Public Board meeting

Thu 05 October 2023, 09:30 - 12:30

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

Information

09:35 - 09:35
0 min

4. Minutes of Previous Meeting - held on 3 August 2023

Decision *Tony Warne*

04 - Public Board Minutes - 3 Aug 2023.pdf (12 pages)

09:35 - 09:40
5 min

5. Action Log

Information *Tony Warne*

05 - Public Board Action Log - Oct 2023.pdf (2 pages)

09:40 - 09:50
10 min

6. Chair's Report

Discussion *Tony Warne*

06 - Chairs Report - October 2023.pdf (5 pages)

09:50 - 10:05
15 min

7. Chief Executive's Report

Discussion *Karen James*

07 - Chief Executive Report - September 2023.pdf (6 pages)

STRATEGY & PLANNING

10:05 - 10:15
10 min

8. Reinforced Autoclaved Aerated Concrete (RAAC) Briefing

Discussion *Paul Featherstone*

- 08a - RAAC Briefing - October 2023.pdf (7 pages)
- 08b - Appendix 1 Reinforced aerated autoclaved concrete (RAAC) Letter.pdf (3 pages)
- 08c - Appendix 2 Report Update - RAAC Planks Appraisal Stepping Hill.pdf (27 pages)

PERFORMANCE

10:15 - 10:45
30 min

9. Integrated Performance Report

Discussion *Karen James / Executive Directors*

- 09a - Integrated Performance Report - Front Sheet - October 2023.pdf (2 pages)
- 09b - Integrated Performance Report (Aug 23 Data) - Final.pdf (22 pages)

10:45 - 11:00
15 min

10. Referral to Treatment Self-Certification: Confirmation of Submission

Decision *Jackie McShane*

- 10 - Protecting and Expanding Elective Capacity.pdf (6 pages)

FINANCE

11:00 - 11:05
5 min

11. PDC Revenue Support 2023/24

Discussion *John Graham*

- 11 - PDC Revenue Support 2023-24.pdf (5 pages)

11:05 - 11:20
15 min

COMFORT BREAK

QUALITY

11:20 - 11:35
15 min

12. Annual Infection Prevention Control Report & Mid-Year Review

Discussion *Nicola Firth*

- 12a - Annual Infection Prevention Control Report 2022-23.pdf (37 pages)
- 12b - IPC Annual Report Presentation.pdf (11 pages)

11:35 - 11:45
10 min

13. Safer Care Report

Discussion *Nicola Firth / Andrew Loughney*

- 13a - Safer Care Front Sheet - September 2023.pdf (2 pages)
- 13b - Safer Care Report - September 2023.pdf (17 pages)

PEOPLE

11:45 - 11:55
10 min

14. Freedom to Speak Up Report

Discussion *Nadia Walsh*

14 - Freedom to Speak Up Report - September 2023.pdf (8 pages)

GOVERNANCE

11:55 - 12:05
10 min

15. Board Assurance Framework 2023/24 - Quarter 2

Decision *Karen James*

15a - Board Assurance Framework Q2 2023-24 - Front Sheet.pdf (4 pages)
15b - Appendix 1 - Board Assurance Framework 2023-24 - October 2023.pdf (18 pages)
15c - Appendix 2 - Significant Risk Register (September 2023).pdf (1 pages)

STANDING COMMITTEE REPORTS

12:05 - 12:20
15 min

16. Board Committee - Key Issues Reports

Discussion

16a - Board Standing Committees Key Issues Reports - Front Sheet.pdf (2 pages)

16.1. Finance & Performance Committee

Anthony Bell

16b - F&P Committee Key Issues Report - Sep 2023 - V3.pdf (4 pages)

16.2. People Performance Committee

Beatrice Fraenkel

16c - People Performance Committee Key Issues Report - September 2023.pdf (3 pages)

16.3. Quality Committee - Including Maternity Services Report

Mary Moore

16d - Quality Committee Key Issues Report - September 2023.pdf (4 pages)
16d.1 - Maternity Service Highlight Report Front Sheet - September 2023.pdf (3 pages)
16d.2 - Annex A Maternity Service Highlight Report - September 2023.pdf (36 pages)
16d.3 - PMRT Report - September 2023.pdf (12 pages)

16.4. Audit Committee - Including updated Terms of Reference

David Hopewell

16e - Audit Committee Key Issues Report - September 2023.pdf (2 pages)
16e.1 - Appendix 1 - Audit Committee Terms of Reference.pdf (6 pages)

CLOSING MATTERS

12:20 - 12:20
0 min

17. Any Other Business

DATE, TIME & VENUE OF NEXT MEETING

12:20 - 12:20
0 min

18. Thursday, 7 December 2023, 9.30am, Pinewood House Education Centre

12:20 - 12:20
0 min

19. 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”.

STOCKPORT NHS FOUNDATION TRUST
Minutes of a meeting of the Board of Directors held in public
Held on Thursday 3 August 2023, at 9.30am in Pinewood House Education Centre, Stepping Hill Hospital

Members Present:

Prof Tony Warne	Chair
Dr Samira Anane	Non-Executive Director
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
Mr David Hopewell	Non-Executive Director
Mrs Karen James	Chief Executive
Dr Marisa Logan-Ward	Non-Executive Director / Deputy Chair
Dr Andrew Loughney	Medical Director
Mrs Jackie McShane	Director of Operations
Mrs Mary Moore	Non-Executive Director
Mr Jonathan O'Brien	Director of Strategy & Partnerships
Dr Louise Sell	Non-Executive Director

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

In attendance:

Mr Tom Parker-Evans	Head of Safeguarding
Ms Natalie Davies	Deputy Director of Quality Governance
Ms Sharon Hyde	Divisional Director of Midwifery & Nursing
Ms Zoe Turner	Divisional Director of Women & Children

Observing:

Mrs Sue Alting	Lead Governor
Mrs Michelle Slater	Public Governor
Ms Deborah Pook	Deputy Chief Operating Officer, East Kent Hospitals University NHSFT

Apologies:

Mrs Caroline Parnell	Director of Communications & Corporate Affairs*
Mr Meb Vadiya	Associate Non-Executive Director*

** indicates a non-voting member*

REF No/Yr.	ITEM	ACTION OWNER
84/23	**Apologies for Absence** The Chair welcomed everyone to the meeting. Apologies for absence were noted as above.	
85/23	**Declarations of Interest** There were no declarations of interest.	

86/23	**Patient Story** The Head of Safeguarding read out a patient story relating to a Learning Disability experience, detailing the patient's and his carer's experience coming into hospital. The Board of Directors noted the powerful story and the Trust's actions taken in response, including the sharing of the story in other forums. **The Board of Directors received and noted the Patient Story.**	
87/23	**Minutes of Previous Meeting** The minutes of the previous meeting held on 1 June 2023 were agreed as a true and accurate record.	
88/23	**Action Log** The action log was reviewed and annotated accordingly.	
89/23	**Chair's Report** The 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 Board of Directors received and noted the Chair's Report.**	
90/23	**Chief Executive's Report** The Chief Executive presented a report providing an update on local and national strategic and operational developments. She briefed the Board on the content of the report and highlighted the following areas: • NHS Workforce Plan • NHS 75th anniversary • Industrial action • Community Diagnostic Centre • Emergency and Urgent Care Centre • Awards In response to a question from Dr Louise Sell, Non-Executive Director, regarding the scope of the Community Diagnostic Centre contract, the Chief Executive and the Director of Strategy & Partnerships advised that the contract would be flexible providing opportunity to expand to other diagnostics in future, and where additional volume was required. **The Board of Directors received and noted the Chief Executive's Report.**	
91/23	**Annual Corporate Objectives – Review of Outcome Measures 2022/23** The Chief Executive presented a report providing a high-level overview of delivery against the corporate objectives and key outcome measures for 2022/23. She highlighted progress made and noted that the key outcome measures relating to the corporate objectives for 2022/23 had largely been achieved, as routinely discussed at the relevant Board assurance committees and via the Board of Directors. In response to a question from Mr Tony Bell, Non-Executive Director, regarding feedback on the roll out of the Stockport Accreditation &	

	Recognition Scheme (StARS) across the organisation, the Chief Nurse stated that there had been overwhelming support for the framework, which provided a positive tool for improvement and enabled a greater focus on fundamentals of care. Mr Tony Bell, Non-Executive Director, reflected on the challenges around developing effective partnerships, particularly regarding place-based partnerships. The Chief Executive acknowledged the length of time in establishing structures, and advised that the Provider Partnership Board, which she chaired, had identified and was now progressing workstreams relating to primary and secondary health and wellbeing metrics. Dr Marisa Logan-Ward, Non-Executive Director, referred to the format of the report and suggested that the inclusion whether the outcome measures had been achieved / not achieved / partially achieved would be helpful. Mrs Beatrice Fraenkel, Non-Executive Director, acknowledged how outcome measures would inform strategic planning for the year ahead, and emphasised the importance of quality of evidence during the year to support the Board in confirming achievement of its objectives. **The Board of Directors received and noted the report and confirmed delivery against the key outcome measures for 2022/23.**	
92/23	**Annual Corporate Objectives – Outcome Measures 2023/24** The Chief Executive presented a report outlining the Trust's Corporate Objectives and associated key outcome measures for 2023/24, which would provide a basis for improvements. She noted that the Board had already approved the overarching Corporate Objectives 2023/24 and was now asked to review and approve the key outcome measures for 2023/24, which were set in line with local, regional and national requirements. With respect to local requirements, Mrs Beatrice Fraenkel, Non-Executive Director, queried if the Health & Wellbeing Board were fully cognisant of the changing nature of community and acute care demand in Stockport. The Chief Executive and Chair briefed the Board on locality discussions in this area, noting that the Health & Wellbeing Board were sighted on the issues. In response to a question from Dr Samira Anane, Non-Executive Director, querying if plans were in place to address the financial deficit, the Chief Executive briefed the Board on regular discussions within the Greater Manchester Integrated Care Board (GM ICB) and nationally, noting that work was ongoing to formulate a plan to close the deficit gap. The Chief Finance Officer highlighted drivers for the Trust deficit and the key reasons for the variance to the Trust's plan, including industrial action, pay awards and open escalation wards. He briefed the Board on discussions taking place at GM and advised that the Trust would need to consider if the risks presented would require a declaration in September that the financial plan could not be delivered, given the changing circumstances since the setting of the annual plan. **The Board of Directors received and noted the report and approved the key outcome measures for 2023/24.**	
93/23	**Stockport Locality Board Priorities** The Director of Strategy & Partnerships presented a report detailing the	

	priorities identified by the Stockport Health and Care (Locality) Board and the engagement of Trust Executive Directors with emerging system architecture. He briefed the Board on the content of the report highlighting the priorities identified by the Provider Partnership, including the initial primary and secondary care health and wellbeing workstreams to support improvements in population health. Mrs Beatrice Fraenkel, Non-Executive Director, noted the complex range of partnerships, with each organisation having their own accountabilities, governance arrangements and individual challenges. In this light, she sought further view regarding delivery of shared outcome measures. The Chief Executive commented that the Provider Partnership reported to the Locality Board, who held responsibility for ensuring progress was being made against the outcomes, with all key partner represented. She acknowledged the importance of partners being able to have open and honest conversations and develop mature collaborations to achieve shared objectives. The Chief Executive confirmed issues would be escalated from the Provider Partnership to the Locality Board where required. Dr Samira Anane, Non-Executive Director queried the robustness of structures in place to enable delivery of responsibilities and engagement with primary care to ensure the locality was making best use of all community assets. The Director of Strategy & Partnerships acknowledged that Greater Manchester governance continued to emerge, whilst at a locality level, governance arrangements were in place and a series of workstreams identified. He confirmed that additional organisations would be co-opted to the Provider Partnership, as may be required, in order to deliver a whole population approach. Mrs Beatrice Fraenkel, Non-Executive Director, acknowledged the priorities of the Provider Partnership, with many other factors impacting general population health, and therefore demand on services, and queried the expectations of the outcome measures over time. The Chair and the Director of Strategy & Partnerships noted that the Trust was signed up to the One Stockport Health & Care Plan, covering the broader remit of population health, with the four key areas of priority to work on in 2022/23 specifically relating to improving outcomes in areas for the population where key outcomes could be improved and inequalities persist. **The Board of Directors received and noted the Stockport Locality Board Priorities Report.**	
94/23	**Integrated Performance Report** The Chief Executive introduced the Integrated Performance Report (IPR), which included exception reports for areas of most significant note. **Quality** The Chief Nurse and Medical Director presented the quality section of the IPR and highlighted challenges and mitigation actions regarding mortality, sepsis, infection prevention, pressure ulcers and complaints due to under-achievement in month. With regard to sepsis, it was noted that the Trust was exploring best practice with Bolton and the outcome would be considered by the Quality Committee. The Chair commended the Trust's continuous improvements around falls	

reduction, which had been recognised externally, noting that the Trust would be sharing best practice in this area. Board members welcomed the reduction in falls and the sharing of learning.

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 efficiencies, and theatre efficiency metrics due to under-achievement in month.

The Director of Operations reported positive improvement against the ED 4-hour standard and the new 12-hour metric, despite average attendances trending higher than the 2021/22 baseline. She advised that patient flow continued to be impacted by challenges accessing timely care home beds and community packages of care, and that the loss of 20 discharge to assess beds with an independent provider had added to the challenge.

The Director of Operations advised that diagnostic performance was showing significant improvement, albeit still above target thresholds. The Board heard that ECG remained the biggest area of challenge with staffing pressures.

The Director of Operations reported that cancer activity remained extremely challenged and it was anticipated that performance would continue to be impacted by industrial action in the coming months. Whilst the outpatient efficiency metrics were below local targets, it was noted that the Trust continued to benchmark positively with GM and national peers for Did Not Attend (DNA) rates and the use of Patient Initiated Follow Up (PIFU). Positive benchmarking was also noted around clinic utilisation and theatre performance.

In response to questions from the Chair and Dr Louise Sell, Non-Executive Director, querying the loss of the discharge to assess beds and consequent impact on winter planning, the Director of Operations briefed the Board on plans to maintain 105 beds across Stockport locality, highlighting the importance of maintaining good patient flow.

In response to a comment from the Chair about the national requirement for Integrated Care Boards (ICBs) to confirm winter plans, the Director of Operations noted that there would not be any additional funding for winter, and the key focus would therefore be on productivity. The Chief Finance Officer noted uncertainties around the availability of capital and workforce and the Director of Operations reaffirmed the need to work more efficiently and focus on staff retention.

In response to a question from Mr Tony Bell, Non-Executive Director, about utilising the private sector to support recovery, the Director of Operations confirmed that the GM worked as a collaborative to support the reduction in long waits, and that this Trust was one of the biggest users of the independent sector capacity with good processes in place.

In response to a question from Dr Marisa Logan-Ward, Non-Executive Director, querying the continued provision of independent sector capacity, the Director of Operations advised that there was commitment for the current year, and that from next year this would be determined by contracting

	arrangements. She noted positive relationships between the Trust and a number of independent sector providers. **People** The Director of People & Organisational Development (OD) presented the people section of the IPR and highlighted performance and mitigating actions around turnover, mandatory training, appraisal rates and agency costs due to under-performance in month. The Director of People & OD reported a slight improvement in sickness absence and provided an overview of a deep dive in this area. She also briefed the Board on actions to reduce agency costs and turnover. In response to a question from Mr David Hopewell, Non-Executive Director, there followed a discussion about agency costs, with the Board requesting exploration of quantitative information on the cost of sickness absence and bank and agency usage above target, and what the financial savings would be if the Trust was able to reduce to the target. **(ACTION).** In response to questions from Mrs Beatrice Fraenkel, Non-Executive Director, about the impact of industrial action on finances and patient care, the Board heard that data on the impact on finance and activity was being collected GM-wide and harm reviews were undertaken to review impact on quality. In response to a follow up question from Mrs Beatrice Fraenkel, Non-Executive Director, about the impact of the strikes on staff wellbeing, the Director of People & OD highlighted a number of initiatives in this area and the Director of Operations advised that a well embedded process was in place to support colleagues through industrial action planning and debriefing. **Finance** The Chief Finance Officer presented the finance section of the IPR and advised that the Trust had submitted a plan with an expected deficit of £31.5m for the financial year 2023/24. He advised that the deficit assumed delivery of an efficiency target of £26.2m, of which £10.3m was recurrent. The Chief Finance Officer reported that at month 3, the Trust position was a deficit of £9.3m, which was £0.9m adverse to plan. The Board heard that this was an improvement of £0.3m in month, relating to increased non-recurrent efficiency plan delivery, and that the adverse variance was driven by the impact of industrial action by junior doctors, undelivered efficiency savings, open escalation wards, impact of inflation, enhanced staffing levels to support the high level of ED attendances, and the cost of the pay award for 2023-24 over and above expected funding. The Chief Finance Officer reported that the Trust's efficiency plan for 2023/24 was £26.2m (£10.3m recurrent) and at month 3 the Trust was £1.1m behind plan. He highlighted work ongoing to identify recurrent schemes. The Chief Finance Officer confirmed that the Trust had maintained sufficient cash to operate in June 2023, with the Cash Group taking measures to support cash flow. It was noted that the Capital plan for 2023/24 was £62.7m, but this was subject to confirmation as the GM position remained oversubscribed. The Board heard that at month 3, expenditure was behind plan by £3.3m, however this would be re-profiled into future months. **The Board of Directors received and noted the Integrated Performance**	**Chief Finance Officer**

	Report.	
95/23	**Patient Safety Incident Response Framework & Plan** *The Deputy Director of Quality Governance joined the meeting* The Deputy Director of Quality Governance presented a report and delivered a supporting presentation on the Trust's Patient Safety Incident Response Framework. She advised that at the end of September 2023, the Trust would transition from the Serious Incident Framework to the Patient Safety Incident Response Framework (PSIRF), in relation to the management of patient safety incidents. The Board heard that the PSIRF required all organisations to develop a Patient Safety Incident Response Plan (PSIRP) describing current improvement and transformation work impacting upon patient safety at the Trust, national requirements for incident response, and agreement of local priorities for incident investigation agreed at Trust level. The Chief Nurse was pleased to report that the PSIRF had been embraced by teams across the Trust and welcomed the inclusion of the review of successes in the framework. She highlighted good relationships between the Trust and the Coroner, noting close partnership working around incidents. In response to a question from Dr Louise Sell, Non-Executive Director, about how the Board would discharge its responsibilities around the framework, the Deputy Director of Quality Governance advised that GM was considering the how Trusts would receive assurances on the framework and requirements regarding the Board responsibility for signing off incidents. Mrs Mary Moore, Non-Executive Director, acknowledged, through discussion on this matter at Quality Committee, that the Trust would review oversight and scrutiny in the organisation in line with the framework. The Chair acknowledged the challenges in implementing change of this scale and commended the levels of engagement that had taken place to get to the current position. **The Board of Directors noted the report and the presentation and approved the Patient Safety Incident Response Plan.** *The Deputy Director of Quality Governance left the meeting*	
96/23	**Maternity Services Improvement Presentation** *The Divisional Director of Midwifery & Nursing and the Divisional Director of Women & Children joined the meeting* The Divisional Director of Midwifery & Nursing presented a Maternity Services Highlight Report detailing the current position against key workstreams of the maternity service. She also delivered an associated presentation, which covered the following subject headings: • Maternity update • Maternity Incentive Scheme CNST Year 4 and 5 • Saving Babies Lives Care Bundle v3 • Midwifery Continuity of Carer • Equity and Equality Plan 2022-2027 • Perinatal Mental Health	

	• Ockenden/East Kent Reports/Three-year delivery plan • North West Regional Maternity Strategy 2023-2025 • Pregnancy Loss Review • Maternity Staffing Oversight • Maternity Red Flags • Maternity Voices Partnership • Maternity and Perinatal Safety Champions • Greater Manchester and Eastern Cheshire Strategic Clinical Network • Successes and Achievements Dr Louise Sell, Non-Executive Director, reflected on her recent visit to Jasmine Ward where she had heard about the work on early pregnancy loss. In response to a question from Dr Sell about the development of the North West Maternity Strategy, the Divisional Director of Midwifery & Nursing and the Divisional Director of Women & Children confirmed that the team had been involved in the development of the strategy and had begun to deliver a number of the initiatives. In response to a question from Dr Samira Anane, Non-Executive Director, the Divisional Director of Midwifery & Nursing and Divisional Director of Women & Children briefed the Board on links with mental health support, also noting positive links with health visiting and public health. In response to a comment from Mrs Mary Moore, Non-Executive Director, and Maternity Safety Champion, regarding the significant improvement work that had taken place in recent years, the Board of Directors commended the Maternity Team and recognised the many awards they had been nominated for. In response to a question from Mrs Beatrice Fraenkel, Non-Executive Director, about seeking feedback from refugees regarding the service, the Divisional Director of Women & Children confirmed that the Trust sought feedback from refugees, with a dedicated midwife and health visiting service in place. **The Board of Directors received and noted the Maternity Services Highlight Report and associated presentation.** *The Divisional Director of Midwifery & Nursing and the Divisional Director of Women & Children left the meeting*	
97/23	**Annual Research, Innovation & Development Strategy Report 2022/23** The Medical Director presented a report providing an annual review of Research, Development & Innovation (RD&I) activity at the Trust. He briefed the Board on the content of the report, highlighting performance against key performance indicators, gaps identified in the RD&I service and the proposed mitigating actions. He also provided an update on progress made on the delivery of a joint RD&I strategy with Tameside. In response to a question from the Chair regarding laboratory work, the Medical Director highlighted actions in place to support laboratory staff in undertaking research activities. In response to a question from Mrs Beatrice Fraenkel, Non-Executive Director, querying if there was opportunity for income generation and growth,	

	the Medical Director stated that the research activities supported the Trust in attracting high calibre staff and contributed to income generation, noting the vaccine work as an example. He added that the joint working between the Trust and Tameside & Glossop Integrated Care NHS Foundation Trust provided further opportunity by driving the research agenda across a larger footprint. In response to a question from Dr Marisa Logan-Ward, Non-Executive Director, who queried whether the Trust had plans to obtain teaching status, the Medical Director confirmed that the Trust had reviewed itself against the necessary criteria to become a teaching hospital, but was not in a position to pursue it further at this stage. **The Board of Directors received the report and confirmed:** - **Delivery of the joint RD&I Strategy with Tameside and Glossop Integrated Care NHS Foundation Trust (TGIC) throughout 2022-23 with the resource available** - **Risks to delivery of the RD&I Strategy have been identified and managed appropriately.** - **An appropriate direction of travel for future RD&I sustainability and growth across Stockport NHS Foundation Trust and TGIC.**	
98/23	**Safeguarding:** • **Annual Safeguarding Report 2022/23** The Head of Safeguarding presented the Annual Safeguarding Report 2022/23, highlighting the overall safeguarding activity across the organisation and how the Trust has discharged its statutory safeguarding duties. He provided an overview of the key successes, how the Trust supported the local system approach to safeguarding, and ambitions for next year, noting substantial assurance received from GM ICS. The Board welcomed the report, the integrated approach to safeguarding and the improvements made in this area. **The Board of Directors:** – **Reviewed the Safeguarding Annual Report and endorsed it for publication** – **Confirmed the Trust has discharged its statutory duties for Safeguarding** • **Safeguarding Plan 2023-2026** The Head of Safeguarding presented the Trust's Safeguarding Plan 2023-2026, highlighting the Trust's commitment to safeguarding the welfare of children, young people, adults and families across Stockport and beyond. The report also detailed the strategic approach required to strengthen the foundations of safeguarding practice at the Trust and priorities and ambitions for the next three years. The Board heard that the associated delivery plan was monitored via the Trust's Integrated Safeguarding Group, which reported to the Quality Committee. Mrs Mary Moore, Non-Executive Director, welcomed the plan, commenting that it captured the wide-ranging legislation. The Chair noted that the report provided positive assurance of collaborative working and developing legislation around safeguarding.	

	The Board of Directors received and approved the Safeguarding Plan 2023-2026.	
99/23	**People & Organisational Development Plan Update** The Director of People & Organisational Development (OD) presented a report, providing a progress update on the delivery of the People & OD Plan which had been approved by the Board in February 2023. She briefed the Board on the content of the report noting positive progress made with the actions and highlighted a key focus on organisational culture. In response to a question from Dr Louise Sell, Non-Executive Director, about the delivery of the actions, the Director of People & OD confirmed that the action plan appended to the report provided further information in this area. The Board noted positive progress had been, with some delays regarding the medical leadership programme. The Chief Finance Officer welcomed the progress made in the context of the significant operational challenges. In response to a question from Mrs Beatrice Fraenkel, Non-Executive Director, about the new Fit & Proper Person requirements for Board members, the Director of People & OD confirmed that these would be considered, and policy updated to ensure compliance. In response to a question from Dr Louise Sell, Non-Executive Director, about the Equality, Diversity & Inclusion (EDI) metrics, the Director of People & OD advised that there had been an improvement in the likelihood of ethnic minority staff entering disciplinary, but deterioration in bullying and harassment. She noted that the work on compassionate leadership and civility would be key in supporting improvements in this area. The Chair commented that it would be helpful for the next update report to include details on how the People & OD Plan linked in with the Communications & Engagement Strategy, particularly around culture change. **The Board of Directors received and noted the report and confirmed progress made against the delivery of the People & OD Plan.**	
100/23	**Board Assurance Framework 2023/24** The Chief Executive presented the opening Board Assurance Framework 2023/24 following approval of the Corporate Objectives 2023/24 by the Board in June 2023. Furthermore, a heat map and gap analysis between current and target risk score was provided. The Chief Executive confirmed that, following a Board Risk Appetite Workshop where the Trust's risk appetite in relation to key areas of risk was considered, Principal Risks to achievement of the objectives had been developed via the respective Board Assurance Committees. In response to a question from the Chair regarding the significant operational risk relating to mortality, the Chief Executive confirmed this had been highlighted to the Risk Management Committee via the division. The Medical Director confirmed that a request for review of mortality data would take place via the Patient Safety Group (reporting to Quality Committee) as validation of the risk was required, noting increased patient morbidity but no corresponding increase in serious incidents.	

	The Board of Directors: - **Reviewed and approved the Board Assurance Framework 2023/24** - **Confirmed the Trust's current Significant Risk profile and alignment between operational and principal risks.**	
101/23	**Wellbeing Guardian Report** The Board received a verbal update from the Wellbeing Guardian (Dr Marisa Logan-Ward, Non-Executive Director), who reflected on her activities. She expressed her view that wellbeing was being prioritised throughout the organisation and formed part of departmental meetings. She briefed the Board on her attendance at various wellbeing focused events, including Schwartz Rounds and a Health & Wellbeing Summit, and highlighted wellbeing support available at the Trust, including the Staff Psychology & Wellbeing Service (SPAWS). She provided an overview of areas of focus going forward to understand wellbeing issues for different professional groups. The Board heard that the Wellbeing Guardian principles, which were appended to the People Performance Committee Key Issues Report, had been reviewed and interpreted to reflect the requirements of Stockport NHS Foundation Trust. **The Board of Directors received and noted the verbal report.**	
102/23	**Board Committees – Key Issues Reports** **Finance & Performance Committee** The Chair of Finance & Performance Committee (Mr Tony Bell, Non-Executive Director) presented a key issues report from Finance & Performance Committee meetings held on 15 June 2023 and 20 July 2023. He briefed the Board on the content of the report and detailed key financial and operational issues considered. He highlighted in particular the adverse impact of the out of area no criteria to reside position on the Trust's financial position and patient experience. **The Board of Directors reviewed and confirmed the Finance & Performance Committee Key Issues Report, including actions taken.** **Quality Committee** The Chair of Quality Committee (Mrs Mary Moore, Non-Executive Director) presented a key issues report from the Quality Committee meetings held on 27 June 2023 and 25 July 2023. She briefed the Board on the content of the report and highlighted work around the Stockport Accreditation & Recognition Scheme (StARS). In response to a question from the Chair regarding areas that had received a 'red' StARS rating, the Chief Nurse advised that an action plan was developed following each StARS assessment and a meeting held with the Chief Nurse if a number of red-rated standards had been identified. **The Board of Directors:** • **Reviewed and confirmed the Quality Committee Key Issues Report, including actions taken.** • **Reviewed and supported the Local Maternity and Neonatal Systems (LMNS) Submission as recommended by the Quality Committee.**	

	People Performance Committee The Board of Directors received and noted the key issues report from the People Performance Committee meeting held on 13 July 2023, noting the highlights reported and the Wellbeing Guardian Principles appended to the report. **The Board of Directors reviewed and confirmed the People Performance Committee Key Issues Report, including actions taken.** **Audit Committee (including Audit Committee Annual Review 2022/23)** The Chair of Audit Committee (Dr David Hopewell, Non-Executive Director) presented a key issues report from the Audit Committee meeting held on 18 July 2023. He briefed the Board on the content of the report, highlighting the completion of the External Auditor's Value for Money work, which had reported a significant weakness in relation to financial sustainability based on submission of a deficit plan for 2023/24. It was noted that this was in line with other trusts. The Chair of Audit Committee confirmed that, following the completion of the year-end audit, the annual review of Audit Committee had been undertaken, and presented the outcome of the review including the Terms of Reference and Work Plan 2023/24 for approval. **The Board of Directors:** • **Reviewed and confirmed the Audit Committee Key Issues Report, including actions taken.** • **Reviewed the outcome of the Annual Review of Audit Committee 2022/23 and approved the Terms of Reference and Work Plan 2023/24.**	
103/23	**Any Other Business** There was no other business.	
104/23	**Date and Time of Next Meeting** Thursday, 5 October 2023, 9.30am, Pinewood House Education Centre.	
105/23	**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:_____

Curtis Soile
02/10/2023 07:32:55

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 September 2023** – Further review of toolkit and action plan agreed to be presented to PPC in March 2024 – Confirmed on PPC Work Plan. Action to be closed on Board Action Log.	Director of People & OD / Director of Communications & Corporate Affairs	TBC
02/22	1 Dec 2022	201/22	Wellbeing Guardian Report	It was agreed that further clarity and exploration of the wellbeing principles was required outside of the meeting, with the outcome reported through next Wellbeing Guardian Report to the Board. **Update February 2023** – Next Wellbeing Guardian Report to be presented – August 2023 (In line with PPC Work Plan & Board of Directors	Wellbeing Guardian / Board members	Closed

Action Log Ref No/Yr.	Meeting Date	Minute Ref	Item	Action	Responsible	Status
				Work Plan). **Update August 2023** – On agenda. Action closed.		
01/23	3 Aug 2023	94/23	Integrated Performance Report – Workforce	The Board requested quantitative information on the cost of sickness absence and bank and agency usage above target, and what the financial savings would be if the Trust was able to reduce to the target.	Chief Finance Officer	December 2023

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	5th October 2023	**Public**	X	**Confidential**	
Meeting	Board of Directors				
Report Title	Chair's Report				
Director Lead	Prof. Tony Warne, Chair	**Author**	Prof. Tony Warne, Chair		

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

This paper relates to the following Annual Corporate Objectives

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

The paper relates to the following CQC domains

	Safe		Effective
	Caring		Responsive
X	Well-Led		Use of Resources

This paper relates to the following Board Assurance Framework risks

	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	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

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

1. PURPOSE OF THE REPORT

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

2. EXTERNAL PARTNERSHIPS

The invasion and war in Ukraine continues' and as I write this report, we are on day 580 of this dreadful ongoing conflict. There appears to be no end in sight, and indeed the recent meeting with North Koreas Kim Jong-un does not bode well for an early resolution to this conflict. I'm certain that standing together, love and not hate will eventually triumph. Until then we should keep all those caught up in the Ukraine/Russia war and in the growing number of other conflicts around the world, in our thoughts and prayers.

I attended just one NHS England North West Regional System Leaders meeting since my last report. The meeting coincided with the conviction of Lucy Letby for the awful crimes she committed in murdering 7 babies and attempting to kill 6 other babies at the Countess of Chester Hospital. The meeting reflected on how NHSE could or should work with Boards when something like this case happened. While the police investigation has been on-going, the NHS has not been able to conduct its own investigation. A public inquiry has been announced. Court of Justice Appeal Judge, Lady Justice Thirlwall has been appointed Chair of the Inquiry.

Whilst there was an almost immediate response from NHSE in the form of guidance related to Freedom to Speak Up processes at Trust level, a more measured approach has emerged that recognised the importance of a healthy organisational culture, colleague engagement and communication, a shared set of lived values, and which acknowledged that a wider range of opportunities exists for colleagues to raise issues, concerns and so on.

It was one of the issues raised at the first ICB and Provider Chairs meeting with the NHS England Board. At the last moment, and perhaps reflecting the media attention on the Letby case, Chief Executives were invited too. I was pleased that the focus wasn't just on Letby, but also on other issues being faced by the NHS. These included the impact of the doctor's industrial action, both in terms of cost, and lost productivity; the scale of the RAAC problem across the NHS estate; planning for Winter; and the impact on the morale of colleagues as a consequence of a section of the media that appear persistently hostile towards the NHS.

The meeting was an opportunity to explore these issues through questions and discussion. It was good to be in the room. My only complaint was having to travel to London, something I included in my blog for that week - https://tonywarne.blogspot.com/2023/09/i-have-been-very-pleased-to-have.html

I met with the Chairs from Sector 3, Mastercall, Viaduct, Pennine Care, Health Watch, and Stockport Homes. It was an occasional meeting and an opportunity to share issues and challenges faced by these Stockport focused organisations. At this meeting we explored a number of interrelated issues including: avoidable flows into our emergency department; care close to home or in home; workforce pressures; and prevention and promoting healthy lifestyles, particularly in early years.

I visited The Christie, partly to receive a handover from the outgoing Chair, Chris Outram, but also to see the work of this specialist Trust, and in particular their research programmes.

3. TRUST ACTIVITIES

With the help of Karen James, John Graham, and Jonathan OBrien I was very pleased once again recognise, acknowledge, and celebrate the contribution of **88** colleagues who had worked within the NHS for 20, 30 and 40 years. In total, this year, have recognised the long service of **192** employees across the Trust. Between them this equates to a staggering **4,540** years of service to the NHS.

On an extremely hot afternoon, I chaired our full Council of Governors Meeting, which was very well attended. The challenges and questions were all helpful in providing assurance of the work of Board, and the work of the NEDs in particular.

We held our Annual Members Meeting, with a great turn out from members, governors, and colleagues. Our Annual Report and Accounts were presented and Emma McDonough provided a very informative and interesting presentation on the work of our integrated children's services.

I was able to visit our Emergency Department and to the new Transfer Hub at Regent House. Both visits were amazingly informative and as always, a great opportunity to meet and talk with colleagues about their work and our direction of travel as a Trust.

I chaired two Consultant appointment panels, and we were able to appoint to both posts: one in Rheumatology/General Medicine and the other in Occupational Health.

Finally, I was pleased to be part of our Transformation Services Celebration event. There was a huge number of colleagues who attended both the marketplace and then the presentation of the various transformation improvement projects. It was wonderful to pause and see what has been achieved and achieved during a very challenging last 12 months.

4. STRENGTHENING BOARD OVERSIGHT

We have been able to hold one Board Development event since I last reported to the Board. The session provided an introduction to a different and externally facilitated Board Development programme. The session very much set the scene for the programme. We explored the importance of personal relationships and building trust; the unitary nature of our Board and what that might mean for the way we challenge each other; and how the Board might work more effectively on strategy and culture. Three more sessions over the next six months have been planned.

NHS Stockport NHS Foundation Trust

Meeting date	5th October 2023	**Public**	X	**Confidential**	
Meeting	Board of Directors				
Report Title	Chief Executive Report				
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 the content of the report.					

This paper relates to the following Annual Corporate Objectives

	1	Deliver personalised, safe and caring services
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	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

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

- Industrial Action
- Verdict in the trial of Lucy Letby
- GM Integrated Care System
- Awards

1. Purpose

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

2. Industrial Action

In August, the British Medical Association (BMA) announced that its junior doctor members voted for a further six months of strike action and would coordinate industrial action with its consultant members in September and October. Industrial action with junior doctors and consultants continued in August and September, and the first joint strike took place on 20th September, where Christmas Day levels of cover were provided. Christmas Day cover means that emergency care is provided.

Further joint strike action by junior and consultant doctors is also taking place 2nd October – 5th October (72 hours) with Christmas Day cover provided. As with previous industrial action, actions and plans have been put in place to ensure staffing levels are safe and minimise risk during the strike. However, the cumulative impact of industrial action is having significant adverse impact on the restoration of elective activity, with the cancellation of elective procedures and pause in booking patients referred for elective care.

The renewed mandate for BMA junior doctor members lasts from 14ttth September until the 20 February 2024.

3. Verdict in the trial of Lucy Letby

The verdict in the trial of Lucy Letby and the crimes committed were a betrayal of the trust placed in her, and our thoughts are with the all the families affected. Throughout the NHS and as a Trust, we continue to do everything we can to prevent anything like this happening again. Safeguards in place include the role of Medical Examiners ensuring independent scrutiny of all deaths not investigated by a coroner and improving data quality, making it easier to spot potential problems.

The Patient Safety Incident Response Framework will be implemented across the NHS in the Autumn, with the Board of Directors approving the Patient Safety Incident response plan at its meeting in August 2023. This represents a shift in the way we respond to patient safety incidents, with a sharper focus on data and understanding how incidents happen.

In addition, we ensure that we listen to the concerns of patients, families and staff and we want everyone working in the health service to feel safe to speak up. A strengthened Freedom to Speak Up (FTSU) policy was rolled out last year and we recently welcomed our new Freedom to Speak Up Guardian, Nadia Walsh, who will continue to report to the Board of Directors regarding the Trust's approach to cultivating an open and robust speaking-up culture.

4. Greater Manchester Integrated Care System (GM ICS)

GM has now redefined its operating model which outlines revised governance arrangements for GM ICS. These new arrangements have been shared with localities

and partners across the system. As reported to the Board of Directors in August 2023, Stockport Health and Care (Locality) Board and the Stockport Provider Partnership, led by the Trust, have identified priorities specifically relating to improving outcomes in key areas for the population where key outcomes could be improved and inequalities persist. The priorities support those set out in the GM strategy and Joint Forward Plan to ensure Stockport delivers its delegated duties.

GM remains in a financially challenging position and, as a consequence of the year-to-date financial performance, further meetings are planned with NHS England (NHSE) to review the GM ICS financial plans.

GM is working with a number of external partners to develop both an in-year financial recovery plan (supported by PwC) as well as a strategic financial framework for the next five years (working with Carnell Farrah). Monthly recovery meetings have now been established with each provider Trusts within the GM ICS to support in rapidly improving the financial position.

5. Care Quality Commission (CQC) Inspection – Maternity Services

As part of the planned maternity inspection programme, the Care Quality Commission (CQC) visited the Stepping Hill Hospital site on Thursday 28 September 2023 to inspect our maternity services. As part of the inspection, the inspectors also engaged with our Maternity Board Safety Champions. Further update will be provided to the Board of Directors when formal feedback is received.

6. Trust Service Developments

New electric community ambulance helps reduce carbon emissions

We have introduced our first electric community ambulance to make patient transport more environmentally friendly, helping us to reduce our carbon emissions.

Non-emergency patients can now be transported to and from Stepping Hill Hospital in the environmentally friendly vehicle recently introduced by local provider Ambulnz Community Partners.

The new community ambulance will help us reach the targets of our Green Plan introduced in 2022, which includes ambitions for a 75% cut in business travel emissions by 2030, and a reduction of overall greenhouse emissions of 85% by 2032. Electric delivery vans on the Stepping Hill Hospital site have already been introduced.

New service supporting visual care for stroke patients

Patients at the stroke unit will now receive full orthoptist assessment when admitted with a stroke, thanks to Catalyst Funding from NHS England Stroke Quality Improvement Rehabilitation (SQuIRe). It will mean more successful outcomes in treating the eye conditions which often accompany a stroke. They will then receive orthoptic review and therapeutic support and rehabilitation within the community.

The Catalyst funding of £264,000 from NHS England Stroke Quality Improvement

Rehabilitation (SQuIRe) was successfully secured for 'Implementation of a visual impairment pathway in the Southern Sector of Greater Manchester'. The purpose of Catalyst funding is to support projects that make a difference to patient care, and the Stockport project is one of five new projects, in addition to the current 14 Catalyst projects across the North West.

Music Therapy Recognition

A musician who plays soothing music for patients at our intensive treatment unit (ICU) has spoken at an international conference on the benefits which musical therapy can bring.

Amy Bowles made a presentation to the Neurosciences in Intensive Care International Symposium held at the Institut Pasteur in Paris, as part of a series of lectures sharing evidence of the positive neurological effects which music can have for patients.

Amy is a classically trained guitarist and singer who visits our ICU on a weekly basis, playing calming and melodious music for our patients. Her visits are part of the 'Restore and Recover' project funded by Arts Council England to use music to help soothe patients, staff and visitors.

6. Awards

Long Service Awards 2023
At the end of September, we celebrated the contribution of our colleagues who have worked in the Trust and the wider NHS for 20, 30 or 40 years at our annual Long Service Awards Ceremony. the loyalty, commitment and high level of skill brought by individuals is a key factor in our success.

Recognition for school nurse and health visitor
Two members of our school nursing, health visiting and Start Well early years team have received separate awards recognising their contributions to high quality care for local children and young people.

Health visitor Harriet Griffiths, who qualified last year from Manchester Metropolitan University (MMU), has been recognised for her dedicated and passionate work supporting older vulnerable children, while school nurse apprentice Rachel Donnelly, studying at the same university, has been rewarded for her excellent poster project supporting LGBTQA+ young people.

Both work within the Stockport Family integrated service for 0-19 year olds in partnership between Stockport NHS Foundation Trust and Stockport Metropolitan Borough Council.

Double shortlisting in NHS research awards
Excellence in clinical research and development at Stockport NHS Foundation Trust has been recognised with two separate shortlisted places in regional NHS research awards.

Both Wiesia Woodyatt, Research and Innovation Manager, and Daisy Pegler, Clinical Research Midwife, have been announced as finalists in this year's Greater Manchester Health and Care Research Awards, run by the National Institute for Health Research.

Wiesia Woodyatt has been shortlisted in the Exceptional Research Delivery Leadership category at the awards, while Daisy Pegler is a finalist in the New to Research category.

The winners of the Greater Manchester Health and Care Research Awards 2023 will be revealed during a ceremony at The Etihad Stadium, Manchester, on Thursday 5th October 2023.

NHS
Stockport
NHS Foundation Trust

Meeting date	05 October 2023	**Public**	**X**	**Confidential**	
Meeting	Board of Directors				
Report Title	Reinforced Autoclaved Aerated Concrete (RAAC) Briefing				
Director Lead	Estates and Facilities	**Author**	Paul Featherstone Director, Estates and Facilities		

Paper For:	**Information**	**X**	**Assurance**	**X**	**Decision**	
Recommendation:	The Board are asked to note: • The Trust's appointed surveyors undertook a RAAC survey in January 2021 and identified RAAC in one building on the Stockport NHS Foundation Trust hospital site. • The RAAC is located in Block 16 – Boiler House. This is a non-patient / public area. Immediate steps were taken to install a 'crash deck' scaffolding system to support the RAAC and protect the services located within the boiler house. • A Department of Health funded capital project is on course to be completed this year to remove the RAAC. • After the publication of new guidance, a RAAC revalidation survey was undertaken in September 2023, and no further RAAC was found. • Direct confirmation has been received from NHS Property Services regarding the absence of RAAC in their properties. • Explicit confirmation is still being sought from the Local Authority regarding the presence of RAAC in a number of their buildings that the Trust occupy / use.					

This paper relates to the following Annual Corporate Objectives

	1	Deliver personalised, safe and caring services
X	2	Support the health and wellbeing needs of our community and colleagues
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	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
X	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

	PR1.1	There is a risk that the Trust does not deliver high quality care to service users
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	PR7.1	There is a risk that the Trust does not implement the Digital Strategy to ensure a resilient and responsive digital infrastructure
X	PR7.2	There is a risk that the estate is not fit for purpose and/or meets national standards
	PR7.3	There is a risk that the Trust does not materially improve environmental sustainability
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

Reinforced Autoclaved Aerated Concrete (or "RAAC") is a lightweight concrete that, if not managed robustly, could be prone to sudden collapse due to its physical characteristics.

RAAC has been used in multiple applications in the UK since the 1950s and in various locations.

In 2019 Trusts were asked to undertake RAAC reviews, principally targeted towards flat roofs. However, recent events regarding the extent of the use of RAAC in the education sector has necessitated further corresponding review in the NHS.

In September 2023, Trust Boards were asked by NHS England to assure themselves that the RAAC assessments made of the NHS estate were sufficiently thorough and covered all buildings and areas on their own estate.

This paper details the work that has been undertaken historically, and that is going on currently, to ensure that the Trust is managing any RAAC concerns robustly. Notably, it provides detailed survey information in respect of the hospital estate and reports on the assurances provided by a number of 3rd party landlords for a number of properties that the Trust occupies or uses.

Stockport NHS Foundation Trust

Reinforced Autoclaved Aerated Concrete

1. Introduction

As the Board will be aware, there has been significant media interest over the last month or so in respect of the presence of Reinforced Autoclaved Aerated Concrete (RAAC) in the education sector and other public sector buildings. This paper provides with Board with further information regarding RAAC and an up-to-date position statement regarding its presence in the Trust owned and operated estate.

2. What is RAAC?

RAAC is a lightweight cementitious material. It is aerated and has no coarse aggregate, meaning the material properties and structural behaviour differ significantly from 'traditional' reinforced concrete. RAAC has been used in building structures in the UK and Europe since the late 1950's, most commonly as precast roof panels in flat roof construction. Typically, the compressive strength of RAAC is much lower than traditional concrete, as are flexural, shear, and tensile strength characteristics. Finally, RAAC is highly permeable and, as a result, cover to the reinforcement present within panels does not protect against environmental conditions as with traditional concrete.

Therefore, over time, RAAC can deteriorate and, if not managed robustly, this can lead to unexpected collapse as the integrity of the structure is potentially undermined by a range of environmental and other factors.

3. Management of RAAC (2020)

All guidelines on the identification, monitoring and remediation of RAAC are based upon and driven by expert advice from the Institute for Structural Engineers (IStructE).

In July 2018, part of the roof at Singlewell Primary School in Gravesend, Kent, which was constructed from RAAC, collapsed. Fortunately, it was a Saturday evening so the building was empty.

Subsequently, in May 2019 the Standing Committee on Structural Safety (SCOSS)[1] issued a report to schools, government departments and local authorities which was passed on to the NHS.

In November 2019, NHS England and Improvement wrote to all Trusts asking them to review their local estate records and identify any buildings that could be constructed of RAAC planks. It was notable that the preamble to this request stated:

> *"…. owners of both schools and non-school buildings that have pre - 1980 RAAC plank roofs should arrange for these roofs to be inspected if this has*

[1] The Standing Committee on Structural Safety (SCOSS) was established in the United Kingdom by the Presidents of the Institution of Structural Engineers (IStructE), the Institution of Civil Engineers (ICE) and the Institution of Municipal Engineers (IMunE).

The main function of SCOSS is to identify in advance trends and developments which might contribute to an increased risk to structural safety. To that end, SCOSS interacts with the professions, industry and government on all matters concerned with the design, construction and use of building and civil engineering structures.

not been done since 1994, although generally the deterioration of RAAC planks does not jeopardise structural safety."

In December 2020, the Trust's Head of Estates and Head of Capital, instructed Urban Design & Consult (UDC) to undertake a review of the structural build-up of the Trust's flat roofs throughout the Stepping Hill Hospital estate to check for the presence of RAAC. UDC are a multi-disciplinary practice of property professionals including Chartered Structural Engineers and Chartered Building Surveyors.

Following the appraisal and, where necessary, subsequent invasive analysis, one area of the hospital site was identified to have RAAC roof panels. This roof is a flat roof over the Trust's main boiler house (Block 16). The boiler house provides heating and hot water to a majority of the buildings on the hospital site. The area is accessed regularly for routine and emergency maintenance purposes and there is a small office space within the building.

Given the risks associated with the RAAC panels, the significant spans involved in this particular building, and some visible signs of deterioration, the boiler house was recorded as a high risk on the initial UDC appraisal report. Therefore, in accordance with the guidance issued, steps were immediately taken to mitigate any associated risk by:

- Undertaking regular monitoring of the condition of the RAAC.
- Managing / limiting access into the area beneath the RAAC structure.
- Cancelling planned maintenance works to the boiler house roof covering.
- Constructing and installing a scaffold crash desk to effectively 'catch' any potential falling debris and to provide interim support to the structure.

4. Management of RAAC (2023)

One week before the start of the 2023 / 2024 academic school year, 104 schools were instructed by the Department for Education to vacate buildings constructed from RAAC. Inevitably, this resulted in a significant renewed focus on RAAC and associated media coverage. Very quickly, this extended to other public sector organisations, including the NHS.

On the 01 September 2023, the Trust Director of Estates and Facilities pro-actively asked the Trust estates team to arrange for a revalidation of the 2020 RAAC survey, including establishing the potential presence of RAAC in community-based properties. Subsequently, UDC was recommissioned to undertake a revalidation review of all hospital-site buildings and, for community-based properties, the necessary assurances around RAAC were sought directly from landlords.

Given the then emergent media narrative in terms of where RAAC was allegedly being discovered, the Trust Director of Estates and Facilities also raised a number of queries with the Regional NHSE Estates and Facilities lead around the adequacy of the original 2019 return request.

Further to new guidance published by the Department for Education regarding the approach to the presence of RAAC in the school estate, on 05 September 2023, NHS England wrote to all NHS Trust Chairs, Chief Executives and Estates leads, instructing a number of further actions for the NHS. A copy of this letter is attached at Appendix 1 to this paper.

4.1 Stockport NHS Foundation Trust Hospital

A copy of the UDC revalidation survey report was received on 21 September 2023 and is attached at Appendix 2 to this paper for information.

With reference to the revalidation survey undertaken by UDC, the conclusion of the report is as follows:

"We have inspected all the roof structures of the requested buildings and are pleased to report that none of them exhibit any evidence of RAAC construction. For certain buildings, we conducted further investigations, including core sampling, which also yielded negative results for RAAC."

4.2 Community Properties

The Trust's Head of Estates has received the following confirmation from the respective landlords of community-based properties as follows:

(i) NHS Property Services (NHSP):

Via email:

"NHSPS has completed (national) investigations on 693 freehold properties. We can confirm remedial works to make them safe on five of seven buildings found to have RAAC are now completed. Of the remaining two, one site is vacant and is due to be redeveloped and one has temporary supports and is planned to be vacated. 237 leasehold properties have been checked, with no RAAC identified. A further 34 are being checked by landlords. We are working closely with NHS England, our customers, building landlords and specialist external consultants, including surveyors, to plan any required remedial work as well as necessary additional safety measures."

Additionally, in the August 2023 edition of the NHS Greater Manchester Estates Bulletin it is stated that:

"NHS PS (and CHP) have confirmed that no RAAC has been found in the primary and community care estate in Greater Manchester."

(ii) Stockport Metropolitan Borough Council (SMBC)

The Trust has a presence at / uses a number of Local Authority properties. At the time of writing this paper, the Trust awaits confirmation from SMBCs Assistant Director of Strategic Property regarding the presence of any RAAC in these properties.

The Board will note that the Trust's Director of Estates and Facilities is in the process of writing to his counterparts in each landlord organisation to acknowledge their confirmation of no RAAC present where this has been provided (through whatever means). For SMBC owned properties, enquiries remain ongoing and a further update will be provided by the Director of Estates and Facilities in due course.

5. Summary and Recommendations

The Board of Directors are recommended to note:

(i) RAAC is present in Block 16 of the hospital estate – boiler house.

(ii) Immediate steps were taken to mitigate the risk.

(iii) Upon completing a revalidation of the original RAAC survey by Urban Design and Consult in September 2023, no further RAAC was found to be located within the Stockport Stepping Hill Hospital estate.

(iv) A capital project scheme is on course to be completed this year to remove the RAAC from the boiler house roof.

(v) Direct confirmation has been received from NHS Property Services regarding the absence of RAAC in their properties; and

(vi) Direct confirmation is being sought from the Local Authority regarding the presence of RAAC in their buildings that the Trust occupy / use.

NHS England

To:
- All NHS trusts:
  - chairs
  - chief executive officers
  - estates leads

cc.
- Integrated care boards:
  - chairs
  - chief executive officers
  - estates leads
- Regional directors

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

5 September 2023

Dear Colleagues,

Reinforced aerated autoclaved concrete (RAAC)

Last week new guidance was published by the Department for Education regarding the approach to the presence of RAAC in the school estate. This has generated heightened public interest in the presence of RAAC in the NHS estate, and a number of questions from colleagues.

You are all aware of the risks associated with RAAC as part of the extensive programme of work undertaken over recent years. We are writing to reiterate the position in the NHS estate, and to outline actions you should be taking to assure yourselves as far as possible that RAAC is identified and appropriately mitigated, to keep patients, staff and visitors safe.

To provide co-ordination to these actions, we will be communicating via regional operations centres. **Please therefore ensure that appropriate arrangements are made within your organisation to be able to respond to communication from your regional operations centre (ROC) on this subject.**

Guidance on RAAC identification, monitoring and remediation

All guidelines on RAAC are based and driven by expert advice from the Institute for Structural Engineers (IStructE). There has been no change in IStructE guidance, which government has confirmed continues to be the basis of action to manage the situation in the NHS and wider public sector. We continue to work closely with government departments and technical advisory groups and have asked to be made aware of any changes to the guidance so that we can share these with you immediately.

Following an alert issued by The Standing Committee on Structural Safety (SCOSS) in 2019, the NHS in England put in place a now well-established programme to identify RAAC, support providers to put appropriate mitigations in place, and plan for eradication. We have worked closely with the trusts managing the 27 previously identified sites, including securing funding for investigative, safety/remedial and replacement work, with three of those sites now having eradicated RAAC.

As part of this ongoing work, in May 2023 NHS England sent out additional guidance to organisations including all provider trusts (including mental health, community and ambulance) following updated national guidance from IStructE on RAAC identification, management and remediation and Further Guidance on Investigation and Assessment (April 2023).

Identification of RAAC

We asked trusts to assess their estate again based on this updated guidance. Initial assessments of additional sites identified through this process are already being undertaken and are expected to be completed by the end of this week. The national RAAC programme team are collating information from these assessments, including where appropriate mitigation plans and the steps necessary to remove this material from use.

Given the importance of this work, we ask that – in any instances where this has not already been the case – boards ensure they support their estates teams and review the returns they provided to assure themselves that the assessments made were sufficiently thorough and covered all buildings and areas on your estate (including plant/works, education and other non-clinical areas/buildings).

ICBs will want assurance about the primary care estate and should work with their local primary practices and PCNs to ensure you have confirmation that no RAAC has been identified or, where it has, on the identification and management of RAAC. Guidance for the primary care estate was circulated in January of this year, which ROCs can reshare.

Management of identified RAAC

Trusts which have previously identified RAAC will have put in place management plans in line with the IStructE guidance.

In light of the need to maintain both the safety and confidence of staff, patients and visitors, **we recommend that in those organisations where the presence of RAAC has been confirmed and is being managed, boards take steps now to assure themselves that the management plans in place for each incidence – and particularly where panels are currently subject to monitoring only – are sufficiently robust and being implemented.**

Where you think you require assistance in completing this work, please contact: england.estatesandfacilities@nhs.net.

Planning for RAAC incidents

Effective management of RAAC significantly reduces associated risks; but does not completely eliminate them. Planning for RAAC failure, including the decant of patients and services where RAAC panels are present in clinical areas, is therefore part of business continuity planning for trusts where RAAC is known to be present, or is potentially present.

A regional evacuation plan was created and tested in the East of England. Learnings from this exercise have been cascaded to the other regions.

We would recommend that all boards ensure that they are familiar with the learning from this exercise and that they are being incorporated into standard business continuity planning as a matter of good practice.

This exercise is, however, essential for those organisations with known RAAC, and should be done as a matter of priority if it has not already been completed.

Thank you to you and your teams for the work on this to date, particularly in those organisations where RAAC has been found and management/remediation plans have been enacted. As mentioned above we will communicate further information through ROCs.

Yours sincerely,

Jacqui Rock
Chief Commercial Officer

Dr Mike Prentice
National Director for Emergency Planning and Incident Response

Our Ref.: J000334 & J000607
Prepared by: David B Percy
Mark Mallen
Mike Deacon
Howard Russell
Sarah Costello

Of: Urban Design & Consult Ltd
Original Report Date: 28/01/2021
Addendum Added: 01/12/2022 & 21/09/2023

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Generation House, 15 Jersey St.
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Report Particulars:

UDC have been approached by the Estates Team of Stockport Foundation Trust (SFT) in relation to their site at Stepping Hill Hospital, Stockport and further to a HSJ Strategic Estates publication, regarding the risks associated with Reinforced Autoclaved Aerated Concrete (RAAC).

In Respect of:

Stepping Hill Hospital

On Behalf of:

Stockport NHS Foundation Trust

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Appendix 14	Stepping Hill RAAC – Report Validation & Top UP Survey – Pitched Roofs
Appendix 14	Map of Pitched Roof Structures Surveyed Sept 2023

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The Brief

UDC have been approached by Stockport Foundation Trust (SFT) to identify possible Reinforced Autoclaved Aerated Concrete (RAAC) Planks at Stepping Hill Hospital.

Introduction

Urban Design & Consult Ltd (UDC) have been approached by Stockport Foundation Trust (SFT) in relation to their site at Stepping Hill Hospital, Stockport and further to a HSJ Strategic Estates publication regarding the risks associated with Reinforced Autoclaved Aerated Concrete (RAAC).

It has been identified by HSJ that the deleterious material poses a significant risk to the Healthcare Estate and that to remedy often involves substantial / invasive work or even re-construction. Consequently, SFT are keen to understand any risk they have on their site at Stepping Hill and start to plan / take any immediate action to manage risk.

In order to support SFT with this, UDC have been requested to undertake an appraisal and report on the existing site.

In order to achieve this, we proposed to undertake, as follows:

1. Desktop research and update on latest industry SCOSS, BRE & HSJ guidance on RAAC, it is likely usage and therefore locations across the Stepping Hill Site and symptoms to look out for during the survey.

2. Desktop study and information gathering of the existing estate - we have presumed that we will undertake this activity within SFT Estates offices in order that we may have access to the latest information inclusive of as built drawings and H&S Files.

3. 'Walk the site' - the purpose of this is to attempt to reduce the extent to which detailed survey work is required by eliminating any buildings / or areas of buildings which are not likely to contain RAAC. Dating is a useful way of achieving this together with looking at external condition and flat roofs. These areas will then be marked up on a drawing and the detailed survey area refined.

4. Build a bespoke survey form to capture information on a handheld device in the most efficient manner possible and to ensure information is captured to inform the report, risk assessment, and form a basis for the procurement of short and medium-term actions, if required.

5. Undertake the detailed / targeted survey of roofs and floors noting that we will look to do a 'representative inspection' but anticipate it being impractical to inspect the entire structure (particularly to underside of roofs and floors) due to the nature of internal finishes and occupancy.

6. Desktop extraction of survey data and preparation of report and risk assessment.

7. Final report and recommendations assembly.

The following assumptions have been made:

1. We will be reporting on primary structural elements i.e., roofs and intermediate floors where high risk has a potential to exist.

2. We have included for inspection from ground level, on an inspection ladder or using fixed access equipment provided by SFT. Following the initial survey and if felt necessary, we would use drones to survey flat roof areas and we have included for a day's drone work as an option within this proposal.

3. We will be able to spend time / and have access to Estates records to inform our survey.

4. Reports will be supplied in electronic (PDF) format.

Failure of Reinforced Autoclaved Aerated Concrete (RAAC) Planks

What is RAAC?

Autoclaved aerated concrete (AAC) is different from normal dense concrete. It has no coarse aggregate, and is made in factories using fine aggregate, chemicals to create gas bubbles, and heat to cure the compound. It is relatively weak with a low capacity for developing bond with embedded reinforcement.

It was used in two main forms of structural elements:

- Lightweight masonry blocks.
- Structural units (such as roof planks, wall, and floor units).

When reinforced (Reinforced AAC: RAAC) to form structural units, the protection of the reinforcement against corrosion is provided by a bituminous or a cement latex coating, which is applied to the reinforcement prior to casting the planks. The reinforcement mesh is then introduced into the formwork and the liquid AAC mix added.

Plate 1: A lump sample of AAC

Background

RAAC Planks were used when constructing public sector buildings in the 1960s, 70s and 80s, including a group of prefabricated hospitals under the government's 'Best Buy' building programme. However, RAAC planks used in buildings constructed prior to 1980 have now exceeded their shelf life, meaning affected trusts need to carry out frequent inspections and expensive maintenance.

In May 2019, the unexpected collapse of a roof at a school in Essex prompted a safety alert from the Standing Committee of Structural Safety (SCOSS) over buildings constructed using RAAC planks.

- **See Appendix 1 SCOSS Alert May 2019, Failure of RAAC Planks**

The SCOSS Alert refers to an earlier report compiled by The Building Research Establishment (BRE) in 1996.The 1996 BRE Information Paper IP 10/96 – Reinforced autoclaved aerated concrete planks designed before 1980 outlines a preliminary inspection procedure.

- **See Appendix 2a - IP10 Reinforced autoclaved aerated concrete planks designed before 1980**
- **See Appendix 2b – Reinforced Autoclaved Aerated Concrete (RAAC) Investigation and Assessment – Further Guidance (V9 – April 2023)**

NHS England has notified all trusts of the alert on three separate occasions since May 2019. Furthermore, NHS England released publication reference PRN00777 on 05/09/2023 with the following salient points for NHS Trusts.

- ensure that appropriate arrangements are made within your organisation to be able to respond to communication from your regional operations centre (ROC) on this subject.
- boards ensure they support their estates teams and review the returns they provided to assure themselves that the assessments made were sufficiently thorough and covered all buildings and areas on your estate (including plant/works, education and other non-clinical areas/buildings).
- those organisations where the presence of RAAC has been confirmed and is being managed, boards take steps now to assure themselves that the management plans in place for each incidence – and particularly where panels are currently subject to monitoring only – are sufficiently robust and being implemented.
- recommend that all boards ensure that they are familiar with the learning from this exercise and that they are being incorporated into standard business continuity planning as a matter of good practice. Those organisations with known RAAC, and should be done as a matter of priority if it has not already been completed.

In total, 13 trusts have reported RAAC planks at their facilities.

These trusts are facing billions of pounds of maintenance over 'significant safety issues' arising from outdated construction methods.

In late 2018, the Local Government Association (LGA) and the Department for Education (DfE) contacted all school building owners to draw attention to a recent failure involving a flat roof constructed using RAAC planks. There was little warning of the sudden collapse.

Although the failure was in a school, it is believed that RAAC planks are present in many types of buildings. The alert was to emphasise the potential risks from such construction.

Although called 'concrete', it is very different from traditional concrete and, because of the way in which it was made, it was much weaker. The useful life of such planks has been estimated to be around 30 years.

Pre-1980 RAAC planks are now past their expected service life, and it is recommended that consideration is given to their replacement.

In the 1980s there were many instances of failure of RAAC roof planks installed during the mid-1960s and a large proportion of such installations were subsequently demolished. Several case studies revealed some primary deficiencies:

- Incorrect cover to the tension steel
- High span-to depth ratio
- Insufficient provision of crossbars for providing anchorage for the longitudinal steel
- Failure in performance of roof membrane
- Rapid worsening of local corrosion of steel.

It is known that RAAC was used for walls, and it is possible that there were RAAC floor planks, but no failures of these have been identified in the current review.

The BRE Information Paper in 1996, which stated that excessive deflections and cracking had been identified in a number of RAAC roof planks and evidence of initiation of reinforcement corrosion was found. This was followed in 2002 with further information on performance issues, laboratory testing, and advice on inspection.

More recent investigations of externally exposed load bearing wall panels have found that corrosion was initiated even where the bituminous coating appears to have been visibly intact.

Severe corrosion of the reinforcement embedded in RAAC wall panels bordering shower rooms and toilets has also been recently identified.

Concerns that had arisen with roof planks include:

- Rusting of embedded reinforcement leading to cracking and spalling of the AAC cover
- Cracking, of varying degrees of severity, thought to be associated with moisture and temperature related
- movements in the planks
- Excessive deflections due to creep
- Floor and roof planks tending to act independently, rather than as a single structural entity.
- In some cases, the deflections had become appreciable, with span-to-deflection ratios in the order of 100.

This could lead to:

- Ponding of rainwater, with the potential increase in the imposed loading.
- Distress to certain types of waterproof membrane and associated finishes.
- Water penetration sufficient to promote corrosion of the embedded reinforcement.

In addition, an article was published in HSJ on 3rd December 2020.

See Appendix 3 HSJ Article (3.12.2020)

Based upon the failures reported in the HSJ article, which prompted SFT to act, UDC have concerned themselves with RAAC Planks used in roofs.

Risk Assessment

Problems with RAAC roof planks have been known about since the early 1990s. In many buildings, the planks have been replaced with alternative structural roofs or the spans have been shortened by the introduction of secondary supports, but others will remain.

Therefore, there is a risk, although its extent is uncertain. The risk must be identified by locating buildings where RAAC planks are present and assessing their condition and structural adequacy. If there is doubt about the structural adequacy of the planks, then it is recommended that consideration is given to their replacement.

This report concerns itself with the identification of possible RAAC Planks.

Identification and Inspection of RAAC Planks

There is no national, central register of buildings with RAAC roof planks (and/or floor and wall panels), so identification will depend upon local knowledge and individual inspections.

There is a need to risk assess, suitably plan, and then develop a safe system of work for the identification and inspection work.

The steps to take in identifying RAAC planks include:

- RAAC planks were used for the construction of flat roofs in the 1960-80s, so buildings (or extensions) pre-dating or post-dating this period are unlikely to be affected.
- Determining if any similar buildings in the area are known to have RAAC roof planks.
- Accessing any records relating to construction to see if RAAC is mentioned.
- If the construction type of a roof is not known and could potentially be RAAC planks, then the roof should be inspected, and measures put in place to manage the risk e.g., temporary propping of the roof.

The 1996 BRE Information Paper IP 10/96 outlines a preliminary inspection procedure:

- Inspect the soffit of possible RAAC planks for indications of excessive deflection.
- Inspect roofs from above for signs of rainwater ponding.
- Inspections from above should be done from a place of safety e.g., nearby vantage point, drone, mobile elevated work platform (MEWP) or scaffolding.
- Inspect roofs from the underside, if possible, looking for:
  - Visible cracks (particularly in the vicinity of the end supports).
  - Evidence of water ingress, rust staining or spalling.
  - Consideration should be given to conducting a small intrusive drill sample to assist the inspection.

The Institution of Structural Engineers: Reinforced Autoclaved Aerated Concrete (RAAC) Investigation and Assessment – Further Guidance (V9 – April 2023) (Refer to Appendix 2b for Full Document)

Summary of Guidance:

This report provides further guidance on the critical risk factors associated with RAAC panel construction. It includes a proposed approach to the classification of these risk factors and how these may impact on the proposed remediation and management of RAAC.

Surveys: scope of surveys to be adopted for RAAC panel installations. Survey the panels for:

- Measurement of deflections
- Recording of cracks and defects
- Recording evidence of water leaks
- Hammer tap testing for signs of debonding concrete
- Recordings of panels cut after manufacture
- Recording of any alteration or penetration through panels after construction

The measurement of each panel deflection will allow the greatest level of assessment. However, where this is not possible, measurement of de- flection of a representative sample should be undertaken. A minimum recommended sample size should be proportional to the size and scale of the building or structure being assessed but should typically not be less than 10% of the total number of panels.

The panels selected should provide a representative sample including:

- Structural spans
- Panel width and depth (if known)
- Increased loading resulting from roof access

- Loading from a supported plant or machinery
- Different internal environments, for example, any dry, damp or humid areas
- Areas where there could be an accumulation of external load factors including a build-up of water or drifting of snow

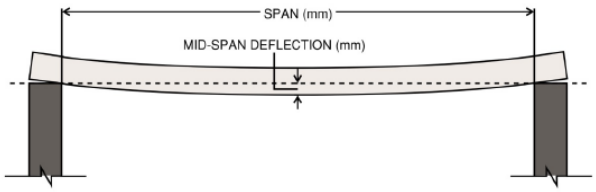


Figure 1 - Deflection schematic (not to scale)

The specification of intrusive investigation works for RAAC panels should be carefully considered. Intrusive surveys can be undertaken to record:

- Panel bearing lengths
- Position of transverse anchorage reinforcement at bearings
- Panel thickness
- Reinforcement quantities and diameter

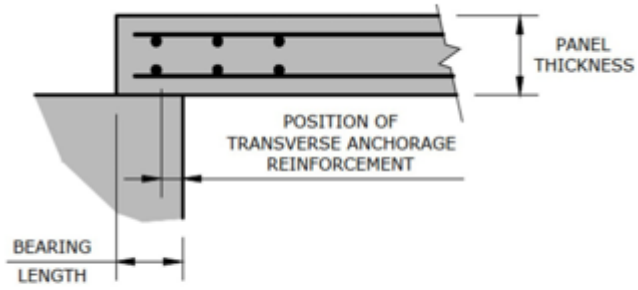


Figure 2 – End bearing configuration

Locations for intrusive investigation should provide a representative sample from around the building or structure. This should include any variation in span or support arrangements. The number of locations selected needs to be sufficient to gain an understanding of the original design intent for the panels and the range of manufacturing or construction installation tolerances.

A minimum as built bearing length 75mm is now considered to be necessary. Any bearing less than 75mm would be considered substandard and present an unacceptable risk to panels from shear failure or slippage and remedial actions are recommended.

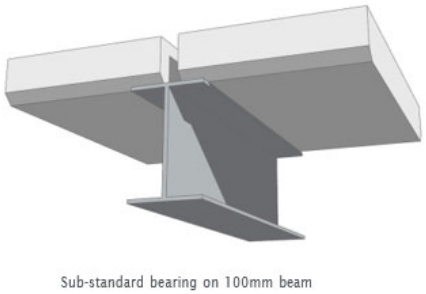


Figure 3 – End bearing condition

However, in many instances visual inspection alone may be inadequate. Numerous examples have been found of panels having short bearing lengths (<75mm) even when supported on wide steel or concrete beams. Therefore, it is recommended that the bearing length is verified. Intrusive surveys are the only effective method for identifying the bearing length and the position of transverse anchorage reinforcement.

Where transverse anchorage reinforcement is absent the longitudinal bars will have significantly reduced tensile capacity and there is an increased risk of failure. The mode of failure is still being assessed by academic research, however sudden brittle shear failure is considered possible. It is not possible to ascertain poor anchorage of reinforcement from visual inspection, therefore intrusive survey techniques are required.

Cut Panels: Cut panels can be created from the manufacturing process where longer panels may have been cast and cut down to create shorter panels or where panels were trimmed at the time of the original construction for building services or other small penetrations. Depending on the span of the panel being supported these conditions may present high risk of panel failure. Cut panels should be identified in all instances. The length of the cut panel, support conditions and defects should be noted.

Cracking: Cracking and spalling can be a visible indicator of excessive deflections, water ingress, mechanical damage or reinforcement corrosion. It is recommended that all visible defects are recorded during a visual inspection. Where applicable, this should be supported by crack measurement and location for assessment and future review. Cracking close to the supports (circa within 500mm) is of significant particular concern because it could be representative of shear cracking. Cracking close to a bearing should be recorded and cracks across the full width of a panel are considered more serious than cracks local to the edges.

Water Ingress: Prolonged water ingress can impact on RAAC. Water ingress can saturate RAAC panels giving risk to a potential increase in panel weight. Water ingress has also been noted as adversely impacting on the material strength and is likely to lead to unseen corrosion to the reinforcement. The corrosion of reinforcement will, over time, lead to spalling of the surrounding RAAC panel resulting in falling debris and potential for loss of panel capacity. The corrosion of reinforcement may also impact on the bond between RAAC and embedded reinforcement, which may adversely impact panel strength. Water ingress presents a significant contributing risk. Therefore, any panels with water ingress should be recorded and the significance assessed.

Deflection: The deflection of RAAC panels can often be noted visually, however measurement is required to ascertain accurate deflection data. The deflection of panels should be recorded and the data should be used to classify the deflection of each panel as follows:

- Deflection equal to panel span/100 or greater
- Deflection between span/100 and span/200
- Deflection between span/200 and span/250
- Deflection equal to panel span/250 or less

The differential deflection between adjacent panels should also be recorded, particularly where this is significant. Deflections exceeding 20mm between panels being considered significant.

Adverse or Changes in Loading: Any increase in loading could significantly impact on the RAAC installation, particularly when combined with other risk factors; such as poor bearing or water ingress.

Assessment of Risk

It is recommended that the surveys information is used to assess a risk classification for the panels/building. The below RAG (Red, Amber, Green) risk rating approach is proposed as set out below.

Red risks have been split into High risk and Critical risk. The application of qualified and experienced engineering judgement is required to assess when a Critical risk

Remediation

Remediation strategies may include:

- The addition of secondary supports or beams at the end bearing to provide an increased effective bearing length. This is applicable to panels with short bearings length and misplaced transverse anchorage bars. This strategy will not be suitable for cut panels with no transverse anchorage reinforcement
- Positive remedial supports to actively take the loading from the panels. This could include the addition of new timber or lightweight structures to support the panels directly
- Passive fail safe supports to mitigate catastrophic failure of the panels if a panel was to fail. Such as a secondary structure designed to support the panels
- Removal of individual panels and replacement with an alternative lightweight solution
- Entire roof replacement

Management of Strategy

The management strategy should consider the current condition of the RAAC panels and include:

- Monitoring plans for RAAC panels and inspection regime
- Risk assessment details
- Areas for proposed future remediation
- The assumption on degradation of RAAC panels that have informed the plans – this should be informed by the structural engineer, based on site conditions
- The management strategy should also include plans for reducing the risks associated with RAAC panels
- These should include plans for limiting:
    - Applied operational loads, for example no-walk zones on RAAC roofs, maintaining roof drainage and removal of ponding water
    - Applied fixed loads, for example, restricting new or removal of existing building services equipment
    - Durability risks, for example reducing humidity in plant or kitchen spaces, re-roofing including insulation laid to falls

UDC's Inspection Criteria

UDC's strategy for identifying RAAC Planks is based on BRE IP/96 and SCOSS Alert May 2019, Failure of RAAC Planks.

If planks are visible from the underside, then it is important to inspect these for warning signs which include:

- Visible cracks (particularly in the vicinity of the end supports).
- Evidence of water ingress, rust staining or spalling*.
- Any planks have deflected more than 1/100 of the span, or a significant number of planks have deflections approaching this magnitude.
- A number of the planks have very small bearing widths (less than 40mm).
- The roof has been re-surfaced since original construction.
  The re-surfacing has a black finish.
- The roof is leaking or has leaked in the past.

From above:

- Signs of rainwater ponding.

If these signs are present, then the structural roof planks may be of RAAC construction, or it could be another form of construction that is not behaving as well as might be expected

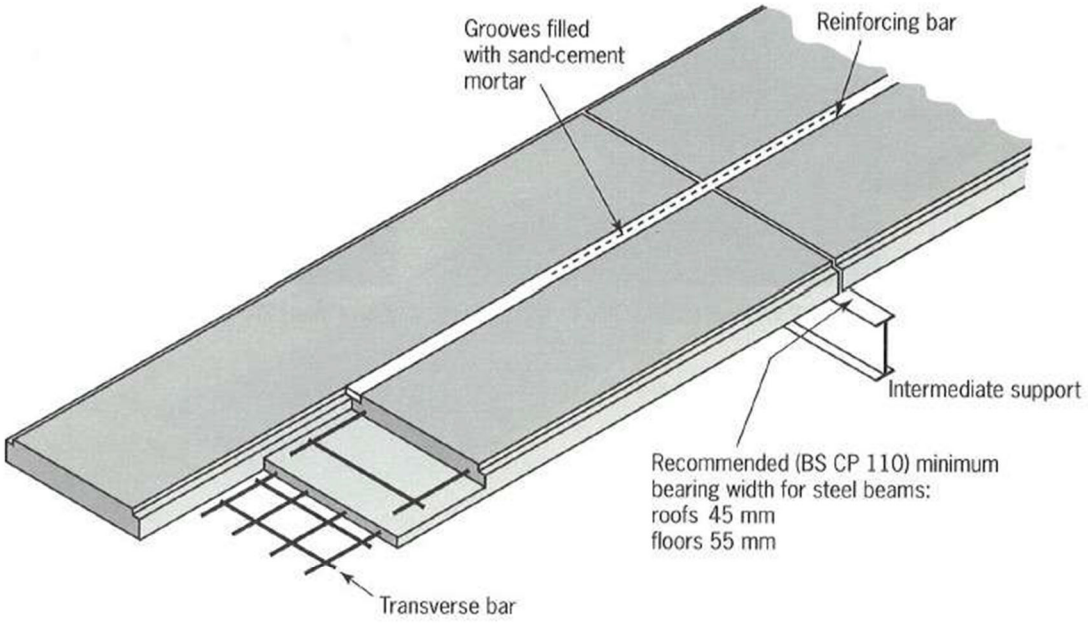


Figure 1 Typical configuration of reinforcement
A short length of reinforcing bar is often introduced into the top surface grooves between planks at intermediate support locations to improve continuity between adjacent rows of simply-supported planks. For other materials, bearing widths will be generally greater than those given here for steel beams.

Figure 2 Widespread hair-line cracking on the soffits of many RAAC planks

* Spalling is the result of surface or sub-surface fatigue, which causes fractures to form in the running surfaces. When the rolling elements travel over these cracks, pieces, or flakes, of material break away. (Spalling is also referred to as 'flaking', 'peeling', or 'pitting'.)

Regulatory Overview

Regulatory Requirements:

The Care Quality Commission (CQC) regulates all providers of regulated health and adult social care activities in England. The CQC's role is to provide assurance that the care given meets essential requirements of quality and safety.

The registration requirements are set out in the Care Quality Commission (Registration) Regulations 2009 (CQC Regulations) and include requirements relating to:

- safety and suitability of premises.
- safety, availability, and suitability of equipment; and
- cleanliness and infection control

The CQC is responsible for assessing whether providers are meeting the registration requirements. Failure to comply with the CQC Regulations is an offence and, under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The CQC has a wide range of enforcement powers that it can use if the provider is not compliant. These include the issue of a warning notice that requires improvement within a specified time, prosecution, and the power to cancel a provider's registration, removing its ability to provide regulated activities.

Health and Safety Legislation

The Health and Safety Executive is the national regulator for workplace health and safety.

The specific regulations regarding roofs are detailed in the Workplace (Health, Safety and Welfare) Regulations 1992, as follows:

Maintenance of workplace, and of equipment, devices, and systems
5. (1) The workplace and the equipment, devices, and systems to which this regulation applies shall be maintained (including cleaned as appropriate) in an efficient state, in efficient working order and in good repair.

The following legislation also applies:

Health and Safety at Work etc. Act 1974, Section 3.
It shall be the duty of every employer to conduct his undertaking in such a way as to ensure, so far as is reasonably practicable, that persons not in his employment who may be affected thereby are not thereby exposed to risks to their health or safety.

Management of Health and Safety at Work Regulations 1999, Regulation 3. (Risk Assessment)
(1) Every employer shall make a suitable and sufficient assessment of
(a) the risks to the health and safety of his employees to which they are exposed whilst they are at work; and
(b) the risks to the health and safety of persons not in his employment arising out of or in connection with the conduct by him of his undertaking.

NHS Constitution

The NHS Constitution sets out the rights to which patients, public and staff are entitled. It also outlines the pledges that the NHS is committed to achieve, together with responsibilities that the public, patients, and staff owe to one another to ensure that the NHS operates fairly and effectively. All healthcare organisations will be required by law to take account of this Constitution in their decisions and actions.

Healthcare organisations need to 'ensure that services are provided in a clean and safe environment that is fit for purpose, based on national best practice (pledge)'.

Guidance and References considered

1. The Institution of Structural Engineers – RAAC Investigation & Assessment Further Guidance (April 23)
2. Cross Safety Report – RARAC in Hospital Pitched Roof (90's Construction).
3. NHS England – Publication PRN00777 05/09/2023
4. SCOSS Alert May 2019, Failure of RAAC Planks
5. IP10 Reinforced autoclaved aerated concrete planks designed before 1980
6. HSJ Article (3.12.2020)

Methodology

UDC Project Team

Project Lead: Mark Mallen, Chartered Health & Safety Consultant
Addendum & Report Updates: Sarah Costello (from Sept 2023)
Director in Charge: Dave Percy, Chartered Building Surveyor
Project Surveyors: Mike Deacon & Howard Russell

7th January 2021

'Desktop' research undertaken by Mark Mallen.

14th January 2021

Initial Interview with James Lee, Estates Department by Mark Mallen at Steeping Hill Hospital. In order to determine the age of the 'Blocks' within the Estate.

The Stepping Hill Hospital - Site Map, was used to develop a spreadsheet detailing the 'Zone & Block', with descriptions against each.

The ages, of the buildings, where known were recorded, and notes taken, based on the contents of the 'Estates Archive'.

See Appendix 4 Stepping Hill Hospital - Site Map

18th January 2021

First site 'walk through' and plan mark-up conducted by Mike Deacon.

See Appendix 5 Initial RAAC Walk-Through (18.1.2021)

22nd January 2021

Conclusion of review of the 'Estates Archive' by Mark Mallen.

Review of site 'walk through', to identify flat roofs on spreadsheet, which have the potential to contain RAAC Planks. In addition, a site plan, detailing 'flat' roofs was prepared, which formed the schedule for subsequent survey work.

See Appendix 6 Stepping Hill Flat Roof Locations (25.1.2021)

25th January 2021

Preparation of RAAC Planks - Site Survey template by Dave Percy.

Preparation and issue of surveyor's briefing notes by Mark Mallen and issue of Stepping Hill Flat Roof Locations (25.1.2021) plan.

26th and 27th January 2021

Detailed site survey conducted by Mike Deacon & Howard Russell.

See Appendix 7 RAAC Internal Inspection (27.1.2021)
See Appendix 8 RAAC Planks - Site Survey (26 & 27.1.2021)

27th January 2021

Drone survey supervised by UDC's Site Surveyors.

See Appendix 9 Indicative Drone Photographs

28th January 2021

Review of surveys conducted on 26th & 27th January, and update of spread sheet to compile possible list of RAAC Plank roofs.

See Appendix 10a - Stepping Hill - Zones & Blocks, RAAC Planks (Flat Roof Structures)

18th September 2023

Following a request from Stockport NHS Foundation Trust, buildings with pitched roof construction have now been introduced to the scope of the Investigation.

See Appendix 10b - Stepping Hill - Zones & Blocks, RAAC Planks (Pitched Roof Structures)

Findings

- Our Findings can be found on the spreadsheet 'Stepping Hill - Zones & Blocks, RAAC Planks'.
- Through a process of interview, archive review, observations, inspections and a drone survey, a list of 5 No potential locations for RAAC Plank has been produced from an initial list of 90 Blocks.

See Appendix 10 Stepping Hill - Zones & Blocks, RAAC Planks

In summary:

Zone & Block	Department	Approx. Age	Site Survey 18/1/2021	RAAC Planks - Site Survey, 26 & 27/1/2021	Drone Comments Survey 27/1/2021
8	Occupational Health	Unknown	Flat Roof Identified	Possible RAAC, some criteria observed	Grey surface, patch repairs, some ponding.
16	Boiler House	1970's	Flat Roof Identified	Possible RAAC, some criteria observed	Grey surface, no ponding.
17	Estates Conference Centre	1970's	Flat Roof Identified	Possible RAAC, some criteria observed	Ponding evident in a contained section.
42	Endoscopy		2 No Flat Roofs Identified	42(b) Possible RAAC, some criteria observed	No ponding.
65	Ante-Natal / Gynaecology	Unknown	Flat Roof Identified	Possible RAAC, no criteria observed, further investigation reqd.	Dry roof, no ponding evident.

Recommendations

- Review of Findings by Structural Engineer to determine if items determined as:
  - **Possible RAAC, some criteria observed**
  - **Possible RAAC, no criteria observed, further investigation reqd.**

  Are RAAC Planks.
- Review the Findings and conduct intrusive work (Drilling, Sampling & Analysing) to determine if items remaining as:
  - **Possible RAAC, some criteria observed**
  - **Possible RAAC, no criteria observed, further investigation reqd.**
- Produce definitive list of RAAC Planks and determine control measures to prevent failure and any remedial works required i.e., to prevent leaks.

Addendum, 1st December 2022.

Pursuant to the Recommendations detailed on page 16 of this report. The following actions have since been undertaken:

Findings

18th February 2021

UDC's Site Surveyor, Mike Deacon, attended site with Fulwood Roofing Services (Northern) Ltd, accompanied by Peter Keeling, to conduct physical investigative works on the roof, which involved removing the bituminous covering and 'chiselling' into the material below. The conclusion, following a review of the materials released was that the roof consisted of cast concrete, not RAAC Planking.

See Appendix 13 Stepping Hill - Zones & Blocks, RAAC Planks revised

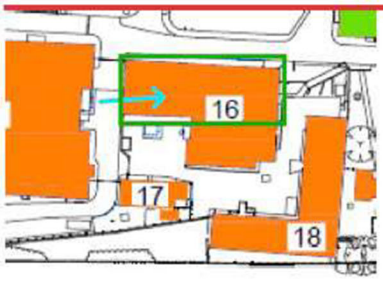
In summary:

Zone & Block	Department	Approx. Age	Site Survey 18/1/2021	RAAC Planks - Site Survey, 26 & 27/1/2021	Drone Comments Survey 27/1/2021	Physical Inspection/Core Drilling
8	Occupational Health	Unknown	Flat Roof Identified	Possible RAAC, some criteria observed	Grey surface, patch repairs, some ponding.	
16	Boiler House	1970's	Flat Roof Identified	Possible RAAC, some criteria observed	Grey surface, no ponding.	
17	Estates Conference Centre	1970's	Flat Roof Identified	Possible RAAC, some criteria observed	Ponding evident in a contained section.	
42	Endoscopy	Unknown	2 No Flat Roofs Identified	42(b) Possible RAAC, some criteria observed	No ponding.	
65	Ante-Natal / Gynaecology	Unknown	Flat Roof Identified	Possible RAAC, no criteria observed, further investigation reqd.	Dry roof, no ponding evident.	**18/2/2021**, roofing material deemed to be concrete. Not RAAC Plank.

7th June 2021

Mike Deacon undertook physical inspections within roof spaces and supervised the coring of suspected 'RAAC Planks'.

Following these activities, the conclusion was that RAAC Planks were present in the Ceiling Space within the Main Boiler House, Block 17.



RACCS LOCATED - POINT 6 - BUILDING 16

Assigned To RAACs Located To Ceiling Space Within Boiler House

Blue = sample area in Point 6

Green = RAACs Located To Ceiling Space Within Main Boiler House

POINT 6

Assigned To Boiler House

POINT 6 - SAME CORE SAMPLE

Assigned To Boiler House

Plate 2: Location, Sample Point and Core Sample

See Appendix 12 RAAC Planks, Core Samples (7.6.2021)

In summary:

Zone & Block	Department	Approx. Age	Site Survey 18/1/2021	RAAC Planks - Site Survey, 26 & 27/1/2021	Drone Comments Survey 27/1/2021	Physical Inspection/Core Drilling
8	Occupational Health	Unknown	Flat Roof Identified	Possible RAAC, some criteria observed	Grey surface, patch repairs, some ponding.	**7/6/2021**, roofing **not RAAC Plank**.
16	Boiler House	1970's	Flat Roof Identified	Possible RAAC, some criteria observed	Grey surface, no ponding.	**7/6/2021**, roofing material found to be **RAAC Plank**.
17	Estates Conference Centre	1970's	Flat Roof Identified	Possible RAAC, some criteria observed	Ponding evident in a contained section.	**7/6/2021**, roofing **not RAAC Plank**.
42	Endoscopy	Unknown	2 No Flat Roofs Identified	42(b) Possible RAAC, some criteria observed	No ponding.	**7/6/2021**, roofing **not RAAC Plank**.
65	Ante-Natal / Gynaecology	Unknown	Flat Roof Identified	Possible RAAC, no criteria observed, further investigation reqd.	Dry roof, no ponding evident.	18/2/2021, roofing material deemed to be concrete. Not RAAC Plank.

Conclusion

Pursuant to preliminary inspection procedure identified in the 1996 BRE Information Paper IP 10/96 BRE and SCOSS Alert May 2019, Failure of RAAC Planks, we have concluded that at least part of the roofing of the Boiler House consists of RAAC Planking.

Recommendations

- Conduct further intrusive survey work to determine the extent of RAAC Plank roofing in the Boiler House.
- Determine control measures to prevent catastrophic failure of the installed RAAC Planks.
- Undertake 'temporary' remedial works e.g., propping in affected areas.
- With the ultimate aim being the full replacement of the affected Boiler House roofs.

Addendum, 20/09/2023 - Addition to Original Scope – Pitched Roof Inspection

Following a request from the client, the pitched roof structures on the site have been inspected for the presence of RAAC.

Findings

20th September 2023

UDC's Site Surveyor, Mike Deacon, attended site on 18th & 19th September 2023 to inspect the pitched roof structures. The Site Surveyor conducted physical investigative works on the pitched roof structures of the building listed below:

- Building 4
- Building 5
- Building 15
- Building 18
- Building 19
- Building 20
- Building 21
- Building 22
- Building 26
- Building 28
- Building 29
- Building 30
- Building 31
- Building 34
- Building 40
- Building 43
- Building 50
- Building 51
- Building 52
- Building 54
- Building 56
- Building 57
- Building 58
- Building 69
- Building 61
- Building 63
- Building 68
- Building 69
- Building 71
- Building 72
- Building 77
- Building 84
- Building 88
- Building 89
- Building 90
- Building 96

Conclusion:

We have inspected all the roof structures of the buildings mentioned above and are pleased to report that none of them exhibit any evidence of RAAC (Reinforced Asbestos-Containing) construction. For certain buildings, we conducted further investigations, including core sampling, which also yielded negative results for RAAC.

For comprehensive details of the findings pertaining to each inspected building, we invite you to refer to Appendix 14 for the full report.

Zone & Block	Department	Approx. Age	RAAC Planks - Site Survey, 18 & 19/09/2023	Physical Inspection
4	Pennine Care Psychiatric		Roof between building 4/5 - Following further investigation - No criteria observed	Roofing not RAAC Plank.
5	Pennine Care Psychiatric Wards		No criteria observed	Roofing not RAAC Plank.
15	Woodlands Unit		No criteria observed	Roofing not RAAC Plank. Further investigation complete – refer to report in appendix 14.
18	Estates		No criteria observed	Roofing not RAAC Plank.
19	Beech House		No criteria observed	Roofing not RAAC Plank.
20	HSDU		No criteria observed	Roofing not RAAC Plank.
21	Birch House		No criteria observed	Roofing not RAAC Plank.
22	EMBE		No criteria observed	Roofing not RAAC Plank.
26	Main Plant Room		No criteria observed	Roofing not RAAC Plank.
28	EEE / Lilac Suite		No criteria observed	Roofing not RAAC Plank.
29	Mortuary		No criteria observed	Roofing not RAAC Plank.
30	Pathology		No criteria observed	Roofing not RAAC Plank.
31	Pathology Store		No criteria observed	Roofing not RAAC Plank.
34	Physiotherapy		No criteria observed	Roofing not RAAC Plank.
40	Radiology B		No criteria observed	Roofing not RAAC Plank.
43	Gas Store		No criteria observed	Roofing not RAAC Plank.
50	Hydrotherapy / Occ Therapy		No criteria observed	Roofing not RAAC Plank.
51	Ward AMU1		No criteria observed	Roofing not RAAC Plank.
52	Pathology Store		No criteria observed	Roofing not RAAC Plank.
54	Voluntary Store		No criteria observed	Roofing not RAAC Plank.
56	Chest Clinic		No criteria observed	Roofing not RAAC Plank.
57	Ash House		No criteria observed	Roofing not RAAC Plank.

Zone & Block	Department	Approx. Age	RAAC Planks - Site Survey, 18 & 19/09/2023	Physical Inspection
58	Holly House		No criteria observed	Roofing not RAAC Plank.
59	Aspen House		No criteria observed	Roofing not RAAC Plank.
61	Chestnut House		No criteria observed	Roofing not RAAC Plank.
63	Cedar House		No criteria observed	Roofing not RAAC Plank.
68	Pharmacy		No criteria observed	Roofing not RAAC Plank.
69	Plant Room		No criteria observed	Roofing not RAAC Plank.
71	Quality Control		No criteria observed	Roofing not RAAC Plank.
72	Urology		No criteria observed	Roofing not RAAC Plank.
77	Security Lodge		No criteria observed	Roofing not RAAC Plank.
84	Power House		No criteria observed	Roofing not RAAC Plank.
88	Aseptic Unit		No criteria observed	Roofing not RAAC Plank.
89	Pennine PICU		No criteria observed	Roofing not RAAC Plank.
90	DMOP		No criteria observed	Roofing not RAAC Plank.
96	Woodland		No criteria observed	Roofing not RAAC Plank.

Appendices

Appendix 1	SCOSS Alert May 2019, Failure of RAAC Planks
Appendix 2	IP10 Reinforced autoclaved aerated concrete planks designed before 1980
Appendix 3	HSJ Article (3.12.2020)
Appendix 4	Stepping Hill Hospital - Site Map
Appendix 5	Initial RAAC Walk-Through (18.1.2021)
Appendix 6	Stepping Hill Flat Roof Locations (25.1.2021)
Appendix 7	RAAC Internal Inspection (27.1.2021)
Appendix 8	RAAC Planks - Site Survey (26 & 27.1.2021)
Appendix 9	Indicative Drone Photographs
Appendix 10	Stepping Hill - Zones & Blocks, RAAC Planks (Flat Roof Structures)
Appendix 11	RAAC Planks, Physical Inspection, Block 65 (18.2.2021)
Appendix 12	RAAC Planks, Core Samples (7.6.2021)
Appendix 13	Stepping Hill - Zones & Blocks, RAAC Planks revised
Appendix 14	Stepping Hill RAAC – Report Validation & Top UP Survey – Pitched Roofs
Appendix 14	Map of Pitched Roof Structures Surveyed Sept 2023

NHS
Stockport
NHS Foundation Trust

Meeting date	5th October 2023	**Public**	x	**Confidential**	
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**	x
Recommendation:	The Board is asked to note and discuss performance against the reported metrics. This includes the described issues that are affecting performance and 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
	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	
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.

Integrated Performance Report - Introduction

Reporting Period 01/08/2023

Integrated Performance Report - Introduction

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

Quality Highlights
Exception reports included this month relate to performance against Sepsis, Infection Prevention and Control, Incidents, Pressure Ulcers, Complaints, and Maternity due to under-achievement in month.

Timely recognition of Sepsis is performing well and back about target levels. Antibiotic administration within timescales continues to be challenging. Key themes include incorrect prescribing, availability of antibiotics, and nurse delays.

Reported infection rates for C.diff and E.coli continue to be higher than the thresholds set by the UKHSA. Due to the high number of cases, the RCA process is currently under review prior to the introduction of PSIRF.

Numbers of hospital acquired category 2 pressure ulcers is now within target thresholds. Community acquired pressure ulcers continues to report above thresholds.

Maternity is performing well against most metrics. The maternity unit was placed on temporary divert twice in August.

Operational 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.

Current performance against the 4-hour standard continues to benchmark well across Greater Manchester, with Stockport ranking 3rd for type-1 performance at 66.16% year-to-date. 12-hour waits are reduced and robust processes for managing, reviewing, and providing assurance for assessment of harm in respect of the delays are fully embedded within the service.

The challenges of accessing timely care home beds continue to severely impact the Trust's ability to discharge or transfer patients with no criteria to reside in a timely manner.

Diagnostic performance is still above the target, and although capacity has been challenged by Industrial action in recent weeks Endoscopy and Imaging are showing much improved positions. ECG capacity continues to be an area of concern but trajectories for improvement are being worked through.

Cancer performance remains extremely challenging, and it is anticipated that performance will continue to be impacted by industrial action in the coming months. Focus on patients waiting 63+ days continues with the Trust successfully achieving its backlog trajectory target for July and August.

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

The Emergency Department, Medicine and career grade medical staff remain the highest proportional cost for agency and bank which relates to cover for escalation areas, the high levels of activity in ED and vacancies

The Trust's 12-month turnover rate remains above our 12.5% target and has remained stable. Recruitment activity continues at pace and in month we have had 12% more staff join the organisation than have left.

Appraisal performance is addressed within the monthly performance review meetings. Divisions are supported by the Education and OD Teams, which includes targeted communications to line managers and employees.

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

At month 5 the Trust position is £1.3m adverse to plan – a deficit of £13.6m. This is a deterioration of £0.5m in month, which relates to an estimate for elective recovery fund (ERF) income reduction relating to Q1.

The drivers of the movement from plan are the impact of industrial action by junior doctors and consultants, undelivered efficiency savings, the ERF estimated penalty in Q1 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 5 is £10.3m; at this point the Trust is behind plan by £1.0m. Much of the CIP delivered is non-recurrent, however there has been an increase in recurrent savings this month. Further work continues to take place to identify additional recurrent schemes.

The Trust has maintained sufficient cash to operate during August.

The Capital plan for 2023-24 is £62.7m as per the latest plan submission, which is subject to final confirmation with GM ICS. At month 5 expenditure is behind plan by £3.5m, however this spend will be re-profiled into future months.

Integrated Performance Report - Scorecard

	Reporting Period	Target 23/24	Actual YTD	6-mth Trend	Actual Month	Current Period	1-mth Forecast
Quality Scorecard							
Mortality: SHMI	Jun-22 to May-23	≤ 100		↑	96	●	●
Sepsis: Timely recognition	Sep-22 to Aug-23	≥ 90%		↗	96.3%	●	●
Sepsis: Antibiotic administration	Sep-22 to Aug-23	≥ 90%		→	73.8%	▲	▲
C.diff infection rate	Sep-22 to Aug-23	≤ 17.63		→	56.86	▲	▲
Covid-19 infection rate	Sep-22 to Aug-23	≤ 4.27		↑	2.51	●	●
MRSA infection rate	Sep-22 to Aug-23	≤ 0		→	2.67	▲	▲
E. coli infection rate	Sep-22 to Aug-23	≤ 20.27		→	121.71	▲	▲
Medication incident rate	Mar-23 to Aug-23	≤ 4.64		↓	5.2	▲	▲
Patient safety incident rate	Mar-23 to Aug-23	≤ 69.24		↓	77.2	▲	▲
STEIS reportable incidents	Aug-23	≤ 4	19	→	3	●	●
Stroke: Overall SSNAP Level	Jun-23	≥ C		→	A	●	●
Falls rate	Aug-23	≤ 3.51	3.1	↑	2.96	●	●
Falls due to lapses in care	Aug-23	≤ 425	136	→	28	●	●
Falls causing moderate+ harm	Aug-23	≤ 22	2	↗	0	●	●
Pressure Ulcers: Hospital, Cat 2	Aug-23	≤ 79	25	→	4	●	●
Pressure Ulcers: Hospital, Cat 3&4	Aug-23	≤ 8	6	→	1	▲	▲
Pressure Ulcers: Community, Cat 2	Aug-23	≤ 114	68	↘	16	▲	▲
Pressure Ulcers: Community, Cat 3&4	Aug-23	≤ 38	22	→	5	▲	▲
Complaints: Written Complaints Rate	Aug-23	≤ 7.9	7.04	↘	8.23	▲	▲
Complaints: Timely response	Aug-23	≥ 95%	88.8%	↗	95.5%	●	●
Early Neonatal Deaths	Aug-23	≤ 0	1	→	0	●	●
Registrable Stillbirths	Aug-23	≤ 0	0	↗	0	●	●
Registrable Stillbirth Rate	Aug-23	≤ 0	0	→	0	●	●
Smoking In Pregnancy	Aug-23	≤ 10%	5.9%	↘	6.1%	●	●
Maternity Diverts	Aug-23	≤ 0	5	→	2	▲	▲

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

	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	Aug-23	≥ 76%	66.3%	↘	64.9%	▲	▲
Patients in department over 12 hrs	Aug-23	≤ 2%	6.1%	↘	6.5%	▲	▲
No criteria to reside (NCTR)	Aug-23	≤ 73	476	↑	88	▲	▲
Diagnostics: 6 Week Standard	Aug-23	≤ 5%	13.7%	↘	17.3%	▲	▲
62-day standard	Aug-23	≥ 85%	48.5%	→	50.7%	▲	▲
28-day standard (FDS)	Aug-23	≥ 75%	64.8%	↘	60.2%	▲	▲
14-day standard (2WW)	Aug-23	≥ 93%	97.1%	↘	95.1%	●	●
Incomplete pathways 18-week %	Aug-23	≥ 92%		↓	48.3%	▲	▲
52-week breaches	Aug-23	≤ 3826		↓	4358	▲	▲
65-week breaches	Aug-23	≤ 0		↘	1360	▲	▲
Activity vs. Plan: Elective	Aug-23	≥ 100%	102.5%	↘	96.3%	▲	▲
Activity vs. Plan: Outpatient	Aug-23	≥ 100%	98.8%	↘	89.7%	▲	▲
Activity vs. Plan: ED Attendances	Aug-23	≤ 100%	98.7%	↗	100.8%	▲	▲
Outpatient DNA rate	Aug-23	≤ 6.3%	7.8%	↑	7.9%	▲	▲
Outpatient clinic utilisation	Aug-23	≥ 90%	88.7%	↘	86.9%	▲	▲
Patient initiated follow up (PIFU)	Aug-23	≥ 4.1%	3.1%	→	2.9%	▲	▲
Capped Touch Time Utilisation	Aug-23	≥ 85%	74.8%	↘	73.2%	▲	▲
Average cases per 4-hour session	Aug-23	≥ 2.4	2.18	↗	2.22	▲	▲
Workforce Scorecard							
Substantive Staff-in-Post	Aug-23	≥ 90%	91.1%	↓	90.7%	●	●
Sickness Absence: Monthly Rate	Aug-23	≤ 6%	5.8%	↑	6%	●	●
Workforce Turnover	Aug-23	≤ 12.5%	14.4%	→	14.6%	▲	▲
Staff Retention Rate	Aug-23		98.8%	↘	98.2%	○	○
Appraisal Rate: Overall	Aug-23	≥ 95%	89.5%	↗	90.1%	▲	▲
Mandatory Training	Aug-23	≥ 95%	93.7%	↑	94.4%	▲	▲
Agency Costs %	Aug-23	≤ 3.7%	6%	↗	5.3%	▲	▲
Finance Scorecard							
Capital Expenditure	Aug-23	≤ 10%		→	-41.2%	●	●
Cash Balance	Aug-23			↘	24.8	○	○
CIP Cumulative Achievement	Aug-23	≥ 0%		↗	-9.5%	▲	▲
Financial Controls: I&E Position	Aug-23	≤ 0%		→	9.4%	▲	▲

Integrated Performance Report - Exception

indicator_name
Multiple values

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%	96.3%			
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%	73.8%			

Timely Recognition

- 96% Timely Recognition August.
- 12 month rolling figure now 96.3%, above trust target of 95%.
- 97 records included in audit- 95 compliant.
- 1 Red Flag fail, 1 Amber Flag fail. Both occurred OOH within Division of Medicine.
- Screening tool not completed at time of trigger in both fails. 2222 not utilised for Red Flag fail.
- Amber Flag delay occurred during junior doctor strike- no harm identified.

Antibiotic Administration

- August compliance 71%.
- 12 month rolling figure now 73.8%, below trust target of 95%.
- 14/97 patients audited were treated for suspected sepsis in August: of these 10 received antibiotics in accordance with trust guidelines.
- All 4 fails occurred within Medicine.
- 3/4 fails involved red flag triggers.
- 2/4 fails occurred Out Of Hours.
- Delays of 4hr 18 min, 11 min, 7 hr59 min and 3 hr 33 min. Mean delay 4hrs significant increase in recent months
- 1 Learning from Death investigation requested following validation.
- Themes: delayed/ incorrect prescribing, antibiotics not available, nurse delays, inappropriate escalation/ compliance screening tool

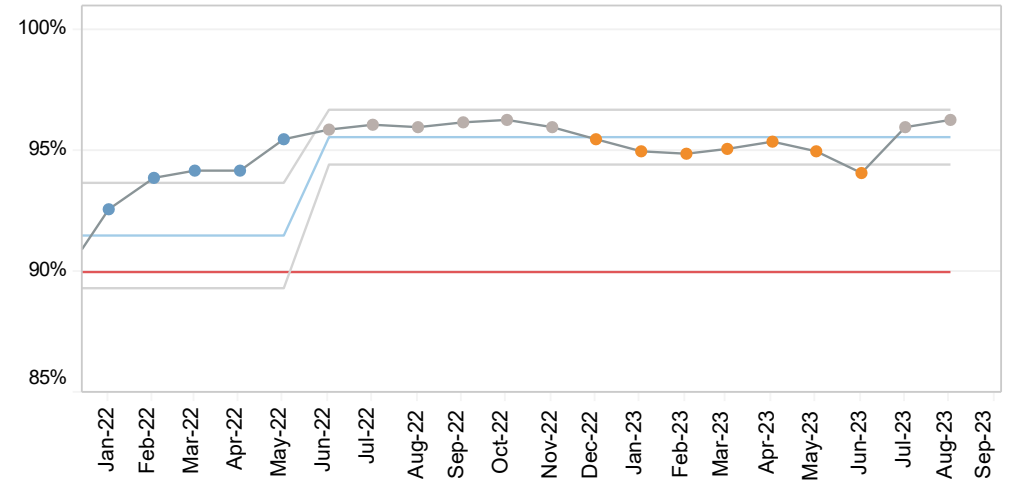
Key Actions September

- World Sepsis Day 13th September.
- Medical Education scoping on E3/ D5 to support engagement sepsis6.
- Toolbox Theme: Red Flag Sepsis 6 within 1 hour (49 staff trained via toolbox August plus 8 link nurses completed training morning)

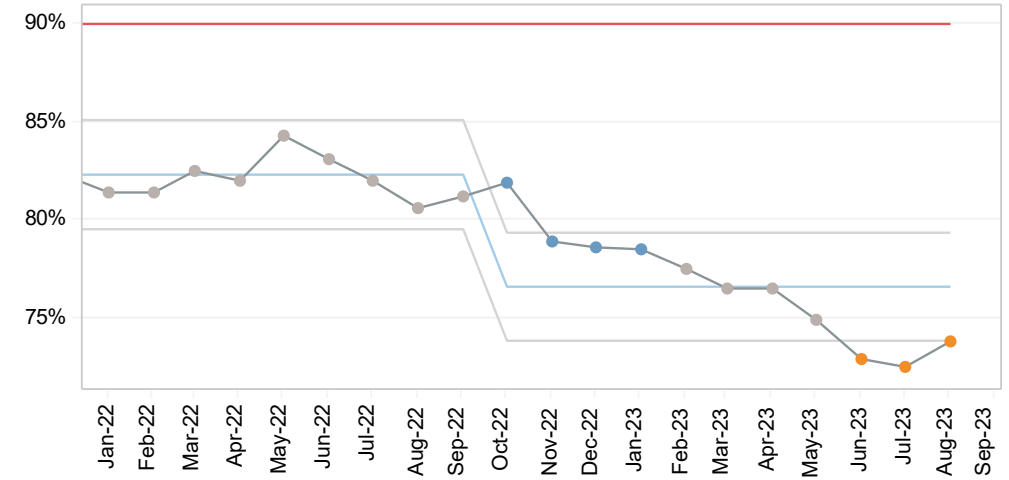
Curtis Soile
02/10/2023 07:32:55

Signed off by	Emily Abdy
Executive Lead	Nicola Firth

Performance for Sepsis: Timely recognition



Performance for Sepsis: Antibiotic administration



Integrated Performance Report - Exception

Quality: Infection Rates		Target	Actual	6-month Trend	Previous Performance	1-month Forecast
C.diff infection rate	The number of hospital-onset Clostridioides Difficile (C. diff) infections per 100,000 bed days for patients aged 2 years and older.	<= 17.63	56.86	→	▲ ▲ ▲ ▲ ▲ ▲	▲
Covid-19 infection rate	The number of Covid-19 infections per 1,000 bed days.	<= 4.27	2.51	↑	▲ ▲ ▲ ● ● ●	●

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

The UKHSA published their thresholds for 2023-24 in May and the Trust has been set a threshold of 40 cases. Each Division is apportioned a share of those cases.

There were 6 HOHA and 0 COHA cases in August totalling 36 YTD. The Trust is over the projected threshold of 16.6 for the end of August.

35 cases have been presented to the HCAI Panel. 6 Cases have been deemed Avoidable and 28 Cases deemed Unavoidable. 1 case requires further investigation after panel review and 1 case awaits panel review in September.

Actions:

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

Covid-19

The Trust has reported 14 COVID-19 positive cases in August of which 5 were nosocomial. This is an increase of 12 positive cases and 5 HOC case numbers on the previous month. The Trust currently has a rate of 36% against a Northwest rate of 48%. This is an increase of 36% in HOC rate from last month and an increase in the Northwest rate of 8%.

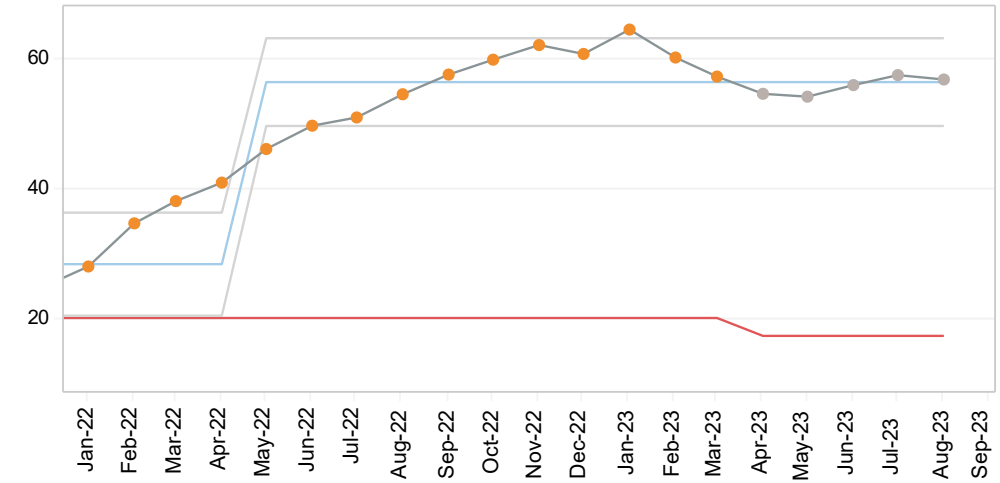
Actions:

- Continue to follow national government guidance.

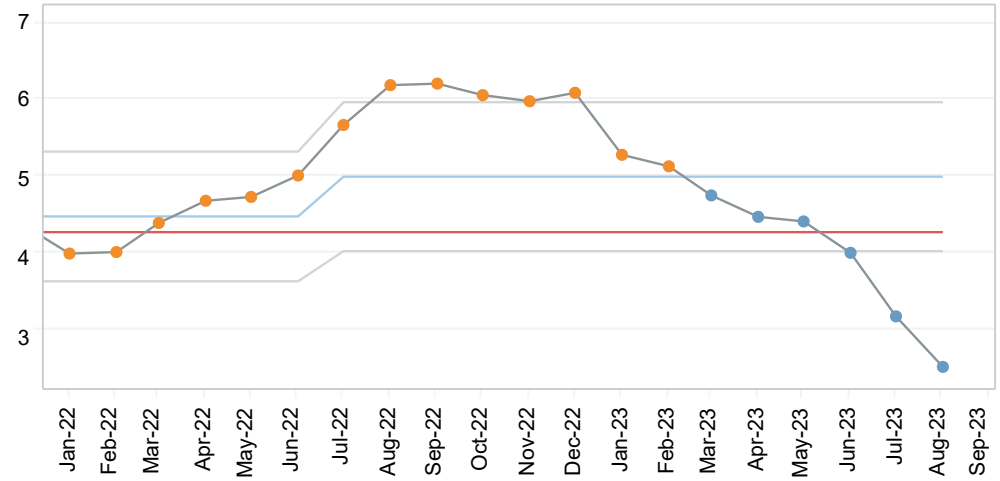
Curtis Soile
02/10/2023 07:32:55

Signed off by	Christine Glynn
Executive Lead	Nicola Firth

Performance for C.diff infection rate



Performance for Covid-19 infection rate



Integrated Performance Report - Exception

Quality: Infection Rates (continued...)		Target	Actual	6-month Trend	Previous Performance	1-month Forecast
E. coli infection rate	The number of Escherichia Coli (E. coli) bacteraemia infections per 100,000 bed days.	<= 20.27	121.71	→	▲ ▲ ▲ ▲ ▲ ▲	▲
MRSA infection rate	The number of hospital-onset Methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemia infections per 100,000 bed days.	<= 0	2.67	→	▲ ▲ ▲ ▲ ▲ ▲	▲

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.

MRSA

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

Actions:

- Continue to monitor compliance with MRSA screening.
- Commence monthly spot audits from September 2023.

E.coli

The UKHSA published their thresholds for 2023-24 in May and the Trust has been set a threshold of 46 cases. Each Division is apportioned a share of those cases.

There were 3 HOHA and 3 COHA cases in August, totalling 29 cases YTD. The Trust is over the projected threshold of 19.2 for the end of August.

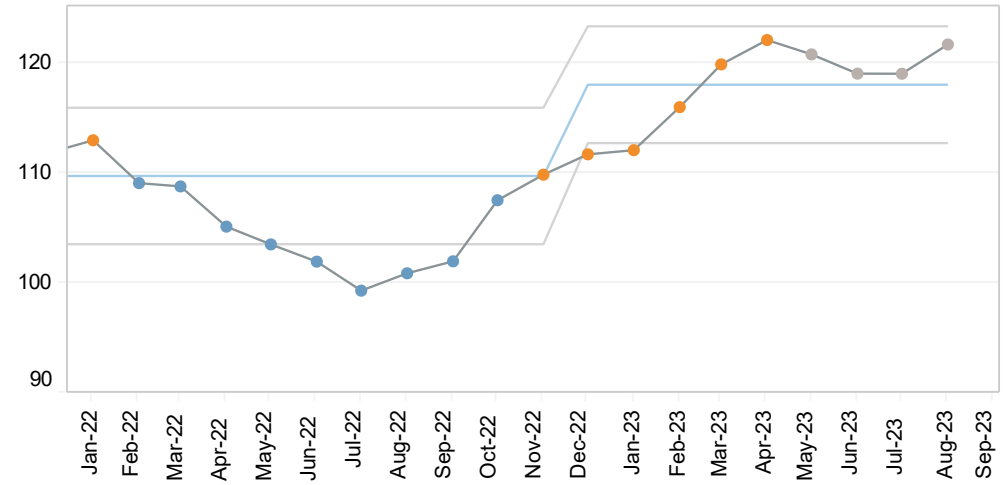
Actions:

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

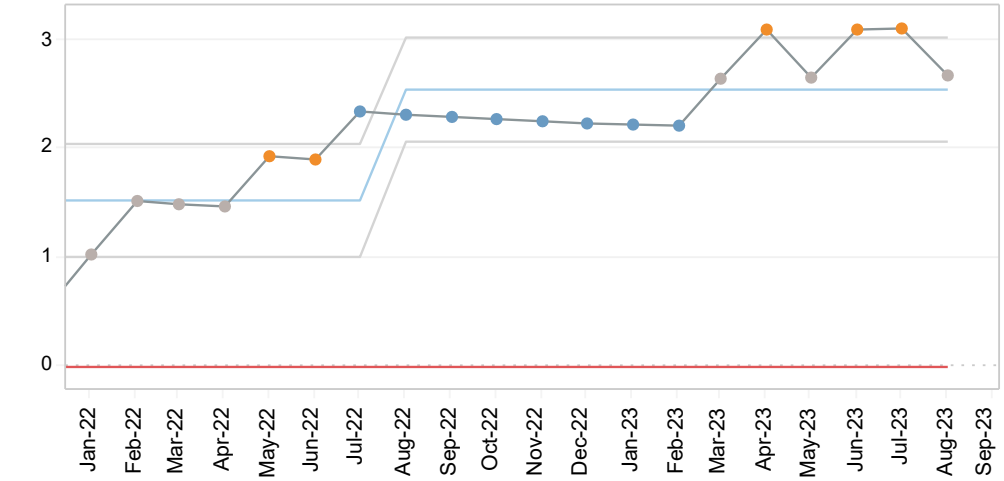
Curtis Soile
02/10/2023 07:32:55

Signed off by	Christine Glynn
Executive Lead	Nicola Firth

Performance for E. coli infection rate



Performance for MRSA infection rate



Integrated Performance Report - Exception

Quality: 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	5.2	↓	▲ ▲ ● ▲ ▲ ▲	▲
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	77.2	↓	▲ ▲ ▲ ▲ ▲ ▲	▲
STEIS reportable incidents	The total number of STEIS reportable incidents. Target/benchmark based on the median performance for 2021/22 financial year.	<= 4	3	→	● ● ● ● ▲ ●	●

Medication Incidents

There are no issues related to medication incidents to report.

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

Patient Safety Incidents

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 at the 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 Incidents

There were 3 serious incident declared and submitted to StEIS in August:

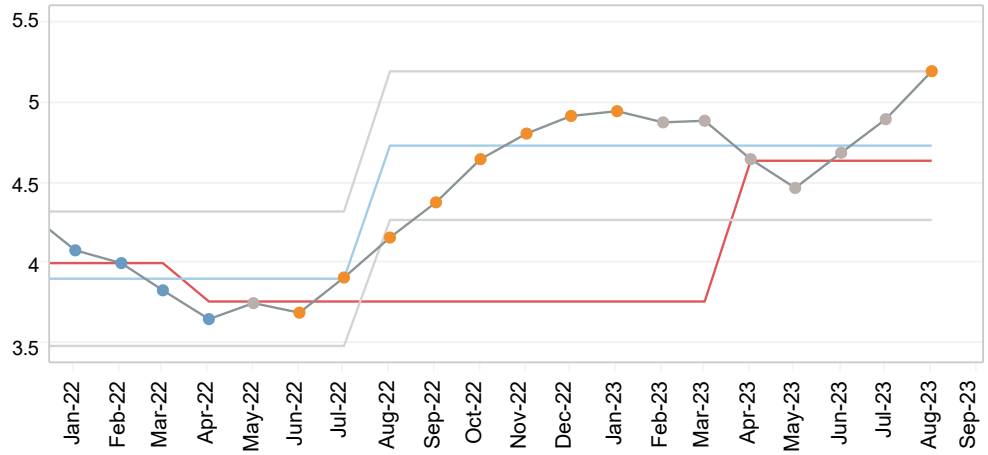
- Delayed diagnosis and surgery
- Child death in Emergency Department
- Inappropriate discharge

Investigations have commenced to identify root causes for each incident and to ensure appropriate actions to reduce future risk of reoccurrence are identified.

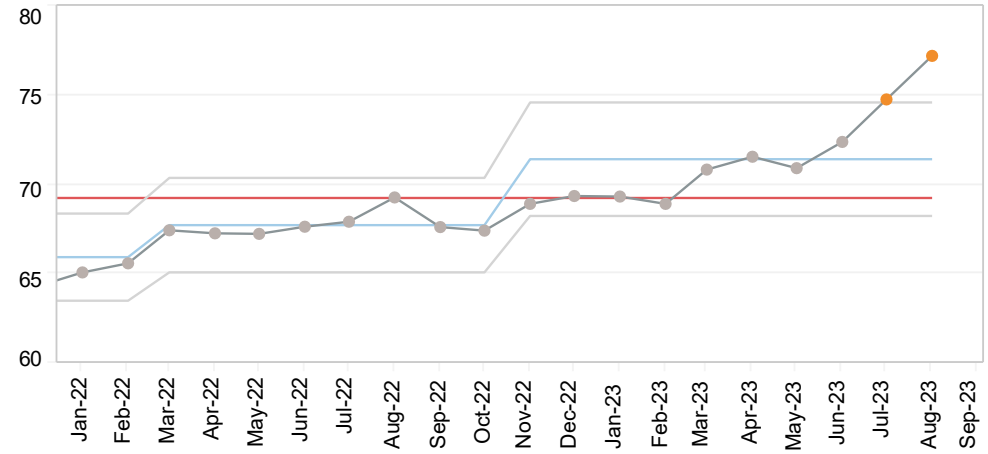
Curtis Soile
02/10/2023 07:32:55

Signed off by	Natalie Davies
Executive Lead	Nicola Firth

Performance for Medication incident rate



Performance for Patient safety incident rate



Integrated Performance Report - Exception

Quality: Pressure Ulcers		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	4	→	▲ ● ● ● ▲ ●	●
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	16	↘	▲ ▲ ▲ ● ▲ ▲	▲
Community, Category 3&4	Total number of category 3 and category 4 pressure ulcers in a community setting - includes device-related pressure ulcers.	<= 3	5	→	● ● ▲ ▲ ● ▲	▲

Hospital

This month (July data) we have had 7 category 2 pressure ulcers reported- of which 3 were as a result of a medical device. The Trust is on trajectory to meet the reduction target.

There has been 1 Category 4 pressure ulcer. This incident occurred within the ED and acute assessment areas, an initial investigation has identified some areas of concern which requires further investigation.

Community

We have had 19 category 2 pressure ulcers reported. The community is currently over trajectory to meet the reduction target

There has been 3 Category 3 or 4 pressure ulcers in the community. All these incidents have been investigation and scrutinised for any lapses in care or areas for learning. Of these incidents 1 case has been identified to require further investigation.

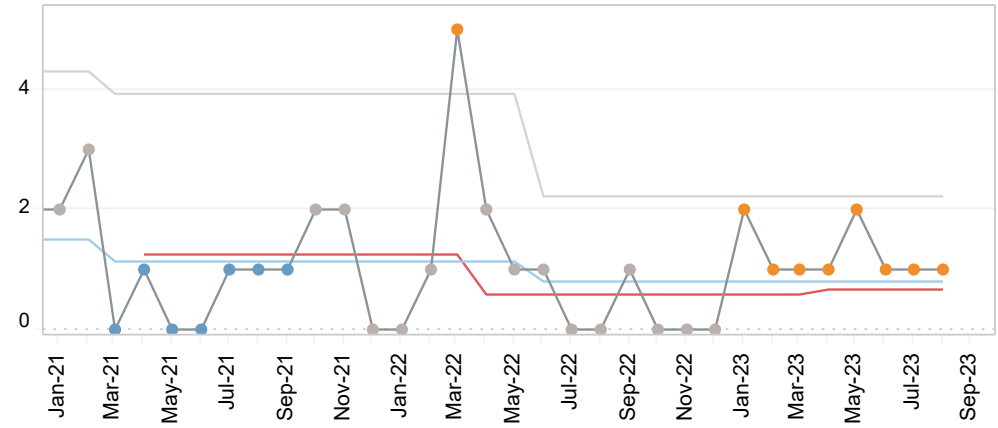
Actions:

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

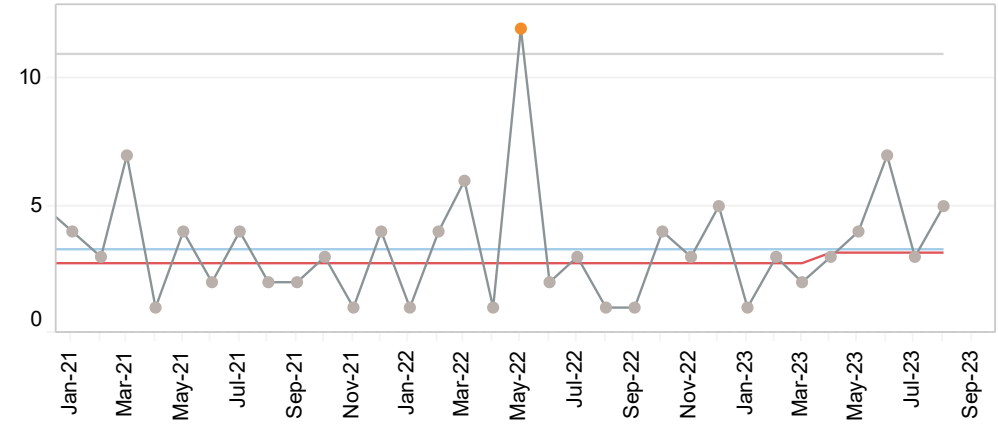
Curtis Soile
02/10/2023 07:32:55

Signed off by	Lisa Gough
Executive Lead	Nicola Firth

Performance for Pressure Ulcers: Hospital, Cat 3&4



Performance for Pressure Ulcers: Community, Cat 3&4



Integrated Performance Report - Exception

Quality: Complaints		Target	Actual	6-month Trend	Previous Performance	1-month Forecast
Timely response	The total number of formal complaints responded to within agreed timescales, as a percentage of all formal complaints responded to.	>= 95%	95.5%			
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	8.23			

44 formal complaints were received in August 2023 - Integrated Care = 7, Medicine = 10, Surgery = 13, Women & Children = 4, Corporate = 2, Estates & Facilities = 1, Emergency Department = 6 and Clinical Support Services = 1

The PALS & Complaints team continue to focus on resolving concerns informally where appropriate however, we have seen a high number of formal complaint received in August compared to previous months.

Top five themes for formal complaints in August 2023 was as follows:
1. Communication
2. Staff values & behaviours
3. Clinical treatment
4. Patient Care
5. Admin procedure & record management

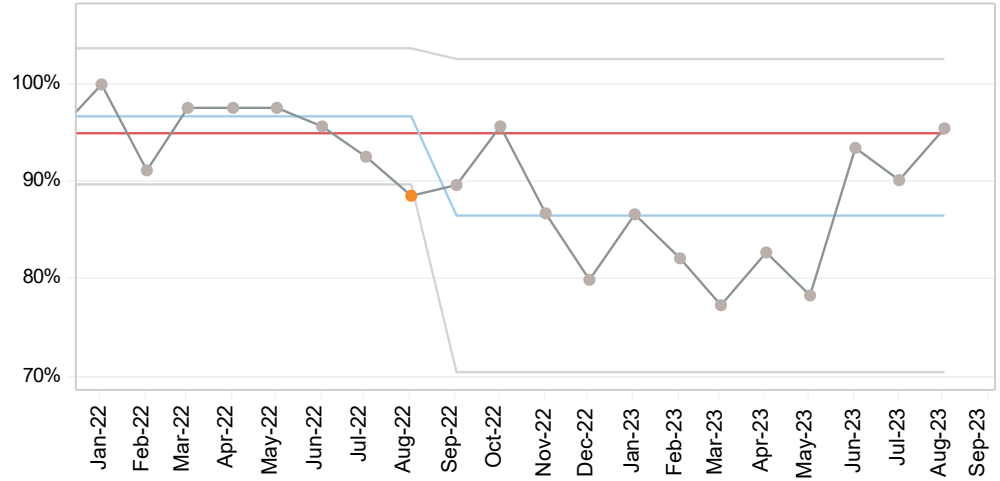
Top five themes for informal concerns in August 2023 was as follows:
1. Appointments
2. Communication
3. Staff values & behaviours
4. Admin procedures & record management
5. Access to treatment or drugs

44 responses were sent out in August 2023 of which, 42 were sent within the agreed timeframe, resulting in a 95.5% response rate.

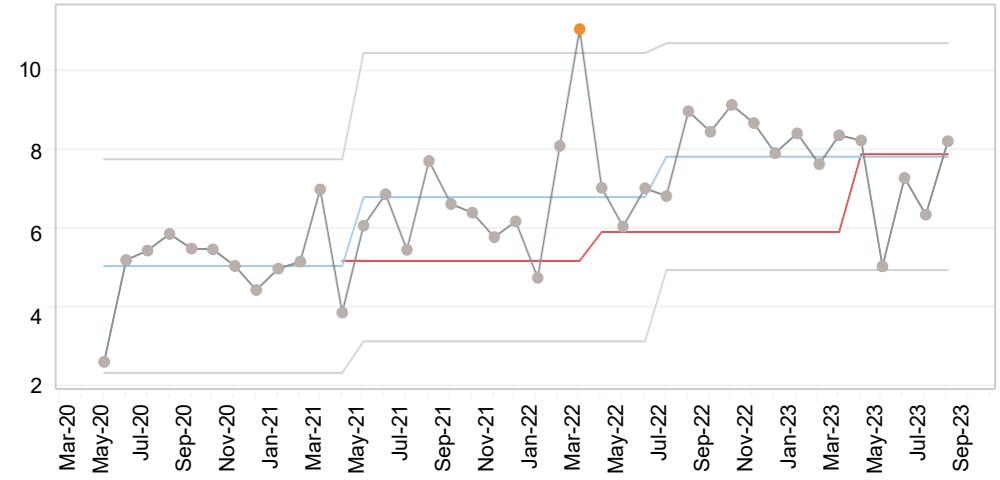
A response rate of 95.5% response rate is a great achievement considering the continued pressures at the Trust to include ongoing industrial action. The divisions have all worked extremely hard to ensure investigations and responses are completed within the agreed timeframe. The division of surgery also reviewed their own processes to aid in the achievement of a higher response rate along with the provision of quality responses. The PALS & complaints team continue to liaise with the divisions and when it becomes apparent that we will not be able to meet the agreed response date set at the outset of the investigation. If considered reasonable i.e. there is a delayed response from an external organisation who are contributing to the complaint response, the case officer may contact the complainant to agree a new response date.

Signed off by	Rebecca Harrison
Executive Lead	Nicola Firth

Performance for Complaints: Timely response



Performance for Complaints: Written Complaints Rate



Integrated Performance Report - Exception

Quality: Maternity		Target	Actual	6-month Trend	Previous Performance	1-month Forecast
Early Neonatal Deaths	The number of babies born with signs of life, that have died with within the first 7 completed days of life.	<= 0	0	→	● ● ● ● ▲ ●	●
Registrable Stillbirths	The number of babies born without signs of life due to stillbirth or termination of pregnancy that occurs after a gestation of 24 weeks (168 days) or more.	<= 0	0	↗	● ● ● ● ● ●	●
Registrable Stillbirth Rate	The number of babies born without signs of life due to stillbirth or termination of pregnancy that occurs after a gestation of 24 weeks (168 days) or more. Calculated..	<= 0	0	→	● ● ● ● ● ●	●
Smoking In Pregnancy	The number of women known to be smokers at the time of delivery, as a percentage of all deliveries in the month.	<= 10%	6.1%	↘	● ● ● ● ● ●	●
Maternity Diverts	The total number of occasions the maternity unit has been unable to admit women during the reporting period.	<= 0	2	→	▲ ● ● ● ▲ ▲	▲

Smoking in Pregnancy: This count excludes women whose smoking status was not known at the time of delivery. Women known to be smokers at the time of delivery are defined as pregnant women who self-reported that they were smokers. This includes any cigarettes or tobacco at all, but excludes non-combustible nicotine products, such as e-cigarettes or other nicotine containing products. If a woman intends to give up smoking after the delivery, but was a smoker up until the delivery date they are included in this count.

Early Neonatal Deaths

There have been 0 babies born over 24 weeks that have died within 7 days of birth in August, compared to 1 that was reported in July. This case continues to be under review by HSIB.

Maternity Diverts

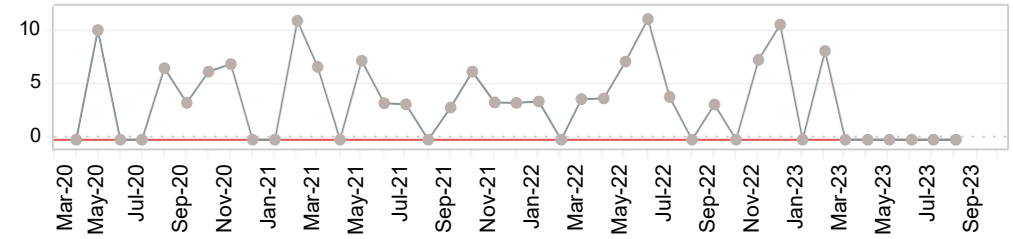
The maternity unit was placed on temporary divert on 2 occasions in August, compared to the 3 that were reported in July. The rational for both the diverts was insufficient staffing due to vacancy and short term/last minute sickness, this was also compounded by increased acuity. 1 of the diverts was escalated in line with policy and agreed by the executive on call, the 2nd divert was not escalated in line with the divert policy and the executive on call was not aware of the maternity divert . No harm was caused as a result of the diverts.

Rapid reviews are undertaken for any divert and presented at serious incident review group, an audit form is also completed and returned to the local maternity and neonatal (LMNS) system for shared learning. All maternity unit temporary diverts are StEIS reported.

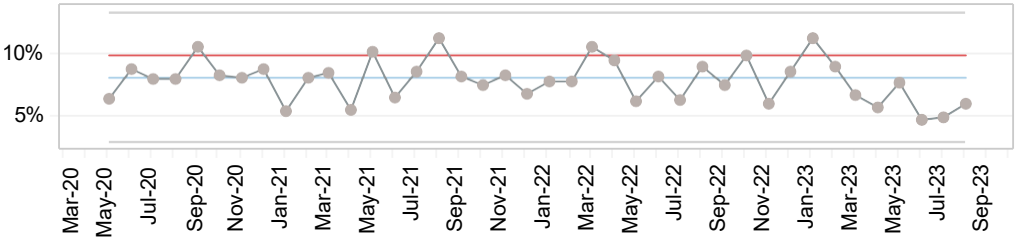
Curtis Soile
02/10/2023 07:32:55

Signed off by	Rachel Alexander-Patton
Executive Lead	Nicola Firth

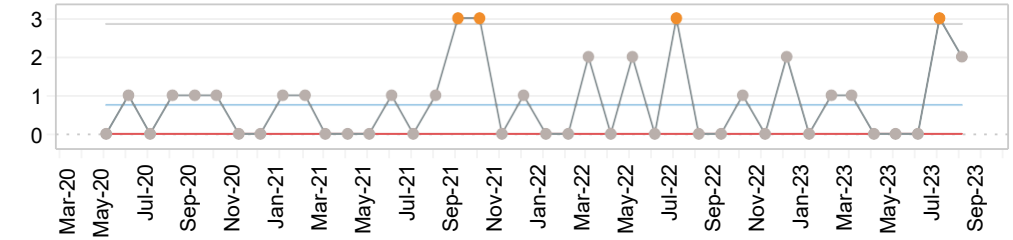
Performance for Registrable Stillbirth Rate



Performance for Smoking In Pregnancy



Performance for Maternity Diverts



Integrated Performance Report - Exception

Operations: ED		Target	Actual	6-month Trend	Previous Performance	1-month Forecast
Ambulance handover delays	The number of ambulance handovers delayed by 30 minutes or more, as a percentage of all ambulance handovers.	<= 5%	22.6%	→	▲	▲
4hr Standard	The number of patients who were admitted, discharged, or leave A&E within 4 hours of their arrival, as a percentage of all patients attending A&E.	>= 76%	64.9%	↘	▲ ▲ ▲ ▲ ▲ ▲	▲
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%	6.5%	↘	▲ ▲ ▲ ▲ ▲ ▲	▲

August's performance against the UEC 4hr standard saw a slight decrease to 64.9% compared to 65.9% in July.

August saw a slight decrease in attendances from 9600 in July to 9032 in August however, the average attendances continued to trend higher than the 2021/22 baseline.

Overall performance benchmarks well across GM. Stockport's ED YTD performance is currently 66.16%, ranking 3rd in GM for type 1 4hr performance.

August saw a reduction in 12 hour waits in ED to 63 compared to 101 in July. Robust processes for managing, reviewing and providing assurance for assessment of harm in respect to 12hr breaches are fully embedded within the service.

The service continues to focus on ensuring that long waits are reduced by reviewing the ED workforce model.

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

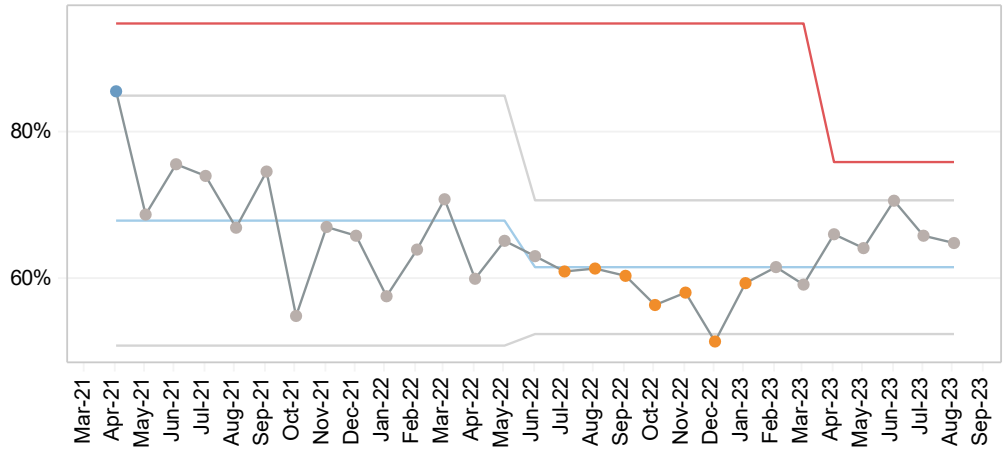
Weekly breach analysis forums with Specialty teams are being established to focus on admitted performance, with the ED team continuing to focus on non-admitted performance.

E-triage transformation piece of work continues to focus on front door streaming and decongestion of department.

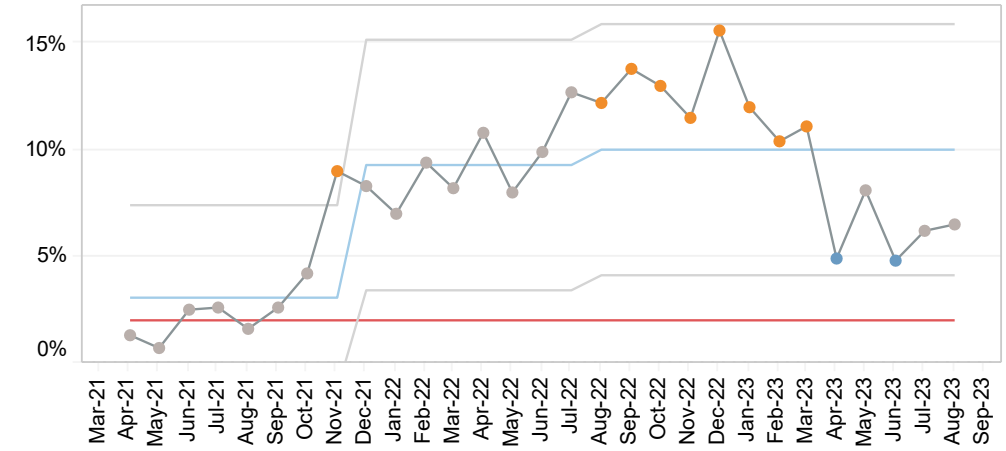
Curtis Soile
02/10/2023 07:32:55

Signed off by	Catherine Cotton
Executive Lead	Jackie McShane

Performance for 4hr Standard



Performance for Patients in department over 12 hrs



Integrated Performance Report - Exception

Operations: Patient Flow

		Target	Actual	6-month Trend	Previous Performance	1-month Forecast
No criteria to reside (NCTR)	Number of patients with "No Criteria to Reside". This metric is a mean average per day for each month.	<= 73	88	↑	▲ ▲ ▲ ▲ ▲ ▲	▲

The number of patients with no criteria to reside in month remains higher than the target level however August position saw an average of 88 patients per day in hospital beds with NCtR, and of those 33 per day were from outside of Stockport. Work continues to embed and improve operational system and processes within the wards and the Transfer of Care Hub to ensure improved discharges across pathways 1 & 2.

The challenges of accessing timely care home beds has severely impacted on the trust ability to discharge/transfer patients with a NCtR in a timely manner. Increased number of patients being discharged on Pathway 1 as opposed to Pathway 2 is encouraging however those patients truly requiring Pathway 2 care home beds are more dependant and requiring increased support. Care homes are increasingly declining these patients which results in longer length of stay within the Acute trust impacting on flow through Acute and community D2A beds.

System partners are meeting weekly to collaborate on a system wide response to Safe and Timely discharge, focusing on community beds and home care provision trying to match required need to provision to support same day next day discharges.

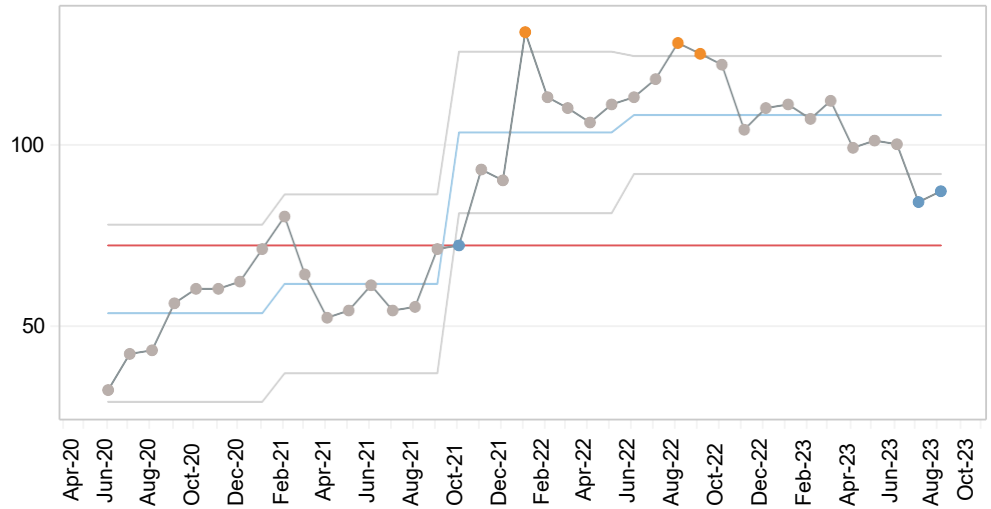
The number of out-of-area patients remains high with other localities struggling to access community capacity within their areas which is impacting on the ability to discharge / transfer patients to their local area. North Derbyshire and East Cheshire continue to have the highest number of out-of-area no criteria to reside patients. Meetings are taking place weekly with out of area partners to escalate and support improved flow out of Acute.

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

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

Signed off by	Margaret Malkin
Executive Lead	Jackie McShane

Performance for No criteria to reside (NCTR)



Integrated Performance Report - Exception

Operations: 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%	17.3%			

The diagnostic backlog has steadily increased between April and August, with 999 patients now waiting over 6 weeks.

Endoscopy

The Endoscopy backlog has decreased to 124 patients waiting over 6 weeks. Pressure on Endoscopy remains, as a result of increased colorectal suspected cancer referrals, the impact of Industrial Action and return/repeat second procedures. However, the endoscopy backlog continues to trend downwards and the service is on track for DM01 compliance in October.

Imaging

Imaging backlog has increased to 45 patients waiting over 6 weeks. Although most imaging modalities remain DM01 compliant, non-obstetric ultrasound had pressure due to the Industrial Action and peak leave period reducing lists.

Echocardiology (ECG)

The ECG backlog has increase to 780 patients waiting over 6 weeks. The service now has a 6th room, which is being used to increase capacity by an additional 5 slots per week.

ECG staffing remains a pressure. With the recent conversion of the vacant Physiologist post to a trainee position, recruitment to this new role is still underway. It should be noted that additional activity from successful recruitment to the trainee post will not support the recovery of our backlog position until the training programme has been completed. In the interim, a bank post has been recruited to, which is currently providing an additional 5 slots per week. Capacity will increase further dependant on uptake of WLIs by the substantive team.

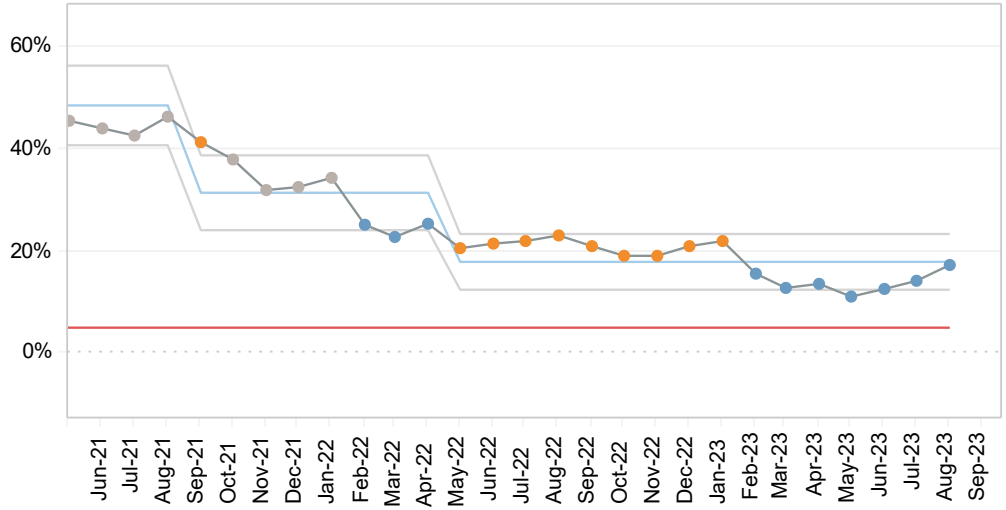
Outsourcing to the new CDC will provide additional ECG capacity to significantly reduce the backlog of patients, whilst timescales are still in development, it is hoped that we will see activity commencing before the end of the calendar year.

Audiology

There are currently 48 patients waiting more than 6 weeks. Staff sickness, patient choice, and a 25% DNA rate throughout the peak holiday period in August has contributed to this position. The service are working up a plan to introduce a 'Hot' audiologist aligned to the new patient clinics which will enable a one-stop clinic.

Signed off by	Mike Allison, Catherine Cotton, Karen Hatchell
Executive Lead	Jackie McShane

Performance for Diagnostics: 6 Week Standard



Integrated Performance Report - Exception

Operations: Cancer		Target	Actual	6-month Trend	Previous Performance	1-month Forecast
62-day standard	The percentage of patients on a cancer two-week-wait pathway that have received their first treatment within 62 days of GP referral.	>= 85%	50.7%	→	▲ ▲ ▲ ▲ ▲ ▲	▲
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%	60.2%	↘	▲ ▲ ▲ ▲ ▲ ▲	▲
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%	95.1%	↘	● ● ● ● ● ●	●

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

Referrals dropped in August with overall growth this year at 0.16% compared to months 1-5 last year.

Referral variance at tumour group level is extremely varied, reduced volume is seen in Urology and Colorectal, with significant growth still in Lung, ENT, Haematology and Gynaecology compared to 2022/23.

The final 62 day performance for July is 53.8%. with 28 day FDS performance at 60.2%.

Focus on patients waiting 63+ days continues with the Trust successfully achieving its backlog trajectory target for July and August.

Strong performance against the 2ww first seen standard is maintained.

It should be noted that the National Cancer Waiting Times Standards have been revised with changes coming into effect in October. The 2ww standard is being retired and the 62 day standard is being consolidate to include all referral types i.e. 2ww, upgrade and screening referrals. The 28 day FDS standard is unchanged.

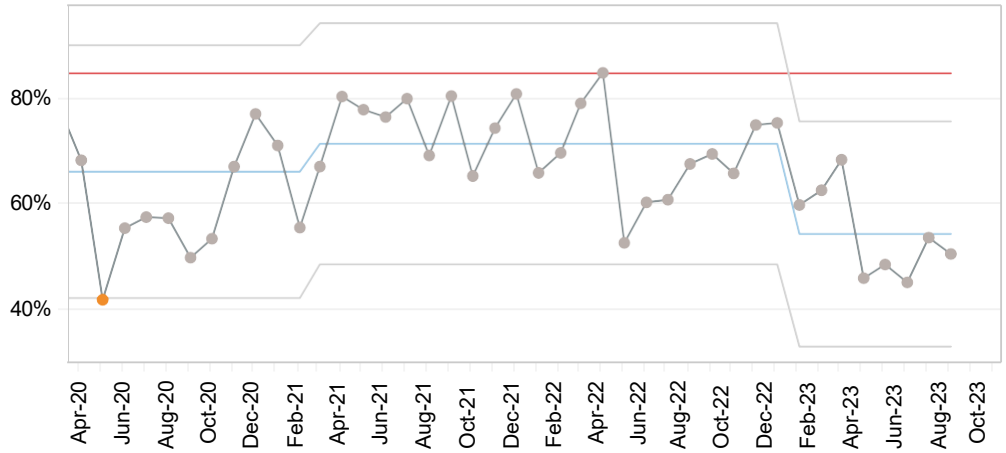
Divisional teams are developing improvement trajectories across these standards.

Urology pathway work between Tameside and Stockport continues and will be progressed via the Clinical Partnership Group. A Haematology service review is also underway.

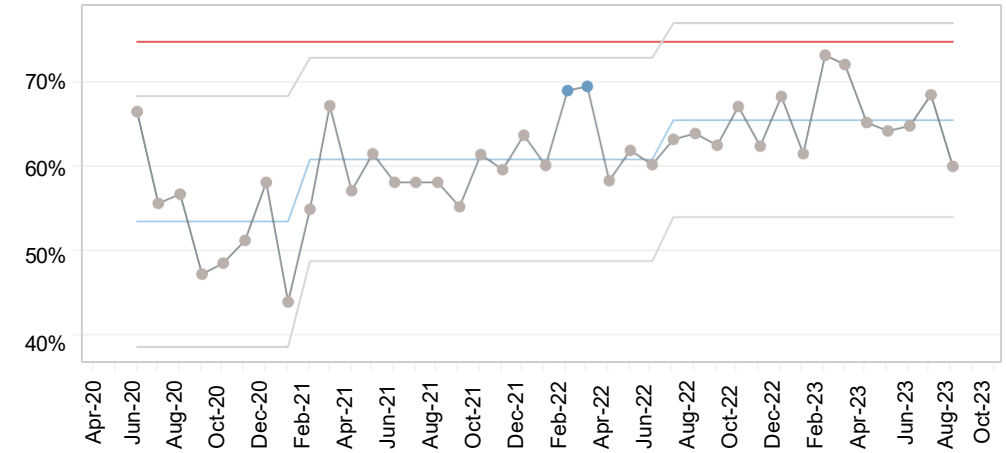
Curtis Soile
02/10/2023 07:32:55

Signed off by	Jo Pemrick
Executive Lead	Jackie McShane

Performance for 62-day standard



Performance for 28-day standard (FDS)



Integrated Performance Report - Exception

Operations: Referral to Treatment (RTT)		Target	Actual	6-month Trend	Previous Performance	1-month Forecast
Incomplete pathways 18-week %	Referral to treatment, the number of patients on an open pathway, whose clock period is less than 18 weeks, as a percentage of all patients on an open pathway.	>= 92%	48.3%	↓	▲ ▲ ▲ ▲ ▲	▲
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.	<= 3826	4358	↓	● ▲ ▲ ▲ ▲ ▲	▲
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	1360	↘	▲ ▲ ▲ ▲ ▲ ▲	▲

The number of patients waiting 65+ & 52+ weeks to commence treatment increased in month due to the concentrated effort to reduce our 78-week patients & the effect of the BMA industrial strike action on capacity.

The Trust still has a very small numbers of patients waiting 104 + weeks - only those where patient choice or transfers in from other trusts are factors remain on the waiting list but there are only 2. Both patients will be treated in September.

The 78 week wait position has remained a challenge due to the significant effect of the BMA industrial action & the lack of mutual aid support has negatively impacted on our recovery and led to end of August breaches.

Teams have worked hard to provide additional capacity, prioritise long waiters and validate the waiting lists against the access policy. Work has now started on the challenge of reducing to zero patients waiting over 65 weeks by end March 2024 & also to ensure all these patients have had their 1st appointment by the end of October 2023. Speciality specific trajectories have been agreed been and work with the Independent sector providers ongoing.

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

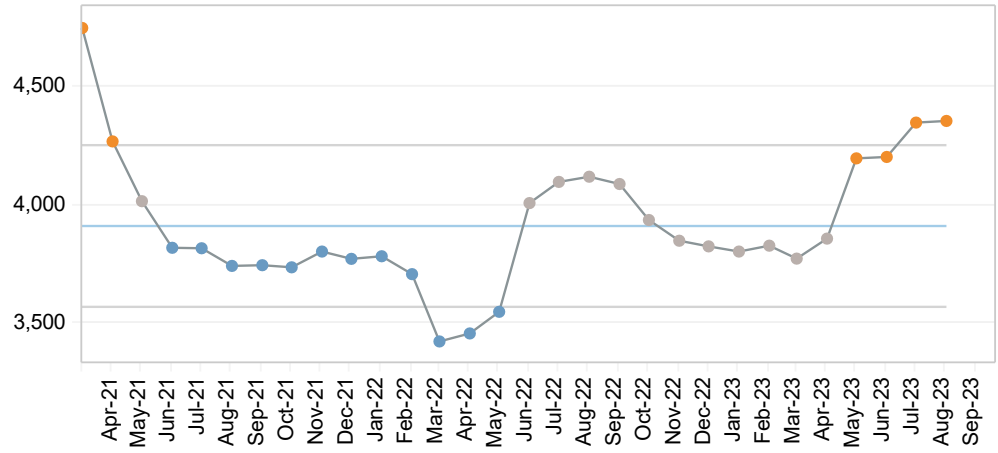
We continue to transfer/treat patients under the GM independent sector contract, taking up increased capacity for Gynaecology, Urology, ENT, Oral Surgery, Gastroenterology and General Surgery - this will continue under the current GM contractual arrangements for the rest of 2023/24.

GM is also developing a mutual aid strategy to eliminate 65+ week waits across the region and the Trust has representation at the weekly meetings to ensure both mutual aid and independent sector capacity is maximised.

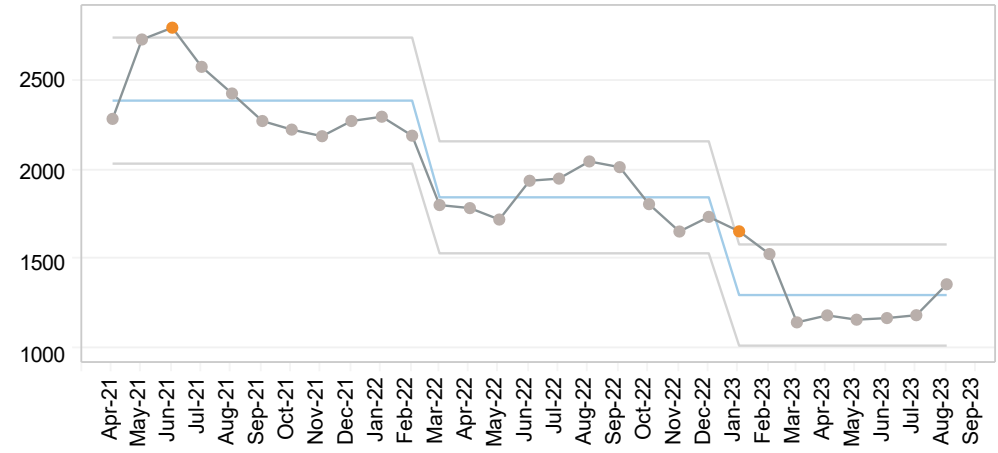
Trust elective performance meetings continue to focus on progressing patient pathways and eliminating long waits. The focus is on eliminating all patients who are waiting over 78 weeks at each month end and those waiting over 65 weeks by end March 2024.

Signed off by	Dan Riley
Executive Lead	Jackie McShane

Performance for 52-week breaches



Performance for 65-week breaches



Integrated Performance Report - Exception

Operations: Outpatient Efficiencies		Target	Actual	6-month Trend	Previous Performance	1-month Forecast
Outpatient DNA rate	The number of appointments where the patient did not attend, as a percentage of all booked appointments.	<= 6.3%	7.9%			
Outpatient clinic utilisation	The number of outpatient appointment slots booked, as a percentage of all outpatient appointment slots planned. Excludes cancelled clinic templates.	>= 90%	86.9%			
Patient initiated follow up (PIFU)	The number of patients moved to a PIFU pathway as a result of an outpatient attendance, as a percentage of all outpatient attendances.	>= 4.1%	2.9%			

DNA

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

The Trust has reached out to peer trusts outside of GM and Tameside with lower DNA rates to review their processes. Piloting of contacting patients for short notice slots via text to commence.

Waiting list Validation of new patients continues to support a better understanding of patients who no longer wish to be seen

We are also looking at benchmarking to support and target areas of concern.

Clinic Utilisation

Clinics managed by the Centralised Booking Team are at 96.9% utilisation. Clinics managed by the services themselves are at 81.5% utilisation.

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

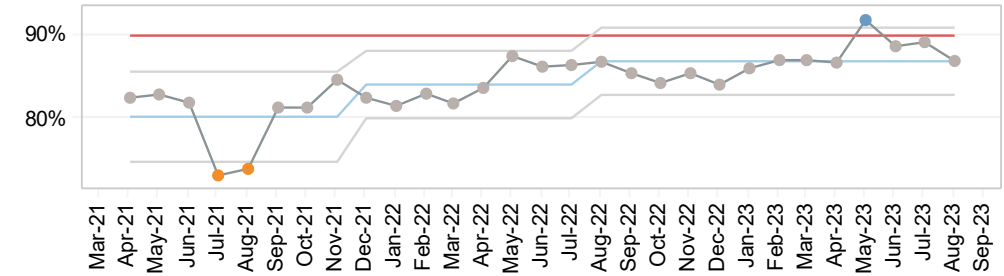
Patient initiated follow up

Performance remains stable at 3%, which is the highest level in GM. Specialities are continuing to utilise GIRFT guidance to identify opportunities for further roll out of PIFU.

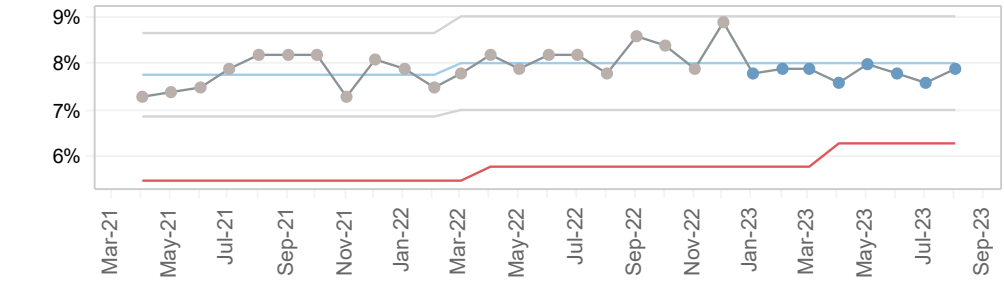
Curtis Soile
02/10/2023 07:32:55

Signed off by	Toni Coyle
Executive Lead	Jackie McShane

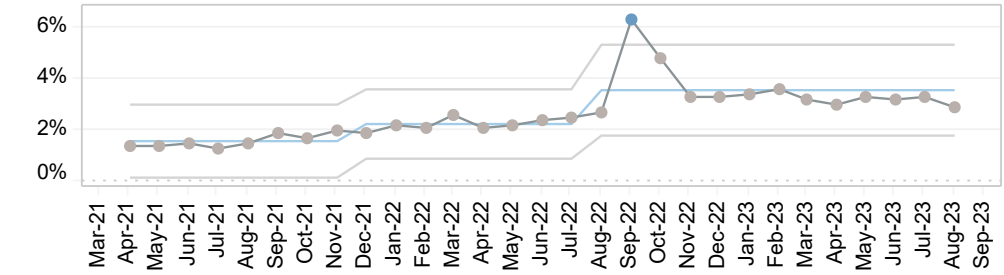
Performance for Outpatient clinic utilisation



Performance for Outpatient DNA rate



Performance for Patient initiated follow up (PIFU)



Integrated Performance Report - Exception

Operations: Theatre Utilisation		Target	Actual	6-month Trend	Previous Performance	1-month Forecast
Capped Touch Time Utilisation	The overall time spent operating, calculated as a percentage of the overall planned session time. Session overrun time is excluded from the calculation of this measur..	>= 85%	73.2%			
Average cases per 4-hour session		>= 2.4	2.22			

Touch-time Utilisation

Performance on capped touch time utilisation has dipped a little in recent months, however uncapped touch time utilisation performance continues to benchmark well against peers and nationally within model hospital for the latest data period at 83%.

Weekly additional theatre booking and utilisation meetings commenced in April to supplement the pre-existing 642 process and these are having a positive impact with good engagement across all surgical specialities. This has coincided with a positive increase in our ACPL.

Nursing vacancies and skill mix, and the anaesthetic medical workforce remain key areas of challenge within the theatre complex. Industrial Action and workforce challenges continue to create some issues around optimising the use of some theatre sessions. Where required, services are converting some theatre sessions to local anaesthetic lists at relatively short notice to offer some mitigation while maintaining clinical activity.

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

An Ophthalmology specific theatre project has been launched within Stockport Eye Centre.

Average cases per 4-hour session

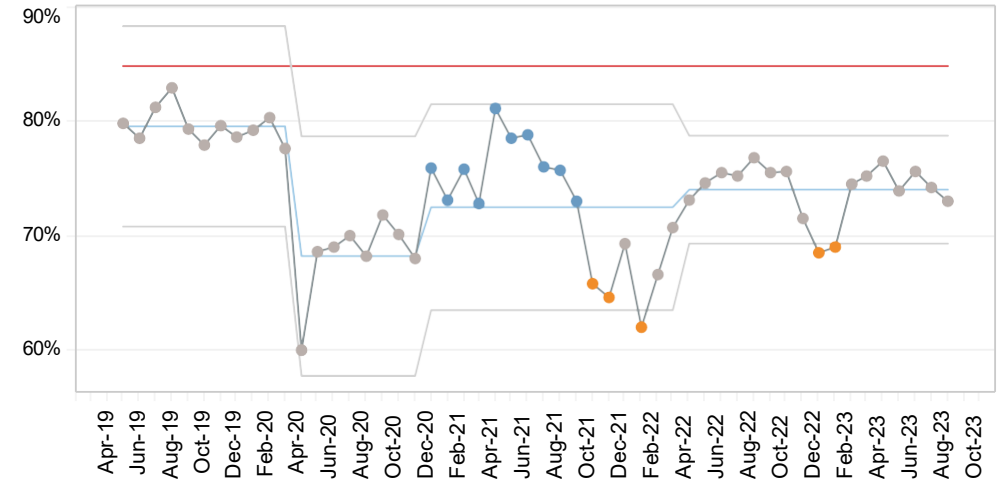
ACPL has showed improvement over the past 2 quarters following the introduction of a new weekly theatre utilisation and booking meeting which has provided increased rigor and scrutiny over list scheduling and prospective review of utilisation. Many specialties have returned to pre-pandemic ACPL levels.

The implementation of a central elective booking team with a dedicated manager to support scheduling and booking processes is also having a positive impact.

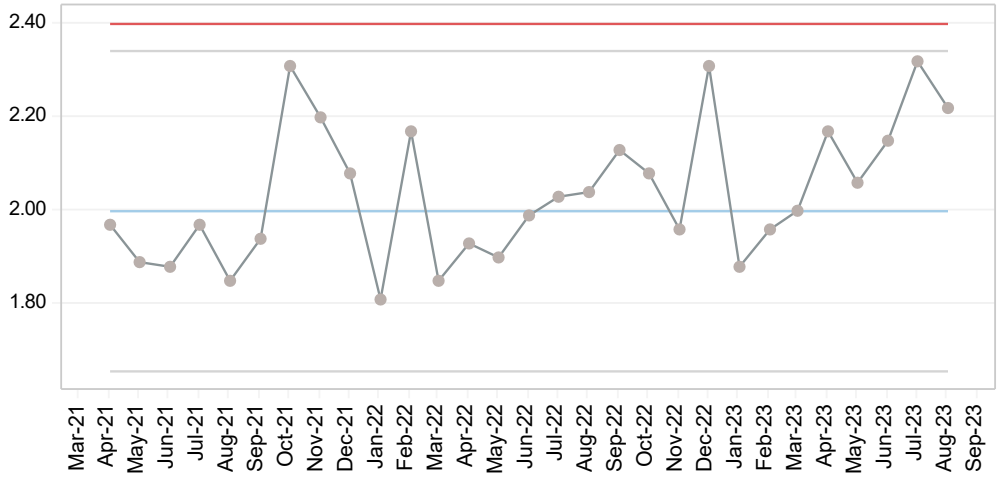
Curtis Soile
02/10/2023 07:32:55

Signed off by	Andrew Tunnicliffe
Executive Lead	Jackie McShane

Performance for Capped Touch Time Utilisation



Performance for Average cases per 4-hour session



Integrated Performance Report - Exception

Workforce: Agency Costs

		Target	Actual	6-month Trend	Previous Performance	1-month Forecast
Agency Costs %	Total agency costs, as a percentage of total PAY costs.	<= 3.7%	5.3%			

The total bank and agency spend in August 23 was £4.71M, which represents 16.5% of the total pay bill within the month and is 231K lower than July 23. The Division with the highest bank & agency spend in August was Medicine (£1.33M).

In August 2023, 5.3% of the total pay bill related to agency usage, while this remains above the target of 3.7% it has remained at the same level as last month. The average agency percentage over the 2022-23 financial year was 7.08% and the rolling 12-month average in August 2023 has reduced slightly to 6.5% (from 6.9%).

The highest divisional spends for agency usage are within Medicine (£560k increase from £496k)) and Surgery (£344k decrease from £360k). 54% of this spend was for medical staff, 32% on registered nursing and 3% on non-medical, non-clinical staff (these workers were within Estates and Facilities and Clinical Coding.

The Emergency Department, Medicine and career grade medical staff remain the highest proportional cost for agency and bank which relates to cover for escalation areas, the high levels of activity in ED and vacancies

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

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

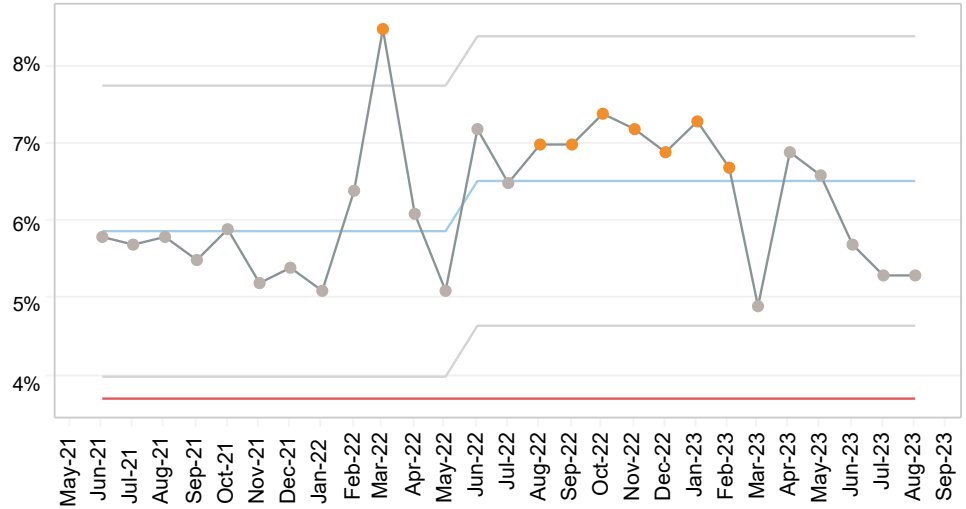
The following actions are underway to reduce agency spend:

- Targeted recruitment events.
- The TempRE agency cascade parameters are under review to ensure all shifts are available to providers within NHS cap rates for adequate timescales, this will be completed early October.
- Establishment of E-Rostering Workforce Group in line with Levels of Attainment standards.

Curtis Soile 02/10/2023 07:32:55

Signed off by	Emma Cain
Executive Lead	Amanda Bromley

Performance for Agency Costs %



Integrated Performance Report - Exception

Workforce: Turnover		Target	Actual	6-month Trend	Previous Performance	1-month Forecast
Workforce Turnover	The percentage of employees leaving the Trust and being replaced by new employees.	<= 12.5%	14.6%			

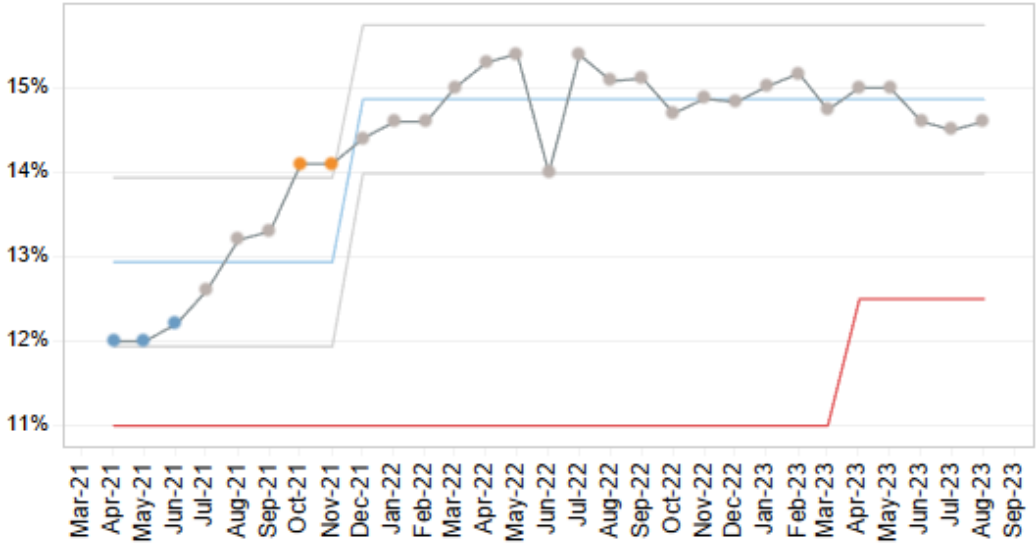
The Trust's 12-month turnover rate remains above our 12.5% target and has remained stable. Recruitment activity continues at pace and in month we have had 12% more staff join the organisation than have left.

We continue to see an elevated turnover rate for Additional Clinical Services staff group (18.32%), reflective of the increased the number Healthcare Support Worker (HSW) recruited through external recruitment events that have left within their first year. As a result, we are continuing to work alongside colleagues providing pastoral and clinical support within the first three months of employment to improve the retention of this staff group.

Our review of the exit questionnaire process has recently been completed. It is anticipated that streamlining this process will encourage greater return rates and a better understanding of the reasons for leaving which will inform our response. The actions stated above will support improved retention, and turnover will be monitored during 2023/24.

Curtis Soile
02/10/2023 07:32:55

Performance for Workforce Turnover



Signed off by	Emma Cain
Executive Lead	Amanda Bromley

Integrated Performance Report - Exception

Workforce: Appraisals		Target	Actual	6-month Trend	Previous Performance	1-month Forecast
Appraisal Rate: Overall	The percentage of overall staff that have been appraised within the last 15 months. Includes both medical staff and non-medical staff.	>= 95%	90.1%			

Appraisal compliance for the organisation currently stands at 90.1% which is below the Trust target of 95%.

The medical appraisal rate has increased to 83.7%, while the non-medical appraisal rate remained at a similar level to last month at 91.63%. Divisions of Clinical Support Services and Women and Children both met the target

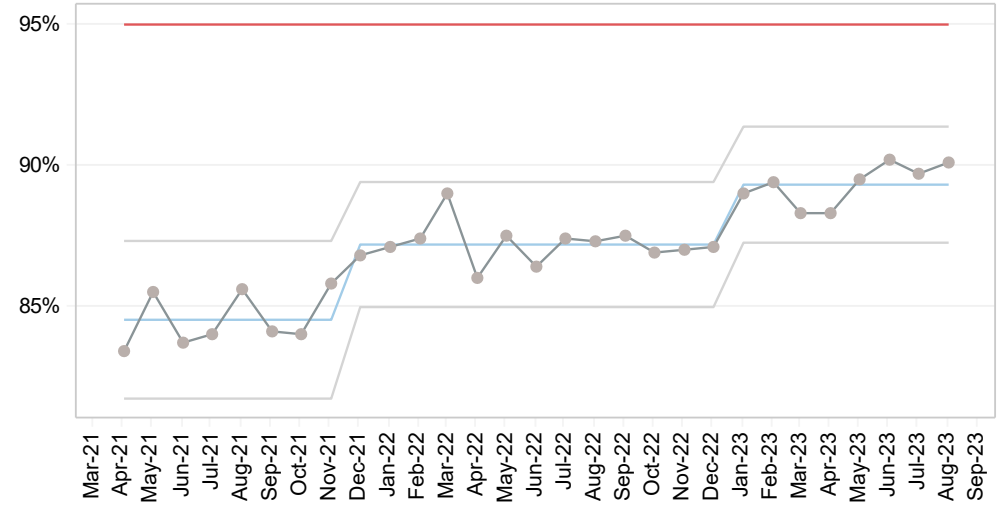
Appraisal performance is addressed within the monthly performance review meetings. Divisions are supported by the Education and OD Teams to improve compliance and training is offered for appraisers to ensure that the quality of appraisals is consistently high and continues to improve. There is a review of the current process to identify better processes and colleague experience.

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

Curtis Soile
02/10/2023 07:32:55

Signed off by	Emma Cain
Executive Lead	Amanda Bromley

Performance for Appraisal Rate: Overall



Integrated Performance Report - Exception

Workforce: Mandatory Training

		Target	Actual	6-month Trend	Previous Performance	1-month Forecast
Mandatory Training	The percentage of statutory & mandatory training modules showing as compliant.	>= 95%	94.4%			

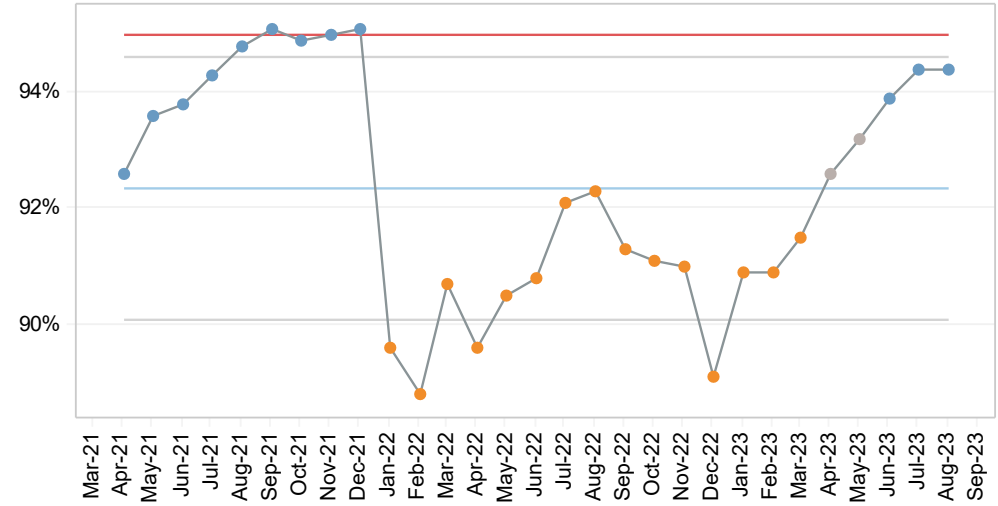
Mandatory training is currently at 94.4% for the organisation which is inching ever closer to the Trust target. Teams have been working hard to improve compliance across the Trust.

Clinical Support Services, E&F, Integrated Care and Women's and Children's are above target. Medical and Dental are the lowest performing staff group and we are engaging with colleagues to improve this position with a trajectory in place.

Curtis Soile
02/10/2023 07:32:55

Signed off by	Emma Cain
Executive Lead	Amanda Bromley

Performance for Mandatory Training



Integrated Performance Report - Exception

Finance		Target	Actual	6-month Trend	Previous Performance	1-month Forecast
Capital Expenditure	The actual capital expenditure, as a percentage of the planned capital expenditure. Performance is displayed as a percentage variance from the planned amount.	<= 10%	-41.2%	→	▲ ● ● ● ● ●	●
Cash Balance	The amount of cash balance in Trust accounts. Figures displayed are millions per month.		24.8	↘		
CIP Cumulative Achievement	The value of the actual CIP achievement, displayed as a percentage variance from the planned CIP achievement.	>= 0%	-9.5%	↗	● ▲ ▲ ▲ ▲ ▲	▲
Financial Controls: I&E Position	The actual financial position, displayed as a percentage variance from the planned financial position.	<= 0%	9.4%	→	● ▲ ▲ ▲ ▲ ▲	▲

There is a forecast £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 cost of the industrial action to date is £1.5m. Further industrial action is planned by junior doctors and consultants in September and October. This will have a financial impact and also an impact on elective and outpatient activity. At this point no further dates have been announced but there continues to be a risk associated with this.

The risk of non-delivery of activity in accordance with ERF is not yet clear from a GM ICS point of view. Month 5 is the first month this has been mandated to be reported, but there is inconsistency between organisations about how this has been presented. In line with GM values a risk of £0.5m has been reported. The latest calculations show that if the Trust were to deliver the plan this would be a range of c.£2m to c.£5m underperformance with the latest case mix data.

The Trust made a bid for GM elective reform monies in gynaecology, urology, ENT and dermatology. Spend of £0.5m has been agreed at risk for the mandated reduction of 65 week wait patients.

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

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

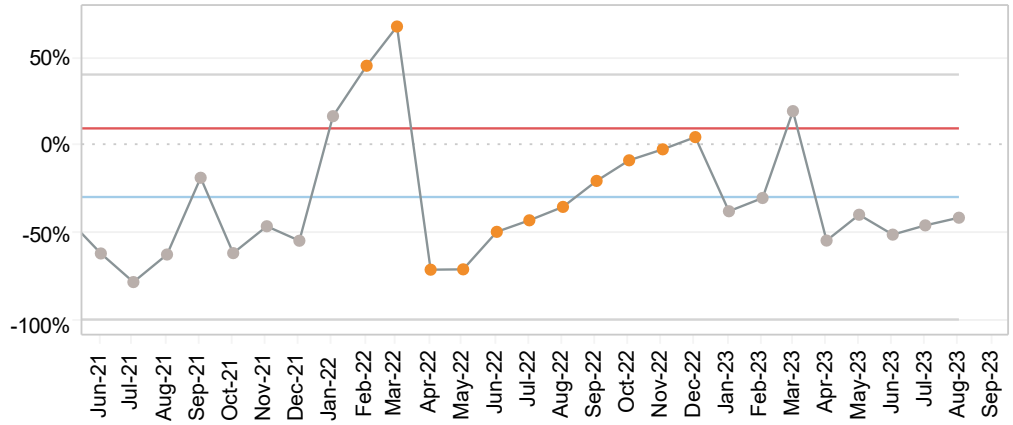
CIP achievement is £1m behind plan; however there has been an improvement in recurrent delivery to 34.2%. Focus remains on recurrent delivery of all plans.

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

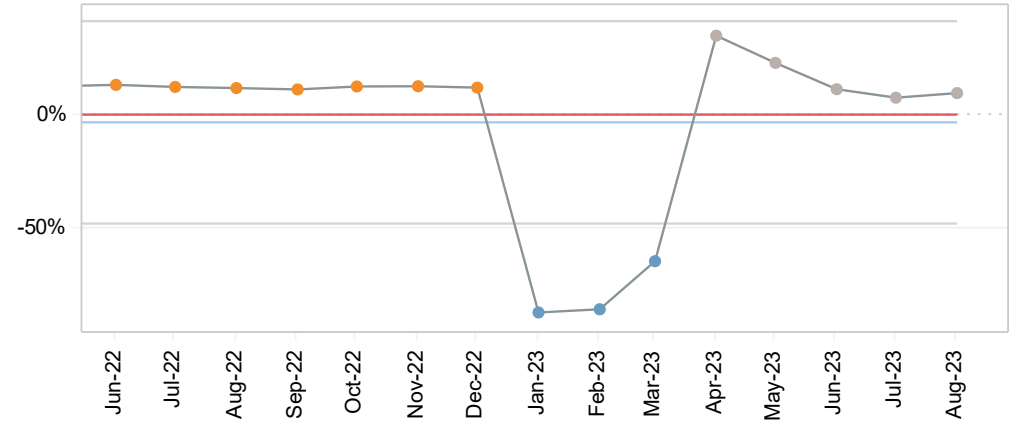
Curtis Soile 02/10/2023 07:32:55

Signed off by	Kay Wiss
Executive Lead	John Graham

Performance for Capital Expenditure



Performance for Financial Controls: I&E Position



NHS
Stockport
NHS Foundation Trust

Meeting date	5th October 2023	**Public**	**X**	**Confidential**	
Meeting	Board of Directors				
Report Title	Protecting and Expanding Elective Capacity				
Director Lead	Jackie McShane Executive Director of Operations	**Author**	Jackie McShane Executive Director of Operations		

Paper For:	**Information**		**Assurance**	**x**	**Decision**	
Recommendation:	The Board of Directors are requested to note the contents of this report and endorse the decision of the Finance & Performance Committee.					

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	**X**	Responsive
	Well-Led	**X**	Use of Resources

This paper relates to the following Board Assurance Framework risks

X	PR1.1	There is a risk that the Trust does not deliver high quality care to service users
	PR1.2	There is a risk that patient flow across the locality is not effective
X	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 purpose of this paper is to ensure that the Board of Directors are sighted on the detailed background to the request from the national team to provide assurance against a set of activities, which will drive the recovery of outpatients at pace.

As agreed at Board in September 2023, the task to deep dive this analysis was delegated to the Finance & Performance Committee, who completed this task at the committee on Thursday 21st September 2023.

The outcome of review what that full assurance could not be provided on all measures and an action plan to address is being developed with regional colleagues, in particular relating to the capacity to deliver first appointments to all patients by 31st October 2023.

Self Certification

About this self-certification

To deliver elective and cancer recovery ambitions, high-quality waiting list management and ambitious outpatient transformation are vital. We are now asking trusts to complete this return to provide assurance on these recovery plans.

Nationally and regionally, we will use this to identify providers requiring more support, as well as areas of good practice that can be scaled up to accelerate recovery. Please return this to NHS England by **30 September 2023**, via NHS England regional teams.

Guidance for completing the self-certification

The return asks for assurance that the board has reviewed and discussed specific outpatient operational priorities and has signed off the completed checklist. Please return this to your NHS England regional team.

Trust return: Stockport NHS Foundation Trust

The chair and CEO are asked to confirm that the board:

Assurance area	Assured?	Key Issues
1. Validation The board: a) has received a report showing current validation rates against pre-covid levels and agreed actions to improve this position, utilising available data quality (DQ) reports to target validation, with progress reported to board at monthly intervals. This should include use of the nationally available LUNA system (or similar) to address data quality errors and identify cohorts of patients that need further administrative and clinical validation.	No	Trust is complaint with the all of the standards however does not report this regularly to board.
b) has plans in place to ensure that at least 90% of patients who have been waiting	Yes	

over 12 weeks are contacted and validated (in line with validation guidance) by 31 October 2023, and has sufficient technical and digital resources, skills and capacity to deliver against the above or gaps identified. We are developing a range of digital support offers for providers to improve validation. c) ensures that the RTT rules and guidance and local access policies are applied and actions are properly recorded, with an increasing focus on this as a means to improve data quality. For example, Rule 5 sets out when clocks should be appropriately stopped for 'non-treatment'. Further guidance on operational implementation of the RTT rules and training can be found on the Elective Care IST FutureNHS page. A clear plan should be in place for communication with patients d) has received a report on the clinical risk of patients sitting in the non RTT cohorts and has built the necessary clinical capacity into operational plans.	Yes Yes	
2. First appointments The board: a) has signed off the trust's plan with an ambition that no patient in the 65 week 'cohort' (patients who, if not treated by 31 March 2024, will have breached 65 weeks) will be waiting for a first outpatient appointment after 31 October 2023. b) has signed off the trust's plan to ensure that Independent Sector capacity is being used where necessary to support recovery plans. To include a medium-term view using both insourcing and outsourcing, the Digital Mutual Aid System, virtual outpatient solutions and whole pathway	No No	No current capacity or GM mutual aid to assure on this. Whilst the Trust is a high user of independent sector capacity there is no published capacity plan available for us to interact with and inform recovery. Capacity adhoc and advised

transfers. National support and information on utilisation of the Independent Sector is available via the IS Co-ordination inbox england.iscoordination@nhs.net		weekly by ISP's. DMAS is being replaced by PIDMAS which is currently on hold due to financial constraints.
3. Outpatient follow-ups The board: a) has received a report on current performance against submitted planning return trajectory for outpatient follow-up reduction (follow-ups without procedure) and received an options analysis on going further and agreed an improvement plan. b) has reviewed plans to increase use of PIFU to achieve a minimum of 5%, with a particular focus on the trusts' high-volume specialties and those with the longest waits. PIFU should be implemented in breast, prostate, colorectal and endometrial cancers (and additional cancer types where locally agreed), all of which should be supported by your local Cancer Alliance. Pathways for PIFU should be applied consistently between clinicians in the same specialty. c) has a plan to reduce the rate of missed appointments (DNAs) by March 2024, through: engaging with patients to understand and address the root causes, making it easier for patients to change their appointments by replying to their appointment reminders, and appropriately applying trust access policies to clinically review patients who miss multiple consecutive appointments. d) has a plan to increase use of specialist advice. Many systems are exceeding the planning guidance target and achieving a level of 21 per 100 referrals. Through job planning and clinical templates, the Board understands the impact of workforce	No Yes Yes Yes	As part of operational planning the Trust did not sign off a reduction in follow ups due to the backlog caused by the pandemic.

capacity to provide advice and has considered how to meet any gaps to meet min levels of specialist advice. The Trust has utilised the OPRT and GIRFT checklist, national benchmarking data (via the Model Health System and data packs) to identify further areas for opportunity. e) has identified transformation priorities for models such as group outpatient follow up appointments, one-stop shops, and pathway redesign focussed on maximising clinical value and minimising unnecessary touchpoints for patients, utilising the wider workforce to maximise clinical capacity.	Yes Yes	
4. Support required The board has discussed and agreed any additional support that maybe required, including from NHS England, and raised with regional colleagues as appropriate.	Yes	

Sign off

	Name, job title and email address	Date
Trust Lead	Peter Nuttall Director of Informatics Jackie McShane Executive Director of Operations	15th September 2023
Signed off by chair and chief executive	Tony Warne Chair Karen James CEO	

NHS Stockport NHS Foundation Trust

Meeting date	5th October 2023	**Public**	X	**Confidential**	
Meeting	Board of Directors				
Report Title	PDC Revenue Support 2023/24				
Director Lead	John Graham, Chief Finance Officer	**Author**	Lisa Byers, Associate Director of Finance – Financial Services		

Paper For:	**Information**		**Assurance**		**Decision**	X
Recommendation:	The Board of Directors are requested to ratify the Board Resolution attached in Appendix 1.					

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
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	N/A
Financial impacts if agreed/not agreed	As per Annual Plan
Regulatory and legal compliance	N/A
Sustainability (including environmental impacts)	N/A

Executive Summary

The purpose of this report is to inform the Board of Directors the position regarding the 2023/24 Revenue Support PDC arrangements from the Department of Health & Social Care (DHSC).

Revenue Support PDC is available to the Trust to support its revenue expenditure as part of a robust and defined process by the Capital and Cash team at NHS England.

The Trust anticipated that it would require cash support in its Annual Plan 2023/24 submission as has been previously approved by the Board.

The Board of Directors must approve any PDC Revenue Support request by the Trust in the form of a Board Resolution. This paper will formally ask for the resolution at **Appendix 1** to be approved in preparation for future monthly PDC Revenue Support in line with the Trust's Annual Plan and cashflow forecasts.

Recommendation

- The Board is requested to ratify the Board Resolution attached in Appendix 1.

1. Purpose

1.1 The purpose of this report is to inform the Board of Directors the position regarding the 2023/24 Revenue Support PDC arrangements from the Department of Health & Social Care (DHSC).

1.2 Revenue Support PDC is available to support revenue expenditure and is available to the Trust to meet necessary and essential expenditure to protect continuity of patient services.

1.3 Revenue support takes the form of Public Dividend Capital (PDC), with no set repayment date, but attracts a dividend payable at the current rate (3.5%).

1.4 The Board of Directors must approve any PDC Revenue Support request by the Trust in the form of a Board Resolution. This paper will formally ask for the resolution at Appendix 1 to be approved in preparation for future monthly PDC Revenue Support in line with the Trust's Annual Plan and cashflow forecasts.

2. Background

2.1 The Trust is forecasting a year end deficit of £31.8 million which is in line with the Board approved plan for 2023/24. The Trust will be reliant upon cash support from the DHSC as reflected in its 2023/24 plan submission to NHS England. This was initially planned at £20 million with a planned drawdown from September 2023 – November 2023.

2.2 The latest cashflow forecast now plans for a drawdown of revenue support from January 2024 to March 2024.

2.3 The current process for funding the deficit is initially through revenue Public Dividend Capital (PDC).

2.4 There is a defined Revenue Support PDC process that all providers must follow with a monthly timetable for the submission of revenue support documentation. This includes cash forecasts, working capital information, approval of memorandum of understandings, cash utilisation requests and receipt of cash into the bank.

2.5 PDC Support for capital expenditure follows a separate process.

3. Matter under consideration

3.1 The Trust is to put in place a facility to draw multiple revenue support PDC for the cash required in 2023/24; supported by the single Board resolution.

3.2 Attached at **Appendix 1** is the resolution to be ratified by the Board of Directors, which is to be signed by the Chair and Chief Executive and sent to DHSC, in line with the draw-down of the revenue PDC.

4. Recommendations

4.1 The Board is requested to ratify the Board Resolution attached in **Appendix 1.**

Appendix 1

Board Resolution

Statement from the Chair and Chief Executive of Stockport NHS Foundation Trust, regarding the Board of Directors approval of Revenue Public Dividend Capital Support.

We certify that a paper was presented to the Board of Directors on Thursday 5th October 2023 regarding the planned Revenue Support Public Dividend Capital (PDC) submissions for 2023/24 (henceforth referred to as the Finance Documents). This recommends that multiple requests for PDC revenue support totalling £20,000,000 are taken.

We confirm that the Board has accepted this recommendation and therefore approves the facility on behalf of the Trust.

In line with the Finance Documents, we also confirm that the Board has:

a) approved the terms of, and the transactions contemplated by, the Finance Documents to which it is a party; and resolved to execute the Finance Documents to which the Trust is a party;

b) authorised the Director of Finance to execute the Finance Documents to which the Trust is a party, on its behalf; and

c) authorised the Director of Finance to sign and/or dispatch all documents and notices (including the Utilisation Request) in connection with the Finance Documents to which the Trust is a party, on its behalf.

Anthony Warne - Chair
Stockport NHS Foundation Trust

Signature:

Karen James - Chief Executive
Stockport NHS Foundation Trust

Curtis Soile 02/10/2023 07:32:55

Signature

NHS
Stockport
NHS Foundation Trust

Meeting date	5th October 2023	**Public**	X	**Confidential**	
Meeting	Board of Directors				
Report Title	Infection Prevention & Control Service Annual Report 2022/23				
Director Lead	Nic Firth, Chief Nurse & DIPC	**Author**	N Featherstone, AND for the IP&C Service		

Paper For:	**Information**	X	**Assurance**	X	**Decision**	
Recommendation:	The Board is asked to receive the infection prevention annual report.					

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
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
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Where issues are addressed in the paper

	Section of paper where covered
Equality, diversity and inclusion impacts	None
Financial impacts if agreed/not agreed	None
Regulatory and legal compliance	All Objectives
Sustainability (including environmental impacts)	None

Executive Summary

This report provides an annual review of the mandatory reporting and activities undertaken by the Infection Prevention & Control (IP&C) Service Team during 2022-2023.

The annual report was presented and approved at the IPC Group 31st May 2023.

The key achievements during this period were:

- The Surgical site surveillance infection rate remains at 0%
- The development of the ventilation strategy
- The implementation of the National Standards for Cleaning
- Re-introduction of PLACE
- Hospital Sterilisation and Decontamination Unit (HSDU) & Endoscopy decontamination unit (EDU) were successful in passing their BSI and JAG accreditation.

The key challenges during this period were:

- The national healthcare associated infections trajectories were not met.
- Full submission of the UTI CQUIN was not achieved.
- Limited progress with the central vascular access service
- Uptake of staff flu and Covid vaccinations
- Reduction in compliance of management of sharps
- ANTT compliance for medical staff

NHS
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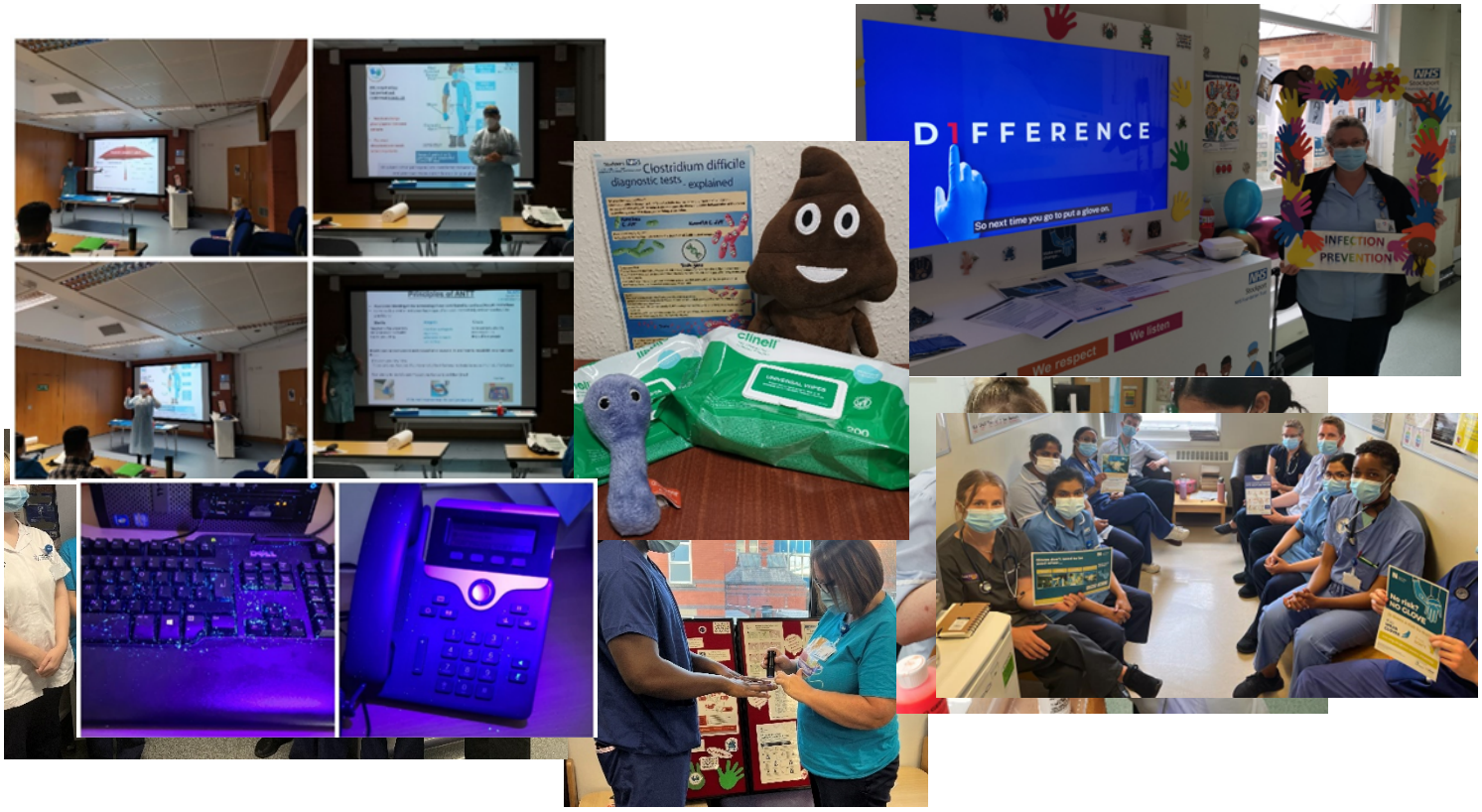
INFECTION PREVENTION & CONTROL SERVICE ANNUAL REPORT

April 2022- March 2023



Contents

Foreword

2022-23 continued to be a challenging year as the Trust balanced 'living with Covid' with supporting clinical services to return to pre-pandemic levels. At the centre, supporting the journey remained the infection prevention and control team whose guidance and expertise enable the Trust to maintain a safe journey for our patients/service users.

I am proud to introduce Stockport NHS Foundation Trust's (SNHSFT) Annual Infection Prevention and Control Service Report for the period 2022-23.

This report follows the format of the infection prevention and control board assurance framework demonstrating progress with the requirements associated with the criteria.

Finally, the report outlines the key objectives for 2023-24.

Nic Firth

Chief Nurse/DIPC

Introduction

This report provides the Trust board with an annual review of the mandatory reporting and activities undertaken by the Infection Prevention & Control (IP&C) Service Team over the past 12 months.

The Trust recognises that effective prevention and control of Healthcare Acquired Infections (HCAI's) is essential to ensure patients using our services receive safe and effective care. Effective prevention and control are both integral parts of everyday practice and the Trust is committed to ensure this is applied consistently to ensure the safety of our patients.

Key Achievements 2022-23

The following is a summary of the key achievements over the last twelve months:

- The Surgical site surveillance infection rate remains at 0%
- The development of the ventilation strategy
- The implementation of the National Standards for Cleaning
- Re-introduction of PLACE
- Hospital Sterilisation and Decontamination Unit (HSDU) & Endoscopy decontamination unit (EDU) were successful in passing their BSI and JAG accreditation.

Compliance with the IPC Board Assurance Framework (BAF)

Criterion 1: Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other service users may pose to them.

a. Organisational accountability for Infection Prevention and Control (IP&C) Roles and Responsibilities

IP&C is the responsibility of everyone within the organisation. Key roles and arrangements are detailed below:

Chief Executive

The Chief Executive has overall responsibility for ensuring that there are effective management and monitoring arrangements provided for IP&C to meet all statutory requirements.

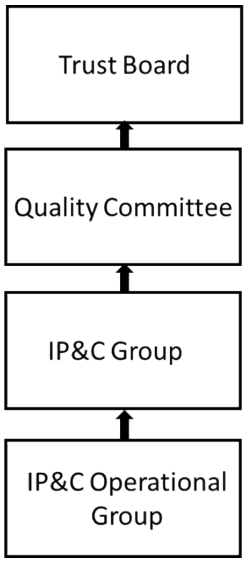
Director of Infection Prevention and Control

The Director of Infection Prevention and Control (DIPC) role is the responsibility of the Chief Nurse. The DIPC is responsible for ensuring that systems and processes are in place in response to external and internal requirements to minimise risk to staff, service users and visitors and ensure compliance with the Health and Social Care Act 2008: Code of Practice for the prevention of healthcare-associated infections. The DIPC is the chair of the Infection Prevention and Control group.

Infection Prevention and Control Group

The Infection Prevention and Control (IP&C) group is a mandatory requirement. It is the key forum for providing assurance that the Trust has structures and arrangements in place to meet all statutory requirements for IP&C.

The chart below demonstrates the IP&C reporting arrangements:



Infection Prevention and Control Service

During 2022-23, the Infection Prevention & Control Service Team covered Stepping Hill Hospital and other Specialist centres, as well as the Community Health Service across Stockport.

To meet the requirements of the Health and Social Care Act 2008: Code of Practice for the prevention of healthcare-associated infections (updated 2010 and 2015), related guidance in addition to other requirements such as the core standards of the Care Quality Commission (CQC). The Infection Prevention & Control Service Team for Stockport NHS Foundation Trust in the period of 2022-23 which has 778 beds and over 5,000 staff consisted of:

DIPC	
Associate Nurse Director- IP&C	1.0 WTE
Matron – IP&C	1.0 WTE
IP&C Service Nurses	5.0 WTE
IV Nurse Practitioners	2.0 WTE
IP&C practitioner	1.0 WTE
IP&C support practitioners	5.63 WTE
IP&C Team Administrator	1.0 WTE
IP&C Information Analyst	1.0 WTE
Consultant Microbiologists	4.0 WTE
Antibiotic Pharmacist	1.00 WTE (consisting of 2 PT staff)

All the above is supported by a CPA accredited Microbiology Laboratory.

Infection Prevention and Control Doctor/Microbiology Consultant

The role of the Infection Prevention and Control Doctor/Microbiology Consultant provides clinical advice for staff to manage patients with specific alert organisms.

Prevention of Infection Practitioners (PIPs)

The role of the Prevention of Infection Practitioners (PIPs) supports the function of the IP&C team and are an important and effective means of disseminating information and good practice guidance. PIPs act as visible role models and local IP&C leaders and advocate high standards of IP&C.

They provide a link between their colleagues and the IP&C team to facilitate good practice and improve standards within their team.

b. Monitoring the Prevention and Control of Infection

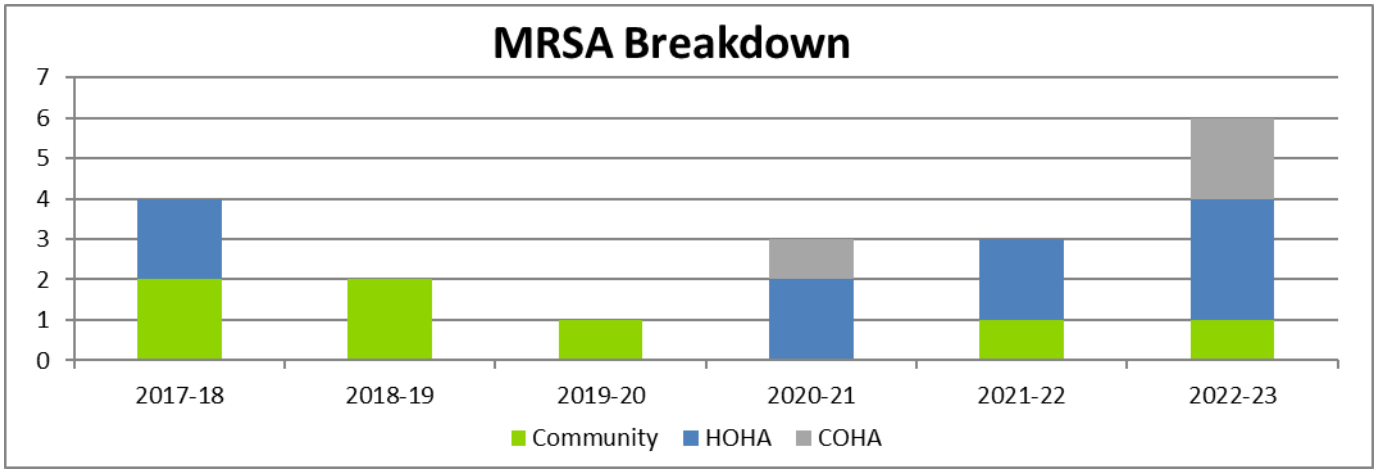
Surveillance of Alert Organisms & Mandatory Reporting

In accordance with Department of Health guidelines, Infection Prevention & Control Teams carry out mandatory reporting of clostridium difficile and bacteraemia's associated with MRSA, MSSA, E. coli, Pseudomonas aeruginosa and Klebsiella sp.

Mandatory cases for 2022-23 are reported as a combination of Hospital-onset healthcare-associated (HOHA) and Community-onset healthcare-associated (COHA) for all isolates. In previous years this reporting structure was just for clostridium difficile.

MRSA Bacteraemia

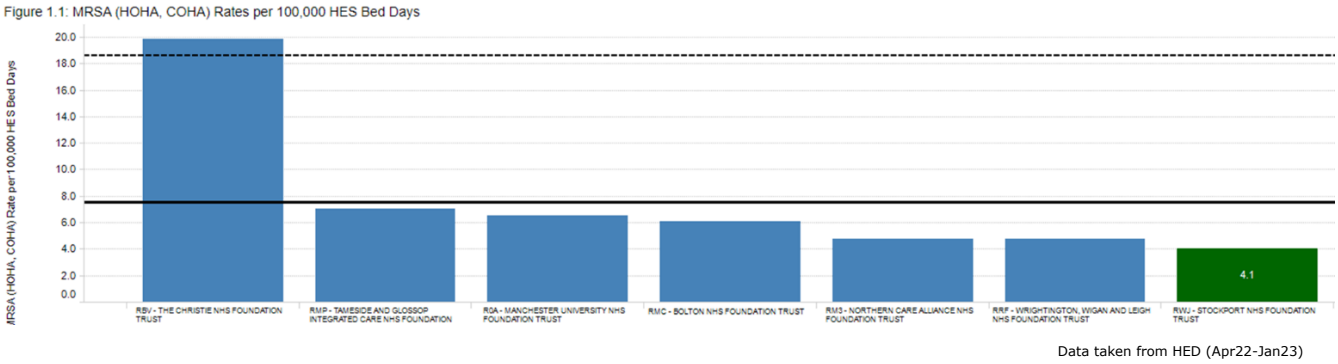
The national tolerance for MRSA bacteraemia cases continues to be zero. In 2022-23 the Trust had 3 Hospital Onset, Hospital Apportioned (HOHA) cases and 2 Community Onset, Hospital Associated (COHA) cases. 1 further Community Onset, Community Acquired (COCA) case was attributed to the community.



Post Infection Review (PIR) investigations were undertaken for all HOHA and COHA cases and were presented to the Trusts Health Care Associated Infections (HCAI) panel for their

consideration. 2 cases were deemed unavoidable and 3 avoidable. Themes from the avoidable cases were collated and presented Trust wide.

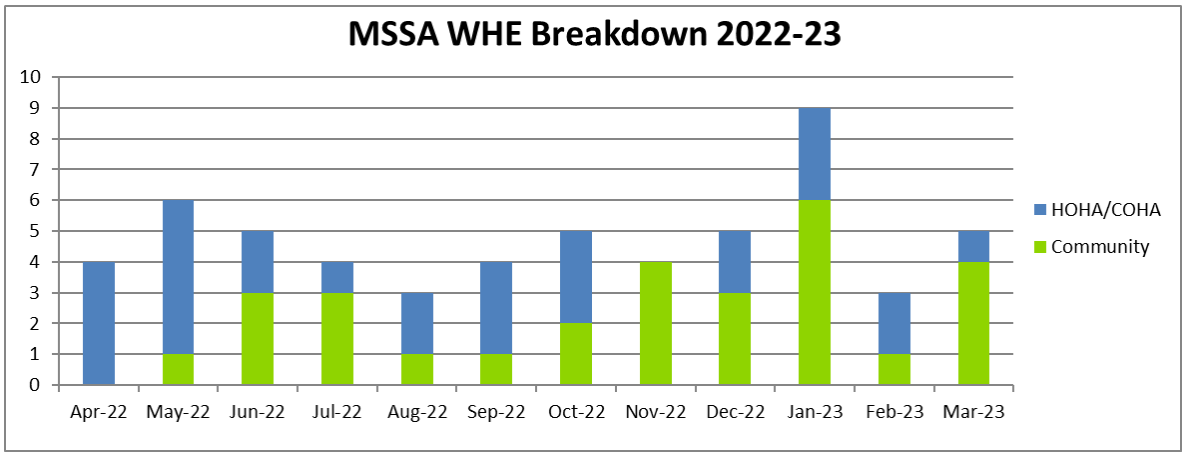
Peer Group Comparison: The Trusts monitors its performance against a Northwest Peer group. Below illustrates the Trust in comparison with its peers for MRSA Bacteraemia's.



Action: To implement learning from the avoidable cases to prevent further avoidable MRSA bacteraemia cases during 2023-24.

Methicillin Sensitive Staphylococcus Aureus (MSSA) Bacteraemia

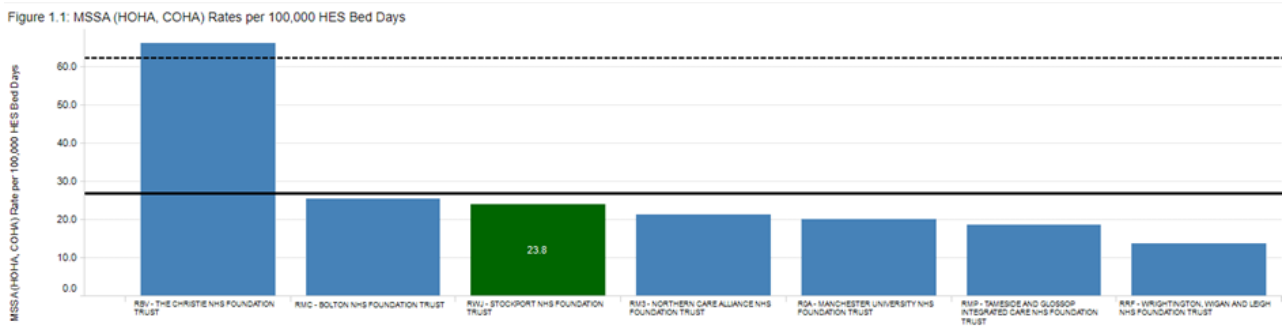
In 2022-23 The Trust had 21 Hospital Onset, Hospital Apportioned (HOHA) cases and 7 Community Onset, Hospital Associated (COHA) cases, totalling 28 cases. This is an increase of 7 from the previous year.



The average age of patients developing an MSSA bacteraemia during this year was 68 years old. The average acquisition day was 12 ranging from 0 to 63 days. During 2022-23

the total threshold was set at 18 cases allowing 4.5 per quarter. This threshold was exceeded by 10 cases.

Peer Group Comparison: The Trust monitors its performance against a Northwest Peer group. Below illustrates the Trust in comparison with its peers for MSSA Bacteraemia's.



Data taken from HED (Apr22-Jan23

Action: To identify themes from root cause analysis (RCA) investigations to enable achievement of Trust internal thresholds set for 2023-24.

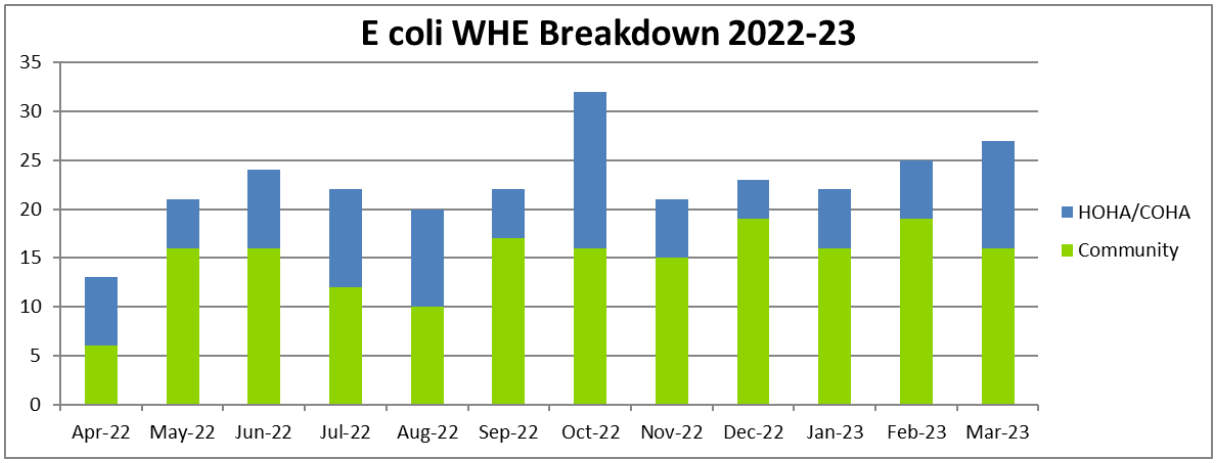
Gram negative blood stream infection (GNBSI)

GNBSI includes all positive blood cultures for Escherichia coli, Klebsiella species and Pseudomonas aeruginosa.

Escherichia coli (E. coli) Bacteraemia

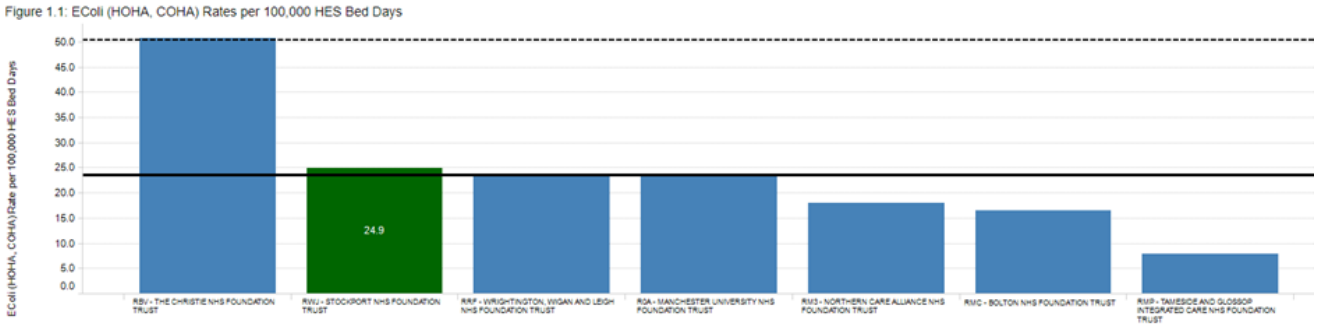
E. coli data collection continued with the predominant cases being community acquired.
In 2022-23 the Trust had 59 Hospital Onset, Hospital Apportioned (HOHA) cases and 35 Community Onset, Hospital Associated (COHA) cases, totalling 94 cases an increase of 33 from the previous year.

The average age of patients developing an E. coli bacteraemia was 75 years old. The average acquisition day was 15, however this ranged from 0 to 129 days which is a decrease on the previous year.



During 2022-23 the total threshold was set at 49 cases allowing 12.25 per quarter. This threshold was exceeded by 45 cases.

Peer Group Comparison: The Trusts monitors its performance against a Northwest Peer group. Below illustrates the Trust in comparison with its peers for E. coli Bacteraemia's.

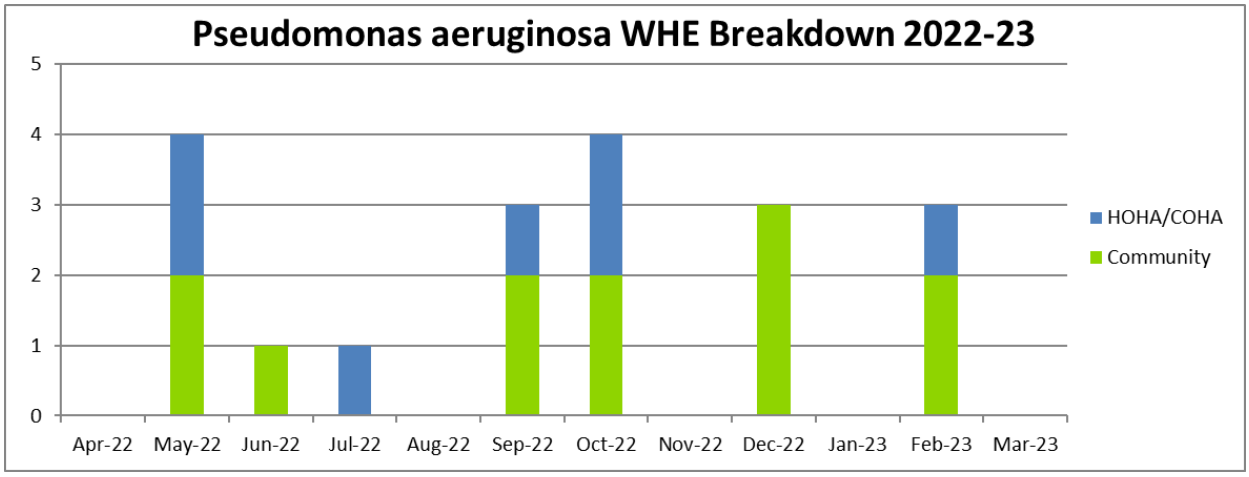


Data taken from HED (Apr22-Jan23

Action: To identify themes from RCA investigations to enable achievement of the Trust internal thresholds set for 2023-24.

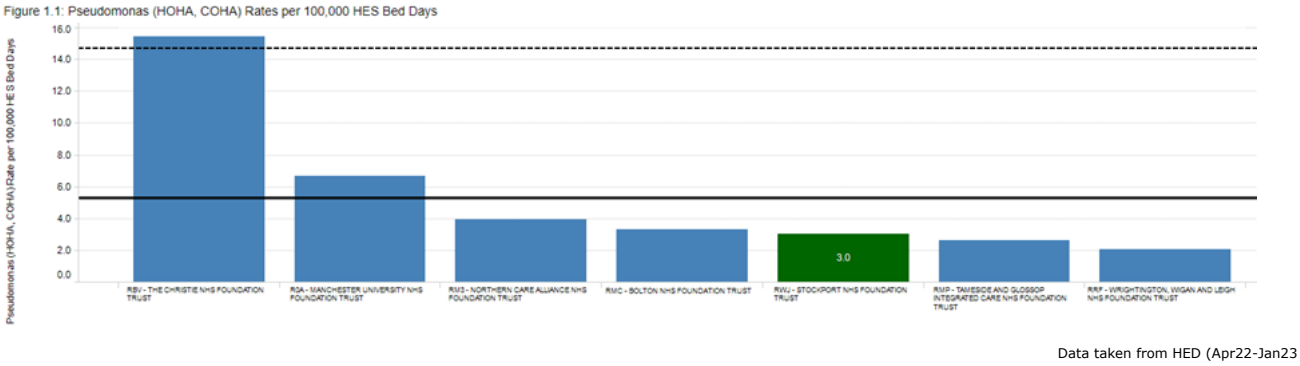
Pseudomonas aeruginosa

In 2022-23 the Trust had 6 Hospital Onset, Hospital Apportioned (HOHA) cases and 1 Community Onset, Hospital Associated (COHA) cases, totalling 7 cases an increase of 3 from the previous year. The average age of patients developing Pseudomonas aeruginosa was 63 years old and the average acquisition day was 13 with a range of 0 to 24 days which is a decrease from the previous year.



During 2022-23 the total threshold was set at 3 cases allowing 0.75 per quarter. This threshold was exceeded by 4 cases.

Peer Group Comparison: The Trusts monitors its performance against a Northwest Peer group. Below illustrates the Trust in comparison with its peers for pseudomonas aeruginosa Bacteraemia's.

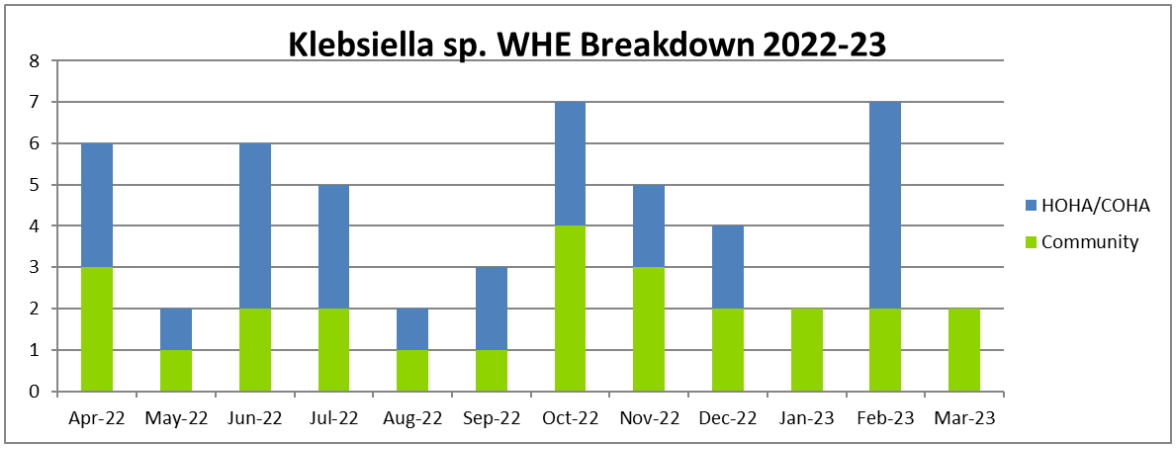


Data taken from HED (Apr22-Jan23

Action: To achieve the Trust internal threshold set for 2023-24.

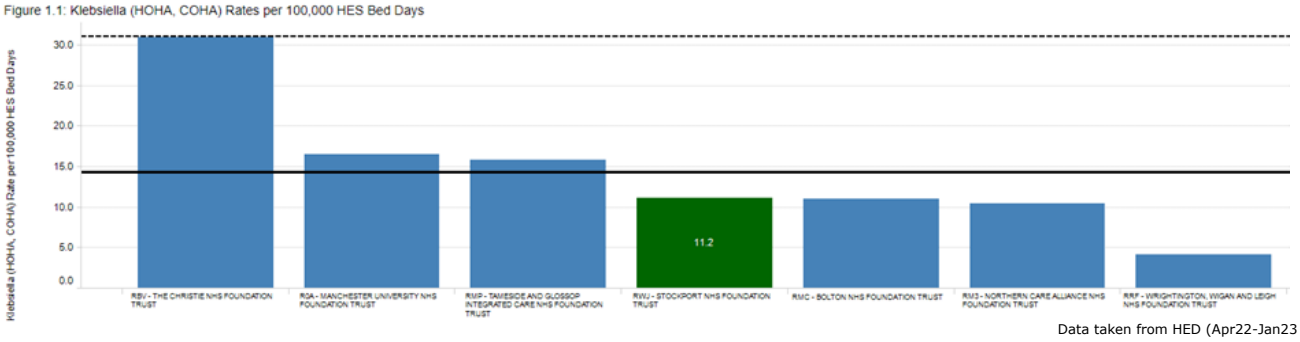
Klebsiella sp.

In 2022-23 the Trust had 22 Hospital Onset, Hospital Apportioned (HOHA) cases and 4 Community Onset, Hospital Associated (COHA) cases, totalling 26 cases an increase of 7 from the previous year. The average age of patients developing Klebsiella pneumoniae was 74 years old and the average acquisition day was 21 ranging from 0 to 156 days.



During 2022-23 the total threshold was set at 23 cases allowing 5.75 per quarter. This threshold was exceeded by 3 cases.

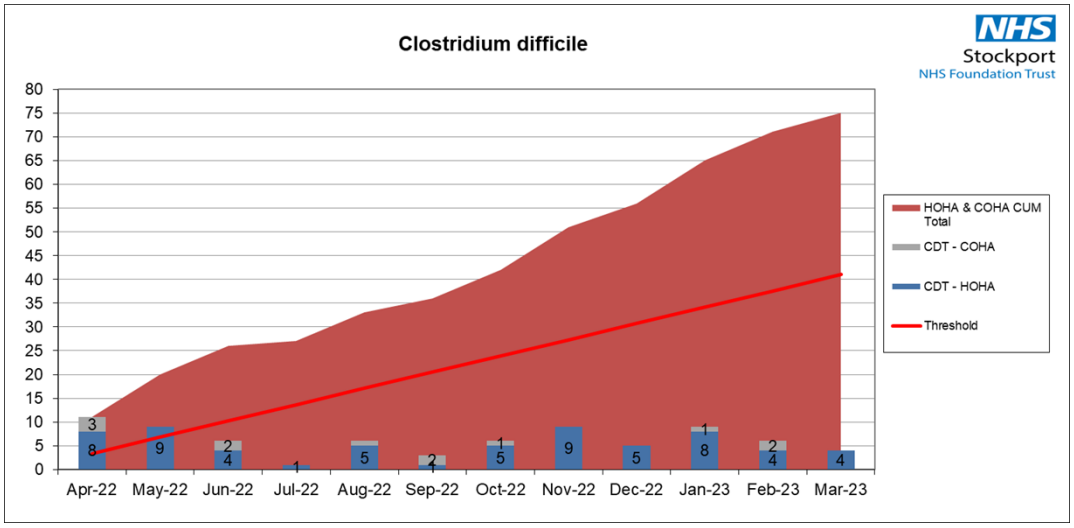
Peer Group Comparison: The Trusts monitors its performance against a Northwest Peer group. Below illustrates the Trust in comparison with its peers for Klebsiella sp. Bacteraemia's.



Action: To achieve the Trust internal threshold for 2023-24.

Clostridium difficile

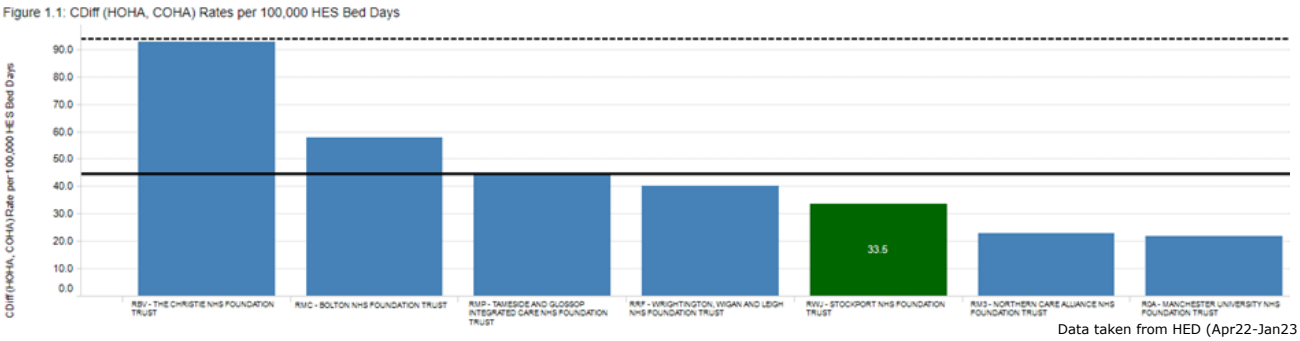
The nationally set threshold for 2022-2023 was 41. In 2022-23 the Trust had 63 Hospital Onset, Hospital Apportioned (HOHA) cases and 12 Community Onset, Hospital Associated (COHA) cases. The threshold was exceeded by 34 as a total of 75 cases were recorded which was a decrease of 2 cases from the previous year.



All Trust attributed cases underwent a root cause analysis investigation and were presented to a Healthcare Associated Infection panel (HCAI) for review. The panel is chaired by the DIPC alongside the IP&C doctor, IP&C Associate Nurse Director and an Antibiotic Pharmacist who determined that 13 cases were avoidable.

Following the notable increase of clostridium difficile after the antimicrobial change in November 2021, the antimicrobial guidelines during 2023-23 were changed to reduce cephalosporin use. Clostridium difficile remains high but there has showed to be a marked reduction.

Peer Group Comparison: The Trusts monitors its performance against a Northwest Peer group. Below illustrates the Trust in comparison with its peers for Clostridium difficile.



Data taken from HED (Apr22-Jan23

Actions:

- 2023-24 zero tolerance of avoidable clostridium difficile cases.
- To meet the National threshold for 2023-24.

Carbapenemase Producing Enterobacteriaceae (CPE)

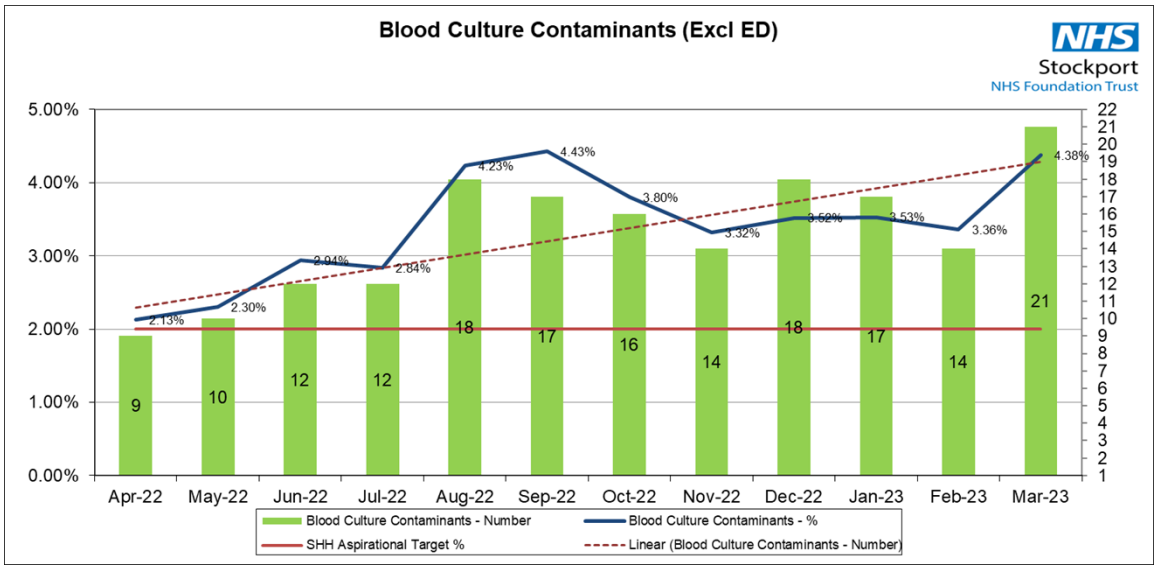
There is no mandatory surveillance or National threshold for CPE.

During 2022-23 there were 69 new CPE cases. 40 were hospital attributed and 29 were community apportioned. This is an increase of 48 cases on the previous year and correlates to a significant increase in screening activity, up by 61%.

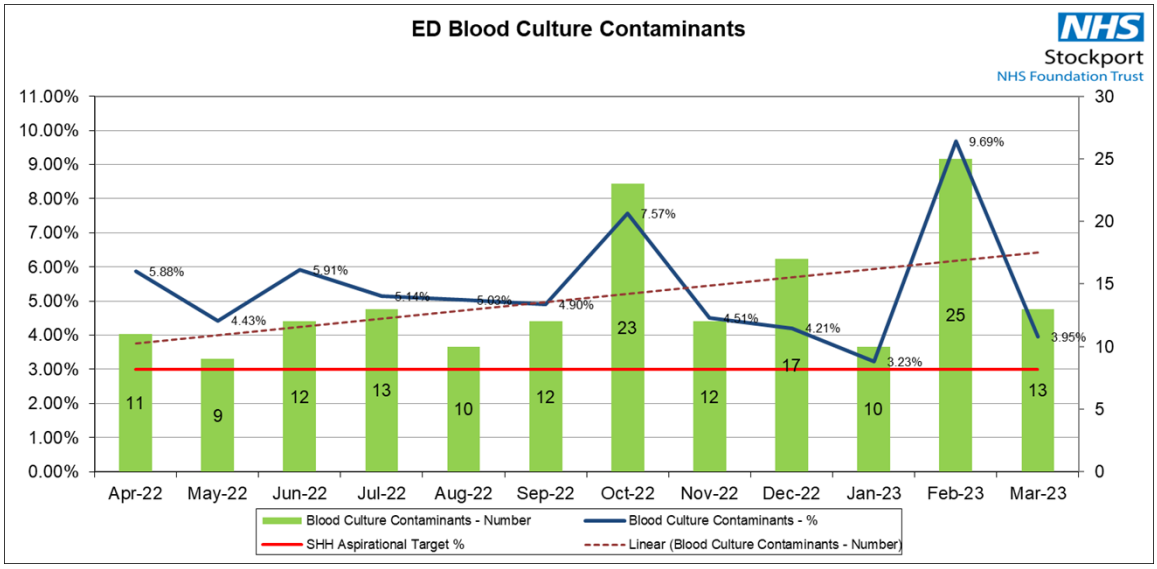
Action: To reduce the number of hospital CPE cases.

Blood Culture Contaminants

The average rate of blood culture contaminants for the Trust (Excluding ED) was 4.12% against a Trust aspirational target of 2% which is an increase of 0.4% from the previous year.



The average rate of blood culture contaminants for patients within the Emergency Department (ED) was 5.37% a decrease of 0.72% from last year against our Trust aspirational target of 3%.



Action: To continue to reduce number of blood culture contaminants.

Mandatory Orthopaedic Surgical Site Surveillance Infection (SSSI)

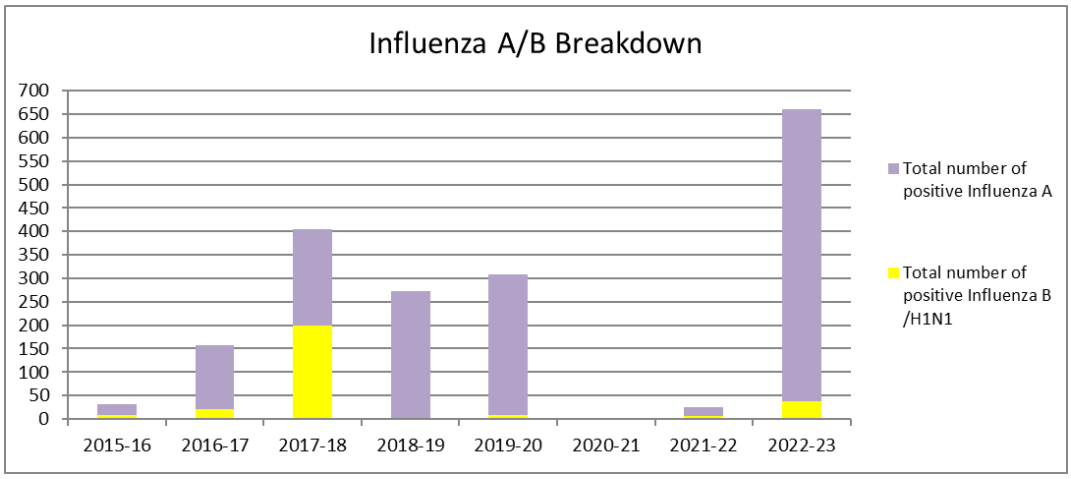
The mandatory requirement of the UK Health Security Agency (UKHSA) is to survey one orthopaedic procedure for a period of 3 months. During 2022-23 our surveillance exceeded the mandatory requirements by undertaking knee replacements over two different quarterly periods as shown in the table below.

Report Quarter	***No. of Operations***	**No of Surgical Site Infections**	**% Infection Rate**
April – June 2022 Repair of neck of femur	50	0	0%
October – December 2022 Hip replacement. Knee replacement	33 29	0 0	0% 0%
January – March 2023 Hip replacement. Knee replacement	46 45	*Unknown – Report not yet available	*Unknown – Report not yet available

Outbreak reports

Influenza

During 2022-23, the Trust saw an increased number of cases of the influenza virus. These cases were effectively managed within the Trust isolation framework and resulted in no outbreaks associated with confirmed influenza across the Trust.



COVID-19

During 2022-23 COVID-19 remained prominent for the IP&C team and the Trust continued to follow national guidance. The Trust had a minimum of 1 COVID-19 ward open at any time and a maximum of 3 wards being open.

The table below shows distribution of positive and negative tests analysed by the Trust's pathology department since the start of COVID-19 records.

Result	Total Tests	%
Negative	177364	94.96%
Positive	9229	5.04%
Grand Total	**186593**	**100.00%**

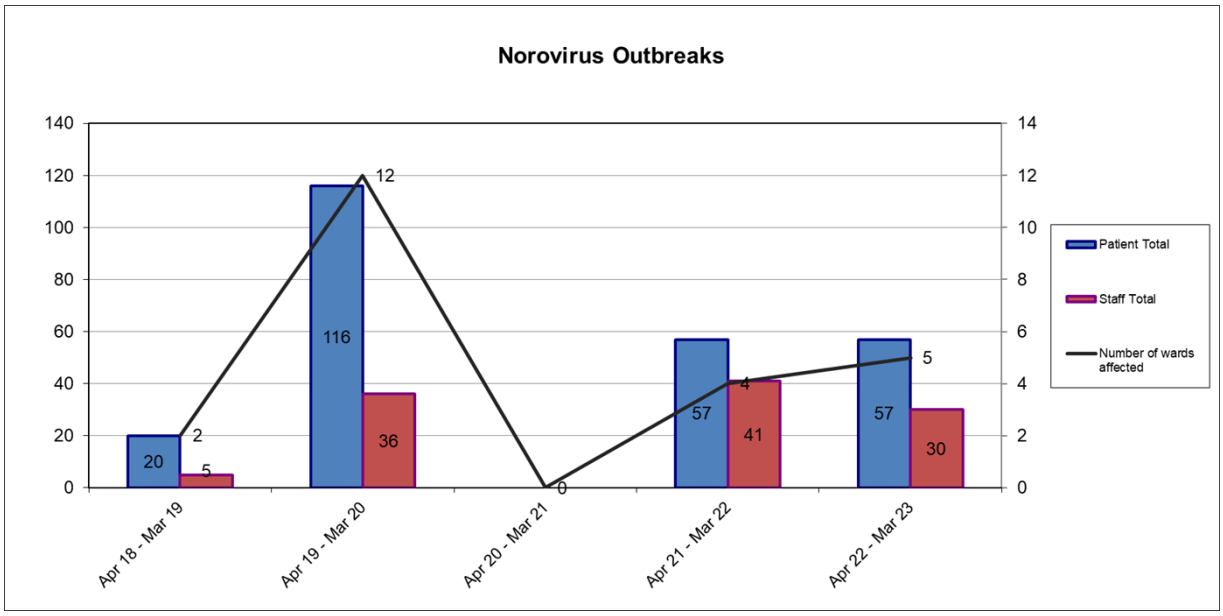
The table below shows the total number of positive COVID-19 patients who were discharged or died at the end of their inpatient stay. Any patient who developed a hospital acquired (nosocomial) COVID-19 infection and subsequently died were investigated to determine any learning and actions to be undertaken.

Inpatient Discharge	Inpatient Deaths
5142	988

Action: - To continue to follow national guidance

Norovirus

During 2022-23 there were 5 ward outbreaks associated with diarrhoea and vomiting across the Trust which is an increase of 1 from the previous year.



All ward outbreaks were confirmed Norovirus. Two outbreaks occurred during April and May 2022, the other three outbreaks occurred between February and March 2023. It is difficult to determine where the outbreaks originated from as during that period COVID-19 restrictions had been lifted in line with national guidance.

Criterion 2: Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

Water Safety

During 2022-23 the Water Safety Group met and reported on a quarterly basis to the Infection Prevention and Control Group. The purpose of this group is to ensure the Trust is

compliant with national legislation and guidance and to develop, manage, and monitor appropriate system of controls in relation to water safety.

In 2022-23, the group ensured any positive legionella or pseudomonas samples were traced with appropriate remedial actions taken in line with national standards. The group ensured that a compliant temperature-control program was in place by working with stakeholders to ensure contract specifications were being adhered to and that suitable and sufficient risk assessments had been undertaken throughout the site, and that hazards identified within the risk assessments were managed appropriately.

Ventilation

During 2022-23 the Ventilation Safety Group met and reported on a quarterly basis to the Infection Prevention and Control Group. The purpose of this group is to ensure the Trust is compliant with national legislation and guidance and to develop, manage, and monitor appropriate schemes of controls in relation to Trust ventilation systems.

In 2022-23 the group further developed the Trust's ventilation strategy, which is intended to inform the capital planning programme. The group ensured that a program for statutory maintenance was in place and managed appropriately. In addition, any ventilation failures/incidents were logged, discussed, and appropriate remedial measures agreed upon and actioned.

Decontamination Services

During 2022-23 the Trust decontamination services, both sterile services and Endoscopy Decontamination continued to strive to deliver the best possible service.

Both the Hospital Sterilisation and Decontamination Unit (HSDU) and Endoscopy Decontamination Unit (EDU) were successful in passing their accreditation by the British Standards Institute providing the Trust with assurance of quality and safety for our patients.

The Endoscopy Decontamination Unit also successfully achieved their Joint Advisory Group (JAG) annual accreditation.

Action: To continue to provide service delivery assurance against national guidance and regulations through the Trust decontamination group, reporting through the Trust IPC group.

Cleaning Services

During 2022-23 the implementation of the new cleaning standards was successfully completed following the introduction of the new National Standards of Cleaning (NSOC) the previous year. The success was due to excellent collaborative working between the facilities department, IPC and clinical teams across the Trust. The commitment to the cleanliness charter and star ratings are displayed in all areas across the Trust. All inpatient areas and ED star ratings are displayed on electronic screens. Implementation of this in Outpatient areas is in progress and completion scheduled for the end of April 2023.

The Domestic Supervisors monitored cleaning to ensure everyone was working to the NSOC standards, with the training and cleanliness monitoring officers ensuring staff received the necessary support and refresher training. During 2022-23 the cleaning schedules were updated in line with national guidance.

Action: Continue to ensure that cleanliness across the Trust achieves the requirement of the NSOC, therefore contributing to increased patient safety and a better patient experience.

PLACE (Patient Led Assessment of the Care Environment)

As active members of the national PLACE working group, the Facilities team were pleased to have the support of the Trust's Infection Prevention and Control Team to recommence this important annual inspection after a 2-year hiatus.

During 2022-23 PLACE visits were undertaken across all services and divisions ensuring a broad assessment. Supporting the green agenda with the use of mobile devices, there was

a reduction in time on manual data recording resulting in an opportunity for teams to debrief together ensuring assessment findings were agreed.

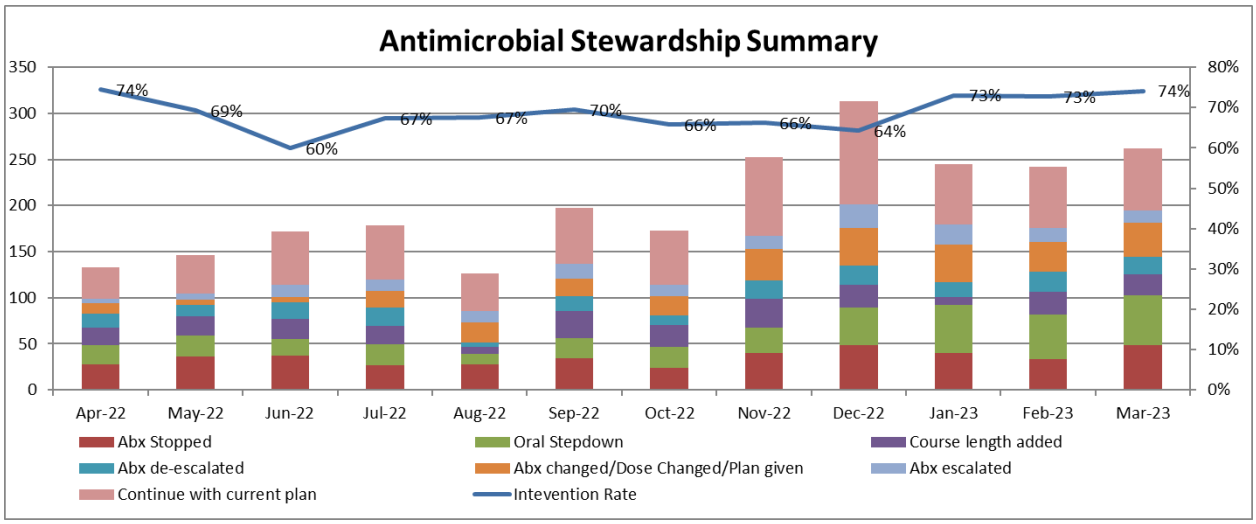
As one of the first Trusts within Greater Manchester to complete PLACE 2022 and the vision to 'do it differently' the team have been approached by other Trusts to replicate process and ideas.

Action: To develop a comprehensive action plan following formal PLACE results.

Criterion 3: Ensure appropriate antimicrobial use to optimise patient outcome and to reduce the risk of adverse events and antimicrobial resistance.
Antimicrobial Stewardship

2022-2023 came with the addition of an experienced lead antimicrobial pharmacist to the Trust establishing a full-time post enabling increased activity in antimicrobial stewardship depending on other pharmacy demands.

Antimicrobial ward rounds increased with daily visits to critical care and daily stewardship rounds across the rest of the hospital. The team has a high intervention rate and provides invaluable education to medical teams.



The antimicrobial stewardship data is presented monthly to the divisional quality boards to aid learning and reduce antimicrobial resistance. A Trust-wide antibiotic point prevalence audit was completed during 2022-23 and the results presented to divisions at the Clinical Audit and Quality forums.

During 2022-23 the Antimicrobial Steering Group focused on learning from cases presented by divisions to promote discussion and learning especially around IV to oral switch and stopping IV antibiotics.

The CQUIN for UTI's proved difficult to fulfil due to several factors. The first two quarters were submitted showing compliance with all aspects, unfortunately the second two quarters were not submitted.

Action: To enable effective and efficient antimicrobial stewardship rounds.

Criterion 4: provide suitable accurate information on Infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion.

A variety of methods are used to communicate the IP&C message to service users, staff and other providers. During 2022-23 visiting followed national guidelines and at times it was difficult for families who were supported by the patient experience team.

The IP&C annual report and other relevant documents are available on the Trust website.

IP&C notice boards are prominent is all areas and updated regularly to promote key messages.

Criterion 5: Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.

Central Vascular Access Device Service (CVADS)

During 2022-23 there was minimal progress with the nurse led CVAD service due to unexpected events.

Action: To progress the inpatient nurse led CVAD service.

Criterion 6: Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.

Part of the recognised role of the infection prevention & control team is training and education. During 2022-23 face to face sessions on practical training was re-introduced alongside the statutory and mandatory infection prevention E-learning.

The Trust training compliance for IP&C at the end of 2022-23 was 96.2%. During 2022-23 235 toolbox training sessions were provided by the IP&C team.

During December 2022 the IP&C team took to twitter with our own Elf-Care-Assistant. Each day a different message or video was portrayed showing what was not good practice. The team were overwhelmed with positive responses, discussion, and re-tweets.

Divisional groups

Surgery

Our divisional actions for 2022-23 included a complete Multidisciplinary Team (MDT) approach to investigating and learning from our Healthcare Associated Infection Panel (HCAI) reviews. Whilst the division saw some improvement during the year, the 2023-2024 action plan will continue to focus on this MDT approach in particular engagement from our medical colleagues.

The division continues to work closely with the IPC team introducing weekly assurance walk arounds, spot checks with the Ward managers and Matrons. The toolbox training sessions continue to ensure the environment is optimal for patient care and to ensure the risk of infection is mitigated. The division is committed to ensure there is an MDT approach to IPC.

During 2022-23 the spot checks highlighted areas where further assurance was required. The division introduced an internal audit for monitoring compliance which is discussed at senior meetings for shared learning.

An action for improving uniform compliance has seen the introduction of peer-to-peer challenge at safety huddles, where staff are tasked with assessing the compliance of the person standing next to them for compliance in a supportive manner.

Prevention of Infection practitioners were reinvigorated during 2022-23 to support the division and challenge IPC compliance.

Action: To implement a matron as an IPC link practitioner for senior support across the division ensuring effective lines of communication regarding changes with IPC guidance or practice.

Medicine & Urgent Care

2022-23 continued to be a challenging year for the Medicine and Urgent Care where staff have continued to display professionalism when dealing with ever changing demands of the clinical service.

The action set in 2021-22 was to embed the healthcare environmental policy and this is a continued piece of work with focus on robust attendance for the environmental workarounds in the clinical areas. These walk rounds are being undertaken weekly across all clinical areas including outpatient settings involving nursing teams, IP&C team, estates and facilities. We know that embedding this will ensure high levels of cleanliness which are fundamental in providing a safe, healthy environment for care to be delivered as well as promoting patient and staff wellbeing.

Our Quality metrics data has seen a general overall improvement in compliance with Hand Hygiene and PPE for our ward teams. This is also triangulated with the evidence of improvement in the infection prevention standard in the StARS accreditation process. We have a continued focus on ANTT compliance with both our nursing and medical teams sharing actions and learning in our Quality Boards.

As a division we continue to share assigned actions following the HCAI panel with both nursing and medical teams to improve future practice.

Actions:

- To embed the attendance from Senior nursing team on the environmental walk around.
- Share actions and learning of any themes and trends that are highlighted through deep dive of blood culture contaminants and monitor throughout the year.

Emergency Department

2022-2023 continued to be a challenging year for the Emergency Department where the team have continued to demonstrate a high level of professionalism. The senior nurse walk rounds have increased the compliance with the cleaning standards and highlighted areas for improvement.

The action for 2021-2022 was to ensure that all cleaning standards are continually maintained, and that IP&C targets are met. The StARS accreditation has supported the

senior team to continue to embed the IPC standards in line with patient safety and staff wellbeing. The environmental walk rounds involving the nursing teams, estates and facilities department and the IP&C team continue which has been beneficial to ensuring patients are cared for in a well-maintained environment.

The use of the high acuity respiratory area remained to maintain IP&C standards for our patients in a controlled environment and staff have continued to maintain high levels of infection prevention control measures.

Action: To ensure that all cleaning standards and environmental checks are maintained.

Women & Children

The division of Women and Children has a robust system in place to review any blood culture contaminants and meet with associated individuals to review and ensure appropriate action is taken and training is in place.

There has been no MRSA bacteraemia over the past year within the division.

The neonatal unit has reported one case of pseudomonas and works closely with the IPC team to ensure raised awareness and learning.

All areas have continued to support family and extended family visiting to the units throughout the pandemic and have fully reinstated visiting in all areas, including attendance to all outpatient appointments.

Integrated Care

There continues to be a Multidisciplinary Team approach to improving and sustaining 5 moment hand hygiene compliance and infection prevention and control. The division was disappointed with their hand hygiene compliance which averaged at 90%, all team members are aware of their role and responsibilities to challenge noncompliance. The senior team continue with daily spot checks and audits supported with additional light box

training from the IP&C team and PIPs. This focus will continue to ensure Hand hygiene compliance is 100% in all areas.

The division continues to monitor and learn from hospital acquired infections. Unfortunately the division exceeded the divisional trajectory for CDI and MRSA. The division reported 11 CDI all of which were unavoidable and 1 MRSA bacteraemia which was also unavoidable. The findings from these investigations have been shared within the teams and across the MDT.

The teams have embraced the new cleaning standards with AMU and AFU achieving 5-star cleanliness ratings. In addition, the Matrons and ward managers complete an environment audit each day, which includes compliance with decontamination of equipment and the use of Clinell labels. All Acute Care areas are above 90% with ANTT, with action plans in place to ensure all staff are trained for July 23.

The IPC team have linked in with the community services and are in the process of visiting community teams to allow audit of community-based sites to oversee the management of community infection prevention & control measures.

The IPC team continue working alongside Estates and Facilities in designing an annual audit of community areas. As part of Stockport Accreditation and Recognition (StARs) process the environmental factors are assessed and a RAG assessment rating will be issued as part of the actions set out. Part of this process will include links with Stockport Metropolitan Borough Council (SMBC) / NHS Property Services if their buildings or facilities require any attention.

Clinical Support Services

During 2022-23 a new division was created to incorporate clinical support services including endoscopy, pharmacy, radiology, pathology, outpatients, and patient access.

These services although not inpatient areas are still required to implement IPC practices and undertake IPC audits.

Action: During 2023-24 work closely with the IPC team to adapt and embed IPC practice.

Criterion 7: Provide or secure adequate isolation facilities.

Isolation facilitation is managed by the clinical site co-ordinator (CSC) team. During 2022-23 isolation remained challenging partly due to the old estate and transitioning out of a pandemic whilst managing COVID-19 and other HCAI's.

Action: IP&C team to provide education and training to assist the CSC with IPC isolation.

Criterion 8: Secure adequate access to laboratory support as appropriate

The laboratory support team being on site remains invaluable providing a fast turnaround of results enabling timely movement of patients to ensure they are in the right place.

The IP&C team work closely with the laboratory team with 24-hour microbiology advice being available.

Criterion 9: Have and adhere to policies designated for the individual's care and provider organisation that will help to prevent and control infections.

Policies and procedures are essential to ensure all staff have access to evidence-based information aimed at ensuring high standards of Infection Prevention.

During 2022-2023 policies, SOPs and guidelines were updated in line with national guidance and approved through the IP&C group. With the publication of a standardised national IP&C manual several Trust SOPs have now been archived.

All Infection prevention policies, SOPs, guidelines and related documents have been uploaded to the infection prevention & control microsite and the Trust intranet.

Action: To update policies, SOPs and guidelines in line with evidence-based practice and national guidance.

Audit Activity

Aseptic Non-Touch Technique (ANTT)

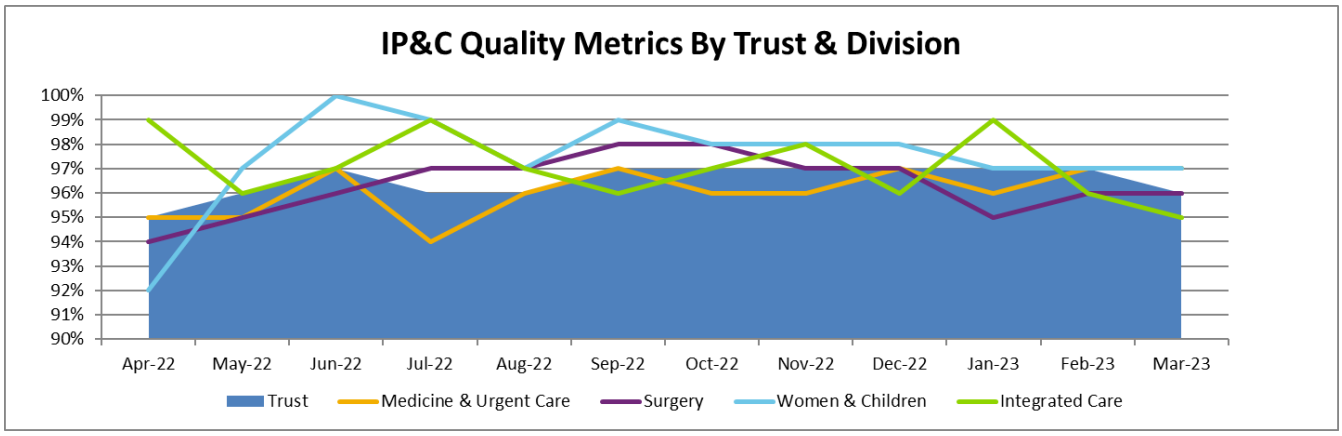
ANTT remains a central component in safeguarding patients who undergo procedures which breech the skins natural defence system, including the insertion, removal or manipulation of indwelling devices.

During 2022-23, the commencement of mandatory ANTT assessments for clinical medical staff began. Although a challenge, the Trust enlisted two medical staff who became ambassadors for ANTT and supported the IPC team in assessing their colleagues.

Action: To assist divisions with mandatory ANTT assessments for clinical medical staff.

IP&C Quality Metrics

Divisional Matrons undertake the IP&C Quality Metrics monthly. The average compliance for the Trust during 2022-23 was 97% which is an increase of 4% over the previous year.



Action: To sustain IP&C Quality Metrics above 90%.

IP&C Spot Audits

During 2022-23 the IP&C team undertook spot audits on Hand Hygiene, PPE and Commode Cleanliness across areas where an increase of HCAI's was noted.

Below are the average results for each division:

	No. Spot Audits	Average Compliance
Medicine & UC	379	78%
Surgery	221	80%
Integrated Care	50	74%
W&C	3	50%
Trust	653	71%

Action: To continue to undertake spot audits to provide compliance and assurance to the IPC group.

Sharps Audit

A sharps audit undertaken by Daniels an external company was undertaken during 2022-23. The results from the audit and the one prior are outlined below.

	Incorrectly assembled	**Items above fill line**	**On floor or unsuitable height**	**Unlabelled whilst in use**	**Had significant inappropriate contents**	**Temporary closure not in use when left unattended or during movement**
Percentage achieved 2021-22	0.34%	0.00%	2.01%	6.70%	3.02%	0.34%
Percentage achieved 2022-23	0.00%	0.81%	0.00%	1.62%	1.35%	5.14%
Direction	↓	↑	↓	↓	↓	↑

Action: To work with the supplier on areas where compliance has decreased since the previous year.

Criterion 10: Have a system in place to manage occupational health needs and obligations of staff in relation to infection.

Trust employees encounter several infectious agents which may theoretically be passed from patients/service users i.e., Hepatitis B, Tuberculosis, Measles and Mumps.

New employees attend Occupational Health for an immunity check; a vaccination programme is then commenced as necessary.

The Occupational Health team provide support and advice to Trust employees and managers on specific additional measures that might be required following an incident where exposure to an infected individual, pathogen or contaminated instrument occurs.

Influenza Vaccination

National data collection of staff uptake for the seasonal influenza vaccine during the 2022-23 was 39% for frontline staff (a decrease from the previous year which was 81.6%). This uptake is below the national average of 49.9%. The CQUIN target set for 2023-24 is 80% for frontline staff which will be a challenge for the Trust.

The Trust aim is to increase the uptake of the influenza vaccine by staff and to promote a message of the importance of staff having an annual influenza vaccination to protect themselves their families and their patients. This year has been a challenge due to the reporting system changing and vaccination fatigue.

Action: To achieve the CQUIN target.

Covid-19 vaccination

During 2022-23 the vaccination hub was re-established to support staff in receiving their COVID-19 vaccinations.

The uptake of the COVID-19 vaccine by frontline staff with the COVID-19 booster was 33.8% which was below the national average of 42.1%. At present there is no national remit to further vaccinate healthcare workers during 2023-24.

Inoculation Injuries

The recording of inoculation injuries is undertaken with Occupational Health (OH) software and the numbers for the whole year were reported to the divisional leads and the Infection Prevention & Control Group. All injuries are reported via the Trusts incident reporting system.

The number of inoculation injuries to staff (including bites, scratches and splashes) was 134 which is an 8.8% decrease on the previous year.

Sharps related incidents remains one of the common types of injury to staff, with between 7 and 15 incidents per month. As in previous years, the Nursing & Midwifery occupational group had the highest incident numbers which is no surprise as they are the largest staff group in the Trust.

There were 68 incidents related to the handling of a hollow bore needle used either for injection or venepuncture. This a slight increase on the previous year.

Action: Divisions to review and minimise inoculation injuries.

Fit Testing Service

The FIT testing service is delivered by the IPC team and is available to all staff. During 2022-23 National support was provided for all Trusts.

An online booking system was implemented during 2022-23 providing an easily accessible system for all staff to arrange appointments. The system includes advice on actions to take prior to the appointment to enable the best use of their time.

During 2022-23 approximately 1200 staff were fit tested for their first mask and 190 staff for a second mask. Divisional monitoring of compliance is undertaken by the IPC operational group.

Action: To continue to provide a robust fit testing service for the Trust following the withdrawal of the national support.

Conclusion

2022-23 remained a challenging year with the Trust balancing 'living with COVID-19' and supporting clinical services to return to pre-pandemic levels. The Trust is disappointed that national trajectories weren't achieved but knew it was going to be a challenge with the new national reporting for all HCAI's. The Trust is proud of its overall achievements in other areas and progress against objectives.

Key Objectives for 2023-24

- Meet or end within the HCAI thresholds set by the UK Health Security Agency (UKHSA)
- Zero tolerance for avoidable clostridium difficile cases.
- To further develop the nurse led central vascular access device service.
- To maintain the IPC Board Assurance Framework (BAF)
- To work closely with the risk management team to align the new NHS patient safety incident response framework (PSIRF) with HCAI investigations.

Infection prevention & control 2 year strategy

NHS Stockport NHS Foundation Trust

Nesta Featherstone
Associate Nurse Director IPC

Barzo Faris
Consultant Microbiologist

Nic Firth
Chief Nurse

AIM	HOW
To have no preventable healthcare acquired infections by March 2024	Embed IPC practice across Trust and community Provide an IPC appropriate environment Enhance surveillance
To develop a nurse-led central vascular access device (CVAD) service to improve patient outcomes by March 2024	Improve clinical standards for management of CVAD's Improve patient outcomes by timely and appropriate insertion of CVAD's Have a robust sustainable seven day service
To enhance the collaborative working with Tameside and MacclesfieldIPC teams by March 2024	To work in partnership with other IPC teams across the Northwest Streamline policies
To enhance staffs' ability and confidence to promote the principles and practices of IPC to patients, visitors and colleagues across the trust by March 2024	Ensure all policies, SOP's and guidelines are in date and evidence based Develop a safety culture
To develop a robust effective antimicrobial stewardship program that delivers and changes practice to improve patient safety by March 2024	To enable prompt initiation of necessary and appropriate antibiotics to treat infections To strengthen data collection and ownership To assist clinicians to improve the quality of patient care and improve patient safety through better infection cure rates

Making a DIFFERENCE every day

Infection Prevention & Control

2022-23 Annual Report

NHS
Stockport
NHS Foundation Trust

Successes

- The Trust began living with Covid
- Water safety group ensured the trust remained compliant with national legislation and guidance
- Ventilation group ensured the trust remained compliant with national legislation and guidance
- HSDU & EDU were successful in passing their BSI accreditation.
- EDU received their JAG accreditation
- New cleaning standard star ratings electronically displayed for ED and all inpatient areas
- PLACE visits recommenced
- Decrease in inoculation injuries
- Robust fit testing service

IP&C Strategy: Aim 1

- The Surgical Site Surveillance Infection rate remains at 0%

IP&C Strategy: Aim 4

- IP&C eLearning compliance 96.20%
- IP&C Elf on the shelf , interactive sessions positive feedback.
- Divisional engagement
- IP&C spot audit results improved

IP&C Strategy: Aim 5

- Experienced lead antimicrobial pharmacist joined the Trust
- Increase in antimicrobial ward rounds

To ensure... Tailored Support, Enhanced Patient Experience, Achievement of HCAI Trajectories, Maintain Quality Improvement

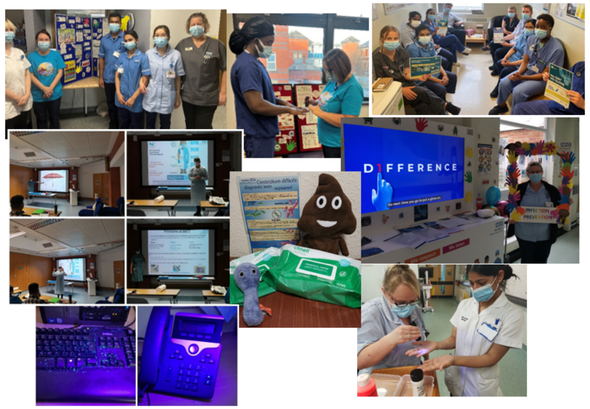
Is to work... Innovatively, Practically, Collaboratively

Challenges

- UTI CQUIN to fulfil
- Sharps audit compliance
- The overall uptake of the seasonal Influenza vaccine amongst frontline staff was 39% which is below the national figure of 49.9%.
- COVID-19 vaccination by frontline staff with booster was 33.8% which is below the national figure 42.1%

INFECTION PREVENTION & CONTROL SERVICE ANNUAL REPORT

April 2022- March 2023



IP&C Strategy: Aim 1

- Trajectories not met
  - MRSA Bacteraemia
  - MSSA Bacteraemia
  - E. coli Bacteraemia
  - Pseudomonas aeruginosa Bacteraemia
  - Klebsiella Bacteraemia
  - Clostridium difficile
- Blood culture contaminant rate over target.
- Mandatory ANTT for medics

IP&C Strategy: Aim 2

- CVAD service slow progression

To ensure... Tailored Support, Enhanced Patient Experience, Achievement of HCAI Trajectories, Maintain Quality Improvement

Is to work... Innovatively, Practically, Collaboratively

Curtis Solle 02/10/2023 07:32:55

IP&C 2 Year Strategy

Nesta Featherstone
Associate Nurse Director IPC

Barzo Faris
Consultant Microbiologist

Nic Firth
Chief Nurse

To ensure... Tailored Support, Enhanced Patient Experience, Achievement of HCAI Trajectories, Maintain Quality Improvement

TEAM

Is to work... Innovatively, Practically, Collaboratively

IPC

AIM	HOW
To have no preventable healthcare acquired infections by March 2024	Embed IPC practice across Trust and community Provide an IPC appropriate environment Enhance surveillance
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Making a DIFFERENCE every day

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Infection Prevention & Control

Trust position 2023-24

NHS
Stockport
NHS Foundation Trust

Clostridium difficile

NHS
Stockport
NHS Foundation Trust

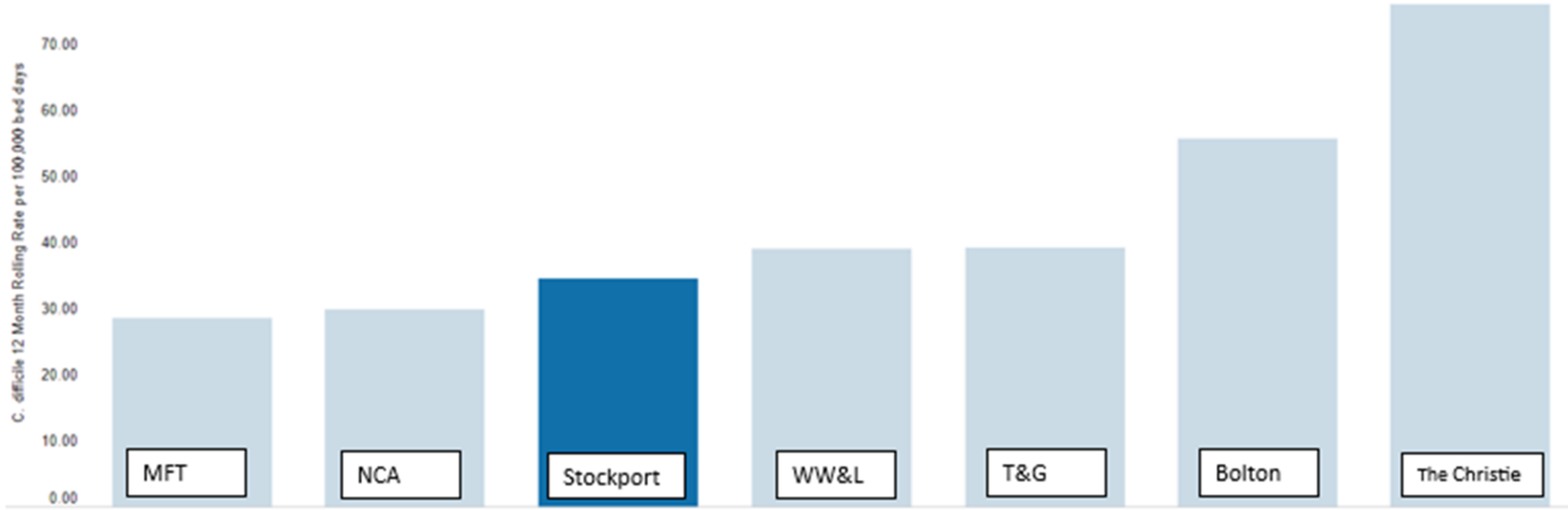
To ensure...
Tailored Support
Enhanced Patient Experience
Achievement of HCAI Trajectories
Maintain Quality Improvement

Is to work...
Innovatively
Practically
Collaboratively

- **Majority of cases are unavoidable.**
- **Quarter of the cases have been in hospital 4 weeks prior to CDI result.**

Focus

- **Sampling- repeat samples**
- **Community antibiotics**
- **Isolation**



*Extracted from National HCAI database. Latest data incl. July 23.

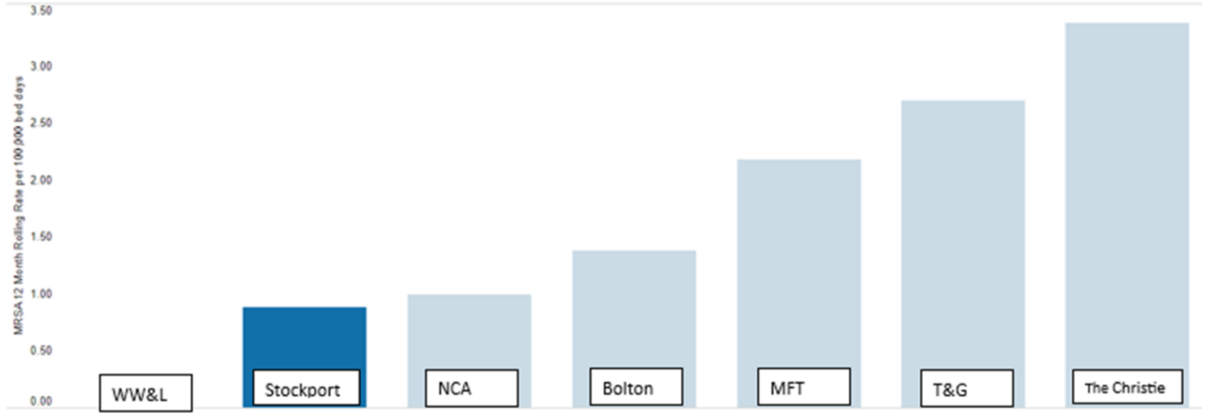
Staphylococcus aureus

Stockport NHS Foundation Trust

To ensure... Tailored Support, Enhanced Patient Experience, Achievement of HCAI Trajectories, Maintain Quality Improvement

Is to work... Innovatively, Practically, Collaboratively

MRSA Bacteraemia



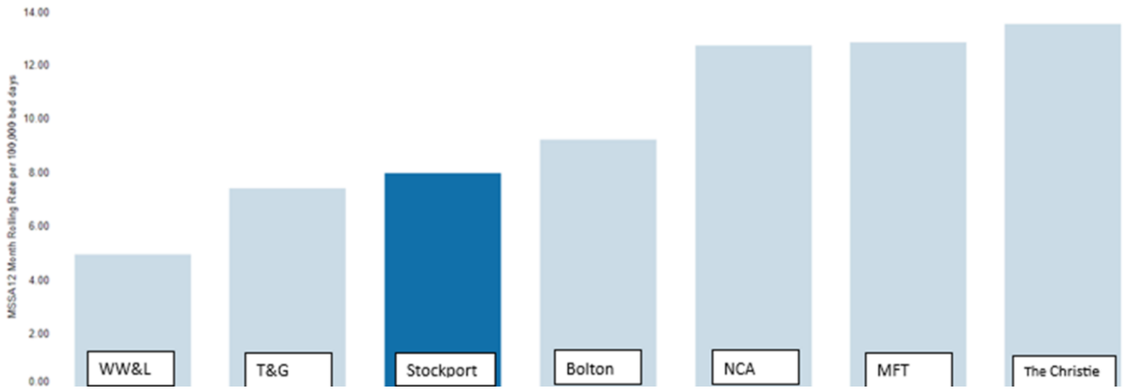
- Last MRSA Bacteraemia March 2023

Focus
- ANTT compliance
- Care and management of vascular access devices
- Development VAD service

*Extracted from National HCAI database. Latest data incl. July 23.

Focus
- ANTT compliance
- Care and management of vascular access devices
- Care and management of catheters

MSSA



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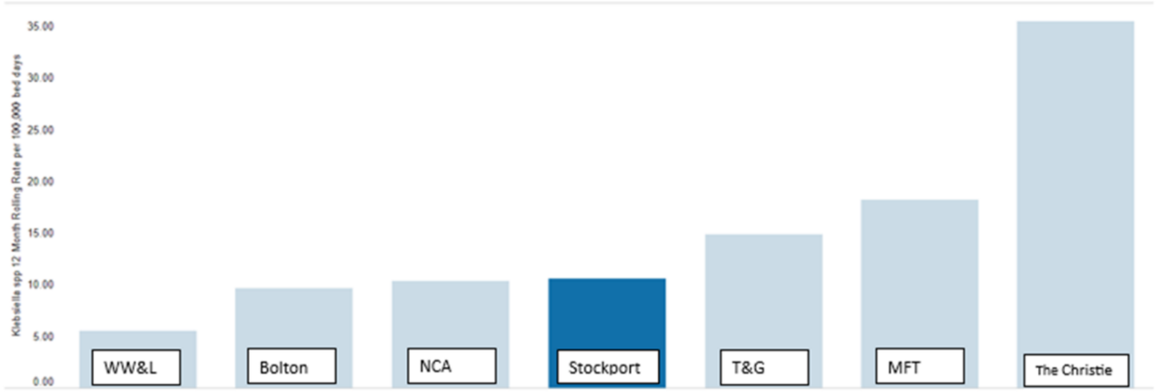
Gram negatives

Stockport NHS Foundation Trust

To ensure... Tailored Support, Enhanced Patient Experience, Achievement of HCAI Trajectories, Maintain Quality Improvement

Is to work... Innovatively, Practically, Collaboratively

Klebsiella sp.



No highlighted themes due to variation of conditions.

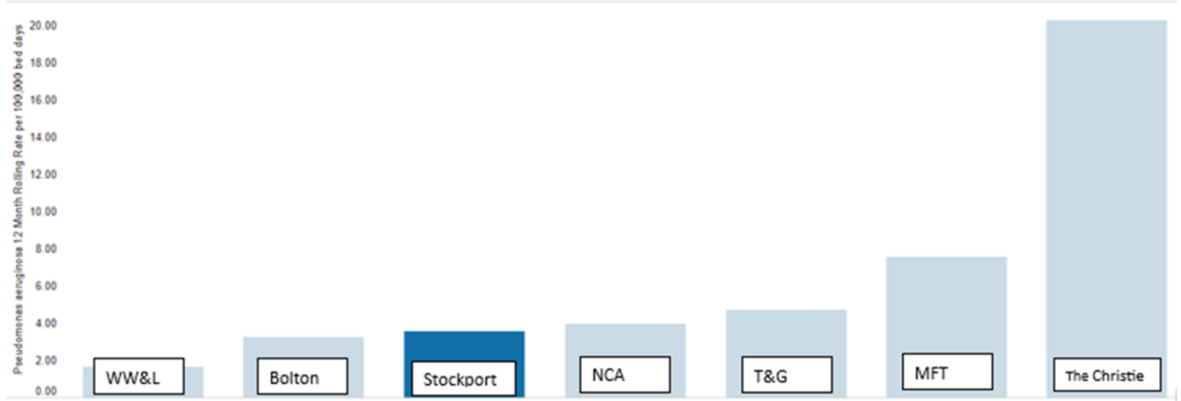
Focused approach in collaboration with the other organisms

*Extracted from National HCAI database. Latest data incl. July 23.

Pseudomonas aeruginosa (PAE)

Focus

- **ANTT compliance**
- **Care and management of vascular access devices**



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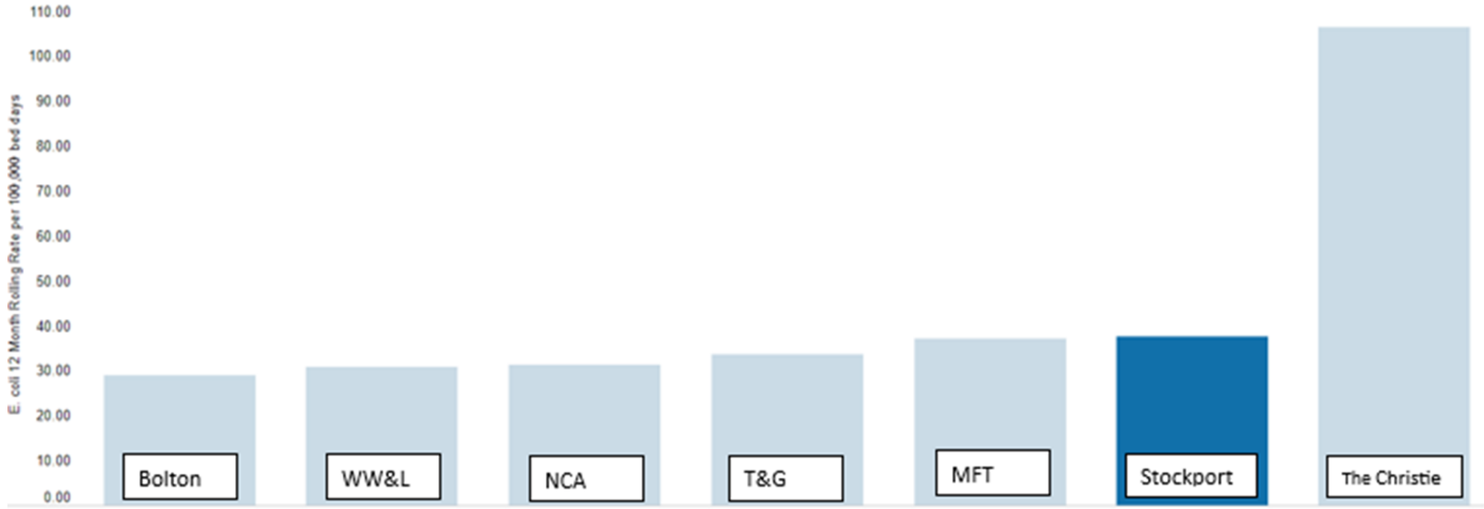
E coli

Stockport NHS Foundation Trust

To ensure... Tailored Support, Enhanced Patient Experience, Achievement of HCAI Trajectories, Maintain Quality Improvement

Is to work... Innovatively, Practically, Collaboratively

Focus
- **Catheter management**
- **Hydration**



*Extracted from National HCAI database. Latest data incl. July 23.

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2023-24 Trust position

Stockport NHS Foundation Trust

2023-24 UKHSA Thresholds				
	National Threshold	Current position	RAG Rating	Reason
CDI	40	47	R	Over Trajectory
MRSA	0	0	G	On track to meet trajectory
E coli	46	29	A	Not on track to meet trajectory
Klebsiella	22	8	G	On track to meet trajectory
Pseudomonas	3	5	R	Over Trajectory

2023-24 Trust Thresholds				
	National Threshold	Current position	RAG Rating	Reason
MSSA	24	12	A	Not on track to meet trajectory

To ensure... Tailored Support, Enhanced Patient Experience, Achievement of HCAI Trajectories, Maintain Quality Improvement

Is to work... Innovatively, Practically, Collaboratively

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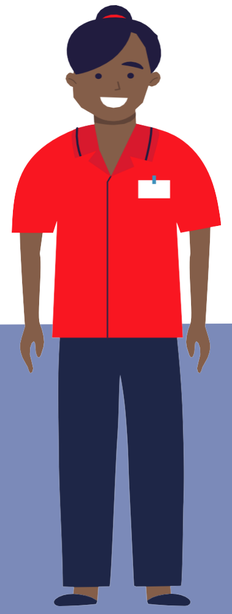
IF YOU HAVE ANY QUERIES OR

REQUESTS PLEASE CONTACT

IP&C Tel: 114669 or by email at
Infection.prevention@stockport.nhs.uk

NHS
Stockport
NHS Foundation Trust

INFECTION PREVENTION & CONTROL



Making a DIFFERENCE every day

NHS Stockport NHS Foundation Trust

Meeting date	5th October 2023	**Public**	X	**Confidential**	
Meeting	Board of Directors				
Report Title	Safer Care Report				
Director Lead	Nic Firth Chief Nurse Andrew Loughney, Medical Director	**Author**	Helen Howard, Deputy Chief Nurse		

Paper For:	**Information**		**Assurance**	X	**Decision**	
Recommendation:	The Board of Directors is asked to review and note the assurances regarding safe staffing and action being taken to maintain safety.					

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
X	6	Use our resources efficiently and effectively
	7	Develop our estate and digital infrastructure to meet service and user needs

The paper relates to the following CQC domains

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

This paper relates to the following Board Assurance Framework risks

X	PR1.1	There is a risk that the Trust does not deliver high quality care to service users
	PR1.2	There is a risk that patient flow across the locality is not effective
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

	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	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.

Additionally strike action has been a key feature during the last quarter and continues to be a challenge.

Safe Staffing Report – September 2023

Report of: Nic Firth
Chief Nurse

Contents

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 & risk mitigations the actions being taken to mitigate risks identified

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

2. Vacancies (July 2023 data)

NHS Stockport NHS Foundation Trust

Nursing Staff	WTE Actual	Variance WTE	Post Recruited to in Trac WTE
Clinical Support Services	67.27	-7.28	2.69
Corporate Services	91.20	-4.80	60.52
Emergency Dept	107.68	-30.97	16.44
Integrated Care	369.74	-47.52	38.76
Medicine & Urgent Care	358.96	-41.34	12.84
Surgery & GI	447.29	-32.02	22.39
Women & Children's	398.95	-47.77	45.28
Grand Total	**1841.09**	**-211.70**	**198.92**

Healthcare Support Workers	WTE Actual	Variance WTE	Post Recruited to in Trac WTE
Clinical Support Services	31.28	-6.83	4.78
Corporate Services	5.80	-0.63	11.53
Emergency Dept	35.23	-7.95	0
Integrated Care	173.05	-20.61	9.52
Medicine & Urgent Care	199.43	-61.19	22.43
Surgery & GI	193.75	-35.45	17.71
Women & Children's	87.59	-3.05	5.43
Grand Total	**726.13**	**-135.71**	**71.4**

Issues :

- RN vacancies are at 211 WTE
- HCA vacancies are 135 WTE

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Key Actions :

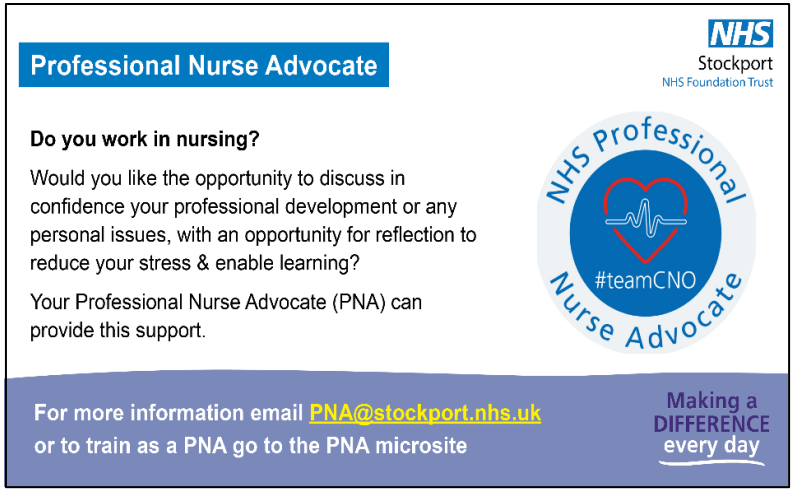
- Safecare Live is used as a tool to support and provide assurance of safe nursing staffing levels
- Medicine recruitment event for nursing students, RNs and nursing associates scheduled for 27th & 28th October at The Alma Lodge Hotel, Hazel Grove, Stockport
- Recruitment event for HCAs to be held on the 7th October at Pinewood House
- 66 newly qualified nurses are due to start in September 2023. Once they have started at the Trust, the updated vacancy figure for RNs will show an improved picture

* *Data provided by Workforce*

3. Retention, Health & Well-being

NHS Stockport NHS Foundation Trust

We have developed a communications plan to promote health & wellbeing through challenging times. We work with our local health & wellbeing champions, local staff networks, trades unions & leaders across the organisation to regularly communicate local health &wellbeing priorities and the availability of support.



Issues :

- National funding for the PNA course yet to be agreed by NHSEI
- Trust staff still awaiting approval to start the programme & allocation to a University

Key Actions :

- The Attract, Development & Retain (ADR) Group promote flexible working, as it supports staff to have a greater choice in where, when & how they work & helps achieves a healthier work life balance (NHS People Promise)
- Staff well-being is on the Professional Nurse Advocate (PNA) agenda & supported throughout the PNA training programme
- The Trust has supported the clinical psychology teams to provide support to the PNAs
- Significant interest in the training to be a PNA with high numbers of staff applying for the programme
- Launch of the PNA microsite & screensaver
- Information leaflet about the role of the PNA has been created
- Comms promoting the PNA Week 9th-13th October, celebrating the role of the PNA
- The Grow and Retain Our Workforce (GROW) SOP for the retention of nursing staff was presented by the Workforce Matron to the Nursing, Midwifery & AHP Group & approved
- Development of GROW microsite

4. Student Recruitment

NHS Stockport NHS Foundation Trust

Key Actions :

- Recruitment events & job opportunities advertised on university websites & career portals
- All students contacted & invited to trust recruitment events
- 66 student nurses qualifying in September 2023 allocated to wards/units
- Medicine recruitment event scheduled for 27th & 28th October at The Alma Lodge Hotel, Hazel Grove
- Information leaflet about the Preceptorship Programme designed by the PEFs
- Scheduled to attend University of Manchester's nursing careers event with PEFs on the 19th September
- Workforce Matron to visit the University of Salford on the 7th December to talk about career opportunities at the Trust to 3rd year nursing students
- Student application process reviewed & updated

5. Internationally Educated Nurses

Stockport NHS Foundation Trust

Issues :

- The Trust have made the decision not to continue with the NHSE international educated nurse recruitment programme

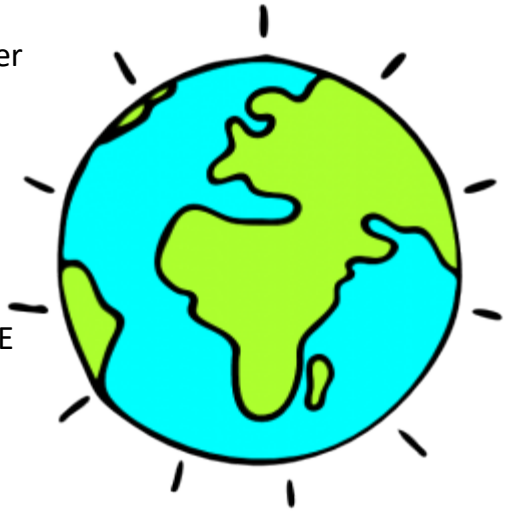
Keys actions :

- The Trust currently employs over 57 health care assistants (HCAs) who are registered nurses in their country of origin and who are interested in completing their registration and obtaining their PIN

- Originally to apply for the OSCE programme they had to pass the International English Language Testing System (IELTS) or Occupational English Test (OET) and nursing computer based test (CBT)

- A number of HCAs are already working towards this and have self-funded the courses & training :
  - 7 passed or studying the CBT
  - 5 have passed their CBT & IELTS/OET and have dates scheduled for their OSCE examination

- The NMC have now changed the requirements to apply for the OSCE programme, as a result more HCAs are now eligible able to take the programme



6. Maternity Staffing Oversight

NHS Stockport NHS Foundation Trust

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

	WTE Actual	Number of WTE Vacancies	Post WTE Recruited to in Trac WTE
Registered Midwives	160.48 (including Band 8 & above)	Vacancy 20.81 Maternity Leave 5.4	13.04 (11.44 due to start Sep/Oct 1.6 due to start August

Challenges :

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

Actions :

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

Assurance :

- All shift coordinators have supernumerary status.
- July it is showing we achieved 95.9% 1 to 1 care in labour (2BBA, precipitate birth, 1 short staffing, 1 no reason given) as reported via euroking
- Maternity Red Flags monitored and reported through division
- Fully engaged with Maternity support workers framework working group
- Funding extended until 23/24 for Recruitment and Retention Midwife
- Engaged with the International Educated Midwifery (IEM) recruitment programme, three IEMs recruited in 1 st wave. 1 commenced in post, 2nd awaiting pin number
- The Trust has applied for further funding for 2 IEMs to be appointed to Stockport NHS Foundation Trust.

** Data provided by the Women & Children's Division*

7. 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 who have overall responsibility for patient care. In the medical workforce these are our consultants.

Tier 2: Senior clinical decision makers

These are clinicians who are capable of making a prompt clinical diagnosis and deciding the need for specific investigations and treatment. For the medical grades this is largely specialty doctors and senior clinical fellows.

Tier 1: Competent clinical decision makers

These are clinicians who are capable of making an initial assessment of a patient. For the medical grades this is largely foundation doctors and junior clinical fellows.

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.

7. Medical Staffing (July 2023 data)

NHS Stockport NHS Foundation Trust

The table below gives an overview of the directly employed medical workforce position within the Trust:

Medical Staff (NB Tier definitions as previous slide)	WTE Budgeted	WTE Actual	Variance WTE
Tier 3	247.08	224.81	-22.27
Tier 2	67.9	59.85	-7.34
Tier 1	114.61	129.35	14.73
Total	**428.89**	**414.02**	-14.87

- ✓ **Consultant Recruitment** –
  - a) Medical Staffing continue to work with divisions to target recruitment campaigns in advance of when doctors in training are set to become eligible to work as consultants. This has seen recent success eg the appointment of a consultant in Rheumatology in August 2023.
  - b) Medical Staffing & Dr Shashidhara, North West CESR Lead, are continuing a full review of those doctors pursuing the CESR route in their applications to become consultants & will present an options paper to the Medical Workforce Group regarding how current and future doctors undertaking CESR will be managed to enable good workforce planning.
- ✓ **MTI Scheme** – Medical Staffing work with divisions to utilise the MTI Scheme to secure international doctors to work at the Trust. This has seen success eg a Senior Clinical Fellow in Medicine.
- ✓ **Safe care functionality** - A phased role out commenced in December 2022, & demonstrates the minimum medical staffing requirement per area, alongside the actual staff available each day. This better aids the movement of doctors between areas to ensure that safe staffing is maintained.
- ✓ **International Medical Recruitment** – Medical Staffing has met with the GMC to explore whether it is viable & beneficial for the Trust to become a GMC Sponsoring Organisation in order to help with employing doctors from this group in a more seamless way. An options paper will be presented to the Medical Workforce Group.

*Data provided by Medical Staffing

8. Allied Health Professionals (July 2023 data)

NHS Stockport NHS Foundation Trust

Radiographers

Clinical Support Services	Establishment WTE	Staff in post WTE	Vacancy WTE
Radiographers	**82.7**	**73.02**	**9.68**

- Due to difficulty in recruiting radiographers in the UK the Trust is now recruiting from overseas. Six joined in March 2023
- Vacancies advertised on social media & recruitment events to be scheduled

Physiotherapists

Division	Establishment WTE	Staff In Post WTE	Variance
Corporate	0.50	0.50	0.00
Integrated Care	135.18	138.46	-3.28
Reserves	11.60	0.00	11.60
Surgery	6.48	6.49	-0.01
Women & Children	6.55	6.45	0.10
Grand Total	**160.31**	**151.90**	**8.41**

Occupational Therapists

Division	Establishment WTE	Staff In Post WTE	Variance
Integrated Care	73.33	65.10	8.23
Reserves	3.80	0.00	3.80
Surgery	0.85	0.85	0.00
Women & Children	8.49	9.01	-0.52
Grand Total	**86.47**	**74.96**	**11.51**

SALT

Division	Establishment WTE	Staff In Post WTE	Variance
Integrated Care	18.61	16.69	1.92
Reserves	1.00	0.00	1.00
Women & Children	44.11	43.37	0.74
Grand Total	**63.72**	**60.06**	**3.66**

Dieticians

Division	Establishment WTE	Staff In Post WTE	Variance
Integrated Care	24.73	24.69	0.04
Reserves	1.00	0.00	1.00
Women & Children	2.89	2.09	0.80
Grand Total	**28.62**	**26.78**	**1.84**

*Data provided by Clinical Support Services

9. Healthroster

NHS Stockport NHS Foundation Trust

Roster period : 14th August – 10th September 2023									Roster period 17th July - 13th August 2023	
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	TOTAL	Additional duties in hours (total hours)	Safecare % compliance across 3 Census periods (average)
ED	14.4%	36.0	33.0%	26.6%	432.5	221.8	210.7		31.75	0
Integrated Care	17.1%	42.12	22.6%	24.6%	706.7	739.3	-110.4		3036.86	54.29%
Medicine	14.0%	51.27	25.7%	44.4%	1726.7	739.3	420.9		3012.71	58.24%
Surgery, GI & CC	16.3%	60.58	28.5%	39.4%	1745.8	976.6	768.8		2993	53.57%
W&Cs	20.5%	37.35	40.7%	20.5%	646.2	524.1	122.1		258.5	36.00%
CSS	19.3%	34	20.90%	11.6%	222.83	112.75	110.08		802.25	0
					5481	3314	1522		10135.07	50.53%

Issues:

- Monthly roster challenge meetings in place to ensure rosters are approved 10 weeks in advance now show significant improvements
- There has been an increase in the number of additional duties in comparison to previous month
- There appears to be an excessive number of unused hours. However this is challenged at the monthly Healthroster meetings & is related to staff hours being carried forward due to different shift patterns. This is closely monitored by the Deputy Chief Nurse, DND's & Workforce Matron.

Key Actions:

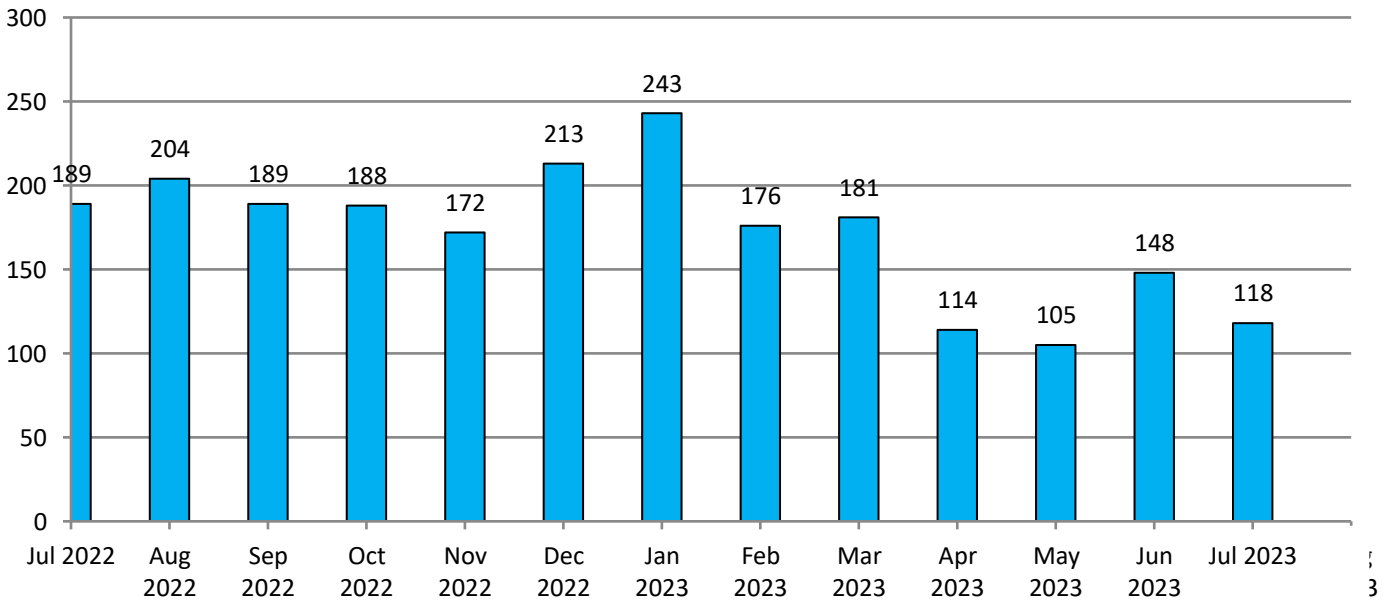
- Rostering indicators developed & in use highlight teams where practice falls short of expected standards
- Deputy Chief Nurse, DNDs & Workforce Matron meet weekly to review safe staffing
- Twice daily overview of the staffing position using the SafeCare Live system at the staffing meeting
- In collaboration, the Healthroster Team and Workforce Matron have close oversight of the roster building, requests for annual leave, sickness recording & actions required
- Healthroster Policy is now being updated
- Auto rosters being used in a number of areas

*Data provided by Healthroster Team

10. Risk & Assurance (July 2023 data)

Stockport NHS Foundation Trust

Staffing incidents reported rolling monthly



Issues :

- 118 staffing incidents registered in July 2023

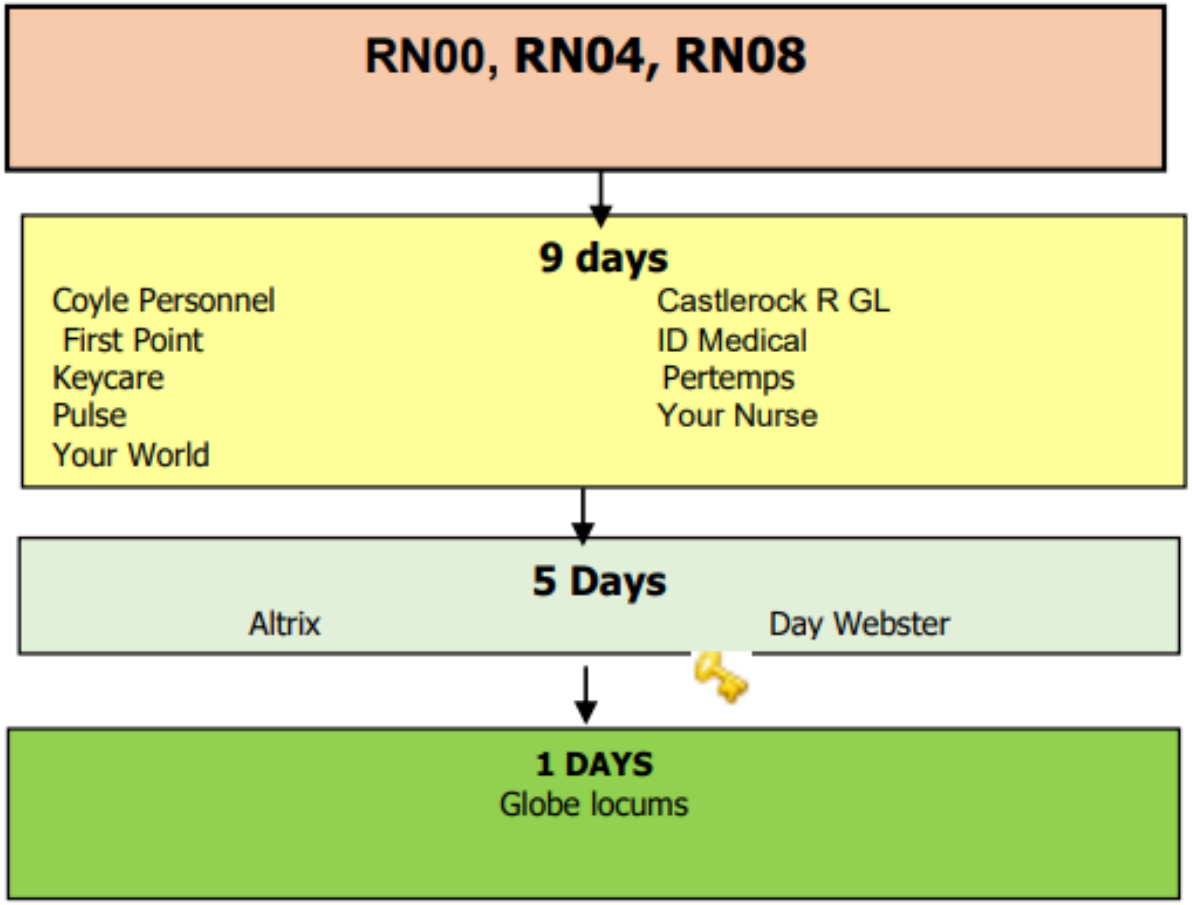
Key Actions :

- All staffing incidences reviewed with the DNDs at weekly incident review meeting
- Continue to raise awareness of the staffing escalation processes. Continued focus on the scrutiny of all types of incidents, complaints & patient feedback to triangulate & provide assurance where needed
- Promoting transparency by incident reporting across the site

*Data provided by Datix

11. Bank & Agency Nursing Cascade

NHS Stockport NHS Foundation Trust



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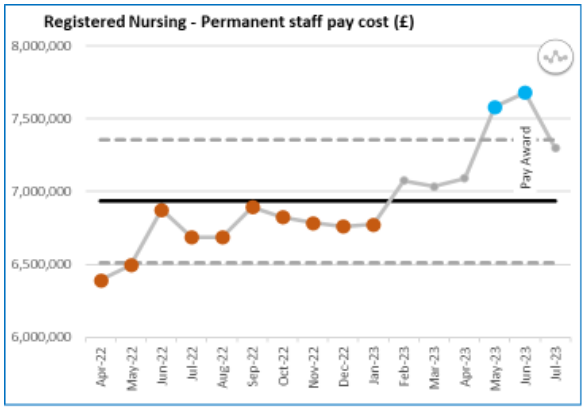
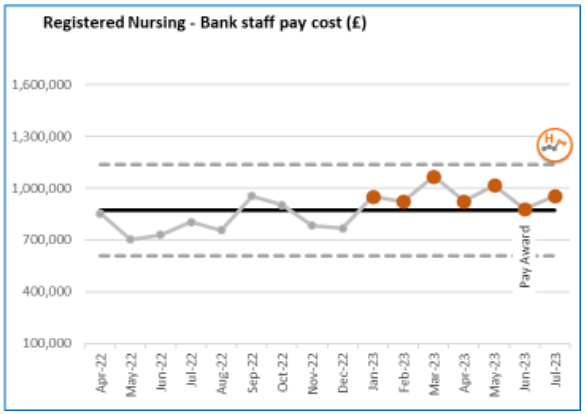
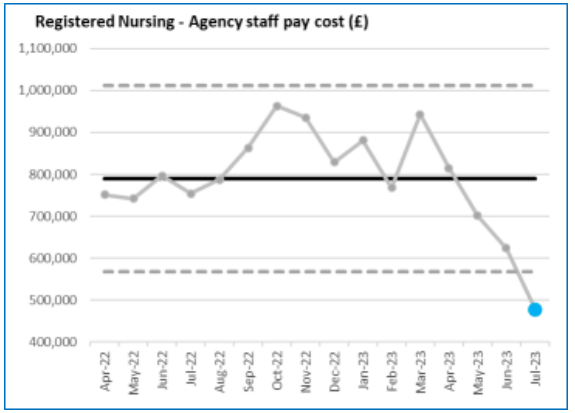
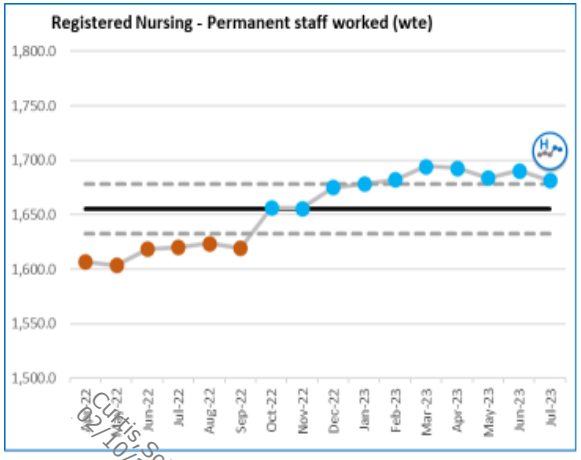
11. Bank & Agency Nursing

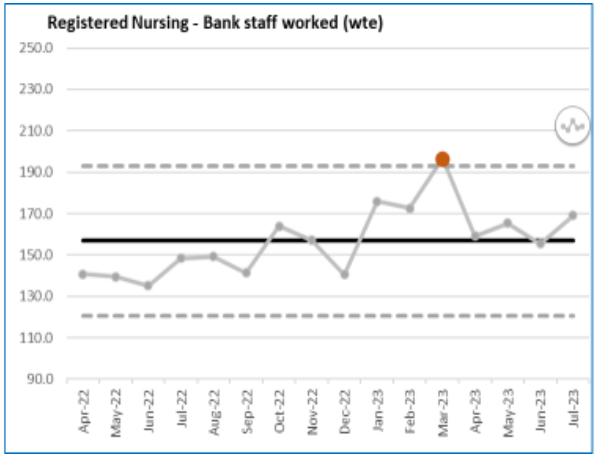
Stockport NHS Foundation Trust

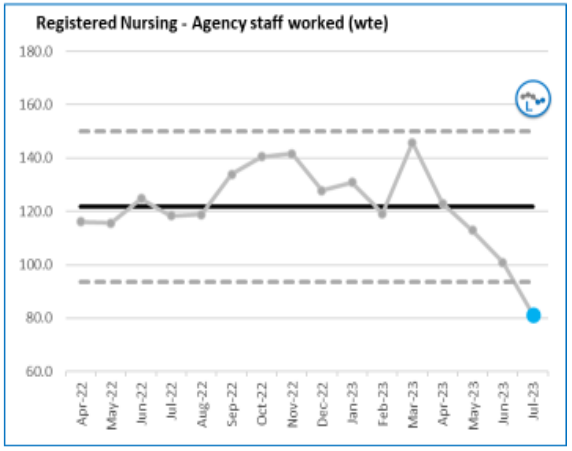












The above SPC charts show the impact over the last 3 months of the reduction in the agency cascade from 21 days to 10 days and more recently to 5 days. Average agency expenditure on registered nursing for January to April was £851k per month, for May to July that has dropped to an average of £601k with July being the lowest month at £478k in over 2 years. As can be seen from the charts above there has been an uptake in bank shifts but the cost has remained relatively constant.

12. Next Steps

Stockport NHS Foundation Trust

Issues :

Contract with Just R ended 1st June 2023. Company had supported the Trust by co-ordinating the promotion of recruitment campaigns, which involved :

- Taking photographs
- Interviewing & filming staff – provided films
- Promoting events on social media platforms
- Contacting individuals who had registered an interest in attending the events
- Manage #supportteamstockport facebook page & @stockportnursing twitter account

Key Actions :

- Medicine recruitment events scheduled for the 27th & 28th October at The Alma Lodge Hotel, Hazel Grove
- Workforce Matron to visit University of Salford on the 7th December & discuss careers opportunities at the Trust
- Identification of a role with the skillset to promote recruitment campaigns & the Trust as an employer of choice (previously managed by social media Just-R)
- Introduction and promotion of retention initiative the GROW pathway
- Ward allocation for nursing students qualifying in December 2023
- Formalise the pathway for international nurses working as HCAs to qualify as Band 5 registered nurses

13. Conclusion

NHS Stockport NHS Foundation Trust

- Maintaining safe staffing levels to meet the current demands of services.
- Considering and planning safe staffing for further strikes remains a challenge
- Significant recruitment of nursing staff, AHPs, midwives and medical workforce
- There is a continued focus on scrutiny of all types of incidents, complaints and patient feedback to triangulate and provide support where needed
- Safecare Live giving oversight for all areas of acuity and safe staffing levels
- There is ongoing work, in partnership with NHS Professionals, to significantly reduce agency costs and Increase shift fill rates.
- Attending and representing Stockport NHS Foundation Trust university recruitment events which have increased in number due to the start of the new academic year

NHS Stockport NHS Foundation Trust

Meeting date	5th October 2023	**Public**	X	**Confidential**	
Meeting	The 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 recommended to: Note the positive assurance on the implementation, approach, and activities of the FTSU agenda and the FTSUG role					

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

	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	Throughout the paper
Sustainability (including environmental impacts)	

Executive Summary

The report highlights the initial efforts of the FTSUG in increasing visibility and engagement with staff, including training compliance, awareness campaigns, culture, and cases.

The recent Lucy Letby trial has prompted specific actions which have been included within the report.

1. **Introduction**

The purpose of this report is to provide the Board of Directors with an independent perspective 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). This is the current Guardians first report to the committee since commencing the role in June 2023.
Speaking up has no limitations – it is about anything which gets in the way of patient care and worker well-being. We are working to make speaking up business as usual. That means being able to speak up about anything.

2. **Guardian accessibility and initiatives**

The first three months in post have been focused on visibility, promotion and establishing myself in the organisation as the new Guardian.

The National Guardians Office requires all FTSUG to complete a two-part training programme on appointment and undertake regular refresher training throughout their tenure. Both parts of the training programme were completed by the FTSUG within three months of commencing the role.

National initiatives for FTSU include promoting awareness with Boards and within trusts about the Guardians service.

The Northwest Regional network is useful to review practice and to share on-going challenges between services. I am scheduled to attend this meeting in October.

The Visibility and accessibility of the Guardian is key for effective use of the service. To raise the profile of FTSU a Trust-wide communication campaign has been implemented, including design and distribution of posters, screensavers, an Information video, features in trust communication such as Weekly Trust Updates, regular communication on social media, drop-in sessions, attending team meetings and walk abouts.

Staff comment that they notice the screens and posters and recognise the Guardian. However, the best way of creating visibility is through site visits and these are becoming an established part of the Guardian function.

For cohorts of staff who do not have frequent use of a laptop or computer as part of their role, site visits are particularly important for communicating the Freedom to Speak Up raising awareness and supporting an open culture and particularly promoting a connection with staff from floor to board.

Typically visits include speaking to staff about how they are feeling, making them aware of how to raise concerns more broadly through their management line, and to make them aware of the FTSU role and what additional support can be provided. This helps staff feel relaxed and makes them aware that they could raise concerns to the FTSU Guardians in a confidential way.

As well as promoting the role of the Freedom to Speak Up Guardian, engagement across the trust enables the Guardian to keep in touch with the lived experience of staff.

The Guardian has made two off site visits to wards in the community and one within the Trust, attended six team meetings, and has a further seven scheduled in

September/October. To ensure accessibility, plans are in place or visits have taken place to accommodate diverse shift patterns, even during unsociable hours.

The guardian has arranged three regular drop-in session based on the wants and needs of staff. These will be held at Devonshire, Bluebell and Neo Natal.

Trust inductions will continue to convey the essence of the Freedom to Speak Up initiative through personal attendance and/or pre-recorded videos. Inductions included are Trust, Junior Dr inductions, Student, and the Cadets programme.

Best practice sessions have taken place with six FTSUG based within other trusts and included implementation of a Champion network and anonymous reporting systems.

The Guardian has linked in with the SPAWS team and initiated a consensual referral process. One case of speaking up has come from a SPAWS referral to date.

A pivotal aspect of enhancing our Freedom to Speak Up initiative involves proactively showcasing the positive outcomes resulting from speaking up and this will be a future area of focus.

3. **Actions following the Lucy Letby Verdict**

Following the recent Lucy Letby trial NHS England has written to every NHS organisation stressing the importance that everyone working in the health service feel safe to speak up and are confident that it will be followed by a prompt response.

Specifically, NHS leaders and Boards must urgently ensure:

- The strengthened Freedom to Speak Policy is adopted by January 2024 – the Trust actioned this prior to the former Guardian leaving the Trust.

- All staff have easy access to information on how to speak up – information on FTSU is available across the Trust in a variety of formats and is regularly shared with staff via the communication methods we know they use. The wider Speaking Up policy and strategy is due for review by the Deputy Director of Organisational Development with support from the Guardian.

- Relevant departments, such as Human Resources and Freedom to Speak Up Guardians, are aware of the national Speaking Up Support Scheme and can actively refer individuals to the scheme if needed –The Guardian is aware of the scheme and how to appropriately refer individuals and has sent the relevant links and information regarding the scheme to HR.

- Approaches or mechanisms are put in place to support those staff who may have cultural barriers to speaking up, or who are in lower paid roles and may be less confident to do who, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up – the Guardian is just one route for speaking up but their efforts to increase the visibility and accessibility is helping to raise the profile of speaking up. The development of a network of FSU champions from various backgrounds and role will further support the work to address barriers to speaking up, as will an updated Speaking Up strategy.

- Boards seek assurance that staff can speak up with confidence and whistle-blowers are treated well – there are a variety of assurance reports that are presented to People Performance Committee and other Board committees and the Audit Committee is due to review the suite of assurance available. Board members also take part in a range of activities to gather informal feedback from staff e.g., Big Conversation, Wednesday Walkabouts.

- Boards are regularly reporting, reviewing, and acting upon available data – the Guardian provides regular detailed reports to the People Performance Committee and Board.

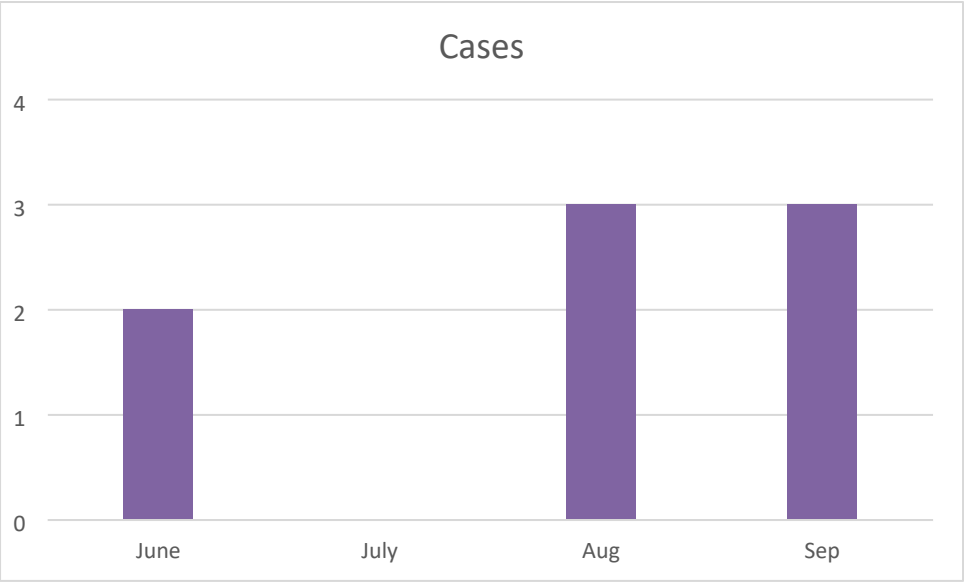
  In addition to the requirements set out in the letter from NHS England, the Trust's maternity team has reviewed its speaking up arrangements including inviting the Guardian to attend a meeting with senior managers on the maternity unit to discuss how I can promote freedom to speak up and support the department. As a result of this regular drop in sessions with staff are to be arranged.

  The Guardian has joined the Northwest FTSU network for maternity related support to enable best practice and share experience.

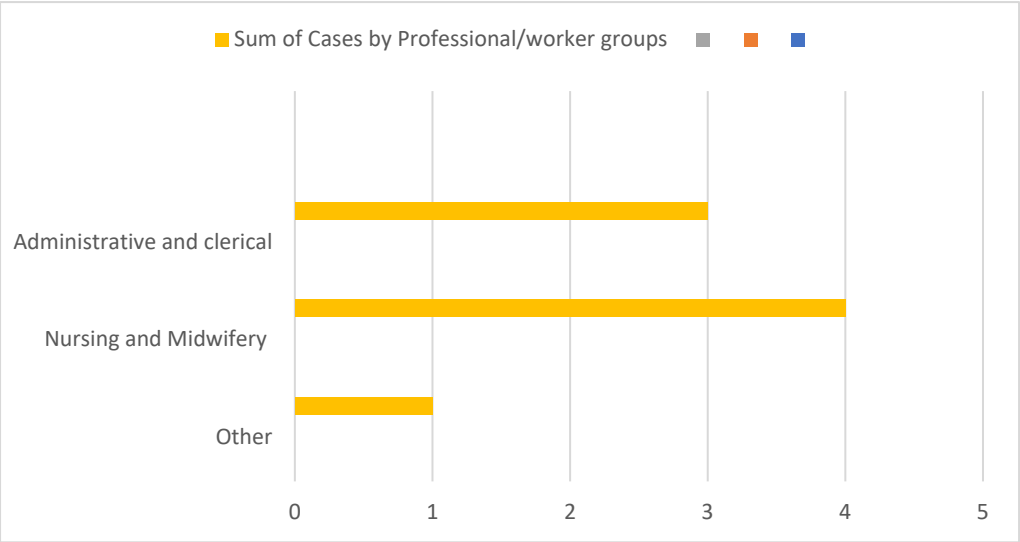
  The week following the verdict of Lucy Letby six members of staff asked me to meet them to see how I can support them in making staff aware of FTSU within their teams

4. **Case Work**

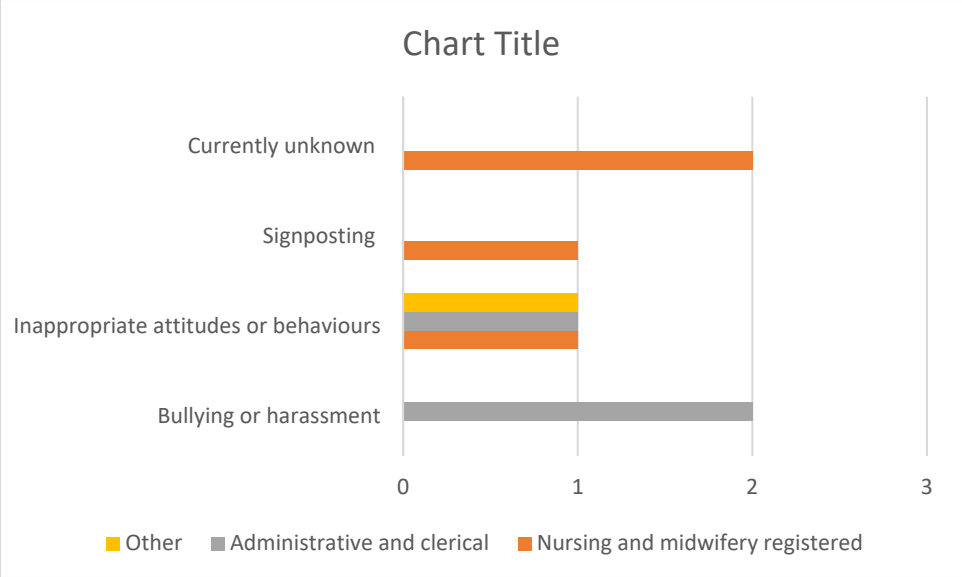
   The table below represents the number of Freedom to Speak up referrals since 12 June 2023. Cases are divided by month in this instance due to my short length of service within the trust.



The sum of cases by professional/worker groups have been highlighted below.



The element in which cases have been reported has also been included.



All issues raised were responded to within 24 hours.

Currently, there are three ongoing investigations.

Three other Cases have been closed and two are scheduled in for an initial meeting to discuss a concern.

5. Themes and trends

Due to the small number of cases raised since the current Guardian took up their post, there are no specific themes or trends within the data.

However, site walkabouts saw staff sharing their hesitance to speak up due to a perception of unsupportive management and, fear of detriment. The hesitance to speak up appears to be woven tightly within multiple pockets of the trust and include cohorts of staff both on site and in the community within the following areas.

- Administration and Clerical

- Nursing and Midwifery
- Allied Heath professionals

There appear to be three main barriers to speaking up and include.

- Vulnerability
- Psychologically safety
- Trusting the process

Staff felt that the benefits of speaking up did not outweigh the perceived negative impact that was associated with raising concerns.

Some work has been done to triangulate this information, conversations have taken place with HR colleagues to check on any themes or trends. This has led to further exploration within specific areas of Nursing and midwifery. More work will be done in this area going forward and include conversations with the patient experience team.

It's important to recognise that our ability to draw robust conclusions is constrained by the size of our data pool. Nonetheless, these early indications offer a starting point for refining our strategies and concentrating our efforts on addressing prevalent issues.

By nurturing a culture of open communication and continually refining our approach, we strive to effectively respond to emerging trends and foster a proactive, solution-driven environment.

6. Freedom To Speak Up Champions

As part of last year's Freedom to Speak Up campaign the Freedom to Speak Up Guardian launched an initiative to recruit a group of champions within the organisation.

Four members of staff expressed their interest in the voluntary roles, and the recruitment of a network of champions is an important part of the Trust's strategy to provide a range of routes for people to raise issues.

As part of Freedom to Speak Up month in October there will be a further drive to recruit additional champions from a range of backgrounds and professions. This year's theme is "Breaking the Barriers" and will focus on removing the barriers that can stop staff from speaking up.

7. Anonymous reporting

In cultivating an open and robust speaking-up culture, it is crucial to recognise that there are situations where anonymous reporting and the gathering of informal feedback can play a pivotal role.

Discussions with other Guardians have highlighted the value in having a system for staff to report concerns anonymously, and this is a potential area for development that will be explored in the coming months.

There are occasions when staff may not want to raise a concern formally but choose to highlight issues informally with the Guardian. Since taking up post the Guardian has shared such informal feedback from visits to services to help management address potential and emerging issues.

Discussions with other Guardians have highlighted the value in having a system for staff to report concerns anonymously.

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 Engagement, who is the executive lead for FSU and an experienced former Guardian,

An essential aspect to consider in our endeavour to enhance the concern reporting process is the Verdict in the trial of Lucy Letby

9. Recommendations

The Board of Directors 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	5th October 2023	**Public**	X	**Confidential**	
Meeting	Board of Directors				
Report Title	Board Assurance Framework 2023/24 – Quarter 2				
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 Q2, 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 having taken place during September 2023. In reviewing the principal risks and determining risk score, consideration was given to the key controls and assurances in relation to each, any gaps and required actions.

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 Q2. Operational performance, finance, workforce, and estates related risks remain as the Trust's most significant scoring risks.

With regards to proposed changes to risk scores from Q1, an increased risk score, from 12 to 16, is proposed for Principal Risk 1.3, relating to the restoration of elective activity and achievement of national access standards. This is based on current performance due to the cumulative impact of industrial action having significant adverse impact on un-booked and cancelled appointments, significant increase in

referrals for elective care and lack of availability of mutual aid within Greater Manchester.

Furthermore, an increased risk score, from 12 to 16, is proposed for Principal Risk 7.3 relating to environmental sustainability, with key action to mitigate risk including a decarbonisation plan and recruitment of a Sustainability Manager.

The Trust is beginning to see improvement in several 'people' metrics, including sickness absence, with a broad suite of initiatives to support colleagues' health and wellbeing in place. It is proposed Principal Risk 2.1, relating to engagement and support for our people's well-being, is reduced from 16 to 12.

No.	Principal Risk	C	L	Q1	Q2	Target Score
PR1.2	There is a risk that patient flow across the locality is not effective	4	4	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	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	8
PR6.1	There is a risk that the Trust does not deliver the annual financial plan	4	4	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	6
PR7.2	There is a risk that the estate is not fit for purpose and does not meet national standards	4	4	16	16	8
PR7.3	There is a risk that the Trust does not materially improve environmental sustainability	4	4	12	16	8
PR7.4	There is a risk that there is no identified funding mechanism or insufficient funding to support strategic regeneration of the hospital campus	4	4	16	16	8
PR1.1	There is a risk that the Trust does not deliver high quality care to service users	4	3	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	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	8
PR2.2	There is a risk that the Trust's services do not fully support neighbourhood working	3	3	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	6
PR4.2	There is a risk that the Trust's workforce is not reflective of the communities served	3	3	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	6
PR5.1	There is a risk that the Trust does not implement high quality transformation programmes	3	2	6	6	6
PR5.2	There is a risk that the Trust does not implement high quality research & development programmes	3	2	6	6	6

In addition, the Trust's significant risks from the corporate risk register (as presented to Risk Management Committee in September 2023), are provided at Appendix 2 to ensure alignment between operational and

principal risks. The significant risks relate to the following areas:

Risk Subtype	No of Risks	Risks Identified
Capacity and demand of services	2	- 4 hr ED access target (16) - Access to Rapid Access Chest Pain Clinic (16)
Environment	2	- Pathology estate not fit for purpose (15) - Outpatient B environmental condition (15)
Compliance	1	- Breach of Regulatory Reform (Fire Safety) Order 2005 (16)
Staffing	1	- Employee Relations & Industrial Action (16)
Financial	2	- Risk of insufficient cash reserves (15) - Risk the Trust will be unable to deliver statutory reporting responsibilities and core finance requirements (15)

Stockport NHS Foundation Trust

Board Assurance Framework

2023/2024

Corporate Objectives 2023/24

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

1. Key to Board Assurance Framework

CONSEQUENCE MARKERS		LIKELIHOOD MARKERS		
5	Multiple deaths caused by an event; ≥£5m loss; May result in Special Administration or Suspension of CQC Registration; Hospital closure; Total loss of public confidence	5	Very Likely	No effective control; or ≥1 in 5 chance within 12 months
4	Severe permanent harm or death caused by an event; £1m - £5m loss; Prolonged adverse publicity; Prolonged disruption to one or more Directorates; Extended service closure	4	Somewhat Likely	Weak control; or ≥1 in 10 chance within 12 months
3	Moderate harm – medical treatment required up to 1 year; £100k – £1m loss; Temporary disruption to one or more Directorates; Service closure	3	Possible	Limited effective control; or ≥1 in 100 chance within 12 months
2	Minor harm – first aid treatment required up to 1 month; £50k - £100K loss; or Temporary service restriction	2	Unlikely	Good control; or ≥1 in 1000 chance within 12 months
1	No harm; 0 - £50K loss; or No disruption – service continues without impact	1	Extremely Unlikely	Very good control; or ≤ 1 in 1000 chance (or less) within 12 months

Risk Matrix					
Impact	Likelihood				
	1 - Rare	2 - Unlikely	3 - Possible	4 - Likely	5 - Certain
1 - Negligible	1	2	3	4	5
2 - Minor	2	4	6	8	10
3 - Moderate	3	6	9	12	15
4 - Major	4	8	12	16	20
5 - Catastrophic	5	10	15	20	25

Gap Score Matrix (Difference between Target Score and Current Score)	
Gap score ≤0	Risk target achieved
Gap score 1 - 5	Tolerable
Gap score 6 - 9	Close monitoring
Gap score 10	Concern
Gap score > 10	Serious

2. Risk Appetite Framework

Risk Level ➡ **Key Elements** ⬇	**Avoid** Avoidance of risk is a key organisational objective.	**Minimal** Preference for very safe delivery options that have a low degree of inherent risk and may only have a limited reward potential.	**Cautious** Preference for safe delivery options that have a low degree of residual risk and may only have a limited reward potential.	**Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.	**Seek** Eager to be innovative and to choose options which may offer higher levels of reward, despite greater inherent risk.	**Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust and highly embedded.
Financial / Value for Money How will we use our resources	We have no appetite for decisions or actions that may result in financial loss.	We are only willing to accept the possibility of very limited financial risk.	We are prepared to accept the possibility of limited financial risk. However, VFM is our primary concern.	We are prepared to accept some financial risk as long as appropriate controls are in place. We have a holistic understanding of VFM with price not the overriding factor	We will invest for the best possible return and accept the possibility of increased financial risk.	We will consistently invest for the best possible return for stakeholders, recognising that the potential for substantial gain outweighs inherent risks.
Compliance / Regulatory How will we be perceived by our regulator	We have no appetite for decisions that may compromise compliance with statutory, regulatory of policy requirements.	We will avoid any decisions that may result in heightened regulatory challenge unless essential.	We are prepared to accept the possibility of limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some regulatory challenge as long as we can be reasonably confident, we would be able to challenge this successfully	We are willing to take decisions that will likely result in regulatory intervention if we can justify these and where the potential benefits outweigh the risks.	We are comfortable challenging regulatory practice. We have a significant appetite for challenging the status quo in order to improve outcomes for stakeholders.
Quality / Outcomes How will we deliver quality services	We have no appetite for decisions that may have an uncertain impact on quality outcomes.	We will avoid anything that may impact on quality outcomes unless essential. We will avoid innovation unless established and proven to be effective in a variety of settings.	Our preference is for risk avoidance. However, if necessary, we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place.	We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation.	We will pursue innovation wherever appropriate. We are willing to take decisions on quality where there may be higher inherent risks but the potential for significant longer-term gains.	We seek to lead the way and will prioritize new innovations, even in emerging fields. We consistently challenge current working practices in order to drive quality improvement.
Reputation How will we be perceived by the public and our partners	We have no appetite for decisions that could lead to additional scrutiny or attention on the organisation.	Our appetite for risk taking is limited to those events where there is no chance of significant repercussions.	We are prepared to accept the possibility of limited reputational risk if appropriate controls are in place to limit any fallout.	We are prepared to accept the possibility of some reputational risk as long as there is the potential for improved outcomes for our stakeholders.	We are willing to take decisions that are likely to bring scrutiny of the organisation. We outwardly promote new ideas and innovations where potential benefits outweigh the risks.	We are comfortable to take decisions that may expose the organisation to significant scrutiny or criticism as long as there is a commensurate opportunity for improved outcomes for our stakeholders.
People How will we be perceived by our workforce	We have no appetite for decisions that could have a negative impact on our workforce development, recruitment and retention. Sustainability is our primary interest.	We will avoid all risks relating to our workforce unless absolutely essential. Innovative approaches to workforce recruitment and retention are not a priority and will only be adopted if established and proven to be effective elsewhere.	We are prepared to take limited risks with regards to our workforce. Where attempting to innovate, we would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some workforce risk, as a direct result from innovation as long as there is the potential for improved recruitment and retention, and developmental opportunities for staff.	We will pursue workforce innovation. We are willing to take risks which may have implications for our workforce but could improve the skills and capabilities of our staff. We recognize that innovation is likely to be disruptive in the short term but with the possibility of long-term gains.	We seek to lead the way in terms of workforce innovation. We accept that innovation can be disruptive and are happy to use it as a catalyst to drive a positive change.
Innovation How will we transform services	We have no appetite for decisions to innovate, our aim is to maintain or protect, rather than to create or innovate. General avoidance of system / technology developments.	We will avoid innovations unless essential or commonplace elsewhere. Only essential systems / technology developments to protect current operations.	We tend to stick to the status quo, innovations generally in practice avoided unless really necessary. Systems / technology developments limited to improvements to protection of current operations.	We support innovation, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery.	We will pursue innovation – desire to 'break the mould' and challenge current working practices. New systems / technologies viewed as a key enabler of operational delivery.	Innovation is the priority – consistently 'breaking the mould' and challenging current working practices. Investment in new systems / technologies as catalyst for operational delivery.
Appetite	**None**	**Low**	**Moderate**	**High**	**Significant**	

3. Heat Map & Gap Analysis

Risk Matrix					
Impact	**Likelihood**				
	1 - Rare	2 - Unlikely	3 - Possible	4 - Likely	5 - Certain
1 - Negligible					
2 - Minor					
3 - Moderate		**5.1, 5.2**	**2.2, 3.1, 4.2, 7.1**		
4 - Major			**1.1, 3.2**	**1.2, 1.3, 2.1, 4.1, 6.1, 6.2, 7.2, 7.3, 7.4**	
5 - Catastrophic					

Gap Score Matrix (Difference between Target Score and Current Score)		
Gap score ≤0	Risk target achieved	**5.1, 5.2**
Gap score 1 - 5	Tolerable	**1.1, 1.3, 2.1, 2.2, 3.1, 3.2, 4.2, 7.1, 7.3**
Gap score 6 - 9	Close monitoring	**1.2, 4.1, 6.1, 6.2, 7.2, 7.4**
Gap score 10	Concern	
Gap score > 10	Serious	

4. Board Assurance Framework 2023/24

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score		
								Impact	Likelihood	Current	Q4 22/23	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 1 - Deliver personalised, safe and caring services																		
Principal Risk Number: PR1.1				**Risk Appetite: Moderate**														
There is a risk that the Trust delivers suboptimal quality of care to service users, which may lead to suboptimal patient safety, effectiveness and/or experience and failure to meet regulatory standards.	Quality Committee	Quality Committee Subgroups established to direct policies and procedures relating to: Patient Safety, Clinical Effectiveness, Patient Experience, Health & Safety, Integrated Safeguarding Divisional Quality Boards established. SFT Quality Strategy 2021-2024 - Established subgroup of Patient Safety Group - Quality Safety & Improvement Group SFT Patient, Carer, Family & Friends Experience Strategy 2022-2025 SFT Mental Health Plan 2022-2025 CQC Action Plans in place (2022) Board approved Patient Safety Incident Response Plan, Aug 2023 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. Learning from Industrial Action Reviews established. StARS - Ward assurance & accreditation process established. Also established for:	Impact of employee relations & industrial action issues Impact of continuing operational pressures	**Level 1 - Management:** Divisional Quality Boards (Monthly) – Quality & Safety Integrated Performance Report Divisional Clinical Audit Meeting (Quarterly) **Level 2 – Corporate** Quality Committee: - Quality IPR - Key Issues & Assurance Reports: o Patient Safety (Serious Incidents & Duty of Candour) o Clinical Effectiveness (Clinical Audit & NICE Compliance) o Patient Experience o Health & Safety o Integrated Safeguarding - CQC Report including CQC Action Plan Update, CQC Preparation (Quarterly) - StARS Position Statement & Key Themes (Quarterly): 3 Blue StARS - 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) - Guardian of Safe Working / Freedom to Speak Up Report to Board (Bi-annually) - Quality Strategy (Annual) Annual Quality Accounts **Level 3 - Independent** Friends & Family Test National Patient Experience Surveys: - Adult Inpatient Survey - National Cancer Survey - Emergency Department Survey MIAA Internal Audits 2022-23: • Risk Management (Substantial) • Clinical Audit (Substantial) • StARS (Substantial) • Quality Spot Checks (Substantial) GMC Medical Trainees Survey		Full implementation of Patient Safety Incident Response Framework & Plan Mortality governance review, incorporating wider Stockport activity	December 23 October 23	4	3	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	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 1 - Deliver personalised, safe and caring services																		
		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.																
Principal Risk Number: PR1.2					**Risk Appetite: Moderate**													
There is a risk that patient flow across the locality is not effective which may lead to patient harm, suboptimal user experience, and inability to achieve national access standards for urgent care and elective care	Finance & Performance Committee	Established models of emergency and urgent care in place in line with national standards Rapid emergency diagnostic pathway in place – General Surgery & Medical Rapid Ambulance Handover process in place. 'Programme of Flow' established and informed by Working Intelligently Group Reporting via Service Improvement Group Virtual Ward Weekly Trust Performance Meeting and ~~twice~~ weekly locality tactical meeting to seek support to mitigate risk – Attended by Nurse Director of the Day (Divisional Director). Weekly – Locality Patient Flow meeting established. System wide Urgent & Emergency Care (UEC) Board in place (oversight of patient flow management plans). Urgent & Emergency Care Delivery Group established (biweekly), feeding into UEC Board. Trust and system escalation process in place, aligned to a single OPEL system – Including divert of resource from elective activity to support flow. Winter Planning Debrief Process in place at GM, Locality and Trust – Informing Winter Plan 2023/24 Bed Modelling – 18 Month Plan	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 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. Locality plan for intermediate bed base to be agreed for 2024.	**Level 1 – Management** Divisional Operations Boards (Monthly) – Performance Management Report - ED Attendance - Overall bed occupancy rate - Patients No Criteria to Reside - ED 4 Hour Target Performance - Ambulance Handover times - ED 12 hour waits - Time to triage Daily Bed meetings (x 4) System dashboard of acute, intermediate and domiciliary care capacity		Finalise recurrent Medical Staffing model	Nov 2023	4	4	16	16	16	16			4	2	8
				Level 2 – Corporate Divisional Performance Review (Monthly) including targeted 'Deep Dives' Finance & Performance Committee - Operational Performance Report (Monthly) - Themes from Performance Review Working Intelligently Programme - Elective Length of Stay Integrated Performance Report – Board (Bimonthly)		Locality agreement for community capacity for 2024	Nov 2023										
				Level 3 – Independent Urgent & Emergency Care Delivery Board NHSE – Activity Returns GM ICS reporting aligned to Tier 1 – Urgent Care													

4. Board Assurance Framework 2023/24

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score		
								Impact	Likelihood	Current	Q4 22/23	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 1 - Deliver personalised, safe and caring services																		
		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.																
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 Winter Plan 2023/24 established. 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 – not available. Current independent sector providers unwilling to takeover care for long waiting patients. Significant increase in referrals for elective care, including from out of area. Cumulative impact of industrial action (Consultants & Juniors) having significant adverse impact on unbooked and cancelled appointments.	**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				4	4	12	12	12	16			4	2	8
				Level 2 – Corporate Divisional Performance Review (Monthly) including targeted 'Deep Dives' Finance & Performance Committee Operational Performance Report (Monthly) - 52+ week waits - 65+ week waits - Overall RTT waiting list size - Cancer 2ww - Cancer 62 day - Diagnostic waits Quality Committee - Waiting List Harms Review (3 x year) Integrated Performance Report (Operational Performance) – Board (Bimonthly)													
				Level 3 – Independent SFT Tier 2 Elective Restoration Monitoring NHSE – Activity Returns GM productivity ranking – Benchmarked 2nd 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 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 and Covid. Comprehensive staff wellbeing programme established including staff psychology and wellbeing service. Occupational Health Service – 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 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 pressures	**Level 1 - Management:** People, Engagement & Leadership Group - People Plan – Workstream Reports Equality Diversity & inclusion Steering group - EDI Strategy Industrial Action Planning Group **Level 2 – Corporate** Performance Reviews – Workforce Metrics NHS People Plan Self-Assessment People Performance Committee - People Plan Update (bimonthly) - Workforce KPIs (bimonthly) - Freedom to Speak-up Report (Quarterly) - Freedom to Speak-up Guardian (Bi-annually) Integrated Performance Report (Workforce) - Board (Bimonthly) **Level 3 - Independent** CQC Well-led Mapping Report – Recognition of Staff Health & Wellbeing offer NHS National Staff Survey		Delivery Plan, including timescales and outcomes to support pledge for 'the wellbeing of our NHS people' to be developed in line with policies and guidance from the regional working group. Implementation of collaborative Occupational Health function with T&G, including joint IT system.	Dec 2023 (Awaiting regional guidance) October 2023	4	3	16	16	16	12			4	2	8
Principal Risk Number: PR2.2				**Risk Appetite: Moderate**														
There is a risk that the Trust's services do not fully support	Finance & Performance Committee	Operational & Winter Planning processes established with system arrangements.	Unfunded growth in demand for community services	**Level 1 – Management** Divisional Quality & Operations Boards (Monthly) Performance Management Report	Community Services Dashboard	Align Trust community services & workforce to PCNs	Ongoing	3	3	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 2 - Support the health and wellbeing needs of our communities and colleagues																		
neighbourhood working leading to suboptimal improvement in population health		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 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.	Capacity & demand modelling for community services to support appropriate deployment of resources. Alignment of Community Services to PCNs – Potential change to PCN geographical footprints	- 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	ICS Acute Flow Dashboard	Integration of Community Services Dashboard to IPR Locality Neighbourhood Working Programme	Q3 2023/24 Q3 2023/24									

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score		
								Impact	Likelihood	Current	Q4 22/23	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 3 - Develop effective partnerships to address health and wellbeing inequalities																		
Principal Risk Number: PR3.1					**Risk Appetite: Significant**													
There is a risk in implementing the Provider Collaborative model to support delivery of priorities/objectives of the Stockport's ONE Health & Care (Locality) Board leading to a delay in delivery of models of care which support improvements in population health and operational recovery following the pandemic	Finance & Performance Committee	Locality ICS arrangements developed and approved by partners. CEO and Chair members of Stockport Health & Wellbeing Board ONE Stockport Health and Care (Locality Board) operational. Membership includes CEO, Director of Strategy & Partnerships & Chief Finance Officer ONE Stockport Plan and ONE Stockport Health and Care Plan. Stockport Provider Partnership operational, chaired by SFT CEO Provider Partnership identified key workstreams for 2023/24 based on population health metrics. Operational & Winter planning processes well established with system arrangements as a focus. Recovery Objectives published in Planning Guidance 2023/34 in Trust Plan 2023/24	Controls not yet designed for the management of the One Stockport Health & Care Plan	**Level 1 – Management** **Level 2 – Corporate** Executive Team / Finance & Performance Committee oversight of key strategic matters Trust Board Reports as required and CEO Report including key strategic developments - ICS - Stockport One Health & Care Plan Joint system meetings on ONE Stockport plan Locality Provider Partnership (Monthly) Locality Board (Monthly) ICS Executive Meeting (Monthly) **Level 3 – Independent** Health & Wellbeing Board	Robust neighbourhood data to enable Provider Partnership to measure improvement in population health outcomes	Neighbourhood profiles to be produced by Local Authority BI	Q3 2023/24	3	3	9	9	9	9			3	2	6
Principal Risk Number: PR3.2					**Risk Appetite: Significant**													
There is a risk that the Trust does not deliver a joint Clinical Strategy with East Cheshire NHS Trust (ECT), leading to suboptimal pathways of care and/or limited-service resilience across the footprint of both Trusts	Finance & Performance Committee	Established Board to Board meetings with ECT. Established ECT & SFT programme governance arrangements with clinical and support workstreams identified: Joint Programme Board in place (Monthly). Approved SFT & ECT Case for Change in June 2022. Case for Change presented to NHSE and ICB. Work programme in place for 2023/24 including development of transformation workstreams and services to be considered as part of the OBC. Stakeholder engagement plan in place including ICBs, LA, Healthwatch, DPHs, VCSE and NHSE regulators. NHSE Regulators and ICB Commissioners engaged in plans.	Failure to gain key stakeholder support for Joint Clinical Strategy and Case for Change. Currently no long-term funding strategy for the programme of work and no funding identified for 2023/24 financial year	**Level 1 – Management** Joint Programme Board and Clinical Advisory Groups Programme Governance Meeting **Level 2 – Corporate** Executive Team oversight of key strategic matters. Trust Board & ECT/SFT Board to Board Reports **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		Produce Models of Care and Pre-Consultation Business Case Plan for and commence implementation of service changes where no formal further process is required.	Q4 2023/24 Q1 2024/25	4	3	12	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 4 - Develop a diverse, capable and motivated workforce to meet future service and user needs																		
Principal Risk Number: 4.1				**Risk Appetite: High**														
There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit & retain the optimal number of staff, with appropriate skills and values, which may lead to suboptimal staff and patient experience.	People Performance Committee	Approved People Plan in line with national People Strategy objectives – Including enabling approaches to Workforce Transformation (Planning); Leadership Development; Health & Wellbeing; Coaching; Resourcing; Organisational Development; Equality, Diversity & Inclusion, Talent Management & Succession planning E-rostering and Job Planning in place to support staff deployment. Recruitment & Retention Implementation Plan in place, supported by Attract, Develop & Retain Group. Medical Workforce Group established. Defined safe medical and nurse staffing levels for all wards and departments. Safe Staffing Standard Operating Procedure deployed. Temporary staffing and approval processes with defined authorisation levels Bank & Agency Usage Deep Dive Undertaken. Mandatory Training Requirements set. Realignment of Role Essential Training Requirements Range of leadership and management development training sessions available 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	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		E-Rostering Workforce Group to be established.	Sept 2023	4	4	16	16	16	16			4	2	8
				Level 2 – Corporate People Performance Committee – - Workforce Integrated Performance Report (Sickness Absence / Substantive Staff /Recruitment Pipeline / Appraisal, Turnover, Flexible Working Requests, Bank & Agency) - Safe Staffing Report (Quarterly) - Annual Nurse Establishments - Annual Medical Job Planning) - Annual Medical Revalidation Report Bank & Agency Usage – Review via Exec Team (Monthly)		Launch & deliver a Medical Leadership Programme Develop and implement phase one of a talent management and succession planning approach.	Q4 2023/24 September 2023										
				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		Introduce a refreshed 121/Appraisal process	Q3 2023/24										
Principal Risk Number: 4.2				**Risk Appetite: High**														
There is a risk that the Trust's workforce is not reflective of the communities served and staff with a protected characteristic having a suboptimal staff experience (career progression, turnover) which may	People Performance Committee	Approved People Plan in line with national People Strategy objectives – Including Equality, Diversity & Inclusion, Talent Management & Succession planning Equality, Diversity & Inclusion Strategy & Implementation Plan Staff Networks (BAME / Disability / Carer/ LGBTQ+) Completed review of staff	Career Development Programmes for staff with protected characteristics Development of Staff Network Chairs and the Staff Networks	**Level 1 - Management** WRES / WDES Steering Group - Oversight of WRES / WDES Annual Report and Action Plan Equality, Diversity & Inclusion Steering Group - Oversight of the EDI Action Plan		Establish Staff Neurodiversity Group Relaunch the Staff Networks under the agreed improved arrangements. Hold staff listening sessions to understand the barriers to career progression.	October 2023 October 2023 Q3 2023/24	3	3	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																		
lead to a poorer patient experience.		networks and improvement arrangements identified. 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.		**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 **Level 3 - Independent** NHS National Staff Survey	EDI metrics to be built into People Analytics Dashboard.												

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score		
								Impact	Likelihood	Current	Q4 22/23	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 5 – Drive service improvement through high quality research, innovation and transformation																		
Principal Risk Number: 5.1						**Risk Appetite: Significant**												
There is a risk that the Trust does not implement high quality transformation programmes which may lead to suboptimal service improvements.	Quality Committee	Director of Transformation working across SFT and Tameside & Glossop (utilising experience and knowledge of system-wide transformation programmes across other localities) Trust Transformation Programmes identified through a formal process of prioritisation linked to corporate objectives (Aims, KPIs, Milestones) Standardised governance & assurance in place for Transformation Programmes - Service Improvement Group (SIG) chaired by the Chief Executive. Senior Responsible Officer, Clinical & Operational Lead in place for each Transformation Programme Transformation Team supporting Stockport Provider Partnership identified key priority workstreams	Capacity of operational teams to implement change due to operational pressures.	**Level 1 – Management** Transformation - Programme Boards Provider Partnership Key Priority Areas – Programme Boards		Explore use of current AQUA resource to support AKI & Sepsis Programmes	October 23	3	2	6	6	6	6			3	2	6
				Level 2 – Corporate Service Improvement Group – Monthly Transformation Programme Report & Quarterly Deep Dive: Review KPIs/Milestones Stockport Provider Partnership (Monthly) - Priority Workstreams Board Report: Transformation Programme (Biannually)														
				Level 3 - Independent														
Principal Risk Number: 5.2						**Risk Appetite: Significant**												
There is a risk that the Trust does not implement high quality research & development programmes which may lead to suboptimal service improvements.	Quality Committee	SFT Research Team established. Joint Clinical Research, Development & Innovation Strategy 2022-2027 (SFT & T&G) & governance meetings in place to review work programme (as derived from strategy) Annual research programme in place.	Alignment of RD&I to clinical strategies, particularly cancer.	**Level 1 – Management** Clinical Effectiveness Group - Research & Innovation Progress Report - Annual Research & Innovation Report		Review of the RD&I governance team structures across SFT & T&G and implement revision to support improved workforce resilience.	2023/24	3	2	6	6	6	6			3	2	6
				Level 2 – Corporate Quality Committee: - Clinical Effectiveness Group Key Issues & Assurance Report - Annual Research & Innovation Report 2022-23	Link between SFT & T&G governance to be defined	Cancer Strategy development to include Research, Development & Innovation element.	December 23											
				Level 3 - Independent DHSC KPIs for Research NIHR GMCRN KPIs for Research Participant research experience survey (PRES)														

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score		
								Impact	Likelihood	Current	Q4 22/23	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 6 – Use our resources efficiently and effectively																		
Principal Risk Number: 6.1				**Risk Appetite: Moderate**														
There is a risk that the Trust does not deliver the 2023/24 financial plan leading to increased regulatory intervention	Finance & Performance Committee	Annual financial plan 2023/24 approved – Confirmed deficit as part of GM control total Indicative SFT Capital Plan 2023/24 set. Annual cash plan 2023/24 in place – Cash support if required from GM Approved Opening Budgets 2023/24 including requirement for recurrent and non-recurrent CIP Established STEP Programme (CIP) and oversight of delivery. Working Intelligently Group established – Data Analysis & Benchmarking – Workplan in place, informing STEP Programme Divisional Performance Review process - including financial escalation actions based on control totals for divisions. SFT Finance Improvement Group established, chaired by Chief Executive Delivery of budget holder training and enhancements to financial reporting SFI's & Scheme of Delegation in place including authorisation limits – Revised & Board approved – December 2022 GM Financial Recovery Committee established – Chief Finance Officer member as Chair of GM DoFs GM 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 industrial action Lack of clarity on mechanism for accessing cash support. Lack of clarity on Elective Recovery Fund (ERF) – Trust not currently at activity levels compared to 2019/20. Resource gap impacting coding activity in line with 'flex and freeze' requirements. 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**	Regular benchmarking data to support monitoring of service delivery, productivity & efficiency. Visibility of performance against income block and non-block.	Action to be determined subject to outcome of GM Finance Recovery Meeting (September 23)		4	4	16	12	16	16			4	2	8

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Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score		
								Impact	Likelihood	Current	Q4 22/23	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 6 – Use our resources efficiently and effectively																		
				NHSE - North West Region oversight and triangulation of finance, activity and workforce data. Monthly Finance Return – Detailed commentary on financial position and Oversight of GM ICS based on the GM NHS SOF Rating 3													
Principal Risk Number: 6.2					**Risk Appetite: Moderate**													
There is a risk that the Trust does not develop and agree with partners a multi-year financial recovery plan, optimising opportunities for financial recovery through system working, leading to lack of financial sustainability.	Finance & Performance Committee	GM ICS financial planning/position processes established including GM DoFs Planning Group. Board review of high-level actions required in order to avoid submitting a deficit plan (June 2023) GM Financial Recovery Committee established - Chief Finance Officer member as Chair of GM DoFs. GM Mandated Support & Turnaround Director appointed. Locality financial planning/position processes in place including monthly meeting Local Authority Treasurer & Trust CFO. Stockport System Financial Recovery Group established – Chief Finance Officer, Director of Finance & Director of Operations. Prioritisation of investments linked to planning priorities. Drivers of financial deficit review including benchmarking data and levels of efficiency & two-year financial forward view – Deficit & Opportunities to address – Review via Finance & Performance Committee (Jan 23) Established Trust planning processes - Triangulates activity, workforce and cost.	Underlying financial deficit Lack of certainty regarding system funding beyond 2023/24 including reductions due to convergence factor. Requirement for increased % CIP (recurrent/non-recurrent) GM Financial Risk Framework to be agreed. Elective Recovery Fund (ERF) remains unclear) – Trust not at activity levels compared to 2019/20. Growth in demand not recognised.	**Level 1 - Management** **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) **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		Action to be determined subject to outcome of GM Finance Recovery Meeting (September 23)		4	4	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 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			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 2022 DCB 1596 Secure Email Standard Accreditation – Achieved February 2023. Internal Audit Report: Data Security and Protection (DSP) Toolkit – Moderate Assurance, MIAA, June 2023. Data Security and Protection Toolkit self-assessment submission June 2023 – Standards Met.		Development of action plan for Data Protection & Security Toolkit (DSPT) Assessment 2023	Q3 2023/24											
Principal Risk Number: 7.2				**Risk Appetite: Moderate**														
There is a risk that the estate is not fit for purpose and/or meets national standards due to increasing maintenance requirements, which may lead to inefficient utilisation of the estate to support high quality of care and increased health & safety incidents.	Finance & Performance Committee	Approved Capital Programme including backlog maintenance Robust process in place for identification and stratification of estates related risks and backlog maintenance 6-facet survey completion and review – Action Plan in place Premises Assurance Model (PAM) Action Plan in place Estates & Facilities Performance Dashboard (Compliance & Performance Metrics) Site Development Strategy in place. 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.	**Level 1 – Management** Capital Programme Management Group - Compliance with agreed delivery programme - Confirmation of spend against approved budget Health & Safety Group - Compliance with regulatory standards Health & Safety Incidents				4	4	16	12	16	16			4	2	8
				Level 2 – Corporate Quality Committee - Health & Safety Group Key Issues Report Finance & Performance Committee - Capital Programme Management Group Key Issues Report		Develop site development strategy delivery plan to reduce maintenance costs aligned to Project Hazel	October 2023											
				Level 3 - Independent Estates Return Information Collection (ERIC) Model Hospital Data Set														

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score		
								Impact	Likelihood	Current	Q4 22/23	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 7 - Develop our estate & digital infrastructure to meet service and user needs																		
		Project Board and Senior Responsible Officer identified for major capital developments Trust Head of Operational Estates and Compliance appointed as National E&F compliance lead for HEFMA (NHS Health Estates and Facilities Management Association)		Estates & Facilities Compliance Review (MIAA 2020/21) – Substantial Assurance														
Principal Risk Number: 7.3				**Risk Appetite: Moderate**														
There is a risk that the Trust does not materially improve environmental sustainability which may lead to suboptimal support to locality ambitions and the NHS commitment to carbon reduction.	Finance & Performance Committee	Approved Green Plan in place. Green Plan Committee established and Green Plan Work Plan in place monitored by the committee. Approved Capital Programme 2022/23 Robust identification and stratification of sustainability-related risks. 6-facet survey completion and review of information Mechanisms in place to explore and develop sustainability approach across Stockport locality.	Insufficient financial resources to enable optimum levels of investment to deliver sustainability improvements. Decarbonisation Plan Sustainability Manager not in post and recruitment ongoing.	**Level 1 – Management** Capital Programme Management Group - Compliance with agreed delivery programme - Confirmation of spend against approved budget Green Plan Committee - Monitoring of Green Plan delivery - Development of sustainability opportunities				4	4	12	8	12	16			4	2	8
				Level 2 – Corporate Annual Sustainability Report Finance & Performance Committee Estates Progress Report including Sustainability (Biannually)		Decarbonisation Plan Sustainability Manager to be appointed.	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	4	16	12	16	16			4	2	8
				Level 2 – Corporate Strategic Regeneration Framework Prospectus and Expression of Interest – Reviewed by Board		Consideration of resources for development of New Hospital Strategic Outline Business Case (OBC)	Q2 2023/24											
				Level 3 - Independent														

Appendix 2 – Stockport NHS Foundation Trust Significant Risk Register (as at September 2023)

Risk ID	Business Group	Risk Title	Consequence	Likelihood	Rating	Target Rating	Change since last report
130	Emergency Department and Clinical Decision Unit	There is a risk the Trust does not meet the 4 hour access standard and this leads to delays in treatment and potential patient harm.	4	4	16	10	↔
1004	Corporate – Estates and Facilities	There is a risk that the Trust is in breach of the Regulatory Reform (Fire Safety) Order 2005.	4	4	16	4	↔
2337	Medicine	There is risk of rapid access chest pain patients coming to harm as a result of delays in booking first appointments.	4	4	16	8	↔
1711	Corporate – Workforce	There is a risk of deterioration in employee relations and industrial action.	4	4	16	4	↔
2452	Clinical Support Services	There is a risk of the pathology estate not being fit for purpose or safe.	3	5	15	3	↔
2465	Clinical Support Services	There is a risk to outpatient appointment delivery and patient and staff health and wellbeing due to environmental condition in OPB.	3	5	15	6	↔
101	Corporate - Finance	There is a risk that the Trust has insufficient cash reserves to operate.	5	3	15	5	↔
305	Corporate - Finance	There is a risk the Trust will be unable to deliver statutory reporting responsibilities and core finance requirements	5	3	15	5	NEW (Increased from 10)

NHS Stockport NHS Foundation Trust

Meeting date	5th October 2023	**Public**	X	**Confidential**	
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**	X
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 – Review and approve the Audit Committee Terms of reference as recommended by Audit 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

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 September 2023.

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	21 September 2023
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	The Committee received an update regarding key financial performance indicators for Month 5 2023/24. The Committee heard that overall, the Trust position at month 5 was adverse to plan by £1.3m, with a planned year-end deficit of £31.5m, which was in line with the annual plan for 2023/24. It was noted that the key reasons for the variance to plan in month related to strike action, pay award, open escalation wards, undelivered cost improvements, elective recovery fund (ERF) estimated penalty for Q1 as calculated by GM, impact of inflation, enhanced staffing levels to support the high level of ED attendances and cover for vacancies and sickness absence. The Director of Finance advised that £2.3m was offset by other budget underspends and non-contract income above plan. It was noted that the Stockport Trust Efficiency Programme (STEP) plan for 2023/24 was £26.2m (£10.3m recurrent), and that the delivery of the plan was £1m behind target. It was noted that that ERF had been reported at month 5 in line with national guidance, with an estimated underperformance of £0.5m based on months 1-3. The Committee heard that the Trust had maintained sufficient cash to operate during August, but noted risks in this area and heard that the Trust would require revenue support in 2023/24. The Director of Finance advised that the cash risk for the Trust had been increased to a score of 15 and was included on the significant risk register. It was noted that the Cashflow Monitoring Group continued to closely monitor the cash position. Good performance was noted against the Better Payment Practice Code standard. It was noted that the Capital Plan for 2023/24 was £62.7m, but subject to confirmation, and at month 5 expenditure was behind plan by £3.5m. The Committee reviewed and noted the financial position as at Month 5, and acknowledged the significant risk around the delivery of the financial plan. **Assurance Received:** • Lack of assurance regarding the delivery of the £31.5m planned deficit (due to impact of industrial action, under-funding of pay award, servicing large numbers of out of area No Criteria to Reside patients, open escalation wards, undelivered cost improvements, elective recovery fund (ERF) estimated penalty for Q1 as

	calculated by GM, impact of inflation, enhanced staffing levels to support the high level of ED attendances and cover for vacancies and sickness absence). **Action:** To agree the steps and actions required to get the Trust back on track, including the current monitoring review with GM/turnaround director. **Timescale:** As per GM timetable. • Lack of assurance regarding cash to meet the demands for the rest of the year 2023/24. **Action:** To agree the process, timetable and sign offs (as well as any further implications, e.g. PDC charge to income and expenditure) required to secure the additional cash required. **Timescale:** As per GM timetable.
Greater Manchester (GM) Financial Position Update	The Committee received a detailed overview of the key messages from the Financial & Performance Recovery Meeting held on 19 September 2023, and plans and actions that would need to be covered ahead of the follow up meetings scheduled for October 2023 – March 2024. The Committee noted the key messages and actions, including the need to develop a medium-term financial plan. Committee members highlighted the need to include quality and safety in the considerations, as finance and performance could not be considered in isolation. It was noted that a full discussion would be held at the October Private Board meeting to ensure all Board members were appraised of the position. **Action:** The Committee recognised that its work plan would need to be reviewed and flexed, as appropriate, in light of the Financial & Performance Recovery Meeting and the consequent requirements for this Trust. **Assurance Received:** • Lack of assurance regarding the medium-term financial performance **Action:** To agree the process and timetable required to complete the Medium Term Financial Plan including the current monitoring review with GM/turnaround director. **Timescale:** As per GM timetable.
Operational Performance Report Curtis Soile 02/10/2023 07:32:55	The Committee received the Operational Performance Report, including performance against the strategic core operating standards, benchmarking of performance against the four key standards (A&E 4-hour standard, Cancer 62-day standard, 18-week Referral to Treatment (RTT) standard, and Diagnostic 6-week wait standard), and key Productivity, Efficiency & Transformation programmes. The Committee acknowledged the continued operational pressures and the 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. The Committee acknowledged the impact of the BMA Industrial Action, particularly in relation to cancer and elective performance, with over 4,500 elective appointments cancelled. It was noted that a suite of reports were included in the Quality Committee Work Plan 2023/24 to review the impact of poor patient flow/timely access to care on the quality of care provided, including safety, effectiveness and experience. With regard to Urgent & Emergency Care, the Committee noted the continued high attendance levels and challenges to flow, and issues around no criteria to reside, particularly for out of area patients. The Committee heard that the internal Programme of Flow work was having a positive impact on performance. It was noted that the diagnostic backlog had deteriorated, with Echocardiology remaining the biggest area of challenge. The Committee heard that the sixth room was now operational and a revised trajectory was being developed, and that outsourcing to the Community Diagnostic Centre capacity in Q3/Q4 was being explored. **Assurance Received:** • Lack of assurance regarding the delivery of the core performance targets by March 2024, acknowledging the significant impact of the BMA industrial action. **Action:** Production of the forecast trajectory to year-end for key delivery targets and the underpinning actions to deliver these, to provide assurance rather than reassurance. **Timescale:** October meeting
Protecting and Expanding Elective Capacity – Referral to Treatment (RTT) Board Self Declaration	The Committee received a report providing a detailed background to the request from NHS England to provide assurance against a set of activities to drive the recovery of outpatients at pace. It was noted that the Trust was required to complete a self-certification against these activities, with Board discussion challenged, by 30 September 2023. The Committee reviewed the proposed Trust response against the following assurance areas: • Validation • First appointments • Outpatient follow-ups • Support required The Committee recommended the RTT Board Self Certification to the Chair and Chief Executive for sign off, as delegated by the Board of Directors.
Winter Planning Curtis Soile 02/10/2023 07:32:55	The Committee received a report providing an update on the operational planning to deliver resilience to address winter pressures in 2023/24. The Committee heard that the planning was based on national guidance and included the key steps localities were required to take collectively to meet the challenges ahead. The Committee noted work around the three key delivery plans to provide winter resilience for Urgent & Emergency Care Services, Primary Care and Elective Recovery. The Committee noted the guidance and the steps being taken by the Trust and wider

	Stockport locality to deliver resilience over the winter period and endorsed the proposed approach. The Committee acknowledged, however, the financial risk due to the lack of additional winter funding, and raised concerns around staff resilience.
Green Plan	The Committee received a report providing an update on progress made against the Green Plan and actions being taken in order to reach net zero by 2040. It was noted that a Green Group had been established, with representation from Executive Directors and senior leaders to oversee the delivery of the objectives of the Green Plan, and the Committee heard about proactive actions to develop a green culture. The Committee confirmed progress against the Green Plan during the first 18 months of implementation.
Board Assurance Framework 2023/24 and Aligned Significant Risks	The Committee reviewed a report detailing the current position of the 11 principal risks assigned to the Finance & Performance Committee. It was noted 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. **Action:** 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 October 2023.
RAAC Business Case	The Committee reviewed a business case relating to the eradication of Reinforced Autoclaved Aerated Concrete (RAAC) capital scheme, noting the recent confirmation of external capital funding. **Action:** The Committee recommended the RAAC Business Case to the Board of Directors for approval.
Standing Committees	The Committee received and noted the following key issues reports: • Capital Programmes Management Group • Digital & Informatics Group
Any Other Business	• **Capital Scheme: Paediatric Enabling for Emergency & Urgent Care Centre** The Committee agreed for the revised business case to go straight to the Board due to the tight timescales and limited impact of the proposed changes.

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KEY ISSUES REPORT	
Name of Committee/Group	People Performance Committee
Chair of Committee/Group	Mrs Beatrice Fraenkel, Noon-Executive Director
Date of Meeting	15 September 2023
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 attendance, appraisals, mandatory training, turnover, vacancies, time to hire and agency expenditure. The Committee confirmed performance in relation to attendance, vacancies, workforce stability and time to hire was within target, with all other metrics below target. It was noted, however, that performance had improved from last month for turnover, mandatory training, role specific training, children's resus, safeguarding (adults & children) and agency spend.
Medical Appraisal and Revalidation Report	The Committee received a report detailing the Trust's medical appraisal and revalidation processes, its quality assurance (QA) mechanisms and the numbers of appraisals completed. The Committee confirmed that the Trust had generally robust processes in place for medical appraisal and revalidation, including positive engagement. It was noted, however, that the active recruitment of new appraisers was an ongoing area of focus, particularly in the Medical and Integrated Care Divisions. The Committee received and noted the report and confirmed the Trust's continued good performance with respect to the completion of medical appraisals and compliance with its medical revalidation requirements and recommended the annual return for sign off by the Chief Executive.
Violence Prevention & Reduction Standard	The Committee received a report providing an update on progress made in relation to the Violence Prevention & Reduction Standard and further detail on issues specific to the Trust in relation to sources of aggression, incidents by division and victim profiling. It was noted that compliance with the Violence Prevention & Reduction Standard and local initiatives and activity would be monitored quarterly by the Health & Safety Joint Consultative Group, with annual / biannual report to People Performance Committee (schedule to be confirmed).

NHS Stockport NHS Foundation Trust

Item	Key issues and matters to be escalated
Freedom to Speak Up Report	The Committee received a report providing an overview of the proactive efforts of the Freedom to Speak Up (FTSU) Guardian in increasing visibility and engagement with staff, including training compliance, awareness campaigns, culture and cases. It was noted that the recent Lucy Letby trial had prompted specific actions, which were included in the report. It was noted that due to the small number of cases raised to date, there were no specific themes or trends to report, and noted a hesitancy to speak up in some areas due to fear of detriment. The next Freedom to Speak Up Report to PPC (March 2024), to include progress and evaluation of the high-levels actions set out in the Trust's self-reflection tool (Nov 22), and identification of any further actions through review of the self-reflection tool, to support the Trust in identifying and responding to emerging trends and driving improvement.
GMC Annual National Trainee Survey	The Committee received a General Medical Council (GMC) Annual National Trainee Survey report, which indicated that the trainees' experiences were in line with other trusts in most of the clinical areas. The Committee heard about areas where negative feedback had been received and noted associated mitigating actions. A detailed specialty-by-specialty analysis of the data was ongoing. It was noted that the action plan was being monitored by the Education Governance Group, which reported to the People Performance Committee.
Safe Care (Staffing) Report	The Committee received a report providing assurances and risks associated with safe nurse and midwifery staffing, medical staffing, and allied health professionals, alongside actions to mitigate the risks to patient safety and quality, based on patients' needs, acuity, dependency and risks. The Committee 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 was being operationally managed by senior teams and on-call colleagues with continual dynamic risk assessments conducted. The Committee also acknowledged the impact and associated challenges of the continued industrial action.
Fit & Proper Person Test Framework for Board Members	The Committee received a presentation detailing the Trust's current implementation status of the new Fit & Proper Person Test Framework. The Committee noted the presentation and the changes to the Fit and Proper Person Test, including communication to Board members.
Board Assurance Framework 2023/24 and Aligned Significant Risks	The Committee received a report detailing the current position of the three principal risks assigned to the People Performance Committee. Given the ongoing concerns around staffing and the impact of industrial action, the Committee confirmed that risk PR 4.1 (recruitment and retention of optimal numbers of staff) remains a significant risk, score 16. As the Trust was beginning to see

Item	Key issues and matters to be escalated
	improvement in several key 'people' metrics, including sickness absence, with a broad suite of initiatives to support colleagues' health and wellbeing in place, the Committee agreed to reduce risk PR 2.1 (engage and support our people's wellbeing) from score 16 to 12. 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 October 2023.
Standing Committees	The Committee received and noted the following key issues reports: • People, Engagement & Leadership Group • Equality, Diversity & Inclusion Group • Educational Governance Group

NHS Stockport NHS Foundation Trust

KEY ISSUES REPORT	
Name of Committee/Group	Quality Committee
Chair of Committee/Group	Mary Moore, Non-Executive Director
Date of Meeting	26/09/2023
Quorate	Yes

The Quality Committee draws the following key issues and matters to the Board of Directors' attention:

Item	Key issues and matters to be escalated
Patient Story	Patient story received relating to visitor feedback on the care of a dementia patient at a time when the family were unable to visit. Positive response from relatives that the ward provided personalised care the reassured and comforted the service user.
Any Other Urgent Business	The Medical Director escalated to the Committee that the Industrial Action (IA) on the 23rd & 24th of September, where both Junior Doctors and Consultants were on strike resulted in very fragile services across the Trust but specifically in ED, Maternity and for Priority 2 elective surgery. The derogation of these services was not supported by Trade Unions or NHS England with a 'Christmas Day' cover supported. The patient activity on both days was consistent with a normal working day. The committee heard that incidents and cancellations of surgery would be reviewed to identify patient harms. Staff reported feelings of anxiety on the IA days the Head of Midwifery described how staff were supported to maintain safe services. Onward monitoring of clinical incidents, staffing metrics and impact on performance including cancer waits will be triangulated across all assurance committees.
Board Assurance Framework	Agreement that Board should review PR5.1 on transformation as it reflects a quality perspective. Consider the risk scope and appetite in triangulation with a performance and finance perspective.
Maternity Services Report	Update received on key maternity improvement workstreams 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) Maternity staffing and red flags for August 2023: • 2 incidents were reported as a result of staffing.

	• 3 incidents were reported as a result of acuity. • 6 were reported as both staffing and acuity. • 1 incident was not as a result of staffing or acuity • 2 active HSIB cases (babies born in poor condition) Continued work with maternity voices partnership to review and action plans in place to address learning. CNST Year 5 – On track to be fully compliant against all 10 safety actions ahead of submission early in 2024. Maternity and Neonatal Champions meetings and walk arounds scheduled to continue and to include divisional quadrumvirate in future. StARS accreditation standards improved in August and September compared to May/June 2023 North West Regional Maternity Strategy in development to streamline all elements of reporting. Maternity Services Report provided as Appendix 1, incline with reporting requirements.
Infant, Children and Young People Strategy	At the last CQC inspection it was highlighted that there was no documented strategy in place for the Infant, Children and Young people's services. The strategy includes a 3-year work plan aligned to the prioritise of the service with the • Improve experience and outcomes • End of life care • Workforce • Learning from incidents • Integrated and partnerships working • Environment • Mental health The strategy will have a further review to align with the Trust Quality Strategy (Start Well) and to define metrics for progress.
Patient Safety Report Curtis Soile 02/10/2023 07:32:55	Overview received of internal qualitative and quantitative data from Quarter 1 of 2023/24 relating to incidents (including serious incidents), inquests, claims and complaints, including learning and improvements to practice implemented. There was one Prevention of Future Death Reports received from HM Coroner during Quarter 1, it related to record keeping practices in the Laurel Suite relating to administration of chemotherapy drugs. Emergency Department and Acute Medical Unit highest reporting areas, reflective of increasing demand, with 'pressure ulcers and skin conditions' and 'administrative processes (excluding documentation)' highest reported types of incidents. The highest proportion of complaints remains in regard to communication. In Quarter 1, the PHSO contacted the Trust in relation to 5 new requests for information. The PHSO concluded no cases in Quarter 1. There are currently five ongoing cases that we are awaiting a decision for, three received in Quarter 1 and two outstanding from

	2022/23.
Mental Health Plan Progress Report	The Mental Health Plan for Stockport NHS Foundation Trust supported by Pennine Care NHS Foundation Trust aims to deliver quality care for the benefit of service users of all ages, families and carers, living with mental health conditions who are accessing services at Stockport NHS Foundation Trust. It complements work already being carried out in the wider community. The committee reviewed data regarding patients presenting with mental ill health to the Emergency Department, including demographic analysis of attendees, length of wait and outcome. The data highlighted key themes including long wait times for patients to be seen by the Mental Health Liaison Team (MHLT) particularly out of hours. The team faces staffing challenges that were not always sufficient to meet the demand through ED. There are other multifactorial issues that contribute to long stays in ED for MH patients including but not limited to no available onward destination, patient lack of capacity due to drugs and alcohol. Business case for increased alcohol care provision is currently paused. The responsibility is devolved from NHS England to Integrated Care Boards for roll out of alcohol care teams. GM ICB is focusing on financial issues at this time. A Quality Impact Assessment for this additionality has been requested from GM ICB and a request that SFT have sight of this. Quarterly reporting is presented to the Mental Health Partnership Board, with work ongoing to align data between SFT and PFT and progress system level response.
National Inpatient Survey 2022.	This embargoed report was reviewed noting overall sustained improvement in 2022.

Quality & Safety Integrated Performance Report	Update received on quality & safety key performance indicators for up to September 2023 Improved performance in incidents falls and pressure ulcers, with all measures on trajectory at Month. Deterioration in infection prevention control rates, with several infections above improvement trajectory, notably C Diff. which is a comparable national issue at this time. Continued underperformance against target for sepsis antibiotic administration, support has been sought from Advancing Quality Alliance (AQuA), with exploration of opportunity to become part of the AQuA audit to providing benchmarking and access to peer support. HSMR is now not reported nationally, however CQ has requested to continue to monitor as SFT have been an outlier in GM for many months. HSMR to be included in future IPR.
Key Issues Reports	Trust Integrated Safeguarding Group, including Dementia Plan: Noted. Clinical Effectiveness Group: Noted – Impact of industrial action. Patient Safety Group: Noted – Focus on the conviction of Lucy Letby and Maternity Services. Area of focus for SFT is Maternity Diverts. Health & Safety Joint Consultative Group: Noted - Successful appointment to the post of Clinical Support Services Governance and Quality Manger

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Meeting date	26 September 2023	**Public**	X	**Confidential**	
Meeting	Quality Committee				
Report Title	Maternity Services Highlight Report				
Director Lead	Zoe Turner Divisional Director for Women's and Childrens	Author	Sharon Hyde Divisional Director of Midwifery and Nursing		

Paper For:	**Information**		**Assurance**	**X**	**Decision**	
Recommendation:	Quality Committee is asked to review and confirm the Maternity Services Highlight Report, including compliance position and action being taken to support continued improvement.					

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	X	Effective
X	Caring		Responsive
X	Well-Led		Use of Resources

This paper relates to the following Board Assurance Framework risks

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

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

Where issues are addressed in the paper

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

Executive Summary

The report incorporates an update on a number of 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

There is a national 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 HSIB
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. HSIB/NHSR CQC or other organisation with a concern or request for action directly with trust
9. Coroner Reg 28 made directly to Trust

In addition, the update includes an overview of Stockport's performance across GMEC, 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 report.

The Maternity Service Highlight Report will be presented on a bi-monthly basis to Patient Safety Group and to Quality Committee and Trust Board.

Maternity Services Highlight Report

Quality Committee
26 September 2023

Maternity Services Highlight report

NHS Stockport NHS Foundation Trust

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)
- 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.

Stockport NHS Foundation Trust

Year 5

- Information published 31 May 2023 (Archived)
- Updated version circulated July 23
- Continue to incentivise the 10 maternity safety actions from year 4 with some further refinement
- CNST Assurance check point presentation for LMNS/ICB to include evidence – 17th October
- Completed board declaration to be submitted to NHSR by **12 noon** on **1 February 2024**

Board reporting

- 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 HSIB
    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. HSIB/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 HSIB, 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

NHS 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.	Process to be confirmed with LMNS	
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 process from safety champions to be reviewed in line with CNST YR 5	

NHS Stockport NHS Foundation Trust

PMRT CNST Year 5 compliance

There have been five cases reported to MBRRACE since May 2023.

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.
88004	18/06/2023	18/06/2023	Reported day 1	Review not supported as Termination of pregnancy	N/A	N/A	N/A
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

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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 HSIB

NHS Stockport NHS Foundation Trust

HSIB cases reported from the introduction of HSIB in April 2019 to 1st September 2023

Cases to date	
Total referrals	17
Referrals / cases rejected	5
Total investigations to date	12
Total investigations completed	10
Current active cases	2
Exception reporting	1

Current investigations

Reference	MI-021836
Criteria	HIE/Cooling
Location	STEPPING HILL HOSPITAL
Date of incident	04/02/2023
Case open date	06/02/2023
Family consent to medical records	04/04/2023
6 month deadline	06/08/2023
Lead MI	Laura Kyriacou
Support MI	Audra Muxlow
Case summary	Baby born in poor condition after cat 2 CB
Investigation status and progress	Draft report with Trust fir factual accuracy check. Due back 4 Sept, thank you
Investigation process issues	Exception reported as MRI for triage unavailable until 21 March
Emerging learning	
Important communication	

Reference	MI-030216
Criteria	Early Neonatal Death
Location	STEPPING HILL HOSPITAL
Date of incident	20/07/2023
Case open date	20/07/2023
Family consent to medical records	26/07/2023
6 month deadline	20/01/2024
Lead MI	Dianne Addison
Support MI	Joyce Ayre
Case summary	Sudden infant death at home
Investigation status and progress	Arranging staff interviews
Investigation process issues	
Emerging learning	
Important communication	

Safety Recommendations to date

In total to date the Trust have received 20 safety recommendations from 8 completed HSIB investigations.

The categories include:

- Documentation
- Clinical attendance and guidance
- Clinical assessment and guidance
- Escalation
- Quality assurance

Two 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 2022

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)	July 2023	HSIB cases*	1 (Awaiting confirmation of acceptance of investigation)
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	3 11 0
		Deflections - • Number of deflections • Number of women affected. • Any serious incidents due to the deflection	0
Stillbirths*	1 stillbirth > 24 weeks White British x 1 1 Termination of Pregnancy > 24 weeks White British Fetal losses 2 prior to 24 weeks White British x 1 Asian x 1 (English first language)	Babies Born <27 weeks gestation in < level 3 unit. *Include gestation and reason for birth outside NICU**	0
Neonatal Deaths*	1 (HSIB referral)	Number of Babies born at home midwife not present*	1 x planned homebirth. White British 1 1 x concealed pregnancy (unplanned homebirth) White British
Total number of StEIS incidents (for month) *	3 (all maternity diverts)	Number of babies born in other location midwife not present*	0
		Complaints – common themes	Sub-subject – **incorrect procedure – cannula management.** Sub-subject – **Delay in receiving results/information.**

Lessons learnt/themes from any StEIS/72-hour report for sharing.

Neonatal Death HSIB referral ***Ethnicity: White British*** ***Deprivation index: 6 Two-day old baby admitted to the Emergency Department with suspected Cardiac Arrest.*** ***Unable to resuscitate Neonatal Death sadly declared.***	G4 P1 – previous instrumental delivery. Nonsmoker at the time of booking. Normal Body Mass Index. No risk factors: booked as low risk and suitable for midwifery led care. Antenatal care provided in line with national guidance. Remained Low Risk. At 37+3 spontaneous rupture of membranes (no meconium) and spontaneous onset of labour. Normal vaginal delivery on the birth centre. Apgar's 9, 10, 10. Birth weight centile 82.3.	Findings from 72-hour review: Breastfed Baby. Newborn and Infant Physical Examination performed prior to discharge home. No abnormalities detected and no referrals required. Short stay requested - discharge information included: • Co-sleeping, bed sharing and reducing the risk of cot death. Primary 1st day visit undertaken by Community Midwife. Maternal and Neonatal Wellbeing reassuring. Safe sleep, ICON and signs of an unwell baby discussed. Plan made to next visit on postnatal day 5. Day 2 – mum found baby unresponsive in bed with her. Immediately called and ambulance and resuscitation attempted and continued on attendance to the Emergency department. Referral made to HSIB. Reported to MBRRACE. Contact made with the family to provide Bereavement support from the Bereavement midwifery team. All midwives involved in providing care being supported by their line managers.

Safety Action 9
3) Number of incidents logged as moderate or above

Stockport NHS Foundation Trust

Three x temporary Maternity Diverts. StEIS reportable. ***1st July 2023 – total time 4 hours.***	Divert as a result of insufficient staffing and increased activity.	There was a deficit of 4 midwives on the night shift. There were 5 midwives available to provide intrapartum care. There were 5 women requiring one to one care in addition to 7 inpatients on the delivery suite which included ongoing induction of labours. (The delivery suite coordinator who should be supernumerary provided care for these women until a midwife became available). No women were redirected during the divert. **Findings from the 72-hour review – appropriate temporary maternity divert.**
2nd July 2023 – total time 8 hours 15 minutes.	Divert as a result of insufficient staffing and increased activity.	There was a deficit of 2 midwives on the nightshift. There were 7 midwives available to provide intrapartum care. There were 6 women requiring one to one care in addition to 6 inpatients on the delivery suite including ongoing inductions of labour. Two women were redirected to East Cheshire during the divert. Both were discharged home following a labour assessment. **Findings from the 72-hour review - appropriate temporary maternity divert.**
23rd July 2023 – total time 8 hours 5 minutes.	Divert as a result of insufficient staffing and increased activity.	There was a deficit of 3 midwives on the early shift and 4 midwives on the late shift this was as a result of last-minute sickness and a cancelled NHSP shift. There were 4 midwives available to provide intrapartum care. At the time of the divert there were 4 women requiring one to one care in addition to 8 inpatients on the delivery suite including ongoing inductions of labour. (The supernumerary delivery suite coordinator provided care for the women until a midwife became available). **Findings from the 72-hour review – appropriate temporary maternity divert.** **Current staffing situation added to the Risk Register.**

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)	August 2023		
Total Number of Moderate or above (Level 3) Incidents validated. *(Use an * next to the number if any are unvalidated).*	1	Diverts - • Number of diverts. • Number of women affected. • Any serious incidents reported due to the divert	2 1 0
		Deflections - • Number of deflections • Number of women affected. • Any serious incidents due to the deflection	0
Stillbirths	1 Termination of Pregnancy > 24 weeks White British Fetal losses 2 prior to 24 weeks White British x 2	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	0
Total number of StEIS Incidents (for month)	2 Maternity Diverts	Number of babies born in other location midwife not present	0

Lessons learnt/themes from any StEIS/72-hour report for sharing.

Temporary Maternity Divert.
27th August 2023 – 72-hour rapid review. **StEIS reportable.**
Rational for temporary maternity divert insufficient staffing and increased activity.
There was a deficit of four midwives on the shift, this was as a result of a level of high level of sickness being experienced throughout the maternity unit in addition to a number of vacancies.
At the time of the divert there were 4 midwives available to provide intrapartum care for three women in addition to four inductions of labour.
There was one woman redirected during the temporary maternity divert.
The total time of the divert was 5 hours 20 minutes.

Temporary Maternity Divert.
29th August 2023 – 72-hour rapid review – **StEIS reportable.**
Rational for temporary maternity divert insufficient staffing.
There was a deficit of 6 of midwives on the shift, this was as a result of last-minute notice of sickness from two members of staff.
The maternity triage department was relocated to the delivery suite and a midwife was redeployed from the antenatal/postnatal ward, this left one midwife on the ward. The Trust 1090 bleep holder arranged for a Registered Nurse to attend the ward and support the remaining midwife.
The total time of the divert was 4 hours. There were no women redirected to neighbouring units.
The rapid review identified that the escalation policy was not followed as it transpired that the Chief Nurse who was on call at the time was unaware of the divert.
A web ex will be arranged for all of the Senior Managers on Call to remind them of the escalation policy for the maternity services.

Safety Action 9
3) Number of incidents logged as moderate or above

NHS Stockport NHS Foundation Trust

Return to theatre – post partum haemorrhage 5000mls.
38-year-old Gravid 3, 2 previous caesarean sections, both undertaken in Nigeria. History of fibroid surgery with T incision. Risk factors identified for pre-term labour. Correct care pathway referrals made.
Elective caesarean section booked for 38+2 weeks gestation following reports of reduced fetal movements.
Pre op bloods obtained, and HB identified as 101, two units of red blood cells cross matched.
Elective caesarean section performed by Consultant Obstetrician. Transverse lower abdominal incision in addition to transverse lower segment uterine incision performed. Atonic uterus identified following delivery of baby. Uterotonics administered – Intravenous oxytocin, oxytocin infusion, tranexamic acid, haemobate, ergometrine. Bakri balloon and vaginal pack inserted. Total estimated blood loss 2500mls.

Transferred to theatre recovery – noted to be hypotensive. Red blood cells transfused. Rotem performed to investigate any clotting issues. Arterial line sited by Anaestatist. Rotem identified that Cryoprecipitate required. 3 units requested. Portable ultrasound performed which evidenced a bulky uterus and a blood clot at fundal height.

Decision made to return to theatre for an examination under anaesthesia. On examination further blood loss noted, the decision was made to perform a laparotomy and hysterectomy. In total 5500mls blood loss. Blood products in total transfused:

- Seven units of red blood cells
- 2-units cryoprecipitate
- 6gm fibrinogen
- 1 pool platelets.

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Transferred to the Intensive Care Unit for observation. Total time in ICU four hours. Once no longer requiring supplementary oxygen transferred back to Delivery Suite.
Rapid review presented at the Serious Incident Review Group and decision made to manage the incident within the Datix. This incident will be presented at the Obstetric and Gynaecology Morbidity and Mortality Meeting to share the good practice which was recognised by the Serious incident review group.

Safety Action 9
3) Number of incidents logged as moderate or above

Stockport NHS Foundation Trust

Incident Category	Description of incident & number of incidents in this category	Actions/learning/ QI work to target themes
Maternity Care	Maternity triggers remain the top theme of obstetric related incidents. In August 2023 there were 16 maternity triggers reported. The main theme within maternity care for August was delays in care specifically performing artificial rupture of membranes, this was as a result of staffing issues experienced during August.	All delays in care have been reviewed and there was no harm caused as a result of a delay in progressing with the induction of labour process.
Workplace stressors/demands	During August there were a number of incidents submitted with regards to workplace stressors, this was as a result of staffing levels being below the recommendation of safe staffing on a number of shifts. These incidents are recorded as maternity red flag incidents.	All maternity red flag incidents are escalated to Trust board via the governance process. The current staffing situation has been added to the risk register. There is currently a high sickness rate within the maternity unit and a number of vacancies. There are 11 new starters due to commence employment in September/October 2023 which will increase the midwifery establishment.
Documentation	There were a number of incidents reported in August with regards to not being able to locate notes. Postnatal records could not be located for an inpatient woman. Antenatal and intrapartum notes could not be located which were required for a review. It was found that they had been sent home for the Community Midwife to be able to complete the NIPE. There has also been a case where paperwork has been misfiled in the incorrect woman's main file.	A poster has been displayed in all areas to remind all members of staff with regards to the importance of filing records in the correct file. This has also been included in safety huddles and hot topics which are discussed at ward handovers.

NHS Stockport NHS Foundation Trust

There are 15 risks on the obstetric risk register

Capacity and Demand	4
IT Systems	2
Environment	2
Security	1
Medication related	1
Equipment	1
Staffing	1
COSHH related	1
Compliance with standards	1
Information Governance	1

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
Capacity and Demand															
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	10/10/2023	Moderate Risk	9	Moderate Risk	6	No Change in Risk Score	Marie Dooley 08/08/2023 13:23:19
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	06/09/2023	Moderate Risk	6	Low Risk	3	No Change in Risk Score	Mrs Jaine Jennings (BG) 31/07/2023 16:46:50
2457	Divisional Risk	Capacity and Demand	Obstetric	Miss Sarah McManus	Mrs Sharon Hyde	Women and Children	There is a risk of poor patient experience due to postponing over listed elective caesarean sections	10/03/2023	10/01/2024	Moderate Risk	6	Low Risk	4		Mrs Jaine Jennings (BG) 31/07/2023 16:52:18
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	31/10/2023	Moderate Risk	9	Moderate Risk	6	New Risk	Marie Dooley 06/09/2023 09:23:01
Compliance (with standards/mandatory or legislative)															
2473	Divisional Risk	Compliance (with standards/mandatory or legislative)	Obstetric	Miss Sarah McManus	Mrs Zoe Turner	Women and Children	There is a risk that the CNST compliance for PROMPT will not be achieved due to the dates of the Junior Doctors strike.	30/03/2023	30/09/2023	Moderate Risk	6	Low Risk	3		Mrs Jaine Jennings (BG) 03/07/2023 11:39:44
COSHH related (Control of Substances Hazardous to Health)															
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
Environment															
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
Equipment															
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	02/10/2023	Moderate Risk	6	Low Risk	3		Mrs Catherine Anne Toksoy 16/06/2023 13:17:59
Information Governance Risk															
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	12/11/2023	Moderate Risk	6	Low Risk	4	New Risk	Marie Dooley 06/09/2023 09:23:58
IT Systems															
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.	30/08/2022	16/09/2023	Moderate Risk	9	Low Risk	3		Mrs Jaine Jennings (BG) 04/09/2023 10:43:05
2263	Divisional Risk	IT Systems	Obstetric	Stephanie Bray	Mrs Sharon Hyde	Women and Children	Risk of previously issued CC numbers being re-issued to babies at birth	23/05/2022	16/09/2023	Moderate Risk	6	Low Risk	3	Decrease in Risk Score	Mrs Jaine Jennings (BG) 04/09/2023 10:44:45
Medication Related															
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	29/11/2023	Moderate Risk	6	Moderate Risk	6	New Risk	Marie Dooley 05/09/2023 13:54:10
Security (including Lone Worker, Security Audit, Violence & Aggression)															
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	23/09/2023	Moderate Risk	6	Moderate Risk	6	No Change in Risk Score	Mrs Jaine Jennings (BG) 31/07/2023 16:38:23
Staffing															
2565	Divisional Risk	Staffing	Obstetric	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	06/12/2023	Moderate Risk	12	Moderate Risk	6	New Risk	Marie Dooley 06/09/2023 09:23:26

Safety Action 9
4) Report on training compliance in line with core competency framework

NHS Stockport NHS Foundation Trust

Core Competency Number	Core Competency	Type of Training	May - August 2023 (Submit to LMNS by 29.9.23)
1	SBL		**Percentage of staff compliant**
	Element 1 : Smoking	Face to face training	Midwives 64% Obstetricians 84%
		NCSCT E-learning	Midwives 85% Obstetricians 45%
		Risk Perception Training for ANC staff	Training TBA
	Element 2 : Fetal Growth Surveillance	E-learning for Health Module	Midwives 85% Obstetricians 45%
		Serial Fundal Height Face to face training and competency	Midwives 76% Obstetricians 100%
		Face to face training	Midwives 94% Obstetricians 93%
	Element 3: Reduced Fetal Monitoring	E-learning for Health module	Midwives 85% Obstetricians 45%
		Face to face training	Midwives 94% Obstetricians 93%
	Element 4: Fetal monitoring	see Core Competency 2	
	Element 5 : Preterm Birth	E-learning for Health module	Midwives 85% Obstetricians 45%
		face to face training	Midwives 94% Obstetricians 93%
	Element 6 : Diabetes in Pregnancy	Face to face training	Midwives 83%
2	Fetal Monitoring GMEC Package: Full day Fetal monitoring training to include CTG, Antenatal and Intermittent Auscultation	Face to face training	Midwives 94% Obstetricians 93%
	CTG competency	GMEC Competency document	Midwives 93% Obstetricians 66%
	Intermittent Auscultation Competency	GMEC Competency document	Midwives 55% Obstetricians NA
3	Maternity Emergencies - Multidisciplinary Team - Full day	Face to face training	Midwives 91% Obstetricians 97% Anaesthetics 84% Other 86%
4	Equality, Equity and Personalised Care	Face to face training	Midwives 91% Obstetricians 97% Other 86%
5	Care during Labour and Immediate Postnatal Period	Face to face training	Midwives 91% Obstetricians 97% Other 86%
6	Neonatal Basic Life Support	Face to face training	Midwives 91%

Safety Action 9
5) Minimal staffing overview

NHS Stockport NHS Foundation Trust

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

Current Maternity position

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

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 20.81wte, in addition to this there is currently a gap of 5.4 wte on Maternity leave (due back April 24 – June 24). This equates to a total deficit of 26.21wte.

Actions

- Weekly planned roster scrutiny meetings/E.Roster training sessions - continue
- Rolling advert for Band 5/6 midwives – ongoing rolling advert and interviews planned for 6/9/23

Assurance

- All shift coordinators have supernumerary status.
- July it is showing we achieved 97.4% 1 to 1 care in labour (2BBA, precipitate birth, 1 short staffing, 1 no reason given) as reported via euroking
- Maternity Red Flags monitored and reported through division
- Fully engaged with Maternity support workers framework working group – Agreed uplift for B2 to B3 Maternity assistants (August 23)
- Funding extended until 23/24 for Recruitment and Retention Midwife
- Engaged with the International Educated Midwifery (IEM) recruitment programme, three IEMs recruited in 1st wave. 1 commenced in post, 2nd awaiting pin number
- The Trust has applied for further funding for 2 IEMs to be appointed to Stockport NHS Foundation Trust.

Stockport NHS Foundation Trust

MVNP Engagement

- New MVNP Chair appointed April 2023
- Monthly 1:1 with Deputy HOM
- MNVP Quarterly meetings represented by Exec and Non Exec Safety Champions, Maternity, Obstetric and Neonatal safety champions.
- Face to Face MVNP meeting planned for September 23
- MVNP Chair invited to Maternity and Perinatal safety champions meetings as standing agenda item and HSIB quarterly meetings
- Minutes or Patient Experience Group shared with MVNP chair

Working in Collaboration

- Inpatient welcome to ward leaflet/ antenatal aromatherapy leaflet – co produced
- Maternity Infographic shared monthly
- 15 Steps action plan ongoing – 15steps follow up walk round date to be confirmed
- Meetings with community matron to prioritise hearing the voices of women from Black, Asian and Minority ethnic backgrounds and women living in area's with high deprivation.
- Planning to meet with the neonatal ward manager to hear the voices of women and families of babies requiring support from the neonatal unit/team
- Explore opportunity to have a MVNP padlet which is accessible to all service users

Safety Action 9
7) Staff feedback from frontline champions and walk about

The Maternity and Perinatal Safety Champions walk rounds take place Bi-monthly. The next one is due to take place on 29th September 2023.

Andrew Loughney under took the walk round on Thursday 10th August 23
Area's visited

- Maternity and Neonatal unit visited excluding community
- Met with various Midwives and neonatal nurses
- M2 – Met with the ward manager

Discussions held regarding:

- Staffing challenges
- Everyone welcomed the discussions
- Environmental improvements recognised
- Use of space on M2

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 9

8) HSIB/NHSRCQC or other organisation with a concern or request for action made directly with the trust

- No reports for July/August

9) Coroner Regulation 28 made directly to the Trust

- No reports for July/August

Saving Babies Lives Care Bundle V3 (SBLCBv3)

NHS Stockport NHS Foundation Trust

Background

- The Saving Babies' Lives Care Bundle provides evidence based best practice, for providers and commissioners of maternity care across England to reduce perinatal mortality.
- Version 3 of the SBLCB was released on 1 June 2023, and builds on the SBLCBv1 (March 2016) and SBLCBv2 (March 2019)
- Stockport Maternity services successfully implemented all **5** elements of the SBLCBv2.
- Version 3 of the SBLCB builds on the achievements of previous iterations and includes a refresh of all existing elements, drawing on national guidance such as from NICE or RCOG Green Top Guidelines, and frontline learning to reduce unwarranted variation where the evidence is insufficient for NICE and RCOG to provide guidance.
- Version 3 includes a new, additional element on the management of pre-existing diabetes in pregnancy based upon data from The National Pregnancy in Diabetes (NPID) Audit. There are now 6 elements of care:

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

Saving Babies Lives Care Bundle V3 (SBLCBv3)

NHS Stockport NHS Foundation Trust

- 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 due 15th September
- SBLCBv3 also sets out a number of important wider principles to consider during implementation. These are not mandated by the care bundle but reflect best practice care and are recommended to be followed in conjunction with the 6 elements.

Midwifery Continuity of Carer (MCoC) Update July 2023

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.
- A small team providing enhanced MCoC to asylum seekers & Young parents specifically, also provide intrapartum support according to availability. The team plan their roster around the needs of their woman and families including on call for birth to increase the potential for MCOC throughout the pregnancy and postnatal period.

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

	MAY	June	July
Total Bookings	291	260	273
% Women in receipt of full MCOC	6%	10%	6%
Homebirths With MW in attendance With no MW in attendance	2.68% 5 2	4.70% 10 1	3.43% 2 3

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 plans have begun within community teams to align to the family hubs footprints. This is to enable both increased efficiency and more joined up and integrated care around vulnerable families within the community.
- 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 of the plan 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 the LMNS and GMEC developed The Maternity Equity & Equality Action Plan 2022-2027, we have commenced the process of benchmarking ourselves against the 5 priorities and inclusive recommendations, the action plan is currently being updated to reflect the changes.

  - Restore NHS services, following COVID pandemic
  - Mitigate against digital exclusion
  - Ensure datasets are complete and timely
  - Accelerate preventative programmes that engage those at greatest risk of poor health outcomes
  - Strengthen leadership

Progress so far

- In June 2022 we produced a Standing Operating Procedure (SOP) titled 'Reducing inequality in Black Asian and minority Ethnic communities during the perinatal period'
- Our service collects data on a monthly basis through the maternity data set system which enables mapping in relation to local deprivation utilising postcodes – to be reported on from October 23
- We have a community team leader taking the lead on equity & equality
- We have a Midwife working specifically and providing enhanced care to with asylum seeker families. The needs of these particularly vulnerable families is inclusive to the cultural & Diversity training for Midwifery which incorporates tackling unconscious bias, cultural sensitivity, and trauma informed care.
- We have recruited 3 International educated midwives, with funding to recruit a further two

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 infant parent service within Stockport family.
- Stockport NHS Foundation trust have adopted the GMEC Perinatal Mental Health Guideline
- A screening tool comprising of a series of questions known as PHQ4 (Patient health questionnaire) is a universal offer within the booking procedure to identify current maternal depression & anxiety.
- Partners of women booked with poor mental health are signposted to Dad Matters or Stockport Talking therapies for additional psychological support.
- Families are prioritised within Stockport talking therapies for psychological support in the perinatal period
- Stockport fall within cluster 1 of the development of the specialist Community MH services which ensures complex need is managed appropriate
- Women have personalised plans
- The perinatal mental health team were recently recognised with a chief-nurse award for their 'Walk into wellbeing' initiative
- As a result of recent PN survey for dads there are plans in place to develop collaborative initiatives with dad matters that support the MH of partners, attachment relationships and bonding. This is part of the 1001 critical days initiative and will be focused on the most vulnerable families in the family Hubs early adopter areas

Collaborative working

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

Ockenden/East Kent Reports/Three year delivery plan

NHS Stockport NHS Foundation Trust

Ockenden Interim report (2020)

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

Regional Insights assurance visit (May 2022)

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

Final Ockenden report (2022)

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

East Kent Report (2022)

- 4 Key areas for action

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

Three-year delivery plan (March 2023)

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

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

North West Regional Maternity Strategy 2023-25

Stockport NHS Foundation Trust

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

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

Aim

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

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

Pregnancy Loss Review

NHS Stockport NHS Foundation Trust

Aim

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

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

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

Recommendations

The review has published 73 recommendations , which cover:

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

Pregnancy Loss Review

Stockport NHS Foundation Trust

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

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

Future Plan

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

Maternity 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

NHS Stockport NHS Foundation Trust

During August 2023 there were 12 maternity red flags reported via datix

Datix number 103374. Poor staffing across the unit resulting in a delay in performing an artificial rupture of membranes.
Datix number 103667. Missed medication due to incomplete cares prior to transfer to the ward.
Datix number 103982. Time critical category two emergency caesarean section delayed because of **acuity.**
Datix number 103989. Delay of over 48 hours for performing an artificial rupture of membranes due to **acuity.**
Datix number 103987. Unable to provide one to one care due to **staffing** and **acuity**.
Datix number 103990. Delay of commencing intravenous oxytocin due to **staffing** and **acuity**.
Datix number 103992. Delay of completing a caesarean section due to Obstetric Registrar being required to attend theatre 2 because of **acuity**.
Datix number 103994. Delay of over 48 hours for performing an artificial rupture of membranes due to **staffing and acuity.**
Datix number 103995. Delay of over 72 hours for performing an artificial rupture of membranes due to **staffing and acuity.**
Datix number 104201. Delay in performing an artificial rupture of membranes due to **staffing**.
Datix number 103996. Unable to provide one to one care due to **staffing** and **acuity.**
Datix number 104280. Unable to provide one to one care due to **staffing** and **acuity**.

Curtis,Soile 02/10/2023 07:32:55

2 incidents were reported as a result of staffing.
3 incidents were reported as a result of acuity.
6 were reported as both staffing and acuity.
1 incident was not as a result of staffing or acuity.

Maternity StARS overview

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.
The number signifies the first, second and third assessment overall result;

MATERNITY	Nov 22	Jan/Feb 23	May/June 23	August/Sept 23
M1 (DS)		1	2	3
M2	1	2	3	4
M3 (BC)		1	2	

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

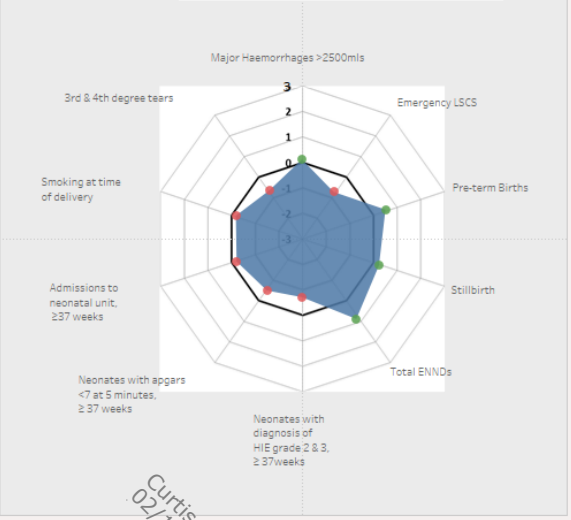
Stockport NHS Foundation Trust

Maternity Quality Surveillance | Updated: 22/08/23 | Provider Choice: Stockport

Lastest 12 months | Jul, 2022 to Jun, 2023

Stillbirth (per 1,000)	3.119
Early Neonatal Deaths (per 1,000)	0.313
HIE (per 1,000)	1.038
Maternal Deaths (per 1,000)	0.000

Further Maternity data available here



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	GM Avg	
Stillbirths		3.119
Total ENNDs		0.313
Maternal Deaths		0.000
Neonates with a diagnosis of HIE Grade 2 and ...		1.04
Apgars <7 at 5 minutes, ≥ 37 weeks		14.54
Major haemorrhages >2500mls		4.10
3rd & 4th degree tears		3.03
Admissions to neonatal unit, ≥37 weeks		5.12
Emergency LSCS		25.86
Pre-Term Births		9.58
Women smoking at time of delivery		7.83

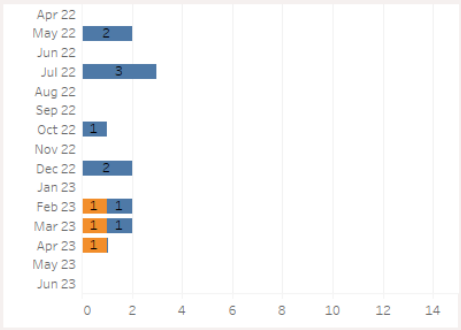
% Compliant:

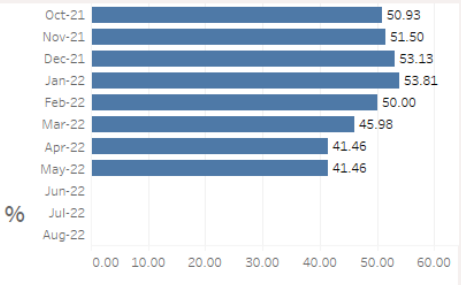
Element 1	100.0%	0.0%	0.0%
Element 2	100.0%	0.0%	0.0%
Element 3	100.0%	0.0%	0.0%
Element 4	100.0%	0.0%	0.0%
Element 5	100.0%	0.0%	0.0%

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

Total	
	10
	3

No. of StEIS/Divert INCIDENTS:





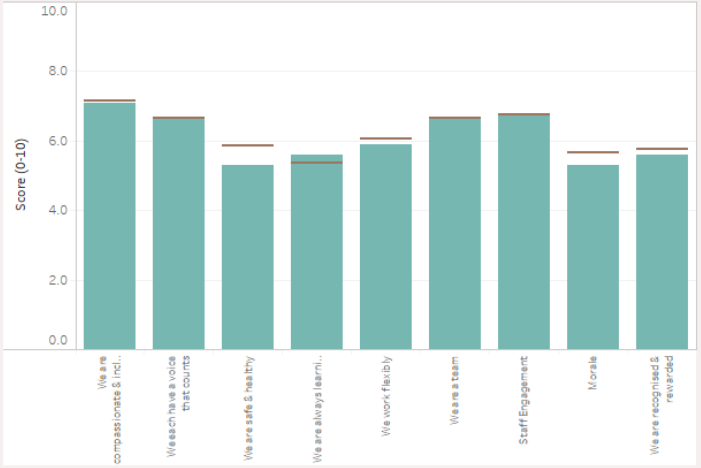
Care Quality Commission: Requires Improvement

NHS Resolution
CNST MIS Status (Year 3):
10

SURVEYS

Breakdown | Your Org

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



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

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

69%

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

GMEC CQC Maternity Survey

The Start of Your Care During Pregnancy	Antenatal Check-Ups	During Your Pregnancy	Your Labour and Birth	Staff Caring for You	Care in Hospital After Birth	Feeding Your Baby	Care at Home After Birth	Overall average
5.46	8.66	8.61	7.43	8.08	7.89	8.19	7.[illegible]	7.[illegible]

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Meeting date	26th September 2023	**Public**	X	**Confidential**	
Meeting	Quality Committee				
Report Title	Perinatal Mortality Review Tool (PMRT) April - June 2023				
Director Lead	Zoe Turner Director of Women and Children Division	**Author**	Amanda Lightbown Lead Bereavement Specialist Midwife Nicola Kempson Bereavement Specialist Midwife		

Paper For:	**Information**		**Assurance**	**X**	**Decision**	
Recommendation:	Quality Committee is asked to receive the quarterly Perinatal Mortality Review Tool (audit) as assurance that the Trust are meeting the standards set out in safety action 1 of the Maternity Incentive Scheme Year Five, and provide confirmation of progress to the Board.					

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

Executive Summary

Due to the recommendation that all perinatal mortality reviews are completed within six months of reporting, the Perinatal Mortality Review Tool report which is generated by MBRRACE will demonstrate that no reviews have been completed within the quarter that this report relates to (see below)

During quarter one the division have reported 3 cases to MBRRACE.

The 3 reported cases were termination of pregnancy for fetal abnormalities at 23+0, 23+3 & 24+3 weeks gestation.

The notifications were completed within the requirement of 7 working days.

Surveillance and PMRT review is not supported for these 3 cases following notification of termination of pregnancy.

This is in comparison to 8 cases reported in the same quarter in 2022.

4 cases were termination of pregnancy for fetal abnormalities at 22+5, 25+4, 28+1,37+1 weeks gestation.

1 case of NND at 21+5 weeks gestation.

3 cases of antepartum stillbirth at 25+1, 26+4, 39+4 weeks gestation.

Royal Oldham Hospital (ROH) reported one cases to MBRRACE where the mother booked at Stockport NHS FT. 05.04.23 NND of baby born at 24+4 weeks gestation on 23.03.23 at ROH. Primigravida booked for low risk care, referred to FMU Manchester following 20 week anatomy scan following identification of enlarged cystic kidney, enlarged heart and atypical shaped head. Attended Stockport NHS FT triage at 22+5 wks gestation with rupture of membranes, admitted to delivery suite and transferred to ROH. Stable and discharged from ROH at 24+1 with a plan to deliver at MFT with care at ROH until 28weeks. 24+4 attended triage with pain and spotting, in labour and proceeded to delivery. The booking & antenatal information has been completed as requested by ROH. A joint MDT PMRT review meeting date has been received from ROH.

To conclude of the cases reported during quarter 1 there are no reviews which require an MDT PMRT review. Three cases are not supported for a review in view of them not meeting the criteria as they are terminations of pregnancy. There is one neonatal death review which Stockport NHS Foundation Trust are responsible for reviewing jointly with Royal Oldham Hospital as the mother booked at Stockport NHS FT, this review is planned for 6.7.23.

1. Purpose

This paper provides evidence that the division are monitoring standards against safety action 1 of the Maternity Incentive Scheme Year Five.

The paper provides assurance to the Trust Board that all reportable fetal losses are notified to MBRRACE and reviewed by a multi-disciplinary team using the national standardised Perinatal Mortality Review Tool (PMRT)

2. Introduction / Background

Safety action 1 of the Maternity Incentive Scheme – year five asks:
Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

Required standard

a) All eligible perinatal deaths from should be notified to MBRRACE-UK within seven working days. For deaths from 30 May 2023, MBRRACE-UK surveillance information should be completed within one calendar month of the death.
b) For 95% of all the deaths of babies in your Trust eligible for PMRT review, parents should have their perspectives of care and any questions they have sought from 30 May 2023 onwards.
c) For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from 30 May 2023. 95% of reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed to the draft report stage within four months of the death and published within six months.
d) Quarterly reports should be submitted to the Trust Executive Board from 30 May 2023.

3. Matter under consideration

In view of the timing of the MBRRACE reports, each Trust quarterly report will include the report from the previous quarter for information. The following reports provide a summary and are generated directly from the PMRT data base following the mortality review.

PMRT - Perinatal Mortality Reviews Summary Report

This report has been generated following mortality reviews which were carried out using the national Perinatal Mortality Review Tool

Stockport NHS Foundation Trust

Report of perinatal mortality reviews completed for deaths which occurred in the period:

1/1/2023 to 31/3/2023

Summary of perinatal deaths*

Total perinatal* deaths reported to the MBRRACE-UK perinatal mortality surveillance in this period: *2*

Summary of reviews**

Stillbirths and late fetal losses				
Number of stillbirths and late fetal losses reported	Not supported for Review	Reviews in progress	Reviews completed ***	Grading of care: number of stillbirths and late fetal losses with issues with care likely to have made a difference to the outcome for the baby
4	2	0	2	0

Neonatal and post-neonatal deaths				
Number of neonatal and post-neonatal deaths reported	Not supported for Review	Reviews in progress	Reviews completed ***	Grading of care: number of neonatal and post-neonatal deaths with issues with care likely to have made a difference to the outcome for the baby
0	0	0	0	0

*Late fetal losses, stillbirths and neonatal deaths (does not include post-neonatal deaths which are not eligible for MBRRACE-UK surveillance) – these are the total deaths reported and may not be all deaths which occurred in the reporting period if notification to MBRRACE-UK is delayed. Deaths following termination of pregnancy are excluded.

** Post-neonatal deaths can also be reviewed using the PMRT

*** Reviews completed and have report published

Table 1: Summary information for the babies who died in this period and for whom a review of care has been completed – number of babies (N = 2)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
Late Fetal Losses (<24 weeks)	0	1	--	--	--	--	1
Stillbirths total (24+ weeks)	0	0	1	0	0	0	1
Antepartum stillbirths	*0*	*1*	*1*	*0*	*0*	*0*	*2*
Intrapartum stillbirths	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Timing of stillbirth unknown	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Early neonatal deaths (1-7 days)*	0	0	0	0	0	0	0
Late neonatal deaths (8-28 days)*	0	0	0	0	0	0	0
Post-neonatal deaths (29 days +)*	0	0	0	0	0	0	0
Total deaths reviewed	0	1	1	0	0	0	2
Small for gestational age at birth:							
IUGR identified prenatally and management was appropriate	0	0	0	0	0	0	0
IUGR identified prenatally but not managed appropriately	0	0	0	0	0	0	0
IUGR not identified prenatally	0	0	0	0	0	0	0
Not Applicable	0	1	1	0	0	0	2
Mother gave birth in a setting appropriate to her and/or her baby's clinical needs:							
Yes	0	1	1	0	0	0	2
No	0	0	0	0	0	0	0
Missing	0	0	0	0	0	0	0
Parental perspective of care sought and considered in the review process:							
Yes	0	1	1	0	0	0	2
No	0	0	0	0	0	0	0
Missing	0	0	0	0	0	0	0
Booked for care in-house	0	0	0	0	0	0	0
Mother transferred before birth	0	0	0	0	0	0	0
Baby transferred after birth	0	0	0	0	0	0	0
Neonatal palliative care planned prenatally	0	0	0	0	0	0	0
Neonatal care re-orientated	0	0	0	0	0	0	0

*Neonatal deaths are defined as the death within the first 28 days of birth of a baby born alive at any gestational age; early neonatal deaths are those where death occurs when the baby is 1-7 days old and late neonatal death are those where the baby dies on days 8-28 after birth. Post-neonatal deaths are those deaths occurring from 28 days up to one year after birth

Table 2: Placental histology and post-mortems conducted for the babies who died in this period and for whom a review of care has been completed – number of babies (N = 2)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
Late fetal losses and stillbirths							
Placental histology carried out							
Yes	0	1	0	0	0	0	1
No	0	0	1	0	0	0	1
Hospital post-mortem offered	0	1	1	0	0	0	2
Hospital post-mortem declined	0	0	1	0	0	0	1
Hospital post-mortem carried out:							
Full post-mortem	0	1	0	0	0	0	1
Limited and targeted post-mortem	0	0	0	0	0	0	0
Minimally invasive post-mortem	0	0	0	0	0	0	0
External review	0	0	0	0	0	0	0
Virtual post-mortem using CT/MR	0	0	0	0	0	0	0
Neonatal and post-neonatal deaths:							
Placental histology carried out							
Yes	0	0	0	0	0	0	0
No	0	0	0	0	0	0	0
Death discussed with the coroner/procurator fiscal	0	0	0	0	0	0	0
Coroner/procurator fiscal PM performed	0	0	0	0	0	0	0
Hospital post-mortem offered	0	0	0	0	0	0	0
Hospital post-mortem declined	0	0	0	0	0	0	0
Hospital post-mortem carried out:							
Full post-mortem	0	0	0	0	0	0	0
Limited and targeted post-mortem	0	0	0	0	0	0	0
Minimally invasive PMpost-mortem	0	0	0	0	0	0	0
External review	0	0	0	0	0	0	0
Virtual post-mortem using CT/MR	0	0	0	0	0	0	0
All deaths:							
Post-mortem performed by paediatric/perinatal pathologist*							
Yes	0	1	0	0	0	0	1
No	0	0	0	0	0	0	0
Placental histology carried out by paediatric/perinatal pathologist*:							
Yes	0	1	0	0	0	0	1
No	0	0	0	0	0	0	0

*Includes coronial/procurator fiscal post-mortems

Table 3: Number of participants involved in the reviews of late fetal losses and stillbirths without resuscitation

Role	Total Review sessions	Reviews with at least one
Chair	2	100% (2)
Vice Chair	2	100% (2)
Admin/Clerical	0	0%
Bereavement Team	1	50% (1)
Community Midwife	0	0%
External	1	50% (1)
Management Team	0	0%
Midwife	8	100% (2)
Neonatal Nurse	0	0%
Neonatologist	0	0%
Obstetrician	5	100% (2)
Other	0	0%
Risk Manager or Governance Team	4	100% (2)
Safety Champion	0	0%

Table 4: Number of participants involved in the reviews of stillbirths with resuscitation and neonatal deaths

Role	Total Review sessions	Reviews with at least one
Chair	0	0%
Vice Chair	0	0%
Admin/Clerical	0	0%
Bereavement Team	0	0%
Community Midwife	0	0%
External	0	0%
Management Team	0	0%
Midwife	0	0%
Neonatal Nurse	0	0%
Neonatologist	0	0%
Obstetrician	0	0%
Other	0	0%
Risk Manager or Governance Team	0	0%
Safety Champion	0	0%

Table 5: Grading of care relating to the babies who died in this period and for whom a review of care has been completed – number of babies (N = 2)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
STILLBIRTHS & LATE FETAL LOSSES							
Grading of care of the mother and baby up to the point that the baby was confirmed as having died:							
A - The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died	0	0	1	0	0	0	1
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	1	0	0	0	0	1
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the mother following confirmation of the death of her baby:							
A - The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby	0	1	1	0	0	0	2
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
NEONATAL AND POST-NEONATAL DEATHS							
Grading of care of the mother and baby up to the point of birth of the baby:							
A - The review group concluded that there were no issues with care identified up the point that the baby was born	0	0	0	0	0	0	0
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the baby from birth up to the death of the baby:							
A - The review group concluded that there were no issues with care identified from birth up the point that the baby died	0	0	0	0	0	0	0
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the mother following the death of her baby:							
A - The review group concluded that there were no issues with care identified for the mother following the death of her baby	0	0	0	0	0	0	0
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0

Table 6: Cause of death of the babies who died in this period and for whom a review of care has been completed – number of babies (N = 2)

Timing of death	Cause of death
Late fetal losses	**1 causes of death out of 1 reviews**
	Fetal vascular malperfusion Hyper coiled cord
Stillbirths	**1 causes of death out of 1 reviews**
	Congenital CMV infection.
Neonatal deaths	**0 causes of death out of 0 reviews**
Post-neonatal deaths	**0 causes of death out of 0 reviews**

Table 7:Issues raised by the reviews identified as relevant to the deaths reviewed, by the number of deaths affected by each issue* and the actions planned

Issues raised which were identified as relevant to the deaths	Number of deaths	Actions planned

*Note - depending upon the circumstances in individual cases the same issue can be raised as relevant to the deaths reviewed and also not relevant to the deaths reviewed.

Table 8: Issues raised by the reviews which are of concern but not directly relevant to the deaths reviewed, by the number of deaths in which this issue was identified* and the actions planned

Issues raised which were identified as not relevant to the deaths	Number of deaths	Actions planned
The baby had to be transferred elsewhere for the post-mortem	1	No action entered
This mother booked late. Are there any organisations to consider in relation to her booking late?	1	No action entered
This mother booked late. Did this affect her care?	1	No action entered
This mother lives with family members who smoke but they were not offered referral to smoking cessation services because there is no service available	1	No action entered

*Note - depending upon the circumstances in individual cases the same issue can be raised as relevant to the deaths reviewed and also not relevant to the deaths reviewed.

Table 9: Top 5 contributory factors related to issues identified as relevant to the deaths reviewed, by the frequency of the contributory factor and the issues to which the contributory factors related

Issue Factor	Number of deaths	Issues raised for which these were the contributory factors

23rd January 2023 – 23+4 week gestation late fetal loss

Booked at East Cheshire Hospital, booked as shared care. Smoker at booking – referral made to Smoking Cessation Midwife. 23+1 wks- attended maternity triage department reporting reduced fetal movements for 3 days. Fetal death in utero confirmed by ultrasound scan. Normal vaginal delivery, birth weight 420g, 0.8 centile.

Following the review which took into account the information from the post-mortem, placental histology and other investigations the cause of death of the baby was determined to be:
Fetal vascular malperfusion, Hyper coiled cord

Grading of care of the mother and baby up to the point that the baby was confirmed as having died:

B

The review group identified care issues which they considered would have made no difference to the outcome for the baby. The review group felt that there was a delay in an obstetric review on the maternity triage admission following the midwife being unable to auscultate the fetal heart. It was noted that the midwife escalated to Delivery suite on 2 occasions after contacting the Registrar on call and took into consideration the impact of this on Charlotte and Jason at an emotionally distressing time.

Grading of care of the mother following confirmation of the death of her baby:

A

The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby.

MDT PMRT review was undertaken jointly with East Cheshire. Review complete and debrief date arranged with Consultant for 14.7.23.

18th February 2023 – 25+0 week gestation antepartum stillbirth

Booked appropriately for Midwifery led care, too late for 1st trimester screening, low chance Trisomy 21 on Quad test. Smoker at the time of booking, referral made to smoking cessation. Abnormalities identified at 20+5 week anatomy scan and referred to FMU Manchester. Amniocentesis result - CMV infection, informed of result by FMU and wished for time to consider options therefore follow up planned with FMU. Prior to this follow up appointment at 24+5 wks gestation - attended maternity triage with abdominal pain and 1st episode of reduced fetal movements for 1 week. Fetal death in utero confirmed by ultrasound scan. Normal vaginal delivery, birth weight 330g, 0 centile.

Post-mortem and placental histology findings:
Not sent in view of positive CMV result of amniocentesis

Cause of death:
Congenital CMV infection

Grading of care of the mother and baby up to the point that the baby was confirmed as having died: A – The review group concluded that there were no issues with care identified up to the point that the baby was confirmed as having died

Grading of care of the mother following confirmation of the death of her baby: A - The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby.

MDT PMRT review was undertaken with an external reviewer. Review is complete and a debrief date has been requested with consultant.

In summary during quarter 4 2022/2023 there were 4 fetal losses reported to MBRRACE. This is in comparison to 2 antepartum stillbirths (24-31week gestation) reported in the same quarter the previous year. For this quarter 2 reviews were not supported as they did not meet the criteria in view of being termination of pregnancies at 23 & 35 week gestation. 2 reviews have been completed for a 23+4 week late fetal loss and a 25+0 week stillbirth.
2 NND cases were reported by MFT in this period for which Stockport NHS FT were the booking hospital. Invite to a joint PMRT review is awaited from MFT for these cases.

4. Recommendations

4.1 Quality Committee is asked to note the contents of the report and the Trusts progress against Safety action 1of the Maternity Incentive Scheme Year Five

NHS
Stockport
NHS Foundation Trust

KEY ISSUES REPORT	
Name of Committee/Group	Audit Committee
Chair of Committee/Group	David Hopewell, Non-Executive Director
Date of Meeting	19th September 2023
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
Audit Committee Terms of Reference	The Committee reviewed the minor changes to the terms of reference that were previously presented to the July Audit Committee. These were specifically in reference to the Audit Committee's role and responsibilities in the appointment process of the internal auditor and external auditor. The Committee were assured that these had been updated in line with the Code of Governance and were comparable to other Trusts. The Committee approved the amended terms of reference to be presented to the Board of Directors (Appendix 1).
Risk Management Committee Report	The Committee received: • a report on the work of the Risk Committee • a list of significant risks at July 2023. The Committee received additional assurances on risk 2234 relating to increased mortality on ward E3 and that this was being followed up with the Patient Safety Group. The Committee received assurance on risk 1004 that Trust is in breach of the Regulatory Reform (Fire Safety) Order 2005 and that the explanation of the risk would be updated to reflect current status.
Internal Audit 2023/24 Plan Progress Report	The Committee received: • Internal Audit 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. Follow up actions on recommendations relate largely to the IT Audit report and are being tracked by the IT auditor. The Quality Spot Check report received substantial assurance. No patient harms issues were reported and there was good engagement and drive from the nursing team to deliver the recommended actions. The report will be fed back to the Quality Committee for review of the recommendations on nutritional care.

Anti-Fraud Progress Report	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 July – September 2023. The Committee received clarification on the progress and deadlines on the National Fraud Initiative duplicated payment exercise.
External Audit Progress Report	The Committee received an External Audit Progress Report for 2023/24 which confirmed closure of the 2022/23 Annual Accounts process. The Committee noted the positive feedback from the External Audit presentation at the Council of Governors meeting in September. The Committee received assurance that the Charity Independent Examination was scheduled for completion by November 2023. The Committee also noted the update from Mazars on national publications issued for advice with specific mention of the NAO Good Practice Guide – Quality Assurance of Models: A guide for audit committees.
Board Assurance Framework Review	The Audit Committee reviewed the Board Assurance Framework (BAF) for 2023/24. The Committee were assured that the process for review of the BAF was working well. The Internal Audit Plan had been developed for the year as a risk based plan, is appropriately reviewed throughout the year and emerging risks are reported through Audit Committee.
Arrangements by which Staff Can Raise Issues	The Committee received report on the mechanisms by which staff can raise concerns. It was assured of the Trust's compliance with the National Raising Concerns reporting policy and the work of the Freedom to Speak Up Guardian to develop further support in the organisation. It was also confirmed that a detailed report on this matter had been considered by the People Performance Committee.
Any Other Business	The Audit Committee noted that its February and May meetings will consider key issues relating to and approval of the Annual Accounts and Report for 2023/24. It was agreed that both will be in person meetings.

NHS Stockport NHS Foundation Trust

AUDIT COMMITTEE

TERMS OF REFERENCE

1. CONSTITUTION

1.1. The Board of Directors hereby resolves to appoint a Committee, to be known as the Audit Committee (the Committee).

1.2 It shall have terms of reference and powers delegated by the Board of Directors and is subject to such conditions, such as reporting to the Board of Directors, in accordance with any legislation, regulation or direction issued by the Trust.

1.3 The Audit Committee will provide report to the Council of Governors identifying any matters in respect of which it considers that action of improvement is needed and recommendation as to the action to be taken.

2. PURPOSE OF THE COMMITTEE

The overarching purpose of Audit Committee is to:

2.1 review the establishment and maintenance of an effective system of governance, and internal control, including risk management, across the whole of the organisation's activities (both clinical and non-clinical);

2.2 ensure there is an effective internal audit function established which provides appropriate independent assurance to the Committee;

2.3 review the findings of the External Auditor, as appointed by the Council of Governors, as part of its delegated authority from the Board of Directors and consider the implications and management's responses to their work;

2.4 review and approve for audit the annual report (including Annual Governance Statement), annual accounts and financial statements as part of its delegated responsibility from the Board.

3. COMPOSITION & CONDUCT OF THE COMMITTEE

3.1 Membership

3.1.1 Membership will comprise:

- A non-executive director who should have relevant financial experience and should be appointed Chair of the Committee by the Board.
- In addition to the Chair, at least three non-executive directors, to include the Chair of each of the Trust's Board assurance committees.

3.1.2 All statutory non-executive directors, except for the Chair, are authorised to attend as members of

the Audit Committee.

3.1.3 The Chair of the Foundation Trust shall neither chair nor be a member of the Committee but can attend meetings by invitation of the Chair of the Committee.

3.1.4 There is an expectation that the membership will attend all Committee meetings during the financial year. Individual attendance levels will be monitored by the Chair of the Committee who will take appropriate measures should attendance be less than 75%.

3.1.5 The following shall attend the Committee meetings on a regular basis:

- Chief Executive
- Chief Finance Officer
- Director of Finance
- Associate Director of Finance (Financial Services)
- Company Secretary
- A representative of the Internal Auditors
- A representative of the External Auditors
- Counter-Fraud Lead

3.1.5 Executive Directors and/or senior leaders shall be invited to attend those meetings in which the Audit Committee will consider areas of risk or operation that are their responsibility.

3.2. Chair

3.2.1 The Chair of the Committee will be a Non-Executive Director with relevant financial experience.

3.2.2 Another Non-Executive Director will deputise as the Chair of the Committee in the Chair's absence.

3.3 Quorum

3.3.1 A quorum will consist of at least two independent non-executive directors.

3.3.2 Members withdrawing from the meeting owing to a conflict of interest shall no longer count towards a quorum.

3.3.3 However, at the discretion of the Chair, matters and decisions deemed urgent may proceed within the absence of a quorum with any actions from that meeting being confirmed at the next full meeting.

3.4 Notice of meeting

3.4.1 Before each meeting, a notice of the meeting specifying the business proposed to be transacted and supporting papers for the business expected shall be sent by electronic mail to the usual place of business of each member, to be available at least five clear days before the meeting.

3.4.2 The Chair of the Committee may, at their discretion, allow additional agenda items and papers to be circulated after the notice of the meeting.

3.5 Frequency of meetings

3.5.1 Meetings shall be held at least five times per year, with additional meetings where necessary.

3.5.2 The External Auditor and Internal Auditor shall have the opportunity at least once per year to meet with the Audit Committee without executive directors present.

3.5.3 The Chair may at times convene additional meetings of the Committee to consider business that requires urgent attention.

3.6. Administration

3.6.1 The Trust Secretary will ensure appropriate administrative arrangements are in place and that minutes are recorded, confirmed and appropriately archived from each meeting.

4. DELEGATED AUTHORITY

The Audit Committee is authorised by the Board of Directors to:

4.1 Investigate any matter within these terms of reference.

4.2 Seek information from any Director, officer, or employee; and all Directors, officers and employees are directed to extend the fullest co-operation to the Committee in the discharge of its functions.

4.3 Within the procedures approved by the Board, obtain outside legal or other independent professional advice. The Committee is authorised by the Board of Directors to request the attendance of individuals and authorities from outside the Foundation Trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions.

5. RESPONSIBILITIES

5.1 Integrated governance, risk management and internal control

5.1.1 To review provision of an effective system of integrated governance, including systems for risk management and clinical audit, and internal control aligned to the overall governance agenda.

5.1.2 To maintain oversight of the Trust's risk management structures, processes and responsibilities, including the production and issue of any risk and control-related disclosure statements.

5.1.3 To review processes to ensure appropriate information flows to the Audit Committee from executive management and other Board Committees in relation to the Trust's overall internal control and risk management.

5.1.4 To review the adequacy of underlying assurance processes that indicate the degree of achievement of corporate objectives and the effectiveness of the management of principal risks. In respect of the controls in place to manage risks recorded on the Board Assurance Framework, each Board Committee (through its Chair) shall report regularly to the Audit Committee.

5.1.5 To review the adequacy of arrangements by which staff can raise issues in confidence about possible improprieties in matters of financial reporting and control and related matters or any other matters of concern.

5.1.6 To review the adequacy of the policies and procedures in respect of all local counter-fraud services work.

5.1.7 To review the adequacy of policies and procedures for ensuring compliance with relevant regulatory,

legal and code of conduct requirements.

5.2 Internal Audit & Counter Fraud

5.2.1 To review and approve the internal audit strategy and programme, ensuring that it is consistent with the needs and priorities of the organisation.

5.2.2 To consider the provision of the Internal Audit service and the costs involved (and make a recommendation to the Board of Directors for award of contract where required).

5.2.3 To oversee on an on-going basis the effective operation of internal audit in respect of:
- Adequate resourcing;
- Co-ordination with external audit;
- Meeting relevant internal audit standards;
- Providing adequate independence assurances;
- Having appropriate standing within the Foundation Trust; and
- Meeting the internal audit needs of the Foundation Trust.

5.2.4 To consider the findings of internal audit investigations and management's response and their implications and monitor progress on the implementation of recommendations.

5.2.5 To evaluate performance of the internal audit service against relevant key performance indicators on an annual basis.

5.2.6 Receive the Head of Internal Audit Opinion

5.2.7 To review and approve the Trust's annual counter-fraud workplan, ensuring that it is consistent with the needs of the organisation.

5.2.8 To satisfy itself that the organisation has adequate arrangements in place for anti-fraud, bribery and corruption that meets the NHS Counter Fraud Authority's (NHS CFA) standards. In doing so, the Audit Committee will refer any suspicious of fraud, bribery and corruption to the NHS CFA via its Counter-Fraud Specialist.

5.3 External Audit

5.3.1 To oversee the appointment of the external auditor, including the conduct of a market testing exercise at least once every ten years and, based on the outcome, make a recommendation to the Council of Governors for award of contract.

5.3.2 To assess the external auditor's work and fees in line with the contract award, and based on this assessment, make the recommendation to the Council of Governors with respect to the re-appointment or removal of the auditor. This assessment should include the review and monitoring of the external auditor's independence and objectivity and effectiveness of the audit process in light of relevant professional and regulatory standards.

5.3.3 To discuss with the external auditor, before the audit commences, the nature and scope of the audit, and ensure co-ordination, as appropriate, with other external auditors in the local health economy.

5.3.4 To review all external audit reports, including the 'auditor's annual report', together with the management response, and to monitor progress on the implementation of recommendations.

5.3.5 To develop and implement a policy on the engagement of the external auditor to supply non-audit services.

5.3.6 To consider the provision of the external audit service, the cost of the audit and any questions of resignation and dismissal of the auditors.

5.3.7 To ensure mechanisms are in place to engage with the external auditor out with the Audit Committee as maybe required.

5.4 Annual Report & Accounts

5.4.1 To review and approve for audit the Annual Accounts, before they are presented to the Board of Directors, in order to determine their completeness, objectivity, integrity and accuracy. This review will cover but is not limited to:

- The meaning and significance of the figures, notes and significant changes;
- Areas where judgment has been exercised;
- Adherence to accounting policies and practices;
- Explanation of estimates or provisions having material effect;
- The schedule of losses and special payments;
- Any unadjusted statements; and
- Any reservations and disagreements between the external auditors and management which have not been satisfactorily resolved.

5.4.2 To review and approve for audit the Annual Report and Annual Governance Statement, before they are presented to the Board of Directors, to determine completeness, objectivity, integrity and accuracy.

5.4.3 To review accounting and reporting systems on a cyclical basis for reporting to the Board of Directors, including in respect of budgetary control.

5.5 Scheme of Reservation & Delegation, Standing Financial Instructions and Standards of Business Conduct

5.5.1 To review on behalf of the Board of Directors the operation of, and proposed changes to, the Standing Orders, Scheme of Reservation & Delegation and Standing Financial Instructions.

5.5.2 To examine the circumstances of any significant departure from the requirements of any of the foregoing, and whether those departures relate to a failing, an overruling or a suspension.

5.5.3 To monitor the implementation of policy of the Standards of Business Conduct and Codes of Conduct, on behalf of the Board of Directors.

5.6 Other

5.6.1 To examine any other matter referred to the Audit Committee by the Board of Directors and to initiate investigation as determined by the Audit Committee.

5.6.2 To review each year the accounting policies of the Foundation Trust and make appropriate recommendations to the Board of Directors.

5.6.3 Review and approve the Annual Report, Work Plans and Terms of Reference of any group/committee that reports directly to the Committee.

5.6.4 To consider the outcomes of significant reviews carried out by other bodies which include but are not limited to regulators and inspectors within the health and social care sector and professional bodies with responsibilities that relate to staff performance and functions.

6. RELATIONSHIP WITH THE BOARD OF DIRECTORS

6.1 The Committee will report to the Board of Directors by means of a Key Issues Report summarising business conducted by the Committee together with key actions and/or risks.

6.2 The Key Issues Report will be forwarded to the Board of Directors following each Committee meeting.

7. RELATIONSHIP WITH OTHER GROUPS

7.1 The Committee will receive reports, in the form of Key Issues Reports, from the following:
- Risk Management Committee

8. REVIEW

8.1 The Committee will review its terms of reference and membership annually and recommend any changes to the Board of Directors for approval.

8.2 The Committee will review the effectiveness and performance of the Committee on an annual basis and report the outcome to the Board of Directors.