORMATION MANAGEMENT AND DIGITAL

14.1 General

14.1.1 The Director of Informatics and the Chief Finance Officer are responsible for the accuracy and security of the computerised financial data of the Trust, shall develop the financial systems in accordance with the Trust's Digital Strategy and:

a. devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs, networks and computer hardware for which he/she is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 2018 and the Computer Misuse Act 1990;
b. ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;
c. ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;
d. ensure that adequate controls exist to maintain the security, privacy, accuracy and completeness of financial data sent via transmission networks; and
e. ensure that an adequate management (audit) trail exists through the computerised systems and that such computer audit reviews as he/she may consider necessary are being carried out.

14.1.2 The Chief Finance Officer shall satisfy himself that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained from them prior to implementation.

14.1.3 In the case of computer systems which are proposed General Applications (e.g. stock control system, patient audit tool)) all responsible directors and employees will send to the Director of Informatics:

a. details of the outline design of the system; and
b. in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

14.1.4 The Chief Finance Officer shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

14.1.5 Where another health organisation or any other agency provides a computer service for financial applications, the Chief Finance Officer shall periodically seek assurances that adequate controls are in operation.

14.1.6 Where computer systems have an impact on corporate financial systems the Chief Finance Officer shall satisfy him/herself in conjunction with the Director of Informatics that:

a. systems acquisition, development and maintenance are in line with corporate policies such as the Digital Strategy;
b. data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;
c. finance staff have access to such data;
d. have adequate controls in place; and
e. such computer audit reviews as are considered necessary are being carried out

14.1.7 The Director of Informatics shall publish and maintain a Freedom of Information (FOI) Publication Scheme. A publication scheme is a complete guide to the classes or types of information about the Foundation Trust that is made publicly available.

14.1.8 The Director of Informatics is responsible for ensuring the integrity of all other information systems, including those relied upon to report the Trust's performance to external parties.

14.1.9 No software package for use on the Trust's equipment should be procured without the knowledge of the IT Department. No hardware equipment should be connected to the network without the knowledge of the IT Department. This is in accordance with the principles set out in the IT Acceptable Use Policy.

15 PATIENTS' PROPERTY

15.1 GENERAL

15.1.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients or found in the possession of patients dying in hospital or dead on arrival, across all sites occupied by the Trust.

15.1.2 Staff have a duty of care to make effort to take care of patients' possessions which are **not** handed in for safe keeping, particularly if the patient does not have the capacity to look after their own possessions. This includes items of daily living such as glasses, false teeth, hearing aids etc.

15.1.2 The Chief Executive is responsible for ensuring those patients or their guardians, as appropriate, are informed before or at admission by:

- notices and information booklets, including appropriate disclaimer notices
- hospital admission documentation and property records, and
- the oral advice of administrative and nursing staff responsible for admissions, of the Trust's policy that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody through the sealed patient pouch system or a copy of an official patients' property record is obtained as a receipt.

15.1.3 The Chief Finance Officer must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty it is to administer, in any way, the property of patients. These instructions will incorporate adequate separation of duties on all patients' property transactions and the obtaining of witnesses' signatures, where appropriate. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

15.1.4 Where the sealed patient pouch system is not used, a patient's property record, in a form determined by the Chief Finance Officershall be completed in respect of the following:

a. property handed in for safe custody by any patient (or guardian as appropriate); and
b. property taken into safe custody having been found in the possessions of:

i) mentally disordered patients;
ii) confused and/or disorientated patients;
iii) unconscious patients;

iv) patients dying in hospital;
v) patients found dead on arrival at hospital (property removed by police);

c. a record shall be completed in respect of all persons in category b, including a nil return if no property is taken into safe custody.

15.1.5 The record shall be completed by a member of the hospital staff in the presence of a second member of staff and the patient (or representative) where practicable. It shall then be signed by both members of staff and by the patient, except where the latter is restricted by physical or mental incapacity. Any alterations shall be validated by signatures as requested for the original entry on the record.

15.1.6 Where the Department of Health and Social Care or NHS England instructions require the opening of separate accounts for patients' monies, these shall be opened and operated under arrangements agreed by the Chief Finance Officer.

15.1.7 Patients' income, including pensions and allowances, shall be dealt with in accordance with current Department of Health and Social Care instructions and guidance.

15.1.8 Refunds of cash handed in for safe custody will be dealt with in accordance with current Department of Health and Social Care guidelines. Property other than cash, which has been handed in for safe custody, shall be returned to the patient as required, by the officer who has been responsible for its security. The return shall be receipted by the patient or guardian as appropriate and witnessed.

15.1.9 The disposal of property of deceased patients shall be effected by the officer who has been responsible for its security, such disposal shall be in accordance with written instructions issued by the Chief Finance Officer, in particular, where cash or valuables have been deposited for safe custody, they shall only be released after written authority has been given by the Chief Finance Officer. Such authority shall include details of the lawful kin or other person entitled to the cash and valuables in question.

15.1.10 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released and a form of indemnity obtained. Where the total value of property is £5,000 or less, forms of indemnity shall also be obtained.

15.1.11 Property handed over for safe custody shall be placed into the care of the appropriate administrative staff. Where there are no administrative staff present, the property shall be placed into the care of the most senior member of nursing staff on duty.

15.1.12 In respect of deceased patients, if there is no will and no lawful next of kin the property vests in the Duchy of Lancaster Crown and particulars shall, therefore, be notified to the Treasury Solicitor.

15.1.13 Any funeral expenses necessarily borne by the Trust are a first charge on a deceased person's estate. Where arrangements for burial or cremation are not made privately, any element of the estate held by the Trust may be appropriated towards funeral expenses, upon the authorisation of the Chief Finance Officer.

15.1.14 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

15.1.15 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

15.1.16 Where a deceased patient is intestate and there is no lawful next-of-kin, details of any monies or valuables held should be notified to the Treasury Solicitor.

15.1.17 Any funeral expenses necessarily borne by the Trust in respect of a deceased patient shall be reimbursed from any of the patient's monies held by the Trust.

16 CHARITABLE FUNDS

16.1 General

16.1.1 The Foundation Trust has a responsibility as a corporate trustee for the management of funds it holds on trust. Although the management processes may overlap with those of the organisation of the Foundation Trust, the trustee responsibilities must be discharged separately and full recognition given to its dual accountabilities to the Charity Commission for charitable funds held on trust.

16.1.2 The Charity Scheme of Reservation and Delegation makes clear where decisions and discretion must be exercised, are to be taken and by whom.

16.1.3 As management processes overlap most of the sections of these Standing Financial Instructions will apply to the management of funds held on trust. This section of the SFIs cover those instructions which are specific to the management and governance of funds held on trust.

16.1.4 The over-riding principle is that the integrity of each trust must be maintained and statutory and trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

16.1.5 Charitable Funds are those gifts, donations and endowments made under the relevant charities legislation and held on trust for purposes relating to the Trust and the objectives of which are for the benefit of the NHS in England. They are administered by the Foundation Trust Board of Directors acting as Corporate Trustee.

16.1.6 The Chief Finance Officer shall maintain such accounts and records as may be necessary to record and protect all transactions and funds of the Foundation Trust as trustees of non-exchequer funds.

16.1.7 The Trust shall ensure the establishment of the Charitable Funds Committee, to which it delegates the majority of its Trustee role as set out in the Committee's Terms of Reference.

16.2 Existing Charitable Funds

16.2.1 The Chief Finance Officer shall arrange for the administration of all existing funds. A "Deed of Establishment" must exist for every subsidiary Charity Commission registered fund and detailed codes of procedure shall be produced covering every aspect of the financial management of charitable funds, for the guidance of fund managers. The Deed of Establishment shall identify the restricted nature of certain funds, and it is the responsibility of fund managers, within their delegated authority, and the Board of Directors as corporate trustees to ensure that funds are utilised in accordance with the terms of the Deed.

16.2.2 The Chief Finance Officer shall periodically review the funds in existence and shall make recommendations to the Board of Directors regarding the potential for rationalisation of such funds within statutory guidelines.

16.2.3 The Chief Finance Officer shall ensure that all funds are currently registered with the Charities Commission in accordance with the Charities Act 2011 or subsequent legislation.

16.3 New Charitable Funds (Subsidiary Special Purpose Charities)

16.3.1 The Chief Finance Officer shall only recommend the creation of a new fund where funds and/or other assets, received for charitable purposes, cannot adequately be managed as part of an existing fund or a designated fund. All new restricted funds must be covered by a Deed of Establishment formally approved by the Corporate Trustee and registered with the Charity Commission.

16.3.2 The Deed of Establishment for any new fund shall clearly identify, inter alia, the objects of the new fund, the nominated fund manager, the estimated annual income and, where applicable, the Corporate Trustee's power to assign the residue of the fund to another fund contingent upon certain conditions e.g. discharge of original objects.

16.4 New Designated Charitable Funds

16.4.1 Where a new designated charitable fund is required under the Trust's "umbrella" of registration with the Charities Commission, the request must be made, in writing, to the Chief Finance Officer for internal approval.

16.5 Sources of New Funds

16.5.1 All gifts accepted shall be received and held in the name of the Charity and administered in accordance with the Charity's policy, subject to the terms of specific funds. As the Charity can accept gifts only for all or any purposes relating to the NHS, officers shall, in cases of doubt, consult the Chief Finance Officer before accepting any gift. Advice to the Board of Directors on the financial implications of fund raising activities by outside bodies or organisations shall be given by the Chief Finance Officer.

16.5.2 All gifts, donations and proceeds of fund-raising activities, which are intended for the Charity's use, must be handed immediately to the Chief Finance Officer via the Cash Office to be banked directly to the Charitable Funds Bank Account.

16.5.3 In respect of Donations, the Chief Finance Officer shall:-

a. provide guidelines to Officers of the Foundation Trust as to how to proceed when offered funds. These will include:-

i) the identification of the donor's intentions;

ii) where possible, the avoidance of creating excessive numbers of funds;
iii) the avoidance of impossible, undesirable or administratively difficult objects;
iv) sources of immediate further advice; and
v) treatment of offers for personal gifts.

b. provide secure and appropriate receipting and thanking arrangements, which will indicate that donations have been accepted directly into the appropriate fund and that the donor's intentions have been noted and accepted.

16.5.4 In respect of Legacies and Bequests, the Chief Executive shall be kept informed of and record all enquiries regarding legacies and bequests. Where required, the Chief Executive shall:-

a. provide advice covering any approach regarding:-

i) the wording of wills;
ii) the receipt of funds/other assets from executors;

b. after the death of a testator all correspondence concerning a legacy shall be dealt with on behalf of the Charity by the Chief Executive who alone shall be empowered to give an executor a good discharge;
c. where necessary, obtain grant of probate, or make application for grant of letters of administration;
d. be empowered to negotiate arrangements regarding the administration of a will with executors and to discharge them from their duty; and
e. be directly responsible, in conjunction with the Board of Directors, for the appropriate treatment of all legacies and bequests.

16.5.5 In respect of fund-raising, the final approval for appeals will be given by the Corporate Trustee in accordance with financial limits. The Chief Finance Officer shall:

a. advise on the financial implications of any proposal for fund-raising activities;
b. deal with all arrangements for fund-raising by and/or on behalf of the Charity and ensure compliance with all statutes and regulations;
c. be empowered to liaise with other organisations/persons raising funds for the Charity and provide them with an adequate discharge;
d. be responsible for alerting the Board of Directors to any irregularities regarding the use of the Charity's name or its registration numbers; and
e. be responsible for the appropriate treatment of all funds received from this source.

16.5.6 Application for funds from external grants, partnerships, foundations and trusts (such as NHS Charities Together) shall be authorised by the Chief Finance Officer on behalf of the Corporate Trustee.

16.5.6 In respect of Trading Income (see also NHS Charitable Funds Guidance Chapter 6), the Chief Finance Officershall:-

a. be primarily responsible, along with designated fund managers, for any trading undertaken by the Charity; and
b. be primarily responsible for the appropriate treatment of all funds received from this source.

16.5.7 In respect of Investment Income, the Chief Finance Officer shall be responsible for the appropriate treatment of all dividends, interest and other receipts from this source (see below).

16.6 Investment Management

16.6.1 The Chief Finance Officer shall be responsible for all aspects of the management of the investment of charitable funds as delegated under the terms of the approved investment policy. The issues on which the Chief Finance Officer shall be required to provide advice to the Board of Directors shall include:-

a. the formulation of investment policy which meets statutory requirements (Trustee Investment Act 1961) with regard to income generation and the enhancement of capital value;
b. the appointment of advisers, brokers and, where appropriate, investment fund managers and:-
   i) the Chief Finance Officer shall recommend the terms of such appointments; and
   ii) for which written agreements shall be signed by the Chief Executive;
c. pooling of investment resources and the preparation of a submission to the Charity Commission for them to make a scheme;
d. the participation by the Charity in common investment funds and the
e. agreement of terms of entry and withdrawal from such funds;that the use of assets shall be appropriately authorised in writing and
   charges raised within policy guidelines;
f. the review of the performance of brokers and fund managers; and
g. the reporting of investment performance.

16.6.2 The Chief Finance Officer shall prepare detailed procedural instructions concerning the receiving, recording, investment and accounting for Charitable Funds.

16.7 Expenditure from Charitable Funds

16.7.1 Expenditure from Charitable Funds shall be managed by the Chief Finance Officer. In so doing the Chief Finance Officer shall be aware of the following:-

a. the objects of various funds and the designated objectives;
b. the availability of liquid funds within each trust;
c. the powers of delegation available to commit resources;
d. the avoidance of the use of exchequer funds to discharge charitable fund liabilities (except where administratively unavoidable), and to ensure that any indebtedness to the Exchequer shall be discharged by trust funds at the earliest possible time;
e. that funds are to be spent rather than preserved, subject to the wishes of the donor and the needs of the Foundation Trust; and
f. the definitions of "charitable purposes" as agreed by the Charity Commission.

16.7.2 Delegated authority to incur expenditure which meets the purpose of the funds are set out in the Scheme of Reservation and Delegation; exceptions are as follows:-

a. any staff salaries/wages costs require the Chief Finance Officer's approval
b. no funds are to be "overdrawn" except in exceptional circumstances where prior approval has been given by the Chief Finance Officer.

16.8 Banking Services

16.8.1 The Chief Finance Officer shall advise the Board of Directors and, with its approval, shall ensure that appropriate banking services are available in respect of administering the Charitable Funds. These bank accounts should permit the separate identification of liquid funds to each trust where this is deemed necessary by the Charity Commission.

16.9 Asset Management

16.9.1 Assets in the ownership of or used by the Foundation Trust, shall be maintained along with the general estate and inventory of assets of the Foundation Trust.

The Chief Finance Officer shall ensure:-

a. in conjunction with the Director of Estates, that appropriate records of all donated assets owned by the Foundation Trust are maintained, and that all assets, at agreed valuations are brought to account;
b. that appropriate measures are taken to protect and/or to replace assets. These to include decisions regarding insurance, inventory control, and the reporting of losses;
c. that donated assets received on trust shall be accounted for appropriately;
d. that all assets acquired from Charitable Funds which are intended to be retained within the funds are appropriately accounted for.

16.10 Reporting

16.10.1 The Chief Finance Officer shall ensure that regular reports are made to the Corporate Trustee with regard to, inter alia, the receipt of funds, investments and expenditure.

16.10.2 The Charity Committee shall prepare annual accounts in the required manner, which shall be submitted, to the Corporate Trustee within agreed timescales.

16.10.3 The Corporate Trustee shall prepare an annual trustees' report and the required returns to the Charity Commission for adoption by the Corporate Trustee.

16.11 Accounting and Audit

16.11.1 The Charity Committee shall maintain all financial records to enable the production of reports as above and to the satisfaction of internal and external audit.

16.11.2 Distribution of investment income to the charitable funds and the recovery of administration costs shall performed on a basis determined by the Chief Finance Officer.

16.11.3 The Chief Finance Officerhall ensure that the records, accounts and returns receive adequate scrutiny by internal audit during the year. He/she will liaise with external audit and provide them with all necessary information.

16.11.4 The Corporate Trustee shall be advised by the Director of Finance on the outcome of the annual audit.

16.12 Taxation and Excise Duty

16.12.1 The Corporate Trustee shall ensure that the Charity's liability to taxation and excise duty is managed appropriately, taking full advantage of available concessions, through the maintenance of appropriate records, the preparation and submission of the required returns and the recovery of deductions at source.

17 RETENTION OF RECORDS AND INFORMATION

17.1 General

17.1.1 All NHS records are public records under the terms of the Public Records Act 1958 section 3 (1) – (2). The Secretary of State for Health and all NHS organisations have a duty under this Act to make arrangements for the safe keeping and eventual disposal of all types of records, information and data.

17.1.2 The Trust must achieve the standards set out in the General Data Protection Regulations (GDPR), including the requirements of the Data Protection Act 2018 (which is the UK's implementation of GDPR) and the Freedom of Information Act 2000.

17.2 Accountability

17.2.1 The Chief Executive and senior managers are personally accountable for records management within the organisation. Additionally, the organisation is required to take positive ownership of, and responsibility for, the records legacy of predecessor organisations and / or obsolete services. Under the Public Records Act, all NHS employees are responsibility for any records that they create or use in the course of their duties. Thus any records created by an employee of the NHS are public records and may be subject to both legal and professional obligations.

17.2.2 The Chief Executive shall be responsible for maintaining archives for all documents as delegated to the Chief Finance Officer which are required to be retained under the direction contained in the Records Management Code of Practice for Health and Social Care 2020 and also the National Archive Retention Schedule.

17.3 Types of Record Covered by the Code of Practice

17.3.1 The guidelines apply to NHS records of all types (including records of NHS patients treated on behalf of the NHS in the private healthcare sector) regardless of the media on which they are held (usually these records will be on paper or digital):

- Health and care records
- Registers e.g. birth, death, Accident and Emergency, Theatre, minor operations
- Administrative records e.g. personnel, estates, financial and accounting records, notes associated with complaint-handling
- X-ray and imaging reports, output and other images
- Secondary uses records (i.e. records that relate to uses beyond individual care) e.g. records used for service management, planning, research

The format may include

- Digital
- Paper
- Photographs, slides and other images
- Microform (i.e. fiche / film)
- Audio and video tapes, cassettes, CD-ROM etc.
- Emails
- Computerised records
- Scanned records
- Text messages (SMS) and social media (both out-going from the NHS and in-coming responses from the patient) such as Twitter and Skype
- Metadata added to, or automatically created by, digital systems when in use. Content can sometimes be of little value if it is not accompanied by relevant metadata.
- Websites and intranet sites that provide key information to patients/service users and staff.

17.3.2 The documents held in archives shall be capable of retrieval by authorised persons.

17.3.3 Documents shall be retained for at least the retention periods indicated in the Records Management Code of Practice for Health and Social Care 2020 (Appendix II) and also the National Archive Retention Schedule depending upon the types of documents involved.

17.3.4 Where appropriate under the Records Management Code of Practice for Health and Social Care 2020 the National Archive Retention Schedule, documents held shall only be destroyed at the express instigation of the Chief Executive. Records shall be maintained of documents so destroyed.

17.3.5 The methods used for the destruction of confidential records should ensure that their confidentiality is fully maintained. Destruction should normally be by incineration or shredding.

17.4 Scanning of Documents

17.4.1 Where Departments with the Trust adopt the practice of scanning documents as a means of retention, the principles should follow as above.

18. RISK MANAGEMENT, INSURANCE AND LITIGATION

18.1 GENERAL

18.1.1 The Chief Executive shall ensure that the Trust has an effective system of risk management and internal control set out in strategy, policy and procedural documentation. The functioning and efficacy of the system of risk management and internal control shall be monitored and assessed for suitability by the Board of Directors and its duly established committees.

18.1.2 The risk management strategy and framework shall contain the following elements:

a. the continuous identification and prioritisation of key risks
b. a description of actions taken to manage each key risk; and
c. the identification of how risk is measured.

18.1.3 The programme of risk management shall include:

a. a process for identifying and quantifying risks and potential liabilities;
b. engendering among all levels of staff a positive attitude towards the control of risk;
c. management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;
d. contingency plans to offset the impact of adverse events;
e. audit arrangements including; Internal Audit, External Audit, clinical audit and health and safety reviews;
f. a clear indication of which risks are required to be insured;
g. arrangements to review the Risk Management programme.

18.1.4 The existence, integration and evaluation of the above elements will assist in providing the basis for the Annual Governance Statement as required by NHS England.

18.2 Insurance arrangements

18.2.1 The Board shall decide whether the Trust will insure through the risk pooling schemes administered by NHS Resolution or self-insure for some, or all of the risks covered by the risk pooling schemes. If the Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

18.2.2 The following arrangements are to be followed by the Boards in agreeing Insurance cover:

a. Where the Board decides to use the risk pooling schemes administered by the NHS Resolution the Trust Secretary shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Trust Secretary shall ensure that documented procedures cover these arrangements.
b. Where the Board decides not to use the risk pooling schemes administered by the NHS Resolution for one or more of the risks covered by the schemes, the Trust Secretary shall ensure that the Board is informed of the nature and extent of the risks that are self insured as a result of this decision. The Trust Secretary will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed from the schemes.
c. All the risk pooling schemes require Scheme members to make some contribution to the settlement of claims (the 'deductible'). The Chief Finance Officer should ensure documented procedures also cover the management of claims and payments below the deductible level in each case.

18.2.3 Standard Areas for Commercial Insurance Cover

Foundation Trusts may enter commercial arrangements for various activities. The Board shall ensure that appropriate insurance is in place for any commercial activities not covered by the arrangements under 20.2.2 including:

a. The insuring of motor vehicles owned by the Trust and insuring third party liability arising from their use;

b. Where the Foundation Trust is involved with a consortium in a Private Finance Initiative contract and the other consortium members require that commercial insurance arrangements are entered into; and
c. Where income generation activities take place. Income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the Trust for a NHS purpose the activity may be covered in the arrangements entered into under 20.2.2l. Confirmation of such coverage must be obtained from NHS Resolution. In any case of doubt concerning the Trust's powers to enter into commercial insurance arrangements the Chief Finance Officer should consult the Department of Health and Social Care.

18.2.4 Consideration for Other Areas of Insurance Cover

As a Foundation Trust the Board need to consider the adequacy of insurance cover recognising the Public Benefit Corporation status. Key areas to consider include:

a. Directors' and Officers' Liability – Recognising the cover available through the NHS Resolution, consideration is required to the adequacy of the cover in respect of selling assets, entering into contracts and insolvency indemnity cover.
b. Property Damage – consider the provision for underwriting claims.
c. Business interruption resulting from property damage – consider the provision to cover for loss of income.

18.2.5 The Trust Secretary shall act as the Trust's contact on insurance matters, liaising with insurance brokers over queries and negotiating renewal terms.

18.2.6 The Chief Nurse shall ensure timely reporting of incidents against insurance provision on the third-party liability scheme in line with the limits set in the Scheme of Reservation and Delegation.

18.2.7 The Trust Secretary shall ensure timely reporting of losses and the submission of claims against insurance provision.

18.3 Clinical risk management / CNST

18.3.1 The Chief Nurse shall:

(a) Provide a central point of contact within the Trust for NHS Resolution/CNST issues,
(b) Report on claims to Trust Board within the set limits and values as detailed in the Scheme of Reservation and Delegation

18.4 Litigation payments

18.4.1 Claims from Staff, Patients and the Public

18.4.1.1 Out of court settlement of claims from staff, patients and the public shall be made where the NHS Resolution considers it appropriate to do so. Occupier liability claims carry an excess of £3k and employer liability claims carry an excess of £10k. The approval levels for these are detailed within the Scheme of Reservation and Delegation.

18.4.1.2 The financial responsibility for the payment of all claims is the responsibility of the NHS Resolution with Stockport NHS Foundation Trust as the defendant. However the Deputy Director of Quality Governance will notify the Chief Nurse of any claims over £100k. The Chief nurse will appraise the private board of any cases over £100k where appropriate.

18.4.1.3 The Chief Nurse must be consulted before making any special payments that are novel, contentious or repercussive. Any payments which are made against the legal advice given must be approved by the Chief Executive and Board of Directors.

18.5 Health and Social Care Act 2003 – NHS Charges

18.5.1 Part 3 of the Health and Social Care (Community Health and Standards) Act 2003 makes provision for the establishment of a scheme to recover the costs of providing treatment to an injured person in all cases where that person has made a successful personal injury compensation claim against a third party.

18.5.2 Regarding any claim settled by the Trust and/or by NHS Resolution, there is a requirement to report all such matters in advance of settlement to the Compensation Recovery Unit (DWP). In the event that any NHS charges are payable, these will be met in full by the compensator i.e. any other NHS Trust. In the event the compensator is Stockport NHS Foundation Trust the act provides that SFT is exempt from repaying their “own” costs.

18.6 Employment Tribunals

18.6.1 All settlement agreements must be approved by the Director of People and Organisational Development or in their absence the Chief Executive.

18.6.2 Any settlement agreement in excess of contractual entitlement must be approved by the Director of People and OD and the Chief Finance Officer. In

certain cases, according to the current guidance, additional approval should be sought from NHS England and/or HM Treasury.

18.6.3 The out of court settlement of Employment Tribunal applications shall only be made where the Director of People and OD advises it to be prudent to so do and only after taking into account the monetary sum involved and any legal advice received. The limits are detailed in the Scheme of Reservation and Delegation.

18.6.4 NHS England must be consulted before making any special payments that are novel, contentious or repercussive. The Director of People and OD in the case of any compromise agreements shall submit a business case to be approved by Treasury. Any payments made against legal advice must be approved by Trust Board.

19 TENDERING AND CONTRACT PROCEDURE

19.1 Duty to comply with SFIs

19.1.1 The procedure for making all contracts by or on behalf of the Foundation Trust, both in relation to income and expenditure shall comply with these SFIs.

19.1.2 All tendering and contracting must be carried out by the Procurement Department with the exception of Pharmacy. However, the Procurement Department should still be involved to provide guidance and support, as appropriate, to ensure procurement in this area is undertaken in accordance with the requirements of these Standing Financial Instructions.

19.1.3 No employee is to enter into commercial discussions with potential or actual suppliers without the full agreement and involvement of the Procurement Department.

19.2 Directives governing public procurement

19.2.1 The UK Public Contracts Regulations 2015 prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in these Standing Financial Instructions. (Note that the EU regulations were removed from 1.1.2020).

19.2.2 Procedure notes detailing Public Contract Thresholds and the differing procedures to be adopted must be maintained within the Foundation Trust. These are detailed within Appendix 1 of the Trust's Procurement Policy; the thresholds are subject to change, up or down.

19.2.3 The Foundation Trust shall comply as far as is practicable with the requirements of “Estate code” in respect of estate and property transactions.

19.2.4 The Foundation Trust shall comply as far as practicable with best financial practice and accounting standards when conducting estate and property transactions.

19.2.5 In the case of management consultancy contracts the Trust shall comply as far as is practicable with Department of Health and Social Care guidance "The Procurement and Management of Consultants within the NHS".

19.3 Formal Competitive Tendering

19.3.1 The Trust shall ensure that competitive tenders are invited for the supply of goods, materials and manufactured articles and for the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by DHSC); for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); and for disposals.

19.3.2 The only exceptions to the above are the Pharmacy Department, which is permitted to procure drugs without seeking the advice of Procurement. The procurement of drugs will be undertaken through the Pharmacy Department, where the Chief Pharmacist will follow similar procurement procedures to those set out below.

19.3. Where the Foundation Trust elects to invite tenders for the supply of healthcare these SFIs shall apply as far as they are applicable to the tendering procedure.

19.3.3 The contract value should be calculated by aggregating the estimated total annual value of the goods, service or works and multiplying this by the number of years that the contract is to run. If the contract does not specify the contract length, then four years shall be taken as the multiplier.

19.3.4 Formal tendering procedures need not be applied where:

a) the estimated expenditure or income does not, or is not reasonably expected to, exceed the limit set in the Scheme of Reservation and Delegation, (this figure to be reviewed annually); or
b) where the supply is proposed under special arrangements negotiated by DHSC in which event the said special arrangements must be complied with; or

c) regarding disposals as set out in standing financial instruction no. 13.

19.3.5 Other than the above, Formal Tendering Procedures may be waived in the following circumstances, with the exception of tenders in excess of the Public Contract Regulation upper thresholds:

a. in very exceptional circumstances where the Chief Executive decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are detailed in an appropriate Trust record;

b. where the requirement is covered by an existing contract;

c. Formal tendering is not required if goods and services are obtained via a framework contract put in place by a recognised body and which is open for the Trust to utilise. This work will still be undertaken by the Procurement Department.;

d. where the timescale genuinely precludes competitive tendering. Failure to plan the work properly is not a justification for single tender;

e. where specialist expertise is required and is available from only one source;

f. the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;

g. there is a clear benefit to be gained from maintaining either continuity with an earlier project and/or conformity with existing equipment. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering;

h. There is a clear benefit to be gained from maintaining continuity with an earlier project. However, in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering.

i. for the provision of legal advice and services providing that any legal firm or partnership commissioned by the Trust is regulated by the Law Society for England and Wales for the conduct of their business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel's

opinion) and are generally recognised as having sufficient expertise in the area of work for which they are commissioned;

j. the goods or materials to be supplied consist of repairs to parts for existing equipment or extensions thereto which, for practical reasons, must be from the same manufacturer

19.3.6 The waiving of competitive tendering procedures and the limited application of the single tender rules should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

19.3.7 Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented (using the approved form) and reported by the Chief Finance Officer to the Audit Committee meeting for ratification.

19.3.8 The Board shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, having regard to their capacity to supply the goods or materials or to undertake the services or works required. The minimum number of tenders to be invited is three (not less than five for EU tenders).

19.3.9 The Trust shall ensure that the firms/individuals invited to tender (and where appropriate, quote) are among those on approved lists. Where in the opinion of the Chief Finance Officer it is desirable to seek tenders from firms not on the approved lists the reason shall be recorded in writing to the Chief Executive.

19.3.10 Competitive tendering shall be carried out in accordance with the Tendering Procedure set out in the Trust's Procurement Policy.

19.4 Quotations

19.4.1 Competitive Quotations are required where formal tendering procedures are waived under SFI 19.3.5(a) or (c) and where the intended expenditure or income exceeds, or is reasonably expected to be more than £15,000 (but not exceed £50,000) including VAT irrespective of recovery arrangements.

19.4.2 Where quotations are required they should be obtained from at least three firms/individuals based on specifications or terms of reference prepared by, or on behalf of, the Board.

19.4.3 Quotations should be in writing unless the Chief Executive or his/her nominated officer determines that in exceptional circumstances it is

impractical to do so, in which case quotations may be obtained by email or telephone. Confirmation of email or telephone quotations must be obtained in writing as soon as possible and the reasons why the email/telephone quotation was obtained should be set out in a permanent record.

19.4.4 A permanent record should be retained for all quotations.

19.4.5 All quotations should be treated as confidential and should be retained for inspection.

19.4.6 The Chief Executive or his nominated officer should evaluate the quotations and select the one that gives the best value for money and/or the most economically advantageous. If this is not the lowest then this fact and the reasons why the lowest quotation was not chosen should be in a permanent record.

19.4.7 Non-competitive quotations in writing may be obtained for the following purposes (with the exception of quotations that breach the Public Contracts Regulation upper threshold):

a) the supply of goods/services of a special character for which it is not, in the opinion of the Chief Executive or his nominated officer, possible or desirable to obtain competitive quotations;
b) the goods/services are required urgently;
c) miscellaneous services, supplies and disposals within financial limits determined by the Foundation Trust;
d) specialist expertise is required and is available from only one source;

e) the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate; or
f) there is a clear benefit to be gained from maintaining either continuity with an earlier project and/or conformity with existing equipment. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tenders or quotations;

19.4.8 All requests to progress with waivers must receive prior approval. All such non-competitive action will require the completion of a waiver form. Waiver forms should be initially sent to the Head of Procurement to review and authorise, if appropriate. Waiver forms require authorisation as set out in accordance with the financial limits.

19.4.8 Where it is decided that the requirement for competitive quotations is not applicable and should be waived, the fact of the waiver and the reasons

should be documented and reported by the Chief Finance Officer to the Audit Committee meeting for ratification through the provision of regular reports by the Head of Procurement.

19.4.9 Where tenders or quotations are not required, because expenditure is below £15,000, the Trust shall procure goods and services in accordance with procurement procedures approved by the Board.

19.5 Frameworks

19.5.1 Where a Framework Agreement has been established by other public sector bodies, the Head of Procurement will assess its appropriateness to the Foundation Trust prior to utilisation. Framework agreements can be complex and must be reviewed by Procurement; it is not sufficient to take the advice of a supplier as confirmation.

19.5.2 The Head of Procurement will ensure the Trust's register of suppliers suitable for the supply of goods or services is kept via the Trust's contracts database. The Head of Procurement will also access such other registers available for use by the NHS.

19.5.3 The Head of Procurement will determine which register (framework agreements) may be used.

19.5.4 The Head of Procurement shall ensure all tenders provide open competition and comply with relevant Department of Health & Social Care guidance.

19.5.5 This does not preclude the assessment at either, or both, pre-qualification questionnaire or evaluation of tender stage, of contractor suitability in for example:

a) Experience and qualifications.

b) Understanding of the Trust's needs.
c) Feasibility and credibility of proposed approach.
d) Viability to deliver the goods or services.
e) Health and safety record.
f) Environmental considerations.
g) Financial standing – Chief Finance Officer responsibility.
h) Clinical governance - Medical Director responsibility.

19.6 Auctions

19.6.1 Should the Trust choose to access auctions (of any kind) as a process for procurement, this must be done through the Procurement Department and

the Chief Finance Officer must be assured the process complies with best practice guidelines.

19.7 Contracts

19.7.1 The Trust may only enter into contracts within its statutory powers delegated to it by the Secretary of State and NHSE, and shall comply with:

a. these SFIs;
b. Public Contract Regulations and other statutory provisions;
c. any relevant directions including the Capital Investment Manual, Estate Code, and guidance on the Procurement and Management of Consultants
d. such of the NHS Standard Contract Conditions as are applicable; and
e. Be compliant with the latest government guidance and policy regarding transparency within procurement.

19.7.2 Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

19.7.3 In all contracts made by the Trust, the Board shall endeavour to obtain best value for money. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

19.8 Personnel and Agency or Temporary Staff Contracts

19.8.1 The Chief Executive shall nominate officers with delegated authority to enter into contracts for the employment of other officers, to authorise re-grading of staff, and enter into contracts for the employment of agency staff or temporary staff. This must comply with the Trust's Temporary Staffing Policy and requirements of the Staffing Approval Group.

19.8.2 Employment of agency staff or temporary staff should be through NHS Framework approved agencies, details of which are held within the Procurement Department. Any variation to this requires an authorised waiver as per the tender waiver procedures above.

19.9 Healthcare Services Agreements

19.9.1 Service agreements with NHS providers for the supply of healthcare services shall be drawn up in accordance with the National Health Service Act 2006 and administered by a trust. Such service agreements are not contracts in law and therefore not enforceable by the courts. However, a contract with a

Foundation Trust, being a Public Benefits Corporation, is a legal document and is enforceable in law.

19.9.2 Healthcare Service Contracts made between the Foundation Trust and persons other than Health Service bodies/General Medical Practitioners are likely to constitute legally binding contracts.

19.9.3 The Chief Executive shall nominate officers with power to negotiate for the provision of healthcare services with purchasers of healthcare.

19.10 Cancellation of Contracts

19.10.1 Except where specific provision is made in model Forms of Contracts or Standard Schedules of Conditions approved for use within the National Health Service, there shall be inserted in every written contract a clause empowering the Foundation Trust to cancel the contract and to recover from the contractor the amount of any loss resulting from such cancellation:

a. If the contractor shall have offered, or given or agreed to give, any person any gift or consideration of any kind as an inducement or reward for doing or forbearing to do, or
b. for having done or forborne to do any action in relation to the obtaining or execution of the contract or any other contract with the Foundation Trust, or
c. for showing or forbearing to show favour or disfavour to any person in relation to the contracts or any other contract with the Foundation Trust, or
d. if the like acts shall have been done by any person employed by him or acting on his behalf (whether with or without the knowledge of the contractor), or
e. if in relation to any contract with the Foundation Trust the contractor or any person employed by him/her or acting on his/her behalf shall have committed any offence under the Prevention of Corruption Acts 1889 and 1916, the Bribery Act 2010 and other appropriate legislation.

19.11 Determination of Contracts for the failure to deliver goods or materials

19.11.1 There shall be inserted in every written contract for the supply of goods or materials a clause to secure that, should the contractor fail to deliver the goods or materials or any portion thereof within the time or times specified in the contract, the Trust may without prejudice determine the contract either wholly or to the extent of such default and purchase other goods, or material of similar description to make good

a. such default, or
b. in the event of the contract being wholly determined the goods or materials remaining to be delivered.

19.11.2 The clause shall further secure that the amount by which the cost of so purchasing other goods or materials exceeds the amount which would have been payable to the contractor in respect of the goods or materials shall be recoverable from the contractor.

19.12 Contracts involving Funds Held on Trust

19.12.1 Such contracts shall be maintained individually to a specific named fund. Such contracts involving charitable funds shall comply with the requirements of the Charities Acts.

19.13 Disposals

19.13.1 Competitive Tendering or Quotation procedures (dependant on estimated value and the same competitive process as per 19.3. and 19.4) shall not apply to the disposal of:

a. any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or his nominated officer;
b. obsolete or condemned articles and stores, which may be disposed of in accordance with the policy of the Trust;
c. items to be disposed of with an estimated sale value defined in the Scheme of Reservation and Delegation, (this figure to be reviewed annually);
d. items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;
e. land or buildings concerning which NHS England guidance has been issued but subject to compliance with such guidance.

19.14 In-House Services

19.14.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Trust may also determine from time to time that in-house services should be market tested by competitive tendering.

19.14.2 In all cases where the Trust determines that in-house services should be subject to competitive tendering the following groups shall be set up:

a. Specification group, comprising the Chief Executive or nominated officer(s) and specialist(s);
b. In-house tender group, comprising representatives of the in-house team, a nominee of the Chief Executive and technical support;
c. Evaluation group, comprising normally a specialist officer, a supplies officer and a Director of Finance representative. For services having a likely annual expenditure exceeding £250,000, a non-executive director should be a member of the evaluation group.

19.14.3 All groups should work independently of each other but individual officers may be a member of more than one group. No member of the in-house tender group may however, participate in the evaluation of tenders.

19.14.4 The evaluation group shall make recommendations to the Board.

19.14.5 The Chief Executive shall nominate an officer to oversee and manage the contract.

20. STANDARDS OF BUSINESS CONDUCT

20.1 The Chief Executive shall ensure that all staff, volunteers, and any other person associated with the activities of the Trust are made aware of, and comply with, the Trust's Business Conduct Policy. This policy details the conduct and behaviour expected of individuals with regard to:

a) Interests (financial or otherwise) in any matter affecting the Trust and the provision of services to patients, public and other stakeholders;
b) Conduct by an individual in a position to influence purchases;
c) Employment and business which may conflict with the interests of the Trust;
d) Relationships and loyalties which may conflict with the interests of the Trust;
e) Hospitality and gifts and other benefits in kind such as sponsorship.

Declarations relating to the above must be made to the Trust Secretary for inclusion in the Register of Interests.

20.2 The Bribery Act 2010 reforms the criminal law of bribery, making it easier to tackle this offence proactively in the public and private sectors. It introduces a corporate offence which means that organisations are exposed to criminal liability, punishable by an unlimited fine, for negligently failing to prevent bribery. In addition, the Act allows for a maximum penalty of 10 years' imprisonment for offences committed by individuals.

20.3 Under the Bribery Act 2010 it is a criminal offence to:

a) Bribe another person by offering, promising, or giving a financial or other advantage to induce them to perform improperly a relevant function or activity, or as a reward for already having done so.
b) Be bribed by another person by requesting, agreeing to receive or accepting a financial or other advantage with the intention that a relevant function or activity would then be performed improperly, or as a reward for having already done so.

20.4 These offences can be committed directly or by and through a third person and, in many cases, it does not matter whether the person knows or believes that the performance of the function or activity is improper. It is, therefore, extremely important that staff adhere to this and other related policies (specifically, Anti-fraud, Bribery and Corruption, Business Conduct and Whistle Blowing policies, available via Trust intranet).

20.5 The action of all staff must not give rise to, or foster the suspicion that they have been, or may have been, influenced by a gift or consideration to show favour or disadvantage to any person or organisation. Staff must not allow their judgement or integrity to be compromised in fact or by reasonable implication.

20.6 Staff should not be afraid to report genuine suspicions of fraud, bribery or corruption and should report all suspicions to the Local Counter Fraud Specialist (LCFS) who is responsible for tackling any concerns. Alternatively, suspicions can be reported via the National fraud and corruption reporting line (0800 028 40 60) or via the National Fraud Reporting website www.reportnhsfraud.nhs.uk.

21. CUSTODY OF THE SEAL, SEALING OF AND SIGNING OF DOCUMENTS

21.1 Sealing documents

21.1.1 As set out in the Standing Orders and Scheme of Delegation, the Trust Secretary on behalf of the Chief Executive shall keep the Common Seal of the Trust.

21.1.2 A document purporting to be duly executed under the Trust's seal or to be signed on its behalf is to be received in evidence and, unless the contrary is proved, taken to be so executed or signed. The Trust is to have a seal, but this is not to be affixed except under the authority of the Board of Directors.

21.2 Requirements to seal

21.2.1 It is a legal requirement to place any property transactions e.g. purchase, sale, and lease, under seal.

21.2.2 Other contracts/documentation should be approved by an authorised signatory 'under hand' i.e. signed.

21.2.3 Before any building, engineering, property or capital document is sealed it must be approved and signed by the Chief Finance Officer (or an officer nominated by him/her) and authorised and countersigned by the Chief Executive (or an officer nominated by him/her who shall not be within the originating directorate).

21.3 **Register of sealing**

21.3.1 An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal.

21.3.2 A report of all sealings shall be made to the Board at least annually. The report shall contain details of the seal number, the description of the document and date of sealing.

21.4 **Signature of documents**

21.4.1 Delegated authority in legal proceedings

Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive or an officer acting on his/her behalf, unless any enactment otherwise requires or authorises, or the Board shall have given the necessary authority to some other person for the purpose of such proceedings.

21.4.2 Delegated authority not required to be executed under deed

The Chief Executive or nominated officers shall be authorised, by resolution of the Board, to sign on behalf of the Foundation Trust any agreement or other document (not required to be executed as a deed) the subject matter of which has been approved by the Board or committee or sub-committee to which the Board has delegated appropriate authority.

21.5 Use of Electronic Signatures

21.5.1 The Accountable Officer has overall responsibility for ensuring that information is handled appropriately in order to protect information from unauthorised disclosure or misuse

21.5.2 The legal definition of an "electronic signature" is anything in electronic form which is:
(a) Incorporated into or otherwise logically associated with any electronic communication or electronic data; and
(b) Purports to be so incorporated or associated for the purpose of being used in establishing the authenticity of a communication or data, the integrity of the communication or data, or both. Electronic Communications Act 2000 and Electronic Signatures Regulations 2002.

21.5.3 From a legal perspective there is normally no need to include an image of a signature in a document. The (typed) text at the end of an email acts as a signature if it meets the requirements in (a) and (b) above. This applies to Trust emails.

21.5.4 Staff implementing electronic signatures must ensure that the appropriate form of electronic signature is used to meet the requirements. The functional requirements of a signature include:
- confirming originality and authenticity of a document;
- demonstrating a document has not been altered;
- indicating a signer's understanding and/or approval;
- indicating a signer's authorisation;
- identifying the signatory and ensuring non-repudiation of a document.

21.5.5 Where signatories are to be inserted as 'on behalf of', authorisation should be obtained in writing, in advance, from the main signatory. This may be in the form of a general delegation of authority or a specific delegation covering a single instance. Verbal approval should be followed up by written approval as soon as possible. In exceptional circumstances, where time is of the essence, (including annual leave), per procurationem (p.p.) signatures may be added without explicit permission. As a minimum, the main signatory must be copied into the document, who should acknowledge receipt.

21.5.6 Requirements

(a) Scanned image of a handwritten signature
As is current practice, a scanned image of a handwritten signature can be used as an equivalent to a written signature. Scanned images must only be used where express permission has been granted by the author and are therefore more likely to be acceptable for high volume processes such as

mass mailings. Scanned images of signatures must be kept securely to prevent unauthorised access and fraudulent use.

Responsibility for authorisations made by scanned signature remains with the signature's author however the author will not be held responsible for any malicious, fraudulent or negligent activity carried out by the proxy. Though it is only a small deterrent to copying images of signatures, they should be sent outside the organisation in PDF files rather than emails, Word documents or spreadsheets.

Documents containing the image of another person's signature must not be sent without the express agreement of the person concerned, unless prior delegation and clearance procedures have been agreed. In addition:

- such agreement, including the list of recipients, must be obtained in advance for each document.
- the content of the document must not be changed after authorisation to issue it has been obtained.
- once such a document has been sent, it must not be sent again (or to additional recipients) without further explicit authorisation.

(b) Authorisation by email

An email from an individual user's Trust e-mail address can be used as an equivalent to a written signature for internal purposes. Responsibility for authorisations made by email remains with the email account holder unless the proxy is acting maliciously, fraudulently or negligently or unauthorised access to the account has been obtained in breach of the Computer Misuse Act 1990.

(c) Advance or qualified electronic signatures

Advance or qualified signatures may be required by third parties when greater assurance is required particularly for contractual signatures.

22 MISCELLANEOUS

22.1. New Employee Notification of SFIs

22.1.1 It is the duty of the Chief Executive to ensure that existing members and officers and all new appointees are notified of and understand their responsibilities within Standing Financial Instructions. Updated copies shall be issued to staff designated by the Chief Executive.

22.2 Review of Standing Financial Instructions

22.2.1 SFIs shall be reviewed every three years by the Board.

REFERENCES

The following table shows the website addresses for obtaining the documents contained in these instructions and for additional reference:

Website	Document
https://www.gov.uk/government/organisations/department-of-health-and-social-care Department of Health & Social Care	NHS Internal Audit Manual NHS Costing Manual Commercial Sponsorship – Ethical Standards National Tariff CONCODE NHS Charitable Funds Procurement & Management of Consultants in the NHS Capital Investment Manual
https://www.nao.org.uk/code-audit-practice/	Code of Audit Practice
www.legislation.gov.uk	Health and Social Care Act 2012
www.nhsbsa.nhs.uk	NHS Protect Fraud & Corruption Manual
www.hmrc.gov.uk HM customs & excise	Construction Industry Tax Deduction Scheme
www.resolution.nhs.uk	NHS Resolution (formerly NHS Litigation Authority)
Department for Work and Pensions - GOV.UK (www.gov.uk)	Department of Works and Pensions
www.frc.org.uk	Financial Reporting Council
www.charitycommission. gov.uk	Charities Commission
www.digital.nhs.uk	NHS Digital
Records Management Code of Practice - NHS Transformation Directorate (england.nhs.uk)	Records Management Code of Practice 2020

Stockport NHS Foundation Trust intranet site also provides copies of key documents which can be found under the following headings:

Intranet Menu	Section	Details
Microsites - Finance & Procurement	Documents	Scheme of Reservation & Delegation Procurement Policy Financial Procedure instructions
Microsites - Human Resources	Documents	Recruitment and staffing documentation
Corporate Documents	Policies	Freedom of Information policy Standards of Business Conduct Policy
Corporate Documents	Standard Operating Procedures	Tender Opportunities Process

Table of key amendments

No	Section	Date
	AMENDMENTS FROM 2021 VERSION	
1	References to NHS Improvement amended to NHS England	Feb 2024
2	Section 1.4 Inclusion of new section on escalation of non-compliance with Standing Financial Instructions	Feb 2024
3	Section 2 – update to the responsibilities of the Audit Committee and update to reference the Trust Local Anti-Fraud, Bribery and Corruption Policy	Feb 2024
4	Section 4 – Remove the reporting requirements for the Annual Quality Report	Feb 2024
5	Section 5 – Inclusion of section 5.5 for the use of electronic bank transfers.	Feb 2024
6	Section 6 – Amendment to reference to payments by results at 6.2.1, 6.5.1 reference to online charitable giving platforms and update to section 6.2.4 on sponsorship section to reference Trust Standards of Business Conduct and Conflict of Interest Policy.	Feb 2024
7	Section 7 – removal of sections that reference legal contracts with commissioners	Feb2024
8	Section 9 – Inclusion of section 9.3.5 on charitable funds.	Feb 2024
9	Section 11 – Updating of external borrowing to include reference to revenue support.	Feb 2024
10	Section 8.3.1 Replace Establishment Control Panel with Staffing Approval Group	Feb 2024
11	Section 9.3.3 – CFO responsibility for design of procedures for purchasing cards	Feb 2024
12	Section 13.1.1 – replace Protected Property with assets to deliver Commissioner Requested Services	Feb 2024
13	Section 13.2.4: new line on review of admin controls following losses	Feb 2024
14	Section 14 Amend title to Information Management and Digital from IM and Technology	Feb 2024
15	Section 15.1.3 – remove reference to managing money held in account for patients incapable of handling own affairs	Feb 2024
16	Section 16 – replace Board of Directors with Corporate Trustee, replace Internal Funds with Designated Funds, new section on external grants	Feb 2024
17	Section 17.1 split to reference General Data Protection Regulations (GDPR)	Feb 2024

18	Section 19.1.2 and 19.3.2 – include reference to separate ordering process for Pharmacy	Feb 2024
19	Section 19.1.3 – include responsibility for no employee to enter into commercial discussions without involvement of the Procurement Department	Feb 2024
20	Section 19.4.8 – new line on requirement for the prior approval of waivers	Feb 2024
21	Section 19.5 – new section on the use of Frameworks	Feb 2024
22	Section 19.6 – update to wording on use of auctions by Procurement	Feb 2024
23	Amend Director of Finance to Chief Finance Officer throughout document	Feb 2024
24	Amend Director of Workforce and OD to Director of People and OD throughout document	Feb 2024

Equality Impact Assessment – Policies, SOP's and Services not undergoing re-design

1	**Name of the Policy/SOP/Service**	Standing Financial Instructions	
2	**Department/Business Group**	Finance & Procurement	
3	**Details of the Person responsible for the EIA**	Lisa Byers	Associate Director of Finance
4	**What are the main aims and objectives of the Policy/SOP/Service?**	These financial instructions are one of the key governance documents for the Trust and are applicable to all employees.	

For the following question, please use the EIA Guidance document for reference:

5	**A) IMPACT** **Is the policy/SOP/Service likely to have a <u>differential</u> impact on any of the protected characteristics? If so, is this impact likely to be positive or negative?** **Consider:** • Does the policy/SOP apply to all or does it exclude individuals with a particular protected characteristic e.g. females, older people etc? • What does existing evidence show? E.g. consultation from different groups, demographic data, questionnaires, equality monitoring data, analysis of complaints. Are individuals from one particular group accessing the policy /SOP /Service more/less than expected?	**B) MITIGATION** **Can any potential negative impact be justified? If not, how will you mitigate any negative impacts?** ✓ Think about reasonable adjustment and/or positive action ✓ Consider how you would measure and monitor the impact going forward e.g. equality monitoring data, analysis of complaints. ✓ Assign a responsible lead. ✓ Designate a timescale to monitor the impacts. ✓ Re-visit after the designated time period to check for improvement.	**Lead**
Age	Workforce Data: Average age 44.5 Stockport Population Data: Largest age band 40 – 49 Older people are more likely to experience serious complications from the virus	- Consider are there any age related impacts? - Is the proposal for all ages or particular age groups? - Mitigating any increased risks. - Dignity & Modesty	NA
Carers / People with caring responsibilities	The 2011 Census showed there are 31,982 unpaid carers in Stockport. 6,970 (22% of all carers) provide 50+ hours of care per week. Signpost for Carers estimate the total value of unpaid care in Stockport is £570 million a year. Trust Workforce: No Data	- Chaperones - Mitigating any increased risks. - Accessible Information	NA

	Carers are more likely to come into contact with vulnerable patients		
Disability	The 2011 census indicates that 18.4% of Stockport residents are living with a limiting long-term illness Trust Workforce: 3.32% report disability. 11.94% not declared COVID impacts are higher among people with long-term conditions COVID impacts are higher among people with long-term conditions	- Accessible communication. - BSL interpreters - Mental capacity - Pictorial images - Hearing loops - learning difficulties - visually impaired - Mitigating any increased risks. - Dignity & Modesty	NA
Race / Ethnicity	Stockport's Black & Minority Ethnic (BME) population has risen from just 4.3% in 2001 to around 8% at the 2011 Census Trust Workforce: BAME make up 16.18% People from Black, Asian and Minority Ethnic (BAME) backgrounds are more likely to experience serious complications from the virus	- Interpreters - Mitigating any increased risks. - Dignity & Modesty	NA
Gender	Stockport's population is split almost equally by gender (51.1% female, 48.9% male), which mirrors the national trend. Trust Workforce: 79.9% female Although women were more likely to have a positive COVID test, men were more likely to die from the disease	- Dignity & Modesty - Mitigating any increased risks. -	NA
Gender Reassignment	It is estimated that 1% of the UK population is gender variant, based on referrals to and diagnoses of people at gender identity clinics. This would equate to 3,000 people in the borough Trust Workforce: No Data Increased risk of severe COVID-19 in people who are on antiretroviral treatment and are not immunosuppressed.	- Dignity & Modesty - Mitigating any increased risks. - Gender Dysphoria - Treating in accordance to preferred identity. - Pronouns	NA
Marriage & Civil Partnership	38% married 0.2% of people in the 2011 census were in a civil partnership – a figure which is consistent across Stockport, the North West and nationally.	- Mitigating any increased risks.	NA

	Trust Workforce: 54.9% married & 0.7% Civil Partnership		
Pregnancy & Maternity	2% fertility rate On average there are over 3,300 births to Stockport resident mothers each year. Trust Workforce: 2.14% on maternity or adoption leave* Pregnant women are included in the list of 'high risk' groups.	- Mitigating any increased risks. - Dignity & Modesty	NA
Religion & Belief	The majority of Stockport residents are Christian (63.2% - down from 75% at the last census), which is 4% greater than the national average. Trust Workforce: 52.47% Christian	- Interpreters - Mitigating any increased risks. - Dignity & Modesty - Religious beliefs	NA
Sexual Orientation	It is estimated that 5-7% of the UK population is LGB, which would equate to 15-21,000 people in the borough. Trust Workforce: 2.12% LGBT 20.09% did not want to declare	- Gender Dysphoria - Utilising Pronouns	NA
General Comments across all equality strands	This section is useful to clarify mitigations that will be applicable across all groups e.g. dignity and modesty.		NA

EIA Sign-Off	**Your completed EIA should be sent to Annela Hussain Equality Diversity & Inclusion Lead for approval and publication:** equality@stockport.nhs.uk **0161 419 4784**

Data Protection Impact Assessment

Organisations have to ensure that the third parties they both process and share personal confidential data with, will ensure the data is secure and confidential. To assess the implications of using personal data, a risk assessment called a Data Privacy Impact Assessment (DPIA) is required.

If you are doing any of the following you will need to complete a Data Privacy Impact Assessment (DPIA):

- Setting up a new process using personal confidential data (PCD)
- Changing an existing process which changes the way personal confidential data is used
- Procuring a new information system which holds personal confidential data

A DPIA is a proforma or risk assessment which asks questions about the process or new system based on data quality / data protection / information security and technology.

DPIA Screening Questions

		Yes	No	Unsure	Comments *Document initial comments on the issue and the privacy impacts or clarification why it is not an issue*
a)	Will the process described involve the collection of new information about individuals?		no		Click here to enter text.
b)	Does the information you are intending to process identify individuals (e.g. demographic information such as name, address, DOB, telephone, NHS number)?		no		Click here to enter text.
c)	Does the information you are intending to process involve sensitive information e.g. health records, criminal records or other information people would consider particularly private or raise privacy concerns?		no		Click here to enter text.
d)	Are you using information about individuals for a purpose it is not currentlyused for, or in a way it is not currently used?		no		Click here to enter text.
e)	Will the initiative require you to contact individuals in ways which they may find intrusive[1]?		no		Click here to enter text.
f)	Will the information about individuals be disclosed to organisations or people who have not previously had routine access to the information?		no		Click here to enter text.
g)	Does the initiative involve you using new technology which might be perceived as being intrusive? e.g. biometrics or facial recognition		no		Click here to enter text.
h)	Will the initiative result in you making decisions or taking action against individuals in ways which can have a significant impact on them?		no		Click here to enter text.
i)	Will the initiative compel individuals to provide information about themselves?		no		Click here to enter text.

1. Intrusion can come in the form of collection of excessive personal information, disclosure of personal information without consent and misuse of such information. It can include the collection of information through surveillance or monitoring of how people act in public or private spaces and through the monitoring of communications whether by post, phone or online and extends to monitoring the records of senders and recipients as well as the content of messages.

If you answered YES or UNSURE to any of the above you need to continue with the Privacy Impact Assessment. Giving false information to any of the above that subsequently results in a yes response that you knowingly entered as a NO may result in an investigation being warranted which may invoke disciplinary procedures

Quality (Clinical and Quality Impact Assessment Please record 'No Impact' if this is the case)

Date of initial review	09/07/2021	Date of last review	09/07/21

Area of Impact		Consequence	Likelihood	Total	Potential Impact	Impact (Positive or Negative)	Action	Owner
Quality	Duty of Quality			0	How does it impact adversely the rights and pledges of the NHS Constitution?	No impact		
					How does the impact affect the organisations commitment to being an employer of choice?	No impact		
					What is the equality impact on race, gender, age, disability, sexual orientation, religion and belief, gender reassignment, pregnancy and maternity for individuals access to services and experience of the service?	No impact		
	Patient Safety			0	How will this impact on the organisation's duty to protect children, young people and adults?	No impact		
					How will it impact on patient safety? • infection rates • medication errors •significant untoward incidents and serious adverse events •Mortality & Morbidity •Failure to recognise a deteriorating patient •Safe staffing levels	No impact		
					How will it impact on preventable harm? (eg slips, trips, falls)?	No impact		
					How will it impact upon the reliability of safety systems? (eg WHO checklist)	No impact		
					How will it impact on systems and processes for ensuring that the risk of healthcare acquired infections is reduced?	No impact		
					How will this impact on workforce capability, care and/or skills?	No impact		
Experience	Patient Experience			0	What impact is it likely to have on self-reported experience of patients and service users? (Response to national/local surveys/complaints/PALS/incidents)	No impact		
					How will it impact on choice?	No impact		
					Will there be an impact on waiting times?	No impact		
					How will it impact upon the compassionate and personalised care agenda?	No impact		
	Staff Experience			0	How will it impact on recruitment of staff	No impact		
					What will the impact be on staff turnover and absentee rates	No impact		
					How will it impact on staff satisfaction surveys	No impact		
					How does it impact on implementation of evidence based practice?	No impact		
					How will it impact on patient's length of stay?	No impact		

Effectiveness	**Clinical Effectiveness and Outcomes**			**0**	Will it reduce/impact on variations in care? (eg readmission rates)	No impact		
					What will the impact be upon clinical and cost effective care delivery?	No impact		
					How does it impact upon care pathway(s)? Eg mortality	No impact		
					How will it impact on target performance?	No impact		
Other	**Please use this section to detail any other impacts to clinical and quality that are not listed in the questions**			**0**				

DOCUMENT INFORMATION

Type of Document	Policy
Title	Standing Financial Instructions
Version Number	V 3.0
Consultation	Finance & Procurement Senior Team All senior posts with delegated authority within the document at Executive and Deputy level
Recommended By:	Audit Committee
Approved By:	TBC
Approval Date	TBC
Next Review Date	November 2026
Document Author	Associate Director of Finance
Document Director	Chief Finance Officer
For use by:	All Trust employees
Specialty / Ward / Department (if local procedure document)	

Version	Date of change	Date of release	Changed by	Reason for change
2	22nd July 2021	16th August 2021	Deputy Director of Finance	Refresh date, changes to national policy
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NHS
Stockport
NHS Foundation Trust

SCHEME OF RESERVATION AND DELEGATION

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DELEGATED MATTERS

Delegated Matter
STANDING ORDERS/STANDING FINANCIAL INSTRUCTIONS

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2 INTRODUCTION

2.1. Reservation of Powers

The Code of Governance for NHS provider trusts (2022) (the Code) requires the board of directors of NHS foundation trusts to have a 'schedule of matters specifically reserved for its decisions (B.2.17)'. Furthermore, the Code requires that 'this schedule should include a clear statement detailing the roles and responsibilities of the council of governors.'

The Standing Orders provides that the Board of Directors may make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee, or by an Executive Director of the Trust in each case subject to such restrictions and conditions as the Board of Directors thinks fit**.**

The purpose of this document is to detail how the powers are reserved to the Board of Directors, while at the same time delegating to the appropriate level the detailed application of Foundation Trust policies and procedures. However, the Board of Directors remains accountable for all of its functions; even those delegated to committees, sub committees, individual directors or officers and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

For clarity and completeness this document also includes a schedule of Reservation of Powers to the Council of Governors; and these include those matters for which it has responsibility set out in the NHS Act 2006 (as amended by the Health and Social Care Act 2012).

2.2. Role of the Chief Executive

All powers of the Foundation Trust which have not been retained as reserved by the Board of Directors or delegated to an executive committee or sub-committee shall be exercised on behalf of the Board of Directors by the Chief Executive. The Chief Executive shall prepare a Scheme of Delegation identifying which functions they shall perform personally and which functions have been delegated to other directors and officers for operational responsibility. The Chief Executive on appointment shall receive a letter which details their role in relation to the Accounting Officer and the Accountable Officer.

All powers delegated by the Chief Executive can be re-assumed by the Board of Directors should the need arise.

2.3 Caution over the Use of Delegated Powers

Powers are delegated to directors and officers on the understanding that they would not exercise delegated powers in a manner which in their judgement was likely to be a cause for public concern.

2.4 Absence of Directors or Officer to Whom Powers have been Delegated

In the absence of a director or officer to whom powers have been delegated those powers shall be exercised by that director or officer's superior unless alternative arrangements have been approved by the Board of Directors. If the Chief Executive is absent powers delegated to them may be exercised by their nominated deputy. In the absence of both the Chief Executive and the nominated deputy after taking appropriate financial advice, two directors will be required to ratify any decisions within the Chief Executive's thresholds.

If it becomes clear to the Board of Directors that the Accounting Officer is incapacitated and will be unable to discharge their responsibilities over a period of four weeks or more, the Board of Directors should appoint an acting Accounting Officer, pending the Accounting Officers return. The same applies if, exceptionally, the Accounting Officer plans an absence of more than four weeks during which they cannot be contacted.

3. RESERVATION OF POWERS TO THE BOARD OF DIRECTORS

3.1 Accountability

The Board of Directors must determine those matters on which decisions are reserved unto itself. Board members share corporate responsibility for all decisions of the Board. These reserved matters are set out in the table below:

3.2 Duties

It is the Board's duty to:

- act within statutory financial and other constraints;
- be clear what decisions and information are appropriate to the Board of Directors and draw up Standing Orders, a schedule of decisions reserved to the Board and Standing Financial Instructions to reflect these,
- ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives for the main programmes of action and for performance against programmes to be monitored and senior executives held to account;
- establish performance and quality measures that maintain the effective use of resources and provide value for money;
- specify its requirements in organising and presenting financial and other information succinctly and efficiently to ensure the Board can fully undertake its responsibilities;
- establish Audit and Remuneration Committees on the basis of formally agreed terms of reference that set out the membership of the sub-committee, the limit to their powers, and the arrangements for reporting back to the main Board.

MATTERS RESERVED TO THE BOARD OF DIRECTORS	
General Enabling Provision The Board of Directors may determine any matter, for which it has authority, it wishes in full session within its statutory powers.	
1.	**Regulations & Control**
1.1	Approval of Standing Orders (SOs), a schedule of matters reserved to the Board of Directors and Standing Financial Instructions for the regulation of its proceedings and business.
1.2	Suspend Standing Orders or Standing Financial Instructions
1.3	Vary or amend the Standing Orders or Standing Financial Instructions. Suspend Standing Orders
1.4	Ratification of any urgent decisions taken by the Chair and Chief Executive in public session in accordance with the Standing Orders
1.5	Ratify or otherwise instances of failure to comply with Standing Orders brought to the Chief Executive's attention in accordance with Standing Orders.

1.6	Approval of delegation of powers from the Board of Directors to committees.
1.7	Suspend, vary or amend the delegation of powers from the Board of Directors to committees.
1.8	To establish terms of reference and reporting arrangements of all committees and sub-committees that are established by the Board of Directors.
1.9	To confirm the recommendations of the Foundation Trust's committees where the committees do not have executive powers.
1.10	Requiring and receiving the declaration of Board members' interests which may conflict with those of the Foundation Trust and determining the extent to which that director may remain involved with the matter under consideration.
1.11	Requiring and receiving the declaration of officers' interests which may conflict with those of the Foundation Trust.
1.12	Approval of arrangements for dealing with complaints.
1.13	To receive reports from committees including those which the Foundation Trust is required by the Constitution and the Health and Social Care Act 2012 or other regulation to establish and to take appropriate action thereon.
1.14	Approval of arrangements relating to the discharge of the Foundation Trust's responsibilities as a corporate trustee for funds held on trust.
1.15	Approval of arrangements relating to the discharge of the Foundation Trust's responsibilities as a bailer for patients' property.
1.16	Authorise use of the seal (as defined within the scheme of delegation).
1.17	Disciplining Board members' or employees who are in breach of Statutory Requirements or Standing Orders, Standing Financial Instructions or the scheme of delegation.
2.0	**Appointments / Dismissal / Terms & Conditions**
2.1	Approve any changes to the overall structure of the Board
2.2	Confirm the appointment of the Deputy Chair of the Board of Directors, subject to the approval of the Council of Governors.
2.3	Appointment of the Senior Independent Director (SID), following consultation with the Council of Governors.
2.4	The appointment and dismissal of committees (and individual members) that are directly accountable to the Board of Directors.
2.5	Confirm the appointment of members of any Board Committees as representatives of the Foundation Trust on outside bodies where the Trust has a material interest.
2.6	Appoint, discipline and dismiss the Trust Secretary.
2.7	Consider and approve proposals presented by the Chief Executive for terms and conditions for officer not covered by the Remuneration & Appointments Committee or Nominations Committee
3.	**Policy Determination**
3.1	Make arrangements for the approval of Foundation Trust management policies in accordance with the Policy on the Development of Procedural Documents at the appropriate Board committee including:

	• Human Resources policies incorporating the arrangements for the appointment, removal and remuneration of staff. • Policy & procedures for the standards of business conduct including declaration of gifts, hospitality and sponsorship • Ensure proper and widely publicised procedures for voicing complaints, concerns about misadministration, whistleblowing, fraud, breaches of the duty of candour, breaches of Code of Conduct, and other ethical concerns. • A treasury management policy
3.2	Approve the Trust's policies and procedures for the management of risk
4.	**Strategy, Partnerships, Annual Plans & Budgets**
4.1	Definition of the strategic aims and objectives of the Foundation Trust.
4.2	Approve proposals for ensuring quality and developing clinical governance in services provided by the Foundation Trust, having regard to any guidance issued by the Secretary of State or the Independent Regulator.
4.3	Approve Outline and Final Business Cases for Capital Investment in line with Scheme of Delegation
4.4	Approve budgets.
4.5	Approve annually the Foundation Trust's proposed annual plan and capital expenditure plans
4.6	Ratify proposals for acquisition, disposal or change of use of land and/or buildings
4.7	Approve PFI proposals or similar financial transactions.
4.8	Approve the transfer of services between NHS providers
4.9	Approve proposals on individual contracts, including purchase orders (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to over £750,000 per annum or over £2,000,000 in total if the period of the contract is longer than 3 years. Renewals and contract changes would be reported to the Board and approval sought where these amendments exceeded these thresholds.
4.10	Approve proposals in individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and Chief Finance Officer.
4.11	Approve proposals for action on litigation against or on behalf of the Foundation Trust where the likely financial impact is expected to exceed £10,000 or contentious or novel or likely to lead to extreme adverse publicity, excluding claims covered by the NHS Litigation Authority schemes.
4.12	Review use of NHS Litigation Authority schemes or equivalent insurance arrangements
4.13	Approve the opening of bank accounts.
4.14	Approve individual compensation payments outside of normal contractual entitlements.
5.	**Audit Arrangements**
5.1	To receive recommendations from Audit Committee regarding the appointment (and where necessary dismissal) of the internal auditors. Responsibility for the appointment or removal of the external auditors is held by the Council of Governors.

5.2	Receive the annual management letter (through Audit Committee reporting) received from the external auditor and agreement of proposed action, taking account of the advice, where appropriate, of the Audit Committee.
5.3	Receive an annual report from the Internal Auditor (through Audit Committee reporting) and agree action on recommendations where appropriate of the Audit Committee.
5.4	Receive an annual report on Counter Fraud (through Audit Committee reporting) and agree action on recommendations where appropriate of the Audit Committee.
6.	**Annual Reports and Accounts**
6.1	Ensure appropriate delegation of the review and approval of the Annual Report and Accounts to Audit Committee prior to submission to the regulators and the Council of Governors at a member's meeting.
6.2	Receive the Annual Report and Accounts prior to approval by Audit Committee.
6.3	Ensure appropriate delegation of the review and approval of the Annual Report and Accounts for funds held on Trust to the Charitable Funds Committee
6.4	Receive the Annual Report and Accounts for funds held on Trust prior to approval by Charitable Funds Committee.
7.	**Monitoring**
7.1	Receive such reports as the Board of Directors sees fit from committees or individual directors in respect of their exercise of powers delegated.
7.2	Continuous appraisal of the affairs of the Foundation Trust by means of the provision to the Board of Directors as the Directors may require from directors, committees, and officers of the Foundation Trust.
7.3	Receive reports from Chief Finance Officer on financial performance against budget and operational plan

4. RESERVATION OF POWERS TO THE COUNCIL OF GOVERNORS

MATTERS RESERVED TO THE COUNCIL OF GOVERNORS	
General Enabling Provision In accordance with the Standing Orders of the Council of Governors and the Trust's legal framework, the Council of Governors may not delegate any of its powers to a committee or sub-committee, but it may appoint committees consisting of its members, Directors, and other persons to assist the Council of Governors in carrying out its functions. The Council of Governors may, through the Trust Secretary, request that advisors assist them or any committee they appoint in carrying out its duties.	
1.	**Regulations & Control**
1.1	To hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors
1.2	Approve, suspend, vary or amend the Standing Orders (SOs) of the Council of Governors for the regulation of its proceedings and business
1.3	Receive reports from committees to take appropriate action thereon
1.4	Confirm the recommendations of the committees
1.5	Establish terms of reference and reporting arrangements of all committees that are established by the Council of Governors
1.6	Require and receive the declaration of Governors' interests which may conflict with those of the Trust and determining the extent to which that member may remain involved with the matter under consideration
2.	**Appointments / Dismissal / Terms & Conditions**
2.1	To appoint or remove the Trust's external auditor
2.2	To approve an appointment (by the Non-Executive Directors) of the Chief Executive
2.3	To appoint or remove Non-Executive Directors (including the Chair) subject to complying with the procedures incorporated in the Constitution and decide their remuneration and other terms of service
2.4	To appoint the Deputy Chair
2.5	To appoint the Lead Governor of the Council of Governors
2.6	To appoint and/or disband committees that are directly accountable to the Council of Governors and approve the terms of reference.
3.	**Policy Determination**
3.1	Preparation and review of the Trust's Membership and Engagement Strategy and the policy for the composition of the Council of Governors and of the Non-Executive Directors
3.2	Provide views to the Board of Directors when the Board of Directors is preparing the document containing information about the Foundation Trust's forward planning
3.3	Approve changes to the Constitution in conjunction with the Board of Directors
4.	**Strategy, Partnerships, Annual Plans & Budgets**

4.1	To decide the remuneration and allowances and other terms and conditions of office, of the Non- Executive Directors (including the Chair)
4.2	Approve significant transactions as defined within the Trust's Constitution
4.3	Approve an application by the Trust to merge with or acquire another trust, separate the trust or to be dissolved
4.4	Approve any increase of 5% or more in income attributable to activities other than the provision of goods and services for the purposes of the health service in England (including but not limited to private health service provision i.e. any non-NHS income) in a financial year
5.	**Annual Reports and Accounts**
6.1	To receive and accept the Annual Accounts and any report of the External Auditor on them and the Trust's Annual Report
7.	**Monitoring**
7.1	Receive such reports as the Board of Directors sees fit from committees or individual directors in respect of their exercise of powers delegated.

5. DELEGATION OF POWERS

5.1 Delegation to Committees

5.1.1 The Board of Directors may determine that certain of its powers shall be exercised by standing committees. The composition and terms of reference of such committees shall be that determined by the Board of Directors. The Board of Directors shall determine the reporting requirements in respect of these committees. In accordance with standing orders, committees may not delegate executive powers to sub-committees unless expressly authorised by the Board of Directors.

5.1.2 The Board committee structure for the Trust is shown in Appendix 1.

5.1.3 The table below sets out the responsibilities that have been delegated to the committees of the Board of Directors. Further details of the individual responsibilities and delegated matters can be found in the terms of reference.

Name of Committee	Delegated Responsibility of the Committee
Audit Committee	The overarching responsibility of Audit Committee is to: - 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). - ensure there is an effective internal audit function established which provides appropriate independent assurance to the committee. - 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. - 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.
Remuneration & Appointments Committee	The overarching responsibility of Remuneration & Appointments Committee is to: - Be responsible for identifying and appointing candidates to fill all the Executive Director positions on the Board and for determining their remuneration and other conditions of service on an on-going basis. - Review the structure, size and composition of the Board of Directors; ensure that the Board has the appropriate skills, experience and capacity to lead the Trust; and ensure appropriate succession planning is in place. - Be assured on the performance of individual directors against agreed objectives.
Charitable Funds Committee	The overarching responsibility of the Charitable Funds Committee is to: - Be responsible for managing charitable funds on behalf of the Corporate Trustee (Board of Directors of Stockport NHS Foundation Trust acts as the Corporate Trustee). - Approve specific policies and procedures relevant to the committees remit and review the annual accounts as part of its delegated responsibility from the Board.
Finance & Performance Committee	The overarching responsibility of Finance & Performance Committee is to: - Provide oversight and assurance on all aspects of the Trust's financial and operational performance against the agreed annual plan.

	- Support the Board in the development of future business plans. - Provide oversight and ensure appropriate governance mechanisms are in place to assure delivery of the Trust's digital, estates and sustainability related strategies and plans. - Ensure any associated risks, identified in relation to the above, are managed in accordance with the Trust's assurance framework and risk management arrangements. - Have oversight into the Trust's finance and performance related work with locality and system partners. - Approve specific policies and procedures relevant to the committees purpose and responsibilities and duties.
People Performance Committee	The overarching responsibility of People Performance Committee is to: - Provide oversight and assurance on matters relating to delivery of the Trust's people related strategies and plans to support achievement of (related) corporate objectives. - Support the Board in the development of people related strategies and plans. - Ensure any associated risks, identified in relation to the above, are managed in accordance with the Trust's assurance framework and risk management arrangements. - To have oversight into the Trust's people related work with locality and system partners. - Approve specific policies and procedures relevant to the committees purpose and responsibilities and duties.
Quality Committee	The overarching responsibility of Quality Committee is to: - Provide oversight and assurance regarding the operation of systems and processes to ensure the quality of care, encompassing patient safety, clinical effectiveness, and experience, provided to users of the Trust's services. - Support the Board in the development of strategy related to quality of care. - Ensure any associated risks, identified in relation to the above, are managed in accordance with the Trust's assurance framework and risk management arrangements. - To have oversight into the Trust's quality-related work with locality and system partners. - Approve specific policies and procedures relevant to the committees purpose and responsibilities and duties.

5.2 Delegation to Officers

5.2.1 Standing Orders and Standing Financial Instructions set out in some detail the financial responsibilities of the Chief Executive, the Chief Finance Officer and other directors.

5.2.2 The following responsibilities are defined through the Foundation Trust Accounting Officer Memorandum:

The Accounting Officer has responsibility for the overall organisation, management and staffing of the Foundation Trust and for its procedures in financial and other matters. The Accounting Officer must ensure that:

- There is a high standard of financial management in the Foundation Trust as a whole;
- The NHS Foundation Trust delivers efficient and economical conduct of its business and safeguards financial propriety and regularity throughout the

organisation
- Financial considerations are fully taken into account in decisions by the NHS Foundation Trust

The specific personal responsibilities of a Foundation Trust Accounting Officer:
- The propriety and regularity of the public finances for which they are answerable;
- The keeping of proper accounts;
- Prudent and economical administration in line with the principles set out in *Managing public money(www.gov.uk/government/publications/managing-public-money)*
- The avoidance of waste and extravagance; and
- The efficient and effective use of all the resources in their charge.

The Accounting Officer must:
- Personally sign the accounts and, in doing so accept personal responsibility for ensuring their proper form and content as prescribed by NHS England in accordance with the Act.
- Comply with the financial requirements of the NHS provider licence.
- Ensure that proper financial procedures are followed and that accounting records are maintained in a form suited to the requirements of management, as well as in the form prescribed for published accounts. (So that they disclose with reasonably accuracy, at any time, the financial position of the NHS foundation trust).
- Ensure that the resources for which they are responsible as Accounting Officer are properly and well managed and safeguarded, with independent and effective checks of cash balances in the hands of any official.
- Ensure that assets for which they are responsible such as land, buildings and other property, including stores and equipment, are controlled and safeguarded with similar care, and with checks as appropriate.
- Ensure that any protected property (or interest in) is not disposed of without the consent of NHS Improvement.
- Ensure that conflicts of interest are avoided, whether in the proceedings of the Board of Directors, Council of Governors or in the actions or advice of the Foundation Trust staff, including themselves.
- Ensure that, in the consideration of policy proposals relating to the expenditure for which they are responsible as Accounting Officer, all relevant financial considerations, including any issues of propriety, regularity or value for money, are taken into account, and brought to the attention of the Board of Directors

The Accounting Officer should ensure that effective management systems appropriate for the achievement of the Foundation Trust's objectives, including financial monitoring and control systems, have been established. An Accounting Officer should ensure that managers at all levels:
- Have a clear view of their objectives, and the means to assess and, wherever possible, measure outputs or performance in relation to those objectives;
- Are assigned well defined responsibilities for making the best use of resources (both those consumed by their own commands and any made available to organisations or individuals outside the NHS foundation trust), including a critical scrutiny of output and value for money.
- Have the information (particularly about cost), training and access to the expert advice which they need to exercise their responsibilities effectively.

Accounting Officers must make sure that their arrangements for delegation promotes good management and that they are supported by the necessary staff with an appropriate balance of skills. Arrangements for internal audit should accord with the objectives, standards and practices set out in the *Public Sector*

Internal Audit Standards.

5.2.3 **Schedule of Delegation**

Delegated matters in respect of decisions which may have a far reaching effect must be reported to the Chief Executive. The **'Delegated to'** authority is in accordance with the: Standing Orders and Standing Financial Instructions. The **'Operational Responsibility'** shown below is the lowest level to which authority is delegated.

Table A - Delegated Authority
Table B - Delegated Financial Limits

Delegation to lower levels is only permitted with written approval of the Chief Executive who will, before authorising such delegation, consult with other senior managers as appropriate.

5.2.4 **Waivers**

The requirements of the Scheme of Delegation or the Standing Financial Instructions can only be waived in accordance with the delegated authority in Table A2.

Any officer requesting or agreeing the waiving of Standing Financial Instructions, or the Scheme of Delegation needs to be able to satisfy themselves that value for money is being achieved.

Table A: Delegated Authority

**If the Chief Executive is absent powers delegated to them may be exercised by the nominated officer(s) acting in their absence after taking appropriate financial advice, two directors will be required to ratify any decisions within the Chief Executive's thresholds.*

DELEGATED MATTER		DELEGATED TO *	OPERATIONAL RESPONSIBILITY
1.	**Standing Orders/Standing Financial Instructions**		
a)	Final authority in interpretation of Standing Orders	Chair	Chair
b)	Notifying Directors and employees of their responsibilities within the Standing Orders and Standing Financial Instructions and ensuring that they understand the responsibilities	Chief Executive	All Line Managers
c)	Responsibility for security of the Foundation Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming with Standing Orders, Financial instructions and financial procedures	Chief Executive	All Directors and Employees
d)	Suspension of Standing Orders, SFIs or SORD	Board of Directors	Board of Directors
e)	Review suspension of Standing Orders, SFIs or SORD	Audit Committee	Audit Committee
f)	Variation or amendment to Standing Orders	Board of Directors	Board of Directors
g)	Emergency powers relating to the authorities retained by the Board of Directors.	Chair and Chief Executive with two Non-Executives	Chair and Chief Executive with two Non-Executives
h)	Disclosure of non-compliance with Standing Orders to the Chief Executive (report to the Board of Directors).	All staff	All staff
i)	Disclosure of non-compliance with SFIs to the Chief Finance Officer (report to the Audit Committee)	All staff	All staff
j)	Advice on interpretation or application of SFIs and this Scheme of Delegation	Chief Finance Officer	Director of Finance/Internal Audit/Trust Secretary

Delegated Matters

Delegated matters in respect of decisions which may have a far reaching effect MUST be reported to the Chief Executive. The delegation shown in the following cases is the lowest level to which authority is delegated. Delegation to lower levels than specified is only permitted with the prior written approval of the Chief Executive who will, before authorising such delegation, consult with other Senior Officers as appropriate. All items concerning Finance must be carried out in accordance with Standing Financial Instructions.

The following are details of the posts that are covered by a specific heading within the scheme of delegation:

TITLE & ABBREVIATION	POSTS COVERED (OR NOMINATED DEPUTY)
Chair	Nominated Deputy: Deputy Chair (Board of Directors)
Chief Executive (CE)	Nominated Deputy: Deputy Chief Executive
Deputy Chief Executive	Chief Finance Officer
Executive Director (ED)	Chief Finance Officer Medical Director Chief Nurse Executive Director of Operations Director of People & Organisational Development Director of Communications & Corporate Affairs* (non-voting)
Other Directors (shared with Tameside FT and non-voting posts)	Director of Strategy & Partnerships Director of Estates & Facilities Director of Informatics Director of Transformation
Functional Director (FD) and Divisional Directors (Div'l Directors)	Director of Finance Deputy Director of Operations Chief Information Officer Chief Technical Officer Chief Data Officer Associate Director of Estates & Facilities Deputy Director Strategy & Partnerships Chief Pharmacist Deputy Director of Quality Governance Deputy Director of People & Organisational Development Deputy Director of Organisational Development Deputy Chief Nurse Associate Director of Finance (3 roles) Divisional Director of Medicine and ED Divisional Director of Women and Children Divisional Director of Surgery Divisional Director of Integrated Care Divisional Director of Clinical Support Services
Associate Medical Director (AMD)	Divisional AMD of Medicine and ED Divisional AMD of Women and Children Divisional AMD of Surgery Divisional AMD of Integrated Care Divisional AMD of Clinical Support Services Deputy Medical Director
Senior Finance Team	Chief Financial Accountant Head of Costing & Benchmarking Senior Divisional Accountant (3 roles) Head of Procurement Chief Contracts Accountant
Head of Procurement (HOP)	Nominated Deputy: Deputy Head of Procurement (2 roles)
Corporate Trustee	Board of Directors

Table A2 - Delegated Matters

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
1.	**Audit Arrangements**		
a)	Appointment, re-appointment and removal of the financial auditor, and approve the remuneration in respect of the financial auditor.	Council of Governors	Council of Governors with support and advice from the Audit Committee and the Chief Finance Officer
b)	Monitor and review the effectiveness of the internal audit function.	Audit Committee	Chief Finance Officer
c)	Review, appraise and report in accordance with Government Internal Audit Standards (GIAS) and best practice.	Audit Committee	Head of Internal Audit
d)	Provide an independent and objective view on internal control and probity.	Audit Committee	Internal Audit / External Audit
e)	Ensure cost-effective audit service	Audit Committee	Chief Finance Officer
f)	Implement recommendations	Chief Executive	Relevant Officers
2.	**Authorisation of Clinical Trials & Research Projects (Subject to commercial sponsorship criteria in section 7)**	Chief Executive	Medical Director
3.	**Authorisation of New Drugs**	Chief Executive	Medicines Optimisation Group
4.	**Bank/OPG Accounts/Cash** (Excluding Funds Held on Trust Accounts)		
a)	Operation:		
	• Managing banking arrangements and operation of bank accounts (Board of Directors approves arrangements)	Chief Finance Officer	Associate Director of Finance (FS)
	• Opening bank accounts with Board approval	Chief Finance Officer	Associate Director of Finance (FS)
	• Authorisation of transfers between Foundation Trust bank accounts	Chief Finance Officer	To be completed in accordance with bank mandate/ Treasury Management policy
	• Approve and apply arrangements for the electronic transfer of funds	Chief Finance Officer	To be completed in accordance with bank mandate/ Treasury Management policy
	• Authorisation of: - OPG schedules - BACS schedules - Automated cheque schedules - Manual cheques	Chief Finance Officer	To be completed in accordance with bank mandate and Treasury Management Policy
b)	Investments:		
	• Investment of surplus funds in accordance with the Foundation Trusts Treasury Management policy	Chief Finance Officer	Associate Director of Finance(FS)/Director of Finance
	• Preparation of investment procedures	Chief Finance Officer	Associate Director of Finance (FS)
c)	Petty Cash	Chief Finance Officer	**Refer To Table B Delegated Limits**
5.	**Capital Investment**		
a)	Programme:		
	• Ensure that there is adequate appraisal and approval process for determining capital expenditure priorities and the effect that each has on business plans / service development strategy	Director of Strategy & Partnerships	Deputy Director Strategy & Partnerships
	• Quantification of the cash available for capital investment	Chief Finance Officer	Associate Director of Finance (FS)
	• Preparation of Capital Investment Programme	Director of Strategy & Partnerships	Deputy Director Strategy & Partnerships
	• Preparation of a business case	Director of Strategy & Partnerships	Deputy Director Strategy & Partnerships Associate Director of Finance (FS)
	• Financial monitoring and reporting on all capital scheme expenditure including	Chief Finance Officer	Associate Director of Finance (FS)

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
	variations to contract		
	• Authorisation of business cases for capital expenditure/ capital requisitions	Chief Executive	**Refer To Table B Delegated Limits**
	• Assessing the requirements for the operation of the construction industry taxation deduction scheme.	Director of Finance	Associate Director of Finance (FS)
	• Responsible for the management of capital schemes and for ensuring that they are delivered on time and within cost budgeted.	Chief Finance Officer	Associate Director Estates & Facilities, Director of Informatics, Deputy Director Strategy & Partnership
	• Ensure that capital investment is not undertaken without availability of resources to finance all revenue consequences.	Chief Finance Officer	Associate Director of Finance (FS)
	• Issue procedures governing financial management of capital investment projects, including variations to contract and staged payments	Chief Finance Officer	Associate Director of Finance (FS)
	• Issue procedures for the valuation (for accounting purposes) of the Trust's property in accordance with the Trust's accounting policies, IFRS and Foundation Trust Annual Reporting Manual	Chief Finance Officer	Associate Director of Finance (FS)
	• Issuing the capital scheme project manager with specific authority to commit capital, proceed / accept tenders in accordance with the SO's and SFI's	Director of Strategy & Partnerships	Associate Director of Finance (FS)
b)	Private Finance (or similar IFRIC 12 transaction): • Demonstrate that the use of private finance represents best value for money and transfers risk to the private sector. Proposal to use PFI must be specifically agreed by the Board of Directors	Chief Executive	Chief Finance Officer
c)	Leases (including leases embedded in others contracts for services) • Granting, renewal and early termination of leases with an annual rent < £100k and where dilapidations or early termination clause penalties, do not exceed £50k in cases of termination	Chief Finance Officer	Associate Director of Finance (FS)
	Granting, renewal and early termination of leases of > £100k and where dilapidations or early termination clause penalties do not exceed £50k	Board of Directors	Chief Finance Officer – Provided reported to the Board of Directors
6.	**Clinical Audit**		
	• Provision of fit for purpose clinical audit function that addresses clinical risks highlighted in the risk register	Chief Executive	Medical Director
	• Annual plan and report to be presented to the Audit Committee	Chief Executive	Medical Director
7.	**Commercial Sponsorship**		
	• Agreement to proposal	Director of Strategy & Partnership	Deputy Director Strategy & Partnership and Director of Communications & Corporate Affairs. Approval and registration in line with Trust Conflicts of Interests Policy.
8.	**Complaints (Patients & Relatives)**		
a)	Overall responsibility for ensuring that all complaints are dealt with effectively and in line with the Trust's overall duty of candour	Chief Executive	Chief Nurse & Deputy Director of Quality Governance

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
b)	Responsibility for ensuring complaints relating to a division / department are investigated thoroughly.	Chief Executive	Deputy Director of Quality Governance
c)	Medico - Legal Complaints Coordination of their management.	Chief Executive	Chief Nurse & Deputy Director of Quality Governance
9.	**Confidential Information**		
	Review of the Foundation Trust's compliance with the Caldicott report on protecting patients' confidentiality in the NHS	Chief Executive	Medical Director
	Freedom of Information Act compliance code	Chief Executive	Chief Finance Officer (SIRO)
10.	**Data Protection Act (DPA)**		
a)	Review of Foundation Trust's compliance	Chief Finance Officer (SIRO)	Data Protection Officer
11.	**Declaration of Interest**		
	• Maintaining registers of interests	Chief Executive	Trust Secretary
	• Declaring relevant and material interest	Board of Directors	Board of Directors / Governors / Senior Managers / Consultants / All staff in line with the Conflicts of Interest Policy
12.	**Disposal, Condemnations and Impairments**		
	• Assets that are obsolete, redundant, irreparable, cannot be repaired cost effectively or are otherwise impaired	Chief Finance Officer	Associate Director of Estates & Facilities / Div'l Directors in accordance with agreed policy and completion of disposal forms
	• Develop arrangements for the sale of assets	Chief Finance Officer	Director of Finance/ Associate Director of Finance (FS)/ Associate Director of Estates & Facilities/ Head of Procurement
	• Disposal of relevant assets no longer needed to fulfil the Trust's obligations to provide commissioner requested services	Board of Directors (with authorisation of the Independent Regulator)	Chief Finance Officer
13.	**Environmental Regulations**		
	Review of compliance with environmental regulations, for example those relating to clean air and waste disposal	Director of E&F	Associate Director of Estates & Facilities
14.	**External Borrowing**		
a)	Advise Board of Directors of the requirements to repay / draw down Public Dividend Capital.	Chief Finance Officer	Associate Director of Finance (FS)
b)	Approve a list of employees authorised to make short term borrowings on behalf of the Foundation Trust.	Board of Directors	Chief Executive/ Chief Finance Officer (with evidence of Board approval)
c)	Application for draw down of Public Dividend Capital, overdrafts and other forms of external borrowing.	Chief Executive / Chief Finance Officer	Associate Director of Finance (FS)
d)	Preparation of procedural instructions concerning applications for loans and overdrafts.	Chief Finance Officer	Associate Director of Finance (FS)
15.	**Financial Planning / Budgetary Responsibility**		
a)	Setting:		
	• Submit budgets to the Board of Directors	Chief Finance Officer	Director of Finance
	• Submit to Board financial estimates and forecasts	Chief Executive	Chief Finance Officer
	▪ Compile and submit to the Board an annual plan which takes into account financial targets and forecast limits of available	Chief Executive	Chief Finance Officer

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
	resources. The annual plan will contain: ○ a statement of the significant assumptions on which the plan is based; ○ details of major changes in workload, delivery of services or resources required to achieve the plan.		
b)	Monitoring:		
	○ Devise and maintain systems of budgetary control.	Chief Finance Officer	Director of Finance
	○ Monitor performance against budget	Chief Finance Officer	Director of Finance
	○ Delegate budgets to budget holders	Chief Executive	Chief Finance Officer
	○ Ensuring adequate training is delivered to budget holders to facilitate their management of the allocated budget.	Chief Finance Officer	Director of Finance
	○ Submit in accordance with the Independent Regulator's requirements for financial monitoring returns	Chief Executive	Chief Finance Officer / Director of Finance
	○ Identify and implement cost improvements and income generation activities in line with the Business Plan	Chief Executive	All budget holders
	Preparation of:		
	• Annual Accounts	Chief Finance Officer	Director of Finance
	• Annual Report	Chief Executive	Trust Secretary
c)	Budget Responsibilities		
	• Ensure that ○ no overspend or reduction of income that cannot be met from virement is incurred without prior consent of Board; ○ approved budget is not used for any other than specified purpose subject to rules of virement; ○ no permanent employees are appointed without the approval of the Chief Executive other than those provided for within available resources and establishment.	Chief Finance Officer	Div'l Directors / Functional Directors / Budget Holders
d)	Authorisation of Virement: It is not possible for any officer to vire: • from non-recurring headings to recurring budgets • from capital to revenue • from revenue to capital Virement signed between different budget holders requires the agreement of both parties.	Chief Executive	**Refer To Table B Delegated Limits**
16.	**Financial Procedures and Systems**		
a)	Maintenance & Update on Foundation Trust Financial Procedures	Chief Finance Officer	Director of Finance / Associate Director of Finance (FS/FM/I&C)
b)	Responsibilities:- ○ Implement Foundation Trust's financial policies and co-ordinate corrective action through financial recovery plans, if necessary. ○ Ensure that adequate records are maintained to explain Foundation Trust's transactions and financial position. ○ Providing financial advice to members of the Board of Directors and staff. ○ Ensure that appropriate statutory records are maintained. ○ Designing and maintaining compliance with all financial systems	Chief Finance Officer	Director of Finance/ Associate Director of Finance (FS/FM/I&C)

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
17.	**Fire precautions**		
	• Ensure that the fire precautions and prevention policies and procedures are adequate and that fire safety and integrity of the estate is intact.	Director of E&F	Associate Director of Estates & Facilities
	• Comply with the Fire Code	Director of E&F	Associate Director of Estates & Facilities
18.	**Fixed Assets (Property, Plant & Equipment)**		
a)	Maintenance of asset register including asset identification and monitoring	Chief Finance Officer	Associate Director of Finance (FS)
b)	Ensuring arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with JCT Contracts, OJEU, PFI, P21	Director of E&F	Associate Director of Estates & Facilities
c)	Calculate and pay capital charges in accordance with the requirements of the Department of Health & Social Care	Chief Finance Officer	Associate Director of Finance (FS)
d)	Responsibility for security of Foundation Trust's assets including notifying discrepancies to the Chief Finance Officer and reporting losses in accordance with Foundation Trust's procedures	Director of E&F	All staff
19.	**Fraud (See also 27, 37)**		
a)	Monitor and ensure compliance with Secretary of State Directions on fraud and corruption including the appointment of the Anti- Fraud Specialist.	Chief Executive and Chief Finance Officer	Counter-Fraud Specialist.
b)	Notify NHS Counter Fraud Authority and External Audit of all suspected Frauds	Chief Finance Officer	Counter-Fraud Specialist.
20.	**Funds Held on Trust (Charitable and Non Charitable Funds)**		
a)	Management: • Funds held on trust are managed appropriately.	Charitable Funds Committee	Associate Director of Finance (FS)
b)	Maintenance of authorised signatory list of nominated fund holders.	Chief Finance Officer	Associate Director of Finance (FS)
c)	Expenditure Limits	Chief Finance Officer	**Refer To Table B Delegated Limits**
d)	Developing systems for receiving donations	Chief Finance Officer	Associate Director of Finance (FS)
e)	Dealing with legacies	Chief Executive	Chief Executive/ Associate Director of Finance (FS)
f)	Fundraising Appeals	Board of Directors	Charitable Funds Committee
g)	Operation of Bank Accounts: * Managing banking arrangements and operation of bank accounts	Chief Finance Officer	Director of Finance/ Associate Director of Finance (FS)
	• Opening bank accounts	Chief Finance Officer	Associate Director of Finance (FS)
h)	Investments: • Nominating deposit taker	Charitable Funds Committee	Chief Finance Officer
	• Placing transactions	Chief Finance Officer	Associate Director of Finance (FS)
i)	Regulation of funds with Charities Commission	Chief Finance Officer	Associate Director of Finance (FS),
j)	Making grants	Charitable Funds Committee	Chief Finance Officer
21.	**Health and Safety**		
	Review of all statutory compliance with legislation and Health and Safety requirements including control of Substances Hazardous to Health Regulations	Chief Executive	Chief Nurse / Director of E&F

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
22.	**Healthcare Contract**		
a)	Negotiation of Foundation Trust Contract and Non Commercial Contracts	Chief Executive	Chief Finance Officer / Director of Operations
b)	Quantifying and monitoring out of area treatments	Chief Finance Officer	Associate Director of Finance (I&C)
c)	Reporting actual and forecast income	Chief Executive	Associate Director of Finance (I&C)
d)	Costing Foundation Trust Contract and Non Commercial Contracts	Chief Finance Officer	Associate Director of Finance (I&C)
e)	National Cost Collection/ Payment by Results	Chief Finance Officer	Associate Director of Finance (I&C)
f)	Ad hoc costing relating to changes in activity, developments, business cases and bids for funding	Chief Finance Officer	Director of Finance
g)	Signing of contracts	Chief Executive	**Refer To Table B Delegated Limits**
h)	Variation to contracts	Chief Executive	**Refer To Table B Delegated Limits**
23.	**Hospitality/Gifts**		
a)	Keeping and updating of gifts & hospitality register	Chief Executive	Trust Secretary
b)	Applies to both individual and collective hospitality receipt items.		All staff declaration required in Foundation Trust's Hospitality Register **See Appendix B for limits.**
24.	**Reporting and managing Infectious Diseases & Notifiable Outbreaks**	Chief Executive	Medical Director
25.	**Information Management & Technology**		
	All systems (excluding financial)	Director of Informatics	Chief Information Officer
	• Developing systems in accordance with the Foundation Trust's Digital Strategy.		
	• Implementing new systems ensure they are developed in a controlled manner and thoroughly tested.	Director of Informatics	Chief Information Officer
	• Seeking third party assurances regarding systems operated externally.	Director of Informatics	Chief Technical Officer
	• Ensure that contracts for computer services for applications define responsibility re security, privacy, accuracy, completeness and timeliness of data during processing and storage.	Director of Informatics	Chief Technical Officer
	• Ensure that risks to the Trust from use of IT are identified and considered and that disaster recovery plans are in place.	Director of Informatics	Chief Technical Officer & IT System Owners
	Financial Systems • Developing financial systems in accordance with the Foundation Trust's Digital Strategy.	Chief Finance Officer	Director of Finance / Associate Directors of Finance
	• Implementing new systems ensure they are developed in a controlled manner and thoroughly tested.	Chief Finance Officer	Director of Finance / Associate Directors of Finance
	• Seeking third party assurances regarding financial systems operated externally.	Chief Finance Officer	Director of Finance / Associate Directors of Finance
	• Ensure that contracts for computer services for financial management purposes define responsibility re security, privacy, accuracy, completeness and timeliness of data during processing and storage.	Director of Informatics	Chief Information Officer / Chief Technical Officer / Chief Data Officer / System Owners
26.	**Legal Proceedings**		

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
a)	Engagement of Foundation Trust's Solicitors / Legal Advisors for matters relating to: • Complaints • Workforce • Commercial or property • Claims & inquest • All other **Subject to the powers reserved by the Board in Section 3.7**	Chief Executive	• Deputy Director of Quality Governance • Director of People & OD • Chief Finance Officer / Director of E&F • Deputy Director of Quality Governance • Chief Executive or Trust Secretary
b)	Approve and sign all documents which will be necessary in legal proceedings, i.e. executed as a deed.	Chief Executive	Deputy Chief Executive & as above
c)	Sign on behalf of the Foundation Trust any agreement or document not requested to be executed as a deed.	Chief Executive	Executive Directors
27.	**Losses, Write-off & Compensation**		
a)	Prepare procedures for recording and accounting for losses and special payments including preparation of a Fraud Response Plan and informing NHS Counter Fraud Authority of frauds	Chief Executive	Chief Finance Officer
b)	<u>Losses</u>		
	Losses of cash due to theft, fraud, overpayment & others.	Chief Executive	**Refer To Table B Delegated Limits**
	Fruitless payments (and constructive losses)	Chief Executive	**Refer To Table B Delegated Limits**
	Bad debts and claims abandoned.	Chief Executive	**Refer To Table B Delegated Limits**
	Damage to buildings, fittings, furniture and equipment and loss of equipment and property in stores and in use due to: Culpable causes (e.g. fraud, theft, arson).	Chief Executive	**Refer To Table B Delegated Limits**
c)	Reviewing appropriate requirements to ensure adequate and appropriate insurance cover is taken out and the processes for making and monitoring of claims	Chief Finance Officer	Senior Contracts Manager
d)	A register of all of the payments should be maintained by the Finance Department and made available for inspection	Chief Finance Officer	Associate Director of Finance (FS)
e)	A report of all of the above payments should be presented to the Audit Committee	Chief Finance Officer	Associate Director of Finance (FS)
f)	<u>Special Payments</u> Compensation payments by Court Order	Chief Executive	Above Excess – NHSR Below Excess – Chief Executive/ Chief Finance Officer
g)	<u>Ex gratia Payments:-</u>		
	• To patients/staff for loss of personal effects	Chief Executive	**Refer To Table B Delegated Limits**
	• For clinical negligence after legal advice	Chief Executive	Chief Executive/ Chief Finance Officer
	• For personal injury after legal advice	Chief Executive	Chief Executive /Chief Finance Officer
	• Other clinical negligence and personal injury	Chief Executive	Chief Executive / Chief Finance Officer
	• Other ex-gratia payments	Chief Executive	Chief Executive / Chief Finance Officer
28.	**Meetings**		
a)	Calling meetings of the Foundation Trust Board	Chair	Trust Secretary
b)	Chair all Foundation Trust Board meetings and associated responsibilities	Chair	Chair
c)	Calling meetings of the Council of Governors	Chair	Chair/ Trust Secretary/ Seven Governors by notice to the Secretary

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
d)	Chair all Council of Governors meetings and associated responsibilities	Chair	Chair
29.	**Medical**		
	• Clinical Governance arrangements	Chief Executive	Medical Director / Chief Nurse
	• Medical Leadership	Medical Director	Associate Medical Directors & Deputy Medical Director
	• Programmes of medical education	Medical Director	Associate Medical Directors & Deputy Medical Director
	• Medical staffing plans	Medical Director	Associate Medical Directors & Deputy Medical Director
	• Medical Research	Medical Director	Associate Medical Directors & Deputy Medical Director
30.	**Non Pay Expenditure**		
a)	Maintenance of a list of managers authorised to place requisitions/orders and accept goods in accordance with Table B	Chief Executive	Director of Finance / Associate Director of Finance (FS/FM)
b)	Obtain the best value for money when requisitioning goods / services	Chief Executive	Head of Procurement/ Associate Director of Estates & Facilities/ Director of Finance/ Div'l Directors/ Budget Holders
e)	Non-Pay Expenditure for which no specific budget has been set up and which is not subject to funding under delegated powers of virement. (Subject to the limits specified above in (a))	Chief Executive	Chief Finance Officer
d)	Develop systems for the payment of accounts	Chief Finance Officer	Associate Director of Finance (FS)
e)	Prompt payment of accounts	Chief Finance Officer	Associate Director of Finance (FS)
f)	Financial Limits for ordering / requisitioning goods and services	Chief Finance Officer	**Refer To Table B Delegated Limits**
g)	Approve prepayment arrangements	Chief Finance Officer	Director of Finance/ Associate Director of Finance (FS)
31.	**Nursing**		
	Compliance with ○ statutory and regulatory arrangements relating to professional nursing and midwifery practice. ○ Matters involving individual professional competence of nursing staff. ○ Compliance with professional training and development of nursing staff. ○ Quality assurance of nursing processes.	Chief Executive	Chief Nurse
32.	**Patients' Property** (in conjunction with financial advice)		
a)	Ensuring patients and guardians are informed about patients' monies and property procedures on admission	Chief Executive	Chief Nurse / Deputy Chief Nurse Associate Director of Estates & Facilities
b)	Prepare detailed written instructions for the administration of patients' property	Chief Finance Officer	Chief Nurse / Deputy Chief Nurse / Associate Director of Estates & Facilities
c)	Informing staff of their duties in respect of patients' property	Chief Finance Officer	Chief Nurse / Deputy Chief Nurse /Associate Director of Estates & Facilities/ / Heads of Department
d)	Issuing property of deceased patients	Chief Finance Officer	**Refer To Table B Delegated Limits**
33	**Workforce & Pay**		
a)	Nomination of officers to enter into contracts of	Chief Executive	Director of People & OD/ Deputy Director

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
	employment regarding staff, agency staff or consultancy service contracts		of People & OD
b)	Develop human resource policies and strategies including training, industrial relations.	Director of People & OD	Deputy Director of People & OD
c)	Authority to fill funded post on the establishment with permanent staff.	Chief Finance Officer	Div'l Director / Functional Directors / Budget Holder All vacancies reviewed at Staffing Approval Group All vacancies at Band 8A and above reviewed by Executive Team
d)	The granting of additional increments to staff within budget	Chief Executive	Deputy Director of People & OD
e)	All requests for re-grading shall be dealt with in accordance with Foundation Trust procedure	Director of People & OD	Deputy Director of People & OD
f)	Establishments		
	• Additional staff to the agreed establishment with specifically allocated finance.	Chief Finance Officer	Staffing Approval Group
	• Additional staff to the agreed establishment without specifically allocated finance.	Chief Executive	Executive Team
	• Self-financing changes to an establishment	Chief Finance Officer	Staffing Approval Group
	• Agreement to recruit at risk to turnover	Chief Finance Officer	Staffing Approval Group
g)	Pay		
	* Presentation of proposals to the Board of Directors for the setting of remuneration and conditions of service for those staff not covered by the Remuneration Committee.	Chief Executive	Director of People & OD
	* Authority to complete standing data forms effecting pay, new starters, variations and leavers	Director of People & OD	Div'l Director / Functional Directors / Budget Holder
	* Authority to complete and authorise positive reporting forms including online recording systems for e-rostering	Director of People & OD	Div'l Director / Functional Directors / Budget Holder
	* Authority to authorise overtime	Director of People & OD	Div'l Director / Functional Directors / Budget Holder
	• Authority to authorise travel & subsistence expenses within agreed timeframe (2 months)	Director of People & OD	Div'l Director / Functional Directors / Budget Holder
	• Authority to authorise travel & subsistence expenses outside agreed timeframe (over 2 months)	Chief Finance Officer	Director of Finance
	* Authority to authorise Waiting list payments, on call claims and other additional duties within agreed timeframe (2 months)	Director of People & OD	Staffing Approval Group / Div'l Director / Functional Directors
	* Authority to authorise waiting list payments, on call claims and other additional duties outside agreed timeframe (over 2 months)	Director of People & OD	*Up to £2,500 gross payment – Director of Finance* *Greater than £2,500 Staffing Approval Group* *Form ESR110*

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
* Authority to authorise "unusual" pay claims for other individual or collective issues relating to arrears of pay. This also covers where pay arrears cover a considerable period of underpayment.	Chief Finance Officer	*Up to £2,500 gross payment – Director of Finance* *Greater than £2,500 – Staffing Approval Group* *Form ESR110 – To be completed by Divisional Director or other Director before agreement is made to make payment.* Staffing Approval Group
* Authority to agree pay rates for additional duties undertaken	Director of People & OD	Staffing Approval Group prior to recommendation to Executive Team and implemented by Deputy Director of People & OD
* Authority to approve incentive payments for staff under escalation circumstances	Director of People & OD	
h) Leave *(Note entitlement may be taken in hours)*	Director of People & OD	*Refer to Annual Leave Policy*
<u>Annual Leave</u>		
- Approval of annual leave		Line / Departmental Manager (as per departmental procedure)
- Annual leave - approval of carry forward (up to maximum of one week of basic contracted hours	Director of People & OD	Director of People & OD/ Functional Directors
- Annual leave – approval of carry forward over one week of basic contracted hours (to occur in exceptional circumstances only)	Director of People & OD	Functional Directors / Associate Medical Director
<u>Special Leave</u>		
• Compassionate leave	Director of People & OD	Line / Departmental Manager
• Special leave arrangements for domestic/personal/family reasons • paternity leave • carers leave • adoption leave (to be applied in accordance with Foundation Trust policy)	Director of People & OD	Div'l Director / Functional Directors /Heads of Department
• Special Leave – this includes Jury Service, Armed Services, School Governor (to be applied in accordance with Foundation Trust policy)	Director of People & OD	Div'l Director / Functional Directors
* Leave without pay	Director of People & OD	Div'l Director / Functional Directors
* Medical Staff Leave of Absence – paid and unpaid	Director of People & OD	Div'l Director / Functional Directors/ Associate Medical Director
* Time off in lieu	Director of People & OD	Line Manager
* Maternity Leave - paid and unpaid	Director of People & OD	Automatic approval with guidance
* Selling of Annual leave	Director of People & OD	Deputy Director of Finance and Deputy Director of People & OD
* Buying of Annual Leave	Director of People & OD	Functional Directors/Div'l Directors
<u>Sick Leave</u>		
i) Extension of sick leave on pay	Director of People & OD	Deputy Director of People & OD
ii) Phased return to work	Director of People & OD	Functional Directors / Line Manager in accordance with Attendance Policy
<u>Study Leave</u>		
• Study leave outside the UK	Chief Executive	Relevant Executive Director
• Medical staff study leave (UK). Consultant / Non Career Grade/ Career Grade	Medical Director	Medical Director

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
	• All other study leave (UK)	Director of People & OD	Executive Directors /Heads of Department (in accordance with agreed Foundation Trust policy)
h)	Authorisation of: • payment of removal expenses incurred by officers taking up new appointments (providing consideration was promised at interview) • payment of recruitment and retention premium in relation to medical posts • Payment of recruitment and retention premium to all other posts	Chief Executive	Form to be completed by Divisional Director or other Director ***Staffing Approval Group***
j)	Individual and Collective Grievance Procedure	Director of People & OD	All grievances cases must be dealt with strictly in accordance with the Grievance Procedure and the advice of the Deputy Director of People & OD must be sought.
k)	Payment of expenses including travel, parking & subsistence	Director of People & OD	In accordance with the Trust's expenses policy
l)	Use of Mobile Phones / Portable Devices	Director of Informatics	Chief Technical Officer/Functional Directors/ Div'l Director
m)	Renewal of Fixed Term Contract	Director of People & OD	Div'l Director / Functional Directors / Budget Holder Note link to Staff Approval Group on funding requirements
n)	Staff Retirement Policy ▪ Authorisation of return to work	Chief Executive	Div'l Director / Functional Directors / Budget Holder
o)	Statutory or Voluntary Redundancy	Chief Executive	Director of People & OD/ Director of Finance *Form ESR 110*
p)	Ill Health Retirement Decision to pursue retirement on the grounds of ill-health following advice from the Occupational Health Department.	Director of People & OD	Div'l Director / Functional Directors / Budget Holder
q)	Disciplinary Procedure (excluding Executive Directors)	Director of People & OD	To be applied in accordance with the Foundation Trust's Disciplinary Procedure
r)	Ensure that all employees are issued with a Contract of employment in a form approved by the Board of Directors and which complies with employment legislation.	Director of People & OD	Deputy Director of People & OD
s)	Engagement of staff not on the establishment		**Refer To Table B Delegated Limits**
	a. Management Consultants over £50k are subject to approval from NHS England after completion of template and authorisation by Executive Director	Chief Executive	Executive Directors / Staffing Approval Group
	▪ Booking of bank staff		
	a. Nursing	Chief Nurse	Associate Nurse Directors
	b. Medical	Medical Director / Director of Operations	Associate Medical Directors
	c. Other clinical		Budget Holder
	d. Other non-clinical	Executive Directors	Budget Holder
	▪ Booking of agency staff in line with procedural requirements of the Staffing Approval Group and the regulations of the Agency Cap		
	a. Nursing	Chief Nurse	Associate Nurse Directors
	b. Medical	Medical Director	Associate Medical Directors
	c. Other clinical	Director of Operations	Functional Directors

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
d. Other	Executive Directors	Functional Directors
▪ Booking of staff with payment via invoice which are deemed outside of IR35	Director of People & OD	Staffing Approval Group
t) Salary Sacrifice Schemes		
▪ Approval of scheme with HMRC	Director of People & OD	Deputy Director of People & OD
▪ Approval of scheme for goods where Trust enters into a contract and employee repays over a contracted period e.g. car, electronics, cycle	Chief Finance Officer	Associate Director of Finance (FS)
▪ Procedures for operation of salary sacrifice schemes including authorisation	Chief Finance Officer	Deputy Director of People & OD / Director of Finance
34. Quotation, Tendering & Contract Procedures		
a) Services: • Best value for money is demonstrated for all services provided under contract or in-house	Chief Executive	Chief Finance Officer / Director of Finance / Head of Procurement/ Associate Director of Estates & Facilities/ / Div'l Directors
* Nominate officers to oversee and manage the contract on behalf of the Foundation Trust.	Chief Executive	Executive Directors
b) Competitive Tenders:		**Refer To Table B Delegated Limits**
• Setting Authorisation Limits	Chief Executive	Chief Finance Officer
• Operation of e-tendering system.	Chief Executive	Head of Procurement
• Should the e-tendering system be unavailable then the Head of Procurement will maintain a register to show each set of competitive tender invitations despatched.	Chief Executive	Head of Procurement/ Associate Director of Estates & Facilities
• Issue of Tender Documentation	Chief Executive	Head of Procurement/ Associate Director of Estates & Facilities
• Receipt and custody of tenders prior to opening	Chief Executive	Chief Finance Officer
• Opening Tenders	Chief Executive	**Refer To Table B Delegated Limits**
• Decide if late tenders or missing information should be considered	Chief Executive	Chief Finance Officer
For all tenders:		
• Ensure that appropriate checks are carried out as to the technical and financial capability of the firms invited to tender or quote.	Chief Executive	Chief Finance Officer
• Acceptance of lowest tender (following recommendation Head of Procurement)	Chief Executive	Project Sponsor/ Exec Director / Functional Director
• Waiving of lowest tender acceptance (report to Audit Committee)	Chief Executive	Chief Finance Officer
• Post tender negotiations/ clarification (only to be used in line with EU procurement directives)	Chief Executive	Chief Finance Officer
c) Competitive Quotations	Chief Executive	**Refer To Table B Delegated Limits**
d) Waiving the requirement to request • tenders - subject to SFI's (reporting to the Board) via Audit Committee	Chief Executive	**Refer To Table B Delegated Limits**
• Quotes - subject to SFI's	Chief Executive or Chief Finance Officer	
e) Submission of tender for services to be provided by the Trust	Chief Executive	Director of Strategy & Partnerships in accordance with Tender Opportunities Process – SOP

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
35.	**Records**		
a)	Review Foundation Trust's compliance with the Records Management Code of Practice	Chief Finance Officer / SIRO	Chief Information Officer
b)	Ensuring the form and adequacy of the financial records of all departments	Chief Finance Officer / SIRO	Associate Directors of Finance
36.	**Reporting of Incidents to the Police**		
a)	Where a criminal offence is suspected * criminal offence of a violent nature * arson or theft * other	Chief Executive	Executive Directors
b)	Where a fraud is involved (reporting to the NHS Counter Fraud Authority)	Chief Finance Officer	Internal Auditor / Counter- Fraud Specialist in conjunction with Chief Finance Officer
c)	Deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption.	Chief Finance Officer	Director of Finance
37.	**Risk Management**		
	• Ensuring the Foundation Trust has a Risk Management Strategy and a programme of risk management	Chief Executive	Chief Nurse
	• Developing systems for the management of risk.	Chief Nurse	Deputy Director of Quality Governance
	• Developing incident and accident reporting systems	Chief Nurse	Deputy Director of Quality Governance
	• Compliance with the reporting of incidents and accidents	Chief Nurse	All staff
38.	**Seal and signing of contracts**		
a)	The keeping of a register of seal and safekeeping of the seal	Chief Executive	Trust Secretary
b)	Attestation of seal in accordance with Standing Orders	Chair /Chief Executive	Chair / Chief Executive or two Executive Directors/ Trust Secretary (report to Trust Board)
c)	Property transactions and any other legal requirement for the use of the seal.	Chair /Chief Executive	Chair / Chief Executive or two Executive Directors/ Trust Secretary (report to Trust Board)
c)	The signing of contracts on behalf of the Trust	Chair /Chief Executive	**Refer To Table B Delegated Limits**
39.	**Security Management**		
a)	Monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management including appointment of the Local Security Management Specialist.	Chief Executive	Director of E&F
40.	**Setting of Fees and Charges (Income)**		
a)	Private Patient, Overseas Visitors, Income Generation and other patient related services.	Chief Finance Officer	Director of Finance
b)	Non patient care income	Chief Finance Officer	Director of Finance
c)	Informing of monies due and invoices to be raised to the Foundation Trust	Chief Finance Officer	All Staff
d)	Recovery of debt	Chief Finance Officer	Associate Director of Finance (FS)
e)	Security of cash and other negotiable instruments	Chief Finance Officer	Associate Director of Estates & Facilities/ Associate Director of Finance (FS)
41.	**Stores and Receipt of Goods**		
a)	Responsibility for systems of control over stores	Director of E&F	Associate Director of Estates & Facilities/

DELEGATED MATTER		DELEGATED TO	OPERATIONAL RESPONSIBILITY
	and receipt of goods, issues and returns		Chief Pharmacist
b)	Stocktaking arrangements	Chief Finance Officer	Director of Finance/ Associate Director of Finance (FS)
c)	Responsibility for controls of pharmaceutical stock.	Director of Operations	Chief Pharmacist
42.	**Transfer of Healthcare Services between NHS Providers**		
a)	Strategy for transfer of services between NHS Providers.	Chief Executive	Director of Strategy & Partnerships
b)	Agreement of contract for transfer of services (transfer in or transfer out)	Chief Executive	Chief Finance Officer
c)	Agreement of budgetary changes	Chief Finance Officer	Director of Finance (As per Section 13 of Table B)

Table B – Delegated Financial Limits

DELEGATED MATTER	DELEGATED LIMIT	OPERATIONAL RESPONSIBILITY
1. CHARITABLE FUNDS		
Charitable Spend Designated and restricted funds	Up to £5,000	Nominated Fund Manager AND Divisional Director with review by the Charity Manger
	£5,001 - £15,000	As per above AND Director of Finance or Associate Director of Finance – FS
	£15,001 to £49,999	Charitable Funds Committee
	£50,000 and above	Corporate Trustee
General Fund / Unrestricted Funds	Up to £5,000	Charity Manager and Associate Director of Finance - FS
	£5,001 to £15,000	As above AND Director of Finance
	£15,001 to £49,999	Charitable Funds Committee
	£50,000 and above	Corporate Trustee
Charitable Donations Staff wishing to make a donation to a charitable fund in lieu of receiving a professional fee may do so, subject to ensuring that they take personal responsibility for ensuring that any tax liabilities related to such donations are properly discharged and accounted for.		All Staff
2. GIFTS AND HOSPITALITY ***(please refer to the Conflicts of Interest policy)***		
2.1 Cash & Vouchers		
Cash and vouchers Should always be declined.	Any value	All Staff
2.2 Gifts		
Gifts	up to £25 (Single)	All Staff

DELEGATED MATTER	DELEGATED LIMIT	OPERATIONAL RESPONSIBILITY
do not need to be declared		
Gifts Multiple Multiple gifts from the same source over a 12 month period should be treated the same as single gifts **over £25 (see below)**	up to £25 (Multiple)	
Gifts should be accepted on behalf of the Trust (not in a personal capacity) They should be recorded on the register and, where appropriate be used for the benefit of patients	Over £25	
Gifts from suppliers or contractors doing business (or likely to do business) with the Trust should be declined, whatever their value. Low cost branded aids such as pens, post-it notes, or calendars may, however, be accepted where they are under the value of £6 in total and need not be declared		
2. GIFTS AND HOSPITALITY ***(please refer to the Conflicts of Interest policy)***		
2.3 Hospitality		
Meal and refreshments May be accepted and need not be declared	up to £25	All Staff
Meal and refreshments May be accepted and must be declared	£25 - £50	
Meal and refreshments should be refused unless (in exceptional circumstances) senior approval is given.	Over £50	
Travel and accommodation modest offers to pay some or all of the travel and accommodation costs related to attendance at events may be accepted but must be declared. Offers which go beyond modest, or are of a type that the organisation itself might not usually offer, need line manager approval, should only be accepted in exceptional circumstances, and must be declared. A clear reason should be recorded on the Trust's register(s) of interest as to why it was permissible to accept travel and accommodation of this type (e.g. offers of business or first class travel and accommodation, offers of foreign travel and accommodation)		
3. LITIGATION CLAIMS		

DELEGATED MATTER	DELEGATED LIMIT	OPERATIONAL RESPONSIBILITY
Clinical Negligence scheme for the Trust (CNST) and Clinical Risk Pooling Scheme (LTPS & PES - above excess only) for the Trust		NHS Resolution (NHSR) on behalf of the Trust
Employers Liability (EL) claims within excess	up to £3,000	Deputy Director of Quality Governance
Public Liability (PL) claims within excess	Up to £3,000	Deputy Director of Quality Governance
Public Liability (PL) claims within excess	£3,001 to £10,000	Chief Nurse and reported to Board
4. LOSSES AND SPECIAL PAYMENTS		
Losses:		
1. Losses of cash due to theft, fraud and other	Up to £100	Associate Director of Finance (FS)
	Over £100	Chief Finance Officer
2. Fruitless payments and constructive losses	up to £10,000	Chief Finance Officer
	£10,001 - £250,000	Chief Executive
	Over £250,000	Board of Directors
3. Bad debts and claims abandoned in relation to:		
a. private patients b. overseas visitors c. other including salary overpayment	up to £5,000	Associate Director of Finance (FS)
	£5,001 - £10,000	Director of Finance
	£10,001 - £50,000	Chief Finance Officer
	£50,001 - £250,000	Chief Executive and Chief Finance Officer
	Over £250,000	Board of Directors
4. Damage to buildings, property etc. (including stores losses) due to:		
a. theft, fraud etc. b. stores losses c. other	Up to £5,000	Associate Director of Finance (FS)
	£5,001 - £10,000	Director of Finance
	£10,001 - £50,000	Chief Finance Officer
	£50,001 - £250,000	Chief Executive
	Over £250,000	Board of Directors
4. LOSSES AND SPECIAL PAYMENTS		
Special payments:		
5. Compensation under court order or legally binding arbitration award	up to £50,000	Chief Finance Officer
	£50,001 - £250,000	Chief Executive
	Over £250,000	Board of Directors
6. Extra contractual to contractors	up to £50,000	Chief Finance Officer
	£50,001 - £250,000	Chief Executive
	Over £250,000	Board of Directors
Special payments:		
7. Ex gratia payments in respect		

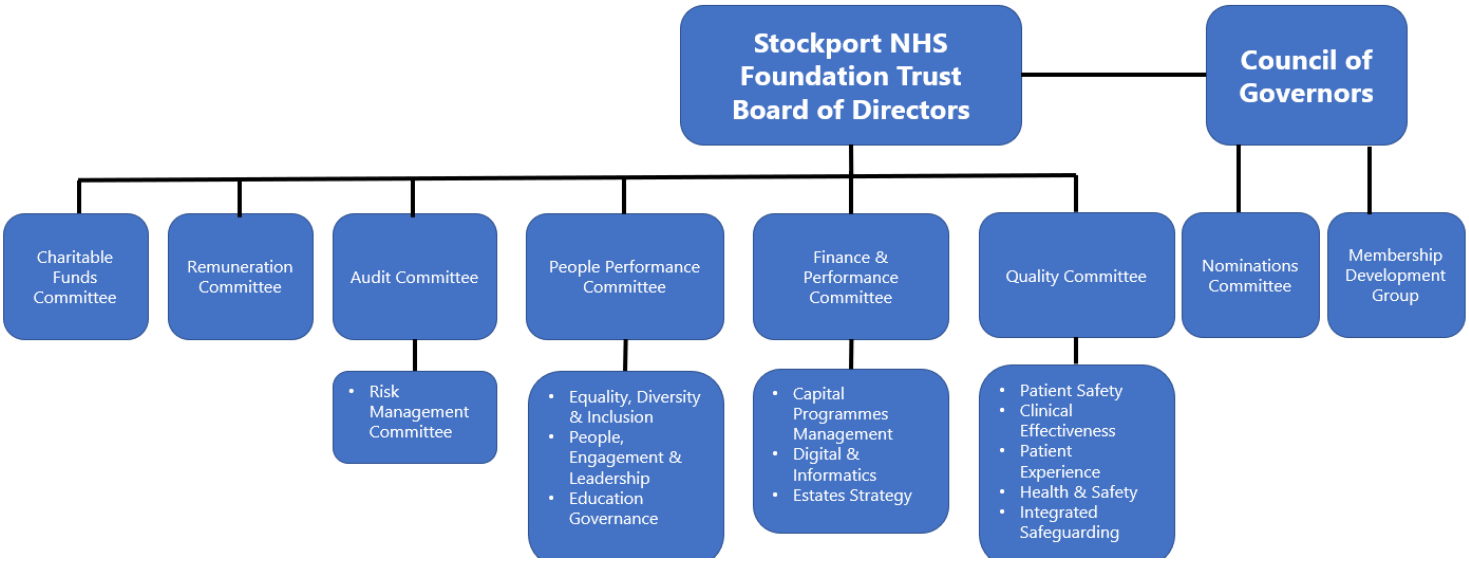
DELEGATED MATTER	DELEGATED LIMIT	OPERATIONAL RESPONSIBILITY
of:		
a. loss of personal effects b. clinical negligence with advice c. personal injury with advice d. other negligence and injury e. other employment payments (not including special severance payments which are disclosed below) f. patient referrals outside the UK and EEA Guidelines g. other h. maladministration, no financial loss	Up to £5,000	Deputy Director of Quality Governance
	£5,001 - £50,000	Chief Finance Officer
	£50,001 - £250,000	Chief Executive
	Over £250,000	Board of Directors
8. Special severance payments Special severance payments when staff leave a public sector employer should only rarely be considered. They will always require HM Treasury approval because they are usually novel, contentious and potentially repercussive: NHS bodies have no delegated authority to make such payments unless so approved. NHS bodies must complete a template for submission to HM Treasury for approval.	All levels	HM Treasury
9. Extra statutory and regulatory Extra statutory and regulatory are within the broad intention of the state of regulation, respectively, but go beyond a strict interpretation of its terms.	Up to £50,000	Chief Finance Officer
	£50,001-£250,000	Chief Executive and Chief Finance Officer
	Over £250,000	Board of Directors
5. PETTY CASH DISBURSEMENTS		
Petty Cash	Up to £50	Petty Cash Holder
	Up to £100	Chief Financial Accountant
	Over £100	Chief Finance Officer or Nominated Deputy
6. PATIENTS PROPERTY (issuing property of deceased patients)		
In accordance with agreed Foundation Trust policies	Up to £5,000	General office staff
Only on production of a probate letter of administration	Over £5,000	Associate Director Estates & Facilities
7. REQUISITIONING GOODS AND SERVICES AND APPROVING PAYMENTS		
7.1 Revenue Expenditure - Delegated Authority (excluding consultancy services, capital and removal expenses)	Up to £250	Level 1 budget holder
	Up to £1,000	Level 2 budget holder
	Up to £5,000	Level 3 budget holder Level 1 to 3 in accordance with overall cost centre budget level and agreed with Divisional/Functional Director. This is defined in the approval hierarchy

DELEGATED MATTER	DELEGATED LIMIT	OPERATIONAL RESPONSIBILITY
	Up to £25,000	Functional Director
	Up to £50,000	Executive Director Director of Finance
	Up to £100,000	Chief Finance Officer
	Up to £750,000	Chief Executive or Nominated Deputy
	Over £ 750,000	Chair & Chief Executive (with Board Approval)
7.2 Consultancy Services	Up to £50,000	Chief Executive/Executive Director before submission to NHS England
	Over £50,000	NHS England
7.3 Capital Expenditure		
Annual capital programme	n/a	Board of Directors
Amendments to the capital programme	n/a	Capital Programme Management Group (with Finance & Performance Committee approval where necessary as per delegated limits below)
Orders for schemes within the capital programme	Up to £25,000	Associate Director of Finance (FS) Deputy Director of Strategy & Partnerships
	Up to £50,000	Executive Director Director of Finance
	Up to £100,000	Chief Finance Officer
	Up to £750,000	Chief Executive or Nominated Deputy
	Over £ 750,000	hair & Chief Executive (with Board Approval)
Emergency schemes approved by	Up to £250,000	Chief Finance Officer or Director of Finance
	£250,000-£500,000	Chief Executive
	Over £500,000	Board of Directors
7.4 Removal Expenses	Maximum of £6,000	For all Staff, in line with Foundation Trust Policy – Staffing Approval Group
	Exceptional circumstances (over £6,000)	Director of People & Organisational Development / Director of Finance
8. QUOTATIONS AND TENDERS		
Quotations: inviting minimum of 3 written quotations for goods/services	Up to £15,000	Via Procurement/Estates (within delegated financial limits for requisitioning)
	£15,000 - £50,000	Procurement/Estates
Competitive Tenders: inviting a minimum of 3 written competitive tenders for goods/services via the e-tendering portal (in compliance with UK Government directives) in line with the Find a Tender Service (FTS) *upper threshold limits and subsequent changes to be provided	£50,001 to £122,976*	Procurement/Estates (refer to Guide to Buying)

DELEGATED MATTER	DELEGATED LIMIT	OPERATIONAL RESPONSIBILITY
under separate correspondence by the Head of Procurement		
Full Upper Threshold Tender	Over £122,976*	Procurement / Estates (refer to Guide to Buying)
Waiver of Tender/Quotation (capital & revenue) *The Trust waiver form is to be used*	Up to £50,000	Director of Finance
	Up to £100,000	Chief Finance Officer
	Up to £250,000	Chief Executive or Nominated Deputy (needs to include approval of Chief Finance Officer)
	Over £250,000	Chief Executive & Chair
9. BUSINESS CASE APPROVAL		
Revenue business case (where funding is identified from an external source.)	Up to £750,000	Executive Team
	Over £750,000	Executive Team Finance & Performance Committee Board of Directors
All Other Revenue business cases *(NB Clarification on Greater Manchester Integrated Care approval process to be determined)*	Up to £750,000	Executive Team
	Over £750,000	Executive Team Finance & Performance Committee Board of Directors
Capital business case	Up to £100,00	Capital Programmes Management Group
	Up to £750,00	Executive Team
	Over £750,000	Executive Team Finance & Performance Committee Board of Directors
10. REDESIGNATION OF BUDGET (VIREMENT)		
Trust must still meet financial targets. Total Trust budget remains under spent. Total divisional / departmental budget remains under spent and CIP recurrent target is achieved. Any workforce changes are subject the approval by the Staffing Approval Group.	Up to £25,000	Functional / Divisional Director / Executive Director
	Up to £50,000	Director of Finance
	Up to £100,000	Chief Finance Officer
	Up to £250,000	Executive Team Chief Executive
	Over £250,000	Board of Directors
11. CONTRACT AWARD		
Approval of Contract Award	up to £50,000 per annum	Director of Finance
	Over £50,000 per annum	Chief Finance Officer
12. SIGNING OF CONTRACTS		
Where standard NHS terms & Conditions apply This includes Service Level Agreements for the provision and receipt of services	As per section 7.1	As per section 7.1
Non standard contracts	Up to £100,000 (total contract	Associate Director of

DELEGATED MATTER	DELEGATED LIMIT	OPERATIONAL RESPONSIBILITY
	length)	Finance FS FM I&C
	Up to £250,000 (total contract length)	Director of Finance
	Up to £500,000 (total contract length)	Chief Finance Officer
	Up to £2,000,000 (total contract length) where 1 year does not exceed £750,000	Chief Executive or Nominated Deputy
	Over £2,000.000 or where 1 year exceeds £750,000	Chief Executive & Chair subject to Board approval
13. TRANSFER OF SERVICES		
Approval of transfer of service (based on income value)	up to £500,000 per annum	Chief Executive
	Over £500,000 per annum	Board of Directors

APPENDIX 1 – BOARD STRUCTURE – January 2024



APPENDIX 2

Stockport NHS Foundation Trust

RECORD OF AMENDMENTS

Version 4 November 2022 to Version 5 February 2024

NO	SECTION	DATE
1	Inclusion of scheme of delegation for Council of Governors – Insertion of section 4	Feb 2024
2	Assurance Committees responsibilities – Section 5	Feb 2024
3	Board structure diagram – Appendix 1	Feb 2024
4	Change Director of Finance title to Chief Finance Officer	Feb 2024
5	Changes to ToR of Staffing Approval Group	Feb 2024
6	Inclusion of Decisions delegated to Committees	Feb 2024
7	Revision to approval of business case	Feb 2024
8	Revision to pay: Authority to authorise waiting list payments, on call claims and other additional duties outside agreed timeframe (over 2 months)	Feb 2024
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Submission Date:	
Approved By:	
Full EIA needed:	Yes/No

Equality Impact Assessment – Policies, SOP's and Services not undergoing re-design

1	**Name of the Policy/SOP/Service**	Scheme of Delegation & Reservation	
2	**Department/Business Group**	Finance & Procurement	
3	**Details of the Person responsible for the EIA**	Kay Wiss	Director of Finance
4	**What are the main aims and objectives of the Policy/SOP/Service?**	This is the Trust's main financial governance document which sets out who has delegated authority in order to make decisions and the levels of approvals of those. This document ensures clarity across those.	

For the following question, please use the EIA Guidance document for reference:

5	**A) IMPACT** **Is the policy/SOP/Service likely to have a <u>differential</u> impact on any of the protected characteristics? If so, is this impact likely to be positive or negative?** **Consider:** • Does the policy/SOP apply to all or does it exclude individuals with a particular protected characteristic e.g. females, older people etc? • What does existing evidence show? E.g. consultation from different groups, demographic data, questionnaires, equality monitoring data, analysis of complaints. Are individuals from one particular group accessing the policy /SOP /Service more/less than expected?	**B) MITIGATION** **Can any potential negative impact be justified? If not, how will you mitigate any negative impacts?** ✓ Think about reasonable adjustment and/or positive action ✓ Consider how you would measure and monitor the impact going forward e.g. equality monitoring data, analysis of complaints. ✓ Assign a responsible lead. ✓ Designate a timescale to monitor the impacts. ✓ Re-visit after the designated time period to check for improvement. **Lead**	
Age	Workforce Data: Average age 44.5 Stockport Population Data: Largest age band 40 – 49 Older people are more likely to experience serious complications from the virus	- Consider are there any age related impacts? - Is the proposal for all ages or particular age groups? - Mitigating any increased risks. - Dignity & Modesty	No impact
Carers / People with caring responsibilities McCarthy Rebecca 28/03/2024 17:31:14	The 2011 Census showed there are 31,982 unpaid carers in Stockport. 6,970 (22% of all carers) provide 50+ hours of care per week. Signpost for Carers estimate the total value of unpaid care in Stockport is £570 million a year. Trust Workforce: No Data Carers are more likely to come into contact with vulnerable patients	- Chaperones - Mitigating any increased risks. - Accessible Information	No impact
Disability	The 2011 census indicates that 18.4% of Stockport residents are living with a limiting	- Accessible communication. - BSL interpreters	No impact

	long-term illness Trust Workforce: 3.32% report disability. 11.94% not declared COVID impacts are higher among people with long-term conditions COVID impacts are higher among people with long-term conditions	- Mental capacity - Pictorial images - Hearing loops - learning difficulties - visually impaired - Mitigating any increased risks. - Dignity & Modesty	
Race / Ethnicity	Stockport's Black & Minority Ethnic (BME) population has risen from just 4.3% in 2001 to around 8% at the 2011 Census Trust Workforce: BAME make up 16.18% People from Black, Asian and Minority Ethnic (BAME) backgrounds are more likely to experience serious complications from the virus	- Interpreters - Mitigating any increased risks. - Dignity & Modesty	No impact
Gender	Stockport's population is split almost equally by gender (51.1% female, 48.9% male), which mirrors the national trend. Trust Workforce: 79.9% female Although women were more likely to have a positive COVID test, men were more likely to die from the disease	- Dignity & Modesty - Mitigating any increased risks. -	No impact
Gender Reassignment	It is estimated that 1% of the UK population is gender variant, based on referrals to and diagnoses of people at gender identity clinics. This would equate to 3,000 people in the borough Trust Workforce: No Data Increased risk of severe COVID-19 in people who are on antiretroviral treatment and are not immunosuppressed.	- Dignity & Modesty - Mitigating any increased risks. - Gender Dysphoria - Treating in accordance to preferred identity. - Pronouns	No impact
Marriage & Civil Partnership	38% married 0.2% of people in the 2011 census were in a civil partnership – a figure which is consistent across Stockport, the North West and nationally. Trust Workforce: 54.9% married & 0.7% Civil Partnership	- Mitigating any increased risks.	No impact
Pregnancy & Maternity	2% fertility rate On average there are over 3,300 births to Stockport resident mothers each year. Trust Workforce: 2.14% on maternity or adoption leave* Pregnant women are included in the list of 'high risk' groups.	- Mitigating any increased risks. - Dignity & Modesty	No impact
Religion & Belief	The majority of Stockport residents are Christian (63.2% - down from 75% at the last	- Interpreters - Mitigating any increased	No impact

	census), which is 4% greater than the national average. Trust Workforce: 52.47% Christian	risks. - Dignity & Modesty - Religious beliefs	
Sexual Orientation	It is estimated that 5-7% of the UK population is LGB, which would equate to 15-21,000 people in the borough. Trust Workforce: 2.12% LGBT 20.09% did not want to declare	- Gender Dysphoria - Utilising Pronouns	No Impact
General Comments across all equality strands	This section is useful to clarify mitigations that will be applicable across all groups e.g. dignity and modesty.		No impact

EIA Sign-Off	**Your completed EIA should be sent to Annela Hussain Equality Diversity & Inclusion Lead for approval and publication:** equality@stockport.nhs.uk **0161 419 4784**

Data Protection Impact Assessment

Organisations have to ensure that the third parties they both process and share personal confidential data with, will ensure the data is secure and confidential. To assess the implications of using personal data, a risk assessment called a Data Privacy Impact Assessment (DPIA) is required.
If you are doing any of the following you will need to complete a Data Privacy Impact Assessment (DPIA):

- **Setting up a new process using personal confidential data (PCD)**
- **Changing an existing process which changes the way personal confidential data is used**
- **Procuring a new information system which holds personal confidential data**

A DPIA is a proforma or risk assessment which asks questions about the process or new system based on data quality / data protection / information security and technology.

The DPIA Process

1) **Complete the screening questions below – this is to determine whether or not completion of a full DPIA is required**
2) If a full DPIA is required, you will be advised by the Information Governance Team and sent the full DPIA proforma for completion

If DPIA's are not completed, there may be data protection concerns that have not been identified which could result in breaching the Data Protection Act/GDPR.

Advice/Guidance on completing the screening questions or the full DPIA can be provided by the Information Governance Team (Khaja Hussain x5295/Joan Carr x4364)

DPIA Screening Questions

		Yes	No	Unsure	Comments *Document initial comments on the issue and the privacy impacts or clarification why it is not an issue*
a)	Will the process described involve the collection of new information about individuals?		no		Click here to enter text.
b)	Does the information you are intending to process identify individuals (e.g. demographic information such as name, address, DOB, telephone, NHS number)?		no		Click here to enter text.
c)	Does the information you are intending to process involve sensitive information e.g. health records, criminal records or other information people would consider particularly private or raise privacy concerns?		no		Click here to enter text.
d)	Are you using information about individuals for a purpose it is not currentlyused for, or in a way it is not currently used?		no		Click here to enter text.

e)	Will the initiative require you to contact individuals in ways which they may find intrusive[1]?		no		Click here to enter text.
f)	Will the information about individuals be disclosed to organisations or people who have not previously had routine access to the information?		no		Click here to enter text.
g)	Does the initiative involve you using new technology which might be perceived as being intrusive? e.g. biometrics or facial recognition		no		Click here to enter text.
h)	Will the initiative result in you making decisions or taking action against individuals in ways which can have a significant impact on them?		no		Click here to enter text.
i)	Will the initiative compel individuals to provide information about themselves?		no		Click here to enter text.

1. Intrusion can come in the form of collection of excessive personal information, disclosure of personal information without consent and misuse of such information. It can include the collection of information through surveillance or monitoring of how people act in public or private spaces and through the monitoring of communications whether by post, phone or online and extends to monitoring the records of senders and recipients as well as the content of messages.

If you answered YES or UNSURE to any of the above you need to continue with the Privacy Impact Assessment. Giving false information to any of the above that subsequently results in a yes response that you knowingly entered as a NO may result in an investigation being warranted which may invoke disciplinary procedures

DOCUMENT INFORMATION

Type of Document	Policy
Title	Scheme of Reservation & Delegation
Version Number	V 5.0
Consultation	Finance & Procurement Senior Team Executive Team
Recommended By:	Audit Committee
Approved By:	TBC
Approval Date	Audit Committee 20/02/2024 Board TBC
Next Review Date	February 2026
Document Author	Director of Finance
Document Director	Chief Finance Officer
For use by:	All Trust employees
Specialty / Ward / Department (if local procedure document)	

Version	Date of change	Date of release	Changed by	Reason for change
3	June 2021	14 June 2021	Deputy Director of Finance	Organisational changes and changes to Exec portfolio. Due for refresh
4	November 2022	XX	Director of Finance	Levels of authorisation following Covid Changes to Divisional Structures
5	February 2024		Director of Finance	Level of authorisation, changes to Exec posts and inclusion of Council of Governors

NHS Stockport NHS Foundation Trust

Meeting date	4th April 2024	**Public**	X	**Agenda No.**	16
Meeting	Board of Directors				
Report Title	Annual Review: Code of Governance for NHS Provider Trusts				
Director Lead	Karen James, Chief Executive	**Author**	Rebecca McCarthy, Trust Secretary		

Paper For:	**Information**		**Assurance**	X	**Decision**	
Recommendation:	The Board of Directors is asked to review and confirm the outcome of the annual review of compliance with the Code of Governance, including disclosures to be included within the Annual Report 2023/24.					

This paper relates to the following Annual Corporate 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
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
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	Specific Code Provisions
Financial impacts if agreed/not agreed	Specific Code Provisions
Regulatory and legal compliance	All
Sustainability (including environmental impacts)	Specific Code Provisions

Executive Summary

The NHS Foundation Trust Code of Governance (the Code) was first published in 2006 and updated in July 2014. Following significant regulatory change on account of the Health and Social Care Act 2022, a new code of governance for NHS provider trusts was published in October 2022, taking effect from 1 April 2023.

The new Code applies to both foundation trusts and NHS trusts. Key changes related to:

- Incorporation of requirement for boards to assess its contribution to the Integrated Care Partnership (ICP) and Integrated Care Board (ICB) and place-based partnerships.
- Board's role in assessing and monitoring culture of the organisation.
- Focus on equality, diversity, and inclusivity at board.
- Potential involvement of NHS England and/or ICB in recruitment and appointment of Executive and Non-Executive Directors.

As previous, the Code sets out principles to help trusts deliver effective corporate governance, and provisions with which Trusts should comply, or explain how the principles have been met in other ways. There are several statutory requirements, where compliance is mandatory. The provisions are drawn together in a disclosures section, which must be reported against in Trust's Annual Report.

In line with the Foundation Trust Annual Reporting Manual 2023/24, the Trust is required to report compliance against the Code within its Annual Report 2023/24.

A compliance checklist with each of the Code provisions has been prepared and included at Appendix A, confirming that the Trust complies with the Code's provisions, except for:

- **Explain: Provision C.4.7** – Boards strongly encouraged to carry out an externally facilitated developmental review using the well-led framework at least every three years.

Explanation: An independent board governance review was completed by Deloitte LLP during 2014/15. Subsequently a series of external reviews including CQC Well Led Inspection (October 2018 and February 2020) and NHS England/Improvement Governance Review (November 2019) undertaken. An independently facilitated Well Led mapping review was conducted by AQuA in 2021, providing an overview of the Trust's evidence against the Key Lines of Enquiry (KLOEs) within the Well Led framework, and developmental actions for the purpose of continuous improvement. In March 2023, completion of self-assessment and agreed KLOE ratings considered by Board, March 2023. Full external facilitated review not undertaken; internal audit plan utilised to undertake a Well led Position Statement (Substantial Assurance).

- **Explain: Provision E.2.2** – Levels of remuneration for the chair and other non-executive directors should reflect the Chair and non-executive director remuneration structure.

Explanation: In February 2022, the Council of Governors agreed that all new Non-Executive Director positions would be remunerated in line with 'NHS England Chair and non-executive director remuneration structure'. This decision has subsequently been implemented. Furthermore, the Council of Governors agreed that existing non-executive directors, who are reappointed for a further term of office, would remain at the level of remuneration to which they were originally appointed, subject to a robust performance appraisal and confirmation that performance continues to be effective, thereby differing to the 'NHS England Chair and non-executive director remuneration structure'. The Chair's remuneration is in line with the NHS England remuneration structure.

In support of the compliance checklist, an internal audit: Well Led Position Statement was conducted in November – December 2023. The overall objective of this review was to provide an overview of the effectiveness of the design and operation of the Trust Board, including a focus on compliance against good practice outlined in the Code of Governance for Provider Trusts. The outcome of the internal audit was 'substantial assurance'.

Section A: Board leadership and purpose

Provision	Code Provision	Current Position	Developmental Action	Comply or Explain
A.2.1	Board of Directors (BoD) should assess the basis on which the trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the ICP and ICB, and place-based partnerships. BoD should ensure the trust actively addresses opportunities to work with other providers to tackle shared challenges through entering into partnership arrangements such as provider collaboratives. Trust should describe in its annual report how opportunities and risks to future sustainability have been considered and addressed, and how its governance is contributing to the delivery of its strategy.	▪ Trust engaged in development of GM ICP Strategy 2023-2028. ▪ Annual Operational Plan (including activity, workforce, and finance), developed in line with national planning guidance, and developed, and agreed, as part of the GM ICS Plan, with programme of work focussed on financial performance recovery for 2024/25 and beyond. ▪ Trust's Corporate Objectives & Outcomes Measures are developed based on the agreed operational plan, incorporating national, system and locality based measures. ▪ Executive Directors are part of key governance arrangements within GM, ensuring opportunities to work with other providers. CEO is chair of GM Trust Provider Collaborative (TPC); all Executive Directors are members of respective professional/portfolio GM groups. ▪ Collaboration and joint leadership arrangements with Tameside & Glossop Integrated Care NHS Foundation Trust (T&G) to support sustainability and workforce challenges, and unwarranted variation in access and experience. ▪ Joint Clinical Strategy agreed with East Cheshire Hospitals NHS Trust (ECT). ▪ At Place, Executive Directors are part of key governance arrangements within Stockport Locality, including Locality Board and Place-Based Provider Partnership. Chair member of Stockport Health & Well Being Board. ▪ 'ONE Stockport' Health & Care Plan developed bringing together all parts of the borough. The One Stockport Health & Care Board (Locality Board) and Stockport Provider Partnership (led by SFT) established. ▪ Stockport Provider Partnership has identified a series of population health focused workstreams (Diabetes, Frailty, Alcohol related Admissions, Cardiovascular Disease) to support improved population health outcomes. ▪ Board committee structure in place to oversee delivery of annual operational plan. Regular review by Board and Board Committees of: Integrated Performance Report,		Comply

Provision	Code Provision	Current Position	Developmental Action	Comply or Explain
		Finance, Operational Performance, People and Quality & Safety Dashboards and suite of reporting, including relevant benchmarking with GM. ▪ Annual Report, subject to external audit, to be prepared in line with Annual Reporting Manual.		
A.2.2	BoD should develop and articulate a clear vision and values for the trust, with reference to the ICP's integrated care strategy and the trust's role within system and place-based partnerships, and provider collaboratives. Agreed statement of the organisation's purpose and intended outcomes, and the behaviours used to achieve them.	▪ The Trust acknowledges that the Trust Strategy 2020-2025 was developed prior to legal establishment of ICS and publication of GM ICP Strategy and Joint Forward Plan to set the direction of the system. ▪ However, the current Trust Strategy clearly articulates vision and values/behaviours of the Trust and recognises the role the Trust plays a key partner within GM & Stockport. ▪ Annual corporate objectives and key outcomes measures include vision to work with partners to improve health and well-being outcomes for communities served and development of effective partnerships to address health and well-being inequalities.	Refresh Trust Strategy	Comply
A.2.3	BoD should assess and monitor culture. Where it is not satisfied that policy, practices or behaviour throughout the business are aligned with the trust's vision, values and strategy, it should seek assurance that management has taken corrective action. Annual Report should explain the board's activities and any action taken, and the trust's approach to investing in, rewarding and promoting the wellbeing of its workforce.	▪ Board approved Organisational Development (OD) Plan to further build awareness of organisational values, identify situations not aligned to those values and implement series of interventions aimed at changing behaviour, hearts and minds. OD Plan implementation, monitored via People Performance Committee and Board. ▪ Staff engagement activities in place as part of the OD Plan, include Values into Action, Schwartz Rounds, Walkabout Wednesday, Civility Saves Lives Programme. ▪ Freedom to Speak Up Guardian and Guardian of Safe Working Hours in place, with regular report to the People Performance Committee and Board, including themes and action taken. ▪ Approved Health & Wellbeing Plan in place, aligned to the NHS Health and Wellbeing Framework; implementation and outcome reported to People Performance Committee. ▪ Trust Disciplinary Policy and Just Culture guide in place to ensure that any disciplinary matter is dealt with fairly. Board review Staff Exclusions Report, which provides insight into colleagues entering the disciplinary process. ▪ Suite of quality-based reports that includes lessons learned and improvements to practice further to thematic review of incidents, inquests, claims and complaints reported via the		Comply

Provision	Code Provision	Current Position	Developmental Action	Comply or Explain
		Trust's incident reporting system. Reviewed by Quality Committee. ▪ NHS Staff Survey Results and Staff Friends & Family utilised to review progress within SFT. Outcomes reported to People Performance Committee and action plans developed and monitored via Divisions to support improvement. ▪ Annual Report, subject to external audit, to be prepared in line with Annual Reporting Manual.		
A.2.4	BoD should ensure that adequate systems and processes are maintained to measure and monitor the trust's effectiveness, efficiency and economy, the quality of its healthcare delivery, the success of its contribution to the delivery of the five-year joint plan for health services and annual capital plan agreed by the ICB and its partners (This may also include working to deliver the financial duties and objectives the trust is collectively responsible for with ICB partners, and improving quality and outcomes and reducing unwarranted variation and inequalities across the system), and that risk is managed effectively. BoD should regularly review the trust's performance in these areas against regulatory and contractual obligations, and approved plans and objectives, including those agreed through place-based partnerships and provider collaboratives.	See A.2.1 and A.2.2 ▪ Reporting schedules of the Board and Board Committees allow quality, operational performance, financial performance objectives, set as part of system & locality planning, to be reported, reviewed and challenged. ▪ Trust has fully engaged in the GM financial performance recovery process. ▪ Key operational systems and processes in place to support the above and the Trust in its duty to exercise functions effectively, efficiently and economically, and have regard to likely effects of the decision in relation to the quality of services provided to individuals and on quality of care delivery. Including (but not limited to) Staffing Approval Group, cost improvement planning, QIA & EIA, business case approval process, divisional performance framework.	Trust Self-Assessment: Reducing Health Inequalities – A guide for NHS trust board members.	Comply
A.2.5	BoD should ensure relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and performance, ensuring performance reports are disaggregated by ethnicity and deprivation where relevant. Where appropriate and particularly in high risk or complex areas, the BoD should commission independent advice, e.g. from the internal audit function, to provide an adequate and reliable level of assurance.	▪ An Integrated Performance Report (IPR) is reviewed by the Board on a bimonthly basis to ensure any relevant action required is taken to improve performance. The IPR is supplemented by a suite of assurance reports, alongside progress with respect to key strategic developments. ▪ Trust has developed performance reporting more broadly in recent years, with Board subcommittee performance reports / dashboards and data packs supporting the Trust's governance and assurance processes and the approach of 'measurement for improvement'. ▪ Divisional Performance Review process established. ▪ Independent advice commissioned by Board, as appropriate.	Trust Self-Assessment: Reducing Health Inequalities – A guide for NHS trust board members.	Comply
A.2.6	BoD should report on its approach to clinical governance and its plan for the improvement of clinical quality.	▪ Board approved Quality Strategy in place. ▪ Oversight of clinical governance and quality established		Comply

Provision	Code Provision	Current Position	Developmental Action	Comply or Explain
	BoD should record where in the structure of the organisation clinical governance matters are considered.	within approved Board governance arrangements – Patient Safety, Clinical Effectiveness, Patient Experience reporting via Quality Committee, and onward to Board as required. ▪ Quality Accounts produced annually.		
A.2.7	Chair and BoD should regularly engage with stakeholders, including patients, staff, the community and system partners, in a culturally competent way to understand their views on governance and performance. Committee chairs should engage with stakeholders on significant matters related to their areas of responsibility. Chair should ensure that the BoD as a whole has a clear understanding of the views of all stakeholders including system partners. NHS foundation trusts must hold a members' meeting at least annually.	▪ Number of stakeholder engagement processes and practices in place for Board to engage with patients, public and staff engagement, including Walkabout Wednesday, Staff Networks, governor and membership meetings/seminars. ▪ Board members engage with system partners via number of GM and locality forums/meetings. ▪ Chair's and Chief Executive Report provide high-level overview of engagement at Board (& CoG for Chair) ▪ Annual Members Meeting held each year, positive attendance.		Comply
A.2.8	BoD should describe in the annual report how the interests of stakeholders, including system and place-based partners, have been considered in their discussions and decision-making, and set out the key partnerships for collaboration with other providers into which the trust has entered. BoD should keep engagement mechanisms under review so that they remain effective.	▪ Directors Statements and Annual Governance Statement included in Annual Report incorporating all required statements. ▪ Annual Report, subject to external audit, to be prepared in line with Annual Reporting Manual.		Comply
A.2.9	Workforce should have a means to raise concerns in confidence and – if they wish – anonymously. BoD should routinely review this and the reports arising from its operation. It should ensure that arrangements are in place for the proportionate and independent investigation of such matters and for follow-up action.	▪ Freedom to Speak Up (FTSU) Guardian in post to act in an independent and impartial capacity to support staff who raise concerns. Reporting to People Performance Committee & Board. Self-assessment undertaken in line with national planning tool. ▪ FTSU Policy revised in line with new national policy, and national training packages for all staff adopted. ▪ Guardian for Safe Working Hours in place. Six monthly reports to People Performance Committee and annual report to Board. ▪ Annual review via Audit Committee of systems in place to ensure staff can raise issues in confidence about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters and		Comply

Provision	Code Provision	Current Position	Developmental Action	Comply or Explain
		proportionate investigation. ▪ Regular counter-fraud update reports received by Audit Committee		
A.2.10	BoD should take action to identify and manage conflicts of interest and ensure register available to the public in line with Managing conflicts of interest in the NHS: Guidance for staff and organisations.	▪ Conflicts of Interest Policy in place in line with NHS England guidance. ▪ Annual review of Board Register of Interest via Board and annual review of trust-wide Register of Interests undertaken by Audit Committee. ▪ Board minutes fully record any interests raised during Board/Board Committee meeting, and action taken. ▪ Public register available via SFT website. ▪ Internal Audit of Conflicts of Interest 2023/24 – Substantial Assurance		Comply
A.2.11	Where directors have concerns, which cannot be resolved, they are recorded in the board minutes. On resignation, director to provide written statement if have any concerns	▪ Board minutes fully record all matters raised, discussions, concerns, and agreements. Board meeting minutes are reviewed at the subsequent Board meeting to ensure they provide a true account of the proceedings. ▪ Resignation of director not occurred in year.		Comply

Section B: Division of Responsibilities

Provision	Code Provision	Current Position	Developmental Action	Comply or Explain
B.2.1	Chair responsible for leading agenda setting for board and council of governors, and ensuring time for discussion, on strategic issues.	▪ Chair leads agenda setting for BoD and CoG in line with work plan, which considers balance of operational, regulatory, and strategic matters.		Comply
B.2.2	Chair responsible for ensuring that directors and, for foundation trusts, governors receive accurate, timely and clear information that enables them to perform their duties effectively. A foundation trust chair should take steps to ensure that governors have the necessary skills and knowledge to undertake their role.	▪ Relevant information made available to BoD and CoG regarding finance, quality of care, operational performance and people performance, alongside key strategic developments. ▪ Suite of reports, including background information provided to BoD and CoG. ▪ Standardised front sheet, with executive summary and recommendation section to ensure clarity and appropriate review of paper. ▪ Training and development programme established for governors, including both internal and external opportunities. Information included in Annual Report.		Comply
B.2.3	Chair should promote a culture of honesty, openness, trust and debate by facilitating the effective contribution of non-executive directors in particular and ensuring a constructive relationship between executive and non-executive directors.	▪ Chair, and Interim Chair, during 2023/24, promotes culture of openness and debate and facilitates contribution of both executive and non-executive directors as evidenced via Board and Board Committee minutes.		Comply
B.2.4	A foundation trust chair is responsible for ensuring that the board and council work together effectively.	▪ Mechanism in place to resolve disagreements between the Board and CoG as stated within Constitution. ▪ Executive and Non-Executive Director attendance at CoG meetings, and informal meetings between governors and Non-Executive Directors and Chair. ▪ Senior Independent Director (SID) supports CoG and Board relationships as required. Annual Report describes how Board and CoG operate.		Comply
B.2.5	Chair should be independent on appointment. The roles of chair and chief executive must not be exercised by the same individual. A chief executive should not become chair of the same trust. BoD should identify a deputy or vice chair who could be the senior independent director.	▪ Chair recruitment process ensure Chair independent on appointment. Annual Report identifies each NED considered by the Board to be independent. ▪ Board states its reasons if it determines that a director is independent despite relevant circumstance/criteria ▪ Role of Chair and Chief Executive are not exercised by same individual. ▪ Deputy Chair in place. Currently undertaking position of Interim Chair until appointment of substantive Chair concluded.		Comply

Provision	Code Provision	Current Position	Developmental Action	Comply or Explain
	Chair should not sit on the audit committee. The chair of the audit committee, ideally, should not be the deputy or vice chair or senior independent director.	▪ Audit Committee established by Board. Membership includes at least 4 independent NEDs and does not include the Chair. Trust Chair attends Audit Committee by invitation only. Vice Chair / SID does not Chair Audit Committee.		
B.2.6	BoD should identify in the annual report each non-executive director it considers to be independent based on circumstances that are likely to impair, or could appear to impair, a non-executive director's independence include.	▪ Board undertakes annual review of independence and states its reasons if it determines that a director is independent despite relevant circumstance/criteria. ▪ Annual Report identifies each NED considered by the Board to be independent.		Comply
B.2.7	At least half the BoD, excluding the chair, should be non-executive directors whom the board considers to be independent.	▪ There are currently 13 voting members of the Board, this includes 6 Executive Directors and 7 NEDs, one of whom is undertaking the role of Interim Chair. Following appointment of a substantive Chair the composition of NEDs will be 7 NEDs and a Chair ▪ All current NEDs considered to be independent (as above)		Comply
B.2.8	No individual should hold the positions of director and governor of any NHS foundation trust at the same time.	▪ Constitution prevents an individual holding office as both director and governor at the same time. ▪ Provisions included in eligibility for directors and governors.		Comply
B.2.9	The value of ensuring committee membership refresh and no undue reliance placed on individuals should be taken into account in deciding chairship and membership of committees. Council of governors should take into account the value of appointing a non-executive director with a clinical background and appointing diverse range of non-executive directors.	▪ Annual review of all Board committees, including membership and chairship. Also considered on appointment of new non-executive directors. ▪ 3 NEDs with clinical experience. Selection and recruitment process for NEDs designed to encourage applicants with range of skill sets, backgrounds and lived experience.		Comply
B.2.10	Only the committee chair and committee members are entitled to be present at nominations, audit or remuneration committee meetings, but others may attend by invitation of the particular committee.	▪ Terms of reference for Audit, Nominations, and Remuneration Committees set out membership and those who may attend by invitation.		Comply
B.2.11	BoD to appoint Senior Independent Director (SID), in consultation with the Council of Governors. Led by the SID, the foundation trust non-executive directors should meet without the chair present at least annually to appraise the chair's performance.	▪ Current SID - Dr Louise Sell. CoG consulted on proposed appointment in February 2022, appointment confirmed by Board in April 2022. ▪ SID presents process for appraisal of the Chair to CoG annually (February 2024), and leads appraisal process, reporting to Nominations Committee and CoG.		Comply
B.2.12	Non-executive directors have a prime role in appointing and removing executive directors. They should scrutinise and	▪ Remuneration Committee established for this purpose, as set out in Terms of Reference. Annual performance		Comply

Provision	Code Provision	Current Position	Developmental Action	Comply or Explain
	hold to account the performance of management and individual executive directors against agreed performance objectives. Chair should hold meetings with the non-executive directors without the executive directors present.	evaluation of each Executive Director presented to Remuneration Committee. ▪ Chair, and Interim Chair, holds regular meetings (weekly) with Non-Executive Directors, without Executive Directors present.		
B.2.13	Responsibilities of the chair, chief executive, senior independent director, board and committees should be clear, set out in writing and publicly available. Annual Report should give the number of times the board and its committees met, and individual director attendance.	▪ Job Description and Role Specifications set out the role of Chair, Chief Executive and Senior Independent Director. Role of Board, Board Committees set out in Constitution, Scheme of Reservation & Delegation (SoRD) and terms of reference. Publicly available via Trust Secretary. ▪ Annual Report, subject to external audit, prepared in line with Annual Reporting Manual.		Comply
B.2.14	When appointing a director, the BoD should take into account other demands on their time. Prior to appointment, the individual should disclose their significant commitments with an indication of the time involved. They should not take on material additional external appointments without prior approval of the BoD, with the reasons for permitting significant appointments explained in the annual report. Full-time executive directors should not take on more than one non-executive directorship of another trust or organisation of comparable size and complexity, and not the chairship of such an organisation.	▪ Job description for directors covers time commitment and availability in times of emergency. Considered as part of appointment process to ensure no significant commitments that would interfere with the demands of the role. ▪ Joint leadership appointments considered by Remuneration Committee and reported to the Board. ▪ No Executive Director holds NED or chair role in another trust.		Comply
B.2.15	All directors should have access to the advice of the company secretary. Appointment and removal of the company secretary should be a matter for the board.	▪ All directors have access to advice of company secretary. ▪ Constitution sets out the appointment/removal of Company Secretary is a matter for BoD.		Comply
B.2.16	All directors have a responsibility to constructively challenge during board discussions and help develop proposals on priorities, risk mitigation, values, standards and strategy. Non-executive directors should scrutinise the performance	▪ Effective challenge and request for further information, and input to strategic developments demonstrated at Board and Board Committees – evidenced within relevant minutes, action sheet and follow-up actions. ▪ Board Assurance Framework established and reviewed via Internal Audit as compliant with NHS requirements.		Comply

Provision	Code Provision	Current Position	Developmental Action	Comply or Explain
	of the executive management in meeting agreed goals and objectives, request further information if necessary. They should satisfy themselves as to the integrity of financial, clinical and other information, and make sure that financial and clinical quality controls, and systems of risk management and governance, are robust and implemented.	▪ Approved Risk Management Strategy. Chief Executive chairs Risk Management Committee reporting to Audit Committee. ▪ Annual Internal Audit Plan is risk based and constructed in full collaboration with Audit Committee to ensure that there is an effective internal audit function established by management that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee and Board.		
B.2.17	BoD should meet sufficiently regularly to discharge its duties effectively. A schedule of matters should be reserved specifically for its decisions. For foundation trusts, this schedule should include a clear statement detailing the roles and responsibilities of the council of governors. Statement should describe how any disagreements between the council of governors and the BoD will be resolved. The annual report should include this schedule of matters or a summary statement of how the BoD and the council of governors operate, including a summary of the types of decisions to be taken by the board, the council of governors, board committees and the types of decisions that are delegated to the executive management of the BoD.	▪ Board meets sufficiently regularly to fulfil responsibilities, in public bimonthly, within additional in month private meetings as required, and bimonthly board development. Attendance register held by Company Secretary. ▪ Approved Constitution, Standing Orders (SO)s and SoRD in place setting out: ▪ Decisions reserved for the Council of Governors (CoG) includes role and responsibilities of CoG ▪ Decisions reserved for the BoD includes role and responsibilities of Board. ▪ Mechanism in place to resolve disagreements between the Board and CoG as stated within Constitution. ▪ Senior Independent Director (SID) supports CoG and Board relationships as required. Annual Report describes how Board and CoG operate. ▪ Annual Report, subject to external audit, to be prepared in line with Annual Reporting Manual.		Comply

Section C: Composition, Succession and Evaluation

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
C.2.1	Nominations committee/s responsible for the identification and nomination of executive and non-executive directors and consider succession planning. Best practice is that a selection panel includes at least one external assessor from NHS England and/or a representative from relevant ICB and engage with NHS England to agree approach.	▪ Nominations Committee in place for NED appointments ▪ Remuneration Committee in place for Executive Director appointments ▪ Membership of selection panels, including external assessor, considered as part of each recruitment and selection process and agreed by respective nominations committee. NHS England and ICB to be engaged in approach.	Update Nominations and Remuneration Committee Terms of Reference regarding external assessors	Comply
C.2.2	There may be one or two nominations committees. If there are two, one will be responsible for considering nominations for executive directors and the other for non-executive directors (including the chair). Nominations committee(s) should regularly review the structure, size and composition of the BoD and recommend changes where appropriate. In the light of this evaluation, describe the role and capabilities required for appointment of both executive and non-executive directors, including the chair.	▪ Nominations Committee in place for NED appointments ▪ Remuneration Committee in place for Executive Director appointments ▪ Remuneration Committee reviews the structure, size and composition of the Board and, where appropriate, make recommendation/s to the Board. ▪ Review of Board composition, including Executive Director succession planning and NEDs skills audit conducted in 2023/24 determined forthcoming non-executive directors' expertise. Recommendation supported by CoG Nominations Committee. ▪ Job Description & Person Specifications prepared including specific expertise, background, skills and qualities (as agreed) for each vacancy, and the balance of skills/experience on the board.		Comply
C.2.3	Chair or an independent non-executive director should chair the nominations committee(s).	▪ Chair identified as chair for both nominations committees. ▪ When the Chair's nomination is being considered the Deputy Chair or relevant identified member chairs the committee.		Comply
C.2.4	Governors should agree with the nominations committee a clear process for the nomination of a new chair and non-executive directors. Once suitable candidates have been identified, the nominations committee should make recommendations to the Council of Governors.	▪ Nominations Committee agree process for recruitment of NEDs and Chair, including final recommendation to the CoG. In 2023/24 CoG supported the recommendation from Nominations Committee for re-appointment of four NEDs.		Comply
C.2.5	Open advertising and advice from NHS England's Non-Executive Talent and Appointments team is available for use by nominations committees to support the council of governors in the appointment of the chair and non-executive directors.	▪ Open advertising, including promotion via NHSE Talent & Appointment Team for recent NED appointments. No external consultancy used. ▪ If external consultancy engaged, information to be included in Annual Report as per Annual Reporting Manual.		Comply

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
	If an external consultancy is engaged, it should be identified in the Annual Report alongside a statement about any other connection it has with the Trust or individual directors.			
C.2.6	Where an NHS foundation trust has two nominations committees, the nominations committee responsible for the appointment of non-executive directors should have governors and/or independent members in the majority. If only one nominations committee exists, when nominations for non-executives, including the appointment of a chair or a deputy chair, are being discussed, governors and/or independent members should be in the majority on the committee and also on the interview panel.	▪ Trust has separate Nominations Committee for appointment of NEDs. Only governors and the Chair are members of the Nominations Committee, as set out in Terms of Reference.		Comply
C.2.7	When considering the appointment of non-executive directors, the Council of Governors should take into account the views of the BoD and the nominations committee on the qualifications, skills and experience required for each position.	▪ Nominations Committee received recommendation via Remuneration Committee and Board regarding recent future NED appointments. Information presented to the CoG prior to each appointment.		Comply
C.2.8	Annual Report should describe the process followed by the Council of Governors to appoint the chair and non-executive directors. Main role and responsibilities of the nominations committee should be set out in publicly available written terms of reference.	▪ Information to be included in Annual Report as per Annual Reporting Manual includes section about the Remuneration Committee / Nominations Committee and details of any Executive Director / NED appointment processes. ▪ Nominations Committee Terms of Reference publicly available via Trust Secretary.		Comply
C.2.9	Elected governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. The names of governors submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to make an informed decision on their election. This should include prior performance information.	▪ Elected governors' term of office set at no more than three years. Biography details and relevant performance information published during election.		Comply
C.2.10	The chair, the other non-executive directors and – except in the case of the appointment of a chief executive – the chief executive are responsible for deciding the appointment of executive directors. The nominations committee with responsibility for executive director nominations should identify suitable candidates to fill executive director vacancies as they arise and make recommendations to the chair, the other non-executives directors and, except in the case of the appointment of a	▪ Chair, NEDs and CEO approval of all Executive Director appointments (CEO does not approve a CEO appointment). Responsibilities set out in Remuneration Committee Terms of Reference.		Comply

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
	chief executive, the chief executive.			
C.2.11	Non-executive directors appoint and remove the chief executive. The appointment of a chief executive requires the approval of the council of governors.	▪ CoG approved substantive appointment of CEO, made by Chair and NEDs in October 2021.		Comply
C.2.12	Governors are responsible at a general meeting for the appointment, re-appointment and removal of the chair and other non-executive directors.	▪ CoG Nominations Committee oversees the processes leading to CoG fulfilling its responsibility to appoint, reappoint or remove chair and other Non-Executive Directors.		Comply
C.2.13	Non-executive directors, including the chair, should be appointed by the council of governors for the specified terms subject to re-appointment thereafter at intervals of no more than three years and subject to the 2006 Act provisions relating to removal of a director.	▪ Term of office for NEDs and Chair considered and agreed by Nominations Committee, in full consideration of NHS England guidance of terms of no more than three years and any term beyond six years requiring rigorous review. ▪ Chair confirms to governors, via Nominations Committee, that performance of any NED proposed for re-appointment continues to be effective or otherwise.		Comply
C.2.14	Terms and conditions of appointment of non-executive directors should be made available to the council of governors. The letter of appointment should set out the expected time commitment. Non-executive directors should undertake that they will have sufficient time to do what is expected of them. Their other significant commitments should be disclosed to the Council of Governors before appointment, with a broad indication of the time involved, and the Council of Governors should be informed of subsequent changes.	▪ NED terms and conditions outlined in recruitment pack and role description, considered by Nominations Committee, and available online during appointment process and via Trust Secretary's office at other times. ▪ Chair's job description covers time commitment and availability in times of emergency. Commitments reviewed by Nominations Committee during appointment process to ensure no significant commitments that would interfere with the demands of the role. ▪ Letter to NED on appointment – confirms expected time commitment Changes in commitments would be reported to CoG if they arise.		Comply
C.3.1	NHS England is responsible for appointing chairs and other non-executive directors of NHS trusts. A committee consisting of the chair and non-executive directors is responsible for appointing the chief officer of the trust. A committee consisting of the chair, non-executive directors and the chief officer is responsible for appointing the other executive directors. NHS England has a key advisory role in ensuring the integrity, rigour and fairness of executive appointments at NHS trusts. The selection panel for the posts should include at least one external assessor from NHS England.	*N/A (NHS Trust specific)*		
C.4.1	Directors on the BoD and, for foundation trusts, governors on the council of governors should meet the 'fit and proper' persons test described in the provider licence.	▪ Compliance regime in place for Fit and Proper Persons requirement – reviewed annually by Board. ▪ Directors sign Annual Fit and Proper Person Self-		Comply

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
	Trusts should also have a policy for ensuring compliance with the CQC's guidance Regulation 5: Fit and proper persons: directors.	Attestation. ▪ At election, governors self-declare eligibility in line with fit and proper person requirements for governors. ▪ Governors complete annual declaration of interests and self-assessment of compliance with fit and proper person for governor.		
C.4.2	BoD should include in the annual report a description of each director's skills, expertise and experience. Alongside this, the BoD should make a clear statement about its own balance, completeness and appropriateness to the requirements of the trust. Both statements should also be available on the trust's website.	▪ Annual Report detail's each director's area of expertise and statement about Board balance, completeness, and appropriateness to the Trust. Information to be included in Annual Report as per Annual Reporting Manual. ▪ Annual Report available on SFT website.		Comply
C.4.3	Chairs or NEDs should not remain in post beyond nine years from the date of their first appointment to the BoD and any decision to extend a term beyond six years should be subject to rigorous review. To facilitate effective succession planning and the development of a diverse board, this period of nine years can be extended for a limited time, particularly where on appointment a chair was an existing non-executive director. The need for all extensions should be clearly explained and should have been agreed with NHS England.	▪ Term of office for NEDs and Chair considered and agreed by Nominations Committee, in full consideration of NHS England guidance of terms of no more than three years and any term beyond six years requiring rigorous review.		Comply
C.4.4	Elected foundation trust governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. Best practice is that governors do not serve more than three consecutive terms to ensure that they retain the objectivity and independence required to fulfil their roles.	▪ Elected governors' term of office set at no more than three years. ▪ Trust Constitution prevents governor remaining in post for more than three consecutive terms.		Comply
C.4.5	There should be evaluation of the performance of the BoD, its committees, the chair and individual directors. For NHS foundation trusts, the council of governors should take the lead on agreeing a process for the evaluation of the chair and non-executive directors. The governors should bear in mind that it may be desirable to use the senior independent director to lead the evaluation of the chair. NHS England leads the evaluation of the chair and non-executive directors of NHS trusts.	▪ BoD utilises independent review to support evaluation of effective working. Board Committee and individual evaluations undertaken. Remuneration Committee reviews performance evaluation of each Executive Director. Nominations Committee reviews performance evaluation of each NED and Chair. ▪ SID leads evaluation of Chair.		Comply
C.4.6	The chair should act on the results of the evaluation by recognising the strengths and addressing any weaknesses of the BoD. Each director should engage with the process	▪ Board development sessions in place to support members to work together to achieve objectives. ▪ Individual director personal and professional development		Comply

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
	and take appropriate action where development needs are identified.	objectives in place.		
C.4.7	All trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the well-led framework every three to five years, according to their circumstances. The external reviewer should be identified in the annual report and a statement made about any connection it has with the trust or individual directors or governors.	▪ Independent Board Governance Review completed by Deloitte LLP during 2014/15. ▪ Series of external reviews: CQC well led review (October 2018), NHS England/Improvement Governance Review (November 2019), CQC well-led review (February 2020). ▪ Independently facilitated Well Led mapping review, conducted by AQuA (October – December 2021), providing an overview of the Trust's evidence against the 8 Key Lines of Enquiry (KLOEs) within the Well Led framework, and further developmental actions for the purpose of continuous improvement. ▪ Completion of self-assessment and agreed KLOE ratings by Board, March 2023. Full external facilitated review not undertaken during 2023/24 due to resource considerations. Internal audit plan utilised to undertake a Well led Position Statement (Substantial Assurance).		Explain
C.4.8	Led by the chair, foundation trust councils of governors should periodically assess their collective performance and regularly communicate to members and the public how they have discharged their responsibilities, including their impact and effectiveness on: • holding the non-executive directors individually and collectively to account for the performance of the BoD • communicating with their member constituencies and the public and transmitting their views to the BoD • contributing to the development of the foundation trust's forward plans	▪ Presentation to AMM about CoG performance including how they have performed statutory duties and responsibilities. ▪ Regular communications to members via Members Newsletter ▪ Governor observation of Board meetings. ▪ NED attendance and interaction at CoG meetings. ▪ Regular Chair & NED briefing sessions with governors ▪ CoG approved Chair & NED appraisal process. ▪ CoG established Nominations Committee for detailed review of Chair and NED appraisal, with final CoG review and approval. ▪ CoG appoint all NEDs (& Chair) and ensures this responsibility is highlighted during selection and appointment process.	Develop formal CoG performance evaluation to be implemented in 2024/25	Comply
C.4.9	Clear policy and a fair process for the removal of any governor that consistently and unjustifiably fails to attend CoG meetings, has a conflict of interest, or fails to discharge their responsibilities.	▪ Approved Code of Conduct for Governors in place that details values and outlines circumstances that would result in removal of governor - agreed and signed by all governors. ▪ Process for removal of governors included within Constitution.		Comply
C.4.10	It may be appropriate for the process to provide for removal	▪ As above, approved Code of Conduct for Governors in		Comply

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
	from the council of governors if a governor or group of governors behaves or acts in a way that may be incompatible with the values and behaviours of the NHS foundation trust. Where there is any disagreement as to whether the proposal for removal is justified, an independent assessor agreeable to both parties should be asked to consider the evidence and determine whether or not the proposed removal is reasonable. NHS England can only use its enforcement powers to require a trust to remove a governor in very limited circumstances.	place that details values and outlines circumstances that would result in removal of governor - agreed and signed by all governors. ▪ Process for removal of governors included within Constitution. Consideration of independent assessor would be made if situation arose.		
C.4.11	BoD should ensure it retains the necessary skills across its directors and works with the council of governors to ensure there is appropriate succession planning.	▪ Remuneration Committee reviews the structure, size and composition of the Board and, where appropriate, make recommendation/s to the BoD and CoG ▪ Review of Board composition, including Executive Director succession planning and NEDs skills audit conducted in 2023/24. Recommendations supported by BoD and CoG.		Comply
C.4.12	Remuneration Committee should not agree to an executive member of the Board leaving the employment of an NHS foundation trust, except in accordance with the terms of their contract, including but not limited to service of their full notice period and/or material reductions in their time commitment to their role, without risk assessment.	▪ Remuneration Committee provide full consideration to such matters as they arise.		Comply
C.4.13	Annual report should describe the work of the nominations committee(s), including board appointments process, approach to succession planning to support the development of a diverse board, policy on diversity and inclusion, ethnic diversity of the board and senior managers, with reference to indicator nine of the NHS Workforce Race Equality Standard (WRES) and the gender balance of senior management and their direct reports.	▪ Annual report currently describes the work of the Nominations Committee and Remuneration Committee. ▪ Information to be included in Annual Report as per Annual Reporting Manual, including specific WRES indicators and information on EDI Strategy in relation to diversity of Board.		Comply
C.5.1	All directors and, for foundation trusts, governors should receive appropriate induction on joining the BoD or the Council of Governors and should regularly update and refresh their skills and knowledge. Both directors and, for foundation trusts, governors should make every effort to participate in training that is offered.	▪ Induction programmes in place for directors and governors. ▪ Training and development plan in place to support governors in conducting roles and duties. ▪ Training and development for Executive and Non-Executive Directors agreed as part pf appraisal process.		Comply
C.5.2	Chair should ensure directors and governors update their skills, knowledge and familiarity with the trust to fulfil their roles.	▪ Training and development programme established for governors, including both internal and external opportunities. Information included in Annual Report. ▪ Members of Nominations Committee provided with		Comply

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
	Directors should be familiar with the integrated care system(s) that commission material levels of services from the trust. Trust should provide the resources for directors and governors to develop and update skills, knowledge and capabilities. Those involved in recruitment, should receive appropriate training, including on equality, diversity and inclusion, and unconscious bias.	recruitment specific training prior to NED recruitment process, including EDI and unconscious bias. ▪ All Directors required to complete mandatory training. ▪ Directors have access to individual and collective training/development as identified. ▪ Development needs for all directors are agreed via Chair (for NEDs) and CEO (for Exec Directors) and reviewed annually. Chair aware of all development needs for individual directors via Remuneration Committee. ▪ All directors familiar with GM ICS.		
C.5.3	All directors need appropriate knowledge of the Trust and appropriate access to its operations and staff. Directors and governors to be appropriately briefed on values and all policies and procedures adopted by the Trust.	▪ All directors have appropriate knowledge of the Trust and appropriate access to operations and staff. Additional knowledge requirements formally identified as part of appraisal and informally on continuing basis. ▪ Directors and Governors Code of Conduct ensures knowledge of values and procedures. ▪ Relevant policies and procedures considered by Board, Board Committees and/or CoG during year.		Comply
C.5.4	Chair should ensure that new directors and, for foundation trusts, governors receive a induction on joining the board or the council of governors. As part of this, directors should seek opportunities to engage with stakeholders, including patients, clinicians and other staff, and system partners. Directors should also have access at the trust's expense to training courses and/or materials that are consistent with their individual and collective development programme.	▪ Induction programmes in place for directors and governors, including externally facilitated induction. ▪ Directors aware of duty to cooperate and scope of cooperation with third party bodies. ▪ Number of stakeholder engagement processes and practices in place that involve patients, public and staff engagement. Directors engage with system partners via number of GM and locality forums/meetings. ▪ Directors have access to individual and collective training/development as identified		Comply
C.5.5	Chair should regularly review and agree with each director their training and development needs as they relate to their role on the board.	▪ Development needs for all directors are agreed via Chair (for NEDs) and CEO (for Exec Directors) and reviewed annually. Chair aware of all development needs for individual directors via Remuneration Committee		Comply
C.5.6	A foundation trust board has a duty to take steps to ensure that governors are equipped with the skills and knowledge they need to discharge their duties appropriately.	▪ Training and development programme established for governors, including both internal and external opportunities. Information included in Annual Report.		Comply
C.5.7	Board and CoG to receive appropriate information to discharge its respective duties. Governors should be provided with information on ICS plans, decisions and delivery that directly affect the	▪ Relevant information made available to Board and CoG regarding finance, quality of care, operational performance and people performance, alongside key strategic developments. ▪ CoG have received presentation and training on ICS. CoG		Comply

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
	organisation and its patients.	informed of GM ICS planning process and assumptions and progress against Stockport Locality priorities.		
C.5.8	Chair is responsible for ensuring that directors and governors receive accurate, timely and clear information. Management has an obligation to provide such information but directors and, for foundation trusts, governors should seek clarification or detail where necessary.	▪ Suite of reports, including background information provided to Board and CoG. Provenance of data internal audit (High Assurance) and data Quality Audit reported via Audit Committee. ▪ Standardised front sheet, with executive summary and recommendation section for Board and CoG papers to ensure clarity and appropriate review of paper. ▪ Board has access to all sources of information as requested.		Comply
C.5.9	Chair's responsibilities include ensuring good information flows across the board and, for foundation trusts, across the council of governors; between directors and governors; and for all trusts, between senior management and non-executive directors; as well as facilitating appropriate induction and assisting with professional development as required.	▪ Suite of reports, including background information provided to Board and CoG. ▪ Non-Executive Director provide Highlight Report to Council of Governors providing high level overview of delivery against key performance metrics throughout the year. ▪ Induction & Training see C.5.4 and C.5.5		Comply
C.5.10	BoD and, for foundation trusts, the council of governors should be provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make. BoD and, for foundation trusts, the council of governors should agree their respective information needs with the executive directors through the Chair. The information for boards should be concise, objective, accurate and timely, and complex issues should be clearly explained. BoD should have complete access to any information about the Trust that it deems necessary to discharge its duties, as well as access to senior management and other employees.	▪ Suite of reports, including background information, provided to BoD and CoG on specific matters relevant to their functions. ▪ Relevant information made available to BoD and CoG regarding finance, quality of care, operational performance and people performance, alongside key strategic developments. Additional information requested by BoD and CoG on specific matters. ▪ NEDs provide regular summary report to CoG regarding matters considered via Board Committees. Chief Executive, Executive Directors and NEDs routinely attend CoG meetings.		Comply
C.5.11	In challenging assurances received from Executive, BoD need not seek to appoint an adviser for every issue but should ensure sufficient information and understanding to make informed decision. When complex or high risk issues arise, first course of action should be to encourage deeper analysis in timely	▪ Effective challenge and request for further information and analysis demonstrated at Board and Board Committees – evidenced within relevant minutes, action sheet and follow-up actions. ▪ Independent advice, information and training made available as necessary/requested.		Comply

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
	manner within the FT. On occasion, Non-Executive Directors may reasonably decide that external assurance is appropriate.			
C.5.12	Board to ensure Non-Executive Directors have access to independent professional advice and training courses/material where judged necessary. Decisions to appoint an external adviser should be collective decision of the majority of Non-Executive Directors Availability of independent external sources of advice should be made clear at appointment.	▪ Independent advice made available as necessary/requested.		Comply
C.5.13	Committees should be provided with sufficient resources to undertake their duties. The BoD of foundation trusts should also ensure that the council of governors is provided with sufficient resources to undertake its duties with such arrangements agreed in advance.	▪ Committees and CoG provided with sufficient resources, supported by Corporate Affairs team.		Comply
C.5.14	Non-Executive Directors should consider whether they are receiving necessary information in a timely manner and feel able to raise appropriate challenge of recommendations of the Board. They should expect and apply similar standards of care and quality in their role as a non-executive director of a Trust as they would in other similar roles.	▪ Papers, in general, disseminated in line with agreed Terms of Reference. ▪ Standardised front sheet for Board papers to ensure clarity regarding recommendation. ▪ Board has full access to all sources of information as requested. ▪ NED's able to raise any concerns about the information they receive and their ability to raise appropriate challenge via Chair, Executive Lead and or Trust Secretary. ▪ NED challenge is routinely recorded in minutes of Board / Committee meetings. ▪ Committee Effectiveness Internal Audit – Substantial Assurance. Provenance of Data Internal Audit – High Assurance.		Comply
C.5.15	Governors should canvass the opinion of their members, and for appointed governors the bodies they represent, on the FTs forward plans. Annual Report to state how this requirement has been undertaken.	▪ Governors aware of responsibility to canvas opinion of members/bodies they represent. ▪ Views of Council of Governors sought in development of the Trust's Strategy 2020-2025. ▪ Membership Strategy & Action Plan approved by CoG in July 2022, to support in fulfilling this duty. Governors share feedback received from members/bodies at CoG meetings and informal meetings with Chair & NEDs on key strategic developments and plans.		Comply

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
		▪ Member's newsletter highlights key developments for the Trust giving information on how members can contact their governor representatives		
C.5.16	Where appropriate, the BoD should in a timely manner take account of the views of the Council of Governors on the forward plan, and then inform the council of governors which of their views have been incorporated in the NHS foundation trust's plans and explain the reasons for any not being included.	▪ Views of Council of Governors sought in development of the Trust's Strategy 2020-2025. ▪ Governors remained appraised of key strategic developments in relation to the forward plans of the Trust via the Chair's Report and identified topic presentations, including GM & locality plans, at each meeting of the CoG and were able to provide view. ▪ Annual discussion regarding Trust Planning at CoG regarding forthcoming year plans and priorities.		Comply
C.5.17	NHS Resolution's Liabilities to Third Parties Scheme includes liability cover for trusts' directors and officers. There is no legal requirement for trusts to provide an indemnity or insurance for governors, where an indemnity or insurance policy is given, this can be detailed in the Trust's constitution.	▪ No further indemnity/insurance policy for governors.		Comply

Section D: Audit, Risk & Internal Control

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
D.2.1	Board must establish an audit committee composed of at least three independent NEDs. Chair of the trust should not chair or be a member of the audit committee but can attend by invitation as appropriate. The vice chair or senior independent director should not chair the audit committee. Board should satisfy itself that at least one member of audit committee has recent/relevant financial experience and committee should have competence relevant to the sector.	▪ Audit Committee established, includes 4 independent NEDs ▪ Board has appointed Chair of Audit Committee with relevant financial experience, this is not the Deputy Chair or SID. ▪ Trust Chair attends Audit Committee by invitation only.		Comply
D.2.2	The main roles and responsibilities of the audit committee should include: - monitoring the integrity of the financial statements of the trust and any formal announcements relating to the trust's financial performance, and reviewing significant financial reporting judgements contained in them - providing advice (where requested by the BoD) on whether the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's position and performance, business model and strategy - reviewing the trust's internal financial controls and internal control and risk management systems, unless expressly addressed by a separate board risk committee composed of independent non-executive directors or by the board itself - monitoring and reviewing the effectiveness of the trust's internal audit function or, where there is not one, considering annually whether there is a need for one and making a recommendation to the BoD - reviewing and monitoring the external auditor's independence and objectivity - reviewing the effectiveness of the external audit process, taking into consideration relevant UK professional and regulatory requirements - reporting to the BoD on how it has discharged its responsibilities.	▪ Terms of reference established for Audit Committee including all relevant roles and responsibilities, approved by Board. Publicly available via papers and Trust Secretary. ▪ Chair of Audit Committee provides regular update about matters reviewed at Audit Committee to the BoD and CoG.		Comply

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
D.2.3	Trust should change its external audit firm at least every 20 years. Legislation requires an NHS trust to newly appoint its external auditor at least every five years. An NHS foundation trust should re-tender its external audit at least every 10 years and in most cases more frequently than this.	▪ Comprehensive market-testing and procurement exercise undertaken in 2019 to select External Auditor. CoG appointed Mazars as External Auditor in October 2019 for a period of three years with an option for this to be extended by a further 2 years subject to mutual agreement. ▪ Process for appointment of external auditor underway. CoG considered the options for the procurement of external audit services and supported the preferred option of a direct award. Process currently underway.		Comply
D.2.4	The annual report should include: - the significant issues relating to the financial statements that the audit committee considered, and how these issues were addressed. - an explanation of how the audit committee (and/or auditor panel for an NHS trust) has assessed the independence and effectiveness of the external audit process and its approach to the appointment or reappointment of the external auditor; length of tenure of the current audit firm, when a tender was last conducted and advance notice of any retendering plans - an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services.	▪ Section within the Annual Report comprehensively reports on how Audit Committee has discharged its responsibilities. Information in Annual Report in line with Annual Reporting Manual and subject to external audit.		Comply
D.2.5	An NHS foundation trust's audit committee should develop and implement a policy on the engagement of the external auditor to supply non-audit services. The Council of Governors is responsible for appointing external governors.	▪ 'Policy for the Approval of Non-Audit and Additional Services by the Trust's External Auditors' approved by Audit Committee, February 2023 ▪ In October 2019 CoG awarded external audit contract to Mazars LLP for three years to cover financial years 2019/20, 2020/21 and 2021/22. Further to report and recommendation from Audit Committee, in February 2022, CoG approved extension of the External Audit Contract with Mazars LLP for a further term of two years to the 31st March 2024.		Comply
D.2.6	Directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's performance, business model and strategy.	▪ Directors Statements, Auditors Statements and Annual Governance Statement included in Annual Report incorporating all required statements, in line with Annual Reporting Manual, subject to external audit.		

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
D.2.7	BoD should carry out a robust assessment of the trust's emerging and principal risks. The relevant reporting manuals will prescribe associated disclosure requirements for the annual report.	▪ Board Assurance Framework established and reviewed via Internal Audit as compliant with NHS requirements. ▪ Annual Governance Statement prepared in line with Annual Reporting Manual.		Comply
D.2.8	BoD should monitor the trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the annual report. The board should report on internal control through the annual governance statement in the annual report.	▪ Board Assurance Framework established and reviewed via Internal Audit as compliant with NHS requirements. ▪ Approved Risk Management Strategy. Chief Executive chairs Risk Management Committee reporting to Audit Committee. ▪ Annual Internal Audit Plan is risk based and constructed in full collaboration with Audit Committee to ensure that there is an effective internal audit function established by management that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee and Board. ▪ Annual Governance Statement (AGS) compiled by the CEO, reviewed by Auditors, Audit Committee and approved/signed by CEO		Comply
D.2.9	In the annual accounts, the BoD should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material uncertainties regarding going concern.	▪ Annual review of Going Concern at Audit Committee and relevant inclusion within Annual Report.		Comply

Section E: Remuneration

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
E.2.1	In designing schemes of performance-related remuneration of executive directors, the remuneration committee should: - consider whether the directors should be eligible for annual bonuses. If so, performance conditions should be relevant, stretching and designed to match long-term interests of the public and patients. - Payouts should be subject to challenging performance criteria reflecting objectives and relative to a group of comparator trusts. - Performance criteria and any upper limits for annual bonuses and incentive schemes should be set and disclosed and must be limited to the lower of £17,500 or 10% of basic salary. - consider the pension consequences and associated costs to the trust of basic salary increases and any other changes in pensionable remuneration, especially for directors close to retirement.	▪ Not currently applicable. ▪ The Terms of Reference for the Remuneration Committee cover the requirements of this provision with responsibility for design of performance-related remuneration.		Comply
E.2.2	Levels of remuneration for the chair and other non-executive directors should reflect the Chair and non-executive director remuneration structure.	▪ CoG agreed all new NED positions to be remunerated in line with NHS England Chair and non-executive director remuneration structure. Existing non-executive directors, who are reappointed for a further term of office, remain at the level of remuneration to which they were originally appointed, subject to a robust performance appraisal and confirmation that performance continues to be effective.		Explain
E.2.3	Where a trust releases an executive director, e.g. to serve as a non-executive director elsewhere, the remuneration disclosures in the annual report should include a statement as to whether or not the director will retain such earnings.	▪ Remuneration disclosure of Annual Report will include information if required. Not applicable during 2023/24.		Comply
E.2.4	Remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointments would give rise, to in the event of early termination – the aim to avoid rewarding poor performance.	▪ Provision covered within Remuneration Committee Terms of Reference. Not applicable 2023/24.		Comply
E.2.5	Trusts should discuss any director-level severance payment, whether contractual or non-contractual, with their NHS England Regional Director at the earliest opportunity	▪ To be discussed with NHS England should situation arise. Not applicable 2023/24.		Comply
E.2.6	BoD should establish a remuneration committee of independent non-executive directors, with a minimum membership of three.	▪ Remuneration Committee established including all NEDs. Annual review of NED independence confirmed. Director of People & OD attends Remuneration Committee in an		Comply

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
	Remuneration Committee should make its terms of reference available, explaining its role and the authority delegated to it by the BoD. The board member with responsibility for HR should sit as an advisor on the remuneration committee. Where remuneration consultants are appointed, a statement should be made available as to whether they have any other connection with the Trust.	advisory capacity. ▪ Remuneration Committee Terms of Reference available for review via Trust Secretary ▪ Statement re remuneration consultants would be included in relevant Annual Report where applicable – Not applicable during 2023/24.		
E.2.7	Remuneration Committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments. Remuneration Committee should recommend and monitor the level and structure of remuneration for senior management.	▪ Remuneration Committee Terms of Reference set out all aspects of this provision. ▪ Remuneration of Executive Directors and VSN considered annually.		Comply
E.2.8	Council of Governors is responsible for setting the remuneration of a foundation trust's non-executive directors and the chair.	▪ Level of remuneration for Chair and NEDs reviewed by CoG Nominations Committee annually, in consideration of NHSE remuneration structure for NHS provider chairs and non-executive directors.		Comply

NHS Stockport NHS Foundation Trust

Meeting date	4th April 2024	**Public**	X	**Agenda No.**	17
Meeting	Board of Directors				
Report Title	Use of Common Seal 2023/24				
Director Lead	Karen James, Chief Executive	**Author**	Rebecca McCarthy, Trust Secretary		

Paper For:	**Information**	X	**Assurance**		**Decision**	
Recommendation:	The Board of Directors is asked to note and confirm the use of the Common Seal during 2023/24.					

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
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		Effective
	Caring		Responsive
	Well-Led	x	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
	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	Entire report
Sustainability (including environmental impacts)	

Executive Summary

The purpose of this report is to report the use of the Common Seal to the Board of Directors during 2023/24.

1. INTRODUCTION

1.1 The purpose of this report is to report the use of the Common Seal to the Board of Directors during 2023/24.

2. USE OF COMMON SEAL

2.1 Authority to apply the Seal to relevant documents is detailed at Section 38 of the Trust's Scheme of Reservation and Delegation. Section 38 identifies that authority to apply the Seal is delegated to the Chair / Chief Executive or two Executive Directors/Trust Secretary. It is recognised good practice to report the occasions of use of the Seal to the Board of Directors on an annual basis.

2.2 During the period 1 April 2023 – 31 March 2024, the Trust's Common Seal was applied on one occasion. This was:

Reg No	Date	Reason
143	7 March 2024	Hempsons – Lease of additional property by reference to an existing lease – Mental Health Unit, Stepping Hill Hospital

2.3 A Register of Use of the Common Seal is maintained by the Trust Secretary and includes both authorisation signatures and details of the final distribution of the relevant documentation. The Trust Secretary is responsible for the safe custody of the Common Seal. The Board of Directors can be assured that compliance with the requirements of Section 38 of the Scheme of Reservation & Delegation is being maintained.

3. LEGAL IMPLICATIONS

3.1 There are no direct legal implications associated with the content of this report.

4. RECOMMENDATIONS

4.1 The Board of Directors is recommended to:

- Note the occasions of use of the Common Seal as detailed at s2.2 of the report.

NHS Stockport NHS Foundation Trust

Meeting date	4 April 2024	**Public**	X	**Agenda No.**	18.
Meeting	Board of Directors				
Report Title	Board Committees Annual Reviews 2023/24				
Director Lead	Caroline Parnell, Director of Communications & Corporate Affairs	**Author**	Rebecca McCarthy, Trust Secretary		

Paper For:	**Information**		**Assurance**		**Decision**	x
Recommendation:	The Board of Directors is asked to receive and approve the Board Committee Annual Reviews 2023/24, including approval of Terms of Reference and Work Plans for the following: - Finance & Performance Committee - People Performance Committee - Quality Committee					

This paper relates to the following Annual Corporate 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
x	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	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 sections
Sustainability (including environmental impacts)	N/A

Executive Summary

Effective sub-committees can provide significant benefits to the Board, enabling the Board to make informed decisions and meet their wide-ranging governance and regulatory responsibilities. Likewise, sub-committees should play a key role in supporting directors in their strategic and oversight roles.

The Terms of Reference of the Board sub-committees include a requirement for the respective committee to evaluate their own membership and review their effectiveness and performance on an annual basis. The outcome of the review is to be considered by the Board of Directors, alongside review and approval of the Terms of Reference and Work Plans of the Committees.

During committee meetings in March 2024, the Finance & Performance Committee, People Performance Committee and Quality Committee considered their Committee Annual Review, including draft Terms of Reference and Work Plans for 2024/25 (Appendix 1-3).

As part of the reviews, each committee considered key matters evaluated during the year, including the sources of assurance contained within each report and meeting attendance. Furthermore, each committee considered what had worked well and what could be improved.

General themes recognised the positive challenge at committee meetings, with constructive interaction between attendees, and improved quality of papers. Regarding opportunities for improvement, a continued and greater focus on assurance was recognised, with reports to draw out key matters for attention or decision, highlighting where assurance can or cannot be provided, to avoid prolonged discussion. There was also an appetite for further developing triangulation between committees. Self-assessment against the well-led framework (aligned to the new CQC single assessment framework quality statements under the well-led key question) during 2024/25, could provide a framework for considering evidence of the well-led domain and the way that is reported to the committees and/or Board.

In considering the above, the committees confirmed the effective operation of the committee throughout 2023/24, with opportunities for ongoing improvement to be taken forward during 2024/25, as reflected in committee work plans and reporting.

The Annual Review of the Remuneration Committee and Audit Committee will be presented to the Board in June 2024 and August 2024 respectively, following year-end meetings of these Committees.

NHS Stockport NHS Foundation Trust

Finance & Performance Committee Annual Review 2023/24

1. Introduction

1.1 The Finance & Performance Committee considered and confirmed the outcome of the Committee Annual Review, including the revised Terms of Reference and Work Plan 2024/25 at its meeting in March 2024. The review is recommended to the Board of Directors for approval.

2. Background

2.1 Section 8 of the current Finance & Performance Committee Terms of Reference states that *"The Committee will review its membership, effectiveness and performance of the Committee on an annual basis".*

2.2 Furthermore, the Terms of Reference require that the Terms of Reference of the Finance & Performance Committee shall be reviewed by the Board of Directors annually.

2.3 The current review relates to effectiveness of the Committee during 2023/24.

3. Compliance with Terms of Reference

3.1 The Finance & Performance Committee has an annual work plan, which sets out the matters to be considered by the Committee to fulfil its broad responsibilities as set out in the terms of reference:

- Oversight and assurance on all aspects of the Trust's financial and operational performance against the agreed annual plan
- Oversight and assurance on delivery of the Trust's digital, estates and sustainability related strategies and plans
- Supporting the Board in the development of future business plans

Appendix 1 details key matters and standard reports, including business cases and contracts, considered by the Finance & Performance Committee during 2023/24. In addition, the Committee also considered:

- Charging for Out of Area Discharge Delays
- Contract Income 2023/24
- Referral to Treatment – Board Self-Declaration
- Performance Trajectories
- Quarter 4 PDC Revenue Support Submission to NHS England
- Elective Recovery Plan – National Tiering Status Q4 2023/24
- Cost of Sickness
- Treasury Management Policy (for approval)

3.2 The Finance & Performance Committee will receive the Work Plans and Terms of Reference for its established subgroups in April 2024.

3.3 Attendance at 2023/24 Finance & Performance Committee meetings is provided in Appendix 2. The Committee has met on ten occasions during 2023/24 and all meetings were quorate.

4. Review of Committee Effectiveness 2023/24

4.1 Effective sub-committees can provide significant benefits to the Board, enabling the Board to make informed decisions and meet their wide-ranging governance and regulatory responsibilities. Likewise, sub-committees should play a key role in supporting directors in their strategic and oversight roles.

4.2 An informal review of Committee effectiveness is led by the Chair of the Committee as part of the meeting arrangements. This enables members to provide real-time feedback regarding what has worked well and areas for improvement.

4.3. Furthermore, Finance & Performance Committee members were asked to provide feedback regarding Committee effectiveness during the year considering:

- What has worked well?
- What could be improved?
- Any other comments

4.4 Summary of feedback:

What has worked well?

- Robustness of information provided.
- Focus on key financial issues.
- Clear outcomes and actions from discussions.
- Good constructive discussion.

What could be improved?

- Ensure focus on assurance and action rather than prolonged discussions.
- Improved executive summaries, limiting the amount of time for verbal overview and highlighting where assurance can be provided or where unable to give assurance.
- Greater time spent on key performance issues.

Any other comments

- Sometimes seem rushed for time. The Committee has a huge agenda.

4.5 Consideration of the above, and compliance with the Terms of Reference, confirms the effective operation of the Committee throughout 2023/24, with opportunities for ongoing improvement to be taken forward, particularly with regard to improving the effectiveness of executive summaries to support focus on assurance.

5. Committee Work Plan 2024/25

5.1 The Work Plan 2024/25 (Appendix 3) has been developed in line with feedback received, and consideration by the Committee Chair, lead Executive Directors and Directors, and the Company Secretary.

5.2 Reports detailed within the Work Plan should be action-driven and practical, containing enough data and information to enable the Committee to reach an evidence-based and auditable conclusion.

5.3 The key sources of assurance, both qualitative and quantitative, that will provide evidence to the Committee regarding the effectiveness of systems and controls in place, and the actions being taken to address adverse trends are set out in Appendix 4

5.4 **Board to Ward – Governance Alignment**

5.4.1 The Operational Divisions Performance Review Framework (PRF) supports the Trust to assure delivery of the annual corporate objectives, providing a connection from Board to Ward. The PRF is based on 6 domains:

- Operational Excellence
- Quality of Care
- People & Leadership
- Finance
- Service Transformation & Innovation
- Strategy

Each domain is measured by oversight metrics based on regulatory frameworks, national targets and the outcome measures identified for the annual business plan – and is mirrored within the key sources of assurances considered via respective Board Committees.

6. Terms of Reference

6.1 A review of the Committee Terms of Reference has been conducted. The revised Terms of Reference are included at Appendix 5 of the report for approval.

6.2 Key changes to the terms of reference relate to:

- Revision to core membership and regular attendees
- Inclusion of Estates Strategy Steering Group as a subgroup reporting to the Committee

FINANCE & PEFORMANCE COMMITTEE 2023/24

Topic	20 Apr 2023	18 May 2023	15 Jun 2023	20 Jul 2023	21 Sep 2023	19 Oct 2023	16 Nov 2023	18 Jan 2024	15 Feb 2024	21 Mar 2024
Operational Performance Report	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Performance Framework			✓							
GM Productivity Overview								✓		
Finance Report	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
GM Finance & Performance Recovery					✓	✓	✓	✓	✓	
Opening Budgets	✓	✓								
Annual Stockport Trust Efficiency Programme	✓									✓
Costing Submission				✓				✓		
Trust Planning (inc. Capital Programme Update in Feb & Mar 2024)	✓	✓							✓	✓
Winter Planning					✓					
Annual Review of Treasury Management Procedures							✓			
Post-Implementation Appraisal of Business Cases	✓									
Annual Procurement Programme and Progress Report		✓						✓		
Procurement Update – inc. Contracts for Recommendation to Board		✓	✓	✓		✓		✓	✓	
Business Cases:										
○ Revised Business Case for Wireless Network		✓								
○ Community Diagnostic Centre Business Case			✓							
○ RAAC Business Case					✓					
○ Virtual Desktop Infrastructure										✓
○ Wireless/Cabinets Programme Updated Business Case										✓
○ Digital Technology Programme Implementation Resources										✓
Digital Strategy Progress Report		✓					✓			
Pharmacy Shop Board Report			✓							
Estates & Facilities Assurance Report			✓					✓		
Stepping Hill Site Development Strategy Delivery Plan – Progress Report								✓		
Green Plan Progress Report					✓					
Board Assurance Framework and Aligned Significant Risks				✓	✓			✓		✓
Finance & Performance Committee Annual Review (inc. Terms of Reference and Work Plan 2024/25)										✓

Topic	20 Apr 2023	18 May 2023	15 Jun 2023	20 Jul 2023	21 Sep 2023	19 Oct 2023	16 Nov 2023	18 Jan 2024	15 Feb 2024	21 Mar 2024
Subgroup Annual Reports: ○ **Capital Programme Management Group** ○ **Digital & Informatics Group**	 ✓ ✓									
Key Issues Reports:										
○ **Capital Programme Management Group (inc. approval of ToR and Work Plan in April)**	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
○ **Digital & Informatics Group (inc. approval of ToR and Work Plan in April)**	✓		✓		✓		✓	✓		✓
○ **Estates Strategy Steering Group (inc. ToR for approval in July 2023; Work Plan for approval in Jan 2024)**				✓		✓		✓		✓
Informal Review of Meeting Effectiveness	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Finance & Performance Committee Work Plan 2023/24 and Attendance	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Appendix 2: Finance & Performance Committee 2023/24 Attendance Register

Member	Name	Apr-23	May-23	Jun-23	Jul-23	Sep-23	Oct-23	Nov-23	Jan-24	Feb-24	Mar-24
Core MembersY											
Chair of F&P Committee/Non-Executive Director	Tony Bell	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Non-Executive Director	David Hopewell	Y	Y	Y	Y	Y	Y	Y	Y	A	Y
Non-Executive Director	Samira Anane	Y	A	Y	Y	A	Y	Y	Y	Y	Y
Chief Finance Officer	John Graham	Y	Y	Y	A	Y	Y	Y	Y	Y	Y
Director of Operations	Jackie McShane	Y	Y	Y	Y	Y	A	Y	Y	A	Y
Director of Strategy & Partnerships	Jonathan O'Brien	A	Y	Y	Y	Y					
Regular Attendees											
Director of Finance	Kay Wiss	Y	Y	A	Y	Y	Y	Y	Y	Y	Y
Chief Information Officer	Helen Bennett	Y	Y	Y	N/A	Y	N/A	Y			
Head of Clinical Systems	Rebecca Mayers								Y	N/A	Y
Trust Secretary	Rebecca McCarthy	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Chief Nurse	Nic Firth	Y	Y	Y	Y	Y	A	Y	Y	Y	Y
Associate Non-Executive Director	Meb Vadiya					Y	Y	A			
Deputy Director of Strategy & Partnerships	Andy Bailey	A(D)								Y	Y
Was Meeting Quorate (Y/N)		**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**
Key											
Y	= Present										
A	= Apologies										
A(D)	= Attended as Deputy										

			2024									2025		
	Items		**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
		Papers Due	9.4.	7.5.	11.6.	9.7.		10.9.	8.10.	12.11.		7.1.	11.2.	11.3.
		Committee Date	18.4.	16.5.	20.6.	18.7.		19.9.	17.10	21.11.		16.1.	20.2.	20.3.
		Lead	**Q1**			**Q2**			**Q3**			**Q4**		
Finance														
1.	**Finance Report**	Chief Finance Officer	•	•	•	•		•	•	•		•	•	•
2.	**Opening Budgets**	Chief Finance Officer	•											
3.	**Annual Stockport Trust Efficiency Programme (STEP/CIP)** *(Opening position and mid-year deep dive)*	Director of Operations	•						•					
4.	**Medium/Long Term Financial Recovery Plan**	Chief Finance Officer						•					•	
5.	**Costing Transformation Programme (Reference Costs)**	Director of Finance								•				
6.	**Annual Review of Treasury Management Procedures**	Director of Finance							•					
7.	**Annual Procurement Programme & Progress Report**	Head of Procurement		•						•				
8.	**Business Cases / Contracts for recommendation to Board *(As required):*** - Business cases with an investment value in excess of £750,000 (capital and/or revenue)	Business Case Operational Lead / Procurement	•	•	•	•		•	•	•		•	•	•
9.	**Post-implementation appraisal of Business Cases (approved by Finance & Performance Committee)** *NB. Appraisal of business cases to take place 6 months following full implementation. Timing of report may differ to facilitate this.*	Director of Strategy & Partnerships			•							•		
Commercial Activity														
10.	**Pharmacy Shop Board**	Chief Pharmacist			•									
Operational Performance														
11.	**Operational Performance Report**	Director of Operations	•	•	•	•		•	•	•		•	•	•
12.	**Performance Framework**	Director of Operations		•										
13.	**GM Productivity Overview**	Director of Operations	•			•			•			•		

			2024									2025		
	Items		**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
		Papers Due	9.4.	7.5.	11.6.	9.7.		10.9.	8.10.	12.11.		7.1.	11.2.	11.3.
		Committee Date	18.4.	16.5.	20.6.	18.7.		19.9.	17.10	21.11.		16.1.	20.2.	20.3.
		Lead	**Q1**			**Q2**			**Q3**			**Q4**		
Strategy & Planning														
14.	**Trust Planning**	Director of Strategy & Partnerships	•	•									•	•
15.	**Capital Programme**	Chief Finance Officer											•	•
Estates & Sustainability														
16.	**Stepping Hill Site Development Strategy – Progress Report**	Director of Estates & Facilities				•						•		
17.	**Estates & Facilities Assurance Report**	Director of Estates & Facilities						•						•
18.	**Green Plan Progress Report**	Director of Estates & Facilities						•						•
19.	**Digital Strategy Progress Report**	Director of Informatics		•						•				
Risks														
20.	**BAF & Aligned Significant Risks**	Company Secretary				•		•				•		•
Subgroups														
21.	**Capital Programmes Management Group Key Issues Report**	Chief Finance Officer	•	•	•	•		•	•	•		•	•	•
22.	**Digital & Informatics Group Key Issues Report**	Director of Informatics	•		•			•	•			•	•	
23.	**Estates Strategy Steering Group Key Issues Report**	Director of Estates & Facilities	•		•			•	•			•	•	
Committee Business														
24.	Review and approve of **Terms of Reference**	Chair												•
25.	Review and approve of **Annual Work Plan**	Chair												•
26.	Review and approve **Finance & Performance Committee Subgroup Terms of Reference & Annual Work Plan**	Chairs of Subgroups	•											

			2024									2025		
	Items		**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
		Papers Due	9.4.	7.5.	11.6.	9.7.		10.9.	8.10.	12.11.		7.1.	11.2.	11.3.
		Committee Date	18.4.	16.5.	20.6.	18.7.		19.9.	17.10	21.11.		16.1.	20.2.	20.3.
		Lead	**Q1**			**Q2**			**Q3**			**Q4**		
27.	Informal Review of Committee Effectiveness	Led by Chair	•	•	•	•		•	•	•		•	•	•
28.	Formal Committee Evaluation	Chair												•

Schedule as required:

- Major investigations or reviews (internal of external to the Trust) relevant to finance & performance.
- Development of relevant strategic matters, prior to recommendation to Board

Appendix 4: Finance & Performance Committee Sources of Assurance

Item	Frequency	Sources of Assurance
Finance Report	Monthly	**Quantitative** - Overall Financial Position - Divisional Financial Position - Key Drivers of the Financial Position - STEP/CIP Position (Divisional/Corporate, Recurrent/Non-Recurrent) - Cash - Capital - Forecast and Risks to Delivery - System Financial Update
Operational Performance Report		**Quantitative *(In line with operational guidance)*** - Performance Summary & Benchmarking - Operational Planning Key Assumptions - Operational Scorecard - Emergency Department - Patient Flow - Cancer - Referral to Treatment (RTT) - Diagnostics - Outpatient Efficiencies - Theatres
Subgroups Key Issues Reports		
○ Capital Programmes Management Group		**Qualitative** - Development & Delivery of Annual Capital Programme - Progress of key capital projects and schemes - Capital business case review
○ Digital & Informatics Group		**Qualitative** - Delivery of Digital Strategy Key Programmes - Delivery of digital and informatics functions statutory requirements (Data Quality Assurance, Information Governance & Security) - Assessment of, and delivery of digital capital/revenue investments is in line with Digital Strategy
○ Estates Strategy Group		**Qualitative** - Estates Strategy Review - Joint Working with SMBC - Community Estate - Link to Digital Strategy

Item	Frequency	Sources of Assurance
GM Productivity Overview	Quarterly	**Quantitative** - Executive Summary - NW Overview (CIP/Workforce) - Provider Overview - Next Steps
Trust Planning	2-3 times a year	**Qualitative/Quantitative** - Trust Planning Process & Requirements - Trust Planning Submission - Finance (including Capital), Activity, Workforce Deliverables (Draft & Final)
Annual Procurement Programme & Progress Report	Biannual (6 monthly)	**Qualitative** - Procurement Programme Delivery - Procurement in progress over £750k
Annual Stockport Trust Efficiency Programme *(NB Progress reported monthly via Finance Report)*		**Quantitative** - Allocated Divisional/Corporate Targets - Mid-Year Deep Dive Delivery of STEP **Qualitative** - Look Back/Lessons Learned - Finance Rules – Defining CIP - Data Sources & Benchmarking - Trust Efficiency Programme – Headline Schemes - Assurance Structure & Process including Quality Impact Assessment
Post-Implementation Appraisal of Business Cases		**Quantitative/Qualitative** - Assessment of Benefits Realisation for Approved Business Cases
Estates & Facilities Assurance Report		**Quantitative/Qualitative** - Estates Return Information Collection - Premises Assurance Model - Backlog Maintenance - Estates & Facilities Compliance
Green Plan Progress Report		**Quantitative/Qualitative** - Progress against Green Plan Deliverables & Outcomes (Carbon Footprint, Emissions, Waste, Procurement) - Estates Return Information Collection - Greener NHS Quarterly Data Collection
Digital Strategy Progress Report		**Qualitative** - Progress against Digital Strategy Deliverables & Outcomes
Opening Budgets	Annual	**Quantitative** - Opening Budgets in line with Income and Expenditure Financial Plan **Qualitative**

Item	Frequency	Sources of Assurance
		- Budget setting approach - Key Areas of Risk
Capital Programme		**Quantitative** - Capital Programme in line with Financial Plan **Qualitative** - Capital prioritisation process
Costing Transformation Programme (Reference Costs)		**Quantitative** - Mandated submission of the National Cost Collection (NCC) Exercise (Annual Comparison & Benchmarking)
Annual Review of Treasury Management Policy & Procedures		**Qualitative** - Review of Trust's Treasury Management Policy in line with the current Department of Health and Social Care financial regime.
Operational Divisional Performance Framework		**Qualitative** - Divisional Performance Framework & Process
Pharmacy Shop Board		**Quantitative** - Finance **Qualitative** - Governance
Stepping Hill Site Development Strategy– Progress Report		**Qualitative** - Progress against Stepping Hill Site Development Strategy

FINANCE & PERFORMANCE COMMITTEE

TERMS OF REFERENCE

1. CONSTITUTION

1.1. The Board of Directors (the Board) hereby resolves to appoint a Committee, to be known as the Finance & Performance Committee.

1.2 The Finance & Performance Committee shall have terms of reference and powers delegated by the Board and is subject to such conditions, such as reporting to the Board, in accordance with any legislation, regulation or direction issued by the Trust.

1.3 Save where otherwise provided in these Terms of Reference, the Standing Orders of the Board apply to the proceedings of this Committee.

1.4 The Finance & Performance Committee's activities will support the development and delivery of the Trust's Strategy and Annual Plan.

2. PURPOSE OF THE COMMITTEE

The overarching purpose of Finance & Performance Committee is to:

2.1 Provide oversight and assurance on all aspects of the Trust's financial and operational performance against the agreed annual plan.

2.2 Support the Board in the development of future business plans.

2.3 Provide oversight and ensure appropriate governance mechanisms are in place to assure delivery of the Trust's digital, estates and sustainability related strategies and plans.

2.4 Ensure any associated risks, identified in relation to the above, are managed in accordance with the Trust's assurance framework and risk management arrangements.

2.5 To have oversight into the Trust's finance and performance related work with locality and system partners.

3. COMPOSITION & CONDUCT OF THE COMMITTEE

3.1 Membership

3.1.1 Committee membership will comprise:

- At least three Non-Executive Directors, one of whom shall be the Chair
- Chief Finance Officer
- Director of Operations
- Chief Nurse
- ~~Director of Strategy & Partnerships~~

3.1.2 All statutory Directors are authorised to attend and speak at meetings of the Committee, when they judge appropriate.

3.1.3 There is an expectation that members will attend all 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%.

3.1.4 Nominated deputies may attend in the absence of any member; however, this shall be in an advisory capacity only and attendance of a deputy shall not count towards the attendance level set out in 3.1.2.

3.1.5 The following shall also attend Committee meetings:
- Director of Finance
- Company Secretary
- Director of Strategy & Partnership

3.1.6 The Committee will invite other senior leaders to support specific matters as required.

3.2. Chair

3.2.1 The Chair of the Committee will be a Non-Executive Director.

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 three members, provided that at least two of the attendees are Non-Executive Directors. Deputies in attendance do not count towards the quorum.

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 The Committee shall meet at least 10 times per year.

3.5.2 The Chair may at times convene additional meetings of the Committee and/or request business that requires urgent attention is considered via email, for majority decision making. All decisions made via email will be confirmed at the next full meeting.

3.6. Administration

3.6.1 The Company 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 Finance & Performance Committee is authorised by the Board 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 independent legal or other professional advice where required, including the attendance of independent advisers at meetings of the Committee.

5. RESPONSIBILITIES

The responsibilities of the Committee are to:

5.1 Finance

5.1.1 Seek assurance on the effectiveness of systems and processes that exist in relation to the development and delivery of the Trust's annual financial plan.

5.1.2 Review and recommend to the Board the annual financial plan / budget, including activity and workforce, and the associated financial budget.

5.1.3 Consider the levels of assurance provided from key financial metrics and monitor action/s to address any adverse trends against the agreed financial plan.

5.1.4 Oversee the development of the Trust's medium/long term financial strategy, ensuring annual financial plans are consistent with this, and recommend to the Board.

5.1.5 Seek assurance on:
- the planning of the Trust efficiency programmes and in-year delivery
- the planning and delivery of the capital programme
- the effectiveness of Trust's procurement arrangements and delivery of the Trust's procurement programme to ensure compliance with regulations and maximise value for money

5.1.6 To keep under review issues such as cost transformation (reference costs) to benchmark activity and performance and to act on any learning or remedial action required.

5.1.7 Receive, review and recommend to the Board as appropriate:

- business cases with an investment value in excess of £750,000 (capital and/or revenue)
- revenue expenditure (excluding consultancy services and removal expenses) over £750,000
- orders for schemes within the capital programme over £750,000

5.1.8 Receive and review post implementation reviews of business cases in line with the above to ensure benefits realisation.

5.1.9 To approve the Trust's business case process and associated investment, appraisal, methodology.

5.1.10 Obtain assurance on the effectiveness and sustainability of the Trust's commercial activities.

5.2 Operational Performance

5.2.1 Seek assurance on the effectiveness of systems and processes that exist in relation to the development and delivery of the Trust's annual operational performance standards.

5.2.2 Review the levels of assurance provided from key operational performance metrics and monitor action/s to address adverse trends against the agreed operational plan.

5.2.3 Receive and review key themes, issues, and risks from the Trust's performance review process.

5.3 Digital & Informatics

5.3.1 Oversee development and delivery of the Trust's digital strategy.

5.3.2 Seek assurance on the effectiveness of systems and process to deliver the Trust's digital and information statutory requirements

5.4 Estates

5.4.1 Oversee the development and delivery of the Trust's estates strategy, with recommendation to the Board as required.

5.4.2 Seek assurance on the effectiveness of systems and process to deliver the Trust's estates and facilities statutory requirements.

5.5 Sustainability

5.5.1 Have oversight of the development and delivery of sustainability requirements in line with national NHS guidance.

5.6 Other

5.6.1 Oversee the development of relevant Trust-level strategies and plans and recommend to the Board.

5.6.2 Review the findings or major investigations or reviews (internal of external to the Trust) as delegated by the Board or on the Committees initiatives and consider management's response.

5.6.3 Review assigned risks from the Board Assurance Framework and associated significant risks from the Corporate Risk Register and ensure that mitigations are appropriately actioned.

5.6.4 Review and approve the Work Plans and Terms of Reference of any group/committee that reports directly to the Committee.

5.6.5 Undertake or consider on behalf of the Chairman or the Board such other related tasks or topics as the Chairman or the Board may from to time entrust to the Committee. The Committee will work in partnership with other Committees of the Board to address matters that impact on the responsibilities of several Committees.

6. RELATIONSHIP WITH THE BOARD OF DIRECTORS

6.1 The Committee will report to the Board 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 following each Committee meeting.

6.3 Minutes of all Committee meetings will be available to all members of the Board on request.

7. RELATIONSHIP WITH OTHER GROUPS

7.1 The Committee shall have the power to establish sub-committees for the purpose of addressing specific tasks or areas of responsibility. In accordance with the Trust's Standing Orders, the Committee may not delegate powers to a sub-committee unless expressly authorised by the Board.

7.2 The Committee will receive reports, in the form of Key Issues Reports, from the following:

- Capital Programme Management Group
- Digital & Informatics Group
- Estates Strategy Steering Group

7.3 For the purpose of providing assurance regarding the controls in place for the management and mitigation of risks recorded on the Board Assurance Framework, the Committee (through its Chair) reports regularly to the Audit Committee.

8. REVIEW

8.1 The Committee will review its terms of reference and membership annually and recommend any changes to the Board 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.

NHS
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People Performance Committee Annual Review 2023/24

1. Introduction

1.1 The People Performance Committee considered and confirmed the outcome of the Committee Annual Review, including the revised Terms of Reference and Work Plan 2024/25 at its meeting in March 2024. The review is recommended to the Board of Directors for approval.

2. Background

2.1 Section 8 of the current People Performance Committee Terms of Reference states that *"The Committee will evaluate its own membership and review the effectiveness and performance of the Committee on an annual basis".*

2.2 Furthermore, the Terms of Reference require that the Terms of Reference of the People Performance Committee are reviewed by the Board of Directors annually.

2.3 The current review relates to effectiveness of the Committee during 2023/24.

3. Compliance with Terms of Reference

3.1 The People Performance Committee has an annual work plan, which sets out the matters to be considered by the Committee to fulfil its broad responsibilities:

- Oversight and assurance on matters relating to delivery of the Trust's people related strategies and plans to support achievement of corporate objectives
- Supporting the Board in the development of people related strategies and plans

Appendix 1 details key matters and standard reports considered by the People Performance Committee during 2023/24 in line with the terms of reference. In addition, the Committee also considered:

- Agency expenditure
- Fit & Proper Person Test Framework for Board Members
- Industrial Action Briefing
- Sexual Safety in the Workforce – Organisational Charter
- Staff Facilities

3.2 The People Performance Committee received the Work Plans and Terms of Reference for its established subgroups in March 2024.

3.3 Attendance at 2023/24 People Performance Committee meetings is provided in Appendix 2. The Committee has met on six occasions in 2023/24 and all meetings were quorate.

4. Review of Committee Effectiveness 2023/24

4.1 Effective sub-committees can provide significant benefits to the Board, enabling the Board to make informed decisions and meet their wide-ranging governance and

regulatory responsibilities. Likewise, sub-committees should play a key role in supporting directors in their strategic and oversight roles.

4.2 An informal review of Committee effectiveness is led by the Chair of the Committee as part of the meeting arrangements. This enables members to provide real-time feedback regarding what has worked well and areas for improvement.

4.3 Furthermore, People Performance Committee members were asked to provide feedback regarding committee effectiveness during the year considering:

- What has worked well?
- What could be improved?
- Any other comments

4.4 Summary of feedback:

What has worked well?

- Quality of the papers have improved over the past year, including better cross-referencing between strategies and papers.
- Triangulation of data and information.
- New Chair now settled and knowledgeable with established relationship with Executive Director.
- The reporting has started to be more aligned to what is needed in clarity and context as a result of the training and development of the report writers.

What could be improved?

- The Committee's expectations regarding the reporting and assurance of Education.
- In papers, having a continued focus on providing assurance rather than a description of activities.
- Develop further triangulation between other assurance committees.
- Further development of reporting and analytics to give us better information of the relationship between performance, productivity, patient and staff safety and satisfaction, and finance.
- Understand and receive reporting that cover the increasing collaboration across trusts which in the case of the PPC should reflect the qualitative and quantitative measures regarding staff productivity, performance, safety and finance of so doing. At present we are unclear as to the impact and in terms of the Board Assurance Framework we have not discussed risk in that context, meaning we are not in a strong position to understand what risk ambition we are setting or taking.
- The Committee will need to take account of the changing CQC requirements, particularly around evidence of the Well-Led domain and the way that is reported to this Committee.
- Opportunity for a workshop style meeting with other colleagues to explore setting out a matrix reporting approach over the next twelve months, which would start to address the above points.

Any other comments

- Opportunity to consider a staff story at the start of a meeting.
- We measure the diversity of our workforce, but do we take action outside of our specific EDI strategies to address inclusion.

4.4 Consideration of the above, and compliance with the Terms of Reference, confirms the effective operation of the Committee throughout 2023/24, with opportunities for ongoing improvement to be taken forward.

5. Committee Work Plan 2024/25

5.1 The Work Plan 2024/25 (Appendix 3) has been developed in line with feedback received, and discussion with the Director of People & Organisational Development (OD) and the Chair of the People Performance Committee. We have taken the opportunity to review both this Trust's People Performance Committee and Tameside's Workforce Committee Work Plans to support alignment of reporting.

5.2 Reports detailed within the Work Plan will be action-driven and practical, containing enough data and information to enable the Committee to reach an evidence-based and auditable conclusion.

5.3 Whilst the Wellbeing Guardian is undertaking the role of the Interim Chair, the Wellbeing Guardian Report is going straight to the Board.

5.4 The key sources of assurance, both qualitative and quantitative, that will provide evidence to the Committee regarding the effectiveness of systems and controls in place and the actions being taken to address adverse trends are set out in Appendix 4.

5.5 **Board to Ward – Governance Alignment**

5.5.1 The Operational Divisions Performance Review Framework (PRF) supports the Trust to assure delivery of the annual corporate objectives, providing a connection from Board to Ward. The PRF is based on 6 domains:

- Operational Excellence
- Quality of Care
- People & Leadership
- Finance
- Service Transformation & Innovation
- Strategy

Each domain is measured by oversight metrics based on regulatory frameworks, national targets and the outcome measures identified for the annual business plan – and is mirrored within the key sources of assurances considered via respective Board Committees.

6. Terms of Reference

6.1 A review of the Committee Terms of Reference has been conducted. The revised Terms of Reference are included at Appendix 5 of the report for approval.

6.2 Key revisions to the terms of reference relate to:

- Revision to the regular attendees.

Appendix 1: Key Matters considered by People Performance Committee 2023/24

Topic	24 May 2023	13 July 2023	15 Sept 2023	9 Nov 2023	11 Jan 2024	14 Mar 2024
People Integrated Performance Report	✓	✓	✓	✓	✓	✓
Agency Expenditure		✓				
Organisational Development Plan		✓			✓	
Operational Plan Update						✓
Medical Appraisal and Revalidation Report			✓			
Equality, Diversity & Inclusion Strategy	✓			✓		
Industrial Action Briefing				✓		
WRES Report	✓					
WDES Report	✓					
Annual Workforce EDI Monitoring Report						✓
Consolidated EDI Action Plan						✓
Gender Pay Gap Report						✓
Widening Participation	✓			✓		
Freedom to Speak Up Guardian Report	✓		✓		✓	✓
Wellbeing Guardian Report		✓			✓	
Guardian of Safe Working		✓		✓		
Employee Relations & Exclusions Activity	✓			✓		
Staff Survey		✓		✓		✓
Health & Wellbeing		✓		✓		
Violence & Aggression Standard		✓	✓			✓
GMC Annual National Trainee Survey			✓			
Sexual Safety in the Workplace – Organisational Charter				✓		
Staff Facilities						✓
Safe Care (Staffing) Report	✓		✓	✓	✓	✓
Annual Nursing & Midwifery Establishments					✓	
Resourcing & Retention Programme		✓			✓	
Board Assurance Framework and Aligned Significant Risks		✓	✓		✓	✓
Fit & Proper Person Test Framework for Board Members			✓			
People Performance Committee Annual Review (inc. review of Terms of Reference and Work Plan 2024/25)						✓
Subgroups' Terms of Reference and Work Plans for Approval						✓
Key Issues Reports:						
• **People, Engagement & Leadership Group**	✓		✓	✓		✓
• **Equality, Diversity & Inclusion Group**	✓	✓	✓		✓	✓
• **Educational Governance Group**	✓	✓	✓		✓	

Topic	24 May 2023	13 July 2023	15 Sept 2023	9 Nov 2023	11 Jan 2024	14 Mar 2024
Informal Review of Meeting Effectiveness	✓	✓	✓	✓	✓	✓
People Performance Committee Work Plan 2023/24 and Attendance	✓	✓	✓	✓	✓	✓

Appendix 2: People Performance Committee 2023/24 Attendance Register

Member	Name	May-23	Jul-23	Sep-23	Nov-23	Jan-24	Mar-24
Core Members							
Chair of People Performance Committee/Non-Executive Director	Beatrice Fraenkel	Y	Y	Y	Y	Y	Y
Non-Executive Director / Wellbeing Guardian	Marisa Logan-Ward	Y	Y	Y	A	Y	Y
Non-Executive Director	Mary Moore	Y	Y	Y	Y	A	Y
Director of People & OD	Amanda Bromley	Y	Y	Y	Y	Y	Y
Chief Nurse	Nic Firth	Y	A	A	A	Y	Y
Medical Director	Andrew Loughney	A	A	Y	Y	Y	Y
Non-Executive Director	Louise Sell					A(D)	
Regular Attendees							
Deputy Director of People & OD	Emma Cain	Y	Y	A	Y	A	Y
Deputy Director of OD	Lisa Gammack	Y	Y	Y	Y	Y	Y
Trust Secretary	Rebecca McCarthy	Y	Y	Y	Y	Y	Y
Head of Strategic Workforce Planning	Caroline Durdle	Y	Y	A	Y		
Assistant Director of Human Resources	Stuart McKenna	Y	Y		Y	Y	Y
Chief Finance Officer	John Graham	Y	Y	A	A	Y	Y
Deputy Chief Nurse	Helen Howard	Y	A	Y	Y	Y	A
Director of Communications & Corporate Affairs	Caroline Parnell	Y	Y	Y	Y	A	Y
Freedom to Speak Up Guardian	Nadia Walsh			A		Y	Y
Was Meeting Quorate (Y/N)		**Y**	**Y**	**Y**	**Y**	**Y**	**Y**
Key							
Y	= Present						
A	= Apologies						
A(D)	= Attended as Deputy						

Appendix 3: People Performance Committee Work Plan 2024/25

			2024									2025		
	Items		**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
		Papers Due		30.4.		2.7.		3.9.		5.11.		31.12		4.3.
		Committee Date		9.5.		11.7.		12.9.		14.11		9.1.		13.3.
		Lead	**Q1**			**Q2**			**Q3**			**Q4**		
Assurance Reports														
1.	**People Integrated Performance Report**	Director of People & OD		•		•		•		•		•		•
2.	**Resourcing and Retention Programme**	Deputy Director of People & OD						•						•
3.	**Equality, Diversity & Inclusion Strategy**	Deputy Director of OD				•				•				
4.	**Operating Plan Update**	Director of People & OD												•
5.	**WRES & WDES Report**	Deputy Director of OD		•										
6.	**Gender Pay Gap Report**	Deputy Director of OD												•
7.	**Annual Workforce EDI Monitoring Report**	Deputy Director of OD												•
8.	**Health & Wellbeing Plan**	Deputy Director of People & OD								•				
9.	**Wellbeing Guardian Report**	Wellbeing Guardian				•				•				
10.	**Organisational Development Plan**	Deputy Director of OD				•						•		
11.	**Freedom to Speak Up**	Freedom to Speak Up Guardian		•				•				•		
12.	**Guardian of Safe Working**	Guardian of Safe Working				•				•				
13.	**Employee Relations & Exclusion Activity**	Deputy Director of People & OD		•								•		
14.	**Widening Participation**	Deputy Director of OD		•						•				
15.	**Safer Care (Staffing) Report**	Deputy Chief Nurse / Medical Director		•		•		•		•		•		•
16.	**Annual Nursing & Midwifery Establishments**	Chief Nurse								•				
17.	**GMC Annual National Trainee Survey**	Medical Director / Director of Medical Education						•				•		

			2024									2025		
	Items		**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
		Papers Due		30.4.		2.7.		3.9.		5.11.		31.12		4.3.
		Committee Date		9.5.		11.7.		12.9.		14.11		9.1.		13.3.
		Lead	**Q1**			**Q2**			**Q3**			**Q4**		
18.	**Medical Appraisal & Revalidation Annual Report**	Medical Director						•						
19.	**Staff Survey**	Deputy Director of OD				•				•				•
20.	**Violence & Aggression Standard**	Chief Nurse / Director of People & OD						•						
21.	**Advancing Levels of Attainment E-rostering and Job Planning**	Deputy Director of People & OD						•						
Risks														
22.	**BAF & Aligned Significant Risks**	Company Secretary				•		•				•		•
Subgroups														
23.	**People, Engagement & Leadership Group**	Director of People & OD		•		•		•		•		•		•
24.	**Equality, Diversity & Inclusion Group**	Deputy Director of OD		•		•		•		•		•		•
25.	**Education Governance Group**	Deputy Director of People & OD		•		•		•		•		•		•
Committee Business														
26.	Review and approval of **Terms of Reference**	Chair												•
27.	Review and approval of **Annual Work Plan**	Chair												•
28.	Review and approval of **People Performance Committee Subgroup Terms of Reference & Work Plans**	Chair												•
29.	Informal Review of Committee Effectiveness	Led by Chair		•		•		•		•		•		•
30.	Formal Committee Evaluation	Chair												•

Schedule as required:

- Major investigations or reviews (internal of external to the Trust) relevant to people.
- Development of people related strategy, prior to recommendation to Board

Appendix 4: People Performance Committee Key Sources of Assurance

Item	Frequency	Sources of Assurance	People & Organisational Development Plan: Pillars
People Integrated Performance Report	Bimonthly	**Quantitative** - Sickness Absence - Statutory & Training Compliance - Appraisal Rate - Retention & Vacancies (Turnover) - Recruitment Pipeline - Pay Expenditure (including Bank & Agency Costs) - Staff Vaccination Rate	Strategic Workforce Development, Planning & Performance
Safer Care (Staffing Report)		**Quantitative** - Register Nurse/Healthcare Assistant – Actual / Vacancies - Midwives – Actual / Vacancies - Medical Staffing – Actual / Vacancies - Consultant Job Planning (Annual) **Qualitative** - Safecare Live Analysis - Staffing Incidents Analysis	Strategic Workforce Development, Planning & Performance Culture, Engagement & Retention
Freedom to Speak Up	3 x Year	**Quantitative** - Referrals (Level of Activity) **Qualitative** - Themes & Trends from Referrals - Learning - Policy & Process (in line with National Guidance)	Leadership Development Culture, Engagement & Retention
Staff Survey		**Quantitative** *Defined National Staff Survey*	Culture, Engagement & Retention Leadership Development
Equality, Diversity & Inclusion (EDI) Strategy	2 x Year	**Quantitative/Qualitative** - WRES/WDES Indicators - Staff Survey engagement score & indicators - EDI Strategy Delivery & Outcomes	Strategic Workforce Development, Planning & Performance Resourcing Culture, Engagement & Retention Leadership Development
Health & Wellbeing		**Quantitative** - Sickness Absence - Retention & Vacancies (Turnover) - Staff Survey engagement score & indicators	Culture, Engagement & Retention

Item	Frequency	Sources of Assurance	People & Organisational Development Plan: Pillars
Resourcing & Retention		**Quantitative** - Retention & Vacancies (Turnover) - Recruitment Pipeline **Qualitative** Workforce Plan Delivery	Strategic Workforce Development, Planning & Performance
Wellbeing Guardian Report		**Qualitative** - Self-Assessment: Implementation of Wellbeing Guardian role and delivery of principles (relevant to Stockport NHS FT)	Culture, Engagement & Retention
Organisational Development Plan		**Quantitative/Qualitative** - Staff Survey engagement score & indicators - Organisational Development Plan Delivery & Outcomes	Leadership Development Culture, Engagement & Retention
Guardian of Safe Working		**Quantitative** - Exception Reports (Level of Activity) **Qualitative** - Themes & Areas of Risk - Process (in line with National Guidance)	Culture, Engagement & Retention
Employee Relations & Exclusion Activity		**Quantitative** - Formal "open" disciplinary cases, including related ethnicity information **Qualitative** - Formal disciplinary investigation process	Leadership Development Culture, Engagement & Retention
Widening Participation		**Quantitative** - Statutory & Training Compliance - Appraisal Rate - Preceptorship, Apprenticeships - Cadets, T-Levels **Qualitative** - Place based programmes	Training, Education & Practice Development
Violence & Aggression Standard		**Quantitative** - Datix & Incidences - Employee Relations Case Themes **Qualitative** - National Staff Survey Outcomes	Culture, Engagement & Retention
Annual Workforce EDI Monitoring	Annual	**Quantitative/Qualitative**	Culture, Engagement & Retention

Item	Frequency	Sources of Assurance	People & Organisational Development Plan: Pillars
Report		- WRES/WDES Indicators - Equality, Diversity & Inclusion Strategy Delivery & Outcomes	
WRES Report		*Defined WRES Indicators*	Culture, Engagement & Retention
WDES Report		*Defined WDES Indicators*	Culture, Engagement & Retention
Gender Pay Gap Report		*Defined Gender Pay Gap Reporting*	Culture, Engagement & Retention
Annual Nursing & Midwifery Establishment Review		**Quantitative** - Divisional RN/HCA - Actual/Vacancy **Qualitative** - Compliance with triangulated approach to determining staffing requirements described in the National Quality Board guidance	Strategic Workforce Development, Planning & Performance Resourcing
Medical Appraisal & Revalidation Annual Report		**Quantitative** - Levels of medical appraisal and revalidation **Qualitative** - Process for medical appraisal and revalidation, including quality assurance - Board Declaration Compliance	Training, Education & Practice Development
GMC Annual National Trainee Survey		*Defined GMC Trainee Survey*	Training, Education & Practice Development
Workforce Plan		**Quantitative/Qualitative** Compliance with National People Plan & People Plan Delivery & Outcomes	All

PEOPLE PERFORMANCE COMMITTEE

TERMS OF REFERENCE

1. CONSTITUTION

1.1. The Board of Directors (the Board) hereby resolves to appoint a Committee, to be known as the People Performance Committee.

1.2 The People Performance Committee shall have terms of reference and powers delegated by the Board and is subject to such conditions, such as reporting to the Board, in accordance with any legislation, regulation or direction issued by the Trust.

1.3 Save where otherwise provided in these Terms of Reference, the Standing Orders of the Board apply to the proceedings of this Committee.

1.4 The People Performance Committee's activities will support the development and delivery of the Trust's Strategy and Annual Plan.

2. PURPOSE OF THE COMMITTEE

The overarching purpose of People Performance Committee is to:

2.1 Provide oversight and assurance on matters relating to delivery of the Trust's people related strategies and plans to support achievement of (related) corporate objectives.

2.2 Support the Board in the development of people related strategies and plans.

2.3 Ensure any associated risks, identified in relation to the above, are managed in accordance with the Trust's assurance framework and risk management arrangements.

2.2 To have oversight into the Trust's people related work with locality and system partners.

3. COMPOSITION & CONDUCT OF THE COMMITTEE

3.1 Membership

3.1.1 Membership will comprise:

- Three named Non-Executive Directors, one of whom shall be the Chair
- Director of People & Organisational Development
- Chief Nurse
- Medical Director

3.1.2 All statutory Directors are authorised to attend and take part in meetings of the Committee, when they judge appropriate.

3.1.3 There is an expectation that members will attend all Committee meetings during the financial year. Individual attendance levels will be monitored by the Chair of the Committee, supported by the

Company Secretary, who will take appropriate measures should attendance be less than 75%.

3.1.4 Nominated deputies may attend in the absence of any member; however, this shall be in an advisory capacity only and attendance of a deputy shall not count towards the attendance level set out in 3.1.3.

3.1.5. The following shall also attend Committee meetings:

- Deputy Director of People & Organisational Development
- Deputy Director of Organisational Development
- **Head of Human Resources**
- Well-Being Guardian
- Company Secretary

3.1.6 The Committee will invite other senior leaders to support specific matters as required.

3.2. Chair

3.2.1 The Chair of the Committee will be a Non-Executive Director.

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 three members, provided that at least two of the attendees are Non-Executive Directors. Deputies in attendance do not count towards the quorum.

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 The Committee shall meet at least 6 times per year.

3.5.2 The Chair may at times convene additional meetings of the Committee and/or request business that requires urgent attention is considered via email, for majority decision making by members. All decisions made via email will be confirmed at the next full meeting.

3.6. Administration

3.6.1 The Company Secretary will ensure appropriate administrative arrangements are in place and that minutes are recorded, confirmed and appropriately archived from each meeting.

4. DELEGATED AUTHORITY

4.1 The People Performance Committee is authorised by the Board to 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 independent legal or other professional advice where required, including the attendance of independent advisers at meetings of the Committee.

5. RESPONSIBILITIES

The responsibilities of the Committee are to:

5.1 Seek assurance on the effectiveness of systems and processes that exist in relation to delivery of the Trust's people related strategies and plans to support of achievement of related corporate objectives.

5.2 Review the levels of assurance provided from key people performance related metrics and monitor action/s to address any adverse trends against the agreed plans.

5.3 Receive and review the outcomes of staff surveys, including the annual NHS staff survey and surveys of staff undertaken by professional registration bodies, and associated action/s.

5.4 Review the effectiveness of arrangements in place relating to equality, diversity and inclusion in the Trust's workforce, including oversight of statutory reporting requirements and make recommendation to the Board.

5.5 Review compliance with statutory registration requirements for members of staff and make recommendation to the Board.

5.6 Review current cases of exclusion of staff from working at the Trust.

5.7 Oversee the development of people related strategies and plans and recommend to the Board.

5.8 Review the findings of major investigations or reviews (internal or external to the Trust) relevant to people, as delegated by the Board, or on the Committees initiatives and consider management's response.

5.9 Review people related risks from the Board Assurance Framework and associated significant risks from the Corporate Risk Register and ensure that mitigations are appropriately actioned.

5.10 Review and approve the Work Plans and Terms of Reference of any group that reports directly to the Committee.

5.11 Undertake or consider on behalf of the Chairman or the Board such other related tasks or topics as the Chairman or the Board may from to time entrust to the Committee.

The Committee will work in partnership with other Committees of the Board to address matters that impact on the responsibilities of several Committees.

6. RELATIONSHIP WITH THE BOARD OF DIRECTORS

6.1 The Committee will report to the Board 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 following each Committee meeting.

6.3 Minutes of all Committee meetings will be available to all members of the Board on request.

7. RELATIONSHIP WITH OTHER GROUPS

7.1 The Committee shall have the power to establish sub-committees for the purpose of addressing specific tasks or areas of responsibility. In accordance with the Trust's Standing Orders, the Committee may not delegate powers to a sub-committee unless expressly authorised by the Trust Board.

7.2 The Committee will receive reports, in the form of Key Issues Reports, from the following:

- Equality, Diversity & Inclusion Group
- People, Engagement & Leadership Group
- Educational Governance Group

7.3 For the purpose of providing assurance regarding the controls in place for the management and mitigation of risks recorded on the Board Assurance Framework, the Committee (through its Chair) reports regularly to the Audit Committee.

8. REVIEW

8.1 The Committee will review its terms of reference and membership annually and recommend any changes to the Board 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.

NHS Stockport NHS Foundation Trust

Quality Committee Annual Review 2023/24

1. Introduction

1.1 The Quality Committee considered and confirmed the outcome of the Committee Annual Review, including the revised Terms of Reference and Work Plan 2024/25 at its meeting in March 2024. The review is recommended to the Board of Directors for approval.

2. Background

2.1 Section 8 of the current Quality Committee Terms of Reference states that *"The Committee will review its membership, effectiveness and performance of the Committee on an annual basis".*

2.2 Furthermore, the Terms of Reference require that the Terms of Reference of the Quality Committee shall be reviewed by the Board of Directors annually.

2.3 The current review relates to effectiveness of the Committee during 2023/24.

3. Compliance with Terms of Reference

3.1 The Quality Committee has an annual work plan, which sets out the matters to be considered by the Committee to fulfil its broad responsibilities as set out in the terms of reference:

- Oversight and assurance on matters relating to delivery of the Trust's quality related strategies and plans to support achievement of corporate objectives
- Support the Board in the development of quality related strategies and plans

Appendix 1 details key matters and standard reports considered by the Quality Committee during 2023/24. In addition, the Committee also considered:

- End of Life Care Deep Dive
- Discharge Deep Dive
- Mental Health Presentations (Emergency Department) – Deep Dive
- Safeguarding Plan 2023-2026
- Dementia Plan 2023-2026
- Infant, Young People & Childrens Strategy 2023-2026

3.2 The Quality Committee will receive the Work Plans and Terms of Reference for its established subgroups in March / April 2024.

3.3 Attendance at 2023/24 Quality Committee meetings is provided in Appendix 2. The Committee has met on ten occasions in 2023/24 and all meetings were quorate.

4. Review of Committee Effectiveness 2023/24

4.1 Effective sub-committees can provide significant benefits to the Board, enabling the Board to make informed decisions and meet their wide-ranging governance and regulatory responsibilities. Likewise, sub-committees should play a key role in supporting directors in their strategic and oversight roles.

4.2 An informal review of Committee effectiveness is led by the Chair of the Committee as part of the meeting arrangements. This enables members to provide real-time feedback regarding what has worked well and areas for improvement.

4.3 Furthermore, Quality Committee members were asked to provide feedback regarding committee effectiveness during the year considering:

- What has worked well?
- What could be improved?
- Any other comments

4.4 Summary of feedback:

What has worked well?

- Quality of papers has improved, more robust and assurance focused.
- Positive and effective challenge/questioning and discussion from all committee members.
- Triangulation and handover to other Board Committees of cross cutting themes.
- Papers generally issued on time.
- Positive face to face meeting.
- Support and deputy chairing by Non-Executive director colleagues when chair not available.

What could be improved?

- Continued focus on assurance and effective questioning, and not personal interest / commentary.
- Presenters to draw out key points for attention or decision, highlighting where assurance can be provided or where unable to give assurance. Tendency for in-depth presentation of papers.
- Triangulation with other Board Committees.
- Key Issues Reports from Subgroups, especially Patient Experience Group, are still a work in progress; would still benefit from a workshop on this.
- Broader, consistent representation from Executive Directors.
- Late papers.
- Line of sight to 'quality' at ICB, and potentially at Place.

Any other comments

- Giving more opportunity to Divisions to present papers/observe Quality Committee – Divisional presentations no longer included in workplan.
- Further opportunities for face to face meetings.
- Opportunity for committee development session.

4.5 Consideration of the above, and compliance with the Terms of Reference, confirms the effective operation of the Committee throughout 2023/24, with opportunities for ongoing improvement to be taken forward, particularly with regard to supporting focus on assurance.

5. Committee Work Plan 2024/25

5.1 The Work Plan 2024/25 (Appendix 3) has been developed in line with feedback received and consideration by the Committee Chair, lead Executive Directors and the Company Secretary.

5.2 Reports detailed within the Work Plan are to be action-driven and practical, containing enough data and information to enable the Committee to reach an evidence-based and auditable conclusion.

5.3 The key sources of assurance, both qualitative and quantitative, that will provide evidence to the Committee regarding the effectiveness of systems and controls in place, and the actions being taken to address adverse trends are set out in Appendix 4.

5.4 **Board to Ward – Governance Alignment**

5.4.1 The Operational Divisions Performance Review Framework (PRF) supports the Trust to assure delivery of the annual corporate objectives, providing a connection from Board to Ward. The PRF is based on 6 domains:

- Operational Excellence
- Quality of Care
- People & Leadership
- Finance
- Service Transformation & Innovation
- Strategy

Each domain is measured by oversight metrics based on regulatory frameworks, national targets and the outcome measures identified for the annual business plan – and is mirrored within the key sources of assurances considered via respective Board Committees.

6. Terms of Reference

6.1 A review of the Committee Terms of Reference has been conducted. The revised Terms of Reference are included at Appendix 5 of the report for approval.

6.2 A single change to the Terms of Reference is proposed, confirming oversight of the implementation of quality related strategies.

Appendix 1: Quality Committee Key Matters 2023/24

			2023									2024		
	Items		**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
		Lead	**Q1**			**Q2**			**Q3**			**Q4**		
1.	**Patient Story**	Deputy Chief Nurse	•	•	•	•		•	•	•		•	•	•
Deep Dives														
2.	**End of Life Care**					•								
	Discharge Deep Dive									•				
Quality Performance														
3.	**Quality & Safety Integrated Performance Report**	Medical Director / Chief Nurse	•	•	•	•		•	•	•		•	•	•
Regulatory Compliance														
4.	**CQC Update**	Chief Nurse / Deputy Director Quality Governance			•							•		
5.	**External Visits & Inspections Register Report**	Deputy Director Quality Governance		•						•				
Assurance and Oversight Requirements														
6.	**Learning from Deaths**	Medical Director	•			•			•			•		
7.	**Patient Safety Report including Serious Incidents**	Deputy Director Quality Governance	.	.•				•		•			•	
8.	**Maternity Services Report** *(Additional reports/frequency to be revised in line with external reporting submissions)*	Chief Nurse / Head of Midwifery		•		•		•		•		•		•
9.	**StARS Progress Report**	Deputy Chief Nurse	.•			•			•			•		
10.	**Quality Strategy Progress Report**	Deputy Chief Nurse		•						•				
11.	**Patient, Family & Carer Experience Strategy Progress Report**	Deputy Chief Nurse			•								•	
13.	**Annual National In-Patient Survey Report and Action Plan**	Deputy Chief Nurse						•						
15.	**Mental Health Plan Progress Report**	Deputy Chief Nurse / Medical Director						•						

			2023									2024		
	Items		**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
		Lead	**Q1**			**Q2**			**Q3**			**Q4**		
Standing Committees														
16.	**Trust Integrated Safeguarding Group Key Issues Report**	Chief Nurse		•		•		•		•			•	
17.	**Patient Experience Group Key Issues Report**	Chief Nurse	•		•	•			•			•	•	•
18.	**Health and Safety JCG Key Issues Report**	Deputy Director Quality Governance	•	•	•			•	•	•			•	•
19.	**Clinical Effectiveness Group Key Issues Report** *(Consolidated quarterly report in line with quarterly cycle of Clinical Effectiveness Group business)*	Medical Director	•		•			•				•		•
20.	**Patient Safety Group Key Issues Report**	Medical Director	•	•	•	•		•	•	•		•	•	•
Annual Reports														
21.	**Annual Health & Safety Report**	Deputy Director Quality Governance		•										
22.	**Annual Research & Innovation Report**	Medical Director			•									
23.	**Annual Clinical Audit Report & Forward Programme**	Medical Director			•									
24.	**Annual Complaints Report**	Deputy Director Quality Governance				•								
25.	**Annual Infection Control Report**	Chief Nurse			•									
26.	**Annual Safeguarding Report**	Deputy Chief Nurse				•								
27.	**Annual Quality Account**	Deputy Director Quality Governance		•										
Strategic Developments														
28.	**Patient Safety Incident Response Framework & Plan**	Deputy Director Quality Governance				•								•
Risks														
29.	**BAF & Aligned Significant Risks**	Company Secretary				•		•				•		•

			2023									2024		
	Items		**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
		Lead	**Q1**			**Q2**			**Q3**			**Q4**		
Committee Business														
30.	Review and approve **Terms of Reference**	Chair												•
31.	Review and approve **Annual Committee Work Plan**	Chair												•
32.	Review and approve **Quality Committee Subgroup Terms of Reference & Annual Work Plans**	Chair	•											
33.	Informal Review of Committee Effectiveness	Led by Chair	•	•	•	•		•	•	•		•	•	•
34.	Formal Committee Evaluation	Chair												•
35.	Matters Referred from Board Committees	Led by Chair	•	•	•	•		•	•	•		•	•	•

Appendix 2: Quality Committee 2023/24 Attendance Register

Member	Name	Apr 23	May 23	Jun 23	Jul 23	Sept 23	Oct 23	Nov 23	Jan 24	Feb 24	Mar 24
Core Members											
Chair of Quality Committee/Non-Executive Director	Mary Moore	Y	Y	A	Y	Y	Y	Y	Y	Y	
Non-Executive Director	Marisa Logan-Ward	Y	Y	Y	Y	Y	Y	Y	Y	Y	
Non-Executive Director	Louise Sell	Y	Y	Y	Y	Y	Y	Y	Y	Y	
Medical Director	Andrew Loughney	A	Y	Y	Y	Y	Y	Y	Y	Y	
Chief Nurse	Nic Firth	Y	Y	A	Y	Y	Y	Y	Y	Y	
Director of Operations	Jackie McShane	Y	Y	Y	A	Y	A	Y	A	A	
Regular Attendees											
Deputy Chief Nurse	Helen Howard	Y	Y	Y	Y	Y	Y	A	Y	Y	
Deputy Director of Quality Governance	Natalie Davies	A	Y	Y	Y	A	Y	Y	Y	Y	
Trust Secretary	Rebecca McCarthy	Y	Y	Y	Y	Y	A	Y	Y	Y	
Head of Midwifery / Deputy Head of Midwifery	Sharon Hyde	N/A	N/A	Y	N/A	Y	N/A	Y	Y	Y	
Head of Safeguarding	Thomas Parker Evans	N/A	Y	N/A	Y	Y	N/A	N/A	N/A	N/A	
Director of Communications & Corporate Affairs	Caroline Parnell	Y	Y	Y	A	A	A	A	A	A	
Deputy Medical Director	Tushar Mahambrey	A (D)									
Was meeting quorate?		**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	
Key											
Y	= Present										
A	= Apologies										
A(D)	= Attended as Deputy										
N/A	= No Report										

Appendix 3: Quality Committee Work Plan 2024/25

			2024									2025		
	Items		**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
		Papers Due	12.4	17.5	14.6	12.7		13.9	11.10	15.11.		17.1.	14.2.	14.3.
		Committee Date	23.4	28.5	25.6	23.7.		24.9	22.10	26.11.		28.1.	25.2.	25.3.
		Paper Lead	**Q1**			**Q2**			**Q3**			**Q4**		
1.	**Patient Story**	Deputy Chief Nurse	•	•	•	•		•	•	•		•	•	•
Performance														
2.	**Quality & Safety Integrated Performance Report**	Medical Director / Chief Nurse	•	•	•	•		•	•	•		•	•	•
Regulatory Compliance														
3.	**CQC Update**	Deputy Director Quality Governance			•					•			•	
4.	**External Visits & Inspections Register Report**	Deputy Director Quality Governance			•							•		
Assurance and Oversight Requirements														
5.	**Learning from Deaths**	Medical Director	•			•			•			•		
6.	**Patient Safety Report including Serious Incidents**	Deputy Director Quality Governance		.•				•		•			•	
7.	**Maternity Services Report** *(Additional reports/frequency to be revised in line with external reporting submissions)*	Divisional Director of Midwifery and Nursing		•		•		•	•			•		•
8.	**Infection Prevention and Control Strategy Progress Report** *(Annual Report in June)*	Associate Nurse Director IPC							•					
9.	**StARS Progress Report**	Deputy Chief Nurse	.•			•			•			•		
10.	**Quality Strategy Progress Report** *(May – Review of Annual Aims & Aims Year Ahead)* *(November – Progress)*	Deputy Chief Nurse		•						•				
11.	**Patient, Family & Carer Experience Strategy Progress Report** *(September includes Annual National In-Patient Survey Report and Action Plan)*	Deputy Chief Nurse						•						•
12.	**Mental Health Plan Progress Report**	Deputy Chief Nurse	•					•					•	
Risks														
13.	**BAF & Aligned Significant Risks**	Company Secretary				•		•				•		•

			2024									2025		
	Items		**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
		Papers Due	12.4	17.5	14.6	12.7		13.9	11.10	15.11.		17.1.	14.2.	14.3.
		Committee Date	23.4	28.5	25.6	23.7.		24.9	22.10	26.11.		28.1.	25.2.	25.3.
		Paper Lead	**Q1**			**Q2**			**Q3**			**Q4**		
Strategic Developments														
14.	**Patient Safety Incident Response Framework & Plan**	Deputy Director Quality Governance	•											
15.	**Quality Strategy Development Plan**	Deputy Chief Nurse						•						
Annual Reports														
16.	**Annual Health & Safety Report**	Deputy Director Quality Governance		•										
17.	**Annual Research & Innovation Report**	Research & Innovation Manager / Medical Director			•									
18.	**Annual Clinical Audit Report & Forward Programme**	Head of Clinical Audit / Medical Director			•									
19.	**Annual Complaints Report**	Deputy Director Quality Governance				•								
20.	**Annual Infection Control Report**	Associate Nurse Director IPC		•										
21.	**Annual Safeguarding Report**	Head of Safeguarding				•								
22.	**Annual Quality Account**	Deputy Director Quality Governance		•										
Standing Committees														
23.	**Trust Integrated Safeguarding Group Key Issues Report**	Chief Nurse	•			•		•		•		•		•
24.	**Patient Experience Group Key Issues Report**	Chief Nurse	•	• PLACE	•	•			•	•		•	•	•
25.	**Health and Safety JCG Key Issues Report**	Deputy Director Quality Governance		•				•		•			•	•
26.	**Clinical Effectiveness Group Key Issues Report** *(Consolidated quarterly report in line with quarterly cycle of Clinical Effectiveness Group business)*	Medical Director			•			•				•		•
27.	**Patient Safety Group Key Issues Report**	Medical Director	•	•	•	•		•	•	•		•	•	•

			2024									2025		
	Items		**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
		Papers Due	12.4	17.5	14.6	12.7		13.9	11.10	15.11.		17.1.	14.2.	14.3.
		Committee Date	23.4	28.5	25.6	23.7.		24.9	22.10	26.11.		28.1.	25.2.	25.3.
		Paper Lead	**Q1**			**Q2**			**Q3**			**Q4**		
Committee Business														
28.	Review and approve of **Terms of Reference**	Chair												•
29.	Review and approve of **Annual Work Plan**	Chair												•
30.	Review and approve **Quality Committee Subgroup Terms of Reference & Annual Work Plan**	Chairs of Subgroups	•											
31.	Informal Review of Committee Effectiveness	Led by Chair	•	•	•	•		•	•	•		•	•	•
32.	Formal Committee Evaluation	Chair												•

Schedule as required:

- Major investigations or reviews (internal of external to the Trust) relevant to finance & performance.
- Development of relevant strategic matters, prior to recommendation to Board

Appendix 4: Quality Committee Sources of Assurance

Item	Frequency	Sources of Assurance
Quality & Safety Integrated Performance Report	Monthly	**Quantitative** - Mortality: HSMR - Mortality: SHMI - Sepsis: Timely Recognition - Sepsis: Antibiotic Administration - Hospital Onset Covid Rate - C.Diff - MRSA - MSSA - E Coli - Medication Incidents - Serious Incidents - Never Events - Stroke (Overall SNNAP Level) - Falls Overall / Falls Moderate Harm or Above - Pressure Ulcers Category 2 / Category 3 and 4 - Written Complaints Rate - Complaints Timely Response **Quantitative** - ED 4 hour standard - ED 12 hour trolley waits - Cancer 62 day standard - Referral to Treatment: 52 week breaches - No Criteria to Reside

Maternity Services Report	Bimonthly	**Quantitative/Qualitative**
		- Maternity Continuous Improvement Plan progress – Incorporating evidence to support required submissions:
		  o CNST Year 4
		  o Saving Babies Lives (SBL)
		  o Continuity of Carer pathway (COC)
		  o Sustainability Plan
		  o Ockenden Report
		  o East Kent Report

Learning from Deaths		**Quantitative/Qualitative** - Learning from Deaths Policy & Process - Number of Learning from Deaths Reviews - High level themes and Trust's response - HSMR / SHMI
Patient Safety Report		**Quantitative/Qualitative**

Item	Frequency	Sources of Assurance
	Quarterly	- Number/Rate of Incidents – Highest Reporting Areas / Action Taken - Incident Trends / Action Taken - Serious Incidents / Compliance with Duty of Candour / Lessons learned / Prevention of Future Deaths Notice - Moderate/Severe Harm Incidents Trends - Harms associated with Timeliness of Care - Inquests - Prevention of Future Deaths - Medical Negligence – Claims/Cost - Employment and Public Liability – Claims/Cost - Complaints (Formal/Informal/PALS) – Number & Themes / Action Taken - Complaints Response Rate - Parliamentary and Health Service Ombudsman (PHSO) *(NB. Reporting to change in line with PSIRF)*
StARS Report		**Quantitative** - Number of assessments & ratings for all divisional clinical areas including ED, Theatres, Paediatrics, Community and Maternity - Rolling 12 month period **Qualitative** - Trends – Best Performing Standards / Areas for Improvement
Quality Strategy Progress Report	Biannual	**Quantitative/Qualitative** - Quality Priorities & Collaboratives Overview - Progress against metrics/measures determined for: o Start well – Improve the first 1,000 days of life o Live well – Reduce avoidable harm o Age well – Reduce avoidable harm o Die well with dignity – Improve the last 1,000 days of life
Patient, Family & Carer Experience Strategy Progress Report		**Quantitative/Qualitative** - Progress against Pledges/Objectives & Initiatives Overview - Internal/External Surveys: Friends & Family Test, iPad Inpatients Survey's, Care Opinion, National Inpatient Survey, Maternity Survey
Mental Health Plan Progress Report		**Quantitative/Qualitative** - Mental Health Awareness (Training) - Learning from Experience (Pathways of care for service users) - Collaboration (Improving the service user experience)
Infection Prevention Control Progress Report		**Quantitative** - Clostridium difficile (12 month rolling/SPC Chart/Benchmarking)

Item	Frequency	Sources of Assurance		
		- MRSA (12 month/Benchmarking) - MSSA (12 month rolling/SPC Chart/Benchmarking) - E coli (12 month rolling/SPC Chart/Benchmarking) - Blood Culture Contaminants (12 month)		
CQC Update		**Quantitative/Qualitative** - Processes to ensure compliance with CQC Standards - Progress against Action Plans		
External Visits & Inspections Register Report		**Qualitative** - Planned and unplanned external assessments, accreditations and inspections - Assurance regarding any findings, recommendations and action plans from development to sign off		
Annual National Inpatient Survey Report	Annual	Defined national inpatient survey		
Annual Infection Prevention Control Report		Annual Reports will reflect annual update on assurances considered in progress reports throughout the year		
Annual Complaints Report				
Annual Research & Innovation Report				
Annual Clinical Audit Report & Forward Programme				
Annual Health & Safety Report				
Annual Safeguarding Report				
Annual Quality Account		Defined by statutory requirements		
Subgroup Reports		*Key Issues Reports will provide update on the following matters, in line with the frequency determined in Subgroup Work Plans. The Key Issues Report will provide overview of matters considered, positive highlights of note, and matters of concern/key risks to be escalated.*		
Patient Safety Group	As per Group Schedule	Serious Incidents Sepsis VTE Organ Donation IPC Falls Nutrition & Hydration	Litigation & Claims End of Life Care Cancer Medicines Optimisation Quality & Safety Improvement Pressure Ulcers	Mortality / LfD Medical Examiner Deteriorating Patient Transfusion Resuscitation Maternity Improvement
Clinical Effectiveness Group		Clinical Audit StARS CQUINs 7 Day Services Maternity Dashboard	NICE Clinical Coding Quality Strategy Research & Innovation Healthy Child Programme	CAS Alerts GIRFT/Model Hospital NatSSIPs Screening
Patient Experience Group		Patient Feedback: Internal/External National Surveys Complaints PLACE		

Item	Frequency	Sources of Assurance
		Accessible Standards Volunteers Chaplaincy & Spiritual Care
Health & Safety Joint Consultative Group		Fire Safety Water Safety Medical Devices Emergency Preparedness Health & Safety Compliance Radiation Laser Protection
Integrated Safeguarding Group		Adult Safeguarding Learning Disability Children's Safeguarding Dementia & Delirium Mental Health Safeguarding Reviews

QUALITY COMMITTEE

TERMS OF REFERENCE

1. CONSTITUTION

1.1. The Board of Directors (the Board) hereby resolves to appoint a Committee, to be known as the Quality Committee.

1.2 The Quality Committee shall have terms of reference and powers delegated by the Board and is subject to such conditions, such as reporting to the Board, in accordance with any legislation, regulation or direction issued by the Trust.

1.3 Save where otherwise provided in these Terms of Reference, the Standing Orders of the Board apply to the proceedings of this Committee.

1.4 The Quality Committee's activities will support the development and delivery of the Trust's Strategy and Annual Plan.

2. PURPOSE OF THE COMMITTEE

The overarching purpose of Quality Committee is to:

2.1 Provide oversight and assurance regarding the operation of systems and processes to ensure the quality of care, encompassing patient safety, clinical effectiveness, and experience, provided to users of the Trust's services.

2.2 Support the Board in the development of strategy related to quality of care.

2.3 Ensure any associated risks, identified in relation to the above, are managed in accordance with the Trust's assurance framework and risk management arrangements.

2.4 To have oversight into the Trust's quality-related work with locality and system partners.

3. COMPOSITION & CONDUCT OF THE COMMITTEE

3.1 Membership

3.1.1 Core membership will comprise:

- Three named Non-Executive Directors, one of whom shall be the Chair
- Chief Nurse
- Medical Director
- Director of Operations

3.1.2 All statutory Directors are authorised to attend as members and take part in meetings of the Committee.

3.1.3 There is an expectation that members will attend all 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%.

3.1.4 Nominated deputies for Executive Directors may attend; however, this shall be in an advisory capacity only and attendance of a deputy shall not count towards the attendance level set out in 3.1.3.

3.1.5 The following shall also attend Committee meetings on a regular basis:
- Deputy Director of Quality Governance
- Deputy Chief Nurse
- Divisional Director of Nursing & Midwifery
- Head of Safeguarding
- Maternity Safety Champion
- Company Secretary

3.1.6 The Committee will invite other senior leaders to support specific matters, as required.

3.2. Chair

3.2.1 The Chair of the Committee will be a Non-Executive Director.

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 three committee members, provided that at least two of the attendees are Non-Executive Directors. Deputies in attendance do not count towards the quorum.

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, so as 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 The Committee shall meet at least 10 times per year.

3.5.2 The Chair may at times convene additional meetings of the Committee and/or request business that requires urgent attention is considered via email, for majority decision making. All decisions made via email will be confirmed at the next full meeting.

3.6. Administration

3.6.1 The Company 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 Quality Committee is authorised by the Board 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 independent legal or other professional advice where required, including the attendance of independent advisers at meetings of the Committee.

5. RESPONSIBILITIES

The responsibilities of the Committee are to:

5.1 Seek assurance on the effectiveness of systems and processes that exist to ensure quality of care. including patient safety, clinical effectiveness and patient & service user experience.

5.2 Review the levels of assurance provided from key performance indicators in relation to quality of care and monitor action/s to address any adverse trends.

5.3 Have oversight of compliance with the Care Quality Commission registration requirements and identify any risks that may prevent this, ensuring mitigations are in place and delivered.

5.4 Review compliance with statutory and regulatory requirements and make recommendation / confirmation to Board, as appropriate with respect to:
- infection prevention and control
- safeguarding
- maternity services
- health and safety

5.5 Ensure effective systems for learning are in place to drive change and support improvement in quality of care.

5.6 Review the delivery of clinical audit programmes and the implementation of learning resulting from such programmes.

~~5.7 Review the delivery of activities in place to actively seek feedback from people using services and ensure feedback supports service improvement.~~

5.8 Oversee the development of quality related strategies and recommend to the Board.

5.9 Oversee the implementation of quality related strategies, including progress against aims and objectives, and action being taken to address any adverse trends, including (but not limited to):
- Quality Strategy

- Mental Health Strategy
- Patient, Service User & Carer Strategy

~~5.10 Receive and review the outcomes of national and local patient surveys and associated actions.~~

5.11 Oversee preparation of the statutory Quality Accounts and any associated matters as required by the regulator (in association with Audit Committee).

5.12 Review the findings of major investigations or reviews (internal of external to the Trust) relevant to quality of care, as delegated by the Board or on the Committees initiative and consider management's response.

5.13 Review quality related risks from the Board Assurance Framework and associated significant risks from the Significant Risk Register and ensure that mitigations are appropriately actioned.

5.14 Review and approve the Work Plans and Terms of Reference of any group/committee that reports directly to the Committee.

5.15 Undertake or consider on behalf of the Chairman or the Board such other related tasks or topics as the Chairman or the Board may from to time entrust to the Committee.

The Committee will work in partnership with other Committees of the Board to address matters that impact on the responsibilities of several Committees.

6. RELATIONSHIP WITH THE BOARD OF DIRECTORS

6.1 The Committee will report to the Board 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.

6.3 Minutes of all Committee meetings are available to all members of the Board ~~on request~~.

7. RELATIONSHIP WITH OTHER GROUPS

7.1 The Committee shall have the power to establish sub-committees for the purpose of addressing specific tasks or areas of responsibility. In accordance with the Trust's Standing Orders, the Committee may not delegate powers to a sub-committee unless expressly authorised by the Trust Board.

7.2 The Committee will receive reports, in the form of Key Issues Reports, from the following:
- Patient Safety Group
- Clinical Effectiveness Group
- Patient Experience Group
- Health & Safety Joint Consultative Group
- Integrated Safeguarding Group

7.3 For the purpose of providing assurance regarding the controls in place for the management and mitigation of risks recorded on the Board Assurance Framework, the Committee (through its Chair) reports regularly to the Audit Committee.

8. REVIEW

8.1 The Committee will review its terms of reference and membership annually and recommend any changes to the Board 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.

Meeting date	4 April 2024	**Public**	X	**Agenda No.**	19.
Meeting	Board of Directors				
Report Title	Board Committee Assurance – Key Issues Reports				
Director Lead	Committee Chairs	**Author**	Soile Curtis, Deputy Company Secretary Rebecca McCarthy, Trust Secretary		

Paper For:	**Information**		**Assurance**	X	**Decision**	
Recommendation:	The Board of Directors is asked to: – Review the key issues and matters for escalation provided via the Board Committees – Receive the Maternity Services Report as reviewed and confirmed by Quality Committee, including matters for escalation highlighted within the Quality Committee Key Issues Report					

This paper relates to the following Annual Corporate 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
X	7	Develop our estate and digital infrastructure to meet service and user needs

This 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
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 February and March 2024.

NHS
Stockport
NHS Foundation Trust

KEY ISSUES REPORT	
Name of Committee/Group	People Performance Committee
Chair of Committee/Group	Mrs Beatrice Fraenkel, Non-Executive Director
Date of Meeting	14 March 2024
Quorate	Yes

The People Performance Committee draws the following key issues and matters to the Board of Directors' attention:

Item	Key issues and matters to be escalated
People Integrated Performance Report	The Committee received the People Integrated Performance report, which provided an update on appraisals, time to hire, turnover, agency expenditure and attendance. The Committee confirmed performance in relation to mandatory training and agency spend was within target, with all other metrics below target. It was noted, however, that performance had improved from last month for turnover.
Operational Plan Update	The Committee received a verbal overview on operational planning, acknowledging an emerging and challenging position given the national guidance was still awaited. The Committee heard that the submission deadline was 15 March 2024.
Staff Facilities	The Committee received a report providing an overview of staff facilities available on the Trust site, following concerns raised regarding the adequacy of the facilities. The report highlighted requirements from a regulatory perspective and the Committee heard that further assessment was required regarding the provision of toilet and hand washing facilities and out of hours access to rest and eating areas. Committee members welcomed the review of staff facilities and suggested that as well as the number and condition of facilities, the review should also consider accessibility issues. The Committee discussed other facilities that could be provided to ensure alignment with the Wellbeing Strategy, and in conclusion it was suggested that a project group, reporting to the Health & Wellbeing Group, should be established to explore the options further. The Committee discussed associated funding options, noting that some funding may be available through GM. It was suggested that the Charity Committee should review how funding could be accessed in a more agile and dynamic way. The Committee agreed to receive an update report in July.
Violence Prevention & Reduction Standard Update	The Committee received a report providing an update on progress made in relation to the violence prevention and reduction standards, including progress made against each section of the standards (Plan, Do, Check, Act), highlighting data on incidents related to behaviours, aggression and violence. The Committee heard that processes were in place to review, investigate and appropriately escalate incidents in line with policy, and that actions relating to gaps in indicators were reported to the Health & Safety Joint Consultative Group on a

Item	Key issues and matters to be escalated
	quarterly basis. The Committee noted a focus on the red indicators. The Committee agreed to receive an update report in September.
Annual Workforce Equality Monitoring Report	The Committee received an Annual Workforce Equality Monitoring Report, noting that public authorities were required to publish an annual report with information demonstrating compliance with Equality Duty. The report provided information on the Trust's workforce demographic during 2023, outlining staff in post, recruitment and staff turnover data, segregated between relevant protected characteristics. The report also summarised some of the key equality, diversity & inclusion (EDI) activity over the past 12 months. The Committee received and noted the Annual Workforce Equality Monitoring Report and approved it for publication on the Trust's website.
Gender Pay Gap Report	The Committee received a Gender Pay Gap Report 2022/23, noting that trusts were required to publish the following gender pay gap information on an annual basis: • Mean gender pay gap • Median gender pay gap • Mean bonus gender pay gap • Median bonus gender pay gap • Proportion of males and females receiving a bonus payment • Proportion of males and females when divided into four quartiles in comparison to the number of employees in terms of a) Lower b) Lower Middle c) Upper middle and d) Upper quartile. The Committee heard that the Trust's mean gender pay gap had reduced from 22.10% to 16.96% from last year, with the median pay gap fallen to -5.18%, now favouring women. The Committee received and noted the Gender Pay Gap Report and approved it for publication to the UK Government Portal and the Trust's website.
Consolidated Equality, Diversity & Inclusion (EDI) Action Plan	The Committee received an updated EDI Action Plan, which had been reviewed, consolidated and re-prioritised in light of the new NHS EDI Improvement and the NW Anti-Racism Framework Self-Assessment. The Committee heard that the consolidated EDI Action Plan included 71 actions, reduced from 150+ in the previous individual plans. The Committee heard that a self-assessment exercise had been undertaken with BAME colleagues across the Trust to validate those areas where the Trust was reporting good progress being made, noting that the resultant themes had been cross referenced with the action plan. The Committee received and noted the report and approved the consolidated EDI Action Plan.
Staff Survey	The Committee received the results of the 2023 National Staff Survey, noting an overall response rate of 43.49%, which was 1.12% higher than previous year. The Committee was pleased to hear that the Trust had performed best against the

Item	Key issues and matters to be escalated
	Staff Engagement theme in comparison to Greater Manchester peers, and had achieved the third highest score for the 'We are always learning' and 'We are a Team' themes in comparison to the North West benchmarking group. The Committee noted the following areas of strength: • Staff feel more positive about the Trust being a great place to work and receive treatment. • They are recognised and rewarded for the valuable contribution they make. • Line managers are more compassionate and supportive, and teams are working better together. • Staff have more opportunities to improve their knowledge and skills so they can reach their full potential. The Committee noted the following key areas of focus: • Helping colleagues to put into practice the learning from our Civility Saves Lives Programme and become a more civil and respectful place to learn, develop and work. • Improving appraisal discussions ensuring they are two-way, meaningful and better inform learning and development. • Introducing new approaches to supporting career progression and taking positive action to eliminate discrimination and under representation. • Continue to support colleagues to improve their health and wellbeing and manage work pressures. The Committee welcomed the improved survey results and thanked colleagues for their hard work in this area, albeit acknowledging that further work was required to improve the response rate.
Freedom to Speak Up Annual Self-Assessment	The Committee received the Freedom to Speak Up (FTSU) Annual Self-Assessment. The Committee heard that each year the National Office of the FTSU Guardian recommended that NHS organisations undertake a self-reflection exercise, assessing themselves against a number of statements set out in a reflection and planning tool. The Committee received the outcome of the assessment, which had been completed by the FTSU Guardian and Executive and Non-Executive Director leads, acknowledging improvements made over the past year and focus areas for 2024/25. It was noted that the self-assessment toolkit would be presented to the Board of Directors in April 2024. The Committee welcomed the toolkit and thanked the FTSU Guardian for her energy and passion in improving the speaking up culture. The Committee thanked the Director of Communications & Corporate Affairs for her support, noting that this would be her last PPC meeting, and highlighted the need for a continued review of FTSU capacity and resource requirements to ensure these remained appropriate. The Committee received and noted the annual Freedom to Speak Up self assessment and forward plan, and recommended its presentation to the Board of Directors.

Item	Key issues and matters to be escalated
People Performance Committee Annual Review (inc. review of Terms of Reference and Work Plan 2024/25)	The Committee received the People Performance Committee Annual Review 2023/24. The Committee: • Reviewed and supported recommendation of the following to the Board of Directors for approval: - People Performance Committee Annual Review confirming the effective operation of the Committee in line with its Terms of Reference - People Performance Committee Terms of Reference - People Performance Committee Work Plan 2024/25
Subgroups' Terms of Reference and Work Plans for Approval	The Committee reviewed and approved the Terms of Reference and Work Plans 2024/25 of the following subgroups: - People Engagement & Leadership Group - Equality, Diversity & Inclusion Group - Educational Governance Group
Board Assurance Framework and Aligned Significant Risks	The Committee received a report detailing the current position of the three principal risks assigned to the People Performance Committee. The Committee heard that a management review of the risks had taken place, and subsequently the consequence and likelihood had been scored, with current and target risk scores identified. The Committee reviewed and approved the people related principal risks to be presented as part of the Board Assurance Framework 2023/24 to Board of Directors in April 2024.
Standing Committees	The Committee received and noted the following key issues reports: • People Engagement & Leadership Group • Equality, Diversity & Inclusion Group
Any Other Business	The Committee heard that Mr David Hopewell, Non-Executive Director, would replace Dr Marisa Logan-Ward, Interim Chair, on the People Performance Committee. While it was noted that Dr Marisa Logan-Ward would retain the Wellbeing Guardian role, it was agreed that the Wellbeing Guardian Report would go straight to the Board.

NHS Stockport NHS Foundation Trust

KEY ISSUES REPORT	
Name of Committee/Group	Finance & Performance Committee
Chair of Committee/Group	Mr Anthony Bell, Non-Executive Director
Date of Meeting	15 February 2024
Quorate	Yes

The Finance & Performance Committee draws the following key issues and matters to the Board's attention:

Item	Key issues and matters to be escalated
Finance Report – Month 10 Position	The Committee heard that overall, the Trust position at Month 10 was adverse to plan by £1.6m, with a forecast year-end deficit of £33.9m, which was adverse to the 2023/24 annual plan by £2.4m. The Committee noted the revised year-end forecast position, which had been agreed as part of the GM turnaround process. It was noted that the key reasons for the variance to plan in month related to industrial action, pay award, open escalation wards, elective recovery fund (ERF) estimated penalty as calculated by GM, ongoing depreciation income risk, other budget underspends and non-contract income above plan, enhanced staffing levels to support the high level of ED attendances, and enhanced care for patients with dementia and other continuing healthcare needs. It was noted that the Stockport Trust Efficiency Programme (STEP) plan for 2023/24 was £26.2m (£10.3m recurrent) and that the plan for Month 10 had been delivered (non-recurrently) and was in line with plan in month. The Committee noted a continued focus on recurrent delivery. The Director of Finance advised that ERF had been reported at Month 10 in line with national guidance, with an estimated under-performance of £1.0m. The Committee heard that the Trust had maintained sufficient cash to operate during January, but noted risks in this area and the assumption that the Trust would require revenue support at the end of Quarter 4 2023/24. The Committee heard that the Capital Plan for 2023/24 was £62.7m, and that the internal programme had been reduced following discussions with GM and remained under review. It was noted that at Month 10 expenditure was behind plan by £12.1m. The Committee acknowledged the following key risks to delivery of the financial plan: • Derbyshire ICB contract issues • Industrial action • ERF • Capital • Depreciation funding • Enhanced care for patients • Increased demand / additional cost of staffing cover • Outpatients B closure The Committee concluded that it did not yet have full assurance regarding the financial

	outturn, given the associated risks in this area, acknowledging that most of the issues were not in the Trust's control to resolve.
GM Finance & Performance Recovery	The Committee noted that an update had been provided to the February Board meeting following the Financial Performance Review Meeting held on 25 January 2024. The Committee received a report which summarised the Board discussion and provided an update on the latest position within the GM ICB turnaround work, noting that all associated actions were either in progress or complete.
Operational Performance Report	The Committee received the Operational Performance Report, including performance against the strategic core operating standards, 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 key Productivity, Efficiency & Transformation programmes. The Committee acknowledged the continued operational pressures and action being taken to improve performance. 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 for Emergency Department (ED) and Diagnostics performance. It was noted that the metrics had been adversely impacted by the BMA industrial action, resulting in significant elective cancellations. With regard to Urgent & Emergency Care, the Committee noted challenges in this area due to continued high attendance levels, higher acuity of patients and challenges to flow, and issues around no criteria to reside (NCTR), particularly for out of area patients. The Committee noted the establishment of a twice-weekly ED Performance Meeting to ensure greater grip and control in this area. The Committee noted a significant improvement in a number of areas, including theatre utilisation and cancer performance, which was particularly welcome in the context of ongoing operational challenges and strike action. It was noted that the achievement of the 76% ED target by year-end was based on assumptions and unless these were realised, the Committee did not have assurance that the target would be achieved.
Operational Planning 2024/25, inc. Capital Programme Update	The Committee received a presentation providing an update on operational planning preparations for 2024/25. Furthermore, the Committee noted updated planning assumptions and an interim guidance document. The Committee received an update on GM financial planning, noting a national focus on the underlying position and recurrent savings. The Committee acknowledged the continued planning challenges, given the formal planning guidance was still awaited.
Procurement Contracts for Approval	The Committee received a report detailing procurement processes in progress over £750K and recommended the extension of the Water Contract to the Board of Directors for approval.
Standing Committees	The Committee received and noted the following key issues report: • Capital Programmes Management Group

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KEY ISSUES REPORT	
Name of Committee/Group	Finance & Performance Committee
Chair of Committee/Group	Mr Anthony Bell, Non-Executive Director
Date of Meeting	21 March 2024
Quorate	Yes

The Finance & Performance Committee draws the following key issues and matters to the Board's attention:

Item	Key issues and matters to be escalated
Finance & Performance Committee Annual Review (inc. Terms of Reference and Work Plan 2024/25)	The Committee considered the Finance & Performance (F&P) Committee Annual Review 2023/24, including revised Terms of Reference and Work Plan 2024/25. The Committee discussed feedback received from Committee members regarding Committee effectiveness during the year, which recognised the positive challenge at Committee meetings with constructive interaction between attendees. Regarding opportunities for improvement, a continued and greater focus on assurance was recognised, with a request for improved Executive Summaries of reports to draw out key matters for attention or decision, highlighting where assurance can or cannot be provided, to avoid prolonged discussion. The Committee reviewed and supported recommendation of the following to the Board of Directors for approval: - Finance & Performance Committee Annual Review 2023/24 confirming the effective operation of the Committee in line with its Terms of Reference - Finance & Performance Committee Terms of Reference - Finance & Performance Committee Work Plan 2024/25
Operational Performance Report	The Committee received the Operational Performance Report, including performance against the strategic core operating standards, 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 key Productivity, Efficiency & Transformation programmes. The Committee acknowledged the continued operational pressures and action being taken to improve performance. 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 for Emergency Department (ED) and Diagnostics performance. It was noted that the metrics had been adversely impacted by the BMA industrial action, resulting in significant elective cancellations. The Committee acknowledged challenges relating to Referral to Treatment (RTT), with a significant backlog of RTT waits, noting that recovery was dependent on mutual aid, use of independent sector and/or a significant increase of internal capacity. It was noted that harm reviews continued to be considered through quality Committee. The Committee heard that a piece of work was being undertaken with the locality to understand drivers for the significant increase in A&E attendees.

	The Committee noted that while the Trust was not forecasting to achieve any of the four core standards, performance compared favourably against GM peers in a number of areas. The Committee also acknowledged year on year improvements and positive performance in areas such as theatre efficiencies and outpatients.
Finance Report – Month 10 Position	The Committee heard that overall, the Trust position at Month 11 was adverse to plan by £2.4m, with a forecast year-end deficit of £32.2m, which was adverse to the 2023/24 annual plan by £0.7m. It was noted that the Stockport Trust Efficiency Programme (STEP) plan for 2023/24 was £26.2m (£10.3m recurrent) and that the plan for Month 11 had been delivered (non-recurrently) and was in line with plan in month. The Director of Finance advised that Elective Recovery Fund (ERF) had been reported at Month 11 in line with national guidance, with an estimated under-performance of £1.1m. The Committee heard that the Trust had maintained sufficient cash to operate during February, but that revenue support would be received in March 2024. It was noted that the cash risk score had increased to 15 given the current plan position and position going into 2024/25. The Committee heard that the Capital Plan for 2023/24 was £62.7m, and that the internal programme had been reduced following discussions with GM and remained under review. It was noted that at Month 11 expenditure was behind plan by £16.1m. The Committee acknowledged the following key risks to delivery of the financial plan: • Outpatients B impairment • Derbyshire ICB contract issues • ERF • Industrial action • Revenue to capital transfers • GM capital envelope • Depreciation funding • Further unforeseen estate issues The Committee concluded that it did not yet have full assurance regarding the financial outturn, given the associated risks in this area, acknowledging that most of the issues were not in the Trust's control to resolve.
Operational Planning 2024/25, inc. Capital Programme Update McCarthy Rebecca 28/03/2024 17:31:14	The Committee received a presentation providing an update on the operational planning 2024/25 draft plan submission, noting that the formal planning guidance was still awaited. The Committee heard that the plan was caveated with a requirement for mutual aid, and the associated risks were acknowledged, including a risk relating to unfunded growth. It was noted that the workforce plan had been fully triangulated with the draft Cost Improvement Plan. The Committee acknowledged the significant challenges and risks relating to the 2024/25 capital position.

	The Committee received and noted the draft operational plan, acknowledging the caveats and uncertainty about the GM approach.
Cost Improvement Plan (CIP) / Stockport Trust Efficiency Programme (STEP)	The Committee received a presentation providing an update on Cost Improvement Plan (CIP) planning for 2024/25, as submitted within the financial plan on 19 March 2024. The presentation covered the following subject headings: • Approach taken to date • Requirements for reporting on efficiencies within the financial plan • Profiling of plan • Scheme detail within submission • Next steps. The Committee heard about national and regional expectations, work undertaken to date with divisions/corporate functions, noting that the draft plan was yet to go through the Quality Impact Assessment (QIA) / Equality Impact Assessment (EIA) approval process. The Committee noted the presentation and acknowledged that the CIP planning was still very early in process with a number of internal processes yet to be completed, including QIA/EIA approval.
Digital Business Case	The Committee recommended the Virtual Licensing Extension Business Case to the Board of Directors for approval.
Board Assurance Framework and Aligned Significant Risks	The Committee received a report detailing the current position of the 11 principal risks assigned to the Finance & Performance Committee, noting that a management review of the risks had taken place, and subsequently the consequence and likelihood had been scored, with current and target risk scores identified. The Committee heard that in recognition of the escalating business continuity incidents being managed due to the ageing estate, challenging capital in 2023/24 and anticipation of significantly constrained capital in 2024/25, it was proposed to increase risk scores for Risk 7.2 and 7.4 (relating to a fit for purpose estate and funding to support regeneration of the hospital campus respectively) from 16 to 20. It was noted that following the March Risk Management Committee, a review of the estates risks relating to backlog maintenance and specific buildings would be undertaken. This acknowledges the increasing business continuity incidents being managed, and significantly constrained capital as mentioned above, alongside impact of both patients and staff wellbeing. The Committee reviewed and approved the finance and performance related principal risks to be presented as part of the Board Assurance Framework 2023/24 to Board of Directors in April 2024.
Standing Committees	The Committee received and noted the following key issues reports: • Capital Programmes Management Group • Estates Strategy Steering Group • Digital & Informatics Group

KEY ISSUES REPORT	
Name of Committee/Group	Quality Committee
Chair of Committee/Group	Mary Susan Moore
	27th February & 26th March 2024
Quorate	Yes
The Quality Committee draws the following key issues and matters to the Board's attention:	

Item	Key issues and matters to be escalated
Patient Story February & March 2024	February - The Committee heard a story of positive experience of a patient in the Devonshire Unit. March - The Committee heard a letter written to the Trust from a patient who had experienced a positive outcome and experience following extended attendance at Out Patients A.
Any Other Urgent Business Verbal update Noise in Theatres as a result of building work March 2024	Concerns have been raised by Surgeons and theatre staff regarding unacceptable levels of noise during operating sessions as a result of the co-located building work of the Trusts Urgent Care Centre. Update was received by Chief Nurse, Medical Director and Director of Operations. Context was provided on the scale of the problem and individuals affected. Many factors influence when builders can and can't work and where possible work outside of theatre hours was accommodated. The committee was advised that regulations for building works, noise levels had not been breached. Assurance was provided that due process was being followed in respect of Datix entry and investigations for delays and cancellation of procedures with associated robust risk assessments carried out. Rescheduling of lists is considered where appropriate. Options for Mutual Aid to provide surgery at Wrightington Wigan and leigh NHS Trust are ongoing, however this would be reliant on patients and surgeons being willing to travel out of area. Where work is delayed resulting in an impact on the contract delivery timescales significant cost for the Trust are incurred. The committee was informed that an upcoming 'building breakthrough' is being considered for its impact and mitigations on business as usual. The Chair of Quality Committee agreed to triangulate with the Chair of Finance and Performance Committee to consider financial and performance impact monitoring going forward.
Patient, Family & Carer Experience Strategy Progress Report February 2024	The Deputy Chief Nurse Presented provided an update on themes. • Communication • Staff attitudes/values and behaviours • Waiting times • Noise at night • Information The Committee noted further work required against to consider assurances in

	respect of family and carers Strategy and anticipated metrics. The Deputy Chief Nurse informed the meeting that that a Patient Experience Dashboard was in development.
Patient Safety Report Q3 2023/24 Including Patient Safety Incident Framework Policy (PSIRF) Final March 2024	Deputy Director of Quality Governance presented this Q3 report. This provided positive assurance on lessons learned and improvements to practice implemented from incidents, inquests, claims and complaints reported via Datix. Further clarity was sought on a number of incidents and it was noted that consideration was being given to outsource some Histopathology reporting to reduce delay in reporting. Reassurance form the Medical Director that the Risk stratification process is not affected. Discussion on a lost to follow up incident highlighted further work ongoing on the interoperability of systems to reduce reliance on human factors to identify these. It is being managed via the Risk Register. A review is underway by all specialities , of patient with no future appointments, action plans are monitored through Serious Incident review Group PSIRF will go live at the end of March. March 2024 The plan has previously been approved by Board in August 2024, and this policy supports the move away from the Serious Incident Framework (SI's) and clearly articulates process and roles. Less clear is the role of the Board with the demise of the CCG's who previously held responsibility for sign off of SI's. It was agreed that the Board holds ultimate responsibility for PSIRF sign off.
Readmission Rates February and March 2024	This report was deferred from Februaries meeting and presented by Director of Operations at the March meeting. The data presented evidenced an improvement and downward trend of readmissions from 2020/21, with most recent data showing most months below the average. A discussion was had on understanding further where planned discharges failed and the patients and families experience of discharges not happening on the day planned.
Quality & Safety Integrated Performance Report February and March 2024	**Quality & Safety Integrated Performance Report (IPR)** Quality Committee reviewed the Integrated Performance Report, which included specific update on quality and safety metrics that were not achieving target, alongside areas of sustained improvement and that were not covered elsewhere on the agendas. The Medical Director confirmed sepsis: antibiotic administration remained below target and reaffirmed the improvement work underway with AQUA and the Trust was awaiting feedback on AQUA data collection. The Medication Incidents metrics were discussed and how the narrative reflected the (low number) of incidents and the value the metric gives given that there is thorough review of such incidents through Incident review process. The Q&S performance report will be reviewed for non-statutory and exception reporting going forward.
Maternity Services Report & Local	Update received on key maternity improvement work streams including: Maternity Services

Maternity and Neonatal System (LMNS) Safety Assurance Return **March 2024**	**Highlight Report** The Maternity services highlight report incorporates an update on a number of the elements the service is currently working towards, including: • CNST Year 5 • Saving Babies Lives Care Bundle V3 • 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) • Perinatal quality surveillance dashboard highlight reports The update also includes an overview of Stockport's performance across GMEC using the Quality surveillance toolkit, ongoing work with the MVP, Midwifery staffing, overview of incidents, Harm and risk, Equality and Equity plan, Perinatal mental health, StARS and maternity and perinatal safety champions. Compliance with all the above are on track for compliance with mandated time line assured. A positive visit by our LMNS took place in March with positive feedback on the day. We await our CNST year 6 standards going forward. Our CNST declaration of compliance was submitted on 1st February 2024, with no subsequent requests for information, the feedback report is awaited.
Staffing Approval Group (SAG) & Quality Impact Assessment Assurance March 2024	The context of this item is regarding assurances on quality and safety of services against the financial *Grip and Control* requirements of the financial positions of the Trust and the GM ICB. The Terms of Reference for the SAG were shared with Quality Committee and will also be shared with each of the Board Committees, alongside the Quality Impact Assessment (QIA) process, a key feature of the Stockport Trust Efficiency Programme (STEP) (CIP) to assess impact of schemes to service delivery or patients or staff. The QIA process was also shared and discussed with the Board of Directors on 7th March 2024, when receiving update on the development of CIP Plan for 2024/25. There was positive assurance that the weekly SAG meetings were attended by senior and appropriate Directors and that they had the capacity to so. There was assurance that the QIA process was compliant and working well. The QIA process has also been included as a control in Principal Risk Number: PR1.1
Key Issues Reports February & March 2024	Regular key issues reports received, reviewed, discussed and confirmed/noted. Many of the exceptions from the subcommittees are explored in detail during the main agenda of the Quality Committee. • **Health & Safety Joint Consultative Group (JCG) – Key Issues Report (February & March)** • **Patient Safety Group Key Issues Report (February & March)**

	• **Trust Integrated Safeguarding Group – Key Issues** • **Report** (February) • **Patient Safety Group Key Issues Report (February & March)** • **Patient Experience Group Key Issues Report (February &March)** • **(March)** • **Clinical Effectiveness Group Key Issues Report (March)**

NHS Stockport NHS Foundation Trust

Meeting date	**26th March 2024**	**Public**	X	**Agenda No.**	09
Meeting	Quality Committee				
Report Title	Maternity Services Update				
Director Lead	Andrew Loughney, Medical Director Nic Firth, Chief Nurse	**Author**	Sharon Hyde, Divisional Director of Midwifery Rachel Alexander-Patton, Deputy Head of Midwifery		

Paper For:	**Information**		**Assurance**		**Decision**	
Recommendation:	Quality Committee will receive regular updates on Maternity services by way of a highlight report. The group is asked to note progress.					

This paper relates to the following Annual Corporate 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
x	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
	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 Maternity services highlight report incorporates an update on a number of the elements the service is currently working towards, including:

- CNST Year 5
- Saving Babies Lives Care Bundle V3
- 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)
- Perinatal quality surveillance dashboard highlight reports

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

Annex A is a summary presentation of progress under each area of the plan.

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

Maternity Services Highlight Report

Quality Committee
26th March 2024

Maternity Services Highlight report

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

- CNST Year 5
- Saving Babies Lives Care Bundle V3
- Midwifery Continuity of Carer pathway (MCOC)
- Ockenden Reports (2020/2022)
- East Kent Report (2022)
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- Pregnancy Loss review (July 2023)
- Perinatal quality surveillance dashboard highlight reports

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

MIS CNST Year 5

Stockport NHS Foundation Trust

Year 5

- CNST paper presented at Quality Committee Tuesday 23rd January 2024
- Completed board declaration successfully submitted to NHSR by **12 noon** on **1 February 2024**
- **CNST Year 6 expected to be published and shared April 2024**

MIS CNST Year 5

Following on from the board declaration submission for CNST YR 5 the division will continue to submit papers in accordance with CNST YR 5 reporting requirements. It is anticipated that CNST YR 6 will be published in April 2024, where a review of the reporting requirements will take place.

- There is an ask that the below reports relating to safety actions from CNST Year 5 are reported to board monthly or Quarterly, it is the exception that if board meetings are held bi monthly then this is sufficient to meet the standards.
  - Safety Action 1 – PMRT Quarterly audit report – Standing agenda item on Quality Committee work plan
  - Safety Action 9 - All six requirements of principle 1 of the Perinatal Quality Surveillance model
  - Safety Action 9 - To use a locally agreed dashboard to include, as a minimum:
    1. Findings of review of all perinatal deaths
    2. Findings of review all cases eligible for referral to MSNI
    3. Number of incidents logged as moderate or above
    4. Report on training compliance in line with core competency framework
    5. Minimal staffing overview
    6. Service User Voice feedback
    7. Staff feedback from frontline champions and walk about
    8. MSNI/NHSR/CQC or other organisation with a concern or request for action directly with trust
    9. Coroner Reg 28 made directly to Trust
  - Safety Action 10 – Evidence that 100% of qualifying cases have been reported to MSNI, including evidence that families have received information on the role of HSIB and EN scheme, and duty of candour.

Safety Action 9 - Perinatal Quality Surveillance model
Six requirements to strengthen and optimise board oversight for maternity and neonatal safety

Stockport NHS Foundation Trust

Six Requirements	Where reported	RAG
To appoint a non-executive director to work alongside the board-level perinatal safety champion to provide objective, external challenge and enquiry.	Maternity and Women's Health governance + Risk Women's and Children's Quality Group Patient Safety Group Quality Committee	
That a monthly review of maternity and neonatal safety and quality is undertaken by the trust board.	Maternity and Women's Health governance + Risk Women's and Children's Quality Group Patient Safety Group Quality Committee	
That all maternity Serious Incidents (SIs) are shared with trust boards and	Maternity and Women's Health governance + Risk Women's and Children's Quality Group Patient Safety Group Quality Committee	
To use a locally agreed dashboard, drawing on locally collected intelligence to	Maternity and Women's Health governance + Risk Women's and Children's Quality Group Patient Safety Group Quality Committee	
Having reviewed the perinatal clinical quality surveillance model in full, in collaboration with the local maternity system (LMS) lead and regional chief midwife, formalise how trust-level intelligence will be shared to ensure early action and support for areas of concern or need.	LMNS Safety SIG meetings LMNS Dashboard SIG meetings LMNS Perinatal Loss SIG meeting	
To review existing guidance, refreshed how to guides and a new safety champion toolkit to enable a full understanding of the role of the safety champion, including strong governance processes and key relationships in support of full implementation of the quality surveillance model.	Maternity and Perinatal safety champions meetings and walk rounds held BI-monthly in line with guidance. Staff feedback provided through discussion, posters, newsletters	

Safety Action 9
1) Findings of review of all perinatal deaths using the real time monitoring tool

NHS Stockport NHS Foundation Trust

Case ID	Date of birth	Date of death	Standard 1a All cases to be reported within 7 days.	Standard 1b 95% of parents should have been advised of the review and perspectives of care sought.	Standard 1c Review started within 2 months of reporting.	Standard 1c a minimum of 60% of multi-disciplinary reviews should be completed to the draft report stage within four months of the death	Standard 1c Final report to be published within six months.
88292	08/07/2023	08/07/2023	Reported day 1	Standard Met	Standard Met	Due 08/11/2023	Due 08/01/2024
88525	18/07/2023	20/07/2023	Reported day 2	Standard Met	Standard Met	Due 20/11/2023	Due 20/01/2024
88715	29/07/2023	29/07/2023	Reported day 3	Review not supported as Termination of pregnancy	N/A	N/A	N/A
88988	20/08/2023	20/08/2023	Reported day 0	Review not supported as Termination of pregnancy.	N/A	N/A	N/a
89534	22/09/2023	22/09/2023	Reported day 2	Standard Met	Standard Met		
89714	03/10/2023	03/10/2023	Reported day 1	Standard Met	Standard Met	03/02/2024	03/04/2024
89812	11/10/2023	11/10/2023	Reported day 0	Standard Met	Standard Met	11/02/2024	11/04/2023
90374	11/11/2023	11/11/2023	Reported day 2	Standard Met	Standard Met	15/03/2024	15/05/2024
91372	13/01/2024	13/01/2024	Reported day 1	Review not supported as Termination of pregnancy	N/A	N/A	N/A
91371	14/01/2024	12/01/2014	Reported day 2	Standard Met	Standard Met	14/03/2024	14/05/2014

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- Quarterly PMRT audits and action plans are undertaken and are shared through Maternity and Women's health governance and risk meeting, Women and Children's Quality Group, Patient Safety Group and Quality Committee

Safety Action 9
2) Findings of review all cases eligible for referral to Maternity & Newborn Safety Investigations (MSNI)

NHS Stockport NHS Foundation Trust

HSIB cases reported from the introduction of MSNI to 29th February 2024

Cases 29th February 2023	
Total referrals	19
Referrals / cases rejected	5
Total investigations to date	14
Total investigations completed	12
Current active cases	2

Current investigations

Case number	Referral date	Category	Current status	Next steps
MI-030216	20 July 2023	Neonatal death	Final report accepted at Serious incident review group. 0 recommendations identified	PM report remains outstanding, this will be included in the report and acknowledged once complete
MI-034605	4 October 2023	Intrapartum stillbirth	Draft report received for factual accuracy	Comments to be returned to MNSI by 7th March
MI-035331	18 October 2023	HIE/Cooling	Staff interviews planned for first two weeks in Feb	Staff interviews

Safety Recommendations to date

In total to date the Trust have received 18 safety recommendations from 11 completed MSNI investigations.

The categories include:

- Documentation
- Clinical attendance and guidance
- Clinical assessment and guidance
- Escalation
- Quality assurance

Three reports did not have any safety recommendations.
All safety recommendations have been addressed by a multi-disciplinary agreed action plan.
All actions are closed, the last report was received in January 2024 with 0 safety recommendations

Safety Action 9
3) Number of incidents logged as moderate or above

NHS Stockport NHS Foundation Trust

Hospital	Stockport NHS Foundation Trust		
Reporting Period (Month/Year)	February 2024		
Total Number of Moderate or above (Level 3) Incidents validated. *(Use an * next to the number if any are unvalidated).*	0	Diverts - • Number of diverts. • Number of women affected. • Any serious incidents reported due to the divert	Diverts: 0 Women affected: 0 Incidents: 0
		Deflections - • Number of deflections • Number of women affected. • Any serious incidents due to the deflection	0
Stillbirths	0	Babies Born <27 weeks gestation in < level 3 unit. *Include gestation and reason for birth outside NICU*	0
Neonatal Death	0	Number of Babies born at home midwife not present	1 (P1 precipitant labour, NWAS)
Total number of StEIS Incidents (for month)	0	Number of babies born in other location midwife not present	0
		How many outstanding incidents do you have? Do you have any delays in processing moderate and serious incidents?	Obstetrics Outstanding: 67 Delays: No issues highlighted

Safety Action 9
3) Number of incidents logged as moderate or above

Stockport NHS Foundation Trust

Lessons learnt/themes from any StEIS/72-hour report for sharing.
Please use this section to describe learning/themes from any of your StEIS incidents that could be useful across the GMEC Maternity providers:
No reports received for February

Recommendations from MNSI cases
Please use this section to describe learning from your incidents that could be useful across the GMEC Maternity providers from HSIB cases:
Final report from MNSI received – waiting PMRT & Inquest date prior to sharing. **NND - 2 day old baby found unresponsive at home, no recommendations made**

Themes (from incidents overall, including lower than level 3 - any themes that have been identified)

Incident Category	Description of incident & number of incidents in this category	Actions/learning/ QI work to target themes
Term admissions	There were 7 term admissions to neonatal unit reported.	All cases are reviewed at our ATAIN meeting and themes presented. TC provision and re-launch, education to teams were the main themes for Feb.
Communication	Handover/conflicting decisions making	Themes added to safety huddles, shared with obstetric team members.
Declined in-utero transfers	Declined in-utero transfer – staff/acuity	Inpatient matron reviewing all cases and themes.

Complaints

Number received	3 formal complaints received in February	Number of complaints outstanding	9 on-going
Description of complaint		**Actions/Learning/QI work**	
1. Delay in diagnosis 2. Care concerns 3. Staff attitude		Investigations on-going	

NHS Stockport NHS Foundation Trust

There are 11 risks on the obstetric risk register

Capacity and Demand	**3**
IT Systems	1
Environment	1
Security	1
Medication related	1
Equipment	1
Staffing	1
COSHH related	1
Information Governance	1

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There is one risk on the register which scores 12 – there is a risk of not being able to meet the recommendations of safe staffing within the maternity unit.

Safety Action 9
3) Number of incidents logged as moderate or above

NHS Stockport NHS Foundation Trust

Risk ID	Risk Register Type	Risk Subtype	Specialty / Department	Risk Owner	Risk Manager	Division	What is the risk?	Opened (date risk identified)	Next Review Date	Risk level (Residual Risk)	Residual Rating	Risk level (Risk Appetite)	Risk Appetite	Trend	Last updated	Closed date
2565	Divisional Risk	Staffing	Obstetric	Mrs Sharon Hyde	Mrs Sharon Hyde	Women and Children	There is a risk of not being able to meet the recommendations of safe staffing within the maternity unit.	27/07/2023	12/03/2024	Moderate Risk	12	Moderate Risk	6	New Risk	Mrs Sharon Hyde 12/12/2023 12:49:53	
893	Divisional Risk	Capacity and Demand	Obstetric	Miss Sarah McManus	Mrs Sharon Hyde	Women and Children	This is a risk of poor quality and unsafe care provision relating to delayed induction due to the increased induction rate.	02/01/2019	13/04/2024	Moderate Risk	9	Moderate Risk	6	No Change in Risk Score	Miss Sarah McManus 18/01/2024 13:38:18	
2558	Divisional Risk	Information Governance Risk	Obstetric	Stephanie Bray	Rachel AlexanderPatton	Women and Children	This is an information governance risk assessment for the functionality and data quality of Euroking.	12/07/2023	18/02/2024	Moderate Risk	6	Low Risk	4	New Risk	Stephanie Bray 18/01/2024 16:01:04	
2572	Divisional Risk	Capacity and Demand	Obstetric	Mrs Jane O'Brien	Mrs Jane Armstrong	Women and Children	This is a risk assessment for the unavailability of inpatient DSNs to review patients within maternity.	31/07/2023	14/02/2024	Moderate Risk	9	Moderate Risk	6	No Change in Risk Score	Marie Dooley 14/11/2023 21:33:30	
2326	Divisional Risk	Equipment	Obstetric	Miss Sarah McManus	Mrs Sharon Hyde	Women and Children	This is a risk assessment regarding the manufacturing issue with fetal fibronectin cassettes.	09/12/2022	12/04/2024	Moderate Risk	6	Low Risk	3		Miss Sarah McManus 11/10/2023 11:17:50	
2323	Divisional Risk	Medication Related	Obstetric	Miss Sarah McManus	Mrs Sharon Hyde	Women and Children	This is a risk assessment for uterotonics not stored in a locked cupboard or fridge as per trust drug storage policy	29/11/2022	29/05/2024	Moderate Risk	6	Moderate Risk	6	New Risk	Miss Sarah McManus 12/12/2023 13:06:31	
2262	Divisional Risk	IT Systems	Obstetric	Stephanie Bray	Mrs Sharon Hyde	Women and Children	Document export from MIS to Advantis and out to GP/Health visiting service. ("search for" and duplicates)	30/08/2022	18/03/2024	Moderate Risk	9	Low Risk	3		Stephanie Bray 18/01/2024 15:44:39	
2475	Divisional Risk	COSHH related (Control of Substances Hazardous to Health)	Obstetric	Rachel AlexanderPatton	Mrs Sharon Hyde	Women and Children	There is a risk that midwives and are exposed to high levels of nitrous oxide when caring for women using entonox for analgesia.	30/03/2023	30/03/2024	Low Risk	4	Low Risk	4	Decrease in Risk Score	Mrs Jaine Jennings (BG) 31/07/2023 16:49:51	
2016	Divisional Risk	Security (including Lone Worker, Security Audit, Violence & Aggression)	Obstetric	Matron Louise Burns	Mrs Sharon Hyde	Women and Children	staff within the Women's and Children's Division on occasion being a lone worker	24/09/2021	23/09/2024	Moderate Risk	6	Moderate Risk	6	No Change in Risk Score	Marie Dooley 27/09/2023 16:15:38	
1977	Divisional Risk	Capacity and Demand	Obstetric	Miss Sarah McManus	Mrs Sharon Hyde	Women and Children	This is a risk assessment for being unable to complete all Newborn and Infant Physical Examinations within the recommended 72hrs	22/07/2021	15/03/2024	Moderate Risk	6	Low Risk	3	No Change in Risk Score	Miss Sarah McManus 13/12/2023 16:00:22	
2458	Divisional Risk	Environment	Obstetric	Ms Kati Morrey	Mrs Kelly Curtis	Women and Children	There is a risk with regards to lack of capacity to store maternity notes	10/03/2023	28/04/2024	Low Risk	4	Low Risk	2		Marie Dooley 09/05/2023 11:53:09	

Safety Action 9
4) Report on training compliance in line with core competency framework

NHS Stockport NHS Foundation Trust

The below table demonstrates compliance up to 7/12/23 against the core competency framework in line with CNST YR 5 requirement. The next Quarterly submission data will be available for April report. The table demonstrates compliance has been met in all required competency across the MDT to achieve CNST YR 5. In April 2024 the Maternity training team will be launching an updated version of all training requirements

Core Competency Number	Core Competency	Type of Training	Sept - Dec 2023 (NB 7/12/23) (Submit to LMNS by 31.1.24)
1	SBL		**Percentage of staff compliant as of 7/12/23**
	Element 1 : Smoking	Face to face training	Midwives 93% Obstetricians 94% Other 66%
		NCSCT E-learning	Midwives 100% Obstetricians 87% Other 99%
		Risk Perception Training for ANC staff	TBA
	Element 2 : Fetal Growth Surveillance	E-learning for Health Module	Midwives 100% Obstetricians 87%
		Serial Fundal Height Face to face training and competency	Midwives 86% Obstetricians 100%
		Face to face training	Midwives 92% Obstetricians 91%
	Element 3: Reduced Fetal Monitoring	E-learning for Health module	Midwives 100% Obstetricians 87%
		Face to face training	Midwives 92% Obstetricians 96%
	Element 4: Fetal monitoring	see Core Competency 2	
	Element 5 : Preterm Birth	E-learning for Health module	Midwives 100% Obstetricians 87%
		face to face training	Midwives 92% Obstetricians 91%
	Element 6 : Diabetes in Pregnancy	Face to face training & e learning	Midwives 85%
2	Fetal Monitoring GMEC Package: Full day Fetal monitoring training to include CTG, Antenatal and Intermittent Auscultation	Face to face training	Midwives 92% Obstetricians 91%
	CTG competency	GMEC Competency document	Midwives 98% Obstetricians 91%
	Intermittent Auscultation Competency	GMEC Competency document	GMECMidwives 100% and ELFH Midwives 100%
3	Maternity Emergencies - Multidisciplinary Team - Full day	Face to face training	Midwives 97% Obstetricians 94% Anaesthetics 95% Other 97%
4	Equality, Equity and Personalised Care	Face to face training	Midwives 97% Obstetricians 94% Other 97%
5	Care during Labour and Immediate Postnatal Period	Face to face training	Midwives 97% Obstetricians 94% Anaesthetics 95% Other 97%
6	Neonatal Basic Life Support	Face to face training	Midwives 97% APs 100%

Safety Action 9
5) Minimal staffing overview

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 Maternity position

	WTE Actual	Number of WTE Vacancies	Post WTE Recruited to TRAC
Registered Midwives	160.48 (Including B8 and above)	22.02.2024 Vacancy 4.11 wte Maternity Leave 13.24wte	2.6wte Accepted and awaiting start dates

Obstetrics cover

- 24/7 Consultant obstetric cover on delivery suite
- 2/day 7 day/week Consultant ward rounds in place

Challenges

- Current registered vacancy inclusive of Inpatient and outpatient area's 4.11wte, in addition to this there is currently a gap of 13.24wte on Maternity leave (2.2 wte due back April 24 – June 24). This equates to a total deficit of 17.35wte.

- **Actions**
- Weekly planned roster scrutiny meetings/E.Roster training sessions - continue
- Rolling advert for Band 5/6 midwives
- Plan to recruit to student midwives due to complete training Sept/Oct 2024

- **Assurance**
- All shift coordinators have supernumerary status.
- January showed we achieved 98.3% one to one care in labour
- Maternity Red Flags monitored and reported through division
- Fully engaged with Maternity support workers framework working group
- Recurrent funding confirmed for Recruitment and Retention Midwife, B6 preceptor Midwife and B3 Maternity Support worker retention post – Job descriptions under review
- Engaged with the International Educated Midwifery (IEM) recruitment programme. 3 commenced in post, 1 IEM arrived 28h Dec 23 awaiting arrival dates of an additional 1 IEM's
- Recruited to x2 Housekeeper, 4 MA roles and ward clerk

Safety Action 9
6) Service User Voice feedback

Stockport NHS Foundation Trust

MVNP Engagement

- 2024 MNVP meetings to be scheduled
- 15 steps to be rescheduled date to be confirmed
- MNVP guidance now published – Confirmed funding for 0.5wte MNVP lead post

MNVP Workplan – Key Priorities 2024/25

- Work collaboratively with the leads responsible for the Early pregnancy loss survey results and action plan
- Workplans to be created by MNVP leads, quadrumvirate and LMNS
- Service User recruitment to prioritise:
  - The voices of neonatal and bereaved families
  - The voices of Women from black, Asian and minority ethnic backgrounds
  - The voices of women living in high levels of deprivation
  - The voices in young parents.
- Community engagement with local network leads
- CQC Survey 2023 available to be jointly reviewed with MNVP lead
- Working collaboratively with Parent engagement lead

Safety Action 9
7) Staff feedback from frontline champions and walk about

The Maternity and Perinatal Safety Champions walk rounds take place Bi-monthly. Walk rounds for 2024 confirmed and diarised.

Board safety champions met with the perinatal quadrumvirate, meetings scheduled bi-monthly 2024 – Focus on SCORE survey to be undertaken across Maternity and Neonatal services

Next Maternity and Perinatal safety champions planned for Wednesday 10/04/2024 - 9.00 – 10.30

Andrew Loughney (MD) and Mary Moore (NED) are both registered to the FutureNHS workspace to access: *Safety Culture - Maternity & Neonatal Board Safety Champions - FutureNHS Collaboration Platform workspace*

Safety Action 10

NHS Stockport NHS Foundation Trust

8) HSIB/NHSRCQC or other organisation with a concern or request for action made directly with the trust

We have had 4 HSIB reportable cases in the qualifying period between 6th December 2022 to 7th December 2023
Two of the cases did not meet the criteria for reporting to NHSR
Statutory duty of candour has been adhered to in all required cases

9) Coroner Regulation 28 made directly to the Trust

None to report

Saving Babies Lives Care Bundle V3 (SBLCBv3)

NHS Stockport NHS Foundation Trust

Background

- 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 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.
- 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
- 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.
- LMNS have launched the SBLCBv3 Implementation tool on NHS Future platform to provide assurance against the compliance of all 6 elements and CNST YR 5 – First submission completed on 15th September. All evidence submitted to the LMNS 22nd December and second meeting took place on 8th January 24.

Saving Babies Lives Care Bundle V3 (SBLCBv3)

NHS Stockport NHS Foundation Trust

- To achieve CNST year 5 providers are required to demonstrate implementation of 70% of interventions across all 6 elements overall and implementation of 50% of interventions in each individual element.

Draft LMNS report shared – following meeting, on 8th January 2024

- Significant assurance received – action plan in place to support improved compliance
- Achieved CNST Year 5 Safety Action 6 standard
- Ongoing commitment to achieve full compliance by March 2024

Safety Action	Element	RAG CNST 1st Feb 24	RAG SBLCB V3 March 24
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		

CQC Feedback

- CQC inspection took place over 2 days on 29th + 30th September 2023
- Preliminary feedback session was held on 5th October with the Divisional director of Midwifery and Nursing, Divisional Director, Chief Nurse, Executive Director and Deputy Director of Quality Governance
- Final report remains outstanding – February 2024

Overview of findings

Positives

- We saw effective team working (confident and appropriate relationships with professional challenges).
- The service has recognized vulnerabilities and were working towards reducing inequalities throughout their maternity services
- We saw a positive culture with holistic positive person-centered care focusing on the needs of the woman, birthing people, and babies

Issues of potential concern and actions taken

Staff shortages.

Since September we have appointed and in post 12.88wte midwives across inpatient and outpatient areas, with an additional 1 wte Midwife to commence in post. There is a planned recruitment day to be held on 18th November for B5/6 midwives.

There was a lack of audit and monitoring around risk assessments in triage, a lack of audit and assurance regarding MEOWS.

In response to this an SBAR audit has been added to AMAT and is undertaken monthly across all inpatient area's and will be monitored through Maternity & Women's Health Governance & Risk Group. A MEOWS audit has been undertaken and the proforma is currently being added to AMAT

High Dependency on delivery suite, clarity required as some refer to it as Enhanced Care and others as HDU. Concerns not all staff are appropriately trained / competent to provide high dependency care on the delivery suite

The Care of the Critically ill woman in childbirth guideline has been updated to address the concerns raised, consistent terminology has been used throughout the document and has been ratified through labour ward forum

Midwifery Continuity of Carer (MCoC) Update December 2023

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 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
- A successful home birth service led from community and utilising an on-call system
- The increase in choice for place of birth at home also includes an increasing number of requests for birth outside of guidance and accompanying personalised plans of care to this effect
- Enhanced MCOC offer to the most vulnerable families including young parents and asylum seekers
- Building on the challenges experienced within the previous enhanced (CORA) model, this is no longer confined within a specific team and is spread across the community.
- Continued development of enhanced teams in line with the community hubs and the 1001 critical days agenda. The teams were split on the 11th Sept 23 into these targeted areas which include the most vulnerable families.

Midwifery Continuity of Carer (MCoC)

NHS Stockport NHS Foundation Trust

- The enhanced team currently consists of 3 WTE CMWS and a band 4 as support for early help & intervention and attendance at birth. There are plans to build the assistant practitioner capacity to support MCoC and the team

- Data is being collated to illustrate the positive affect this has begun to have on MCoC and moreover birth experience for both groups.

Local data

	November	December	January
Total Bookings	253	255	284
% Women in receipt of full MCOC	3%	0% Data not available	2 %
Homebirths With MW in attendance	1.8%	2.03%	2 %

Vision

- 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 (MCoC) This is within an integrated early years approach that begins in pregnancy.
- Early adopter sites have been identified in Adswood, Brinnington and Offerton to this effect and community teams have been aligned 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.
- Additional staffing resource to accommodate associated vulnerability within the team caseloads would enable MCoC including intrapartum care and advocacy, to be utilised as a key enabler to improving outcomes for high-risk families within the family hubs agenda.

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

NHS Stockport NHS Foundation Trust

The aim is to improve maternity outcomes and experiences for those women and people using maternity and neonatal services in GMEC who face inequality on the basis of their circumstances or protected characteristics, such as ethnicity, faith, belief, sexual orientation and disability.

- In response to national guidance 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. An action plan will be formulated to update the changes with a particular focus on priority 4 .

  - 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

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

NHS Stockport NHS Foundation Trust

- PROGRESS
- In June 2022 we produced a Standing Operating Procedure (SOP) titled Reducing inequality in Black Asian and minority Ethnic communities during the perinatal period

- The asylum seeker families currently receive enhanced care from a team of Midwives . However we do not currently have a Midwife specifically supporting the families and their needs as was previously the case

- Equity & Equality training is inclusive to the Mat Ed study day and the CMWS caring for the women within hotels will contribute to this to update staff on the challenges vulnerability & specific needs of pregnant asylum seekers when presenting in maternity services.

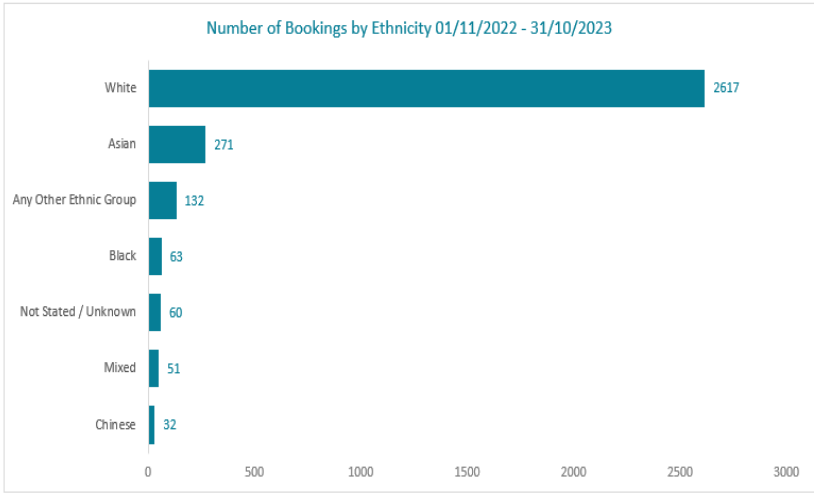
- We have recruited 3 International educated midwives, with an additional two due to commence March/April following completion of OSCE's

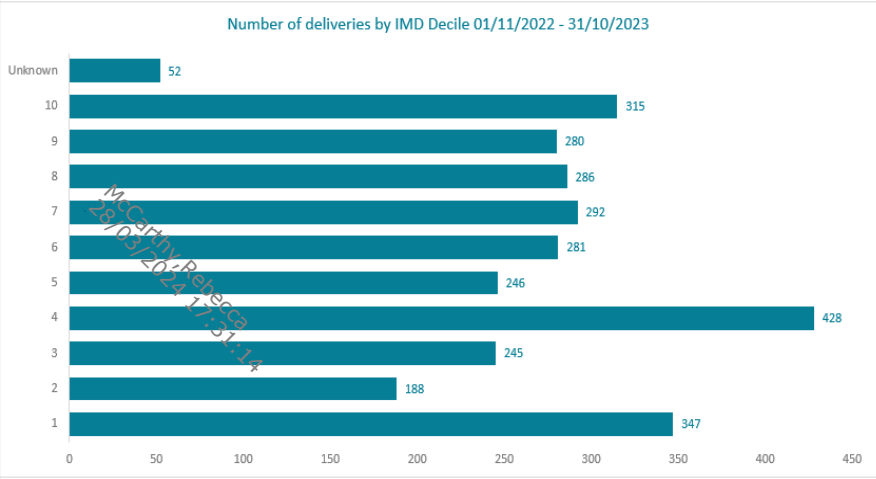
- The current integration work within the community focusing on 1001 critical days incorporates Midwives Health Visitors working together in the perinatal period using a joint assessment tool to identify risk and resilience around families. The 'My World assessment represents the voice of the family and specifically the infant. This is used to formulate a joint and robust plan which includes intervention at the earliest opportunity to improve outcomes for children and improve the their social and emotional health. This fulfils priority 4 addressing vulnerabilities of those most likely to face inequality

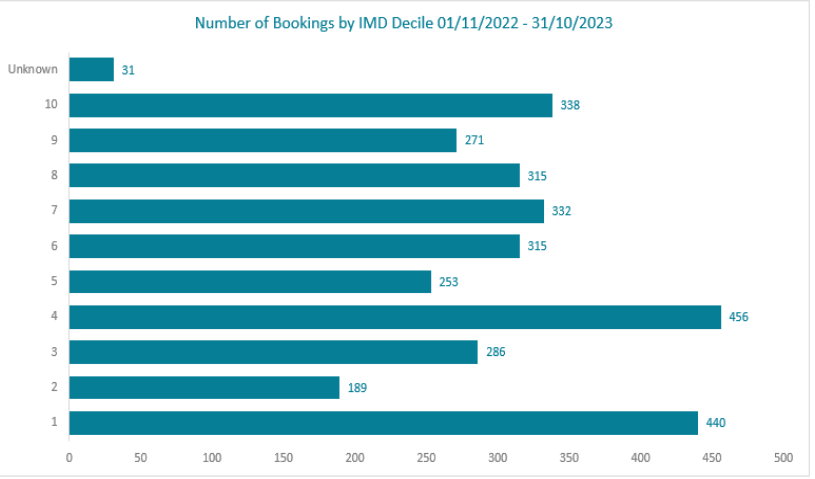
Equity and Equality demographics

NHS Stockport NHS Foundation Trust

Our service collects data monthly through the maternity data set system which enables mapping in relation to local deprivation utilising postcodes







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. The perinatal service is aligned to the wider infant parent mental health service within Stockport family.

- Stockport NHS Foundation trust have adopted the GMEC Perinatal Mental Health Guideline, and currently awaiting alterations to EK to include Parent Infant relationship.

- There are on average 80 targeted referrals for additional MH support during pregnancy each month which are RAG rated. These breakdown into Red Avg 8, Amber Avg. 28 Green Avg. 25 others including info only Avg. 19. All women within Red and Amber category are offered a face to face appointment.

- 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. Plans are in place to coordinate this with Health Visiting data systems to enable impact & comparative data analysis & follow up

- All women with moderate MH needs have a baseline PHQ9 & GAAD & assessment since 2023 – At each contact

- Families are prioritised within Stockport talking therapies for psychological support in the perinatal period. We have a link lead psychology practitioner who leads on infant parent mental health within the service

- Stockport fall within cluster 1 of the development of the specialist community perinatal MH services which ensures complex need is managed appropriately following referral

Perinatal Mental Health

Stockport NHS Foundation Trust

- All women with moderate and above MH issues during pregnancy are offered to create a personalised plan for care, during birth & PN.

- The perinatal mental health team continue to provide a 'Walk into wellbeing' initiative monthly to support wellbeing & positive mental health in communities and peer support.

- As part of the 1001 critical days work within Family Hubs a dad matters coordinator has been secured for Stockport (funded by PH & startwell) to focus on improving mental health & wellbeing of vulnerable dads. The offer will include additional universal outreach, 1:1 referral process, staff training & specific targeted work focussing on attachment, relationships & bonding within most vulnerable F uibs reach areas.

- Increasing dad friendly practice & support for dads MH will align with the integration of CMW & HV supported by Nesta. The joint my world assessment representing the voice of the child and both parents will be utilised to identify additional need & formulate plans in the perinatal period .

- MH team will work across Family Hub early adopter sites to enable networking & more support to midwives working with vulnerable families in the community (February 2024)

- Training dates for ST1/2's planned for the end of February with Rachel Owen and Perinatal Mental Health Lead Midwife

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
- Monthly Joint infant parent health meeting just re-established as face to face & which will include case discussion
- Fortnightly meeting with PNMHT Lead to discuss referrals.

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 quadrumvirate 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

Action Plan to be approved at Women's Health Risk and Governance meeting 6/12/23

Summary of findings

Out of the 20 immediate actions the trust are:

- Fully compliant with 6/20 recommendations
- Partially Compliant 6/20 recommendations
- Non – Compliant 8/20 recommendations, 3 out of 8 are awaiting an update from the government on how to proceed

Maternity Update – Maternity Red Flags

NHS Stockport NHS Foundation Trust

Maternity Red Flags

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

Maternity Update – Maternity Red Flags

During February 2024 there were 4 maternity staffing red flags reported via Datix

115813 – Missed breaks due to staffing levels on a night shift

115815 – Missed breaks due to staffing levels on a night shift

116548 – Delay in patient care on M2 due to staffing – delayed discharges

113868 – Triage relocated to delivery suite – Staffing

Maternity and Jasmine StARS overview

Stockport NHS Foundation Trust

Stockport Accreditation & Recognition System (StARS) is designed to measure the quality of care provided by individuals and teams throughout the Trust. It incorporates key clinical indicators and supports the standards in providing evidence for the Care Quality Commission's Fundamental Standards.

The framework considers 14 standards with each standard subdivided into the following 3 categories Environment, Care and Leadership.

Maternity inpatient areas have been included in the accreditation programme from November 2022 following the development of maternity specific standards. the results are highlighted below.

M2 achieved green ward accreditation on the recent StARS assessment

MATERNITY	Nov 22	Jan/Feb 23	May/June 23	August/Sept 23	December 23
M1 (DS)		1	2	3	
M2	1	2	3	4	
M3 (BC)		1	2	3	

Actions

- Action plans are in place for each area, overseen by the Divisional Director of Midwifery and the Deputy Head of Midwifery.
- Weekly divisional oversight meeting in place to review action plans, share progress and support each other.
- Action plans shared and discussed at directorate and divisional meetings.

Greater Manchester and Eastern Cheshire Strategic Clinical Network
Maternity Quality Surveillance

NHS Stockport NHS Foundation Trust

Lastest 12 months | Jan, 2023 | to | Dec, 2023

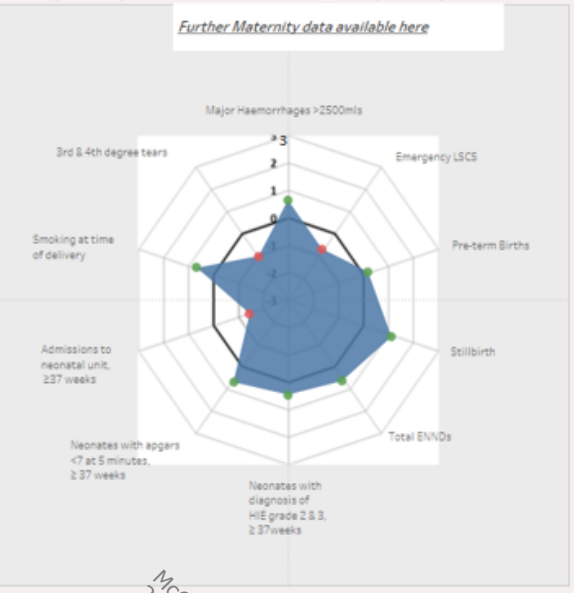
Stillbirth (per 1,000) 2.055

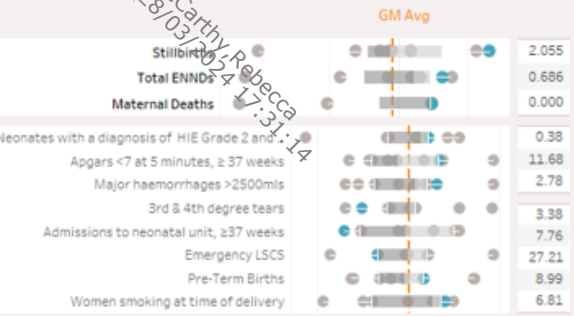
Early Neonatal Deaths (per 1,000) 0.686

HIE (per 1,000) 0.377

Maternal Deaths (per 1,000) 0.000

Further Maternity data available here





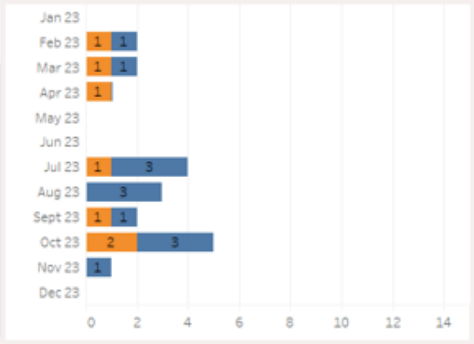
McCarthy, Rebecca 28/03/2024 17:31:14

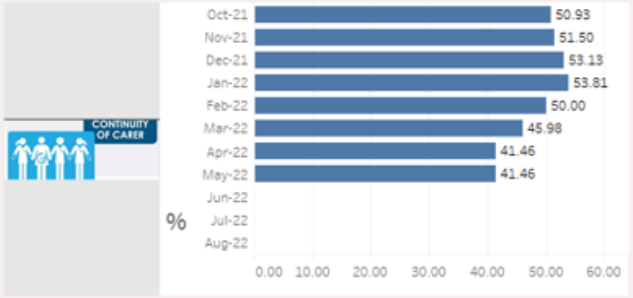
% Compliant as of Jan 2024:

Element 1	80%
Element 2	95%
Element 3	100%
Element 4	100%
Element 5	100%
Element 6	100%
All Elements	96%
CNST Met	Met

STEIS and Diverts
Total number of diverts
Total number of STEIS excluding diverts
Total 13 7

NHS Improvement





CONTINUITY OF CARER

Care Quality Commission — Requires Improvement

NHS Resolution
CNST MIS Status (Year 4):
10

SURVEYS

	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

NHS
Stockport
NHS Foundation Trust

Meeting date	26th March 2024	**Public**	**X**	**Agenda No.**	09
Meeting	Quality Committee				
Report Title	Local Maternity and Neonatal System (LMNS) Safety Assurance Return.				
Director Lead	Zoe Turner Divisional Director Women and Children's	**Author**	Sharon Hyde Divisional Director of Midwifery and Nursing		

Paper For:	**Information**		**Assurance**		**Decision**	
Recommendation:	The Quality Committee will receive the quarterly safety assurance return as required to be submitted to the LMNS. The committee is asked to note update on progress.					

This paper relates to the following Annual Corporate 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

x	Safe		Effective
	Caring		Responsive
	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	
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 2023/2024 demonstrating the Trusts level of implementation to date.

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

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 6th 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 48 of the 49 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 1 question is currently not compliant. A summary of this question with associated actions is outlined in the table below

IEA	Question	Evidence Required	RAG Rating	Action/Info
WF	Q48	More Consultant midwives		There are currently no plans for a consultant midwife

4. Recommendations

4.1 The Quality Committee are 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	06/06/2023	22/05/2023	Nicola Firth	Chief Nurse
Stockport NHS FT	Y	03/08/2023	11/07/2923	Nicola Firth	Chief Nurse
Stockport NHS ft	Y	28/11/2023	11/10/2023	Nicola Firth	Chief Nurse
Stockport NHS FT	Y	01/02/2024	03/01/2024	Nicola Firth	Chief Nurse
Stockport NHS FT	Y		18/03/2024	Nicola Firth	Chief Nurse

Submission dates	Meeting Dates
11-Oct-23	18-Oct-23
10-Jan-23	17-Jan-23
10-Apr-24	17-Apr-24
10-Jul-24	17-Jul-24
09-Oct-24	16-Oct-24
10-Jan-24	17-Jan-24
10-Apr-24	17-Apr-24

Ockenden Initial report recommendations

HA	Question	Action	Evidence Required	GMEC August 2021 Submission - STOCKPORT NHS FOUNDATION TRUST	GMEC March 2022 - STOCKPORT NHS FOUNDATION TRUST	Insight 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 10th April 2023	Details of action to be taken if partially or not compliant	Initial Self Report with % of compliance Report to LMNS by 10th July 2023	Details of action to be taken if partially or not compliant	Initial Self Report with % of compliance Report to LMNS by 11th October 2023	Details of action to be taken if partially or not compliant	Initial Self Report with % of compliance Report to LMNS by 10th January 2024	Details of action to be taken if partially or not compliant	Initial Self Report with % of compliance Report to LMNS by 10th April 2024	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%		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%		100%		100%		100%		100%	
			SOP required which demonstrates how the trust rejects this both internally and externally through the LMS.	100%	100%		100%		100%		100%		100%		100%		100%	
			Submission of minutes and oganogram, that shows how this takes place.	100%	100%		100%		100%		100%		100%		100%		100%	
		Maternity Dashboard to LMS every 3 months Total		**100%**	**100%**		100%		100%		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%		100%		100%		100%		100%	
			Policy or SOP which is in place for involving external clinical specialists in reviews.	100%	100%		100%		100%		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%		100%		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%		100%		100%		100%		100%	
			Submission of private trust board minutes as a minimum every three months with highlighted times where SI's discussed	100%	100%		100%		100%		100%		100%		100%		100%	
			Submit SOP	0%	100%		100%		100%		100%		100%		100%		100%	
		Maternity SI's to Trust Board & LMS every 3 months Total		**67%**	**100%**		100%		100%		100%		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 in a timeliness and external review	100%	100%		60%		100%		100%		100%		100%		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%		100%		100%		100%		100%	
		Using the National Perinatal Mortality Review Tool to review perinatal deaths Total		**100%**	**100%**		60%		100%		100%		100%		100%		100%	
	Q5	Submitting data to the Maternity Services Datyset 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%		100%		100%		100%		100%	
		Submitting data to the Maternity Services Dataset to the required standard Total		**100%**	**100%**		100%		100%		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%		100%		100%		100%		100%	
		Reported 100% of qualifying cases to HSIB / NHS Resolution's Early Notification scheme Total		**100%**	**100%**		100%		100%		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 2023.	100%	100%		100%		100%		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%		100%		100%		100%		100%	
			Submit SOP and minutes and oganogram of organisations involved that will support the above from the trust, signed of via the trust governance structure.	0%	100%		100%		100%		100%		100%		100%		100%	
		Plan to implement the Perinatal Clinical Quality Surveillance Model Total		**67%**	**100%**		100%		100%		100%		100%		100%		100%	
	Q8	**Same as Q3**																
IEA1 Total				**81%**														
	Q9	N/A																
	Q10	N/A																
IEA2 Listening to Women and Families	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%		100%		100%		100%		100%	
			Evidence of link in to MVP, any other mechanisms	100%	100%		100%		100%		100%		100%		100%		100%	
			Evidence of NED sitting at trust board meetings, minutes of trust board where NED has contributed	100%	100%		100%		100%		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%		100%		100%		100%		100%	
			Name of NED and date of appointment	100%	100%		100%		100%		100%		100%		100%		100%	
			NED JD	100%	100%		100%		100%		100%		100%		100%		100%	
		Non-executive director who has oversight of maternity services Total		**100%**	100%		100%		100%		100%		100%		100%		100%	
	Q12	**Same as Q8**																
	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%		100%		100%		100%		100%	
			Evidence of service user feedback being used to support improvement in maternity services (E.G. you said, we did, MVT, 15 Steps)	100%	100%		100%		100%		100%		100%		100%		100%	
			Please upload your C&IT evidence of co-production. If utilised then upload completed templates for providers to successfully achieve maternity safety action 7. C&IT templates to be signed off by the MVP.	100%	100%		100%		100%		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%		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%		100%		100%		100%		100%	
			Log of attendees and core membership.	100%	100%		100%		100%		100%		100%		100%		100%	
			Minutes of the meeting and minutes of the LMS meeting where this is discussed.	100%	100%		100%		100%		100%		100%		100%		100%	
			SOP that includes role descriptors for all key members who attend by monthly safety meetings	0%	100%		100%		100%		100%		100%		100%		100%	
		Trust safety champions meeting bimonthly with Board level champions Total		**75%**	**100%**		100%		100%		100%		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%		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%		100%		100%		100%		100%	
	Q16	Perinatal clinical lead to support the board maternity safety champion	Evidence of participation and collaboration between ED, NED and Maternity Safety Champion, e.g. evidence of sharing issues at trust board, minutes of trust board and evidence of actions taken	0%	100%		100%		100%		100%		100%		100%		100%	
			Name of ED and date of appointment	100%	100%		100%		100%		100%		100%		100%		100%	
			Role description	100%	100%		100%		100%		100%		100%		100%		100%	
		Non-executive director support the board maternity safety champion Total		**67%**	**100%**		100%		100%		100%		100%		100%		100%	
IEA2 Total				**88%**	**100%**													
		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%		100%		100%		100%		100%	

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IEA3 Staff Training and working together	Q17		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%		100%		100%		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%		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%		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%		100%		100%		100%		100%	
		Multidisciplinary training and working occurs. Evidence must be externally validated through the LMS, it times a		**80%**	**100%**		100%		100%		100%		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%		100%		100%		100%		100%	
			SOP created for consultant led ward rounds.	0%	100%		100%		100%		100%		100%		100%		100%	
		Twice daily consultant-led and present multidisciplinary ward rounds on the labour ward. Total		**50%**	**75%**		75%		100%		100%		100%		100%		100%	
	Q19	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%		100%		100%		100%		100%	
			Evidence from Budget statements.	100%	100%		100%		100%		100%		100%		100%		100%	
			Evidence of funding received and spent.	100%	100%		100%		100%		100%		100%		100%		100%	
			Evidence that additional external funding has been spent on funding including staff can attend training in work time.	100%	100%		100%		100%		100%		100%		100%		100%	
			MTP spend reports to LMS	0%	100%		100%		100%		100%		100%		100%		100%	
		External funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only		**60%**	**100%**		100%		100%		100%		100%		100%		100%	
	Q20	**N/A**																
	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%		100%		100%		100%		100%	
			Attendance records - summarised	100%	100%		100%		100%		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%		100%		100%		100%		100%	
		90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies		**67%**	**100%**		100%		100%		100%		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%		100%		100%		100%		100%	
		Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week. Total		**100%**	**75%**		75%		100%		100%		100%		100%		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%		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%		100%		100%		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		**50%**	**100%**		100%		100%		100%		100%		100%		100%	
KA4 Total				**67%**					100%		100%		100%		100%		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%		100%		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%		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		**50%**	**100%**		100%		100%		100%		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 named consultant lead	100%	100%		100%		100%		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%		100%		100%		100%		100%	
		Women with complex pregnancies must have a named consultant lead. Total		**100%**	**100%**		100%		100%		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%		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%		100%		100%		100%		100%	
		Complex pregnancies have early specialist involvement and management plans agreed Total		**100%**	**100%**		100%		100%		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%		100%		100%		100%		100%	
			Guidelines with evidence for each pathway	100%	100%		100%		100%		100%		100%		100%		100%	
			SOP's	100%	100%		100%		100%		100%		100%		100%		100%	
		Compliance with all five elements of the Saving Babies' Lives care bundle Version 2 Total		**100%**	**100%**		100%		100%		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%		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	100%	Audit plan now in place	100%	Audit plan now in place	100%	Audit plan now in place	100%	Audit plan now in place
		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%		100%		100%		100%		100%	
		Do you have agreed maternal medicine network/ centre?	Agreed pathways	100%	100%		100%		100%		100%		100%		100%		100%	
			criteria for referrals to MMC	100%	100%		100%		100%		100%		100%		100%		100%	

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	Q29		The maternity services involved in the establishment of maternal medicine networks evidenced by notes of meetings, agendas, action logs.	100%	100%		100%		100%		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%		100%		100%		100%		100%	
KA6 Total				**93%**	**100%**													
IEAS 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	How this is achieved within the organization.	100%	100%		100%		100%		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 implementation end of May 2023**	100%	**Audit plan now in place**	100%	**Audit plan now in place**	100%	**Audit plan now in place**	100%	**Audit plan now in place**
			Review and discussed and documented intended place of birth at every visit.	100%	100%		100%		100%		100%		100%		100%		100%	
			SOP that includes definition of antenatal risk assessment as per NICE guidance.	0%	100%		100%		100%		100%		100%		100%		100%	
			What is being risk assessed.	0%	100%		100%		100%		100%		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		**60%**	**100%**		75%		80%		100%		100%		100%		100%	
	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%		100%		100%		100%		100%	
			Out with guidance pathway	100%	100%		100%		100%		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 implementation end of May 2023**	100%	**Audit plan now in place**	100%	**Audit plan now in place**	100%	**Audit plan now in place**	100%	**Audit plan now in place**
			SOP that includes review of intended place of birth.	0%	100%		100%		100%		100%		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%		100%		100%		100%		100%	
	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%		100%		100%		100%		100%	
			How this is achieved in the organization	100%	100%		100%		100%		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%	**Currently undertaking Audits adhoc. Robust audit plan due for completion and implementation end of May 2023**	50%		100%	**Audit plan now in place**	100%	**Audit plan now in place**	100%		100%	
			Review and discussed and documented intended place of birth at every visit.	100%	100%		100%		100%		100%		100%		100%		100%	
			SOP to describe risk assessment being undertaken at every contact.	0%	100%		100%		100%		100%		100%		100%		100%	
			What is being risk assessed.	0%	100%		100%		100%		100%		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		**67%**	**100%**		83%		83%		100%		100%		100%		100%	
KA6 Total				**67%**	**100%**													
IEAG Monitoring Fetal Wellbeing	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%		100%		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%		100%		100%		100%		100%	
			Incident investigations and reviews	100%	100%		100%		100%		100%		100%		100%		100%	
			Name of dedicated Lead Midwife and Lead Obstetrician	100%	100%		100%		100%		100%		100%		100%		100%	
		Appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and		**75%**	**100%**		100%		100%		100%		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%		100%		100%		100%		100%	
			Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported e.g clinical supervision	0%	100%		100%		100%		100%		100%		100%		100%	
			Improving the practice & raising the profile of fetal wellbeing monitoring	0%	100%		100%		100%		100%		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%		100%		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%		100%		100%		100%		100%	
			Keeping abreast of developments in the field	0%	100%		100%		100%		100%		100%		100%		100%	
			Lead on the review of cases of adverse outcome involving poor FHR interpretation and practice.	100%	100%		100%		100%		100%		100%		100%		100%	
			Plan and run regular departmental fetal heart rate (FHR) monitoring meetings and training.	0%	100%		100%		100%		100%		100%		100%		100%	
		The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to		**38%**	100%		100%		100%		100%		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%		100%		100%		100%		100%	
			Guidelines with evidence for each pathway	100%	100%		100%		100%		100%		100%		100%		100%	
			SOP's	100%	100%		100%		100%		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%		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 MBRRACE in December 2014?	A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	100%	100%		100%		100%		100%		100%		100%		100%	
			Attendance records - summarised	100%	100%		100%		100%		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 NHSE requirements.	100%	100%		100%		100%		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		**100%**	100%		100%		100%		100%		100%		100%		100%	
	Q38	**Same as Q3**																
KA6 Total				**67%**	**100%**													
		Trusts ensure women have appropriate access to accurate information to enable informed choice of intended place of birth and model of care, including maternal choice for caesarean delivery	Information on maternal choice including choice for caesarean delivery.	100%	**100%**		100%		100%		100%		100%		100%		100%	

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	Q39		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%		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		100%	100%		100%		100%		100%		100%		100%		100%	
	Q40	Do you have Do you have accessible information to enable accurate evidence based information including all care (Ante, Intra/perform & PN)?	Demonstration of the information service users can access for evidence based information in all	100%	100%		100%		100%		100%		100%		100%		100%	
			Demonstration of the information service users can access for evidence based information in all	100%	100%		100%		100%		100%		100%		100%		100%	
			MVP review of information	100%	100%		100%		100%		100%		100%		100%		100%	
		Do you have Do you have accessible information to enable accurate evidence based information including all		100%	100%		100%		100%		100%		100%		100%		100%	
	Q41	Women must be enabled to participate equally in all decision making processes	An audit of 5% of notes demonstrating compliance.						50%	Currently undertaking Audits adhoc. Robust audit plan due for completion and implementation end of May 2022	100%	Audit plan now in place	100%		100%		100%	
			CQC survey and associated action plans						100%		100%		100%		100%		100%	
			SOP which shows how women are enabled to participate equally in all decision making processes and to make informed choices about						25%	SOP in development	50%	SOP continues to be developed	100%	SOP continues to be developed	100%	Personalised care planning SOP in place	100%	Personalised care planning SOP in place
		Women must be enabled to participate equally in all decision making processes Total							50%		66%		100%		100%		100%	
	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 declined a recommended care pathway and those who 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 implementation end of May 2022	100%	Audit plan now in place	100%		100%		100%	
			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%		100%		100%		100%		100%	
		Women's choices following a shared and informed decision making process must be respected Total		50%	100%		50%		50%		100%		100%		100%		100%	
	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 productive 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%		100%		100%		100%		100%	
			Evidence of service user feedback being used to support improvement in maternity services (E.G you said, we did, PIT, 15 Steps)	100%	100%		100%		100%	IOA survey	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%		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%		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%		100%		100%		100%		100%	
			Gap analysis of website against Chelsea & Westminster conducted by the MVP	100%	100%		100%		100%		100%		100%		100%		100%	
			Information on maternal choice including choice for caesarean delivery	100%	100%		100%		100%		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%		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%		100%		100%		100%		100%	
KA7 Total				93%	100%				100%		100%		100%		100%		100%	
WF	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%		100%		100%		100%		100%	
			Evidence of reviews 6-monthly for all staff group and evidence considered at board level.	100%	100%		100%		100%		100%		100%		100%		100%	
			Most recent BR+ report and board minutes agreeing to fund.	100%	100%		100%		100%		100%		100%		100%		100%	
		Demonstrate an effective system of clinical workforce planning to the required standard Total		100%	100%		100%		100%		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%		100%		100%		100%		100%	
		Demonstrate an effective system of midwifery workforce planning to the required standard? Total		100%	100%		100%		100%		100%		100%		100%		100%	
	Q47	Director/Head of Midwifery is responsible and accountable to an executive director	Draft/Dated Job Description with explicit signposting to responsibility and accountability to an executive director	100%	100%		100%		100%		100%		100%		100%		100%	
		Director/Head of Midwifery is responsible and accountable to an executive director Total		100%	100%		100%		100%		100%		100%		100%		100%	
	Q48	Describe how your organization 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%		100%		100%		100%		100%	
			Gap analysis completed against the RCM Strengthening midwifery leadership: a manifesto for better maternity care	100%	100%		75%		100%		100%		100%		100%		100%	
			1. A Director of Midwifery on every trust and health board, and most Heads of Midwifery across the service						100%	Divisional Director of Midwifery in post with a Deputy Head of Midwifery.	100%		100%		100%		100%	
			2. A lead midwife at a senior level in all parts of the NHS, both nationally and regionally						100%		100%		100%		100%		100%	
			3. More Consultant midwives						0%	Currently no Consultant Midwife	0%	No Consultant midwife plans currently	0%	No Consultant midwife plans currently	0%	No Consultant midwife plans currently	0%	No Consultant midwife plans currently
			4. Specialist midwives in every trust and health board						100%		100%		100%		100%		100%	
			5. Strengthening and supporting sustainable						100%		100%		100%		100%		100%	
			6. A commitment to fund ongoing midwifery						100%		100%		100%		100%		100%	
			7. Professional input into the appointment of						100%		100%		100%		100%		100%	
		Describe how your organization 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%											
	Q49	Providers to review their approach to NICE guidelines in maternity settings to ensure that these are assessed and implemented where appropriate	Audit to demonstrate all guidelines are in date.	100%	100%		100%		100%		100%		100%		100%		100%	
			Evidence of risk assessment where guidance is not implemented	0%	100%		100%		100%		100%		100%		100%		100%	
			SOP in place for all guidelines with a demonstrable process for ongoing review	0%	100%		100%		100%		100%		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%		100%		100%		100%		100%	
WF Total				80%	100%				92%		92%		92%		92%		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	Report to LMNS by 11 October 2023	Report to LMNS by 1o January 2024	Report to LMNS by 10 April 2024
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	Green	Green	Green	Green
7	R2, R3	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	Green	Green	Green	Green
			Completion of the Mentoring module	Green	Green	Green	Green	Green	Green	Green
			Suturing competency	Green	Green	Green	Green	Green	Green	Green
			IV therapy competency	Green	Green	Green	Green	Green	Green	Green
			Care of women choosing epidural anaesthesia.	Green	Green	Green	Green	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	Green	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	Green	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	Green	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	Green	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	Green	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	Green	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	Green	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	Green	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	Green	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	Green	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	Amber	Amber	Green	Green
			Identified midwives to have completed RCA training	Green	Green	Green	Green	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	Green	Green	Green	Green
			Develop a local record of staff who have completed RCA training and the investigations undertaken (including dates)	Green	Amber	Amber	Amber	Amber	Green	Green
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/FTSU guardian	Green	Green	Green	Green	Green	Green	Green
37	R31	Provide evidence of how we deal with complaints		Green	Green	Green	Green	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	Green	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	Green	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 REPORT	
Name of Committee/Group	Audit Committee
Chair of Committee/Group	David Hopewell
Date of Meeting	**20th February 2024**
Quorate	Yes

The Audit Committee draws the following key issues and matters to the Board of Directors' attention:

Item	Key issues and matters to be escalated
Risk Management Committee Report	The Committee received: • a report on the work of the Risk Committee • a list of significant risks at November 23 and January 2024. The report illustrated to the Committee that there was a strong functioning risk assessment process; showing clearly how the mitigation measures put in place were making an impact in some areas whilst remaining static in others. The Committee received clarification about the new risk 2247 on electrical capacity and infrastructure. There was a discussion on the existing risk 101 that the Trust will run out of cash with an action taken to review the risk appetite score of the Trust. The Committee were updated on the short term actions to address the risk around Beech House cooling issues and that an appraisal of the longer term options was in progress. An action was taken by the Chair of the Quality Committee to follow up risk 288 – the Inability to provide a robust VAD service for the insertion of VADs. A question was asked on the triangulation of risk across Committees. Assurance was received that the overall strategic risk was addressed through the Board Assurance Framework by the Board of Directors and by the updates provided by the Chair of key Committees (People, Quality and Finance and Performance) at Audit Committee.
Feedback from Board Committees.	The Committee received verbal reports on the key risks from the Chairs of the: • Finance and Performance Committees • Quality Committee • People Committee Within the updates it was highlighted as an example of the shared evaluation of risk how the issues around sickness absence feedback into all three Committees and that there will be evidence of other examples that could be provided to CQC if shared evaluation of risk were to be challenged.

Internal Audit 2023/24 Plan Progress Report Draft 2024/25 Annual Plan	The Committee received: • Internal Audit Plan Progress Report • Internal Audit Reports • Follow up Tracker Update The Committee were assured that the Internal Audit Plan was progressing well and performance indicators all rated green. Three reports were finalised, three at draft report stage (Outpatient Booking, ESR/Payroll and Staff Wellbeing). The Medical Staffing is in progress and there is good engagement with the department to complete to the required timetable. The Committee received the final reports for the Well Led Supporting Position and Key Financial Transactional Process Controls with both audits receiving Substantial Assurance. The Trust Secretary endorsed the thoroughness of the Well Led review and welcomed the independent external assurance following the Trust's own internal review of the Code of Governance. The Committee were assured that the strategic risk from a change in Chair leadership was addressed within the Code of Governance and featured in the Head of Internal Audit Opinion year-end report. The Committee's request was supported for a change to the implementation dates to immediate for the Key Financial Transactional Process Controls review. The IT Medical Devices Review received Limited Assurance and a follow up of recommendations is due by September 2024. The Committee reviewed the Draft Internal Audit Plan for 2024/25. It was agreed to programme the next payroll review jointly with Tameside NHS Integrated Care NHS FT. The Plan was approved in principle subject to confirmation of the fee. The Committee asked to view how the days and fee were allocated across the draft Plan and it was agreed to share this.
Anti-Fraud Progress Report Draft Anti-Fraud Plan 2024/25	The Committee received the Anti-Fraud Progress Report and were assured it was progressing as planned. It received an update on the status of current investigations. The Committee were given assurance that the Trust had not incurred any financial losses on Fraud Prevention notices issued during December 23 – January 2024. The Committee were notified of two anonymous referrals of fraud allegations but received assurance that the Trust internal system controls also played a key role in identifying fraud. The Committee were presented with the draft Anti-Fraud Plan 24/25 that was based on assessments of known risk and now included the Pharmacy Shop. The Committee approved the draft Plan.
External Audit Draft Audit Strategy Memorandum McCarthy Rebecca 28/03/2024 17:31:14	The Committee received the draft Audit Strategy Memorandum for the 2023/24 Annual Accounts and Annual Report. The strategy is consistent in scope with previous years with four significant risks highlighted as management override of controls, risk of fraud in revenue and expenditure and the valuation of property, plant and equipment. The additional risk on the adoption of IFRS 16 in 2022/23 is not included in this year's memorandum. The Committee received assurance that the pre-planning work for the 2023/24 was

	timetabled for early March 2023/24.
Conflicts of Interest Policy	The Committee received a report of the annual review of the Conflicts of Interest Policy. Declarations of Interest. There are limited changes to the previous significant revision of the Policy and it was approved by the Committee. The Annual Review of the Declarations of Interest Policy will be presented to the Audit Committee in May.
Standing Financial Instructions (SFIs) and Scheme of Delegation (SORD).	The Committee reviewed the Standing Financial Instructions and Scheme of Reservation & Delegation. The Committee were assured that these had also been reviewed by the Executive Team. The Committee asked for clarification on the changes to the approval for pay for waiting list initiatives and unusual pay items over £2,500 from the Audit Committee to the Director of Finance only. An update to the Code of Governance has been referenced in the most recent NHSE Provider Accounts e-mails and this will be reviewed against the SFIs and SORD presented to the Committee. Subject to the above the SFIs and SORD will be recommended to for approval by the Board of Directors.
Accounting Policies 2023/24	The Committee received a report of the accounting policies to be included in the 2023/2024 Annual Accounts. It received assurance that the draft accounting policy note was prepared in accordance with relevant International Financial Reporting Standards and latest NHSE, DHSC and HM Treasury guidance. The Committee approved and recommended to the Board the draft accounting policy note for inclusion in 2023/24 financial statements.