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BOARD OF DIRECTORS

MEETING HELD IN PUBLIC

6 APRIL 2023

Making a difference every day.

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NHS Stockport NHS Foundation Trust

Board of Directors Public Meeting
Thursday, 6 April 2023
Held at 09.30am at Pinewood House Education Centre
(This meeting is recorded on Webex)

AGENDA

Time			Enc	Presenting
09.30	**1.**	Apologies for absence		
	2.	Declaration of Interests		**All**
	3.	Staff Story		**Jade Lowe, Staff Nurse, Neonatal Intensive Care Unit**
	4.	Minutes of Previous Meeting – held on 2 February 2023	✓	**Chair**
	5.	Action Log	✓	**Chair**
09.40	**6.**	Chair's Report	✓	**Chair**
09.50	**7.**	Chief Executive's Report	✓	**Chief Executive**
	8.	**Performance**		
10.00	8.1	Integrated Performance Report • Quality • Operational Performance • Workforce • Finance	✓	**Chief Executive / Executive Directors**
	9.	**People**		
10.40	9.1	NHS Staff Survey	✓	**Director of People & Organisational Development**
10.55		**COMFORT BREAK**		
	10.	**Strategy**		
11.05	10.1	Green Plan: Progress Report	✓	**Director of Estates & Facilities**
	11.	**Governance**		
11.20	11.1	Board Assurance Framework Q4 - 2022/23	✓	**Chief Executive**
11.30	11.2	Board of Directors Standards of Business Conduct including: • Annual Fit & Proper Person • Declarations of Interests • Non-Executive Director Independence	✓	**Trust Secretary**

11.40	11.3	Annual Review of Foundation Trust Code of Governance	✓	**Trust Secretary**
11.50	11.4	Annual Trust Seal Report	✓	**Trust Secretary**
12.00	11.5	Board Committees Annual Review: Including Terms of Reference and Work Plans for approval	✓	**Trust Secretary**
	12.	**Standing Committee Reports**		
12.10	12.1	Board Committees – Key Issues & Assurance Reports: • Finance & Performance Committee • People Performance Committee • Quality Committee: - *Including Local Maternity and Neonatal Systems (LMNS) Submission* • Audit Committee: - *Including Policy for the Approval of Non-Audit and Additional Services by the Trust's External Auditors*	✓	**Non-Executive Director Committee Chairs**
	13.	**Closing Matters**		
	13.1	Any Other Business		
	14.	**Date, Time & Venue of Next Meeting**		
	14.1	Thursday, 1 June 2023, 9.30am, Pinewood House Education Centre		
	14.2	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".*		
12.30		**Close**		

STOCKPORT NHS FOUNDATION TRUST

Minutes of the meeting of the Board of Directors held in public on Thursday, 2 February 2023 9.30am in Lecture Theatres, Pinewood House, Stepping Hill Hospital

Present:

Prof T Warne	Chair
Dr S Anane	Non-Executive Director
Mr A Bell	Non-Executive Director
Mrs A Bromley	Director of People & OD
Mrs N Firth	Chief Nurse
Mrs B Fraenkel	Non-Executive Director
Mr J Graham	Chief Finance Officer / Deputy Chief Executive
Mr D Hopewell	Non-Executive Director
Dr M Logan-Ward	Non-Executive Director / Deputy Chair
Dr A Loughney	Medical Director
Mr J O'Brien	Director of Strategy & Partnerships
Dr L Sell	Non-Executive Director
Mr M Vadiya	Associate Non-Executive Director *

** indicates a non-voting member*

In attendance:

Mrs S Curtis	Deputy Company Secretary
Ms L Gammack	Deputy Director of Organisational Development
Mrs R McCarthy	Trust Secretary
Ms C Woodford	Deputy Director of Operations
Ms J Shaliwal	Paediatric Nurse *(for the Staff Story)*

Observing:

Mrs S Alting	Lead Governor
Ms M Gill-West	Partnership Manager, Xyla Elective Care

1/23 Apologies for Absence

Apologies for absence were received from Mrs Karen James (Chief Executive), Mrs Jackie McShane (Director of Operations), Mrs Mary Moore (Non-Executive Director) and Mrs Caroline Parnell (Director of Communications & Corporate Affairs).

The Chair welcomed Board members and observers to the meeting.

2/23 Declaration of Interests

There were no declarations of interest.

3/23 Staff Story

The Board of Directors welcomed Ms Jessie Dhaliwal, Paediatric Nurse to the meeting. Ms Dhaliwal noted that she was passionate about finding ways to involve children and young people in their care and advised that she had come up with an idea of producing a child-friendly patient information booklet containing all the pieces of information that patients and families had highlighted that they wished they knew. The Board heard that a local publishing service had kindly offered to donate a wipeable booklet for each patient bed space at Treehouse, and that the booklet and the story behind it had also been published in Nursing Times.

Ms Dhaliwal commented that she continued to work with children and their parents to establish how further information and support could be created in a leaflet form. She also shared a "2023 My Vision and Goals" template with the Board, which she had created and which had been published on the Greater Manchester Integrated Care website.

In response to a question from a Non-Executive Director who queried if the information booklet was available in the community, the Board heard that it was currently only available in the Treehouse ward but the Trust would explore cascading it wider with the children's community team.

Board members thanked Ms Dhaliwal for the inspirational presentation and commended the information booklet and Ms Dhaliwal's continuing efforts to improve communication with young people and their families.

The Board of Directors:

- **Received and noted the staff story**

Ms Dhaliwal left the meeting

4/23 Minutes of the previous meeting

The minutes of the previous meeting of the Board of Directors held on 1 December 2022 were agreed as a true and accurate record of proceedings.

5/23 Action Log

The action log was reviewed and annotated accordingly.

6/23 Chair's Report

The Chair presented a report reflecting on recent activities within the Trust and the wider health and care system. He noted that he and the Chief Executive had been pleased to host a Christmas lunch for the Trust's volunteers.

The Chair highlighted challenges around finances and commented that managing financial resources next year would require the Trust to be extremely careful in deciding its priorities and how we work across Greater Manchester (GM) in securing the best value for money. He commented that this would inevitably mean that we might not be able to do all that had originally been planned for the next financial year,

and he sought the Board's support in championing the transformative work that would be necessary while trying to maintain positive staff morale during the challenging times.

The Board of Directors:

- **Received and noted the report**

7/23 Chief Executive's Report

The Deputy Chief Executive presented a report providing an update on local and national strategic and operational developments.

He briefed the Board on the content of the report and highlighted the following areas:

- NHS England's Operational Planning Guidance
- NHS England new Board appointments
- Industrial action
- Operational pressures
- Education partnership
- Endoscopy partnership
- Theatre upgrade
- Long Service Awards
- Chief Nursing Officer Award
- Chief Midwifery Officer Awards
- Deputy Finance Director of the Year

The Board of Directors congratulated all the staff members who had won the various prestigious awards.

The Board of Directors:

- **Received and noted the report**

8/23 Clinical Negligence Scheme for Trusts (CNST) Year 4 Maternity Incentive Scheme – Board Declaration

The Chief Nurse presented a report detailing the position of the Trust's maternity service in relation to the ten safety actions the Trust is required to meet as part of the Clinical Negligence Scheme for Trusts (CNST) Year 4 Maternity Incentive Scheme.

She briefed the Board on the content of the report and advised that on review of the standards and in line with the submission requirements of the Board Assurance Framework, the Trust would be compliant and/or working towards full compliance with nine out of ten of the safety standards. In addition, she confirmed the submission would be subject to the approval of the mitigation letter in relation to Safety Action 1 and action plans in relation to Safety Actions 4 and 6 detailed within the report. The Board heard that the Quality Committee had considered the report and recommended it to the Board for approval.

The Chief Nurse confirmed that submission of the Trust Board declaration form of compliance for CNST was due on 2 February 2023. She advised that following review of

the CNST Year 4 Maternity Incentive Scheme submission and Board declaration form, alongside Quality Committee recommendation of approval, the Chief Executive had confirmed she was assured and in agreement with the compliance submission and that her signature be applied to the Board declaration form. Furthermore, the Chief Executive had ensured that the Accountable Officer for the Integrated Care System is apprised of the Maternity Incentive Scheme safety actions' evidence and Board declaration form requirements.

In response to a question from an Associate Non-Executive Director regarding the partially compliant safety action, the Chief Nurse and Medical Director provided further clarity regarding partial compliance regarding completion of the National Perinatal Mortality review tool to review perinatal deaths, and highlighted the mitigations included in the letter appended to the report.

In response to a question from the Chair regarding next steps, the Chief Nurse and Director of Finance commented that the Trust anticipated receipt of the full financial payment, highlighting quality and safety as the key driver for compliance.

The Board of Directors:

- **Reviewed the Maternity Incentive Scheme Year 4 Report and supported the recommendation from Quality Committee to approve submission of the Trust Board declaration form.**

9/23 Integrated Performance Report

The Deputy Chief Executive introduced the Integrated Performance Report (IPR), which included exception reports for areas of most significant note. He highlighted the significant operational pressures experienced system-wide in December 2022, which had adversely impacted on performance.

QUALITY

The Medical Director and Chief Nurse presented the quality section of the IPR and highlighted performance and mitigating actions regarding mortality, sepsis, antibiotic administration, hospital onset Covid, Clostridium Difficile, pressure ulcers and complaints response rates due to under-achievement in month.

In response to a question from a Non-Executive Director regarding the rollout of revised electronic sepsis screening tool, the Medical Director briefed the Board on the anticipated impact of the revised tool, including earlier red flag alerts and escalation when antibiotics had not been administered.

In response to a question from a Non-Executive Director regarding the increasing complaints response rates, the Chief Nurse highlighted the key factor driving increased this, including adverse impact of sustained operational pressures, alongside increasingly complex complaints cases.

In response to a question from a Non-Executive Director about pressure ulcer targets, the Chief Nurse clarified that the targets in the report related to hospital acquired pressure ulcers but that work was ongoing to establish datasets for community. She

confirmed that all category 3 and 4 pressure ulcers were reviewed through the Serious Incident Group, regardless of whether they are hospital or community acquired.

OPERATIONAL

The Deputy Director of Operations presented the operational performance section of the IPR and highlighted the significant operational pressures and consequent adverse impact on the A&E, 6-week diagnostic, Cancer, Referral to Treatment (RTT), No Criteria to Reside (NCTR), elective activity including outpatients, and theatre efficiency metrics.

The Board heard that Emergency Department (ED) performance had deteriorated in December, although the Trust was still benchmarking best in Greater Manchester (GM) for type 1 ED attendances in month. The Deputy Director of Operations advised that the Trust had declared OPEL 4 in December under NHS Operational Pressure Escalation Levels (OPEL) system due to the significant operational pressures, and a consequent full debrief to learn from the event had taken place.

The Deputy Director of Operations highlighted continued issues with no criteria to reside, particularly with out of area discharges, and briefed the Board on mitigating actions. She advised that the forecast diagnostic performance remained consistent and on track to meet national improvement standards, the 62-day cancer performance remained at an improved level, and the 18-week performance remained relatively unchanged, although the longest waits continued to reduce. She was pleased to report that the Trust was performing the best in GM around cancer 2-week waits, despite increased GP referrals.

The Chief Finance Officer highlighted issues around bed occupancy rates and the financial impact of the unfunded escalation wards that had remained open, as well as workforce challenges to staff the wards. Board members commented on the need to ensure these issues were taken into account during the planning process for next year. The Chief Finance Officer also referred to the increase in ED attendances and the consequent impact on patient flow, noting that discussions continued with system partners to increase the community bed base and support in this area.

In response to a comment from an Associate Non-Executive Director about transformational work taking place to improve patient flow, the Deputy Director of Operations described key elements of the programme of flow, including review of processes in place and timely implementation of each stage to challenge the discharge position. The Medical Director commented that there had been great clinical and operational engagement in the process.

In response to a question from a Non-Executive Director about the longer term plan for using the Community Diagnostic Centre (CDC), the Director of Strategy & Partnerships briefed the Board on the CDC developments noting that a full business case would be presented to the Board in due course. He confirmed that the CDC was a longer term solution and would be a flexible programme so it could be expand as required.

A Non-Executive Director referred to the validation exercise that had removed 1,000 patients who no longer wanted an appointment from the outpatient waiting list and queried the consequent impact on the RTT standard. The Deputy Director of

Operations commented that the validation exercise had taken place in December therefore impact would be assessed at the time of the next report.

PEOPLE

The Director of People & Organisational Development (OD) presented the people section of the IPR and highlighted performance and mitigating actions around sickness absence, turnover, statutory & mandatory training, appraisal rates and bank & agency costs due to under performance in month. It was noted that workforce turnover was 14.8% against the 11% target and that the Attract, Develop & Retain group continued to support workforce retention initiatives.

In response to a question from a Non-Executive Director about staff turnover and work/life balance being a key reason for people leaving, the Director of People & OD advised that a key focus for the Attract, Develop & Retain group was flexible working. She noted that the recording of reasons for leaving on the Electronic Staff Record (ESR) was limited, therefore the group was undertaking further exploration in this area.

A Non-Executive Director referred to the back care awareness campaign 'Right Back at Ya!' and highlighted the importance of language used in such titles as they could be perceived in a negative way.

In response to a Non-Executive Director querying if sickness absence targets remained realistic, the Director of People & OD acknowledged the challenges post pandemic and shift in sickness absence and noted that the People Performance Committee would keep the targets under review to ensure they remained valid.

FINANCE

The Chief Finance Officer presented the finance section of the IPR and advised that the Trust's position at month 9 was £2.0m adverse to plan – a deficit of £19.0m but the Trust was still forecasting to deliver the planned £23m deficit. He reported that the primary drivers of the movement from plan were escalation beds remaining open beyond the planned winter period, continued growth in ED attendances and additional inflationary pressures.

The Chief Finance Officer advised that the Cost Improvement Programme (CIP) for 2022/23 was £18.1m (£12.1m recurrent) and highlighted that the CIP plan for month 9 had been delivered, however the majority on a non-recurrent basis. He confirmed that the Trust had maintained sufficient cash to operate during December, and that the capital plan for 2022/23 was £43m. He advised that at month 9 capital expenditure was behind plan by £7.991m, and that the forecast for year-end has been increased due to phasing of Public Dividend Capital (PDC) for a number of capital schemes.

The Board of Directors:

- **Received and noted the Integrated Performance Report**

10/23 Safer Care Report

The Chief Nurse and Medical Director presented a report providing assurances and risks associated with safe nurse, midwifery and medical staffing and the actions to mitigate the risks associated with patient safety and quality, based on patients' needs, acuity, dependency and risks. They briefed the Board on the content of the report highlighting the impact of the operational challenges, and provided an overview of the continued activity to maintain safe staffing levels and drive improvement.

The Chair welcomed the report and the associated actions and noted the improved appointment process for consultants.

The Board of Directors:

- **Received and noted the Safer Care Report.**

11/23 Health Inequalities and Waiting List Report

The Medical Director presented a report providing an update on progress to address health inequalities through the development of analysis delineating reporting by health inequality parameters. He briefed the Board on the content of the report and advised that the analysis confirmed that there was no obvious inequality in terms of deprivation and ethnicity in the way that patients access treatment once on the Trust's waiting list.

The Board heard that the Trust's use of clinical urgency as the principal prioritisation method and chronological management as the secondary parameter acted as safeguards against significant inequality in access. The Medical Director briefed the Board on further work in this area, including exploring the equity of access from the community and to ensure equal outcomes.

The Board of Directors recognised the high level analysis of the Trust's waiting list provided assurance that there was no obvious inequality (in terms of deprivation and ethnicity) in the way that patients accessed treatment once on the Trust's waiting list, however recognised the importance of a whole system approach in tackling health inequalities, and Board's line of sight to the place-based agenda.

The Board of Directors:

- **Received and noted the report.**

The Deputy Director of Organisational Development joined the meeting

12/23 Organisational Development Plan

The Deputy Director of Organisational Development presented an Organisational Development (OD) Plan 2023-25. She briefed the Board on the content of the plan, noting that it completed a suite of linked strategies alongside the People Plan 2021-23, Workforce Equality Diversity and Inclusion (EDI) Strategy 2022-25 and Communications & Engagement Strategy 2022-25.

The Board heard that the OD Plan set out an iterative approach to enhancing performance and culture through sequenced activities with an emphasis on changing hearts, minds and skills, with a focus on the following four priority areas:

- Leadership and working relationships
- Talent management
- Innovation
- OD consultancy

The Deputy Director of OD confirmed that, following detailed consideration, the People Performance Committee were recommending the OD Plan to the Board for approval.

The Chair of the People Performance Committee (PPC) (Non-Executive Director) commented that she would liaise with the Director of People & OD and the Deputy Director of OD to consider the role of the PPC in supporting the delivery of the OD Plan on a more granular level. She highlighted the importance of having the right culture across the organisation to be able to learn from mistakes.

In response to a question from the Medical Director about alignment with Equality, Diversity and Inclusion (EDI), the Director of People & OD noted that whilst there was a separate EDI Strategy, EDI was a golden thread woven into the OD Plan and the delivery of the OD Plan would support the delivery of the EDI Strategy and vice versa. She advised that when the People Plan was next refreshed, the intention would be to amalgamate the plans rather than have separate OD and People Plans. Board members welcomed the suggested approach to amalgamate the plans, with early engagement with Board members via PPC.

In response to a question from an Associate Non-Executive Director regarding the cost of delivering the plan, the Board heard that work was ongoing regarding funding and assessment of the return on investment. A Non-Executive Director suggested that consideration be given to those areas that are working well and impacting positively on the Trust's medium term financial strategy rather than seeing it as an additional cost.

The Board of Directors:

- **Received and noted the report and approved the Organisational Development Plan 2023-25.**

The Deputy Director of Organisational Development left the meeting

13/23 Stockport NHS Foundation Trust and Tameside & Glossop NHS Integrated Care NHS Foundation Trust: Collaboration Principles

The Director of Strategy & Partnerships presented a report setting out a number of principles to underpin and guide the current and future collaboration between Stockport NHS Foundation Trust (SFT) and Tameside & Glossop Integrated Care NHS Foundation Trust (TGICFT). He briefed the Board on the content of the report, which had also been endorsed by the TGICFT Board, and noted that the principles would be reviewed at least on an annual basis.

The Chair commented that the report captured the collaborative principles with further consideration to be given to how they would translate into actions and embed into business as usual.

A Non-Executive Director highlighted the importance of patient involvement in service level collaboration.

The Board of Directors:

- **Received and noted the report and endorsed the principles set out in the report, subject to making the reference to patient involvement in collaboration with patient groups more explicit.**

14/23 Board Assurance Framework 2022/23 – Q3

The Deputy Chief Executive presented the Board Assurance Framework (BAF) 2022/23 Q3, noting that all BAF risks were regularly reviewed by the relevant Board Committees. He briefed the Board on the content of the report and highlighted increased risk scores proposed for a number of operational performance, finance and staff wellbeing related risks in the context of significant operational pressures, risk on income and system funding, alongside external influence of employee relations and industrial action, which continue to impact on the Trust's ability to mitigate risk.

Non-Executive Directors confirmed that the BAF had been considered in detail by the relevant Board Committees and Board members welcomed the robust approach to risk management, including active review of mitigating actions.

The Board of Directors:

- **Received and noted the report**
- **Reviewed and approved the Board Assurance Framework 2022/23 as at 2 February 2023**
- **Reviewed and confirmed the Trust's current Significant Risk profile, including alignment between operational and principal risks**

15/23 Board Committees – Key Issues & Assurance Reports

<u>FINANCE & PERFORMANCE COMMITTEE</u>

The Chair of Finance & Performance Committee (Non-Executive Director) presented a key issues and assurance report from the Finance & Performance Committee meeting held on 19 January 2023. He briefed the Board on the content of the report and highlighted key operational and financial issues considered, noting triangulation with the Integrated Performance Report.

The Board of Directors:

- **Reviewed and confirmed the Finance & Performance Committee Key Issues & Assurance Report, including actions taken**

<u>PEOPLE PERFORMANCE COMMITTEE</u>

The Chair of People Performance Committee (Non-Executive Director) presented a key issues and assurance report from the People Performance Committee meeting held on 12 January 2023. She briefed the Board on the content of the report, which triangulated with the Integrated Performance Report.

The Board of Directors:

- **Reviewed and confirmed the People Performance Committee Key Issues & Assurance Report, including actions taken**

QUALITY COMMITTEE

The Acting Chair of Quality Committee (Non-Executive Director) presented key issues and assurance reports from the Quality Committee meeting held on 7 January 2023. She briefed the Board on the content of the report, noting triangulation with the Integrated Performance Report.

The Board of Directors:

- **Reviewed and confirmed the Quality Committee Key Issues & Assurance Report, including actions taken**

16/23 Any Other Business

There was no other business.

17/23 Date, time and venue of next meeting

The next meeting of the Board of Directors held in public would be held on Thursday, 6 April 2023, commencing at 9.30am in the Lecture Theatres, Pinewood House.

18/23 Resolution

The Board resolved that:

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

Signed:_____Date:_____

BOARD OF DIRECTORS PUBLIC MEETING ACTION TRACKER

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

On agenda
Not due
Overdue
Closed

Stockport NHS Foundation Trust

Meeting date	6 April 2023	x	Public		Confidential	Agenda item
Meeting	Board of Directors					
Title	Chair's Report					
Lead Director	Prof. Tony Warne, Chair		Author	Prof. Tony Warne, Chair		

Recommendations made / Decisions requested

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

This paper relates to the following Corporate Annual Objectives-

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

The paper relates to the following CQC domains-

	Safe		Effective
	Caring		Responsive
x	Well-Led		Use of Resources

This paper is related to these BAF risks		**PR1.1**	There is a risk that the Trust does not deliver high quality of care to service users, which may lead to suboptimal patient safety, effectiveness and/or experience and failure to meet regulatory standards
	x	**PR1.2**	There is a risk that patient flow across the locality is not effective which may lead to potential harm, suboptimal user experience, and inability to achieve national standards for urgent and elective care
	x	**PR1.3**	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan which may lead to suboptimal patient safety, outcomes and user experience and inability to achieve national standards for planned care
	x	**PR2.1**	There is a risk that the Trust fails to sufficiently engage and support our people, which may lead to low morale, higher turnover & sickness absence and gaps in the workforce that may impact on delivery of high-quality care
		PR2.2	There is a risk that the Trust's community services do not fully support neighbourhood working which may lead to suboptimal improvement in neighbourhood population health

	x	**PR3.1**	There is a risk in approving and implementing a new Provider Collaborative model to support delivery of priorities/objectives of the Stockport's ONE Health & Care (Locality) Board which may lead to a delay in delivery of models of care which support improvements in population health and operational recovery following the pandemic
	x	**PR3.2**	There is a risk that the Trust does not deliver a joint Clinical Strategy with East Cheshire NHS Trust (ECT), which may lead to suboptimal pathways of care and/or limited service resilience across the footprint of both Trusts
	x	**PR4.1**	There is a risk that the Trust does not implement high quality research & transformation programmes which may lead to suboptimal service improvements
	x	**PR5.1**	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit the optimal number of staff, with appropriate skills and values, which may lead to suboptimal staff and patient experience
		PR5.2	There is a risk that the Trust fails to have a workforce that is reflective of the communities served which may lead to staff with a protected characteristic having a suboptimal staff experience (career progression, turnover) and a poorer patient experience
		PR6.1	There is a risk that the Trust does not deliver the 2022/23 financial plan which may lead to a poor use of resources and increased regulatory intervention
		PR6.2	There is a risk that the Trust does not develop and agree with partners a multi-year financial recovery plan, optimising opportunities for financial recovery through system working, which may lead to a lack of financial sustainability
		PR7.1	There is a risk that the Trust does not implement the Digital Strategy designed to ensure a resilient and responsive digital infrastructure which may lead to inability to support improvements in quality of care and compromise of data/information
		PR7.2	There is a risk that the estate is not fit for purpose and/or meets national standards which may lead to inefficient utilisation of the estate to support high quality of care and increased health & safety incidents
		PR7.3	There is a risk that the Trust does not materially improve environmental sustainability which may lead to suboptimal support to locality ambitions and the NHS commitment to carbon reduction
		PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus which may lead to an adverse long term impact on the Trust's capability to deliver modern and effective care

Where issues are addressed in the paper-

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

Executive Summary

This report advises the Board of Directors 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

Sadly, as I write this report the invasion and war in Ukraine has been ongoing for over 398 days. The loss of life and the disruption to people's lives continues and we are all, in different ways, experiencing the consequences of this tragic and unwarranted conflict. I believe it is important that we continue to keep all those caught up in the Ukraine/Russia war and in other conflicts around the world, in our thoughts and prayers.

Closer to home, and prompted by conversations at our Board, I embarked on a round robin series of conversations with the other Greater Manchester (GM) Chairs. These conversations focus on three issues: collective procurement across GM; access to the GM Provider Federation Board; and Board relationships with the GM Integrated Care Board. As I write this report, I have spoken with: Eileen Fairhurst – Northern Care Alliance; Mark Jones – Wrightington, Wigan and Leigh; Jane McCall – Tameside and Glossop and Evelyn Asante-Mensah – Pennine Care. I have a few more Chairs to speak with. I am hoping the outcome of these conversations can feed into the wider GM Chairs and NEDs group to help shape the agenda for our future collaborative working.

I attended an NHS Providers CEO and Chairs Network Day. These events are opportunities to hear a well-articulated policy, politics and public opinion analysis. This was the first time that I had an opportunity to speak with the NHS Providers new Chair, Sir Julian Hartley. It was his first go and presenting his state of the nation analysis and commentary. Joined by Saffron Cordery, Deputy Chief Executive and Miriam Deacon, Director of Policy, Julian provided a comprehensive account of the current and future political context; issues faced on the front line; and the strategic direction and the work of NHS Providers in addressing the issues raised.

There was also a very interesting and challenging prestation of by Navina Evans, outgoing CEO of Health Education England, on the proposed workforces issues and in particular the upcoming NHS EDI Improvement Plan. Her message was one about refocusing our approach to EDI through the lens of improvement rather than the rather current and somewhat redundant league table type approach. Whilst the final plan still requires NHSE approval, Boards will need to specifically include EDI 'high impact action' success metrics in senior leader and managers annual objectives. In reflecting on what was suggested these might look like, I am really pleased that we are already able to evidence consistent approaches as part of our EDI strategy.

I have attended three NHSE North West Regional System Leaders meetings. The unremitting focus has been two-fold. (1) Achieving our financial targets both as an individual organisation, but also across the three ICS in the North West. (2) Ensuring our productivity outcomes reflect the national targets. Dealing with these interrelated issues has been very challenging. I wish to fully acknowledge and say thank you for the work our Executive Directors and their teams have done in responding to these challenges, often against very tight time constraints.

I enjoyed a very productive meeting with colleagues from the Sector 3 organisation. Sector 3 is Stockport based charity. They provide a support network for voluntary, community and faith based groups, social enterprises and charitable organisations in Stockport. As a NHS Trust we already have a productive relationship with Sector 3. My discussion was around how we can build upon this existing relationship in developing a collaborative based approach to place-based health and care services. I am particularly interested in working more closely with Sector 3 and the many organisations they work with, in jointly addressing some of the social determinates that impact on people's health and wellbeing.

I have continued to make an active contribution to the work of the Good Governance Institute, and have participated in four webinars since I last reported to the Board. Whilst this is an opportunity to showcase Stockport NHS FT, it is also an opportunity to learn from others, and as such has informed my thinking around improving our governance processes, and our strategic direction.

I attended Jen Connolly's leaving event. Jen was the Director of Public Health at Stockport Council and a great supporter of our Trust. Jen led on the Councils response to the Covid pandemic and worked tirelessly to ensure there was always a joined up and coordinated response being made across the Stockport system. Jen was a major architect of the Stockport's One Health and Care Plan, jointly developed by the former Clinical Commissioning Group, our Trust and Stockport Council. Her contribution was also acknowledged at the March meeting of the Stockport Health and Wellbeing Board.

Finally, at the risk of embarrassing our Chief Executive, I want to say how pleased I am that Karen has been named in the Health Service Journal as one of the Top 50 Chief Executives for 2023. This well-deserved recognition has come from a group of prominent figures across the NHS. In her typically modest way, Karen will be sure to acknowledge that she is part of a team, and its team working that counts, which of course is true. However, Karen continues to consistently provides that great leadership so crucial in times of great turbulence and stress. I am extremely proud to stand beside her as we continue our journey to becoming an outstanding Trust.

3. TRUST ACTIVITIES

With Karen James, I was pleased to participate in the formal opening of our new endoscopy facilities. These are first class, and the teams are already using them to tackle the backlog waiting list. It is very impressive and many thanks to all those colleagues involved in bring this project to fruition.

I was also able to meet with Rachel Campbell, our IBD Specialist Practitioner, to see her work in the use of capsule endoscopy. This is a service provided to patients in Stockport, East Cheshire and Tameside and Glossop. There is huge potential to develop this service further as new technology becomes more available and affordable.

Alongside Mary Moore and Andrew Loughney, I was able to take part in their Maternity Champions Safety Walkabout, and see for myself the improvements that have made to our maternity services and facilities. Again, very impressive.

I have chaired two Consultant appointment panels since my last report, and we were able to successfully appoint a Consultant Physician in Acute Medicine and a Consultant in Urology. The latter appointment will help us take our health robotics' ambitions forward at pace.

Cathy Lloyd and her team were kind enough to allow me to join their morning patient flow meeting and get a glimpse of this complex, critical and often hidden work. I was then able to see how this corporate work is transposed at a local level, by visiting Ward D5 to see their morning white board review of each patient's treatment, care and discharge plans.

I was pleased to be part of the NHS Chef's and NHS National Estates and Facilities Directorate visit to the Trust. During the visit two of our Chefs, Erica Bell and Shelley Pearson-Smith were congratulated on becoming the NHS Chefs of the Year. There was also the opportunity to support our desire to be an exemplar site for other aspects of our estates and facilities work.

Later in the month I was also able to see of the work of our estate and facilities, colleagues first hand. It was a tour that was highly informative and interesting. It really brought home to me just how important clinical and non clinical team working across the Trust was in ensuring high quality and safe patient care was being consistently provided.

Related to this visit was the opportunity to work with Claire Gibson, our Estates and Facilities Matron in understanding what the 2022 Place Assessment had revealed in terms of improving our environment for patients, colleagues, and visitors to the Stepping Hill site. There is more we can do.

Finally, I was pleased to chair a Nutrition and Hydration members Event, facilitated by the ‘Power of Three’, Claire Gibson, Duncan O’Neil, and Orlaith Curran. This was a well-attended event by our members and Council of Governors and provided an opportunity to show case our approach to patient and colleague catering and healthy life choices. Thanks to Soile Curtis and Rebecca McCarthy for organising.

4. STRENGTHENING BOARD OVERSIGHT

The extreme operational demands we face as a Trust continue. Dealing with these has been further complicated by the major construction work being undertaken as our new Urgent and Emergency Care facility is being built and the recent industrial action taken by different health care professions. However, we have been able to hold one Board Development event during this time, which provided us with an opportunity to explore our Well Led Self-Assessment ratings and the implications for future action.

Meeting date	6 April 2023	x	Public		Confidential	Agenda item
Meeting	Board of Directors					
Title	Chief Executive's Report					
Lead Director	Chief Executive		Author	Director of Communications & Corporate Affairs		

Recommendations made / Decisions requested

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

7

This paper relates to the following Corporate Annual Objectives-

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

The paper relates to the following CQC domains-

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

This paper is related to these BAF risks		**PR1.1**	There is a risk that the Trust does not deliver high quality of care to service users, which may lead to suboptimal patient safety, effectiveness and/or experience and failure to meet regulatory standards
	x	**PR1.2**	There is a risk that patient flow across the locality is not effective which may lead to potential harm, suboptimal user experience, and inability to achieve national standards for urgent and elective care
	x	**PR1.3**	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan which may lead to suboptimal patient safety, outcomes and user experience and inability to achieve national standards for planned care
	x	**PR2.1**	There is a risk that the Trust fails to sufficiently engage and support our people, which may lead to low morale, higher turnover & sickness absence and gaps in the workforce that may impact on delivery of high-quality care
		PR2.2	There is a risk that the Trust's community services do not fully support neighbourhood working which may lead to suboptimal improvement in neighbourhood population health

	x	**PR3.1**	There is a risk in approving and implementing a new Provider Collaborative model to support delivery of priorities/objectives of the Stockport's ONE Health & Care (Locality) Board which may lead to a delay in delivery of models of care which support improvements in population health and operational recovery following the pandemic
	x	**PR3.2**	There is a risk that the Trust does not deliver a joint Clinical Strategy with East Cheshire NHS Trust (ECT), which may lead to suboptimal pathways of care and/or limited service resilience across the footprint of both Trusts
	x	**PR4.1**	There is a risk that the Trust does not implement high quality research & transformation programmes which may lead to suboptimal service improvements
	x	**PR5.1**	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit the optimal number of staff, with appropriate skills and values, which may lead to suboptimal staff and patient experience
		PR5.2	There is a risk that the Trust fails to have a workforce that is reflective of the communities served which may lead to staff with a protected characteristic having a suboptimal staff experience (career progression, turnover) and a poorer patient experience
		PR6.1	There is a risk that the Trust does not deliver the 2022/23 financial plan which may lead to a poor use of resources and increased regulatory intervention
		PR6.2	There is a risk that the Trust does not develop and agree with partners a multi-year financial recovery plan, optimising opportunities for financial recovery through system working, which may lead to a lack of financial sustainability
		PR7.1	There is a risk that the Trust does not implement the Digital Strategy designed to ensure a resilient and responsive digital infrastructure which may lead to inability to support improvements in quality of care and compromise of data/information
		PR7.2	There is a risk that the estate is not fit for purpose and/or meets national standards which may lead to inefficient utilisation of the estate to support high quality of care and increased health & safety incidents
		PR7.3	There is a risk that the Trust does not materially improve environmental sustainability which may lead to suboptimal support to locality ambitions and the NHS commitment to carbon reduction
		PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus which may lead to an adverse long term impact on the Trust's capability to deliver modern and effective care

Where issues are addressed in the paper-

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

Executive Summary

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

- Industrial action
- Greater Manchester Integrated Care Board
- Operational pressures
- Safeguarding Award
- Public Health Nurse of the Year Nomination
- Enhanced imaging for hand and food surgery

- CURE Team Achievements

1. PURPOSE OF THE REPORT

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

2. NATIONAL & REGIONAL NEWS

2.1 Industrial Action

The British Medical Association (BMA) and the Hospital Consultant and Specialist Association (HCSA) held planned industrial action for Junior Doctors 13th to 16th March (72-hour stoppage).

Plans were in place to ensure the Trust continued providing safe patient care during this period. However, there was inevitably a greater impact on performance than during previous strikes, due to the duration of the action, the number of doctors taking part and the lack of derogations. A new four-day strike for junior doctors has been announced which will take place after the Easter bank holiday from 11 April – 15 April. The Industrial Action Planning Group will continue to ensure arrangements are in place to provide safe patient care.

Separately the BMA have announced the outcome of a consultative survey of consultants in which 86% said they would support strike action. The Government has been given until 3 April to respond with specific proposals to requests.

Other health unions have been in pay talks and have paused further strike action whilst these talks are ongoing.

2.2 Greater Manchester Integrated Care Board

The locality governance, as part of Greater Manchester (GM) Integrated Care is in advanced development with the Strategic Partnership Board and the Provider Partnership both well established. The appropriate sub-groups that will report through to these and provide the necessary assurance both to the Locality Board (Strategic Partnership Board) and into GM are now being set up.

At a Greater Manchester system level, the work on the GM centralised functions and the locality structures, for the staff that were previously part of Clinical Commissioning Groups (CCGs), is currently being finalised and a consultation exercise will follow from the end of March. GM has adopted a ‘one organisation’ approach to this process therefore, staff from all ten localities and the centralised GM functions staff will all be involved in this consultation process. Once this process is concluded and staff have been redeployed into the new structure, planned to be complete by the end of June 2023, Stockport will retain a team of staff dedicated to delivering services to the population of Stockport, supported by the centralised function teams within GM.

From a financial perspective, NHS England has outlined to GM longer-term expectations on running cost allowances and efficiency requirements for Integrated Care Boards (ICBs), with a view to reducing running costs by 30% by the end of

March 2025. The GM Executive Team are reviewing the proposed structures ahead of the consultation process to consider whether they fulfil the requirements of the localities and functions, but also with a view to the financial challenge. GM has made savings since the transition to the ICB in July, some coming directly through the changes to the organisation on Day 1 and some coming more recently through a number of measures including a successful Mutually Agreed Resignation Scheme (MARS), recruitment controls and running of a STAR financial process. These financial regimes will remain in place to ensure the system is able to make inroads into delivering the required efficiencies.

3. TRUST NEWS

3.1 Operational pressures

The operational pressures of previous months have continued, with Industrial Action adding to this. Ensuring patient safety during this time has been paramount and has led to the postponement of some elective activity. Despite this, as outlined in the performance report, we continue on trajectory with our elective access standards, with improved cancer performance and an improving diagnostic position.

We continue to have a high number of patients in adult beds who have 'no criteria to reside, with the percentage of those from the Derbyshire area being an ongoing issue that we are working with their ICB to resolve. Work continues with our Stockport system partners to ensure that we have sufficient community capacity to support patients to leave hospital and receive the right care provision. Further improvement in discharging patients who no longer need to be in hospital will be essential to achieve effective patient flow from the emergency department and to get us closer to the four-hour A&E standard.

As the Board will be aware, work continues with GM ICS 2023/24 to finalise the operational plan submissions ensuring that activity is triangulated with financial and workforce plans.

3.2 Sustainable Hospital Services – East Cheshire NHS Trust and Stockport NHS Foundation Trust

We are continuing to work closely with East Cheshire Hospitals NHS Trust to understand how some acute services could be improved and sustained in the future. As highlighted in the joint Case for Change, there are opportunities for us to work together to improve services for patients in the longer term.

To support this work we will be asking patients to share their experience of using some of our specialist services and find out what is important when using these services. The feedback will be gathered via on online survey on a dedicated website: https://sustainablehospital.services/. The feedback gathered will be used to help us develop outline ideas for how to improve the services we provide.

3.3 Enhanced Endoscopy

The hospital's state-of-the-art new endoscopy unit has recently opened to provide treatment for greater numbers of patients. The endoscopy unit now has four procedure rooms, when previously there was three. It also has two separate recovery areas, one for men and one for women, an increase from the previous one, which had to be used alternately. With a 33% increase in capacity, many more procedures per year will now be possible to help reduce waiting times for patients, to meet the national standards of two weeks for urgent (including suspected cancer) and six weeks for routine referrals.

Just over £3m was spent on the new suite, which has all the latest facilities for providing high quality diagnosis for a wide variety of conditions.

3.4 Safeguarding Award

Anne-Marie Gallogly, School Nurse, has received national recognition for her excellent performance in providing safeguarding training for colleagues.
Anne-Marie has been with the Stockport NHS school nursing team for over 14 years and regularly delivers training for her health colleagues so that they can maintain the highest standards of promoting the welfare of children and protecting them from harm.

On behalf of SAPHNA, Anne-Marie provided the Care Quality Commission's inspectorate team with a special training session which demonstrated these high standards, which are now being shared with NHS colleagues at both a regional and national level as best practice to follow.

3.5 Public Health Nurse of the Year Nomination

Sara Jackson, Health Visitor, has been shortlisted for the national title of 'Public Health Nurse of the Year' for her outstanding support for local children. Sara was nominated in the British Journal of Nursing Awards 2023, which celebrate the best in nursing care from across the country.

Sara has been in nursing for over 25 years, and with the Stockport NHS community team for the last six years. She is the Start Well Team Leader for Brinnington and Marple, providing community-based NHS healthcare for children and young people in these areas.

4. RECOMMENDATION

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

Meeting date	6th April 2023	x	Public		Confidential	Agenda item
Meeting	Board of Directors					
Title	Integrated Performance Report					
Lead Director	Chief Executive		Author	Head of Performance		

Recommendations made / Decisions requested

Performance against the associated metrics for the last available month (February 2023 for the majority of indicators) is reported. Exception reports have been provided for areas of most significant note.

This paper relates to the following Corporate Annual Objectives-

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The paper relates to the following CQC domains-

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

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		PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus which may lead to an adverse long term impact on the Trust's capability to deliver modern and effective care

Where issues are addressed in the paper-

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

Executive Summary

The Board is asked to note and discuss:

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

Integrated Performance Report

Reporting Period February 2023

Quality | Operations | Workforce | Finance

8.1

Integrated Performance Report

NHS Stockport NHS Foundation Trust

Trust Highlight Report

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

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

Reduced sepsis audits due to the rollout of Sepsis6 continue to be a contributing to performance falling short of the targets.

Infection rates for C.Diff, E.Coli, MRSA and MSSA are all above the thresholds for improvement set by UKHSA. Hospital-Onset Covid rates are back below the GM average.

The Medication Incident rate is 4.5, just above the 3.76 average based on 2021/22 performance. All incidents are reviewed at the Incident Review Group on a weekly basis.

Complaints response rates are being affected by the availability of clinical staff to undertake administrative work. We are also seeing a high number of complex complaints.

Operational Highlights
Exception reports included this month relate to performance against A&E , 6 Week Diagnostic, Cancer, RTT, NCTR, Elective activity, Outpatient Efficiency and Theatre Efficiency metrics due to under-achievement in month.

Current performance against the 4-hour standard remains a challenge to good patient flow. Bed occupancy continually exceeds 98%, which is beyond the recognised safe limits for effective flow.

Diagnostics performance is still above the target, but showing a much improved position due to outsourcing to support the clearance of the Endoscopy diagnostic backlog.

Although our Outpatient efficiency metrics fall short of local targets, we continue to benchmark positively compared to GM and National peers for DNA rates and use of Patient Initiated Followe Up. Clinic utilisation is also performing well, exceeding the target threshold.

Workforce Highlights
Exception reports included this month relate to Sickness Absence, Turnover, Statutory & Mandatory Training, Appraisal Rates and Bank & Agency Costs due to under-performance in month.

Workforce Turnover remains high ay 15.17% for February against the 11% target.

Statuatory & Mandatory training has been affected by the recent industrial action, leading to high DNA rates for courses with the Learning & Education tea.

Agency rates continue to be scrutinised at the weekly Staffing Approval Group (SAG) and recruitment events are on-going inorder to increase substantive staff in post to mitigate agency spend.

Financial Highlights
The Trust has submitted a revised plan with an expected deficit of £23m for the financial year 22-23. This was following agreement to increase the CIP target by £4m to £18.1m and increased contract income of £5m to reduce the deficit.

Following additional allocations from the system the Trust has a deficit of £2.8m at month 11, which is forecast to be £3.3m at month 12.

The drivers of the movement from plan are escalation beds remaining open beyond the planned Winter period, our original planning assumption was that these wards would close at the end of April and continued growth in ED attendances and additional inflationary pressures.

The CIP plan for 22-23 is £18.1m (£12.1m recurrent). The CIP plan for month 11 (based on the revised CIP plan) has been delivered however, at this point the majority is non-recurrent.

The Trust has maintained sufficient cash to operate during February 2023.

The Capital plan for 22-23 is c£40m. At month 11 expenditure is behind plan by £13.9m. The current year-end forecast for capital expenditure is c£40m. Work is ongoing to utilise all available CDEL.

Risks
The CIP programme of £18.1m for 22/23 will be delivered but the recurrent target of £12.1m will not be met on a recurrent basis which adds an additional pressure to the delivery of the financial plan for 23/24.

Cost of inflation remains a high risk for the Trust and whilst the plans included some increase to address the pressure, costs continue to escalate for materials, food, and energy.

Cashflow – As a result of the timing of capital cash flows, no additional cash support is now anticipated in this financial year; however, cash planning for 23/24 will be key.
Emergency Demand – the increase in emergency demand is impacting on the financial position and the elective recovery targets. The Trust is also overperforming on high-cost drugs and the income for this is on a block basis.

Integrated Performance Report

NHS Stockport NHS Foundation Trust

Summary Dashboard

Performance

- Blue indicates that the measure has met the target.
- Orange indicates that the measure has fallen short of the target.

Target assurance

- Grey indicates that variation is inconsistently passing and falling short of the target
- Blue indicates that variation is consistently passing the target
- Orange indicates that variation is consistently falling short of the target

Forecast position

- Blue indicates that the measure is forecast to achieve the target next month
- Orange indicates that the measure is forecast to fall short of the target next month

N=National / L=Local

Quality Metrics	Performance			Target assurance		Forecast
Mortality: HSMR (rolling 12-mth)	Dec-22		111	N	<= 100	
Mortality: SHMI (rolling 12-mth)	Nov-22		99	N	<= 100	
Sepsis: Timely recognition (rolling 12-mth)	Feb-23		94.3%	L	>= 95%	
Sepsis: Antibiotic administration (rolling 12-mth)	Feb-23		77.5%	L	>= 95%	
Hospital Onset Covid (HOC) Rate	Feb-23		50%	L	<= 55.45%	
Infection Rate - C. diff (rolling 12-mth)	Feb-23		60.23	L	<= 20.37	
Infection Rate - MRSA (rolling 12-mth)	Feb-23		2.21	L	<= 0	
Infection Rate - MSSA (rolling 12-mth)	Feb-23		24.36	L	<= 8.94	
Infection Rate - E. coli (rolling 12-mth)	Feb-23		115.15	L	<= 24.34	
Medication Incidents: Rate	Feb-23		4.5	L	<= 3.76	
Never Event: Incidence	Feb-23		0	N	<= 0	
Serious Incidents: STEIS Reportable	Feb-23		3	L	<= 5	
Stroke: Overall SSNAP Level	Dec-22		A	N	>= C	
Falls: Rate of Moderate Harm and Above	Feb-23		0.16	L	<= 0.13	
Pressure Ulcers: Hospital, Category 2	Feb-23		74	L	<= 76	
Pressure Ulcers: Hospital, Category 3 and 4	Feb-23		8	L	<= 6	
Written Complaints Rate	Feb-23		7.65	L	<= 5.93	
Complaints: Timely response	Feb-23		82.2%	L	>= 95%	

Operational Metrics	Latest Performance			Target		Forecast
ED: 4hr Standard	Feb-23		61.6%	N	>= 95%	
ED: 12hr Trolley Wait	Feb-23		134	N	<= 0	
Diagnostics: 6 Week Standard	Feb-23		15.6%	N	<= 1%	
Cancer: 62-day standard	Feb-23		60.6%	N	>= 85%	
Cancer: 28-day standard (FDS)	Feb-23		73%	N	>= 75%	
Cancer: 14-day standard (2WW)	Feb-23		98.2%	N	>= 93%	
Referral to Treatment: Incomplete Pathways	Feb-23		48.7%	N	>= 92%	
Referral to Treatment: 52 Week Breaches	Feb-23		3828	N	<= 0	
No Criteria To Reside (NCTR)	Feb-23		107	L	<= 73	
Activity vs. Plan: Elective Inpatient and Daycase	Feb-23		-14.2%	L	>= 0%	
Activity vs. Plan: Outpatient	Feb-23		-16.2%	L	>= 0%	
Activity vs. Plan: ED Attendances	Feb-23		6.5%	L	<= 0%	
Outpatient DNA rate	Feb-23		7.8%	L	<= 5.8%	
Outpatient Clinic Utilisation	Feb-23		85.7%	L	>= 85%	
Patient Initiated Follow Up (PIFU)	Feb-23		3.5%	L	>= 4.67%	
Theatres: Capped Utilisation	Feb-23		81.8%	L	>= 90%	

Workforce Metrics	Latest Performance			Target		Forecast
Substantive Staff-in-Post	Feb-23		92.4%	N	>= 90%	
Sickness Absence: Monthly Rate	Feb-23		5.9%	N	<= 4%	
Workforce Turnover	Feb-23		15.17%	L	<= 11%	
Appraisal Rate: Overall	Feb-23		89.4%	N	>= 95%	
Statutory & Mandatory Training	Feb-23		90.9%	N	>= 95%	
Bank & Agency Costs	Feb-23		15.9%	L	<= 5%	

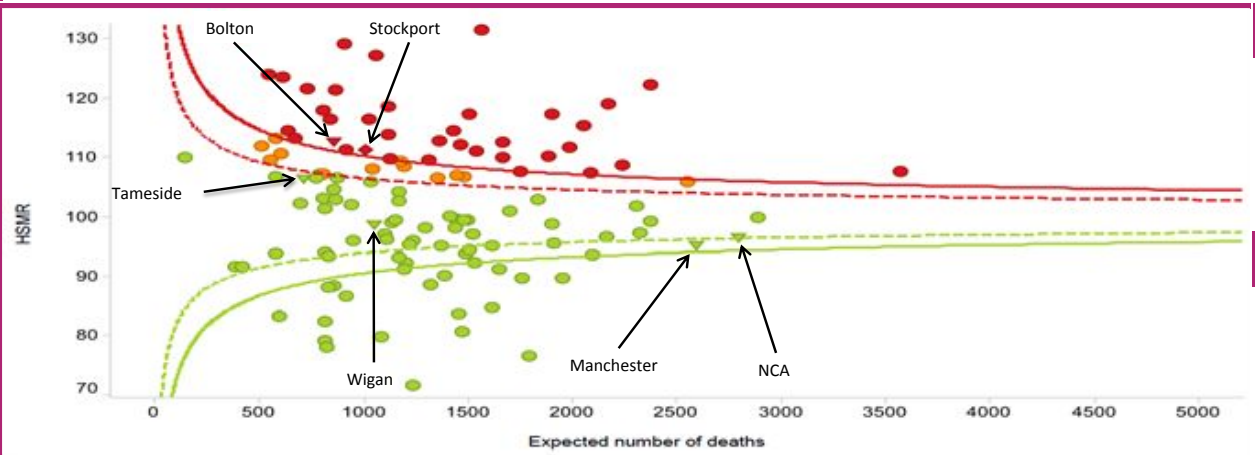
Finance Metrics	Latest Performance			Target		Forecast
Financial Controls: I&E Position	Feb-23		-85.1%	L	<= 0%	
Cash Balance	Feb-23		40			
CIP Cumulative Achievement	Feb-23		2.2%	L	>= 0%	
Capital Expenditure	Feb-23		-29.9%	L	<= 10%	

Quality | Operations | Workforce | Finance

8.1

Integrated Performance Report

NHS Stockport NHS Foundation Trust

Measure	**Mortality: HSMR (rolling 12-mth)** The Hospital Standardised Mortality Ratio (HSMR) shows the ratio of the observed to the expected number of in-hospital deaths at the end of a continuous inpatient (CIP) spell, multiplied by 100. Data sourced from the Healthcare Evaluation Data (HED) system.
Performance of this measure over time	
What the chart tells us	Stockport is one of two GM Trusts that are currently ranked as "very high" with mortality rates outside the statistical control limits in the red zone, the other Trust being Bolton. All other Trusts are all reporting in the green zone, which indicates the mortality rates are within expected range. Data for Pennine is not available.

Latest Performance	Next Month Forecast

Variance

Latest Month	Actual
Dec-22	111

Assurance

Target
<= 100

Narrative

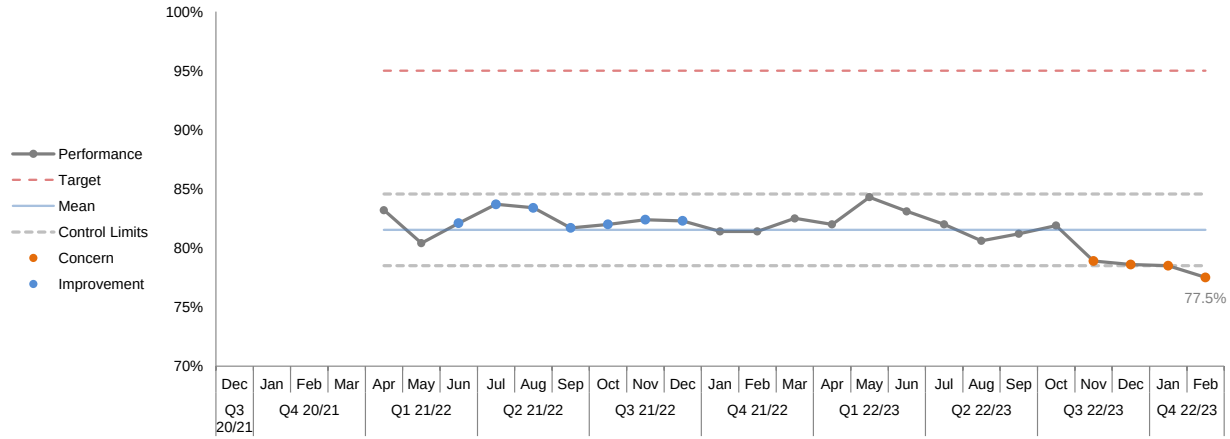
Issues:	Actions & Mitigations:
HSMR is 111.25 for the period January 2022 to December 2022. This is currently 15 points above the GM peer median average, and 10 points above the national median. It should be noted that the HSMR is categorised as 'very high' (i.e. 111.25 is outside statistical control limits). Diagnoses associated with the increased HSMR include Septicaemia, Congestive Heart Failure, and Stroke. These diagnoses are subject to analysis. Data for Pennine Acute has not been available for the last 3 months, so this Trust is not part of the GM and National averages.	Audits are underway for a number of diagnoses groups: Urinary Tract Infections; Fractured Neck- of-Femur; and Perinatal Deaths. Analysis of the diagnoses mentioned in the Issues section is underway.

Integrated Performance Report

NHS Stockport NHS Foundation Trust

Measure	Sepsis: Antibiotic administration (rolling 12-mth) - includes narrative for Sepsis Timely Recognition The number of patients who received IV antibiotics within agreed standards for sepsis patients, as a percentage of those eligible patients audited and found to have sepsis. Performance is based on a rolling 12-month. Data for the current month is based on part-validated data, and a fully validated position is updated one month in arrears.	Latest Performance	Next Month Forecast
			

Performance of this measure over time



Variance

Latest Month		Actual
Feb-23		77.5%

The data shows special cause variation, indicated by a value outside the lower control limits.

Assurance

Target

>= 95%

Performance consistently falls short of the target value

What the chart tells us	Performance for this metric is expressed as a rolling 12- month average. The chart shows that over the last 12 months, performance has been maintained around the average of 82%. Performance for the last several months has been flagged as a significant concern, with performance below the normal range of variation.

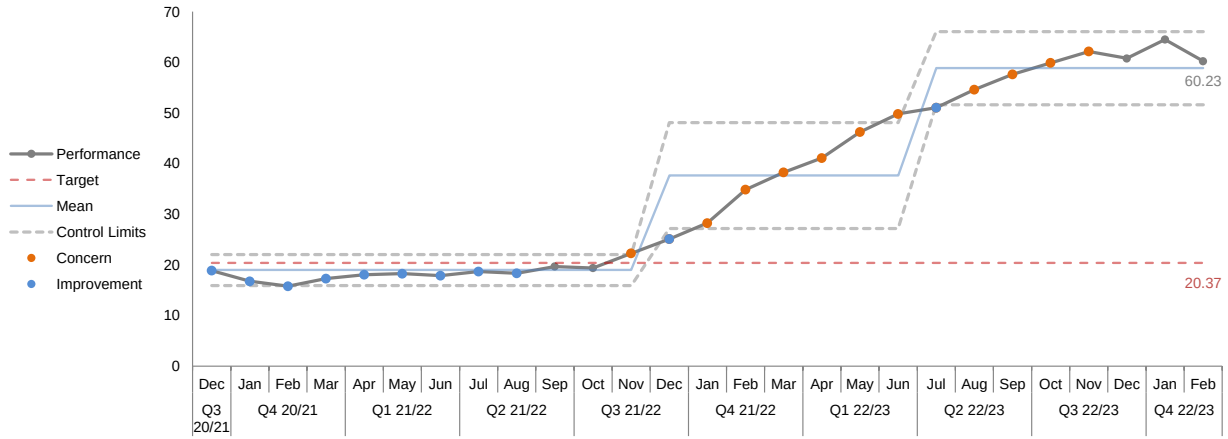
Narrative	Issues:	Actions & Mitigations:
	Timely Recognition: Although February compliance is 100%, a reduced number of audits were undertaken due to the rollout of Sepsis6. For this reason the 12-month rolling metric remains variable and has not shown improvement from last month. Antibiotic Administration: In-month compliance for February is 62%. A reduced number of audits were undertaken due to the rollout of Sepsis6. 57 patients were audited, and only 13 of those were eligible for IV antibiotics. 5 patients did not receive antibiotics within the agreed timescales. All failures occurred within the Division of Medicine and Urgent Care. 4 out of the 5 occurred out-of-hours and were red- flag sepsis triggers. Delayed nurse administration is the theme in all incidents.	Average delay last month was 59 minutes so we are not seeing extensive delays in patients receiving treatment. Awaiting feedback for 2 incidents but poor access cited as reason for one delay and training put in place on wards where other 2 incidents occurred. Sepsis Link Nurse Training date identified for April to support ward engagement. Continued toolboxes for March- red- flag sepsis and Sepsis6.

Integrated Performance Report

NHS Stockport NHS Foundation Trust

Measure	Infection Rate - C. diff (rolling 12-mth) - includes narrative for E.Coli This indicator shows the count of hospital-onset Clostridioides difficile (C. diff) infections per 100,000 bed days for patients aged 2 years and older. The value shown is calculated from data across 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.	Latest Performance	Next Month Forecast

Performance of this measure over time



Variance

Latest Month	Actual
Feb-23	60.23

Data shows common cause variation, suggesting no significant changes in performance

Assurance

Target
<= 20.37

Performance consistently exceeds the target value

What the chart tells us

Since July 2022, a consistent increase to infection rates is seen, rising from 37.65 to 58.85 infections per 100,000 bed days. December 2022 sees the increasing trend level out, with infection rates above average through to February 2023.

Narrative

Issues:	Actions & Mitigations:
C.Diff: There were 4 HOHA (hospital onset) cases and 2 COHA (community onset) cases in February. 2 of these cases have been presented at HCAI Panel and deemed unavoidable. 4 cases are due for HCAI panel review in March. The Trust has 71 cases reported so far in 2022-23, which exceeds the threshold of 41 cases set by the UKHSA. Our greater Manchester peer group also continues to show a month-on-month spikes in their C.Diff rates. E.Coli: There was 1 HOHA case and 3 COHA cases in February. The Trust has 81 cases reported so far in 2022/23, which exceeds the threshold of 49 cases set by UKHSA.	C.Diff: The divisions continue to review their escalation processes to ensure they are being followed. This is to ensure prompt isolation of patients on the commencement of loose stools, and that thorough decontamination of isolation areas takes place once a *C.Diff* case has vacated the area. E.Coli: Following a benchmarking exercise against other Trusts, a draft RCA tool has been developed and is now going through the Trust's internal governance process for approval. It is scheduled to be submitted to the IP&C Operational Group in March 2023 and IP&C Group in April 2023.

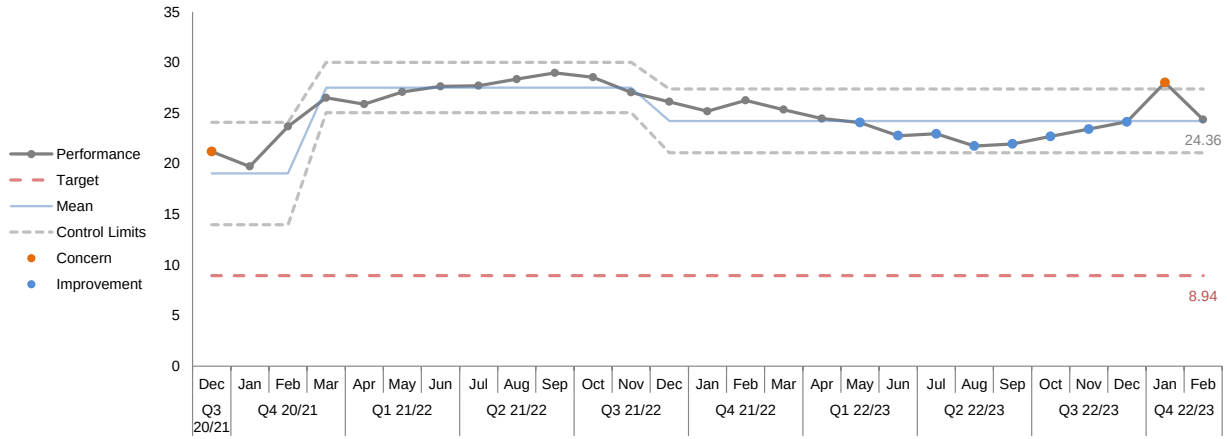
Integrated Performance Report

NHS Stockport NHS Foundation Trust

Measure	**Infection Rate - MSSA (rolling 12-mth) - includes narrative for MRSA** This indicator shows the count of hospital-onset meticillin-susceptible Staphylococcus aureus (MSSA) bacteraemia infections per 100,000 bed days. The value shown is calculated from data across 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.

Latest Performance	Next Month Forecast

Performance of this measure over time



Variance

Latest Month	Actual
Feb-23	24.36

Data shows common cause variation, suggesting no significant changes in performance

Assurance

Target
<= 8.94

Performance consistently exceeds the target value

What the chart tells us

MSSA infection rates have remained consistently high since December 2021. Infection rates significantly improved by December 2022 with a 9- month period where rates are consistently below average. January 2023 does show a spike flagged a statistically significant, but February data shows that rates have dropped back to average.

Narrative

Issues:	Actions & Mitigations:
MSSA: There were 2 HOHA cases reported in February. The Trust has 27 cases reported so far in 2022-23, which exceeds the threshold of 18 cases set by the UKHSA. MRSA: The Trust has had 0 cases of MRSA in February but there has been a community apportioned case. The Trust has had 4 MRSA cases reported so far in 2022/23. 2 of these cases were determined to have been avoidable, and 2 cases were unavoidable.	Following a benchmarking exercise against other Trusts, a draft RCA tool has been developed and is now going through the Trust's internal governance process for approval. It is scheduled to be submitted to the IP&C Operational Group in March 2023 and IP&C Group in April 2023.

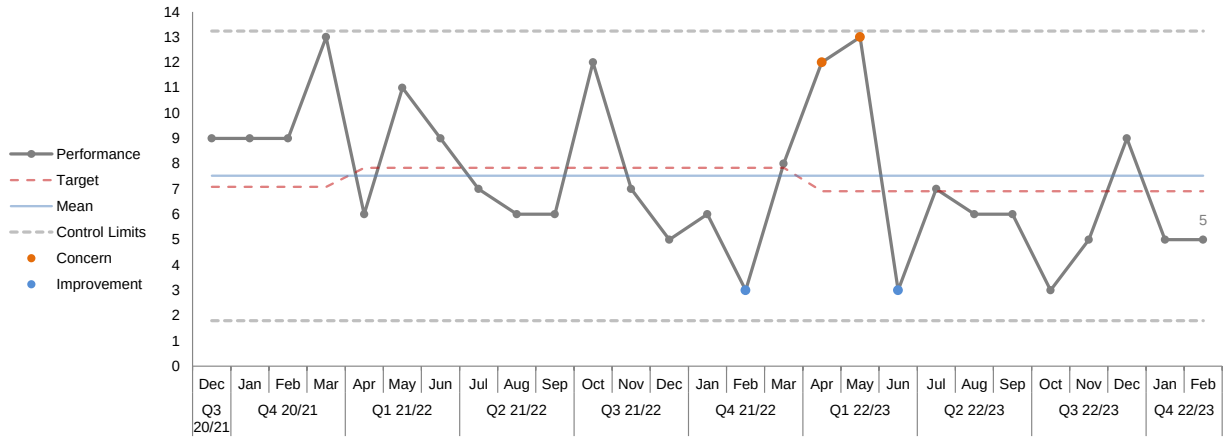
Integrated Performance Report

NHS Stockport NHS Foundation Trust

Measure	**Pressure Ulcers: Hospital, Category 2, 3 and 4** Total number of category 2 pressure ulcers in a hospital setting - includes device-related pressure ulcers.

Latest Performance	Next Month Forecast

Performance of this measure over time



Variance

Latest Month	Actual
Feb-23	74

Data shows common cause variation, suggesting no significant changes in performance

Assurance

Target
<= 76

Performance against the target has not been consistent in the last 6 month period

What the chart tells us	For much of the reporting period, the number of category 2 pressure ulcers reported has been variable and there have been no significant changes. The number of pressure ulcers reported in April and May of 2022 were significantly higher than previous months, but performance reported from June onwards has been on or around the average of 7 per month. The cumulative total for the Trust is now below expected levels.

Narrative

Issues:

There were 5 category-2 pressure ulcers reported in February 2023. Of these, none were as a result of a medical device. The number of incidents for February remains lower than the average for the second month.

In addition, 3 category-2 pressure ulcers reported in previous months have since been investigated and found not to be pressure damage:
- 1 reported in August for Medicine division
- 1 reported in October for Medicine division
- 1 reported in January for Integrated Care division.

As a result of this, the cumulative total number of category-2 pressure ulcers for the year is now 74, which brings us below the expected number of 76. The Trust is now on trajectory to meet the reduction target by the end of March 2023.

There was 1 category-3 pressure ulcer reported in February 2023. This was found to be related to a medical device and initial investigation has identified some areas for learning. A full investigation and action plan is being completed.

Actions & Mitigations:

- Divisional leads are conducting regular pressure ulcer review panels to discuss all incidents reported in their divisions.
- The pressure ulcer verification masterclass continues to be delivered to senior nurses as required.
- A pathway for the management of fractures and the devices used to manage them has been launched which includes the risk assessment and consideration of reducing pressure ulcers caused by these devices.
- The Pressure Ulcer Prevention training programme continues with monthly sessions; the attendance at these training sessions has increased significantly.
- A management of moisture damage guideline has been launched with posters, pocket guides and resources on intranet supported by toolbox training sessions.
- In response to a number of incidents occurring in relation to oxygen tubing, a review of foam protection devices available is taking place.
- The pressure ulcer collaborative annual event is planned for April

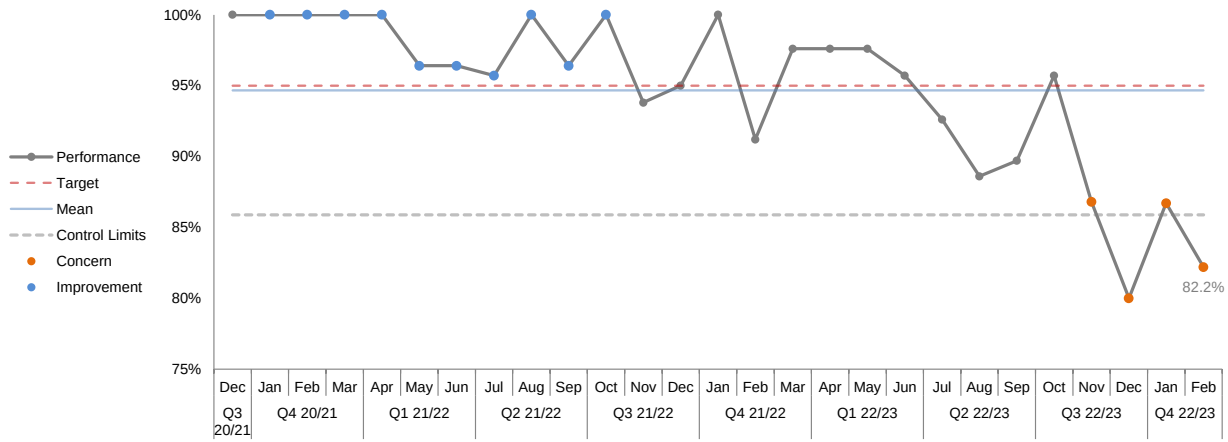
Integrated Performance Report

NHS Stockport NHS Foundation Trust

Measure	**Complaints: Timely response - includes narrative for complaints rate** The total number of formal complaints responded to within agreed timescales, as a percentage of all complaints responded to.

Latest Performance	Next Month Forecast

Performance of this measure over time



Variance

Latest Month	Actual
Feb-23	82.2%

The data shows special cause variation, indicated by a value outside the lower control limits.

Assurance

Target
>= 95%

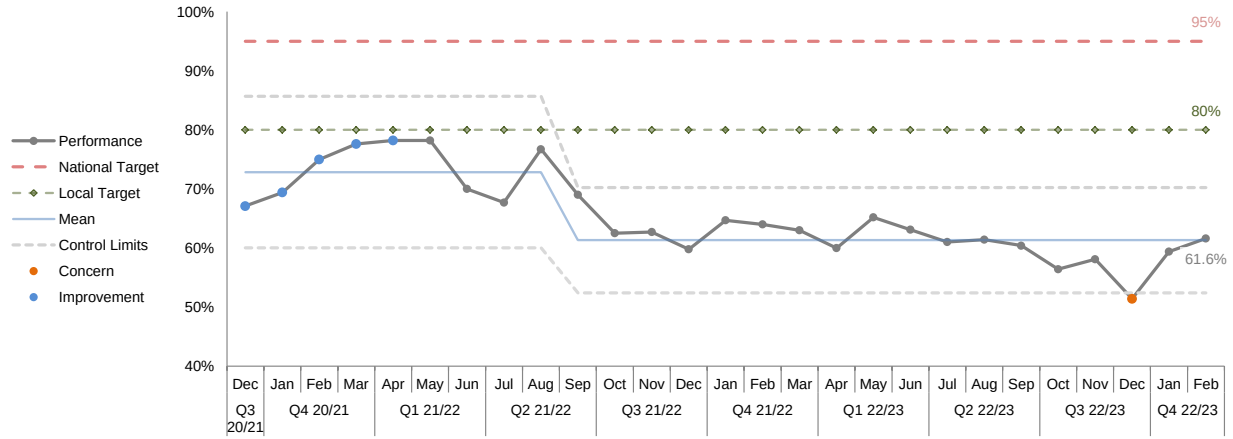
Performance against the target has not been consistent in the last 6 month period

What the chart tells us	For almost the entire reporting period, average performance has been above the 95% target for complaints response times. July 2022 saw a dip in performance, and with the exception of October, performance has continued to drop. Performance in the last 4 months has been significantly lower, with performance in February 2023 at 82.2%.

Narrative	**Issues:**	**Actions & Mitigations:**
	In February 2023, 45 complaint responses were sent. Of these, 37 were sent within the agreed timeframe. 41 new formal complaints were received. Due to the continued pressures at the Trust, and on the availability of clinical staff to undertake administrative work, there have been a number of cases where the divisions have not received responses/statements in a timely manner. This has meant we have not been able to respond to the complaint within the timescale we have provided at the outset of the investigation. Although we aim to resolve concerns informally where appropriate, we are seeing high number of complex complaints being received that require investigation via the formal NHS complaints procedure. The top 3 themes were: 1. Communication / 2. Clinical treatment / 3. Patient care There were 231 informal concerns/enquiries received in February 2023. The top 3 themes were: 1. Appointments / 2. Communication / 3. Property (lost/missing)	Where necessary, new timescales are agreed with the complainant, particularly when the delay is as a result of staff absence or delay from another organisation involved with the complaint. The PALS & Complaints team continues to liaise with the divisions and external organisations with the aim of achieving a response rate above 95%.

Integrated Performance Report

NHS Stockport NHS Foundation Trust

Measure	**ED: 4hr Standard** The percentage of patients who were admitted, discharged, or leave A&E within 4 hours of their arrival.	**Latest Performance**	**Next Month Forecast**
Performance of this measure over time		**Variance** **Latest Month** Feb-23 **Actual** 61.6% Data shows common cause variation, suggesting no significant changes in performance **Assurance** **Target** >= 95% Performance consistently falls short of the target value	
What the chart tells us	Since September 2021, ED performance against the 4hr standard has averaged 61%. Performance has been variable, but with no significant changes until December 2022, which saw a drop to 51%, which is significant because it is below the normal range of variation. Latest performance for January and February has seen a return to the 60% average.		

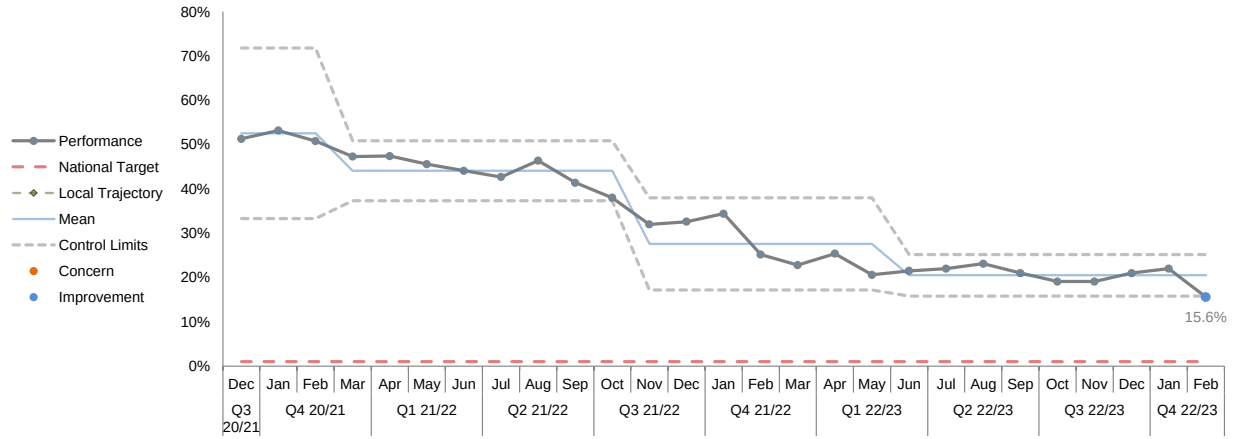
Narrative	**Issues:**	**Actions & Mitigations:**
	Stockport is ranked 3rd out of the 11 GM emergency sites at 61.6% for the current month to date Average attendances increased to 321 per day, with ED attends trending higher than the 2019/20 baseline year. Attendances are currently 6.5% above the YTD plan (Apr22-Feb23), a variance of +6173 attendances. - Overall performance benchmarks well but is significantly deteriorated vs. last year. - Current performance against the 4-hour standard remains a challenge to good patient flow. Bed occupancy continually exceeds 98%, which is beyond the recognised safe limits for effective flow. Timely access to domicile care and community beds is significantly challenging. - Overall levels of patients with no criteria to reside are significantly more than optimised position of 40-50 per day and double the position in the same period last year. - The number of out-of-area patients with no criteria to reside is significant, with other localities failing to meet demand. This relates to North Derbyshire and East Cheshire.	Internal Patient Flow project. A number of projects in place to support flow: - Director of the Day rota continues to support flow and challenge the discharge position. - 7 day support is in place including adult social care and work stream considering overnight ED flow - Long LOS reviews led by Deputy Medical Director now established on 8 wards - Transformational projects continue to support with flow - "One Year On" marketplace review in April - Triage & navigation, ED workforce, UTC & E-triage

Integrated Performance Report

NHS Stockport NHS Foundation Trust

Measure	Diagnostics: 6 Week Standard The percentage of patients referred for diagnostic tests who have been waiting for more than 6 weeks.	Latest Performance	Next Month Forecast
			

Performance of this measure over time



Variance

Latest Month		Actual
Feb-23		15.6%

The data shows special cause variation, indicated by a value below the lower control limits.

Assurance

Target

<= 1%

Performance consistently exceeds the target value

What the chart tells us

Performance has been improving steadily since May 2020. Significant improvements in performance can be seen with changes in March 2021, November 2021, and again in June 2022. Average performance has been at 20.5% since then, with the latest performance for February showing further improvement.

Narrative

Issues:	Actions & Mitigations:
All radiology modalities remain compliant. Pressure on endoscopy remains, as a result of increased colorectal suspected cancer referrals, coupled with high sickness absence. The endoscopy estates scheme completed at the end of January and handed over to the team in early February. Further insourcing option has been secured and will utilise the additional capacity to focus on recovery. Biggest area of challenge, and highest backlog is echocardiology. Estates work being considered to create a 6th room. Latest position does shows a reduction in waiting list size as clinic utilisation improves.	Endoscopy has secured additional insourcing to support further reduction in the backlog at year end. Echocardiology requires as start date for the capital scheme in 2023/24 so that capacity can meet demand recurrently.

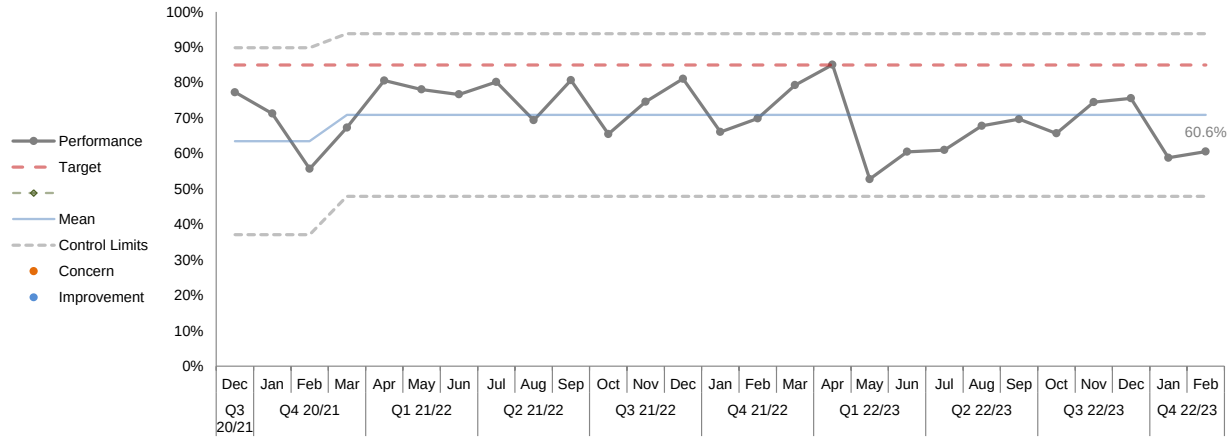
Integrated Performance Report

NHS Stockport NHS Foundation Trust

Measure	**Cancer: 62-day standard - includes narrative for 28-day and 14-day standards** The percentage of patients on a cancer two-week-wait pathway that have received their first treatment within 62 days of GP referral. Screening referrals are not reported as not statistically viable due to low number received

Latest Performance	Next Month Forecast
	

Performance of this measure over time



Variance

Latest Month	Actual
Feb-23	60.6%

Data shows common cause variation, suggesting no significant changes in performance

Assurance

Target
>= 85%

Performance consistently falls short of the target value

What the chart tells us	For much of the reporting period, performance has been variable around the average of 71-72%. There have been no significant changes to performance since the improvement to the average in March 2021.

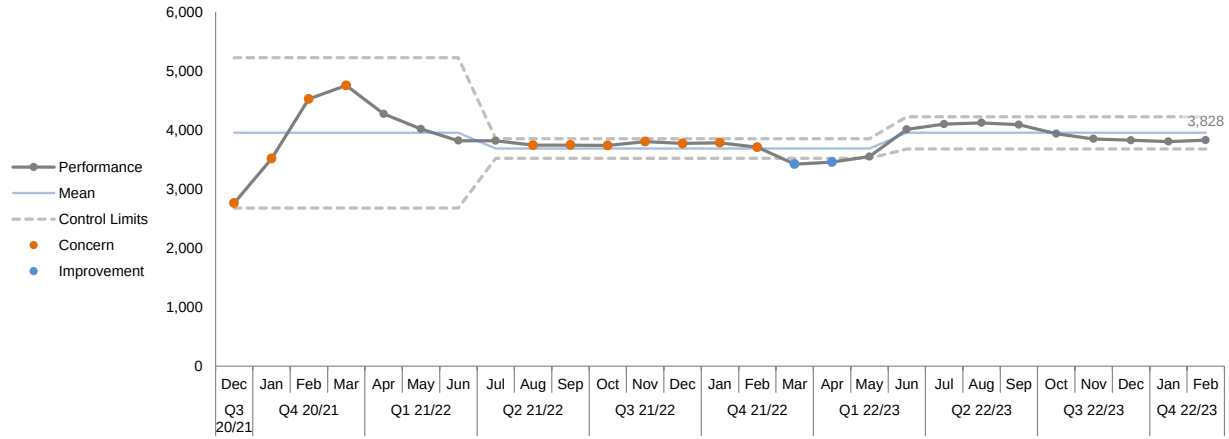
Narrative	Issues:	Actions & Mitigations:
	Referral rates remain high, showing a 22.3% increase April to February compared to the same period in 2021/22. Gynaecology is particularly high at 30%. Access and reporting times for diagnostic tests improved in month, however the challenges of theatre capacity and non-elective bed pressures remain. Performance against the 28-day faster diagnosis standard was much improved in month, achieving 73% against the 75% target. The Trust continues to perform strongly against the 14-day standard.	The wider cancer transformation programme continues with project groups aligned to the Best Timed Pathways. Trust elective performance meetings continue to focus on progressing patient pathways and reducing 63+ day waits for cancer treatment. The Trust continues to utilise capacity at The Christie for Urology and General Surgical cases.

Integrated Performance Report

NHS Stockport NHS Foundation Trust

Measure	Referral to Treatment: 52 Week Breaches The total number of patients whose pathway is still open and their clock period is greater than 52 weeks at month end.	Latest Performance	Next Month Forecast
			

Performance of this measure over time



Variance

Latest Month		Actual
Feb-23		3828

Data shows common cause variation, suggesting no significant changes in performance

Assurance

Target: <= 0

Performance consistently exceeds the target value

What the chart tells us	A significant improvement is seen between March 2022 and May 2022, with the number of breaches reducing. A significant increase is seen from June 2022 where the average number of breaches jumps by 300 a month from 3680 to 3980. Since that time performance has not changes significantly, with the latest non-validated figures for February at 3925.

Narrative	Issues:	Actions & Mitigations:
	The number of patients waiting 52+ weeks to commence treatment increased from 3803 to 3925 this month The Trust continues to reduce the number of patients waiting 104+ weeks and those waiting are either due to patient choice to defer or are clinically complex cases. We are predicting all of these patients will be either treated or addressed through the access policy by the end of March. The return of both the day case ward and the elective orthopaedic ward in February has been positive in terms of our elective activity. The levels of urgent and suspected cancer referrals remain high, resulting in extended waits for routine referrals in some services. Staffing challenges within theatres also continues to impact full recovery of elective activity.	Validation exercise via the digital communications system is now running every 6 weeks to ensure that patients awaiting a new appointment still want to attend. Validation of the admitted waiting list is also being mobilised with the policy being finalised with clinical colleagues in March. Mutual aid for cancer capacity due to anaesthetic staffing issues continues for colorectal and urology. Continue to transfer/treat patients under the GM independent sector contract and have also approached other GM Trusts for support with ENT long waiters. 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 by the end of March 23.

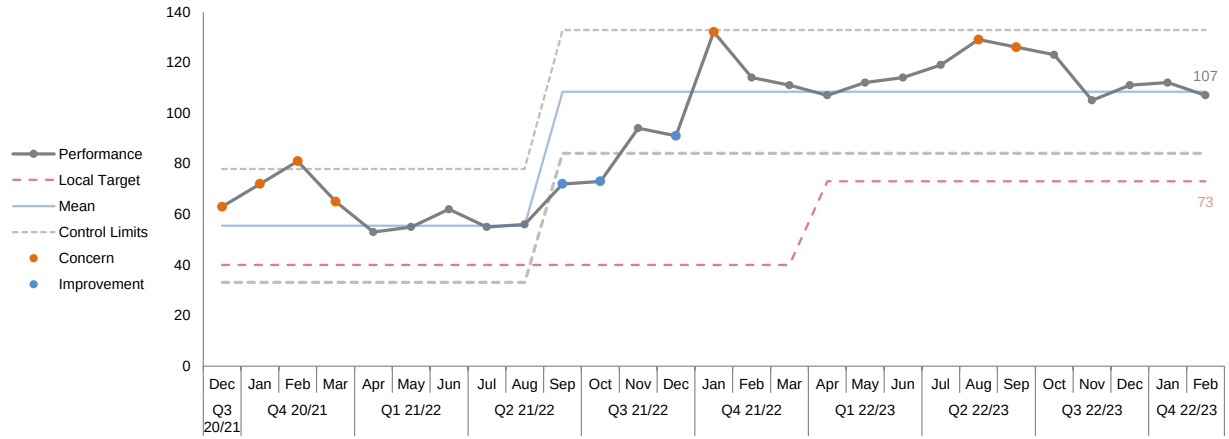
Integrated Performance Report

NHS Stockport NHS Foundation Trust

Measure	**No Criteria To Reside (NCTR)** Number of patients with "No Criteria to Reside". This metric is a mean average per day for each month.

Latest Performance	Next Month Forecast

Performance of this measure over time



Variance

Latest Month	Actual
Feb-23	107

Data shows common cause variation, suggesting no significant changes in performance

Assurance

Target
<= 73

Performance consistently exceeds the target value

What the chart tells us	Between September and January 2022 the number of patients with no criteria to reside increases significantly from 55 to 132. The average number of patients per day has now changed to 109 and there have been no significant changes in performance in the last 12 months.

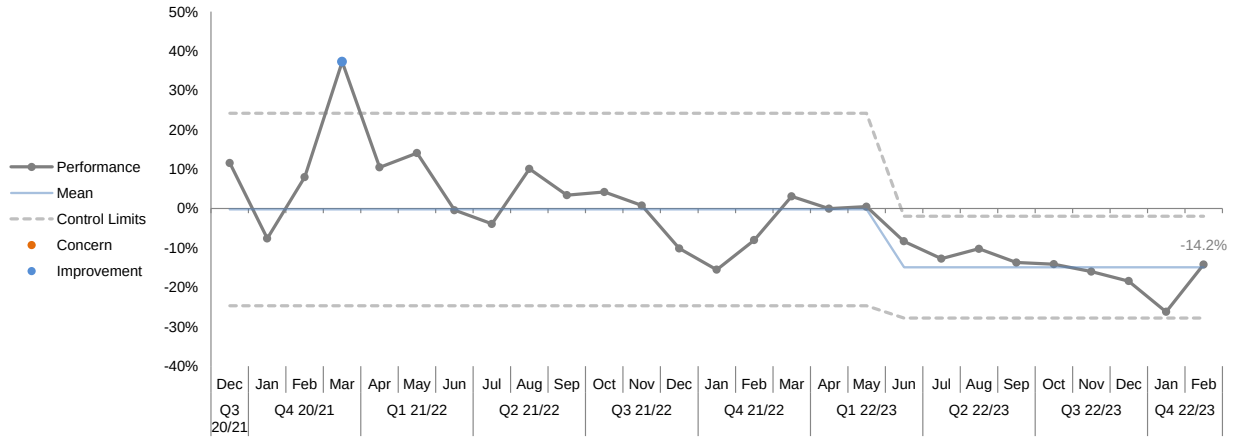
Narrative	**Issues:**	**Actions & Mitigations:**
	- The number of patients with no criteria to reside in month remains higher than the target level and whilst the numbers had been reducing, partly due to the availability of additional GM winter funded community D2A beds commissioned until the end of March 2023, the challenge to achieve manageable numbers remains. - There has been a slight decrease in month and the Transfer of Care Hub has gone live - this will help streamline referrals on Pathways 1 - 3 and ensure an integrated approach to capacity and discharges. - We continue to have issues with capacity due to the closure of some care home beds due to Covid, flu and other infectious diseases. The challenges of accessing timely care home beds and community packages of home care is adversely impacting on patient flow both through the hospital and also on flow through the community D2A beds and the community D2A Hub. - The number of out-of-area patients is 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.	- Continued working with system partners supporting discharge of Stockport patients on pathways 1 & 2. System tactical meetings held 3 x a week as we continue to escalate and increased in frequency as required. Transfer of Care Hub became operational in February bringing together system partners in one geographical place to focus on Pathway 1 - 3 discharges. - Review of all patients on the NCtR list daily to ensure patients are on the correct pathway. - Monitoring use of the additional 20 community D2A beds, - Monitoring of additional hours for packages of care, commissioned from Routes Healthcare, to support flow via Pathway 1. (Operational management for the contract now with SFT.) - Internal Patient Flow project. A number of projects in place to support flow, which includes MDTs taking place daily across the trust to provide support to all wards - Joint SFT and LA Transfer of Hub T&F group established to review processes and improve integrated working. - Working with LA Health Protection team re individual patient risk based assessments for admissions to care homes with IP controls in place - Work with OOA partners continues with daily operational meetings in place with North Derbyshire in particular and East Cheshire colleagues to support mitigating actions preventing flow.

Integrated Performance Report

NHS Stockport NHS Foundation Trust

Measure	Activity vs. Plan: Elective Inpatient and Daycase The percentage variance between the total elective activity (Elective-Inpatient and Daycase) and the total planned elective activity submitted for 2022/23. Excludes Breast Surgery and Swanbourne House activity. Based on the flex/freeze position, not the SUS position. A value above 0% indicates that activity is above planned levels.	Latest Performance	Next Month Forecast
			

Performance of this measure over time



Variance

Latest Month		Actual
Feb-23		-14.2%

Data shows common cause variation, suggesting no significant changes in performance

Assurance

Target >= 0%

Performance consistently falls short of the target value

What the chart tells us	The chart show that elective and daycase performance against the plan has been variable across the reporting period. Data shows that activity delivered has been consistently below the operational plan since June 2022.	

Narrative	Issues:	Actions & Mitigations:
	Activity has been impacted by - the requirement to utilise the elective bed base to support the urgent care pressures and bed occupancy due to sub optimal levels of patients with no criteria to reside. - period of operational escalation in December and January resulting in the need to cancel elective activity to support site safety and increase flow across the acute site - cancellation of elective acuity in order to respond to the BMA strike action in March resulted in a large scale cancellations affecting performance against plan.	Ongoing validation of the waiting list is taking place in order to reduce patient waits Additional lists have been delivered o recover activity where teams are willing to do this.

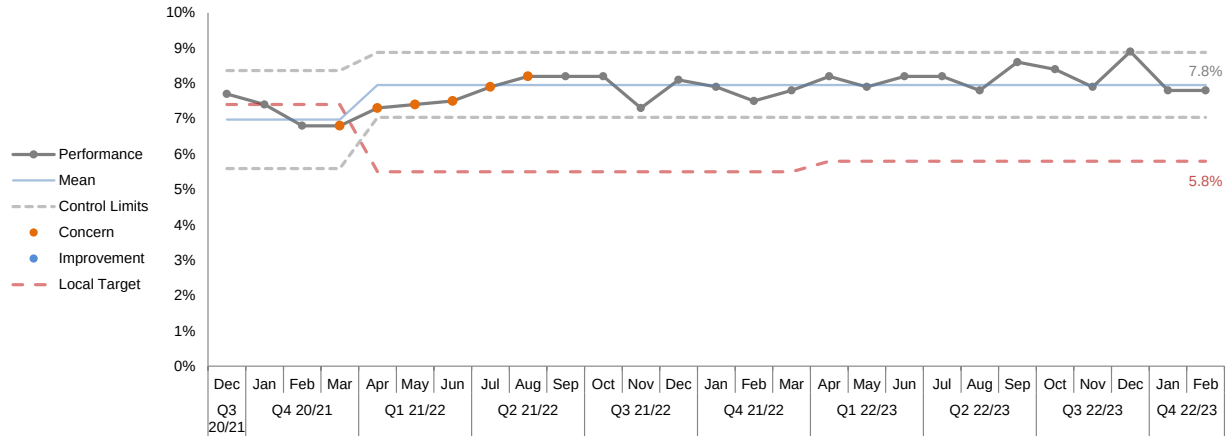
Integrated Performance Report

NHS Stockport NHS Foundation Trust

Measure	**Outpatient DNA rate - includes narrative for Clinic Utilisation and PIFU** The percentage of outpatient appointments where the patient did not attend (DNA). This indicator combines new and follow-up appointment types. The latest target for this metric is based on the peer median performance for April 2021 in NHSEI Model Hospital.

Latest Performance | **Next Month Forecast**

Performance of this measure over time



Performance

Latest Month	Actual
Feb-23	7.8%

Assurance

Target: <= 5.8%

Performance consistently falls short of the target value

What the chart tells us

The data shows that since April 2021 there has been a significant change in the DNA rate rising from 7% to 7.9%. DNA rates have been variable, but consistent with this average since then and there have been no significant changes.

Narrative

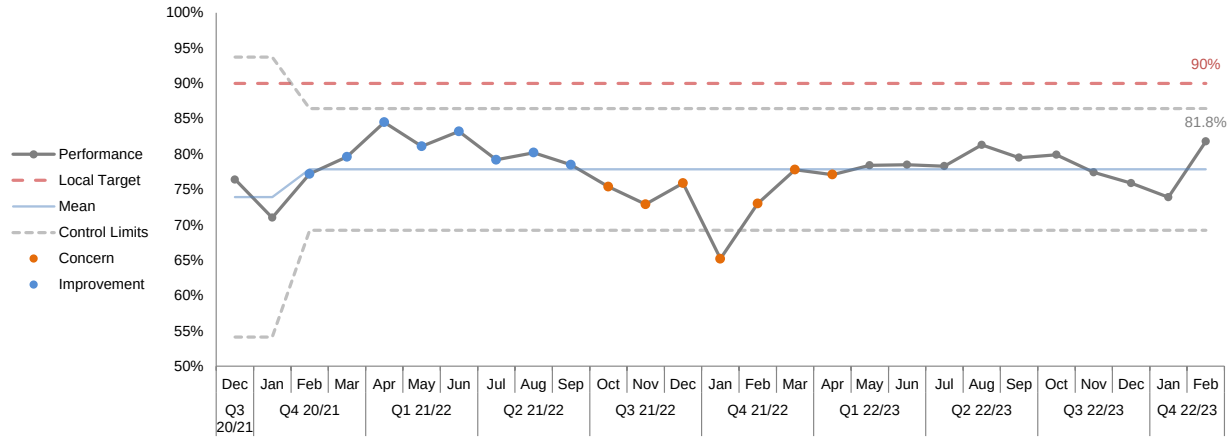
Issues:	Actions & Mitigations:
DNA: With latest DNA rates reported at 7.8%, the Trust continues to benchmark positively compared to GM and National peers, with comparable rates of 10.5% and 7.84% respectively. In order to support productivity and efficiency gains, we will aim to improve rates further with a stretch target of 5.8% planned for 2023/24. Clinic Utilisation: Current performance continues to achieve the target of 85% however there is variability across responsibilities. - Booking Team (95%) - Booked Under Instructions (89%) - Non Booking Team (84%) PIFU: The PIFU target has been challenging but despite not meeting the target Stockport continues to be the best Performing Trust in GM (three fold).	DNA: - Patient-facing RCA exercises have been undertaken to obtain a better understanding from patients. An action plan has been developed based on patient responses. - A review of clinics that are offered reminders is underway. - The outsource company for text reminders to review data and feedback finding and themes - To review and understand better IMD impact of DNAs by specialty Clinic Utilisation: - Further centralisation of the appointment booking is moving at pace for those services agreed - Monthly reviews of performance at speciality level for those under 90% - Reporting and action plans for non booking team areas to be developed by teams and monitored via Trust Performance and Elective Care group PIFU: - GIRFT information reviewed and shared with speciality teams. Gap analysis against undertaken with associated actions plans - PIFU implementation resource packs and leaflets have been developed and shared

Integrated Performance Report

NHS Stockport NHS Foundation Trust

Measure	Theatres: Capped Utilisation The actual session times as a percentage of the planned session time. Based on the time from the start of the session to the end of the session unless it lasts longer than the planned session minutes in which case it is capped at 100%. Downtime between operations in a session is included in these utilised minutes. Includes elective and paediatric sessions only, and excludes maternity and endoscopy theatre locations.	Latest Performance	Next Month Forecast
			

Performance of this measure over time



Performance

Latest Month	Actual
Feb-23	81.8%

Assurance

Target

>= 90%

Performance consistently falls short of the target value

What the chart tells us

The data shows that between October 2021 and April 2022 there was a period when performance was significantly worse than usual. Since then performance has been maintained above average, except for a drop in performance between November 2022 and January 2023.

Narrative

Issues:

Continued organisational flow and urgent care pressures are impacting on the elective bed-base. As a result the number of short-notice cancelled operations adversely affects our theatre utilisation metrics.

Actions & Mitigations:

A Theatres Improvement project support by the transformation team is ongoing through SIG. The project has a particular focus on patient flow, pre-op assessment, and booking and scheduling.

Good progress has been made on the centralisation of our elective booking and scheduling team. The team is now in place, and work has commenced around the standardisation of processes.

A proposal is being worked up around restructure and relaunch of the 642 Theatre Scheduling and Utilisation process.

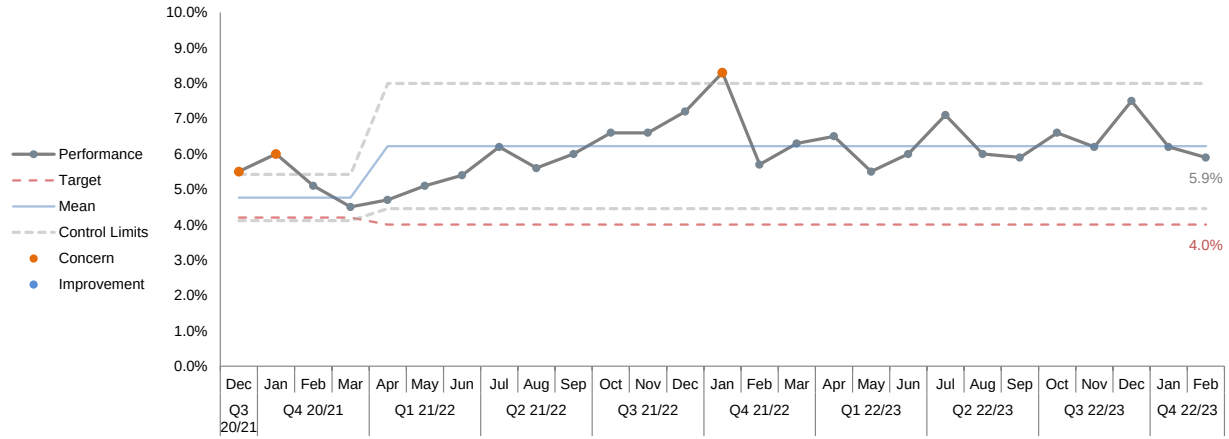
Integrated Performance Report

NHS Stockport NHS Foundation Trust

Measure	**Sickness Absence: Monthly Rate** The total number of staff on sickness absence, calculated as a percentage of all staff-in-post whole time equivalent.

Latest Performance | **Next Month Forecast**

Performance of this measure over time



Variance

Latest Month	Actual
Feb-23	5.9%

Data shows common cause variation, suggesting no significant changes in performance

Assurance

Target

<= 4%

Performance consistently exceeds the target value

What the chart tells us

A significant increase in sickness rates can be seen from April 2021 onwards as the average sickness rates increase from 4.7% to 6.2%. Apart from a spike in sickness levels in January 2022, with a rate of 8.4%, there have been no significant changes in the sickness levels.

Narrative

Issues:

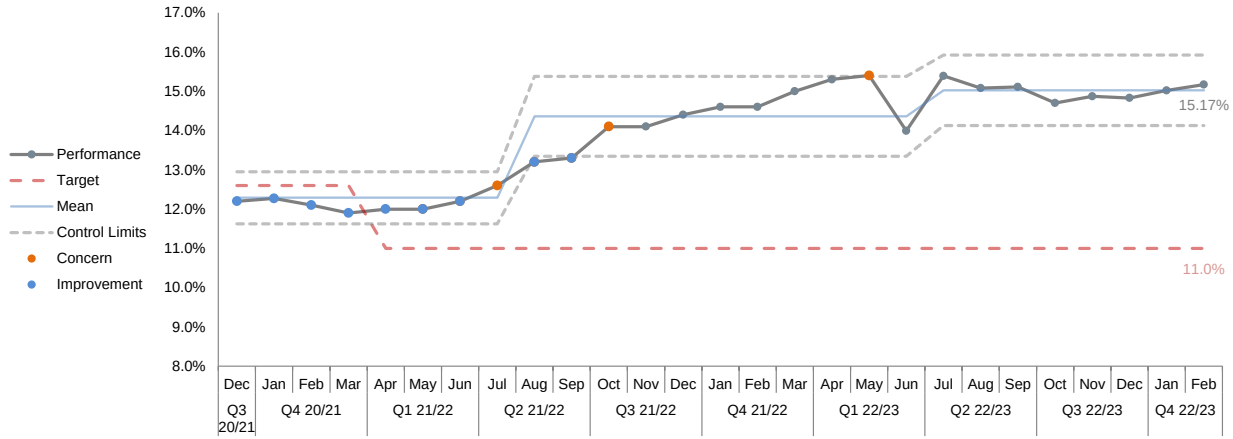
Actions & Mitigations:

The back pain prevention promotion and events recently held across the Trust have been successful and it is hoped this will support a reduction in MSK related sickness absence in the future.

Staff are being supported in context of industrial strike action and the implications this may have on sickness and health & well being.

Integrated Performance Report

NHS Stockport NHS Foundation Trust

Measure	**Workforce Turnover** The percentage of employees leaving the Trust and being replaced by new employees.	**Latest Performance**	**Next Month Forecast**
Performance of this measure over time		**Variance** **Latest Month** Feb-23 **Actual** 15.17% Data shows common cause variation, suggesting no significant changes in performance **Assurance** **Target** <= 11% Performance consistently exceeds the target value
What the chart tells us	In August 2021 a significant increase can be seen with a rise from 12.3% average to 14.3%. Between October 2021 and May 2022 turnover has continued to rise, with significant increased flagged. From July 2022, a consistent increase in turnover is seen as the average moves from 14.3% to 15%. Since then there have been no significant changes to workforce turnover.		
Narrative	**Issues:** Integrated Care division has the highest turnover rate of 17.78%, followed by Corporate with 17.07%. Women's and Children's Division has the lowest turnover rate (12.83%). The top known leaving reasons in February was voluntary resignation: – Voluntary resignation (Promotion) - 22% – Voluntary resignation (Relocation) - 15% – Retirement (Work/Life Balance) - 15%.	**Actions & Mitigations:**	

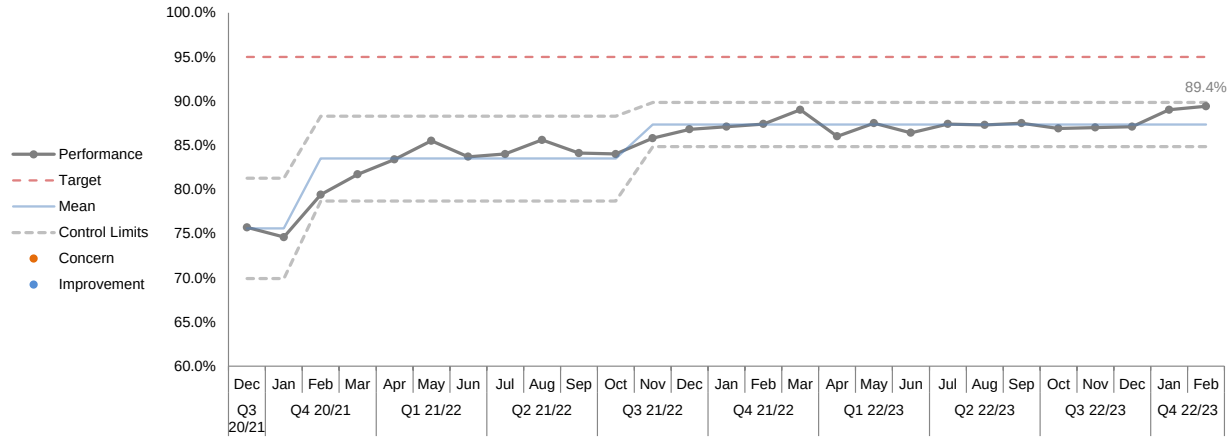
Integrated Performance Report

NHS Stockport NHS Foundation Trust

Measure	**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.

Latest Performance	Next Month Forecast
	

Performance of this measure over time



Variance

Latest Month		Actual
Feb-23		89.4%

Data shows common cause variation, suggesting no significant changes in performance

Assurance

Target

>= 95%

Performance consistently falls short of the target value

What the chart tells us

The chart shows that in February 2021 and then again in November 2021, significant improvements in performance can be seen as average appraisal rates increase. There have been significant changes to appraisal rates November 2021.

Narrative

Issues:

Women's and Children's Division = 96.05%
Clinical Support Services Division = 94.31%
Estates and Facilities Division = 90.26%
Integrated Care Division = 90.99%

All other divisions are reporting below 90%.

The medical appraisal rate increased between January and February from 90.4% to 93%, but remains below the Trust target of 95%.

Actions & Mitigations:

The OD Team is continuing to deliver appraisal training for managers and appraisers to support the improvement and quality of appraisals throughout the Trust.

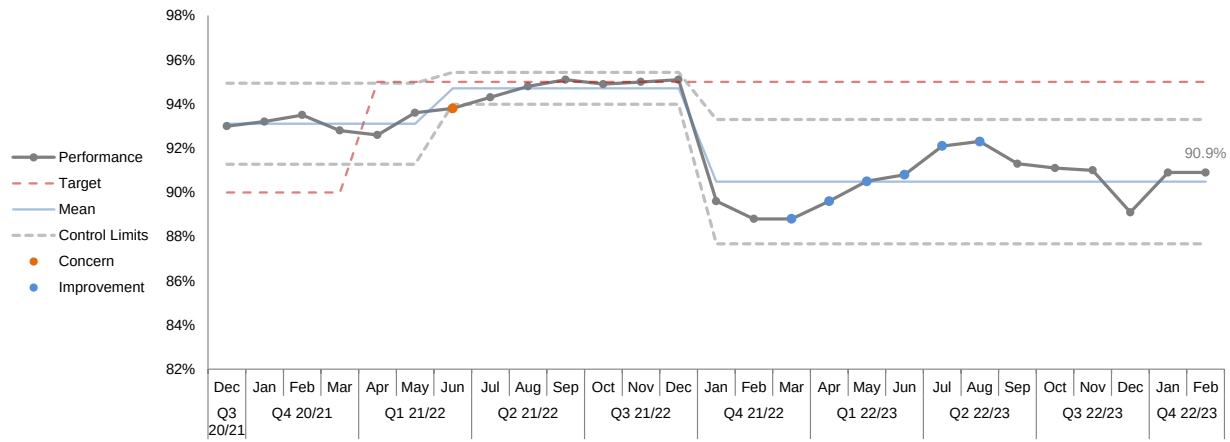
Medical appraisal is continuing to be managed in accordance with national guidance following the pause during the pandemic; this structured approach is monitored within the Divisions.

Integrated Performance Report

NHS Stockport NHS Foundation Trust

Measure	Statutory & Mandatory Training The percentage of statutory & mandatory training modules showing as compliant.	Latest Performance	Next Month Forecast
			

Performance of this measure over time



Variance

Latest Month	Actual
Feb-23	90.9%

Data shows common cause variation, suggesting no significant changes in performance

Assurance

Target

>= 95%

Performance consistently falls short of the target value

What the chart tells us

New competencies added in December 2021 have led to the significant drop in reported performance. From February , there is an improving trend in performance, which is flagged as a significant improvement, but this trend ends with performance in September and October 2022 dropping to 91%, but remaining above the average. There have been no significant changes to performance since then.

Narrative

Issues:	Actions & Mitigations:
Performance has been affected by recent industrial action and a high DNA rate which the Learning and Education Team have tried to mitigate by providing alternative options and extra sessions.	The Learning and Education Team are working with ward managers to book colleagues onto their statutory and mandatory training - targeting hot spot areas such as resuscitation, to improve compliance with these topics. Work is ongoing with HRBMs and Clinical Educators to support creating trajectories and development plans.

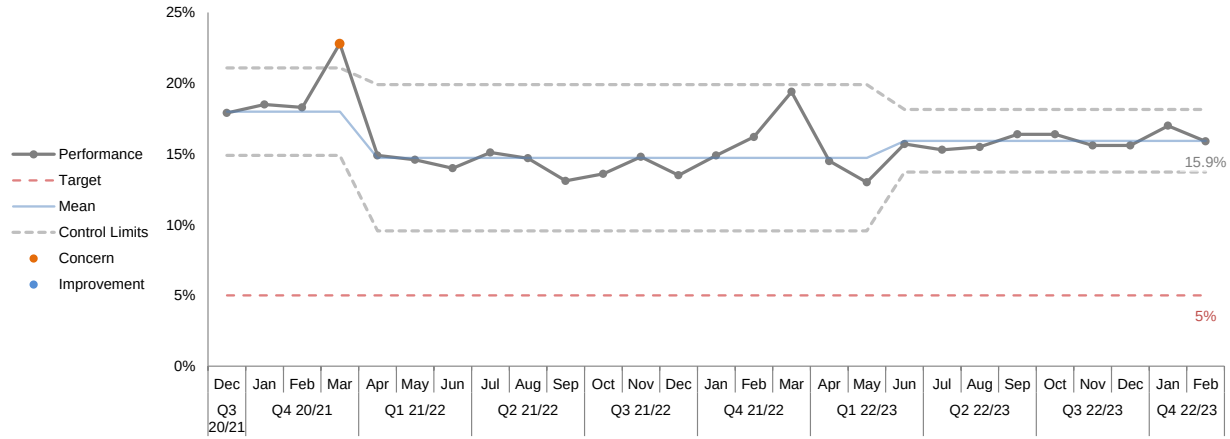
Integrated Performance Report

NHS Stockport NHS Foundation Trust

Measure	**Bank & Agency Costs** The total bank & agency cost as percentage of the total pay costs

Latest Performance	Next Month Forecast
	

Performance of this measure over time



Variance

Latest Month	Actual
Feb-23	15.9%

Data shows common cause variation, suggesting no significant changes in performance

Assurance

Target

<= 5%

Performance consistently exceeds the target value

What the chart tells us	The chart shows that in April 2021 there was a significant drop in the average bank and agency costs to 14.9%. There have been no significant changes in bank and agency costs since that time.

Narrative	Issues:	Actions & Mitigations:
	The total bank and agency spend in February 23 was £4.16M, which represents 15.9% of the total pay bill within the month and is 92K lower than January 23. The Division with the highest bank & agency spend in February was Medicine (£1.17M).	Agency rates continue to be scrutinised at the weekly Staffing Approval Group (SAG) and recruitment events are on-going in order to increase substantive staff in post to mitigate agency spend.

NHS Stockport NHS Foundation Trust

Meeting date	6 April 2023		Public	✓	Confidential	Agenda item
Meeting	Trust Board					
Title	2022 NHS National Staff Survey Results					
Lead Director	Amanda Bromley, Director of People and OD	Author	Stuart McKenna, Assistant Director of HR (Inclusion and Colleague Experience)			

Recommendations made / Decisions requested

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

This paper relates to the following Corporate Annual Objectives-

	1	Deliver safe accessible and personalised services for those we care for
✓	2	Support the health and wellbeing needs of our communities and staff
	3	To work with partners to co-design and provide integrated service models within the locality and across acute providers
	4	Drive service improvement, through high quality research, innovation, and transformation
✓	5	Develop a diverse, capable, and motivated workforce to meet future service and user needs
	6	Utilise our resources in an efficient and effective manner
	7	Develop our Estate and IM&T infrastructure that is fit for purpose and meets service and user needs

The paper relates to the following CQC domains-

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

This paper is related to these BAF risks		**PR1.1**	There is a risk that the Trust delivers sub-optimal quality services and fails to meet regulatory standards
		PR1.2	There is a risk that the Trust fails to reduce harm against agreed baseline
		PR1.3	There is a risk that patient flow plans are not effective leading to decline in A&E performance
		PR1.4	There is a risk that inclusive restoration plans to address elective backlog are not delivered
	✓	**PR2.1**	There is a risk that the Trust fails to support and engage its workforce
		PR2.2	There is a risk that the Trust's services do not reliably support neighbourhood population health and future care needs
		PR3.1	There is a risk that effective partnership and accountability arrangements are not in place at ICS and locality provider level
		PR4.1	There is a risk that there is insufficient capacity and capability to deliver Trust, locality, and system wide transformation programmes
	✓	**PR5.1**	There is a risk that robust plans to recruit, train and retain the right staff to meet service needs

			are not implemented
	✓	**PR5.2**	There is a risk that the Trust does not deliver the Equality, Diversity & Inclusion Strategy
		PR6.1	There is a risk that the Trust fails to deliver its agreed 2021/22 financial position
		PR6.2	There is a risk that the Trust fails to develop a multi-year financial recovery plan to secure financial sustainability
		PR7.1	There is a risk that the estate is not fit for purpose and does not meet national standards
		PR7.2	There is a risk that the Trust does not materially improve environmental sustainability
		PR7.3	There is a risk that there is no identified funding mechanism or insufficient funding to support strategic regeneration of the hospital campus
		PR7.4	There is a risk that the Trust fails to develop and implement a responsive and resilient Digital Strategy

Where issues are addressed in the paper-

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

Executive Summary

Staff experience sits at the very heart of safe and quality focused patient care and employee engagement has been identified by the NHS 10 year plan and its accompanying People Plan as a key driver to success. The NHS Staff Survey provides an opportunity for organisations to survey their staff in a consistent and systematic way. This makes it possible to build up a picture of staff experience and, with care, to compare and monitor change over time and to identify variations between different staff groups.

The 2022 NHS national staff survey was open from 26 September to 25 November 2022. Questionnaires were sent to 5,906, staff across the Trust. After excluding respondents that were later known to be ineligible, a usable sample of 5,885 remained. From the usable sample, 2,481 questionnaires were returned yielding a response rate of 42.4%, compared to 43% in the previous year.

There were 3 questions where the scores showed significant improvement from the previous year. There were 9 questions where the scores have significantly declined since the previous survey. 86 questions have shown no significant movements since 2021 or the score remains the same.

Previous reports presented to the People Performance Committee included benchmark information relating only to other Trusts that had engaged IQVIA as their survey provider. This report provides benchmark information relation to our national benchmark group: Acute and Combined Acute and Community Trusts, of which there are 124 organisations.

Our results show that there has been a statistically significant improvement in the People Promise theme: we work flexibly. The remaining six People Promise theme scores have remained the same or slightly changed but these changes are deemed to be statistically not significant. Our Staff Engagement score has very slightly decreased to 6.7 (again deemed to be statistically not significant) and our Staff Morale score has remained at 5.7 compared to last year. Data for the nine main scores is also provided for comparative Trusts across Greater Manchester.

A full internal communications plan will be implemented that has a focus on celebrating our positive staff survey results and engaging our workforce in helping make our Trust a great place to learn, develop and work.

Divisional/Directorate Leadership Teams will shortly receive their detailed results. They will be supported by People and OD colleagues and the Communications Team to cascade their results to their staff and develop and implement key actions over the next 6 to 12 months that will help improve staff experience.

The Trust's latest staff survey results are a significant achievement against a backdrop of unprecedented operational pressures, staff absence and the cost of living crisis. Regularly listening to our staff with authenticity, and understanding what is working well and where improvements are required helps us to ensure that we are focusing on the things that matter the most to our employees. Our journey is far from over but we are clear on our priorities and we will continue to co-create a better future for our brilliant workforce.

2022 NHS National Staff Survey Results

1. Introduction

1.1 Staff experience sits at the very heart of safe and quality focused patient care and employee engagement has been identified by the NHS 10 year plan and its accompanying People Plan as a key driver to success.

1.2 The NHS national staff survey provides an opportunity for organisations to survey their staff in a consistent and systematic way. This makes it possible to build up a picture of staff experience and, with care, to compare and monitor change over time and to identify variations between different staff groups. Obtaining feedback from staff and taking account of their views and priorities is vital for driving real service improvements in the NHS.

1.3 The 2022 NHS national staff survey was open from 26 September to 25 November 2022. The questionnaire was developed by the NHS Staff Survey Coordination Centre together with the NHS Advisory Board. NHS England and NHS Improvement have comprehensive guidelines on which staff are be included in the survey.

1.4 For the second consecutive year, the questions have been linked to the elements and themes of the NHS People Promise, allowing for a direct comparison to the 2021 survey results.

1.5 The national embargo of the results was lifted on 9 March 2023. The People Performance Committee have received the Trust's survey results which were compared against a benchmark group that comprised of Combined Acute and Community Trusts plus Acute Trusts that used the third party survey provider; IQVIA.

2. Response Rates

2.1 We achieved a 42.4% overall response rate, with 2,481 employees completing the survey. This is a decrease of 0.6% on responses received in the 2021 survey (43%). The median response rate in this year's survey for our national comparator group was 44%.

2.2 Response rates varied between 36% and 94% across the Trust as shown in the table below.

STOCKPORT	2022 Response Rate
Corporate Services	66%
Chief Executive's Department	85%
Finance & Procurement	92%
People & Organisational Development	67%
IT & Information Services	68%
Corporate Nursing	44%
Performance & Transformation	60%
Research & Innovation	94%
Clinical Support Services	48%
Estates & Facilities	41%
Integrated Care	41%
Medicine, Urgent Care & Clinical Support	36%
Surgery	36%
Women's, Children's & Diagnostics	42%
Trust Overall	**42%**

3. People Promise Scores

3.1 For the second consecutive year, the staff survey questions have been mapped to the elements and themes within the NHS People Promise:

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

3.2 Each element and sub-theme of the People Promise is scored out of a possible 10. The table below shows our Trust's People Promise element 2022 scores compared to our 2021 scores.

People Promise elements	2021 score	2021 respondents	2022 score	2022 respondents	Statistically significant change?
We are compassionate and inclusive	7.3	2256	7.2	2470	Not significant
We are recognised and rewarded	5.8	2304	5.8	2460	Not significant
We each have a voice that counts	6.7	2226	6.7	2429	Not significant
We are safe and healthy	5.9	2248	5.8	2445	Not significant
We are always learning	5.3	2159	5.4	2366	Not significant
We work flexibly	5.9	2289	6.1	2451	Significantly higher
We are a team	6.7	2271	6.7	2464	Not significant
Themes					
Staff Engagement	6.8	2309	6.7	2468	Not significant
Morale	5.7	2303	5.7	2471	Not significant

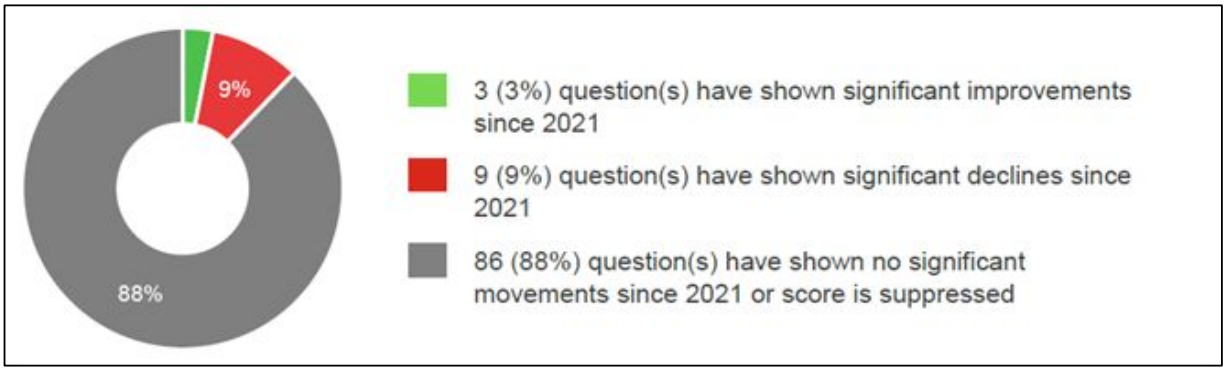
3.3 Subsequent analysis showed that the only statistically significant change was in relation to the People Promise element, "We work flexibly", showing a significant improvement compared to the previous 12 months.

4. Performance Against Our 2021 Results

4.1 There were 3 questions (3%) where the scores showed significant improvement from the previous year, compared to 12 in the previous year.

4.2 There were 9 questions (9%) where the scores have significantly declined since the previous survey, compared to 3 in the previous year.

4.3 **Appendix 1** shows those survey questions where there has been statistically significant difference in the responses from the previous year.



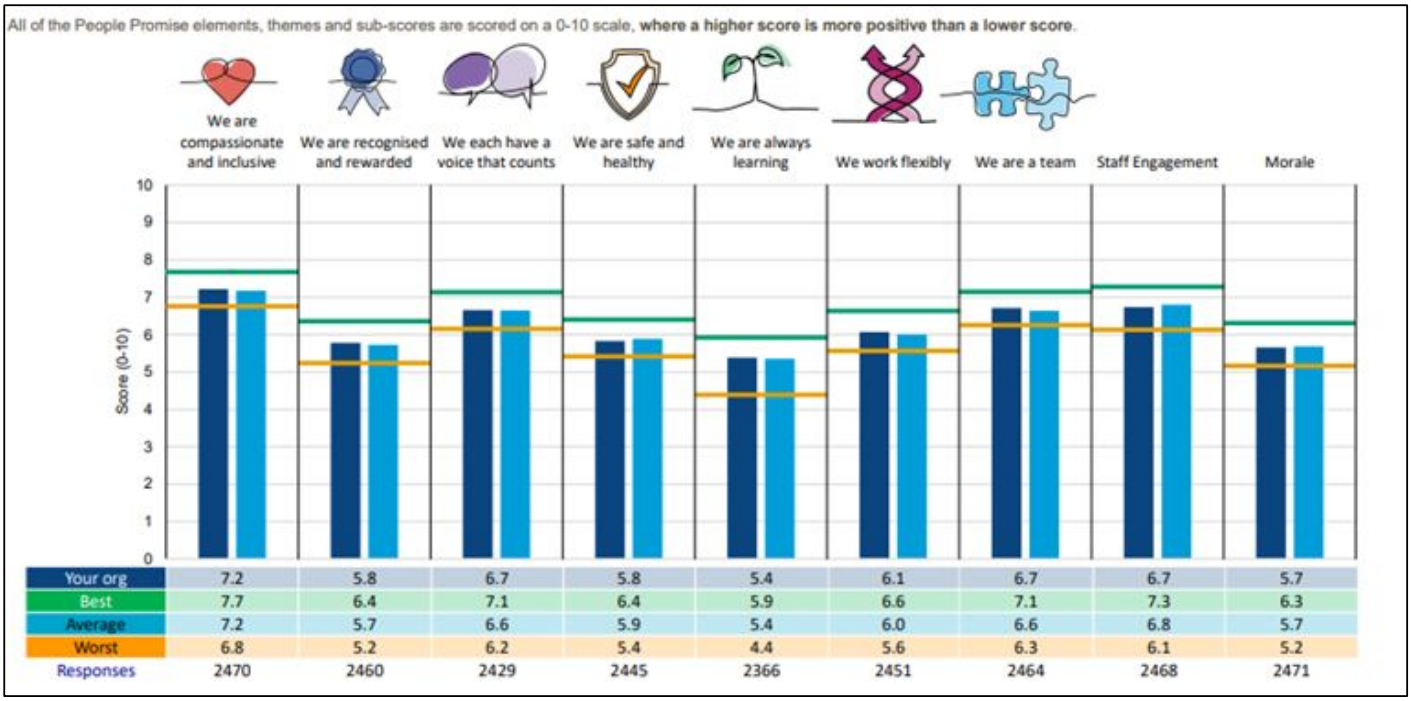
5. Greater Manchester Position

5.1 The table below shows the People Promise scores, plus Staff Engagement and Morale scores for each comparable Trust within the Greater Manchester footprint. Our Trust's performance is shown as a RAG rating against the other organisations' scores.

Trust	We are compassionate & inclusive	We are recognised & rewarded	We each have a voice that counts	We are safe & healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Bolton NHS FT	7.4	6.0	6.9	6.0	5.6	6.1	6.9	7.0	5.9
Tameside and Glossop IC NHS FT	7.2	5.9	6.7	6.0	5.4	6.2	6.7	6.8	5.8
Stockport NHS FT	7.2	5.8	6.7	5.8	5.4	6.1	6.7	6.7	5.7
Northern Care Alliance	7.2	5.7	6.7	5.9	5.2	6.0	6.6	6.7	5.7
Wrightington, Wigan & Leigh NHS FT	7.2	5.8	6.7	6.1	5.1	6.3	6.7	6.9	6.0
Manchester NHS FT	7.0	5.5	6.4	5.8	5.1	5.6	6.4	6.5	5.4
Overall Acute & Acute and Community Benchmark	***7.2***	***5.7***	***6.6***	***5.9***	***5.4***	***6.0***	***6.6***	***6.8***	***5.7***

6. Performance Against Our National Comparator Group

6.1 The chart below shows our Trust's People Promise Scores, Staff Engagement score and Staff Morale score, compared to our national comparator group.



6.2 7 out of our 9 Trust scores above are either equal to or better than the average score for our national comparator group.

6.3 The Trust's full results is available here, including benchmarking and historical scores against each question: https://cms.nhsstaffsurveys.com/app/reports/2022/RWJ-benchmark-2022.pdf

9.1

7. Steps Taken to Improve Staff Experience

7.1 The following provides a summary of some of the activities undertaken by the Trust, based on the feedback of the 2021 staff survey, and in advance of the 2022 survey window:

- Recognising that staffing has been a particular challenge, we have proactively recruited 113 International nurses in the last year, with plans to deliver a further 110 appointments this year, the Trust has recruited to over 900 vacancies in the last year, NHS Professionals have incentivised assignments, and we remain committed to filling vacancies as quickly as possible.
- Establishment of the new Staff Psychological Health and Wellbeing Service (SPAWs) providing individual and team support.
- The Trust, in collaboration with Henpicked, have introduced a variety of initiatives around the menopause including awareness sessions, training sessions for Managers and a Menopause Policy
- Executive Listening Events and Executive Walkabouts where staff can raise concerns with members of the Executive Team.
- The Trust has introduced Mental Health First Aiders, strengthening the offer of psychological support to our staff.
- We have run a number of Foodie Fridays with a variety of food vendors invited on site.
- The Trust has launched a monthly health and wellbeing newsletter providing information, support and signposting on all matters connected with Health and Wellbeing.

- We have increased recruitment and opportunities for career progression including registered nurse degree apprenticeships, AHP apprenticeships and a new HCA recruitment programme
- The Trust has increased the opportunities for flexible working and reviewed the Flexible Working Policy
- Whilst the Trust has re-introduced car parking charges, we have introduced a price reduction for those colleagues who undertake hybrid working and no charges for disabled staff or night staff.
- Iftar celebration in the staff restaurant to celebrate the end of Ramadan.

8. Key Priorities 2023-24

8.1 We will continue to deliver our People and OD Plan, Workforce Equalities Diversity and Inclusion Strategy and new Organisational Development Plan that addresses the areas our employees have identified as requiring improvement. Based on the findings of the NHS national staff survey our key priorities over the next 6 to 12 months include:

- **Improving culture and behaviours** – we will further embed our employee behaviours and deliver Civility Saves Lives sessions for our workforce. We are currently refreshing our leadership and management development offer which will include designing and implementing a Medical Leadership Development Programme.
- **Strengthening relationships** – we will develop and implement tools and interventions that help strengthen the relationship between employees and their immediate line manager. As well as make improvements to working relationships within teams and across the organisation.
- **Career progression** – we will design and implement targeted interventions that support career progression linked to our EDI agenda plus introduce a talent management and succession planning approach.
- **Accelerating our workforce EDI programme** – we will deliver a range of key actions aimed at achieving our EDI ambitions.

9. Next Steps

9.1 A full internal communications plan will be implemented that has a focus on celebrating our positive staff survey results and engaging our workforce in helping make our Trust a great place to learn, develop and work.

9.2 Divisional/Directorate Leadership Teams will shortly receive their detailed results. They will be supported by People and OD colleagues and the Communications Team to cascade their results to their staff and develop and implement key actions over the next 6 to 12 months that will help improve staff experience.

9.3 Subject specific results will continue to be shared with the relevant steering groups, including the EDI Steering Group, Health and Wellbeing Group and the Attract Develop and Retain Group. This will help inform and direct their work programmes.

9.4 The Trust will continue to encourage its' workforce to have their say in the NHS National Quarterly Pulse Survey which replaced the Staff Friends and Family Test. Data is collected in the first month of quarter 1, 2 and 4 and participation in the survey is mandated for all Trusts.

10. Conclusion

10.1 The Trust's latest staff survey results are a significant achievement against a backdrop of unprecedented operational pressures, staff absence and the cost of living crisis. Regularly listening to our staff with authenticity, and understanding what is working well and where

improvements are required helps us to ensure that we are focusing on the things that matter the most to our employees.

10.2 It continues to be a challenging time to work for the NHS and our performance in the NHS national staff survey evidences the hard work, commitment and investment that the Executive Team, divisions/directorates, staff side representatives and staff network members have contributed to making our Trust a great place to work. Our journey is far from over but we are clear on our priorities and we will continue to co-create a better future for our brilliant workforce.

Appendix 1: Significantly changed question results compared to 2021

The table below shows the 3 questions where there has been statistically significant improvement since the previous survey:

Question	2021	2022	Difference
I am satisfied with the opportunities for flexible working patterns.	50.1%	53.0%	2.9%
My organisation is committed to helping me balance my work and home life.	39.3%	43.9%	4.6%
My team has enough freedom in how to do its work.	53.0%	56.3%	3.3%

The table below shows the 9 questions where there has been statistically significant decline since the previous survey:

Question	2021	2022	Difference
I am able to make suggestions to improve the work of my team / department.	73.60%	70.80%	-2.80%
I am satisfied with my level of pay.	30.50%	25.20%	-5.30%
I feel a strong personal attachment to my team.	67.50%	64.80%	-2.70%
In the last three months, I have come to work despite not feeling well enough to perform my duties.	52.8%	56.60%	3.80%
In the last 12 months, I have personally experienced harassment, bullying or abuse at work from patients / service users, their relatives or other members of the public.	24.2%	28.30%	4.20%
In the last 12 months, I have personally experienced harassment, bullying or abuse at work from other colleagues.	16.30%	18.60%	2.30%
Experienced discrimination on grounds of ethnic background.	38.1%	46.60%	8.50%
I would feel secure raising concerns about unsafe clinical practice.	75.60%	71.10%	-4.50%
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.	60.40%	56.70%	-3.70%

Appendix 2

The table below shows the results where there has been no significant change compared to the previous year:

Question	2021 score	2022 Score	Change
I feel that my role makes a difference to patients / service users.	88.80%	88.90%	0.10%
Care of patients / service users is my organisation's top priority.	70.40%	70.10%	-0.30%
My organisation acts on concerns raised by patients / service users.	69.50%	68.80%	-0.70%
I would recommend my organisation as a place to work.	55.50%	53.50%	-2.00%
My immediate manager works together with me to come to an understanding of problems.	67.30%	66.30%	-1.00%
My immediate manager is interested in listening to me when I describe challenges I face.	70.00%	70.00%	0.00%
My immediate manager cares about my concerns.	69.10%	68.30%	-0.80%
My immediate manager takes effective action to help me with any problems I face.	64.60%	70.00%	5.40%
My organisation acts fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age.	57.90%	55.80%	-2.10%
In the last 12 months, I have personally experienced discrimination at work from patients / service users, their relatives or other members of the public.	5.90%	7.20%	1.30%
In the last 12 months, I have personally experienced discrimination at work from a manager / team leader or other colleagues.	6.90%	8.40%	1.50%
I think that my organisation respects individual differences (e.g. cultures, working styles, backgrounds, ideas, etc).	68.70%	68.60%	-0.10%
I feel valued by my team.	72.40%	71.40%	-1.00%
The people I work with are understanding and kind to one another.	75.30%	74.50%	-0.80%
The people I work with are polite and treat each other with respect.	75.50%	75.80%	0.30%
I am satisfied with the recognition I get for good work.	50.70%	49.60%	-1.10%
I am satisfied with the extent to which my organisation values my work.	38.50%	39.90%	1.40%
The people I work with show appreciation to one another.	72.00%	71.20%	-0.80%
My immediate manager values my work.	71.40%	71.90%	0.50%
I always know what my work responsibilities are.	85.40%	87.00%	1.60%
I am trusted to do my job.	90.70%	91.70%	1.00%
There are frequent opportunities for me to show initiative in my role.	73.80%	72.10%	-1.70%
I am involved in deciding on changes introduced that affect my work area / team / department.	51.90%	49.90%	-2.00%
I am able to make improvements happen in my area of work.	54.50%	54.10%	-0.40%
I have a choice in deciding how to do my work.	52.20%	51.90%	-0.30%
I am confident that my organisation would address my concern.	74.90%	55.90%	-19.00%
I feel safe to speak up about anything that concerns me in this organisation.	62.50%	60.40%	-2.10%
If I spoke up about something that concerned me I am confident my organisation would address my concern.	47.90%	47.20%	-0.70%
I am able to meet all the conflicting demands on my time at work.	42.40%	42.30%	-0.10%
I have adequate materials, supplies and equipment to do my work.	49.50%	48.30%	-1.20%
There are enough staff at this organisation for me to do my job properly.	22.90%	22.00%	-0.90%
I have unrealistic time pressures (Never / Rarely).	20.70%	20.30%	-0.40%
My organisation takes positive action on health and well-being.	50.60%	53.70%	3.10%
The last time I experienced physical violence at work, myself or a colleague reported it.	75.70%	74.00%	-1.70%

The last time I experienced harassment, bullying or abuse at work, myself or a colleague reported it.	47.60%	46.20%	-1.40%
I often / always find my work emotionally exhausting.	37.50%	37.00%	-0.50%
I often / always feel burnt out because of my work.	34.70%	34.50%	-0.20%
My work often / always frustrates me.	39.90%	41.70%	1.80%
I am often / always exhausted at the thought of another day / shift at work.	31.90%	30.90%	-1.00%
I often / always feel worn out at the end of my working day / shift.	47.80%	46.20%	-1.60%
I often / always feel that every working hour is tiring for me.	21.10%	21.40%	0.30%
I do not have enough energy for family and friends during leisure time (Often / Always).	31.50%	31.00%	-0.50%
In the last 12 months, I have experienced musculoskeletal problems (MSK) as a result of work activities.	29.20%	30.30%	1.10%
During the last 12 months, I have felt unwell as a result of work related stress.	44.90%	46.50%	1.60%
In the last 12 months, I have personally experienced physical violence at work from patients / service users, their relatives or other members of the public.	12.50%	14.30%	1.80%
In the last 12 months, I have personally experienced physical violence at work from managers.	0.70%	0.90%	0.20%
In the last 12 months, I have personally experienced physical violence at work from other colleagues.	1.50%	1.90%	0.40%
In the last 12 months, I have personally experienced harassment, bullying or abuse at work from managers.	23.80%	12.40%	-11.40%
This organisation offers me challenging work.	70.00%	69.60%	-0.40%
There are opportunities for me to develop my career in this organisation.	48.40%	50.20%	1.80%
I have opportunities to improve my knowledge and skills.	64.80%	67.00%	2.20%
I feel supported to develop my potential.	51.30%	51.30%	0.00%
I am able to access the right learning and development opportunities when I need to.	53.80%	56.40%	2.60%
The appraisal / review helped me to improve how I do my job.	20.30%	22.30%	2.00%
The appraisal / review helped me agree clear objectives for my work.	30.80%	32.40%	1.60%
The appraisal / review left me feeling that my work is valued by my organisation.	29.20%	29.70%	0.50%
I achieve a good balance between my work life and my home life.	51.10%	53.40%	2.30%
I can approach my immediate manager to talk openly about flexible working.	67.20%	69.20%	2.00%
The team I work in has a set of shared objectives.	74.20%	76.10%	1.90%
The team I work in often meets to discuss the team's effectiveness.	57.90%	61.00%	3.10%
I receive the respect I deserve from my colleagues at work.	72.90%	73.00%	0.10%
Team members understand each other's roles.	74.60%	73.90%	-0.70%
I enjoy working with the colleagues in my team.	84.60%	83.30%	-1.30%
In my team disagreements are dealt with constructively.	57.80%	57.40%	-0.40%
Teams within this organisation work well together to achieve their objectives.	51.00%	52.90%	1.90%
My immediate manager encourages me at work.	71.00%	70.60%	-0.40%
My immediate manager gives me clear feedback on my work.	63.30%	63.50%	0.20%
My immediate manager asks for my opinion before making decisions that affect my work.	57.70%	56.70%	-1.00%
My immediate manager takes a positive interest in my health and well-being.	66.10%	67.60%	1.50%
I look forward to going to work.	51.30%	49.80%	-1.50%
I am enthusiastic about my job.	67.90%	66.60%	-1.30%
Time passes quickly when I am working.	75.80%	74.90%	-0.90%
There are frequent opportunities for me to show initiative in my role.	73.80%	72.10%	-1.70%

I am able to make improvements happen in my area of work.	73.30%	54.10%	-19.20%
Care of patients / service users is my organisation's top priority.	70.40%	70.10%	-0.30%
I would recommend my organisation as a place to work.	55.50%	53.50%	-2.00%
I often think about leaving this organisation.	32.70%	31.40%	-1.30%
I will probably look for a job at a new organisation in the next 12 months.	23.30%	21.90%	-1.40%
As soon as I can find another job, I will leave this organisation.	16.10%	15.00%	-1.10%
I am able to meet all the conflicting demands on my time at work.	42.40%	42.30%	-0.10%
I have adequate materials, supplies and equipment to do my work.	49.50%	48.30%	-1.20%
There are enough staff at this organisation for me to do my job properly.	22.90%	22.00%	-0.90%
I always know what my work responsibilities are.	85.40%	87.00%	1.60%
I am involved in deciding on changes introduced that affect my work area / team / department.	51.90%	49.90%	-2.00%
I have unrealistic time pressures (Never / Rarely).	20.70%	20.30%	-0.40%
I have a choice in deciding how to do my work.	52.20%	51.90%	-0.30%
Relationships at work are strained (Never / Rarely).	46.30%	46.30%	0.00%
I receive the respect I deserve from my colleagues at work.	72.90%	73.00%	0.10%
My immediate manager encourages me at work.	71.00%	70.60%	-0.40%
I work additional PAID hours for this organisation, over and above my contracted hours.	38.00%	38.60%	0.60%
I work additional UNPAID hours for this organisation, over and above my contracted hours.	59.10%	59.50%	0.40%
I have felt pressure from my manager to come to work.	24.60%	23.10%	-1.50%
Experienced discrimination on grounds of ethnic background.	38%	46.60%	8.60%
Experienced discrimination on grounds of gender.	24%	22.20%	-1.80%
Experienced discrimination on grounds of religion.	4.50%	4.90%	0.40%
Experienced discrimination on grounds of sexual orientation.	5.10%	4.10%	-1.00%
Experienced discrimination on grounds of disability.	8.60%	7.70%	-0.90%
Experienced discrimination on grounds of age.	25.40%	17.30%	-8.10%
Experienced discrimination on grounds of anything else.	27.80%	22.10%	-5.70%

Meeting date	6th April 2023	X	Public		Confidential	Agenda item
Meeting	Board of Directors					
Title	Green Plan Progress Report					
Lead Director	Paul Featherstone, Director of Estates & Facilities		Author			

Recommendations made / Decisions requested

The Board of Directors is asked to review progress against the Green Plan and actions being taken in order to reach net zero by 2040.

This paper relates to the following Corporate Annual Objectives-

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

The paper relates to the following CQC domains-

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

This paper is related to these BAF risks		**PR1.1**	There is a risk that the Trust does not deliver high quality of care to service users, which may lead to suboptimal patient safety, effectiveness and/or experience and failure to meet regulatory standards
		PR1.2	There is a risk that patient flow across the locality is not effective which may lead to potential harm, suboptimal user experience, and inability to achieve national standards for urgent and elective care
		PR1.3	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan which may lead to suboptimal patient safety, outcomes and user experience and inability to achieve national standards for planned care
		PR2.1	There is a risk that the Trust fails to sufficiently engage and support our people, which may lead to low morale, higher turnover & sickness absence and gaps in the workforce that may impact on delivery of high-quality care
		PR2.2	There is a risk that the Trust's community services do not fully support neighbourhood working which may lead to suboptimal improvement in neighbourhood population health
		PR3.1	There is a risk in approving and implementing a new Provider Collaborative model to support delivery of priorities/objectives of the Stockport's ONE Health & Care (Locality) Board which may lead to a delay in delivery of models of care which support improvements in population health and operational recovery following the pandemic

		PR3.2	There is a risk that the Trust does not deliver a joint Clinical Strategy with East Cheshire NHS Trust (ECT), which may lead to suboptimal pathways of care and/or limited service resilience across the footprint of both Trusts
		PR4.1	There is a risk that the Trust does not implement high quality research & transformation programmes which may lead to suboptimal service improvements
		PR5.1	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit the optimal number of staff, with appropriate skills and values, which may lead to suboptimal staff and patient experience
		PR5.2	There is a risk that the Trust fails to have a workforce that is reflective of the communities served which may lead to staff with a protected characteristic having a suboptimal staff experience (career progression, turnover) and a poorer patient experience
		PR6.1	There is a risk that the Trust does not deliver the 2022/23 financial plan which may lead to a poor use of resources and increased regulatory intervention
		PR6.2	There is a risk that the Trust does not develop and agree with partners a multi-year financial recovery plan, optimising opportunities for financial recovery through system working, which may lead to a lack of financial sustainability
		PR7.1	There is a risk that the Trust does not implement the Digital Strategy designed to ensure a resilient and responsive digital infrastructure which may lead to inability to support improvements in quality of care and compromise of data/information
		PR7.2	There is a risk that the estate is not fit for purpose and/or meets national standards which may lead to inefficient utilisation of the estate to support high quality of care and increased health & safety incidents
	x	**PR7.3**	There is a risk that the Trust does not materially improve environmental sustainability which may lead to suboptimal support to locality ambitions and the NHS commitment to carbon reduction
		PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus which may lead to an adverse long term impact on the Trust's capability to deliver modern and effective care

Where issues are addressed in the paper-

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

10.1

Executive Summary

The report provides the Board of Directors with an update on progress made against the Green Plan approved by the Board in February 2022.

A Green Group has been established, with representation including Executive Directors and senior leaders from a variety of departments to oversee delivery of the objectives of the Green Plan. The Green Group has made a positive start during its first 12 months. As the Green Group develops our ambition should shift to delivering key changes to our estate via the allocation of Capital Expenditure combined with further advances in proactively growing a Stockport NHS FT green culture.

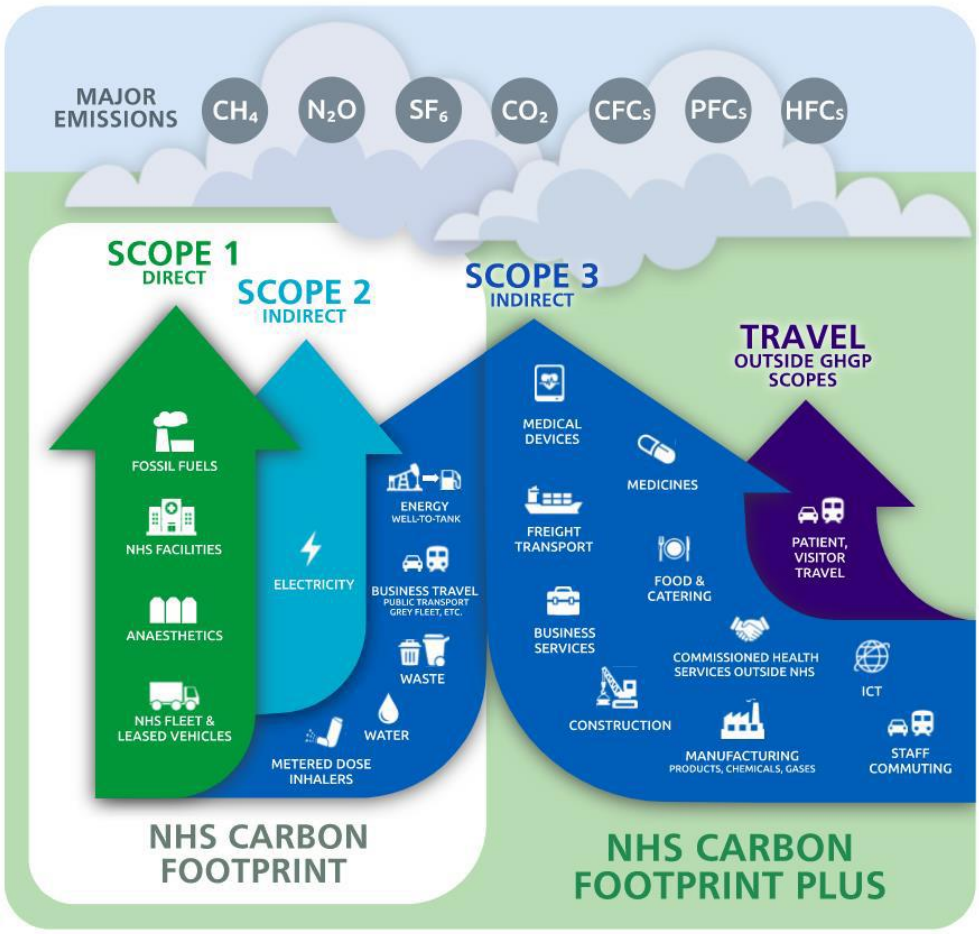
NHS Stockport NHS Foundation Trust

Green Plan Update

10.1

NHS Stockport NHS Foundation Trust

Contents



10.1

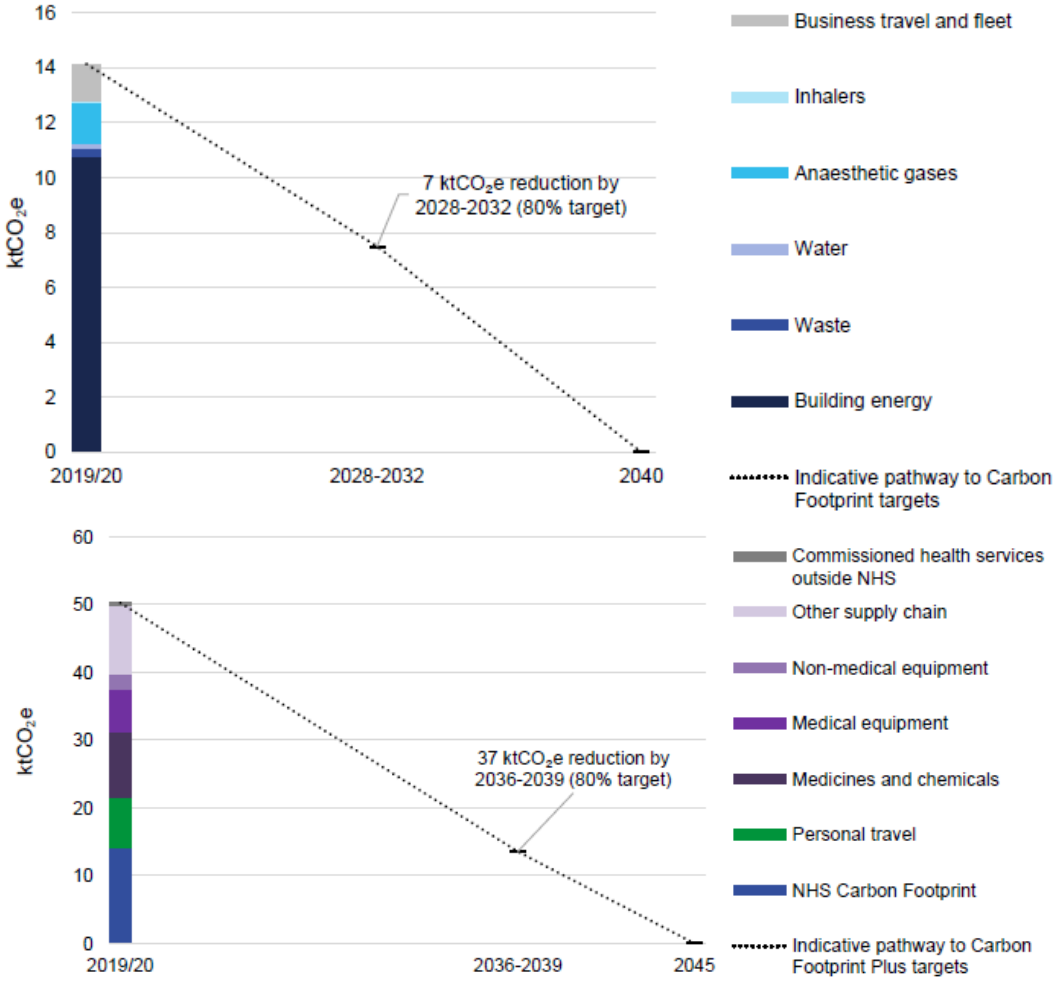
NHS Stockport NHS Foundation Trust

1. Introduction

The Stockport NHSFT Green Plan was approved in February 2022. The plan outlines the Trust's ambition for the emissions we control directly 'Our carbon footprint' in order to reach net zero by 2040.

Stockport NHS FT has delivered an initial 80% reduction on our 2012/13 baseline ahead of our 2032 target. There are further reductions expected for all other emissions we influence 'our Carbon Footprint Plus'. The overall ambition is achieve net zero by 2045, with an interim target of 80% reduction by 2039.

Reduction trajectory is illustrated in the below graphs.



10.1

2022 also saw the launch of the Trusts first Green Group. The group is made up of stakeholders from a variety of departments all committed to delivering the objectives of the Green Plan. The group is currently chaired by an Executive Director.

2. Review of Objectives

2.1 Developing a Low Carbon Organisation and Workforce

The Group has begun to explore carbon literacy training for the Green Group members Team with further plans further plans to expand it to all members of staff. The Trusts Energy and Sustainability Manager is currently exploring opportunities to develop a carbon literacy module of training for widespread delivery. The Carbon Literacy course will teach the basics of climate change science combined with targeted actions which may be affecting climate change and what an individual can do to help. This will support our goal of becoming a carbon literate NHS Trust.

In partnership with Cycle Solutions, Our Cycle to work provider a 'Dr Bike Event' was organised to encourage staff to bring in their bikes for minor repairs and general cycling advice. The event proved popular with the Trusts cyclists and those considering 2 wheels instead of 4. Feedback was positive and staff members were appreciative of the free service provided by the Trust. There are plans to organise similar events during the summer months of 2023 to increase cycle to work uptake.

A Sustainability Day was organised with attendees from Stockport Council, Water Plus, and Cycle Solutions. Staff members' were given sustainability and energy efficiency advice, provided, by the council. Water-plus kindly distributed free water savings kits and had an opportunity to explore new electric bikes and ask questions around the cycle to work scheme. There are plans to organise similar events throughout the year.

Workforce colleagues have assisted with the development of proposed wording to be added to future job description of all Trust employees. This will be a welcomed addition to our pre-employment literature which will help highlight our commitment to all elements of sustainability.

The Trust is committed to behaving responsibly in the way we manage transport, procurement, our facilities, employment and our engagement with the local community so that we can make a positive contribution to the community we represent and the area we are based. All employees of the Trust have a responsibility to take measures to support our contribution and to reduce the environmental impact of our activities relating to energy and water usage, transport and waste.

NHS Stockport NHS Foundation Trust

2.2 Reducing Our Carbon Footprint

Commissioning of an Estate Decarbonisation Plan is underway which will help us identify opportunities to reduce our Scope 1 emissions. This plan is vital to enable the creation of robust plans and investment into our green journey.

2.3 Developing Lower Carbon Care Models

Development of this element of the green plan requires further work during 23/24 and will be managed via the Green Group.

2.4 Reducing Local Air Pollution through Sustainable Transport

The plan to gradually replace all the existing fleet vehicles with electric vehicles is underway. The Trust currently owns 2 electric vehicles with a further 3 to be added. This is in line with our commitments to have a zero emission fleet and reduce our air pollution levels in the communities we serve.

A funding of £10,000 was awarded by Transport for Greater Manchester which we used to install and improve current bike stands. The funding was used to install a new bike shelter near Oak house, and bike stands near Pinewood house. The existing stands were reused in other areas to avoid land-fill waste.

2.5 Reducing Waste and Moving to Zero Landfill

Initial waste audit has been undertaken to identify potential areas for piloting a recycling project. After initial assessments, it was agreed that the theatres would be an ideal setting for this pilot. One of the challenges identified is the lack of space in the waste storage cupboards which could be mitigated by enhanced frequency of bin collection. The waste management team are currently appraising options ahead of a targeted scheme roll out.

2.6 Reducing Water Use and Including Sustainable Drainage Solutions for New Build

The Trust has identified a large number of water leaks which can often go unnoticed for substantial periods of time. To assist with prompt detection of water leaks, installation of sub-meters and water data loggers is underway. The water loggers will be installed and the sub-meters replacement will be carried out in phases to avoid prolonged water supply interruption to the site.

2.7 Lower Carbon Procurement and Catering, including Action to Reduce Single Use Plastics

Sustainability and social value of local tenders is now scored at 15% of the total value which includes specific accountability to environmental and sustainability responsibilities.

The catering department has phased out single use plastics, for example, takeaway meal boxes and takeaway cutlery.

The sandwich supplier is carbon negative meaning that any carbon emissions used in the manufacturing and delivery process are offset by the Supplier.

Patient food waste is monitored and feedback provided to wards in order to improve processes.

Food waste is also sent to off-site and converted to biomass as an alternative going to land-fill.

The standard patient menu has a plant based option which is less carbon intensive.

2.8 Sustainable Building Design and Climate Change Adaptation

A number of Capital projects undertaken in 2022-23 resulted in both energy and financial savings. All new projects, where applicable, use the HTM and BREEAM guideline to achieve the highest sustainability standards possible.

- Pathology Temporary Diesel Steam Generators Replacement
- Replacement of pipework for water and steam and heating
- Main corridor steam leak
- Maternity Roof Replacement
- Endoscopy Extension
- M6 Ward Refurbishment
- EUCC Enabler- Conversion of Store to X-ray room (X-ray B) an alterations to X-ray A, X-ray room 2,3, & 6

3. Engagement

The Green Plan from NHS Greater Manchester Integrated Care was published in July 2022. The Plan has a commitment to achieve a net zero carbon footprint by 2038, in collaboration with partners as part of the Greater Manchester Combined Authority Environment Plan. By 2045, this net zero commitment will also include the carbon impact of goods and services in line with a national NHS target. At present, Greater Manchester's health and care system has a carbon footprint of 1,418,840 CO2e, which is equivalent to 276,070 homes' electricity use for one year. The Green Plan sets out a sizeable reduction of 799,010 CO2e over the next three years – comparable to 155,467 of those homes turning the electricity off.

Stockport Council are developing another heat network in the UK and are investigating the feasibility of connecting a nearby hospital- Stepping Hill – for this scheme the projected

carbon savings are so high that the hospital are preparing a PSDS funding application which could exceed £15 million. The plan is in the design process for the Stockport network, but if approved it could be have significant benefits to all parties.

4. Future Opportunities and Challenges

Through the Green Group we are hoping to develop a financial profile which allows investment into our sustainability objectives and help facilitate a cultural change. The aim is to ensure that all our service users and colleagues are committed to reducing our carbon footprint.

Capital investment should reflect and consider the Green Plan when planning capital expenditure, both for equipment and estate development.

5. Summary

The Green Group has made a positive start during its first 12 months, especially as all stakeholders have positively contributed to the ambitions of the plan. As the Green Group develops our ambition should shift to delivering key changes to our estate via the allocation of Capital Expenditure combined with further advances in proactively growing a Stockport NHS FT green culture.

Stockport NHS Foundation Trust

Meeting date	6 April 2023	X	Public		Confidential	Agenda item
Meeting	Board of Directors					
Title	Board Assurance Framework 2022/23					
Lead Director	Karen James, Chief Executive		Author	Rebecca McCarthy, Company Secretary		

Recommendations made / Decisions requested

The Board of Directors is asked to:
- Review and approve the Board Assurance Framework 2022/23 as of 6 April 2023
- Review the Trust's current Significant Risk profile including alignment between operational and principal risks.

This paper relates to the following Corporate Annual Objectives-

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

The paper relates to the following CQC domains-

	Safe		Effective
	Caring		Responsive
X	Well-Led		Use of Resources

This paper is related to these BAF risks	All

Where issues are addressed in the paper-

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

Executive Summary

The Trust maintains a Board Assurance Framework (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 comprising the Board Assurance Framework 2022/23 have been assigned to the relevant Board level committee for oversight, with review of these risks taking place during March 2023. The Board Assurance Framework Q4 2022/23 (Appendix 1), is presented to the Board, with revisions made from the previous review highlighted throughout. A heat map and gap analysis between current and target risk score is also included.

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.

Since last reported to Board (February 2023), there has been a reduction to Principal Risk 1.3 relating to restoration of elective services and Principal Risk 6.1 relating to delivery of the 2022/23 financial plan, both reducing from 16 to 12 based on assurances received.

All other risk scores remain as previously reported with sustained operational demands, alongside external influences, continuing to impact on the Trust's ability to mitigate significant risks relating to patient flow, medium-long term financial sustainability, recruitment and retention of an optimal workforce and staff health and wellbeing. The Trust has achieved the target risk for two principal risks relating to progress towards environmental sustainability and delivery of high-quality transformation and research programmes.

No.	Principal Risk	C	L	Q1	Q2	Q3	Q4	Change	Target Score
PR1.2	There is a risk that patient flow plans are not effective impacting urgent and elective care performance	4	4	16	16	16	16	⟷	8
PR2.1	There is a risk that the Trust fails to support and engage its workforce	4	43	12	12	16	16	⟷	8
PR5.1	There is a risk that the Trust is unable to recruit optimal number of staff	4	4	16	16	16	16	⟷	8
PR6.2	There is a risk that the Trust fails to develop and agree with partners a multi-year financial recovery plan to secure financial sustainability	4	4	9	9	16	16	⟷	8
PR1.1	There is a risk that the Trust	4	3	12	12	12	12	⟷	8

	delivers sub-optimal quality services and fails to meet regulatory standards								
PR1.3	There is a risk that the Trust does not have sufficient capacity to deliver inclusive restoration plans	4	4	12	12	16	12	↓	8
PR3.2	There is a risk that the Trust does not deliver a joint Clinical Strategy with East Cheshire NHS Trust (ECT),	4	3	12	12	12	12	→	8
PR6.1	There is a risk that the Trust fails to deliver its agreed 2022/23 financial position	4	3	12	12	16	12	↓	8
PR7.2	There is a risk that the estate is not fit for purpose and does not meet national standards	4	3	12	12	12	12	→	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	3	4	12	12	12	12	→	8
PR2.2	There is a risk that the Trust's services do not reliably support neighbourhood population health	3	3	9	9	9	9	→	6
PR3.1	There is a risk in approving and implementing a new Provider Collaborative model	3	3	9	9	9	9	→	6
PR5.2	There is a risk that the Trust fails to develop a workforce reflective of communities served and improve experience of staff with protected characteristics	3	3	9	9	9	9	→	6
PR7.1	There is a risk that the Trust fails to develop and implement a responsive and resilient Digital Strategy	3	3	9	9	9	9	→	6
PR7.3	There is a risk that the Trust does not materially improve environmental sustainability	4	2	12	8	8	8	→	8
PR4.1	There is a risk that there the Trust does not deliver high quality research and transformation programmes	3	2	9	6	6	6	→	6

In addition, the Trust's Significant Risk Register (as at March 2023) (Appendix 2) is provided to ensure triangulation between operational and principal risks. There are currently 4 significant risks relating to the following areas:

- Emergency Department access standard
- Patient flow due to reduced access to community capacity and rising no criteria to reside
- Rapid access to chest pain first appointment
- Industrial Action

The Risk Management Committee has continued oversight and management of the significant risk register, alongside divisional and corporate risk registers, and horizon scanning of future risks, in line with the Risk Management Strategy & Policy.

The Risk Management Committee continues to report to the Audit Committee, as part of its responsibility to review of the establishment and maintenance of an effective system of integrated governance, risk management and internal control, and the effectiveness of the structures, processes and responsibilities for identifying and managing key risks facing the Trust.

Furthermore, at each Audit Committee meeting, the Chairs of Board level Committees provide update with a focus on:

- how significant risks identified by the Risk Management Committee are being addressed or monitored in their Board Committee
- any risks which are not appropriately reflected in the Risk Management Committee report
- emerging or potential risks and matters which may bring into question the adequacy of underlying assurance processes or have implications for other Committees
- effectiveness of controls in place to manage risks recorded on the Board Assurance Framework, with controls generally being applied consistently.

Stockport NHS Foundation Trust

Stockport NHS Foundation Trust

Board Assurance Framework

2022/2023

Corporate Objectives 2022/23

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

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

Risk Appetite Framework

Risk Level ⇨ **Key Elements** ⇩	**Avoid** Avoidance of risk is a key organisational objective.	**Minimal (ALARP)** 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**	

BAF 2022/23 Summary, Heat Map & Gap Analysis

Risk Matrix					
Impact	**Likelihood**				
	1 - Rare	2 - Unlikely	3 - Possible	4 - Likely	5 - Certain
1 - Negligible					
2 - Minor					
3 - Moderate		**4.1**	**2.2, 3.1, 5.2, 7.1**	**7.4**	
4 - Major		**7.3**	**1.1, 1.3, 3.2, 6.1, 7.2**	**1.2, 2.1, 5.1, 6.2**	
5 - Catastrophic					

Gap Score Matrix (Difference between Target Score and Current Score)		
Gap score ≤0	Risk target achieved	**4.1, 7.3**
Gap score 1 - 5	Tolerable	**1.1, 1.3, 2.2, 3.1, 3.2, 5.2, 6.1, 7.1, 7.2**
Gap score 6 - 9	Close monitoring	**1.2, 2.1, 5.1, 6.2, 7.4**
Gap score 10	Concern	
Gap score > 10	Serious	

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	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 1 - To deliver safe accessible and personalised services for those we care for																	
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 and standardised through implementation of NHSE/Divisional Governance Project (Safety, Effectiveness, Experience) 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 (2020 & 2022) Established process for managing and learning from: - Incidents including Serious Incidents - Duty of Candour - Complaints - Legal Claims Patient Flow Associated Harm Review process established. Mechanisms in place to gather patient experience and staff experience: - Family & Friends - Carers Opinion - Patient Stories - Walkabout Wednesday - Senior Nurse Walkarounds - Feedback Friday Clinical Audit & NICE Guidelines - Established clinical audit programme including national and local audit - Compliance Review Process – All NICE documents relevant to SFT portfolio - Established process for review of NICE Guidelines Learning from Deaths - Mortality Review Policy - Learning from Deaths Review process - Medical Examiner Team StARS - Ward assurance & accreditation process established. Also established for: Paediatrics, Maternity, Theatres, Community. Mini CQC Review undertaken for specific areas (Maternity) as part of StARS. Safe Staffing - Defined Nurse Establishments	StARS – Outpatients ~~CQC Mock Inspection Programme~~ 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) StARS: Baseline assessment for inpatients completed		Expansion of StARS: Outpatients	Q4 2022/23	4	3	12	12	12	12	12	4	2	8
				Level 2 – Corporate Quality Committee: - Quality IPR - Key Issues & Assurance Reports: o Patient Safety (Serious Incidents & Duty of Candour) o Clinical Effectiveness (Clinical Audit & NICE Compliance) o Patient Experience o Health & Safety o Integrated Safeguarding - CQC Report including CQC Action Plan Update, CQC Preparation (Quarterly) - StARS Position Statement & Key Themes (Quarterly) - Patient Safety Report (Quarterly) (Incidents, Complaints) - 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) - Waiting List Harm Reviews & Patient Flow Associated Harm Review - LMS Insight Report NHSE/I NW - Learning from Deaths Reports / Mortality Reviews (Quarterly) Board of Directors: - 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	~~Triangulation meeting or~~ Chairs Notes between Quality Committee Subcommittees	~~CQC Mock Inspection Programme~~ ~~Patient Safety Strategy based on~~ Patient Safety Incident Response Framework – Plan ~~NWAS Strike Action Harm Review to be completed.~~	~~Q4 2022/23~~ ~~Q4 2022/23~~ July 2023 ~~February 2023~~								
				Level 3 - Independent CQC Inspection 'Requires Improvement' November 2020 Stockport Improvement Board *(NB Stood down from April 2022)* CQC Inspection Urgent & Emergency Care – 'Good' November 2021 Health & Safety Executive Inspection, November 21. No concerns highlighted. Friends & Family Test		Review outcome of MIAA Internal Audits: • Risk Management (Draft) • Clinical Audit (Draft)	April 2023								

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores				Target Risk Score		
								Impact	Likelihood	Current	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 1 - To deliver safe accessible and personalised services for those we care for																	
		- 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. Trust & GM Command & Control Process established - Before, During and After Strike Action. NWAS Strike Action Harm Review		National Patient Experience Surveys: - Adult Inpatient Survey - National Cancer Survey - Emergency Department Survey MIAA Internal Audits 2021-22 • SI Report (Substantial) • ERostering (Substantial) • Niche Evidence Report (High) • Committee Effectiveness (Substantial) MIAA Internal Audits 2020-21 • CQC Evidence Process Review (High) • Complaints (Substantial) Maternity Safety Support Programme (Formal Exit)												
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 assurance via Service Improvement Group Biweekly Trust Performance Meeting and ~~daily~~ twice weekly locality tactical calls to seek support to mitigate risk – Attended by Director of Operations & Chief Nurse. 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. ~~System wide Intermediate Tier Transformation Programme in place (11 Workstreams)~~ Trust and system escalation process in place, aligned to a single OPEL system – Including divert of resource from elective activity to support flow Winter Planning Debrief Process in place at GM, Locality and Trust – Informing Winter Plan 2023/24 Bed Modelling – 18 Month Plan Workforce models in place – Reflect demand and flexible to adapt to surges. Learning from Deaths process includes: - Delayed admission	Capacity constraints in domiciliary & bed-based care impacting on levels of patients with no criteria to reside High levels of delayed discharges for out of borough patients Significant increase in unfunded non-elective demand Lack of standardised 7-day services across medical & surgical specialties to support discharge of non-elective patients. Locality plan for intermediate bed base to be agreed for 2023/24. Managerial and operational capacity, including ICB, to support key workstreams.	**Level 1 – Management** Divisional Operations Boards (Monthly) – Performance Management Report - ED Attendance - Overall bed occupancy rate - Patients No Criteria to Reside - ED 4 Hour Target Performance - Ambulance Handover times - ED 12 hour waits (Shadow metric) - Time to triage Daily Bed meetings (x 4) System dashboard of acute, intermediate and domiciliary care capacity **Level 2 – Corporate** Divisional Performance Review (Monthly) including targeted 'Deep Dives' Finance & Performance Committee - Operational Performance Report (Monthly) - Themes from Performance Review Integrated Performance Report – Board (Bimonthly) **Level 3 – Independent** Stockport Improvement Board *(NB Stood down from April 2022)* Urgent & Emergency Care Delivery Board NHSE – Activity Returns		Finalise recurrent Medical Staffing model ~~Implementation~~ Expansion of Virtual Ward Working Intelligently Group – Data collection & Deep Dive 3 x Medical Specialties, triangulation with current workforce planning. Locality agreement for community capacity	Q4 2022/23 ~~Jan 2023~~ April 2023 Q4 2022/23 Q4 2022/23	4	4	16	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	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 1 - To deliver safe accessible and personalised services for those we care for																	
		- Delayed discharge Patient Flow Associated Harms – Review via Quality Committee and process for future surveillance Robust phasing programme for building works as part of EUCC to ensure no loss of capacity. ~~Agreement in place with ICB for out of borough patient recharge for excess bed days~~															
Principal Risk Number: PR1.3					**Risk Appetite: Moderate**												
There is a risk that the Trust does not have capacity to deliver inclusive elective, diagnostic and cancer care, including the clearance of surgical backlog caused by the Covid-19 pandemic, which may lead to suboptimal patient safety, outcomes and experience and inability to achieve national access standards	Finance & Performance Committee	Biweekly Trust Performance Meeting. Agreed Specialty Activity Plans & Budget Escalation process in place with Performance Team – 78+ 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 Disaggregation of data to consider health inequalities in Elective Care – Annual Review	~~Expansion of Endoscopy~~ Workforce – Sickness Absence & Recruitment Impact of urgent care pressures on elective capacity Winter Planning 2023/24	**Level 1 – Management** Divisional Operations Boards (Monthly) Trust Performance Meeting: - Elective demand - Activity v Plan (Waits) - % Patients on PIFU - Levels Advice & Guidance - Theatre Utilisation - Outpatient Utilisation - Endoscopy Utilisation Activity Management Group – Data review of elective activity		~~Expansion of Endoscopy (Delayed from Sept 2022 to Feb 23)~~	~~Feb 2023~~	4	3	12	12	12	16	12	4	2	8
				Level 2 – Corporate Divisional Performance Review (Monthly) including targeted 'Deep Dives' Finance & Performance Committee Operational Performance Report (Monthly) - 52+ week waits - 78+ week waits - 104+ 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)	Limited availability of GM wide restoration performance data for benchmarking, including inequalities data.	~~Health Inequalities - Disaggregation of data to consider health inequalities~~	~~Q3 2022/23~~									
				Level 3 – Independent NHSE/I – Activity Returns													

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	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 2 - Support the health and wellbeing needs of our communities and staff																	
Principal Risk Number: PR2.1					**Risk Appetite: High**												
There is a risk that the Trust fails to sufficiently engage and support our people, 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) Risk assessments undertaken for all staff; including BAME & Covid specific Risk Assessments Influenza & Covid 19 vaccination programmes Staff Wellbeing Programme established (including refreshed focus on financial wellbeing) including staff psychology and wellbeing service and menopause service. Occupational Health Service – including Staff Counselling Service & Physio Fast Track Service Dying to Work Charter Values into Action programme established Award & Recognition including Staff Awards (Oct 2022), MADE Awards, Long Service Awards Wellbeing Guardian supported by Schwartz Rounds Freedom to Speak Up Guardian / Guardian of Safe Working Divisional Staff Survey Action Plans 2021 in place. Confirmed approach to flexible working. Industrial Action Planning Group in place	Embedded approach to Wellbeing Conversations System to learn from exit conversations Impact of employee relations & industrial action issues on morale and wellbeing Impact of continuing operational pressures	**Level 1 - Management:** People, Engagement & Leadership Group - People Plan – Workstream Reports Equality Diversity & inclusion Steering group - EDI Strategy Industrial Action Planning Group				4	4	16	12	12	16	16	4	2	8
				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)		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 Scoping exercise to be completed for collaborative Occupational Health function with T&G	~~March 2023~~ April 2023 March 2023										
				Level 3 - Independent CQC Well-led Mapping Report – Recognition of Staff Health & Wellbeing offer NHS National Staff Survey														

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores				Target Risk Score		
								Impact	Likelihood	Current	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 2 - Support the health and wellbeing needs of our communities and staff																	
Principal Risk Number: PR2.2					**Risk Appetite: Moderate**												
There is a risk that the Trust's community services do not fully support neighbourhood working leading to suboptimal improvement in neighbourhood population health	Finance & Performance Committee	Operational & Winter Planning processes established with system arrangements. 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 Director of Strategy & Partnerships supporting Locality ICS and transition prior to commencement of Deputy Place Lead	Unfunded growth in demand for community services Capacity & demand modelling for community services to support appropriate deployment of resources Alignment of Community Services to PCNs – Potential change to PCN geographical footprints Managerial and operational capacity, including ICB, to support key workstreams Deputy Place Lead to commence in post, March 2023	**Level 1 – Management** Divisional Quality & Operations Boards (Monthly) Performance Management Report - Integrated Care Division - Women, Children & Diagnostics Adult's: Neighbourhood Leadership Group (Monthly) Children's: - Joint Public Health Oversight Group - SEND Joint Commissioning Group - CYP mental health & Well-being Partnership Board - Joint Safeguarding Board		Completion of capacity & demand modelling for community services Align Trust community services & workforce to PCNs	Q4 2022/23 Q4 2022/23	3	3	9	9	9	9	9	3	2	6
				Level 2 – Corporate Divisional Performance Review (Monthly) including targeted 'Deep Dives'	Community Services Dashboard	Integration of Community Services Dashboard to IPR Deputy Place Lead to commence in post	Q3 2022/23 March 2023										
				Level 3 – Independent Children's – SEND Inspection Ofsted Report – 'Good' SALT – External multiagency review – Pathways & capacity and demand *(Findings not yet published).*													

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	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: High**													
There is a risk in approving and implementing a new Provider Collaborative model to support delivery of priorities/objectives of the Stockport's ONE Health & Care (Locality) Board 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 Stockport Provider Partnership operational, chaired by SFT CEO ONE Stockport Plan and ONE Stockport Health and Care Plan. Operational & Winter planning processes well established with system arrangements as a focus Recovery Objectives published in Planning Guidance 2023/34 considered in Trust Planning Q4	Controls not yet designed for the management of the One Stockport Health & Care Plan	**Level 1 – Management**				3	3	9	9	9	9	9	3	2	6
				Level 2 – Corporate Executive Team / Finance & Performance Committee oversight of key strategic matters Trust Board Reports as required and CEO Report including key strategic developments - ICS - Stockport One Health & Care Plan Joint system meetings on ONE Stockport plan		A review of the effectiveness of locality arrangements including the Locality Board and Provider Partnership to be undertaken in March-April 2023	Q1 2023/24										
				Level 3 – Independent Health & Wellbeing Board													
Principal Risk Number: PR3.2				**Risk Appetite: High**													
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. Work programme in place for 2023/24 including development of transformation workstreams and services to be considered as part of the OBC ~~clinical workstreams / service options and PCBC (if required).~~ ~~Funding identified for 2022/23 for the programme to continue at pace.~~ Full stakeholder engagement plan in place including LA, Healthwatch, DPHs, VCSE and NHSE/I regulators.	Failure to gain key stakeholder support for Joint Clinical Strategy and Case for Change. Currently no long term funding strategy for the programme of work and no funding identified for 2023/24 financial year	**Level 1 – Management** Joint Programme Board and Clinical Advisory Groups Programme Governance Meeting				4	3	12	12	12	12	12	4	2	8
				Level 2 – Corporate Executive Team oversight of key strategic matters. Trust Board & ECT/SFT Board to Board - Progress Report (Monthly)		Produce Models of Care and Pre-Consultation Business Case Plan for and commence implementation of service changes where no formal further process is required.	~~Q1 2023/24~~ Q2 2023/24 ~~Q4 2023/24~~ Q1 2023/24										
				Level 3 – Independent Oversight and challenge by NHSE and other health care partners on Joint Clinical Strategy Case for Change and models of care development		Present Case for Change and Models of Care to NHSE and ICB	~~Q1 2023/24~~ Q2 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	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 4 - Drive service improvement, through high quality research, innovation and transformation																	
Principal Risk Number: PR4.1				**Risk Appetite: High**													
There is a risk that the Trust does not implement high quality research & 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 SFT Research Team established. Annual research programme in place. Joint Clinical Research, Development & Innovation Strategy 2022-2027 (SFT & T&G) & joint governance meetings in place to review work programme (as derived from strategy)	Understand transformation requirements to address health inequalities Capacity of operational teams to implement change due to operational pressures ~~Establish joint R&D programme of work (SFT & T&G)~~	**Level 1 – Management** Clinical Effectiveness Group - Research & Innovation Progress Report - Annual Research & Innovation Report				3	2	6	9	6	6	6	3	2	6
				Level 2 – Corporate Service Improvement Group – Monthly Transformation Programme Report & Quarterly Deep Dive: Review KPIs/Milestones Board Report: Transformation Programme (Biannually) Quality Committee: - Clinical Effectiveness Group Key Issues & Assurance Report - Annual Research & Innovation Report 2021-22 *(Assurance structure to be reconfirmed in line with Joint Research Strategy and agreed in both organisations)*		~~Establish Research, Development & Innovation Strategy joint work programme~~ Approval of proposal for Stockport system transformation via Provider Partnership Board – Final programme of work to be established.	~~Q4 2022/23~~ Q4 2022/23									
				Level 3 - Independent DHSC KPIs for Research NIHR GMCRN KPIs for Research Participant research experience survey (PRES)													

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores				Target Risk Score		
								Impact	Likelihood	Current	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 5 - Develop a diverse, capable and motivated workforce to meet future service and user needs																	
Principal Risk Number: 5.1					**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. 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 incentive rate in place to enhance staffing levels during the winter months Mandatory Training Requirements set. Realignment of Role Essential Training Requirements Range of leadership and management development training sessions available. Local/ Regional/National Education partnerships Workforce Strategy & Divisional Workforce Plans Alternative development pipelines in place – Degree Apprenticeships, Medical Support Workers, Cadet Programme commenced. Bank & Agency Usage Deep Dive Undertaken.	Review of leadership and management development offer including medical leadership System for identifying and managing talent not yet available Restrictions on staff capacity to attend and participate in mandatory/statutory training. Bank and agency staff costs not reducing. Escalation areas remaining open – staffing additional areas required.	**Level 1 - Management** People, Engagement & Leadership Group - People Plan – Workstream Reports Educational Governance Group - Exception reports for Mandatory & Role Essential Training, Attendance Equality, Diversity & Inclusion Steering Group - Staff Networks				4	4	16	16	16	16	16	4	2	8
				Level 2 – Corporate People Performance Committee – - Workforce Integrated Performance Report (Sickness Absence / Substantive Staff /Recruitment Pipeline / Appraisal, Turnover, Flexible Working Requests, Bank & Agency) - Safe Staffing Report (Quarterly) - Annual Nurse Establishments - Annual Medical Job Planning) - Annual Medical Revalidation Report Bank & Agency Usage – Review via Exec Team (Monthly)		Launch refreshed leadership & management development offer Launch & deliver a Medical Leadership Programme Develop and implement phase one of a talent management and succession planning approach Bank and agency staff Utilisation - Deep Dive Actions	April 2023 June 2023 September 2023 Q4 23/24 – Q1 23/24									
				Level 3 - Independent NHS National Staff Survey GMC Survey Health Education Visits Model Hospital and comparative benchmarking data Confirm and Challenge by NHSEI NW Regional Team											
Principal Risk Number: 5.2					**Risk Appetite: High**												
There is a risk that the Trust fails to have a workforce that is reflective of the communities served leading to staff with a protected characteristic having a suboptimal staff experience (career progression, turnover) and a poorer patient experience.	People Performance Committee	Approved People Plan in line with national People Strategy objectives – Including Equality, Diversity & Inclusion, Talent Management & Succession planning Equality, Diversity & Inclusion Strategy & Implementation Plan Staff Networks (BAME / Disability / Carer/ LGBTQ+) Senior medical leadership roles – Interview panel includes representation from staff with protected characteristics	Career Development Programmes for staff with protected characteristics Development of Staff Network Chairs and the Staff Networks Implementation of OD Plan including Civility/Kindness Programme	**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		Implement new Staff Network Guidance	~~February 2023~~ March 2023	3	3	9	9	9	9	9	3	2	6
				Level 2 – Corporate Performance Review (Monthly) including targeted 'Deep Dives' People Performance Committee - EDI Report (Biannually)	EDI metrics to be built into People Analytics Dashboard.	Civility Saves Lives Programme - Phase 1 Delivery implementation to be agreed	March 2023										

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores				Target Risk Score		
								Impact	Likelihood	Current	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 5 - Develop a diverse, capable and motivated workforce to meet future service and user needs																	
		Hate Crime Reduction Policy in place (Red/Yellow card) Dying to Work Charter Accessible Scheme Risk assessments undertaken for all staff; including BAME & Covid specific risk assessments		- WRES and WDES Report - Gender Pay Gap report to Board - Annual EDI Report **Level 3 - Independent** NHS National Staff Survey													

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores				Target Risk Score		
								Impact	Likelihood	Current	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 6 - Use our resources in an efficient and effective manner																	
Principal Risk Number: PR6.1					**Risk Appetite: Moderate**												
There is a risk that the Trust does not deliver the 2022/23 financial plan leading to a poor use of resources and increased regulatory intervention.	Finance & Performance Committee	Annual financial plan 2022/23 approved – Confirmed deficit as part of GM control total SFT Capital Plan approved – Within GM Capital Plan Annual cash plan 2022/23 in place – Cash support if required from GM Approved Opening Budgets 2022/23 including requirement for recurrent and non-recurrent CIP Established CIP planning processes. PMO coordination of delivery Divisional Performance Review process - including financial escalation based on agreement of control totals for divisions. Divisional Year End Forecast Review – Agreement of actions to achieve divisional control total. Working Intelligently Group established – Data Analysis & Benchmarking – Workplan in place. 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 Financial Forecast 2022/23 Review, incorporating Compliance & Assurance Statement to GM ICS reviewed and approved via Finance & Performance Committee & Board of Directors – December 2022 GM ICS External Review – Agreed Action Plan	Implementation of recurrent CIP Plan. Financial impact of industrial action	**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 Finance & Performance Committee - Finance Report (Monthly) - CPMG – Capital Position Divisional Performance Review (Monthly) including Financial Position/CIP Integrated Performance Report (Finance) - Board (Bimonthly) **Level 3 - Independent** Internal Audit Reports - Key Financial Systems (Substantial) 2021/22 - HFMA Financial Sustainability Review - Confirmation of Self-Assessment. - Provenance of Data (High) Provider Director of Finance GM Meeting Monthly Provider Finance Return (GM & NHSE/I) NHSE - North West Region oversight and triangulation of finance, activity and workforce data. GM Cash Review Process (2023/24)	Opportunities for benchmarking: GIRFT / Model Hospital – Financial benchmarking metrics not current.	CIP Implementation Plan 2022/23 including recurrent delivery ~~Divisional Year End Forecast – Agreement of actions to achieve divisional control total~~ ~~Cash Action Group – Focused work on cash management.~~ ~~Completion of Internal Audits:~~ ~~Provenance of Data~~	Ongoing ~~Jan – March 23~~ ~~Q4 2022/23~~	4	3	12	12	12	16	12	4	2	8
Principal Risk Number: PR6.2					**Risk Appetite: Moderate**												
There is a risk that the Trust does not develop and agree with partners a multi-year financial recovery plan, optimising	Finance & Performance Committee	GM ICS financial planning/position processes established including GM DoFs Planning Group.	Underlying financial deficit Lack of certainty regarding system	**Level 1 - Management**		Review of budget methodology for delivery and transaction of CIP	~~Q3 2022/23~~ Q4 2022/23	~~4~~	~~4~~	16	9	9	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	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 6 - Use our resources in an efficient and effective manner																	
opportunities for financial recovery through system working, leading to lack of financial sustainability.		GM system Financial Recovery Subcommittee established - Chief Finance Officer member. Locality financial planning/position processes in place including monthly meeting Local Authority Treasurer & Trust CFO. 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. Financial planning 2023/24 being undertaken jointly with T&G – Commenced pre-guidance.	funding beyond 2022/23 - Potential requirement for increased % CIP (recurrent/non-recurrent) Draft planning guidance 23023/24 received indicates a higher risk on income and system funding for 2023/34 e.g. Part reintroduction of PBR GM Financial Risk Framework to be agreed	**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) - Multi Year Financial Recovery Plan (Quarterly) – Drivers of the deficit		Determine scope of multiyear financial recovery plan based on confirmed risk appetite ~~(including consideration of key data sources)~~	Q1 2023/24									
				Level 3 - Independent Provider Director of Finance GM Meeting		Review outcome of GM commissioned system wide diagnostic to understand drivers of financial position. GM Financial Risk Framework to be agreed	April 2023 September 2023									

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores				Target Risk Score		
								Impact	Likelihood	Current	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: High**												
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 commenced.		**Level 1 – Management** Digital & Informatics Group Digital Risk Register – Quarterly review via Risk Management Committee				3	3	9	9	9	9	9	3	2	6
				Level 2 – Corporate Finance & Performance Committee - Digital & Informatics Group established Bimonthly - Digital Strategy Progress Report - Capital Programmes Management Group – (Monthly): Including digital capital Board of Directors - Biannual Digital Strategy Progress Report		Completion of MIAA audit (and agreed recommendations) relating to legacy systems and asset control	Q4 2022/23										
				Level 3 - Independent Business Continuity Confirm and Challenge NHSE ISO 27001 Information Security Management Certification Internal Audit Report: Data Protection & Security Toolkit – Moderate Assurance, MIAA, September 2021		Completion of Data Protection & Security Toolkit (DSPT) Assessment 2022	Q4 2022/23										
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 which may lead to inefficient utilisation of the estate to support high quality of care and increased health & safety incidents.	Finance & Performance Committee	Approved Capital Programme including backlog maintenance Robust process in place for identification and stratification of estates related risks and backlog maintenance 6-facet survey completion and review – Action Plan in place Premises Assurance Model (PAM) Action Plan in place Estates & Facilities Performance Dashboard (Compliance & Performance Metrics) Site Development Strategy in place. Project Board and Senior Responsible Officer identified for major capital developments	Financial resources to enable optimum levels of estates investment Inability to deliver required upgrades due to access limitations related to clinical activity pressures	**Level 1 – Management** Capital Programme Management Group - Compliance with agreed delivery programme - Confirmation of spend against approved budget Health & Safety Group - Compliance with regulatory standards - Health & Safety Incidents				4	3	12	12	12	12	12	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, aligned to Project Hazel	April 23										
				Level 3 - Independent Estates Return Information Collection (ERIC) Model Hospital Data Set Estates & Facilities Compliance Review (MIAA 2020/21) – Substantial Assurance													
Principal Risk Number: 7.3					**Risk Appetite: High**												

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	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 7 - Develop our Estate & Digital infrastructure to meet service and user needs																	
There is a risk that the Trust does not materially improve environmental sustainability which may lead to suboptimal support to locality ambitions and the NHS commitment to carbon reduction.	Finance & Performance Committee	Approved Green Plan in place. Green Plan Committee established and Green Plan Work Plan in place monitored by the committee. Approved Capital Programme 2022/23 Robust identification and stratification of sustainability-related risks. 6-facet survey completion and review of information Trust Sustainability Manager in post Mechanisms in place to explore and develop sustainability approach across Stockport locality	Financial resources to enable optimum levels of investment to deliver sustainability improvements	**Level 1 – Management** Capital Programme Management Group - Compliance with agreed delivery programme - Confirmation of spend against approved budget Green Plan Committee - Monitoring of Green Plan delivery - Development of sustainability opportunities				4	2	8	12	8	8	8	4	2	8
				Level 2 – Corporate Annual Sustainability Report Finance & Performance Committee Estates Progress Report including Sustainability (Biannually)													
				Level 3 - Independent - Estates Return Information Collection (ERIC)													
Principal Risk Number: 7.4					**Risk Appetite: High**												
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 Outline Business Case in development 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.	Funding mechanism not confirmed. Awaiting response from DHSC following submission of Expression of Interest. New Hospital Building Outline Business Case	**Level 1 - Management**				3	4	12	12	12	12	12	3	2	6
				Level 2 – Corporate Strategic Regeneration Framework Prospectus and Expression of Interest – Reviewed by Board		Development of New Hospital Strategic Outline Business Case (OBC)	~~Jan 2023~~ Q1 2023/24										
				Level 3 - Independent													

Appendix 2 – Stockport NHS Foundation Trust Significant Risk Register (as at March 2023)

Risk ID	Business Group	Risk Title	Consequence	Likelihood	Rating	Target Rating	Change since last report
130	Emergency Department and Clinical Decision Unit	The Trust does not meet the 4 hour access standard and this leads to delays in treatment and potential patient harm	4	4	16	10	↔
2133	Integrated Care	There is a risk that patient flow may be compromised by the reduced access to community capacity and therefore rising No Criteria to Reside.	4	4	16	6	↓
2337	Division of Medicine	There is a risk of rapid access chest pain patients coming to harm because of booking first appointments	4	4	16	8	New
1711	People	There is a risk of deterioration in employee relations and possible industrial action	4	4	16	1	↑

Stockport NHS Foundation Trust

Meeting date	6 April 2023	x	Public		Confidential	Agenda item
Meeting	Board of Directors					
Title	Standards of Business Conduct					
Lead Director	Caroline Parnell, Director of Communications & Corporate Affairs		Author	Rebecca McCarthy, Trust Secretary		

Recommendations made / Decisions requested

The Board of Directors is asked to:

- Review and confirm the interests declared by the Board of Directors;
- Review and confirm that it considers the Chair and Non-Executive Directors to be independent; and
- Endorse the Chair's annual assessment of the Fit and Proper Person requirements for the Board of Directors.

This paper relates to the following Corporate Annual Objectives-

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

The paper relates to the following CQC domains-

	Safe		Effective
	Caring		Responsive
x	Well-Led		Use of Resources

		PR1.1	There is a risk that the Trust does not deliver high quality of care to service users, which may lead to suboptimal patient safety, effectiveness and/or experience and failure to meet regulatory standards
		PR1.2	There is a risk that patient flow across the locality is not effective which may lead to potential harm, suboptimal user experience, and inability to achieve national standards for urgent and elective care
		PR1.3	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan which may lead to suboptimal patient safety, outcomes and user experience and inability to achieve national standards for planned care
		PR2.1	There is a risk that the Trust fails to sufficiently engage and support our people, which may lead to low morale, higher turnover & sickness absence and gaps in the workforce that may impact on delivery of high-

This paper is related to these BAF risks			quality care
		PR2.2	There is a risk that the Trust's community services do not fully support neighbourhood working which may lead to suboptimal improvement in neighbourhood population health
		PR3.1	There is a risk in approving and implementing a new Provider Collaborative model to support delivery of priorities/objectives of the Stockport's ONE Health & Care (Locality) Board which may lead to a delay in delivery of models of care which support improvements in population health and operational recovery following the pandemic
		PR3.2	There is a risk that the Trust does not deliver a joint Clinical Strategy with East Cheshire NHS Trust (ECT), which may lead to suboptimal pathways of care and/or limited service resilience across the footprint of both Trusts
		PR4.1	There is a risk that the Trust does not implement high quality research & transformation programmes which may lead to suboptimal service improvements
		PR5.1	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit the optimal number of staff, with appropriate skills and values, which may lead to suboptimal staff and patient experience
		PR5.2	There is a risk that the Trust fails to have a workforce that is reflective of the communities served which may lead to staff with a protected characteristic having a suboptimal staff experience (career progression, turnover) and a poorer patient experience
		PR6.1	There is a risk that the Trust does not deliver the 2022/23 financial plan which may lead to a poor use of resources and increased regulatory intervention
		PR6.2	There is a risk that the Trust does not develop and agree with partners a multi-year financial recovery plan, optimising opportunities for financial recovery through system working, which may lead to a lack of financial sustainability
		PR7.1	There is a risk that the Trust does not implement the Digital Strategy designed to ensure a resilient and responsive digital infrastructure which may lead to inability to support improvements in quality of care and compromise of data/information
		PR7.2	There is a risk that the estate is not fit for purpose and/or meets national standards which may lead to inefficient utilisation of the estate to support high quality of care and increased health & safety incidents
		PR7.3	There is a risk that the Trust does not materially improve environmental sustainability which may lead to suboptimal support to locality ambitions and the NHS commitment to carbon reduction
		PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus which may lead to an adverse long term impact on the Trust's capability to deliver modern and effective care

Where issues are addressed in the paper-

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

Executive Summary

This report provides information about:

- The declared interests of all Board members;
- The independence of Non-Executive Directors in line with the NHS FT Code of Governance (Provision B.1.2).
- The Board's compliance with the Fit and Proper Person Requirements (FPPR).

1. Purpose

1.1 The purpose of this report is to facilitate a decision by the Board of Directors relating to:

- Confirmation of the interests declared by the Board of Directors,
- The independence of Non-Executive Directors, and
- Executive and Non-Executive Directors' compliance with the Fit and Proper Person Requirements.

2. Register of Interests

2.1 There is a legal requirement for the Trust to maintain a Register of Directors' Interests which should be available to the public.

2.2 Furthermore, the NHS Standard Contract General Conditions: GC27 Conflicts of Interest and Transparency on Gifts and Hospitality requires trusts to maintain and publish on its website an up-to-date register containing details of all gifts, hospitality, and actual or potential conflicts of interest.

2.3 The Trust uses an online portal to record and publish details of any actual or potential conflicts of interest, alongside gifts, hospitality, and sponsorship, for all staff including the Board of Directors.

2.4 Members of the Board of Directors are required to make an annual entry via the online portal with respect to interests, even if it is to confirm no change to previous declarations or confirm a nil declaration. Furthermore, any changes throughout the year should be declared by the Board member at the earliest convenience, thereby a contemporary Board-level Register of Interests is maintained.

2.5 Interests should be declared if they are material and relevant to the business of the Board relating to:

- *Financial interests* – Where an individual may get direct financial benefit from the consequences of a decision they are involved in making.
- *Non-financial professional interests* Where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making.
- *Non-financial personal interests* - Where an individual may benefit personally in ways that are not directly linked to their professional career and do not give rise to a direct financial benefit, because of the decisions they are involved in decision making.
- Indirect interests - Where an individual has a close association with another individual who has a financial interest.
- Organisational (Loyalty) interests - Where an individual's role in another organisation could result in actual or perceived conflicts of interest.

2.6 Trust adopts a common sense approach to the management of interests as outlined in the Conflicts of interest Policy. Should action be warranted to mitigate conflicts of interest must be proportionate and should seek to preserve the spirit of collective decision-making wherever possible.

2.7 The current Register of Directors' Interests is included for reference in **Appendix 1**. Board members are requested to review and confirm that the current content is accurate and up to date.

3. Independence of Non-Executive Directors

3.1 Provision B.1.2 of the NHS Foundation Trust Code of Governance (July 2014) requires that at least half of the Board of Directors, excluding the Chair, should comprise Non-Executive Directors determined by the Board to be independent.

3.2 Provision B.1.1 of the NHS Foundation Trust Code of Governance requires the Board of Directors to identify in the Annual Report each Non-Executive Director that it considers to be independent. The provision states that:

"The Board should determine whether the director is independent in character and judgement and whether there are relationships or circumstances which are likely to affect, or could appear to affect, the director's judgement".

3.3 The forementioned provisions are also included in the new Code of Governance for provider trusts published in October 2022.

3.4 The Board of Directors should state its reasons if it determines that a director is independent despite the existence of relationships or circumstances which may appear relevant to its determination. The Code of Governance sets out relevant criteria as follows:

- Whether the individual had been an employee of the Trust within the last five years,
- Whether the individual has, or has had within the last three years, a material business relationship with the Trust either directly or as a partner, shareholder, director or senior employee of a body that has such a relationship with the Trust,
- Whether the individual has received, or receives, remuneration from the Trust in addition to a director's fee, participates in a performance-related pay scheme or is a member of the Trust's pension scheme,
- Whether the individual has close family ties with any of the Trust's advisers, directors of senior employees,
- Whether the individual holds cross-directorships or has significant links with other directors through involvement in other companies or bodies,
- Whether the individual has served on the Board of the Trust for more than six years from the date of their first appointment,
- Whether the individual is an appointed representative of the Trust's university, medical or dental school.

3.5 Declarations of independence, based on the criteria detailed, have been completed by the Chair and each Non-Executive Director. **Appendix 2** provides information to enable the Board of Directors to determine the independence of individual Non-Executive Directors.

3.6 All Non-Executive Directors have declared that they do not meet the criteria and therefore would consider themselves to be independent.

3.7 It is recommended that the Board of Directors determine that all Non-Executive Directors are independent and support an appropriate statement in the Annual Report 2022/23.

4. Fit and Proper Person Requirement (FPPR) for Directors

4.1 Since November 2014, Trusts have been required to ensure all director level appointments meet the Fit and Proper Persons Requirement, as set out under Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which were integrated into the Care Quality Commission's registration, monitoring and inspection requirements.

4.2 The Trust's Fit and Proper Persons Policy, developed in line with the regulations, requires every Executive and Non-Executive Director to make an annual Fit and Proper Persons declaration.

4.3 It is the responsibility of the Chair of the Trust to discharge the requirement placed on the Trust to ensure that all directors meet the fitness test and do not meet any of the 'unfit' criteria.

4.4 An annual assessment, with respect to ongoing compliance with the FPPR, has been completed during March 2023. This included review of the following for each individual Board member:

- Director's Annual FPPR Self-Declaration **(Appendix 3)**
- Review against core public information sources
- Professional registration check (applicable to Chief Nurse and Medical Director)
- Undischarged bankrupt or sequestration check
- Disqualified director check

4.5 Comprehensive evidence of all the above is held securely, in individual personal files, by the Trust Secretary and the outcome of the Fit and Proper Persons Assessment has been considered and confirmed by the Chair, with signed confirmation retained electronically by the Trust Secretary.

4.6 The Chair has confirmed all Board members have been assessed as compliant with the Fit & Proper Person requirements in accordance with Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

4.7 A review of the Fit and Proper Persons policy with specific consideration of joint Director appointments is to be undertaken by the Director of People & Organisational Development during Q1 2023/24.

5. Recommendations

5.1 The Board of Directors is asked to:

- Review and confirm the interests declared by the Board of Directors;
- Review and determine the independence of each Non-Executive Director; and
- Endorse the Chair's annual assessment of the Fit and Proper Person requirements for the Board of Directors, subject to any further action to be taken with respect to annual update/DBS checks.

Appendix 1 – Board of Directors Register of Interests

Stockport NHS Foundation Trust Board of Directors
Register of Interests
March 2023

Name and Position	Declared Interests
Professor Tony Warne Chairman	• Nil
Dr Marisa Logan-Ward Non-Executive Director Deputy Chair	• Kingsbridge Health Ltd - Management Consultancy to public and private enterprises in relation to pathology and scientific services. Includes a consultancy contract providing the role of Chief Scientific Advisor to Acacium Group - Provider of healthcare solutions including staffing.
Dr Samira Anane Non-Executive Director	• Company Secretary – Orthpro • Regional BMA Committee Representative: Stockport, Manchester, Salford, Trafford • Co Chair BMA Sessional Committee and North West Regional Representative • Trustee – Clare Wand Fund • Executive Member – Manchester LMC • NIHR In Practice Fellow – University of Manchester • Board Member – Our People Trust • General Practitioner – GP City Health Centre (GTD Healthcare) • PCN Clinical Director (Manchester City Centre and Ancoats)
Mr Tony Bell Non-Executive Director	• Non-Executive Director, Inclusion Housing CIC • Non-Executive Director, Wythenshawe Community Housing Group • Non-Executive Director, Lumen Housing • Vice-Chair – Cariocca Enterprises • Chair of Advisory Group – The Training Brokers
Mrs Beatrice Fraenkel Non-Executive Director	• NHS Confederation Mental Health & Housing Group • Trustee – Design in Mental Health • Trustee – Design Council • Remcol Ltd • Normal Properties Ltd • Sandown Property Holdings Ltd • Sandown Property Co. Liverpool Ltd • Member of the High Street Task Force • Design Code Pathfinders Programme Expert Panel Member • Panel Member for NW RIBA Design Review Panel ‘Places Matter’ • Board Director on the Board of Safehinge Primera
Mr David Hopewell Non-Executive Director	• Nil
Mrs Mary Moore Non-Executive Director	• Shareholder, Scenario Health
Dr Louise Sell Non-Executive Director	• GMC Adviser – Health Examination and Supervision • Consultant Psychiatrist, Pennine Care NHS FT

Name and Position	Declared Interests
	• Treasurer Addiction Faculty, Royal College Psychiatrists • Charitable Trustee, Early Break • Chair, Alcohol Clinical Guidelines Group, Public Health England • RO Appraiser, NHSE/I
Mr Meb Vadiya Associate Non-Executive Director	• Energus Limited – Non-Executive Director • Winterstone Investments Limited – Statutory Director
Mrs Karen James OBE Chief Executive	• Chief Executive, Tameside & Glossop Integrated Care Organisation – joint post with Stockport NHS Foundation Trust • Sixth Form Governor – Tameside College • Member of Tameside TRENT School Academy
Mr John Graham Director of Finance / Deputy Chief Executive	• Chair of the Multi School Academy Trust – Schools in Liverpool, Lydiate Learning Trust • Member, CIMA's NW Area • Member of CIMA's Council • Member of Management Committee of Las Calas, Lanzarote, Resort Solutions Limited • Chief Finance Officer – Joint appointment held between Stockport NHS Foundation Trust and Tameside & Glossop Integrated Care NHS Foundation Trust
Ms Amanda Bromley Director of People & OD	• Director of People & OD – Joint appointment held between Stockport NHS Foundation Trust and Tameside & Glossop Integrated Care NHS Foundation Trust
Mrs Nicola Firth Chief Nurse	• Chief Nurse – Joint appointment held between Stockport NHS Foundation Trust and Tameside & Glossop Integrated Care NHS Foundation Trust
Dr Andrew Loughney Medical Director	• Nil
Mrs Jackie McShane Director of Operations	• Moorfield Community School Governor
Mr Jonathan O'Brien Director of Strategy & Partnerships	• Executive Director of Strategy & Partnerships – Joint appointment held between Stockport NHS Foundation Trust and Tameside & Glossop Integrated Care NHS Foundation Trust • Independent Governor Board of Directors – Trafford College Group
Mrs Caroline Parnell Director of Communications & Corporate Affairs	• Founding Partner of Sentry PR, Communications Consultancy • Associate Consultant, Dearden HR and Kingsgate

Appendix 2: Independence of Non-Executive Directors

Relationships or circumstances which may be relevant to the Board's determination of the independence of Non-Executive Directors *(The NHS FT Code of Governance, Monitor, July 2014)*	**TW**	**SA**	**TB**	**BF**	**DH**	**MLW**	**MM**	**LS**	**MV**
Has been an employee of the Trust within the last five years	N	N	N	N	N	N	N	N	N
Has, or has had within the last three years, a material business relationship with the Trust either directly or as a partner, shareholder, director or senior employee of a body that has such a relationship with the Trust	N	N	N	N	N	N	N	N	N
Has received, or receives, remuneration from the Trust in addition to a director's fee, participates in a performance-related pay scheme or is a member of the Trust's pension scheme	N	N	N	N	N	N	N	N	N
Has close family ties with any of the Trust's advisers, directors of senior employees	N	N	N	N	N	N	N	N	N
Holds cross-directorships or has significant links with other directors through involvement in other companies or bodies	N	N	N	N	N	N	N	N	N
Has served on the Board of the Trust for more than six years from the date of their first appointment	N	N	N	N	N	N	N	N	N
Is an appointed representative of the Trust's university, medical or dental school	N	N	N	N	N	N	N	N	N

Appendix 3 – FPPR Self Declaration

Fit and Proper Person Self Declaration

In line with the requirement for Directors of an NHS Trust to be a fit and proper person, I hereby declare that:-

Declaration	**Confirmed / Not Confirmed**
I am of good character by virtue of the following:-	
• I have not been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence.	
• I have not been erased, removed or struck-off a register of professionals maintained by a regulator of health or social care.	
• I have not been sentenced to imprisonment for three months or more within the last five years.	
• I am not an undischarged bankrupt.	
• I am not the subject of a bankruptcy order or an interim bankruptcy order.	
• I do not have an undischarged arrangement with creditors.	
• I am not included on any barring list preventing me from working with children or vulnerable adults.	
I have the qualifications, skills and experience necessary for the position I hold on the Board.	
I am capable of undertaking the relevant position, after any reasonable adjustments under the Equality Act 2010.	
I have not been responsible for any misconduct or mismanagement in the course of any employment with a CQC registered provider.	
I am not prohibited from holding the relevant position under any other law e.g. under the Companies Act or the Charities Act.	

Signed:	
Name:	
Position:	
Date:	

NHS Stockport NHS Foundation Trust

Stockport NHS Foundation Trust

Meeting date	6 April 2023	x	Public		Confidential	Agenda item
Meeting	Board of Directors					
Title	Annual Review of Foundation Trust Code of Governance - 2022/23					
Lead Director	Caroline Parnell, Director of Communications & Corporate Affairs		Author	Rebecca McCarthy, Trust Secretary		

Recommendations made / Decisions requested

The Board of Directors is asked to review and confirm the outcome of the annual review of compliance with the Code of Governance, including disclosures to be included within the Annual Report 2022/23.

This paper relates to the following Corporate Annual Objectives

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

11.3

The paper relates to the following CQC domains-

	Safe		Effective
	Caring		Responsive
x	Well-Led		Use of Resources

		PR1.1	There is a risk that the Trust does not deliver high quality of care to service users, which may lead to suboptimal patient safety, effectiveness and/or experience and failure to meet regulatory standards
		PR1.2	There is a risk that patient flow across the locality is not effective which may lead to potential harm, suboptimal user experience, and inability to achieve national standards for urgent and elective care

This paper is related to these BAF risks		PR1.3	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan which may lead to suboptimal patient safety, outcomes and user experience and inability to achieve national standards for planned care
		PR2.1	There is a risk that the Trust fails to sufficiently engage and support our people, which may lead to low morale, higher turnover & sickness absence and gaps in the workforce that may impact on delivery of high-quality care
		PR2.2	There is a risk that the Trust's community services do not fully support neighbourhood working which may lead to suboptimal improvement in neighbourhood population health
		PR3.1	There is a risk in approving and implementing a new Provider Collaborative model to support delivery of priorities/objectives of the Stockport's ONE Health & Care (Locality) Board which may lead to a delay in delivery of models of care which support improvements in population health and operational recovery following the pandemic
		PR3.2	There is a risk that the Trust does not deliver a joint Clinical Strategy with East Cheshire NHS Trust (ECT), which may lead to suboptimal pathways of care and/or limited service resilience across the footprint of both Trusts
		PR4.1	There is a risk that the Trust does not implement high quality research & transformation programmes which may lead to suboptimal service improvements
		PR5.1	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit the optimal number of staff, with appropriate skills and values, which may lead to suboptimal staff and patient experience
		PR5.2	There is a risk that the Trust fails to have a workforce that is reflective of the communities served which may lead to staff with a protected characteristic having a suboptimal staff experience (career progression, turnover) and a poorer patient experience
		PR6.1	There is a risk that the Trust does not deliver the 2022/23 financial plan which may lead to a poor use of resources and increased regulatory intervention
		PR6.2	There is a risk that the Trust does not develop and agree with partners a multi-year financial recovery plan, optimising opportunities for financial recovery through system working, which may lead to a lack of financial sustainability
		PR7.1	There is a risk that the Trust does not implement the Digital Strategy designed to ensure a resilient and responsive digital infrastructure which may lead to inability to support improvements in quality of care and compromise of data/information
		PR7.2	There is a risk that the estate is not fit for purpose and/or meets national standards which may lead to inefficient utilisation of the estate to support high quality of care and increased health & safety incidents
		PR7.3	There is a risk that the Trust does not materially improve environmental sustainability which may lead to suboptimal support to locality ambitions and the NHS commitment to carbon reduction
		PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus which may lead to an adverse long term impact on the Trust's capability to deliver modern and effective care

Where issues are addressed in the paper-

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

Executive Summary

The NHS Foundation Trust Code of Governance (the Code) was first published in 2006 and updated in July 2014. Following significant regulatory change on account of the Health and Social Care Act 2022, a new code of governance for NHS provider trusts was published in October 2022, taking effect from 1 April 2023.

The new Code applies to both foundation trusts and NHS trusts. Key changes relate to:

- Incorporation of requirement for boards to assess its contribution to the Integrated Care Partnership (ICP) and Integrated Care Board (ICB) and place-based partnerships.
- Board's role in assessing and monitoring culture of the organisation.
- Focus on equality, diversity, and inclusivity at board.
- Potential involvement of NHS England and/or ICB in recruitment and appointment of Executive and Non-Executive Directors.

As previous, the Code sets out principles to help trusts deliver effective corporate governance, and provisions with which trusts must comply, or explain how the principles have been met in other ways. There are several statutory requirements, where compliance is mandatory. The provisions are drawn together in a disclosures section, which must be reported against in trust's Annual Report.

In line with the Foundation Trust Annual Reporting Manual 2022/23, the trust is required to report compliance against the Code (July 2014) within its Annual Report 2022/23. A compliance checklist with each of the Code provisions has been prepared and included at Appendix A, confirming that the Trust complies with the Code's provisions, except for:

- Provision B.6.2

Evaluation of FT boards should be externally facilitated at least every three years.

SFT's Annual Report 2022/23 will confirm compliance with the provisions of the Code and an explanation of the reasons for departure from B.6.2 on the basis that:

- An independent board governance review was completed by Deloitte LLP during 2014/15. Subsequently a series of external reviews including CQC Well Led Inspection (October 2018 and February 2020) and NHS England/Improvement Governance Review (November 2019) have been undertaken. An independently facilitated Well Led mapping review was conducted by AQuA in 2021, providing an overview of the Trust's evidence against the 8 Key Lines of Enquiry (KLOEs) within the Well Led framework, and further developmental actions for the purpose of continuous improvement. Further to this, the Board agreed an approach to facilitate an external review during 2023/24, with completion of a self-assessment and agreed KLOE ratings supported by Board in March 2023 in preparation.

To ensure the Trust is taking account of provisions of the new Code, a management review has been undertaken. Additional provisions and/or variation to provisions, have been identified, alongside current compliance position (Appendix B). At present the Trust is compliant with the

provisions except for:
E.2.2: Levels of remuneration for the chair and other non-executive directors should reflect the Chair and non-executive director remuneration structure.

This is on the basis that, in February 2022, the Council of Governors agreed that all new Non-Executive Director positions would be remunerated in line with 'NHS England Chair and non-executive director remuneration structure'. This decision has subsequently been implemented. Furthermore, the Council of Governors agreed that existing non-executive directors, who are reappointed for a further term of office, would remain at the level of remuneration to which they were originally appointed, subject to a robust performance appraisal and confirmation that performance continues to be effective, thereby differing to the 'NHS England Chair and non-executive director remuneration structure'. The Chair's remuneration is in line with the NHS England remuneration structure.

Appendix A – 2022/23 Compliance Checklist: NHS foundation trust Code of Governance (July 2014)

A. Leadership

A.1 The role of the board of directors

Section	Code Provision	2022/23 Position	Developmental Action	Comply or Explain
A.1.1	▪ Sufficiently regular meetings of the Board ▪ Formal schedule of matters reserved for decision by the Board ▪ Clear statement detailing role and responsibilities of Council of Governors (CoG) ▪ Statement explaining how disagreements between the CoG and Board will be resolved ▪ Annual Report to describe how Board and CoG operate	▪ Board met sufficiently regularly during 2022/23 to fulfil responsibilities. Attendance register held by Company Secretary. ▪ Approved Constitution and Standing Orders (SO)s in place setting out: – Decisions reserved for the Council of Governors (CoG) includes role and responsibilities of CoG – Decisions reserved for the Board of Directors includes role and responsibilities of Board ▪ Mechanism in place to resolve disagreements between the Board and CoG as stated within Constitution. ▪ Senior Independent Director (SID) supports CoG and Board relationships as required. Annual Report describes how Board and CoG operate.		Comply
A.1.2	▪ Annual Report: ○ Identify Chairman, Deputy Chairman, CEO and SID ○ Chair and members of Audit and Remuneration Committees ○ Number of meetings of Board, Audit, Remuneration Committee and individual attendance of members.	▪ Annual Report 201/22 identifies key members of the Board, Audit and Nominations Committees. Annual Report 2022/23 to include this information *(will be subject to external audit).* ▪ Number of meetings and attendance reported within Annual Reports (as above).		Comply
A.1.3	▪ Board to issue objectives of Trust highlighting balance of interests of patients, community and other stakeholders – as basis for decision making/forward planning	▪ Trust annual plan is developed in line with national planning requirements within year, including the principal objectives and outcome measures that balance interests of patients and local community and key stakeholders.		Comply
A.1.4	▪ Adequate systems in place to measure and monitor effectiveness, efficiency, economy and quality. ▪ Board to regularly review against regulatory requirements and approved plans	▪ Board committee structure (assurance framework) in place to oversee delivery of annual plan and regulatory requirements – Committee Effectiveness Internal Audit – Substantial Assurance. ▪ Regular review by Board and Board Committees of: Integrated Performance Report, Finance, Operational		Comply

Appendix A – 2022/23 Compliance Checklist: NHS foundation trust Code of Governance (July 2014)

Section	Code Provision	2022/23 Position	Developmental Action	Comply or Explain
		Performance, People and Quality & Safety Dashboards. ▪ Finance Report includes overview of Cost Improvement Programme & Medium/Long Term Financial Recovery Plan development, including drivers of the deficit, considered via Finance & Performance Committee during 2022/23. ▪ Established business case review process, including post business case benefits realisation review. ▪ Established Audit Committee, including review of Internal Audit and External Audit plans.		
A.1.5	▪ Relevant metrics, measures, milestones and accountabilities to be in place to assess delivery of performance ▪ Where appropriate, independent advice should be commissioned by the Board (in high risk/complex areas) to provide adequate and reliable level of assurance	▪ Integrated Performance Report sets out performance against relevant internal and external standards/metrics. ▪ Operational Divisional Performance Review process established. Key themes and issues reported to Finance & Performance Committee. ▪ Independent advice commissioned by Board, as appropriate.		Comply
A.1.6	▪ Board to report on its approach to clinical governance and its plans to improve clinical quality ▪ Board to record where, within the structure of the organisation, consideration of clinical governance occurs	▪ Board approved Quality Strategy in place. ▪ Oversight of clinical governance and quality established within approved Board governance arrangements – Patient Safety, Clinical Effectiveness, Patient Experience reporting via Quality Committee, and onward to Board as required. ▪ Quality Accounts produced annually.		Comply
A.1.7	▪ CEO to follow procedure set by Monitor for advising Board and CoG and recording and submitting objections to decisions of Board in matters of regularity and wider responsibilities of the Accounting Officer procedure.	▪ CEO fully aware of responsibilities within Accounting Officer Memorandum – Statement within Annual Report 2021/22. To be included in Annual Report 2022/23 *(will be subject to external audit).* ▪ Scheme of Reservation & Delegation, approved via Audit Committee & Board, sets out Delegations derived from Accounting Officer Memorandum ▪ Responsibilities set out in Standing Orders for Board and CoG.		Comply
A.1.8	▪ Board to establish constitution and standards of conduct for the Trust and its staff in accordance with The Nolan Principles	▪ SFT Constitution in place. ▪ SFT values established. ▪ Conflicts of Interest Policy established for all staff setting out standards of business conduct.		Comply

Appendix A – 2022/23 Compliance Checklist: NHS foundation trust Code of Governance (July 2014)

Section	Code Provision	2022/23 Position	Developmental Action	Comply or Explain
		▪ Annual Standards of Business Conduct Review for all Board Directors		
A.1.9	▪ Board to operate a code of conduct that builds on values and reflects high standards of probity and responsibility ▪ Board should follow policy of openness and transparency and make clear how potential conflicts of interest are dealt with.	▪ Directors and Governors Code of Conduct in place. ▪ Standards of Business Conduct review for Board conducted annually. ▪ Board meetings held in public. Proceedings and decision making that conflict with the need to protect the interest of the public or commercial matters managed in private session and agenda published.		Comply
A.1.10	▪ Appropriate insurance cover to cover the risk of legal action against directors	▪ Directors currently covered by NHSLA/Constitution provisions.		Comply

A.2 Division of responsibilities

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
A.2.1	▪ Division of responsibilities between the chairperson and chief executive should be clearly established, set out in writing by the Board.	▪ Division of responsibility between Chair and CEO set out in writing in Scheme of Reservations and Delegation.		Comply
A.2.2	**Statutory Requirement:** ▪ Role of Chair and CEO must not be undertaken by same individual	▪ Position of Chair and CEO held by different individuals. Confirmed within Annual Report.		Comply

A.3 The chairperson

Section	Code Provision	Current Position	Developmental Action	Comply or Explain

Appendix A – 2022/23 Compliance Checklist: NHS foundation trust Code of Governance (July 2014)

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
A.3.1	▪ Chair should, on appointment, meet the independence criteria set out in B.1.1 ▪ CEO should not go on to be chairperson of the same NHS foundation trust	▪ Chair's job description and person specification details the requirement for the Chair to meet current independence criteria. Confirmed on appointment. ▪ Annual review takes place of the independence of all Non-Executive Directors (NEDs), including Chairman.		Comply

A.4 Non-executive Directors

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
A.4.1	▪ Board to appoint Senior Independent Director (SID), in consultation with the CoG	▪ Current SID - Dr Louise Sell. CoG consulted on proposed appointment in February 2022, appointment confirmed by Board in April 2022.		Comply
A.4.2	▪ Chairperson to hold meetings with the NEDs without the executives present ▪ Led by SID, non-executive directors should meet without the chairperson, at least annually, to appraise chairpersons performance and if deemed appropriate.	▪ Chair meets with NEDs without executives present on a weekly basis. ▪ CoG approved process for Chair's appraisal confirms SID to meet with NEDs without chairperson present.		Comply
A.4.3	▪ Where directors have concerns, which cannot be resolved, they are recorded in the board minutes ▪ On resignation, director to provide written statement if have any concerns	▪ Board minutes fully record all matters raised, discussions, concerns, and agreements. Board meeting minutes are reviewed at the subsequent Board meeting to ensure they provide a true account of the proceedings. ▪ Resignation of director not occurred in year.		Comply

A.5 Governors

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
A.5.1	▪ CoG to meet sufficiently regularly – at least four times a year ▪ Governors should make every effort to	▪ CoG meetings take place regularly, five times a during 2022/23. Annual calendar of meeting produced and disseminated at the beginning of		Comply

Appendix A – 2022/23 Compliance Checklist: NHS foundation trust Code of Governance (July 2014)

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
	attend CoG. Trust should facilitate attendance	the year to facilitate attendance.		
A.5.2	▪ CoG not too large to be unwieldy. ▪ CoG should be of sufficient size for requirements of duties ▪ Role, structure, composition and procedures of the CoG to be reviewed regularly (see B.6.5)	▪ SFT CoG comprises of 29 governors. ▪ Training and development plan in place to support governors in conducting roles and duties. ▪ Standing Orders of the CoG in place.	Review of required changes to the composition of the Council of Governors to be conducted in line with changes to Health & Social Care Act – June 2023.	Comply
A.5.3	▪ Annual Report - to identify governors and constituency, whether elected or appointed and term of office - identifies nominated Lead Gov. ▪ Record of meetings and attendance at CoG to be kept and made available to members on request	▪ Annual Report 2021/22 identifies governors, constituencies, class and term of office. To be included in Annual Report 2022/23 *(will be subject to external audit).* ▪ Record of governor attendance at CoG maintained and available on request		Comply
A.5.4	▪ Roles and responsibilities of CoG set out in written document – with explanation of responsibilities of CoG towards members and other stakeholders, and how governors will seek views and inform them.	▪ Roles & responsibilities of the CoG are set out in the Constitution, Standing Orders and Scheme of Reservations & Delegation and 'Roles & Responsibilities' document shared with governors as part of induction. ▪ Membership Strategy & Action Plan approved by CoG in July 2022 to support governors to inform and seek views of members.		Comply
A.5.5	▪ Governors have a responsibility to make CoG arrangements work and should take the lead in inviting the CEO, Execs and NEDs to meetings ▪ Any Governors may raise questions about the affairs of the NHS foundation trust	▪ Chair and Lead Governor engage in CoG agenda setting process ▪ Chief Executive, Executive Directors and NEDs routinely attend CoG meetings ▪ All Governors proactively invited to raise questions on any issue ▪ Chair and NEDs meet with governors informally during the year to discuss issues and answers any queries.		Comply
A.5.6	▪ CoG to establish policy for engagement with Board – for concerns regarding	▪ Process in place to resolve disagreements between the Board and CoG as stated within		Comply

Appendix A – 2022/23 Compliance Checklist: NHS foundation trust Code of Governance (July 2014)

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
	performance of Board, compliance with new provider licence or other matters ▪ CoG to input into board's appointment of a SID (See A.4.1)	Constitution. ▪ CoG consulted on proposed appointment of SID in February 2022, appointment confirmed by Board in April 2022. Governors aware of role of SID via induction.		
A.5.7	▪ CoG to ensure its interaction and relationship with the Board is appropriate and effective. ▪ Timely communication of relevant information and unambiguous language.	▪ Chief Executive, Executive Directors and NEDs routinely attend CoG meetings ▪ NEDs provide regular summary report to CoG regarding matters considered via Board Committees.		Comply
A.5.8	▪ CoG should only use power to remove chair or NED after exhausting all other means of engagement with Board ▪ CoG should raise any issue with Chairman with the SID in first instance.	▪ This provision is covered within Constitution. Not applicable during 2022/23.		Comply
A.5.9	▪ CoG to receive and consider other appropriate information to discharge its duties, including clinical and operational data	▪ Relevant information made available to CoG regarding finance, quality of care, operational performance and people performance, alongside key strategic developments.		Comply
A.5.10	**Statutory Requirement:** ▪ CoG to hold NEDs individually and collectively to account for the performance of the Board	▪ Governor observation of Board meetings. ▪ NED attendance and interaction at CoG meetings. ▪ Regular Chair & NED briefing sessions with governors ▪ CoG approved Chair & NED appraisal process ▪ CoG established Nominations Committee for detailed review of Chair and NED appraisal, with final CoG review and approval ▪ CoG appoint all NEDs (& Chair) and ensures this responsibility is highlighted during selection and appointment process.		Comply
A.5.11	**Statutory Requirement:** ▪ CoG to receive the annual accounts; any report of the auditor on them; and the annual report.	▪ Received annually at CoG. Last received in September 2022.		Comply
A.5.12	**Statutory Requirement:** ▪ Governors provided with agenda prior to any meeting of the board, and a copy	▪ Agenda and public minutes published on the Trust website prior to any meeting of the Board. There is no legal basis on which the minutes of		Comply

Appendix A – 2022/23 Compliance Checklist: NHS foundation trust Code of Governance (July 2014)

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
	of approved minutes as soon as practicable afterwards	private sessions of board meetings should be exempted from being shared with the governors, however for data protection or commercial reasons, governors should respect the confidentiality of these documents.		
A.5.13	**Statutory Requirement:** ▪ CoG may require one or more directors to attend a meeting to obtain information about trust performance or directors performance of duties to help CoG decide on proposing a vote on trust or directors performance	▪ SFT Constitution sets out that the CoG has this ability ▪ Directors regularly attend CoG meetings.		Comply
A.5.14	**Statutory Requirement:** ▪ Governors can refer question to independent panel for advising governors. ▪ More than 50% of governors must approve this referral ▪ CoG should have dialogue with Board before considering a referral.	▪ *Independent Panel for Advising Governors disbanded in 2017 – Provision no longer applicable.*		
A.5.15	**Statutory Requirement:** ▪ Governors to use their rights and voting powers to represent interests of members/public on major decisions taken by Board: - More than half Board and CoG to approve a change to constitution of the NHS foundation Trust - More than half Board and CoG to approve significant transaction - More than half Board and CoG to approve merger, acquisition, separation or dissolution - More than half Board and CoG to approve increase to non-NHS income ≥ 5% a year Governors to determine whether non-NHS work will significantly interfere with trust's principal purpose.	▪ Provision set out in SFT's Constitution and Standing Orders of the CoG. Not applicable during 2022/23.		Comply

B. Effectiveness

B.1 The composition of the board

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
B.1.1	▪ Board to identify in annual report each NED it considers to be independent ▪ Board should determine whether NEDs are independent in character, judgement and whether there circumstances or relationships could exist that affect such independence ▪ Board to state its reasons if it determines that a director is independent despite relevant circumstance/criteria	▪ Annual Report identifies each NED considered by the Board to be independent. ▪ Board states its reasons if it determines that a director is independent despite relevant circumstance/criteria		Comply
B.1.2	▪ At least half the Board, excluding chairperson, should comprise independent NEDs	▪ There are currently 14 voting members of the Board, excluding the chairperson, this includes 7 Executive Directors and 7 NEDs. ▪ All current NEDs considered to be independent ▪ Annual review of NED independence (April each year)		Comply
B.1.3	▪ No individual should hold at the same time position of director and governors of any NHS foundation trust	▪ Constitution prevents an individual holding office as both director and governor at the same time ▪ Provisions included in eligibility for directors and governors		Comply
B.1.4	▪ Annual Report to detail each director's area of expertise and clear statement about Board's balance, completeness and appropriateness to the FT ▪ Both statements to be available on FT's internet site	▪ Annual Report 2021/22 detail's each director's area of expertise and statement about Board balance, completeness, and appropriateness to the Trust. To be included in Annual Report 2022/23 ▪ Annual Reports available on SFT website.		Comply

B.2 Appointments to the board

Section	Code Provision	Current Position	Developmental Action	Comply or Explain

Appendix A – 2022/23 Compliance Checklist: NHS foundation trust Code of Governance (July 2014)

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
B.2.1	▪ Nominations committee(s) to be responsible for the identification and nomination of executive and non-executive directors ▪ Nominations committee(s) should consider succession planning taking into account future challenges, risks and opportunities facing the FT and skills and expertise required within the Board to meet them.	▪ Board established Remuneration Committee: o reviews the structure, size and composition of the Board and, where appropriate, make recommendation/s to the Board for change o determines succession plans for the CEO and other Executive Directors and assist in determining the responsibilities of and procedures for appointment of Executive Directors, including the CEO ▪ Review of Board composition, including Executive Director succession planning and NEDs skills audit conducted in 2020/21 determined forthcoming non-executive directors with expertise in people/organisational development and place-based care systems to be appointed. Recommendation supported by CoG Nominations Committee. ▪ CoG established Nominations Committee responsible for identification and nomination of NEDs		Comply
B.2.2	▪ Directors and governors to meet "fit and proper" persons test described in provider licence i.e., without recent criminal conviction or director disqualification and not bankrupt. ▪ Trusts to abide by CQC guidance regarding appointments to senior positions	▪ Compliance regime in place for Fit and Proper Persons requirement – reviewed annually by Board (April) ▪ Directors sign Annual Fit and Proper Person Requirement Self-Assessment. ▪ Trust Management of Employment Checks Policy in place and covers all Director level appointments. ▪ At election, governors self-declare eligibility in line with fit and proper person requirements for governors. ▪ Governors complete annual declaration of interests and self-assessment of compliance with fit and proper person for governor.		Comply
B.2.3	▪ There may be one or two nominations committees, if two one for Exec Directors and one for Non-Exec Directors ▪ Nominations committee(s) should	▪ Nominations Committee in place for NED appointments ▪ Remuneration Committee in place for Executive Director appointments ▪ See B.2.1. Job Description & Person		Comply

Appendix A – 2022/23 Compliance Checklist: NHS foundation trust Code of Governance (July 2014)

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
	evaluate, at least annually, the balance of skills/experience on the board and prepare a description of the role and capabilities for a particular appointment, including Chair	Specification prepared including specific expertise, background, skills and qualities (as agreed) for each vacancy, and the balance of skills/experience on the board.		
B.2.4	▪ Chairman or an independent NED to chair the nominations committees ▪ A Governor can chair the committee for the appointment of NEDs or Chairman.	▪ Trust Chair identified as chair for both nominations committees. ▪ When the Chair's nomination is being considered the Deputy Chair or relevant identified member chairs the committee.		Comply
B.2.5	▪ Governors should agree with the nominations committee a clear process for the nomination of a new chair and NEDs ▪ Nominations committee should make recommendations to the CoG	▪ Nominations Committee agreed process for recruitment of NEDs, including final recommendation to the CoG. ▪ In 2022/23 CoG supported the recommendation from Nominations Committee for appointment of two new NEDs.		Comply
B.2.6	▪ Nominations committee responsible for appointment of NEDs, and any interview panel, should consist of a majority of governors	▪ Nominations committee and selection panel for NEDs consists of majority of governors.		Comply
B.2.7	▪ CoG to take into account the views of the board of directors on the qualifications, skills and experience required for each non-executive director position	▪ Nominations Committee received recommendation from Remuneration Committee (proposals approved by Board) regarding recent future NED appointments. Specifications presented to the CoG prior to each recruitment process.		Comply
B.2.8	▪ Annual report should describe the appointment process followed by CoG for NEDs and Chair	▪ Process described in Annual Report 2021/22. To be included in Annual Report 2022/23 *(will be subject to external audit).*		Comply
B.2.9	▪ An independent external adviser should not be a member or have a vote on nominations committee(s)	▪ Independent external advisers do not have vote on nominations committees.		Comply
B.2.10	▪ Separate section of the annual report should describe work of nominations committee, including board appointments process.	▪ Annual Report 2021/22 includes section about the Remuneration Committee / Nominations Committee and details of any Executive Director / NED appointment processes. To be included in Annual Report 2022/23.		Comply

Appendix A – 2022/23 Compliance Checklist: NHS foundation trust Code of Governance (July 2014)

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
B.2.11	**Statutory Requirement:** ▪ Chairperson, NED's and, except in case of appointment of CEO, the CEO appoint executive directors	▪ Chairperson, NEDs and CEO approval of all Executive Director appointments (CEO does not approve a CEO appointment – not applicable in 2022/23)		Comply
B.2.12	**Statutory Requirement:** ▪ CoG to approve CEO appointment following appointment by committee of chair and NEDs.	▪ Constitution requires CEO appointment to be CoG approved. ▪ CoG approved substantive appointment of CEO, made by Chair and NEDs in October 2021.		Comply
B.2.13	**Statutory Requirement:** ▪ CoG responsible for appointment, reappointment and removal of chairperson and other NED's	▪ CoG's Nominations Committee oversees the processes leading to CoG fulfilling its responsibility to appoint, reappoint or remove chairperson and other Non-Executive Directors.		Comply

B.3 Commitment

Section	Code Provision	Current Position	Action Required	Comply or Explain
B.3.1	▪ Chair's appointment: nominations committee should prepare JD, including time commitment and availability in times of emergency ▪ Chair's significant commitments to be disclosed to the CoG before appointment and disclosed in annual report ▪ Changes in commitments to be reported to CoG as they arise and disclosed in next annual report ▪ Chair of FT cannot, at the same time, be the substantive chair of another FT	▪ Chair's job description covers time commitment and availability in times of emergency ▪ Commitments reviewed by Nominations Committee during appointment process to ensure no significant commitments that would interfere with the demands of the role. ▪ Changes in commitments would be reported to CoG if they arised.		Comply
B.3.2	▪ NED terms and conditions should be made available to the CoG ▪ Letter of appointment should set out expected time commitment ▪ NEDs to undertake to have sufficient time to fulfil role	▪ NED terms and conditions outlined in application pack and role description, available online during appointment process and via Trust Secretary's office at other times ▪ Letter to NED on appointment – confirms expected time commitment		Comply

Section	Code Provision	Current Position	Action Required	Comply or Explain
	▪ NED significant commitments should be disclosed to CoG before appointment and as changes arise	▪ NEDs undertake to have sufficient time to fulfil role ▪ Significant commitments disclosed to CoG prior to appointment and reappointment.		
B.3.3	▪ Board should not agree to full-time exec director taking on more than one non-executive directorship of an FT or other organisation of comparable size/complexity, nor chairmanship	▪ This provision would be reviewed if the circumstance arose.		Comply

B.4 Development

Section	Code Provision	Current Position	Action Required	Comply or Explain
B.4.1	▪ Chair should ensure new directors and governors receive full, formal and appropriate induction ▪ Directors should seek to engage with key stakeholders (patients, clinicians, staff) ▪ Directors to have access to training courses	▪ Induction programmes in place for directors and governors ▪ Number of stakeholder engagement processes and practices in place that involve patients, public and staff engagement, including Walkabout Wednesday, site visits for directors. Directors engage with system partners via number of GM and locality forums/meetings. ▪ Directors have access to individual and collective training/development as identified.		Comply
B.4.2	▪ Chair to regularly review and agree with each director training and development needs	▪ Development needs for all directors are agreed via Chair (for NEDs) and CEO (for Exec Directors) and reviewed annually. Chair aware of all development needs for individual directors via Remuneration Committee.		Comply
B. 4.3	**Statutory Requirement:** ▪ Board to ensure CoG have skills and knowledge to discharge duties appropriately	▪ Training and development programme established for governors, including both internal and external opportunities. Information included in Annual Report.		Comply

B.5 Information and Support

Appendix A – 2022/23 Compliance Checklist: NHS foundation trust Code of Governance (July 2014)

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
B.5.1	▪ Board and CoG should be provided with high quality, appropriate information. ▪ Board and CoG should agree their information needs with EDs through the Chair ▪ Information for boards should be concise, objective, accurate and timely, accompanied by clear explanations of complex issues ▪ Board should have complete access to any information necessary, including access to senior managers and other employees	▪ Suite of reports, including background information provided to Board and CoG. ▪ Standardised front sheet, with executive summary and recommendation section for Board and CoG papers to ensure clarity and appropriate review of paper. ▪ Board has full access to all sources of information as requested.		Comply
B.5.2	▪ In challenging assurances received from Executive, Board need not seek to appoint an adviser for every issue but should ensure sufficient information and understanding to make informed decision. ▪ When complex or high risk issues arise, first course of action should be to encourage deeper analysis in timely manner within the FT. On occasion, NEDs may reasonably decide that external assurance is appropriate.	▪ Effective challenge and request for further information and analysis demonstrated at Board and Audit Committee – evidenced within relevant minutes, action sheet and follow-up actions.		Comply
B.5.3	▪ Board to ensure NEDs have access to independent professional advice and training courses/material where judged necessary ▪ Decisions to appoint an external adviser should be collective decision of the majority of NEDs ▪ Availability of independent external sources of advice should be made clear at appointment	▪ Independent advice, information and training made available as necessary/requested		Comply
B.5.4	▪ Committees and CoG to have sufficient resources to undertake duties	▪ Committees and CoG provided with sufficient resources, supported by Corporate Affairs team.		Comply
B.5.5	▪ NED's should consider whether they are receiving necessary information in a timely manner and feel able to raise appropriate challenge of recommendations of the Board	▪ Standardised front sheet for Board papers to ensure clarity regarding recommendation. ▪ Board has full access to all sources of information as requested.		Comply

Appendix A – 2022/23 Compliance Checklist: NHS foundation trust Code of Governance (July 2014)

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
		▪ NED's able to raise any concerns about the information they receive and their ability to raise appropriate challenge via Chair, Executive Lead and or Trust Secretary. ▪ NED challenge is routinely recorded in minutes of Board / Committee meetings. ▪ Committee Effectiveness Internal Audit – Substantial Assurance. Provenance of Data Internal Audit – High Assurance.		
B.5.6	▪ Governors should canvass the opinion of their members, and for appointed governors the bodies they represent, on the FTs forward plans ▪ Annual Report to state how this requirement has been undertaken	▪ Governors aware of responsibility to canvass opinion of members/bodies they represent. ▪ Views of Council of Governors sought in development of the Trust's Strategy 2020-2025. ▪ Membership Strategy & Action Plan approved by CoG in July 2022, to support in fulfilling this duty. Governors shared feedback received from members/bodies at CoG meetings and informal meetings with Chair & NEDs on key strategic developments and plans. ▪ Member's newsletter highlights key developments for the Trust giving information on how members can contact their governor representatives.		Comply
B.5.7	▪ Board should take account of the views of the CoG on the forward plans and communicate where views have been incorporated, and if not, reasons for this.	▪ See B.5.6 ▪ Views of Council of Governors sought in development of the Trust's Strategy 2020-2025. ▪ Governors remained appraised of key strategic developments in relation to the forward plans of the Trust via the Chair's Report and identified topic presentations, including GM & locality plans, at each meeting of the CoG and were able to provide view. Trust Planning discussion at CoG regarding forthcoming year plans,		Comply

Appendix A – 2022/23 Compliance Checklist: NHS foundation trust Code of Governance (July 2014)

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
		February 2023.		
B.5.8	**Statutory Requirement:** ▪ Board must have regard for the views of the CoG on the trusts forward plan	▪ As described at B.5.6 and B.5.7 above.		Comply

B.6 Evaluation

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
B.6.1	▪ Board should state in the annual report how evaluation of board, committees and directors has been undertaken, bearing in mind the desirability for independent assessment, and the reason why the trust adopted a particular method of performance evaluation	▪ Statement included in Annual Report 2022/23. To be included in Annual Report 2022/23 including outcome of annual review of Board Committees and relevant internal audits. ▪ Remuneration Committee reviews performance evaluation of each Executive Director. ▪ Nominations Committee reviews performance evaluation of each NED and Chair.		Comply
B.6.2	▪ Evaluation of FT boards should be externally facilitated at least every three years. ▪ Monitor's board leadership and governance framework to be used as basis for this evaluation ▪ External facilitator to be identified in annual report and statement made to any connection to Trust	▪ Independent Board Governance Review completed by Deloitte LLP during 2014/15. ▪ Series of external reviews: CQC well led review (October 2018), NHS England/Improvement Governance Review (November 2019), CQC well-led review (February 2020). ▪ Independently facilitated Well Led mapping review, conducted by AQuA (October – December 2021), providing an overview of the Trust's evidence against the 8 Key Lines of Enquiry (KLOEs) within the Well Led framework, and further developmental actions for the purpose of continuous improvement. ▪ Approach agreed by Board to facilitate externally facilitated developmental review during 2023/24. Completion of self-assessment and agreed KLOE ratings by Board, March 2023.	Externally facilitated review Q2 2023/24 as agreed by Board.	Explain
B.6.3	▪ SID to lead performance evaluation of Chairperson, within framework agreed by CoG	▪ Appraisal process for Chairman, led by SID, within framework agreed by CoG		Comply

Appendix A – 2022/23 Compliance Checklist: NHS foundation trust Code of Governance (July 2014)

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
B.6.4	▪ Chairperson, with assistance from Trust Secretary, should use performance evaluations to determine individual and collective professional development programme for NED's	▪ Personal and professional objectives for NEDs agreed via Chair as part of appraisal process.		Comply
B.6.5	▪ CoG should periodically assess its collective performance and communicate to members how they have discharged duties	▪ Formal collective performance evaluation of Council of Governors presented in December 2018. ▪ Presentation to AMM about CoG performance including how they have performed statutory duties and responsibilities. ▪ Regular communications to members via Members Newsletter.	Collective CoG performance evaluation mechanism to be considered – September 2023	Comply
B.6.6	▪ Clear policy and a fair process for the removal of any governor that consistently and unjustifiably fails to attend CoG meetings, has a conflict of interest, or fails to discharge their responsibilities ▪ Removal may be appropriate where behaviours or actions by a governor or group of governors is incompatible with values/behaviours of Trust ▪ Independent assessor can be used	▪ Approved Code of Conduct for Governors in place that details of values and the requirement of adherence and outlines circumstances that would result in removal of governor - agreed and signed by all governors. ▪ Process for removal of governors included within Constitution. ▪ Consideration of independent assessor would be made if situation arose.		Comply

B.7 Re-appointment of directors and re-election of governors

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
B.7.1	▪ Chair to confirm to governors that performance of NED proposed for re-appointment continues to be effective ▪ Any term beyond six years (two three year terms) for NED – rigorous review and take account of the need for progressive refreshing of the Board ▪ In exceptional circumstances, NEDs may	▪ Chair confirms to governors, via Nominations Committee, that performance of any NED proposed for re-appointment continues to be effective or otherwise. ▪ Term of office for NEDs and Chair considered and agreed by Nominations Committee, in full consideration of NHS England guidance of terms of no more than three years and any term beyond		Comply

Appendix A – 2022/23 Compliance Checklist: NHS foundation trust Code of Governance (July 2014)

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
	serve longer than six years (two three-year terms following authorisation of the FT) but subject to annual reappointment. May affect independence.	six years requiring rigorous review.		
B.7.2	▪ Elected governors must be re-elected at regular intervals – no more than three years ▪ Biography details, and any other relevant information, to be made available at election ▪ Prior performance information, such as attendance records to also be made available at election	▪ Elected governors' term of office set at no more than three years ▪ Biography details and relevant performance information published during election.		Comply
B.7.3	**Statutory Requirement:** ▪ CoG to approve CEO appointment at first general meeting following appointment by committee of chair and NEDs ▪ Appointment of all other execs by committee of CEO, Chair and NEDs	▪ Constitution requires CEO appointment to be CoG approved. CoG approved appointment of CEO by Chairman and NEDs – October 2021. ▪ Executive Director appointments to-date approved by CEO, Chair and all other NEDs.		Comply
B.7.4	**Statutory Requirement:** ▪ NED's, including chairperson, appointed by CoG for specified terms subject to re-appointment thereafter at intervals of no more than three years	▪ Term of office for NEDs and Chair considered and agreed by Nominations Committee, in full consideration of NHSE's guidance of terms of no more than three years.		Comply
B.7.5	**Statutory Requirement:** ▪ Elected governors subject to re-election by members at regular intervals not exceeding three years	▪ Elected governors' term of office set at no more than three years.		Comply

B.8 Resignation of directors

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
B.8.1	▪ The Board of Directors should not agree to an executive member of the Board leaving the employment of an NHS foundation trust, except in accordance	▪ Remuneration Committee provide full consideration to such matters as they arise. Not applicable during 2022/23.		Comply

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
	with the terms of their contract, including but not limited to service of their full notice period and/or material reductions in their time commitment to their role, without the Board first having completed and approved a full risk assessment.			

C. Accountability

C.1 Financial, quality and operational reporting

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
C.1.1	▪ Directors should explain responsibility for preparing annual report and accounts in the annual report ▪ Directors should state that the report and accounts are fair, balanced and understandable, and provide information necessary for patients, regulators and other stakeholders to assess the trusts performance, business model and strategy ▪ Should be a statement by auditors about their reporting responsibilities ▪ Directors should also explain approach to quality governance.	▪ Directors Statements, Auditors Statements and Annual Governance Statement included in Annual Report 2021/22 incorporating all required statements. To be included in Annual Report 2022/23 *(will be subject to external audit).*		Comply
C.1.2	▪ Directors should report that the FT is a going concern	▪ Annual review of Going Concern at Audit Committee and relevant inclusion within Annual Report.		Comply
C.1.3	▪ At least annually, Board should set out financial, quality and operating objectives and sufficient information to allow members/governors to evaluate FT's performance	▪ Annual Plan including objectives and key performance indicators/measures. Integrated Performance Report reviewed via Public Board and Non-Executive Director's Report to CoG providing high level overview of delivery against key performance metrics throughout the year. ▪ Annual Report and Accounts provides annual		Comply

Appendix A – 2022/23 Compliance Checklist: NHS foundation trust Code of Governance (July 2014)

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
		overview of performance, available on SFT website and presented to CoG annually.		
C.1.4	▪ Board must notify Monitor, CoG and the public if appropriate, about any major new developments which may lead to a substantial financial, performance or reputation change ▪ Board must notify Monitor and CoG and consider whether to bring to public attention all information concerning a financial or performance change which would have a significant impact on the FT if made public.	▪ Board has effective and regular engagement with the NHS England as required. ▪ Board continually considers communication with public. ▪ Chair and NEDs provides regular report to CoG members about key matters discussed and decisions made at Board. ▪ Board meetings held in public and papers published on the Trust website.		Comply

C.2 Risk management and internal control

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
C.2.1	▪ Directors to maintain oversight of risk management and internal control and report to members and governors in the annual report ▪ Review should cover financial, clinical, operational controls, compliance controls and risk management systems	▪ Board Assurance Framework established and reviewed via Internal Audit as compliant with NHS requirements. ▪ Approved Risk Management Strategy. Chief Executive chairs Risk Management Committee reporting to Audit Committee. ▪ Annual Internal Audit Plan is risk based and constructed in full collaboration with Audit Committee to ensure that there is an effective internal audit function established by management that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee and Board. ▪ Annual Governance Statement (AGS) compiled by the CEO, reviewed by Auditors, Audit Committee and approved/signed by CEO ▪ Annual Report (including AGS) presented to Governors and members at CoG and AMM respectively		Comply

Appendix A – 2022/23 Compliance Checklist: NHS foundation trust Code of Governance (July 2014)

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
C.2.2	▪ Disclose in Annual Report if trust has internal audit function, structure and role it performs. If it does not have an internal audit function, processes it employs for evaluating and continually improving internal control processes	▪ Confirmation and relevant information included in Annual Report 2021/22. To be included in Annual Report 2022/23 *(will be subject to external audit).*		Comply

C.3 Audit committee and auditors

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
C.3.1	▪ Board must establish an audit committee composed of at least three independent NEDs ▪ Board should satisfy itself that at least one member of audit committee has recent/relevant financial experience ▪ Chairman of the trust should not chair or be a member of the audit committee, he can attend by invitation as appropriate.	▪ Audit Committee established by Board. Membership includes at least 4 independent NEDs ▪ Board has appointed Chair of Audit Committee with relevant financial experience. ▪ Trust Chair attends Audit Committee by invitation only.		Comply
C.3.2	▪ Main roles and responsibilities of audit committee should be set out in publicly available ToR	▪ Appropriate terms of reference established for Audit Committee. Reviewed by Audit Committee in June 2022, and approved by Board. Publicly available via papers and Trust Secretary. ▪ Chair of Audit Committee provides regular update about matters reviewed at Audit Committee to the CoG.		Comply
C.3.3	▪ CoG should take lead in agreeing with audit committee the criteria for appointing, reappointing and removing auditors	▪ In October 2019 CoG awarded external audit contract to Mazars LLP for three years to cover financial years 2019/20, 2020/21 and 2021/22. Further to report and recommendation from Audit Committee, in February 2022, CoG approved extension of the External Audit Contract with Mazars LLP for a further term of two years to the 31st March 2024.		Comply

Appendix A – 2022/23 Compliance Checklist: NHS foundation trust Code of Governance (July 2014)

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
C.3.4	▪ Audit Committee should make a report to CoG about the performance of the external auditor to enable the CoG to consider re-appointment. ▪ Audit Committee should make recommendations about appointment, re-appointment and removal of external auditor, and approve remuneration and terms of engagement of the external auditor	▪ See C.3.2 and C.3.3		Comply
C.3.5	▪ If the CoG does not accept the audit committee's recommendation, the Board should include explanatory statement in annual report – setting out reasons why CoG has taken different position.	▪ Information to be included in Annual Report if situation arose. Not applicable during 2022/23.		Comply
C.3.6	▪ FT should appoint external auditor for a period of three to five years.	▪ Comprehensive market-testing and procurement exercise undertaken in 2019 to select External Auditor. CoG appointed Mazars as External Auditor in October 2019 for a period of three years with an option for this to be extended by a further 2 year subject to mutual agreement.		Comply
C.3.7	▪ When CoG ends an auditor's appointment in disputed circumstances, chair should inform Monitor of reasons behind decision	▪ An issue of this nature has not arisen to date. Chair to inform NHS England if situation arose.		Comply
C.3.8	▪ Audit committee should review arrangements by which staff can raise issues in confidence about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. ▪ Audit committee should ensure proportionate and independent investigation and follow-up action	▪ Periodic report included in Audit Committee work plan to review systems in place to ensure staff can raise issues in confidence about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters ▪ Regular counter-fraud update reports received by Audit Committee		Comply
C.3.9	▪ Annual Report should describe how Audit Committee has discharged its responsibilities, including: - Significant issues in relation to	▪ Section within the Annual Report 2021/22 that comprehensively reports on how Audit Committee has discharged its responsibilities. To be included in Annual Report 2022/23 *(will be subject to*		Comply

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
	financial statements, operations and compliance and how addressed; - How it assessed effectiveness of external audit process and approach to appointment of external auditor, value of service, length of tender and when tender last conducted - If auditor provided non-audit services, value of non-audit services provided and how auditor objectivity and independence is safeguarded	*external audit)*		

D. Remuneration

D.1 The level and components of remuneration

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
D.1.1	In designing schemes of performance-related remuneration of executive directors, the remuneration committee should: ▪ Consider whether directors should be eligible for annual bonuses. If so, conditions should be relevant, stretching and designed to match long term interests of public. ▪ Payouts should be subject to challenging performance criteria reflecting FT objectives ▪ Performance criteria and any upper limits for annual bonuses and incentive schemes should be set and disclosed	▪ The terms of reference for the Remuneration Committee cover the requirements of this provision. ▪ Not currently applicable.		Comply

Appendix A – 2022/23 Compliance Checklist: NHS foundation trust Code of Governance (July 2014)

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
	▪ Remunerations Committee to consider pension consequences and associated costs of basic salary increases, especially directors close to retirement - only basic pay should be pensionable			
D.1.2	▪ Levels of remuneration for chair and other NEDs should reflect time commitment and responsibilities	▪ Level of remuneration for Chair and NEDs reviewed by CoG Nominations Committee in February 2022, in line with NHSE remuneration structure for NHS provider chairs and non-executive directors. Reported to and approved by CoG – time commitment and responsibilities taken into account.		Comply
D.1.3	▪ When Executive Director is released to work as non-executive elsewhere, the remuneration disclosure of the annual report should include whether or not director will retain such earnings	▪ Remuneration disclosure of Annual Report will include information if required. Not applicable during 2022/23.		Comply
D.1.4	▪ Remuneration committee should carefully consider compensation commitments of directors' in the event of early termination – the aim to avoid rewarding poor performance	▪ Provision covered within terms of reference Remuneration Committee. Not applicable during 2022/23.		Comply

D.2 Procedure

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
D.2.1	▪ Board must establish remuneration committee of NEDs, including at least 3 independent NEDs ▪ Remuneration Committee terms of reference to be made available ▪ Where remuneration consultants are appointed, statement made available about whether connection with FT	▪ Remuneration Committee established including all NEDs. Annual review of NED independence confirmed. ▪ Remuneration Committee terms of reference available for review via Trust Secretary ▪ Statement re remuneration consultants would be included in relevant Annual Report – Not applicable during 2022/23.		Comply
D.2.2	▪ Remuneration committee to have	▪ Remuneration Committee terms of reference set		Comply

Appendix A – 2022/23 Compliance Checklist: NHS foundation trust Code of Governance (July 2014)

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
	responsibility for setting remuneration for all exec directors, including pension rights and any compensation payments ▪ Remuneration committee should recommend and monitor the level and structure of remuneration for senior management	out all aspects of this provision.		
D.2.3	▪ CoG should consult with external professional advisers to market-test remuneration levels of the chair and other non-execs at least once every three years	▪ Level of remuneration for Chair and NEDs reviewed by CoG Nominations Committee in February 2022, in line with NHSE/I remuneration structure for NHS provider chairs and non-executive directors.		Comply
D.2.4	**Statutory Requirement:** ▪ The council of governors is responsible for setting remuneration of NED's and Chairperson	▪ See D.1.2 and D.2.3		Comply

E. Relations with stakeholders

E.1 Dialogue with members, patients and the local community

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
E.1.1	▪ Board should make available a public document setting out its involvement policy			Comply
E.1.2	▪ Board should clarify in writing how public interests will be represented. ▪ Approach to addressing overlap and interface between governors and local consultative forums in place to be included.	▪ Included in Annual Report 2021/22. To be included in Annual Report 2022/23. ▪ Membership strategy describes approach between governors and local community forums. ▪ Composition of CoG includes HealthWatch and Community/Voluntary Sector Appointed Governors to address overlap.		Comply
E.1.3	▪ The Chairman should ensure the views of governors and members are communicated to the Board ▪ The Chair should discuss the affairs of	▪ Chair'S Report at CoG & Board meetings. ▪ Minutes record the attendance of NEDs (including SID) at CoG meetings.		Comply

Appendix A – 2022/23 Compliance Checklist: NHS foundation trust Code of Governance (July 2014)

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
	the FT with governors ▪ NEDs to attend governor meetings ▪ SID should attend sufficient meetings of governors to listen to views and develop understanding	▪ NED (including SID) participation in joint informal NED/Governor sessions. ▪ Chair ensures appropriate discussion of the Trust's affairs with governors.		
E.1.4	▪ Board should ensure effective mechanisms for communication between governors and members from its constituencies ▪ Contact procedures for members that wish to communicate with governors and/or directors should be made clearly available to members on the FTs website and in the annual report	▪ Membership Strategy & Action plan in place. Opportunities to engage directly with members and the public included: Trust Newsletter (3 x year) including update on governors and how to contact governors, Annual members Meeting, Members Seminars, Attendance at Community Champions Networks. ▪ Contact procedures publicly available via website and Annual Report.		Comply
E.1.5	▪ Board should state in annual report how members of the Board, in particular NEDs, develop an understanding of the views of governors and members	▪ Information included in Annual Report. See E.1.3.		Comply
E.1.6	▪ Board should monitor how representative its membership is, and the level and effectiveness of engagement and include in Annual Report ▪ This should be used to review the Membership Strategy, taking into account emerging best practice	▪ Annual Report 2021/22 includes membership section as required. To be included in Annual Report 2022/23 *(will be subject to external audit)* – Including membership demographic analysis.		Comply
E.1.7	**Statutory Requirement:** ▪ Board must make board meetings and annual meeting open to public	▪ Board meetings open to public via virtual attendance throughout 2022/23 ▪ Annual Members Meeting held virtually in 2022.		Comply
E.1.8	**Statutory Requirement:** ▪ Trust must hold annual members meetings, director to present annual report and accounts and any report of the auditor on the accounts	▪ Annual Members Meeting held October 2022, annual report and accounts presented.		Comply

E.2 Co-operation with third parties with roles in relation to NHS foundation trusts

Appendix A – 2022/23 Compliance Checklist: NHS foundation trust Code of Governance (July 2014)

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
E.2.1	▪ Board should maintain a schedule of the third party bodies to which the FT has a duty to co-operate ▪ Directors should be clear of the form and scope of the co-operation	▪ Trust clear through development of Trust Strategy and annual operational plan key stakeholders and third-party bodies which it has a duty to cooperate. ▪ Directors aware of duty to cooperate and scope of cooperation with third party bodies.		Comply
E.2.2	▪ Board should ensure mechanisms are in place to co-operate with relevant third party bodies and that relationships are maintained ▪ Annually the Board should review effectiveness and relationships and take steps to improve them	▪ Trust Strategy and annual plan includes relevant objectives geared to ensuring the Trust is actively pursuing appropriate and effective relationships with third parties. ▪ Trust fully engaged in GM ICS and Locality developments/arrangements.		Comply

Annex B – Code of Governance for NHS Provider Trusts (Effective from 1st April 2023)

The below table refers only to additional provisions and/or variation to provisions included in the new Code of Governance for NHS Provider Trusts (October 2022) published in October 2022 (effective from 1 April 2023) following cross reference with the NHS Foundation Trust Code of Governance (July 2014).

Section A: Board leadership and purpose

Provision	Code Provision	Current Position	Developmental Action	Comply or Explain *(Current Position)*
A.2.1	Adequate systems in place to measure and monitor effectiveness, efficiency, economy and quality and contribution to the objectives of the ICP and ICB, and place-based partnerships.	▪ Annual operational plan, corporate objectives & outcomes measures developed in line with national planning guidance and as part of the GM ICS system and plan. ▪ At place, 'ONE Stockport' Health & Care Plan developed bringing together all parts of the borough. The One Stockport Health & Care Board (Locality Board) and Stockport Provider Partnership (led by SFT) established. The realisation of the 'ONE Stockport health & care plan' will be via the Provider Partnership and a series of population health focused workstreams, which will be reported to Board via strategic report. ▪ Executive Directors are part of key governance arrangements within GM and Stockport ICS, including Provider Collaborative, Locality Board and Place-Based Provider Partnership. Chair member of Stockport Health & Well Being Board. ▪ Board committee structure in place to oversee delivery of annual operational plan. Regular review by Board and Board Committees of: Integrated Performance Report, Finance, Operational Performance, People and Quality & Safety Dashboards, including relevant benchmarking. Locality/GM financial indicators to be incorporated during 2023/24.		Comply
A.2.2	Clear vision and values, with reference to integrated care strategy and role within system and place-based partnerships, and provider collaboratives.	▪ The Trust acknowledges that the Trust Strategy 2020-2025 was developed prior to legal establishment of Integrated Care Systems (ICS) and forthcoming publication of Greater		Comply

Annex B – Code of Governance for NHS Provider Trusts (Effective from 1st April 2023)

Provision	Code Provision	Current Position	Developmental Action	Comply or Explain *(Current Position)*
		Manchester (GM) ICS Strategy and Joint Forward Plan to set the direction of the system. ▪ Corporate objectives and key outcomes measures include vision to work with partners to improve health and well-being outcomes for communities served and development of effective partnerships to address health and well-being inequalities.		
A.2.3	Assess and monitor culture and seek assurance corrective action taken where needed.	▪ Variety of staff engagement programmes in place enable directors to consider culture including Values into Action, Team Brief, Work-Withs, Schwartz Rounds, Walkabout Wednesday. ▪ Freedom to Speak Up Guardian and Guardian of Safe Working Hours in place, with regular report to the People Performance Committee and Board, including themes and action taken. ▪ Trust Disciplinary Policy, in place to ensure that any disciplinary matter is dealt with fairly. Just Culture guide informs pre-liminary investigation checklist, supporting conversation between managers about whether a staff member involved in an incident requires specific individual support or intervention to support appropriate changes in behaviour. ▪ Board approved Organisational Development (OD) Plan to further build awareness of our organisational values, identify situations where we are and not aligned to those values and implement series of interventions aimed at changing behaviour, hearts and minds, including a civility programme. ▪ NHS Staff Survey Results and quarterly Pulse Checks utilised to assess pride and positivity within SFT. Outcomes reported to People Performance Committee and action plans developed and monitored via Divisions to support improvement. ▪ Suite of quality-based reports that includes		Comply

Annex B – Code of Governance for NHS Provider Trusts (Effective from 1st April 2023)

Provision	Code Provision	Current Position	Developmental Action	Comply or Explain *(Current Position)*
		lessons learned and improvements to practice further to thematic review of incidents, inquests, claims and complaints reported via the Trust's incident reporting system. Presented to Quality Committee.		
A.2.4	Adequate systems in place to measure and monitor effectiveness, efficiency, economy and quality and contribution to the delivery of the five-year joint plan and annual capital plan agreed by ICB.	See A.2.1 and A.2.2		Comply
A.2.5	Relevant metrics, measures, milestones and accountabilities in place to assess delivery of performance, including disaggregation by ethnicity and deprivation where relevant. Where appropriate, independent advice should be commissioned by the Board (in high risk/complex areas) to provide adequate level of assurance	▪ Integrated Performance Report sets out performance against relevant internal and external standards/metrics. Board considers potential inequalities through analysis of the datasets relating to waiting lists. Update on place-based population health focused workstreams to be reported to Board. ▪ Divisional Performance Review process established. Key themes and issues reported to Finance & Performance Committee. ▪ Independent advice commissioned by Board, as appropriate.		Comply
A.2.9	The workforce should have a means to raise concerns in confidence and Board of directors should routinely review. Ensure arrangements in place for the proportionate and independent investigation of such matters.	▪ Freedom to Speak Up (FTSU) Guardian in post to act in an independent and impartial capacity to support staff who raise concerns. Reporting to People Performance Committee & Board. Self-assessment undertaken in line with national planning tool and a series of medium and longer term actions to address the identified areas for improvement reviewed by Board, December 2022. Policy revised in line with new national policy, and national training packages for all staff adopted. ▪ Guardian for Safe Working Hours in place. Six monthly reports to People Performance Committee and annual report to Board.		Comply
A.2.10	Board should take action to identify and	▪ Conflicts of Interest Policy in place in line with		Comply

Provision	Code Provision	Current Position	Developmental Action	Comply or Explain *(Current Position)*
	manage conflicts of interest and ensure register available to the public in line with Managing conflicts of interest in the NHS: Guidance for staff and organisations.	NHS England guidance. ▪ Annual Register of Interests review undertaken by Audit Committee. ▪ Board minutes fully record any interests raised during Board/Board Committee meeting, and action taken. ▪ Public register available via SFT website. ▪ Internal Audit of Conflicts of Interest underway.		

Section B: Division of Responsibilities

Provision	Code Provision	Current Position	Developmental Action	Comply or Explain *(Current Position)*
B.2.1	Chair responsible for leading agenda setting for board and council of governors, and ensuring time for discussion, on strategic issues.	▪ Chair leads agenda setting for board and council of governors in line with work plan, which considers balance of operational, regulatory, and strategic matters. Timings agreed as part of agenda.		Comply
B.2.3	Chair should promote culture of openness, trust and debate, facilitating effective contribution of non-executive directors and ensuring constructive relationship between executive and non-executive directors.	▪ Chair promotes culture of openness and debate and facilitates contribution of both executive and non-executive directors as evidenced via Board minutes. ▪ Board development programme 2023/24 to include external facilitation, focused on nurturing relationships, encouraging fresh approaches and thinking to support improved decision making		Comply
B.2.9	The value of ensuring committee membership refresh and no undue reliance placed on individuals should be taken into account in deciding chairship and membership of committees. Council of governors should take into account the value of appointing a non-executive director with a clinical background and appointing diverse range of non-	▪ Annual review of all Board committees, including membership and chairship. Also considered on appointment of new non-executive directors. ▪ 3 non-executive directors with clinical experience. Selection and recruitment process for non-executive directors designed to encourage non-executive director applicants with range of skill sets, backgrounds and lived experience.		Comply

Provision	Code Provision	Current Position	Developmental Action	Comply or Explain *(Current Position)*
	executive directors.			
B.2.15	All directors should have access to the advice of the company secretary. Appointment and removal of the company secretary should be a matter for the board.	▪ All directors have access to advice of company secretary. ▪ Appointment and removal of company secretary to be considered by board should situation occur.	Review and refresh Trust Constitution relating to Company Secretary appointment/removal	Comply

Section C: Composition, Succession and Evaluation

Section	Code Provision	Current Position	Developmental Action	Comply or Explain *(Current Position)*
C.2.1	Nominations committee/s responsible for the identification and nomination of executive and non-executive directors and consider succession planning. Best practice is that a selection panel includes at least one external assessor from NHS England and/or a representative from relevant ICB and engage with NHS England to agree approach.	▪ Nominations Committee in place for NED appointments ▪ Remuneration Committee in place for Executive Director appointments ▪ Membership of selection panels, including external assessor, to be considered as part of recruitment and selection process and agreed by respective nominations committee. NHS England to be engaged in approach.	Review and refresh Trust Constitution relating to appointments	Comply
C.4.13	Annual report should describe the work of the nominations committee(s), including board appointments process, approach to succession planning to support the development of a diverse board, policy on diversity and inclusion, ethnic diversity of the board and senior managers, with reference to indicator nine of the NHS Workforce Race Equality Standard and the gender balance of senior management and their direct reports.	▪ Annual report currently describes the work of the Nominations Committee and Remuneration Committee. ▪ Specific WRES indicators to be included in future Annual Reports as per requirements and policy on EDI for senior leaders as included in EDI Strategy.		Comply

Annex B – Code of Governance for NHS Provider Trusts (Effective from 1st April 2023)

Section	Code Provision	Current Position	Developmental Action	Comply or Explain *(Current Position)*
C.5.2	Chair should ensure directors and governors update their skills, knowledge and familiarity with the trust to fulfil their roles. Directors should be familiar with the integrated care system(s) that commission material levels of services from the trust. Trust should provide the resources for directors and governors to develop and update skills, knowledge and capabilities. Those involved in recruitment, should receive appropriate training, including on equality, diversity and inclusion, and unconscious bias.	▪ Training and development plan in place to support governors in conducting roles and duties. Members of Nominations Committee provided with recruitment specific training prior to NED recruitment process, including EDI and unconscious bias. ▪ All NEDs required to complete mandatory EDI training. ▪ Directors have access to individual and collective training/development as identified. ▪ Development needs for all directors are agreed via Chair (for NEDs) and CEO (for Exec Directors) and reviewed annually. Chair aware of all development needs for individual directors via Remuneration Committee. ▪ Training and development programme established for governors, including both internal and external opportunities. Information included in Annual Report. ▪ All directors familiar with GM ICS.		Comply
C.5.3	All directors need appropriate knowledge of the trust and appropriate access to its operations and staff. Directors and governors to be appropriately briefed on values, policies and procedures.	▪ All directors have appropriate knowledge of the Trust and appropriate access to operations and staff, with support of Trust Secretary. Additional knowledge requirements formally identified as part of appraisal and informally on continuing basis. ▪ Directors and Governors Code of Conduct ensures knowledge of values and procedures. ▪ Relevant policies and procedures considered by Board, Board Committees and/or CoG during year.		Comply
C.5.7	Board and CoG to receive appropriate information to discharge its respective duties. Governors should be provided with information on ICS plans, decisions and delivery that directly affect the organisation and its patients.	▪ Relevant information made available to Board and CoG regarding finance, quality of care, operational performance and people performance, alongside key strategic developments. ▪ CoG have received presentation and training on ICS. CoG informed of GM ICS planning process and assumptions for 2023/24 and development of ICS Strategy, February 2022.		Comply

Annex B – Code of Governance for NHS Provider Trusts (Effective from 1st April 2023)

Section	Code Provision	Current Position	Developmental Action	Comply or Explain *(Current Position)*
		▪ Further information to be provided as available/relevant.		
C.5.17	NHS Resolution's Liabilities to Third Parties Scheme includes liability cover for trusts' directors and officers. There is no legal requirement for trusts to provide an indemnity or insurance for governors, where an indemnity or insurance policy is given, this can be detailed in the Trust's constitution.	▪ No further indemnity/insurance policy for governors.		Comply

Section D: Audit, Risk & Internal Control

Section	Code Provision	Current Position	Developmental Action	Comply or Explain *(Current Position)*
D.2.1	Board must establish an audit committee composed of at least three independent NEDs. Chair of the trust should not chair or be a member of the audit committee but can attend by invitation as appropriate. The vice chair or senior independent director should not chair the audit committee. Board should satisfy itself that at least one member of audit committee has recent/relevant financial experience and committee should have competence relevant to the sector.	▪ Audit Committee established, includes 4 independent NEDs ▪ Board has appointed Chair of Audit Committee with relevant financial experience, this is not the Deputy Chair or SID. ▪ Trust Chair attends Audit Committee by invitation only.		Comply

Annex B – Code of Governance for NHS Provider Trusts (Effective from 1st April 2023)

Section E: Remuneration

Section	Code Provision	Current Position	Developmental Action	Comply or Explain *(Current Position)*
E.2.1	In designing schemes of performance-related remuneration of executive directors, the remuneration committee should: - consider whether the directors should be eligible for annual bonuses. If so, performance conditions should be relevant, stretching and designed to match long-term interests of the public and patients. - Payouts should be subject to challenging performance criteria reflecting objectives and relative to a group of comparator trusts. - Performance criteria and any upper limits for annual bonuses and incentive schemes should be set and disclosed and must be limited to the lower of £17,500 or 10% of basic salary. - consider the pension consequences and associated costs to the trust of basic salary increases and any other changes in pensionable remuneration, especially for directors close to retirement.	▪ Not currently applicable. ▪ The terms of reference for the Remuneration Committee cover the requirements of this provision with responsibility for design of performance-related remuneration.	Review Remuneration Committee ToR – Ensure specific elements of performance related pay included.	Comply
E.2.2	Levels of remuneration for the chair and other non-executive directors should reflect the Chair and non-executive director remuneration structure.	▪ CoG agreed all new NED positions to be remunerated in line with NHS England Chair and non-executive director remuneration structure. Existing non-executive directors, who are reappointed for a further term of office, remain at the level of remuneration to which they were originally appointed, subject to a robust performance appraisal and confirmation that performance continues to be effective.		Explain
E.2.5	Trusts should discuss any director-level severance payment, whether contractual or non-contractual, with their NHS England	▪ To be discussed with NHS England should situation arise.		Comply

Annex B – Code of Governance for NHS Provider Trusts (Effective from 1st April 2023)

Section	Code Provision	Current Position	Developmental Action	Comply or Explain *(Current Position)*
	regional director at the earliest opportunity			

Meeting date	6 April 2023	x	Public		Confidential	Agenda item
Meeting	Board of Directors					
Title	Use of Common Seal 2022/23					
Lead Director	Trust Secretary		Author	Deputy Company Secretary		

Recommendations made / Decisions requested

The Board of Directors is asked to note and confirm the use of the Common Seal during 2022/23.

This paper relates to the following Corporate Annual Objectives-

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

The paper relates to the following CQC domains-

	Safe		Effective
	Caring		Responsive
	Well-Led	x	Use of Resources

This paper is related to the following BAF risks		**PR1.1**	There is a risk that the Trust does not deliver high quality of care to service users, which may lead to suboptimal patient safety, effectiveness and/or experience and failure to meet regulatory standards
		PR1.2	There is a risk that patient flow across the locality is not effective which may lead to potential harm, suboptimal user experience, and inability to achieve national standards for urgent and elective care
		PR1.3	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan which may lead to suboptimal patient safety, outcomes and user experience and inability to achieve national standards for planned care
		PR2.1	There is a risk that the Trust fails to sufficiently engage and support our people, which may lead to low morale, higher turnover & sickness absence and gaps in the workforce that may impact on delivery of high-quality care
		PR2.2	There is a risk that the Trust's community services do not fully support neighbourhood working which may lead to suboptimal improvement in neighbourhood population health
		PR3.1	There is a risk in approving and implementing a new Provider Collaborative model to support delivery of priorities/objectives of the Stockport's ONE Health & Care (Locality) Board which may lead to a delay in delivery of models of care which support improvements in population health and operational recovery following the pandemic
		PR3.2	There is a risk that the Trust does not deliver a joint Clinical Strategy with East Cheshire NHS Trust (ECT), which may lead to suboptimal pathways of care and/or limited service resilience across the footprint of both Trusts

		PR4.1	There is a risk that the Trust does not implement high quality research & transformation programmes which may lead to suboptimal service improvements
		PR5.1	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit the optimal number of staff, with appropriate skills and values, which may lead to suboptimal staff and patient experience
		PR5.2	There is a risk that the Trust fails to have a workforce that is reflective of the communities served which may lead to staff with a protected characteristic having a suboptimal staff experience (career progression, turnover) and a poorer patient experience
		PR6.1	There is a risk that the Trust does not deliver the 2022/23 financial plan which may lead to a poor use of resources and increased regulatory intervention
		PR6.2	There is a risk that the Trust does not develop and agree with partners a multi-year financial recovery plan, optimising opportunities for financial recovery through system working, which may lead to a lack of financial sustainability
		PR7.1	There is a risk that the Trust does not implement the Digital Strategy designed to ensure a resilient and responsive digital infrastructure which may lead to inability to support improvements in quality of care and compromise of data/information
		PR7.2	There is a risk that the estate is not fit for purpose and/or meets national standards which may lead to inefficient utilisation of the estate to support high quality of care and increased health & safety incidents
		PR7.3	There is a risk that the Trust does not materially improve environmental sustainability which may lead to suboptimal support to locality ambitions and the NHS commitment to carbon reduction
		PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus which may lead to an adverse long term impact on the Trust's capability to deliver modern and effective care

Where issues are addressed in the paper-

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

Executive Summary

The purpose of this report is to report the use of the Common Seal to the Board of Directors during 2022/23.

1. INTRODUCTION

1.1 The purpose of this report is to report the use of the Common Seal to the Board of Directors during 2022/23.

2. USE OF COMMON SEAL

2.1 Authority to apply the Seal to relevant documents is detailed at Section 38 of the Trust's Scheme of Reservation and Delegation. Section 38 identifies that authority to apply the Seal is delegated to the Chair / Chief Executive or two Executive Directors. It is recognised good practice to report the occasions of use of the Seal to the Board of Directors on an annual basis.

2.2 During the period 1 April 2022 – 31 March 2023, the Trust's Common Seal was applied on a total of two occasions. These were:

Reg No	Date	Reason
141	19/04/2022	Armitage – Contract Documents for Women's Unit: Acute Surgical Ward (M6) – Proposed Remodelling Works
142	25/10/2022	JCT – Repair and Replacement of Maternity Building Roof – Intermediate Building Contract – Contractor: Benjamin Armitage (Hyde) Ltd

2.3 A Register of Use of the Common Seal is maintained by the Trust Secretary and includes both authorisation signatures and details of the final distribution of the relevant documentation. The Trust Secretary is responsible for the safe custody of the Common Seal. The Board of Directors can be assured that compliance with the requirements of Section 38 of the Scheme of Reservation & Delegation is being maintained.

3. LEGAL IMPLICATIONS

3.1 There are no direct legal implications associated with the content of this report.

4. RECOMMENDATIONS

4.1 The Board of Directors is recommended to:

- Note the occasions of use of the Common Seal as detailed at s2.2 of the report.

Stockport NHS Foundation Trust

Meeting date	6 April 2023	x	Public		Confidential	Agenda item
Meeting	Board of Directors					
Title	Board Committees Annual Reviews 2022/23					
Lead Director	Caroline Parnell, Director of Communications & Corporate Affairs		Author	Soile Curtis, Deputy Company Secretary		

Recommendations made / Decisions requested

The Board of Directors is asked to receive and approve the Board Committee Annual Reviews 2022/23, including approval of Terms of Reference and Work Plans for the following:

- Finance & Performance Committee
- People Performance Committee
- Quality Committee

This paper relates to the following Corporate Annual Objectives-

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

The paper relates to the following CQC domains-

	Safe		Effective
	Caring		Responsive
x	Well-Led		Use of Resources

This paper is related to these BAF risks	x	**PR1.1**	There is a risk that the Trust does not deliver high quality of care to service users, which may lead to suboptimal patient safety, effectiveness and/or experience and failure to meet regulatory standards
	x	**PR1.2**	There is a risk that patient flow across the locality is not effective which may lead to potential harm, suboptimal user experience, and inability to achieve national standards for urgent and elective care
	x	**PR1.3**	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan which may lead to suboptimal patient safety, outcomes and user experience and inability to achieve national standards for planned care
	x	**PR2.1**	There is a risk that the Trust fails to sufficiently engage and support our people, which may lead to low morale, higher turnover & sickness absence and gaps in the workforce that may impact on delivery of high-quality care

	X	**PR2.2**	There is a risk that the Trust's community services do not fully support neighbourhood working which may lead to suboptimal improvement in neighbourhood population health
	X	**PR3.1**	There is a risk in approving and implementing a new Provider Collaborative model to support delivery of priorities/objectives of the Stockport's ONE Health & Care (Locality) Board which may lead to a delay in delivery of models of care which support improvements in population health and operational recovery following the pandemic
	X	**PR3.2**	There is a risk that the Trust does not deliver a joint Clinical Strategy with East Cheshire NHS Trust (ECT), which may lead to suboptimal pathways of care and/or limited service resilience across the footprint of both Trusts
	X	**PR4.1**	There is a risk that the Trust does not implement high quality research & transformation programmes which may lead to suboptimal service improvements
	X	**PR5.1**	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit the optimal number of staff, with appropriate skills and values, which may lead to suboptimal staff and patient experience
	X	**PR5.2**	There is a risk that the Trust fails to have a workforce that is reflective of the communities served which may lead to staff with a protected characteristic having a suboptimal staff experience (career progression, turnover) and a poorer patient experience
	X	**PR6.1**	There is a risk that the Trust does not deliver the 2022/23 financial plan which may lead to a poor use of resources and increased regulatory intervention
	X	**PR6.2**	There is a risk that the Trust does not develop and agree with partners a multi-year financial recovery plan, optimising opportunities for financial recovery through system working, which may lead to a lack of financial sustainability
	X	**PR7.1**	There is a risk that the Trust does not implement the Digital Strategy designed to ensure a resilient and responsive digital infrastructure which may lead to inability to support improvements in quality of care and compromise of data/information
	X	**PR7.2**	There is a risk that the estate is not fit for purpose and/or meets national standards which may lead to inefficient utilisation of the estate to support high quality of care and increased health & safety incidents
	X	**PR7.3**	There is a risk that the Trust does not materially improve environmental sustainability which may lead to suboptimal support to locality ambitions and the NHS commitment to carbon reduction
	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 which may lead to an adverse long term impact on the Trust's capability to deliver modern and effective care

Where issues are addressed in the paper-

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

Executive Summary

Effective sub-committees can provide significant benefits to the board, enabling the board to make informed decisions and meet their wide-ranging governance and regulatory responsibilities. Likewise, sub-committees should play a key role in supporting directors in their strategic and oversight roles.

The terms of reference of the Board sub-committees include a requirement for the respective committee to evaluate their own membership and review their effectiveness and performance on an annual basis. The outcome of the review is to be considered by the Board of Directors, alongside review and approval of the terms of reference and work plans of the committees.

During committee meetings in March 2023, the Finance & Performance Committee, People Performance Committee and Quality Committee, considered their Committee Annual Review, including draft terms of reference and work plans for 2023/24.

As part of the reviews, each committee considered key matters and standard reports evaluated during the year, alongside meeting attendance, to ensure compliance with the terms of reference. Furthermore, each committee considered what had worked well and what could be improved.

General themes recognised the positive challenge at committee meetings, with constructive interaction between attendees, and coverage of all areas within the remit of the respective committees. Regarding opportunities for improvement, there was recognition that the volume of information and frequency of reporting could bring about a shift from board level assurance to operational discussion.

In this light, in reviewing the draft work plans and sources of assurance, committees considered the following:

- Does the work plan enable oversight of the effectiveness of systems and controls in place to deliver related strategies/plans and achieve corporate objectives
- Does the work plan facilitate a proportionate assurance approach, enabling strategic discussion and periodic consideration of either areas facing particular challenges or emerging areas of change.

Consideration of the above, and compliance with the terms of reference, supported confirmation of the effective operation of the committee throughout 2022/23, with opportunities for ongoing improvement to be taken forward during 2023/24 and reflected in the terms of reference and committee work plans as appropriate.

The Annual Review of the Remuneration Committee and Audit Committee will be presented to the Board in June 2023 and August 2023 respectively, following year-end meetings of these Committees.

NHS Stockport NHS Foundation Trust

Finance & Performance Committee Annual Review 2022/23

1. Introduction

1.1 The Finance & Performance Committee considered and confirmed the outcome of the Committee Annual Review, including the revised Terms of Reference and Work Plan 2023/24 at its meeting in March 2023. The review is recommended to the Board of Directors for approval.

2. Background

2.1 Section 8 of the current Finance & Performance Committee Terms of Reference states that "The Committee will review its membership, effectiveness and performance of the Committee on an annual basis".

2.2 Furthermore, the Terms of Reference require that the Terms of Reference of the Finance & Performance Committee shall be reviewed by the Board of Directors annually.

2.3 The current review relates to effectiveness of the Committee during 2022/23.

3. Compliance with Terms of Reference

3.1 The Finance & Performance Committee has an annual work plan, which sets out the matters to be considered by the Committee to fulfil its broad responsibilities as set out in the terms of reference:

- Oversight and assurance on all aspects of the Trust's financial and operational performance against the agreed annual plan
- Oversight and assurance on delivery of the Trust's digital, estates and sustainability related strategies and plans
- Supporting the Board in the development of future business plans

Appendix 1 details key matters and standard reports, including business cases and contracts, considered by the Finance & Performance Committee during 2022/23. In addition, the Committee also considered:

- Divisional Performance Review Framework
- Trust links with the third sector to support admission avoidance and discharge pathways
- Cyber Security Update
- Year-End Financial Forecast 2022/23 – Deep Dive
- Community Diagnostic Centre Update
- Strategic Framework – For strategy development & governance
- Joint Planning Framework – Framework for aligned Trust planning process across Stockport FT and Tameside & Glossop FT

3.2 The Finance & Performance Committee received the Work Plans and terms of reference for its established subgroups in March 2023, with outcome of the annual report of the subgroups to be received in April 2023.

3.3 Attendance at 2022/23 Finance & Performance Committee meetings is provided in Appendix 2. The Committee has met on ten occasions during 2022/23 in line with terms of reference, 1 meeting was not quorate. Acknowledging that Finance & Performance Committee does not formally approve business cases/contracts, the meeting took place, and each of the business cases and contracts considered at the June meeting were subsequently presented to the Board of Directors for review and formal approval.

4. Committee Effectiveness

4.1 Effective sub-committees can provide significant benefits to the board, enabling the board to make informed decisions and meet their wide-ranging governance and regulatory responsibilities. Likewise, sub-committees should play a key role in supporting directors in their strategic and oversight roles.

4.2 An informal review of committee effectiveness is led by the Chair of the Committee as part of the meeting arrangements. This enables members to provide real-time feedback regarding what has worked well and areas for improvement.

4.3 Furthermore, Finance & Performance Committee members were asked to provide feedback regarding committee effectiveness during the year considering:

- What has worked well?
- What could be improved?
- Any other comments

4.3.1 Summary of feedback:

What has worked well?

- Well-structured committee, with balance of operational and financial matters, alongside inclusion of strategy, planning and business developments
- Triangulation of themes emerging from other Board Committees
- Quality of meeting papers enabling quality discussions
- Appropriate membership and attendees
- Challenging planning timeline & process well negotiated and managed throughout the year by the committee

What could be improved?

- Timeliness of meeting papers to enable required level of scrutiny, acknowledging external reporting requirements can present short turnaround timescales for papers.
- True focus on assurance regarding the effectiveness of systems and processes in place to achieve objectives – occasions where level of questioning/detail covered is too operational and focussed on individual items.

Any other comments

- Consider timing of meetings to maximise the availability of data without compromising the requirements of other stakeholders e.g., GM and Board meetings.
- Do we have an appropriate level of reporting on the GM Integrated Care System position - operational and financial?
- The broad remit of the Committee is such that it is challenging to do justice to this within the allotted time.

4.4 Consideration of the above, and compliance with the terms of reference, confirms the effective operation of the committee throughout 2022/23, with opportunities for ongoing improvement to be taken forward.

5. Committee Work Plan 2023/24

5.1 The Work Plan 2023/24 (Appendix 3) has been developed in line with feedback received, and consideration by the Committee Chair, lead Executive Directors and Directors, and the Company Secretary.

5.2 Reports detailed within the Work Plan will be action-driven and practical, containing enough data and information to enable the committee to reach an evidence-based and auditable conclusion.

5.3 The Committee will remain alert to approval of the Trust's Annual Plan - Corporate Objectives and Outcome Measures for 2023/24. Following approval, a review of the Work Plan will take place to ensure the Committee remains connected to the Board objectives and outcome measures that fall within its remit.

5.4 **Board to Ward – Governance Alignment**

5.4.1 The Operational Divisional Performance Review Framework (PRF) supports the Trust to assure delivery of the annual corporate objectives, providing a connection from Board to Ward. The PRF is based on 6 domains:

- Operational Excellence
- Quality of Care
- People & Leadership
- Finance
- Service Transformation & Innovation
- Strategy

Each domain is measured by oversight metrics based on regulatory frameworks, national targets and the outcome measures identified for the annual business plan – and is mirrored within the key sources of assurances considered via respective Board Committees.

6. Terms of Reference

6.1 A review of the Committee Terms of Reference has been conducted. The revised Terms of Reference are included at Appendix 4 of the report for approval.

6.2 Key changes to the terms of reference relate to:

- Member/Attendee Titles
- Oversight of the delivery of estates and facilities functions statutory requirements.

Appendix 1: Key matters considered by Finance & Performance Committee 2022/23

FINANCE & PEFORMANCE COMMITTEE 2022/23

Topic	21 Apr 2022	19 May 2022	16 Jun 2022	21 Jul 2022	15 Sep 2022	20 Oct 2022	17 Nov 2022	19 Jan 2023	16 Feb 2023	16 Mar 2023
Finance Report, including CIP and Capital Programme	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Opening Budgets	✓									
Financial Forecasting Process				✓						
Medium Term Financial Recovery Plan Development				✓		✓		✓		
Costing Transformation Programme (Reference Costs)					✓					
Annual Review of Treasury Management Procedures					✓					
Pharmacy Shop Board Report				✓						
Operational Performance Report	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Winter Planning					✓	✓				
Emergency & Urgent Care Campus: o Full Business Case (April) o Guaranteed Maximum Price (GMP) (July) o GMP & Affordability Update (Sept)	✓			✓	✓					
Business Cases:										
o Wireless Business Case			✓							
o Wireless Network Cabinets Business Case								✓		
o Out of Hours Business Case			✓							
o Virtual Ward Business Case						✓				
o Healthier Together Business Case							✓			
o Health Care Assistants Re-Banding Claim										
Annual Procurement Programme and Progress Report		✓					✓			
Procurement Update / Contract Approvals			✓	✓	✓	✓	✓	✓	✓	
Procurement Policy			✓							
Future MR Provision	✓									
Trust Planning	✓							✓	✓	✓
Post-Implementation Appraisal of Business Cases				✓				✓		
Business Case Template Review Update				✓						
Green Plan Progress Report					✓					✓
Board Assurance Framework and Aligned Significant Risks				✓			✓	✓		✓
Key Issues Reports:										
o Capital Programme Management Group	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
o Digital & Informatics Group (including approval of ToR in Sept)					✓	✓		✓	✓	✓

Topic	21 Apr 2022	19 May 2022	16 Jun 2022	21 Jul 2022	15 Sep 2022	20 Oct 2022	17 Nov 2022	19 Jan 2023	16 Feb 2023	16 Mar 2023
Policies for Approval	✓			✓			✓			
Informal Review of Meeting Effectiveness	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Finance & Performance Committee Work Plan	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Appendix 2: Finance & Performance Committee 2022/23 Attendance Register

Member	Name	Apr-22	May-22	Jun-22	Jul-22	Sep-22	Oct-22	Nov-22	Jan-23	Feb-23	Mar-23
Core Members											
Chair of F&P Committee/Non-Executive Director	Tony Bell	Y	Y	Y	Y	Y	Y	A	Y	Y	Y
Non-Executive Director	Catherine Anderson	Y	Y	A	A	Y	Y	Y			
Non-Executive Director	David Hopewell	Y	Y	A	Y	Y	Y	Y	A	Y	Y
Non-Executive Director	Samira Anane					Y	Y	Y	Y	Y	Y
Chief Finance Officer	John Graham	Y	A	Y	A	Y	Y	Y	A	Y	Y
Director of Operations	Jackie McShane	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Director of Strategy & Partnerships	Jonathan O'Brien	A	Y	Y	Y	Y	Y	Y	Y	Y	Y
Regular Attendees											
Director of Finance	Kay Wiss	Y	Y	Y	Y	A	Y	Y	Y	Y	Y
Chief Nurse	Nic Firth	A	Y	Y	Y	Y	A	Y	A	Y	A
Director of Communications & Corporate Affairs	Caroline Parnell	A	A	Y	A	Y	Y	A	Y	A	A
Chief Information Officer	Helen Bennett						Y		Y	Y	Y
Trust Secretary	Rebecca McCarthy	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Non-Executive Director	Marisa Logan-Ward			A(D)							
Was Meeting Quorate (Y/N)		**Y**	**Y**	**N**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**
Key											
Y	= Present										
A	= Apologies										
A(D)	= Attended as Deputy										

Appendix 3: Finance & Performance Committee Work Plan 2023/24

	Items	Lead	2023 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2024 Jan	Feb	Mar
			Q1			Q2			Q3			Q4		
Finance														
1.	**Finance Report**	Chief Finance Officer	•	•	•	•		•	•	•		•	•	•
2.	**Opening Budgets**	Chief Finance Officer	•											
3.	**Annual Trust Efficiency Programme**	Director of Operations	•											
4.	**Medium/Long Term Financial Recovery Plan**	Chief Finance Officer						•						
5.	**Costing Transformation Programme (Reference Costs)**	Director of Finance							•					
6.	**Annual Review of Treasury Management Procedures**	Director of Finance							•					
7.	**Annual Procurement Programme & Progress Report**	Head of Procurement		•						•				
8.	**Business Cases / Contracts for recommendation to Board *(As required):*** - Business cases with an investment value in excess of £750,000 (capital and/or revenue) - revenue expenditure (excluding consultancy services, capital and removal expenses) over £750,000 - orders for schemes within the capital programme over £750,000	Business Case Operational Lead	•	•	•	•		•	•	•		•	•	•
9.	**Post-implementation appraisal of Business Cases (approved by Finance & Performance Committee)** *NB. Appraisal of business cases to take place 6 months following full implementation. Timing of report may differ to facilitate this.*	Director of Strategy & Partnerships			•							•		
Commercial Activity														
10.	**Pharmacy Shop Board**	Chief Pharmacist	•						•					
Operational Performance														
11.	**Operational Performance Report**	Director of Operations	•	•	•	•		•	•	•		•	•	•
12.	**Performance Framework**	Director of Operations		•										
Strategy & Planning														

13.	**Trust Planning**	Director of Strategy & Partnerships	•	•								•	•
14.	**Capital Programme**	Chief Finance Officer										•	•
15.	**Winter Planning**	Director of Operations						•	•				
Estates & Sustainability													
16.	**Stepping Hill Site Development Strategy Delivery Plan – Progress Report** *(Subject to approval by Board)*	Director of Estates & Facilities						•		•			
17.	**Estates & Facilities Assurance Report**	Director of Estates & Facilities			•							•	
18.	**Green Plan Progress Report**	Director of Estates & Facilities						•					•
Risks													
19.	**BAF & Aligned Significant Risks**	Company Secretary				•		•				•		•
Subgroups													
20.	**Capital Programmes Management Group Key Issues Report**	Chief Finance Officer	•	•	•	•		•	•	•		•	•	•
21.	**Digital & Informatics Group Key Issues Report** - Digital Strategy Progress Report (May/November)	Director of Digital		•		•		•	•			•	•	
Committee Business													
22.	Review and approve of **Terms of Reference**	Chair												•
23.	Review and approve of **Annual Work Plan**	Chair												•
24.	Review and approve **Finance & Performance Committee Subgroup Terms of Reference & Annual Work Plan** *(Annual Reports – April)*	Chair	•											•
25.	Informal Review of Committee Effectiveness	Led by Chair	•	•	•	•		•	•	•		•	•	•
26.	Formal Committee Evaluation	Chair												•

Schedule as required:

- Major investigations or reviews (internal of external to the Trust) relevant to finance & performance.

- Development of relevant strategic matters, prior to recommendation to Board
-

Appendix 4: Finance & Performance Committee Terms of Reference

NHS Stockport NHS Foundation Trust

FINANCE & PERFORMANCE COMMITTEE

TERMS OF REFERENCE

1. CONSTITUTION

1.1. The Board of Directors (the Board) hereby resolves to appoint a Committee, to be known as the Finance & Performance Committee.

1.2 The Finance & Performance Committee shall have terms of reference and powers delegated by the Board and is subject to such conditions, such as reporting to the Board, in accordance with any legislation, regulation or direction issued by the Trust.

1.3 Save where otherwise provided in these Terms of Reference, the Standing Orders of the Board apply to the proceedings of this Committee.

1.4 The Finance & Performance Committee's activities will support the development and delivery of the Trust's Strategy and Annual Plan.

2. PURPOSE OF THE COMMITTEE

The overarching purpose of Finance & Performance Committee is to:

2.1 Provide oversight and assurance on all aspects of the Trust's financial and operational performance against the agreed annual plan.

2.2 Support the Board in the development of future business plans.

2.3 Provide oversight and ensure appropriate governance mechanisms are in place to assure delivery of the Trust's digital, estates and sustainability related strategies and plans.

2.4 Ensure any associated risks, identified in relation to the above, are managed in accordance with the Trust's assurance framework and risk management arrangements.

2.5 To have oversight into the Trust's finance and performance related work with locality and system partners.

3. COMPOSITION & CONDUCT OF THE COMMITTEE

3.1 Membership

3.1.1 Committee membership will comprise:

- At least three Non-Executive Directors, one of whom shall be the Chair
- Chief Finance Officer

- Director of Operations
- Director of Strategy & Partnerships

3.1.2 All statutory Directors are authorised to attend and speak at meetings of the Committee, when they judge appropriate.

3.1.3 There is an expectation that members will attend all meetings during the financial year. Individual attendance levels will be monitored by the Chair of the Committee who will take appropriate measures should attendance be less than 75%.

3.1.4 Nominated deputies may attend in the absence of any member; however, this shall be in an advisory capacity only and attendance of a deputy shall not count towards the attendance level set out in 3.1.2.

3.1.5 The following shall also attend Committee meetings:
- Director of Finance
- Company Secretary

3.1.6 The Committee will invite other senior leaders to support specific matters as required.

3.2. Chair

3.2.1 The Chair of the Committee will be a Non-Executive Director.

3.2.2 Another Non-Executive Director will deputise as the Chair of the Committee in the Chair's absence.

3.3 Quorum

3.3.1 A quorum will consist of three members, provided that at least two of the attendees are Non-Executive Directors. Deputies in attendance do not count towards the quorum.

3.3.2 Members withdrawing from the meeting owing to a conflict of interest shall no longer count towards a quorum.

3.3.3 However, at the discretion of the Chair, matters and decisions deemed urgent may proceed within the absence of a quorum with any actions from that meeting being confirmed at the next full meeting.

3.4 Notice of meeting

3.4.1 Before each meeting, a notice of the meeting specifying the business proposed to be transacted and supporting papers for the business expected shall be sent by electronic mail to the usual place of business of each member, to be available at least five clear days before the meeting.

3.4.2 The Chair of the Committee may, at their discretion, allow additional agenda items and papers to be circulated after the notice of the meeting.

3.5 Frequency of meetings

3.5.1 The Committee shall meet at least 10 times per year.

3.5.2 The Chair may at times convene additional meetings of the Committee and/or request business that requires urgent attention is considered via email, for majority decision making. All decisions made via email will be confirmed at the next full meeting.

3.6. Administration

3.6.1 The Company Secretary will ensure appropriate administrative arrangements are in place and that minutes are recorded, confirmed and appropriately archived from each meeting.

4. DELEGATED AUTHORITY

The Finance & Performance Committee is authorised by the Board to:

4.1 Investigate any matter within these terms of reference.

4.2 Seek information from any Director, officer, or employee; and all Directors, officers and employees are directed to extend the fullest co-operation to the Committee in the discharge of its functions.

4.3 Within the procedures approved by the Board, obtain independent legal or other professional advice where required, including the attendance of independent advisers at meetings of the Committee.

5. RESPONSIBILITIES

The responsibilities of the Committee are to:

5.1 Finance

5.1.1 Seek assurance on the effectiveness of systems and processes that exist in relation to the development and delivery of the Trust's annual financial plan.

5.1.2 Review and recommend to the Board the annual financial plan / budget, including activity and workforce, and the associated financial budget.

5.1.3 Consider the levels of assurance provided from key financial metrics and monitor action/s to address any adverse trends against the agreed financial plan.

5.1.4 Oversee the development of the Trust's medium/long term financial strategy, ensuring annual financial plans are consistent with this, and recommend to the Board.

5.1.5 Seek assurance on:
- the planning of the Trust efficiency programmes and in-year delivery
- the planning and delivery of the capital programme
- the effectiveness of Trust's procurement arrangements and delivery of the Trust's procurement programme to ensure compliance with regulations and maximise value for money

5.1.6 To keep under review issues such as cost transformation (reference costs) to benchmark activity and performance and to act on any learning or remedial action required.

5.1.7 Receive, review and recommend to the Board as appropriate:
- business cases with an investment value in excess of £750,000 (capital and/or revenue)
- revenue expenditure (excluding consultancy services and removal expenses) over £750,000
- orders for schemes within the capital programme over £750,000

5.1.8 Receive and review post implementation reviews of business cases in line with the above to ensure benefits realisation.

5.1.9 To approve the Trust's business case process and associated investment, appraisal, methodology.

5.1.10 Obtain assurance on the effectiveness and sustainability of the Trust's commercial activities.

5.2 Operational Performance

5.2.1 Seek assurance on the effectiveness of systems and processes that exist in relation to the development and delivery of the Trust's annual operational performance standards.

5.2.2 Review the levels of assurance provided from key operational performance metrics and monitor action/s to address adverse trends against the agreed operational plan.

5.2.3 Receive and review key themes, issues, and risks from the Trust's performance review process.

5.3 Digital & Informatics

5.3.1 Oversee development and delivery of the Trust's digital strategy.

5.3.2 Seek assurance on the effectiveness of systems and process to deliver the Trust's digital and information statutory requirements

5.4 Estates

5.4.1 Oversee the development and delivery of the Trust's estates strategy, with recommendation to the Board as required.

5.4.2 Seek assurance on the effectiveness of systems and process to deliver the Trust's estates and facilities statutory requirements.

5.5 Sustainability

5.5.1 Have oversight of the development and delivery of sustainability requirements in line with national NHS guidance.

5.6 Other

5.6.1 Oversee the development of relevant Trust-level strategies and plans and recommend to the Board.

5.6.2 Review the findings or major investigations or reviews (internal of external to the Trust) as delegated by the Board or on the Committees initiatives and consider management's response.

5.6.3 Review assigned risks from the Board Assurance Framework and associated significant risks from the Corporate Risk Register and ensure that mitigations are appropriately actioned.

5.6.4 Review and approve the Work Plans and Terms of Reference of any group/committee that reports directly to the Committee.

5.6.5 Undertake or consider on behalf of the Chairman or the Board such other related tasks or topics as

the Chairman or the Board may from to time entrust to the Committee. The Committee will work in partnership with other Committees of the Board to address matters that impact on the responsibilities of several Committees.

6. RELATIONSHIP WITH THE BOARD OF DIRECTORS

6.1 The Committee will report to the Board by means of a Key Issues Report summarising business conducted by the Committee together with key actions and/or risks.

6.2 The Key Issues Report will be forwarded to the Board following each Committee meeting.

6.3 Minutes of all Committee meetings will be available to all members of the Board on request.

7. RELATIONSHIP WITH OTHER GROUPS

7.1 The Committee shall have the power to establish sub-committees for the purpose of addressing specific tasks or areas of responsibility. In accordance with the Trust's Standing Orders, the Committee may not delegate powers to a sub-committee unless expressly authorised by the Board.

7.2 The Committee will receive reports, in the form of Key Issues Reports, from the following:
- Capital Programme Management Group
- Digital & Informatics Group

7.3 For the purpose of providing assurance regarding the controls in place for the management and mitigation of risks recorded on the Board Assurance Framework, the Committee (through its Chair) reports regularly to the Audit Committee.

8. REVIEW

8.1 The Committee will review its terms of reference and membership annually and recommend any changes to the Board for approval.

8.2 The Committee will review the effectiveness and performance of the Committee on an annual basis and report the outcome to the Board.

NHS Stockport NHS Foundation Trust

People Performance Committee Annual Review 2022/23

1. Introduction

1.1 The People Performance Committee considered and confirmed the outcome of the Committee Annual Review, including the revised Terms of Reference and Work Plan 2023/24 at its meeting in March 2023. The review is recommended to the Board of Directors for approval.

2. Background

2.1 Section 8 of the current People Performance Committee Terms of Reference states that "The Committee will evaluate its own membership and review the effectiveness and performance of the Committee on an annual basis".

2.2 Furthermore, the Terms of Reference require that the Terms of Reference of the People Performance Committee are reviewed by the Board of Directors annually.

3. Compliance with Terms of Reference

3.1 The People Performance Committee has an annual work plan, which sets out the matters to be considered by the Committee to fulfil its broad responsibilities:

- Oversight and assurance on matters relating to delivery of the Trust's people related strategies and plans to support achievement of corporate objectives
- Supporting the Board in the development of people related strategies and plans

Appendix 1 details key matters and standard reports considered by the People Performance Committee during 2022/23 in line with the terms of reference. In addition, the Committee also considered:

- Resourcing & Retention – Turnover Deep Dive
- Industrial Action Planning & Actions
- Sickness Absence Deep Dive

3.2 Attendance at 2022/23 People Performance Committee meetings is provided in Appendix 2. The Committee has met on six occasions and all meetings were quorate.

4. Committee Effectiveness

4.1 Effective sub-committees can provide significant benefits to the board, enabling the board to make informed decisions and meet their wide-ranging governance and regulatory responsibilities. Likewise, sub-committees should play a key role in supporting directors in their strategic and oversight roles.

4.2 An informal review of committee effectiveness is led by the Chair of the Committee as part of the meeting arrangements. This enables members to provide real-time feedback regarding what has worked well and areas for improvement.

4.3. Furthermore, People Performance Committee members were asked to provide feedback regarding committee effectiveness during the year considering:

- What has worked well?
- What could be improved?
- Any other comments

4.3.1 Feedback included:

What has worked well?

- Good focus on key people topics enabling assurance to be provided to the Board.
- Transition to bimonthly meetings, with frequency appearing sufficient.

What could be improved?

- Clarity regarding People Performance Committee subgroups, and how divisional assurance is provided through this.
- Ensuring focus is given to the strategic issues, acknowledging longitudinal approach required to shift certain operational people metrics, specifically those relating to cultural change.
- Focussing discussion on triangulation between the papers received – opportunity to reflect on the papers holistically.

Any other comments

- Benchmarking with T&G useful.
- Ensure there is clarity regarding the purpose of additional papers (in addition to agreed Work Plan)

4.4 Consideration of the above, and compliance with the terms of reference, confirms the effective operation of the committee throughout 2022/23, with opportunities for ongoing improvement to be taken forward.

5. Committee Work Plan 2023/24

5.1 The Work Plan 2023/24 (Appendix 3) has been developed in line with feedback received, and discussion with the Director of People & Organisational Development (OD) and the Chair of the People Performance Committee and is aligned to the People & Organisational Development directorate priorities for the year ahead.

5.2 Reports detailed within the Work Plan will be action-driven and practical, containing enough data and information to enable the committee to reach an evidence-based and auditable conclusion.

5.3 Board to Ward – Governance Alignment

5.3.1 The Operational Divisions Performance Review Framework (PRF) supports the Trust to assure delivery of the annual corporate objectives, providing a connection from Board to Ward. The PRF is based on 6 domains:

- Operational Excellence
- Quality of Care
- People & Leadership
- Finance

- Service Transformation & Innovation
- Strategy

Each domain is measured by oversight metrics based on regulatory frameworks, national targets and the outcome measures identified for the annual business plan – and is mirrored within the key sources of assurances considered via respective Board Committees.

6. Terms of Reference

6.1 A review of the Committee Terms of Reference has been conducted. The revised Terms of Reference are included at Appendix 4 of the report for review, prior to presentation to the Board of Directors for approval.

6.2 Key revisions to the terms of reference relate to:

- Removal of the approval of HR related policy
- Revision to the sub-committees of the People Performance Committee

Appendix 1: Key matters considered by People Performance Committee 2022/23

Topic	12 May 2022	14 July 2022	8 Sept 2022	10 Nov 2022	12 Jan 2022	9 Mar 2023
People Integrated Performance Report	✓	✓	✓	✓	✓	✓
Workforce Modelling and Planning	✓					
Health & Wellbeing / Wellbeing Guardian Report	✓	✓		✓		
Employee Relations & Exclusions Activity	✓			✓		
Safe Staffing Report	✓	✓		✓	✓	
Annual Nursing & Midwifery Establishments				✓		
Consultant Job Planning Annual Report		✓				
Strategic Workforce Plan Report		✓				
Freedom to Speak Up Guardian Report		✓		✓		
Guardian of Safe Working Report				✓		
Equality, Diversity & Inclusion Reports: • **WRES & WDES Reports**		✓				
Annual EDI Workforce Monitoring Report						✓
Annual Gender Pay Gap Report						✓
Messenger Report		✓				
Facility Time Report		✓				
Resourcing Programme		✓				
eRostering Audit – Trust's Response and Action Plan		✓				
Medical Appraisal & GMC Revalidation Annual Report			✓			
GMC National Trainee Survey			✓			
Staff Survey			✓			✓
Overarching People Plan Update				✓		
Training, Education & Clinical Development				✓		
Organisational Development Plan					✓	
Board Assurance Framework and Aligned Significant Risks		✓		✓	✓	✓
Policies for Ratification	✓	✓		✓		
Key Issues Reports:						
• **People, Engagement & Leadership Group**	✓	✓	✓	✓		✓
• **Equality, Diversity & Inclusion Group**	✓	✓	✓	✓		✓
• **Educational Governance Group**	✓	✓		✓		✓
• **Joint Consultative & Negotiating Committee**		✓	✓			
• **Joint Local Negotiating Committee**		✓	✓	✓		
Informal Review of Meeting Effectiveness	✓	✓	✓	✓	✓	✓
People Performance Committee Work Plan	✓	✓	✓	✓	✓	✓

Appendix 2: People Performance Committee 2022/23 Attendance Register

Member	Name	May-22	Jul-22	Sep-22	Nov-22	Jan-23	Mar-23
Core Members							
Chair of People Performance Committee/Non-Executive Director	Louise Sell		Y	Y	Y	Y	
Non-Executive Director (and PPC Chair from March 2023 onwards)	Beatrice Fraenkel					Y	Y
Non-Executive Director	Mary Moore	Y	Y	Y	Y	A	Y
Non-Executive Director	Catherine Barber-Brown	Y	A				
Non-Executive Director	Catherine Anderson	A	A	Y	Y		
Non-Executive Director / Wellbeing Guardian	Marisa Logan-Ward	Y	Y	Y	Y	Y	Y
Associate Non-Executive Director	Meb Vadiya					Y	Y
Director of People & OD	Amanda Bromley	Y	Y	Y	Y	Y	Y
Chief Nurse	Nic Firth	Y	Y	A	A	A	Y
Medical Director	Andrew Loughney	A	Y	Y	A	Y	A
Regular Attendees							
Chief Finance Officer	John Graham	Y	Y	Y	Y	Y	Y
Deputy Director of People & OD	Emma Cain	Y	Y	Y	Y	Y	Y
Deputy Director of OD	Lisa Gammack		Y	Y	A	Y	Y
Head of Learning & OD	Joanne Martin				Y		
Freedom to Speak Up Guardian	Paul Elms	Y	Y		Y		
Guardian of Safe Working	Thomas Finnigan				Y		
Director of Communications & Corporate Affairs	Caroline Parnell	Y	Y	Y	Y	Y	A
Trust Secretary	Rebecca McCarthy	Y	Y	Y	Y	Y	Y
Head of Strategic Workforce Planning	Caroline Durdle		Y			Y	Y
Director of Medical Education	David Baxter	Y	A	Y	Y	Y	A
Associate Director of Workforce Delivery	Suzanne Woolridge	Y	Y	Y	Y		
Deputy Chief Nurse	Helen Howard	Y		Y	Y	Y	
Was Meeting Quorate (Y/N)		**Y**	**Y**	**Y**	**Y**	**Y**	**Y**
Key							
Y	= Present						
A	= Apologies						
A(D)	= Attended as Deputy						

11.5

Appendix 3: People Performance Committee Work Plan 2023/24

			2023									2024		
	Items		**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
		Lead	**Q1**			**Q2**			**Q3**			**Q4**		
Assurance Reports														
1.	**People Integrated Performance Report**	All		●		●		●		●		●		●
2.	**Resourcing and Retention Programme**	Deputy Director of People & OD				●						●		
3.	**Equality, Diversity & Inclusion Strategy**	Deputy Director of OD		●						●				
4.	**Workforce Plan**	Director of People & OD												●
5.	**WRES & WDES Report**	Deputy Director of OD		●										
6.	**Gender Pay Gap Report**	Deputy Director of OD												●
7.	**Annual Workforce EDI Monitoring Report**	Deputy Director of OD												●
8.	**Health & Wellbeing**	Deputy Director of People & OD				●				●				
9.	**Wellbeing Guardian Report**	Wellbeing Guardian				●				●				
10.	**Organisational Development Plan**	Deputy Director of OD				●						●		
11.	**Freedom to Speak Up**	Freedom to Speak Up Guardian		●				●						●
12.	**Guardian of Safe Working**	Guardian of Safe Working				●						●		
13.	**Employee Relations & Exclusion Activity**	Deputy Director of People & OD		●						●				
14.	**Widening Participation**	Deputy Director of OD		●						●				
15.	**Safer Care (Staffing) Report**	Deputy Chief Nurse / Medical Director		●				●				●		
16.	**Annual Nursing & Midwifery Establishments**	Chief Nurse						●						
17.	**GMC Annual National Trainee Survey**	Medical Director / Director of Medical Education						●						
18.	**Medical Appraisal & Revalidation Annual Report**	Medical Director						●						

19.	**Staff Survey**	Deputy Director of OD				●				●				●
Risks														
20.	**BAF & Aligned Significant Risks**	Company Secretary				●		●				●		●
Subgroups														
21.	**People, Engagement & Leadership Group**	Deputy Director of People & OD		●		●		●		●		●		●
22.	**Equality, Diversity & Inclusion Group**	Deputy Director of OD		●		●		●		●		●		●
23.	**Education Governance Group**	Deputy Director of People & OD		●		●		●		●		●		●
Committee Business														
24.	Review and approval of **Terms of Reference**	Chair												●
25.	Review and approval of **Annual Work Plan**	Chair												●
26.	Review and approval of **People Performance Committee Subgroup Terms of Reference & Work Plans**	Chair												●
27.	Informal Review of Committee Effectiveness	Led by Chair		●		●		●		●		●		●
28.	Formal Committee Evaluation	Chair												●

Schedule as required:

- Major investigations or reviews (internal of external to the Trust) relevant to people.
- Development of people related strategy, prior to recommendation to Board

Appendix 4: People Performance Committee Terms of Reference

PEOPLE PERFORMANCE COMMITTEE

TERMS OF REFERENCE

1. CONSTITUTION

1.1. The Board of Directors (the Board) hereby resolves to appoint a Committee, to be known as the People Performance Committee.

1.2 The People Performance Committee shall have terms of reference and powers delegated by the Board and is subject to such conditions, such as reporting to the Board, in accordance with any legislation, regulation or direction issued by the Trust.

1.3 Save where otherwise provided in these Terms of Reference, the Standing Orders of the Board apply to the proceedings of this Committee.

1.4 The People Performance Committee's activities will support the development and delivery of the Trust's Strategy and Annual Plan.

2. PURPOSE OF THE COMMITTEE

The overarching purpose of People Performance Committee is to:

2.1 Provide oversight and assurance on matters relating to delivery of the Trust's people related strategies and plans to support achievement of (related) corporate objectives.

2.2 Support the Board in the development of people related strategies and plans.

2.3 Ensure any associated risks, identified in relation to the above, are managed in accordance with the Trust's assurance framework and risk management arrangements.

2.2 To have oversight into the Trust's people related work with locality and system partners.

3. COMPOSITION & CONDUCT OF THE COMMITTEE

3.1 Membership

3.1.1 Membership will comprise:

- Three named Non-Executive Directors, one of whom shall be the Chair
- Director of People & Organisational Development
- Chief Nurse
- Medical Director

3.1.2 All statutory Directors are authorised to attend and take part in meetings of the Committee, when

they judge appropriate.

3.13 There is an expectation that members will attend all Committee meetings during the financial year. Individual attendance levels will be monitored by the Chair of the Committee, supported by the Company Secretary, who will take appropriate measures should attendance be less than 75%.

3.1.4 Nominated deputies may attend in the absence of any member; however, this shall be in an advisory capacity only and attendance of a deputy shall not count towards the attendance level set out in 3.1.3.

3.1.5. The following shall also attend Committee meetings:

- Deputy Director of People & Organisational Development
- Deputy Director of Organisational Development
- Well-Being Guardian
- Company Secretary

3.1.6 The Committee will invite other senior leaders to support specific matters as required.

3.2. Chair

3.2.1 The Chair of the Committee will be a Non-Executive Director.

3.2.2 Another Non-Executive Director will deputise as the Chair of the Committee in the Chair's absence.

3.3 Quorum

3.3.1 A quorum will consist of three members, provided that at least two of the attendees are Non-Executive Directors. Deputies in attendance do not count towards the quorum.

3.3.2 Members withdrawing from the meeting owing to a conflict of interest shall no longer count towards a quorum.

3.3.3 However, at the discretion of the Chair, matters and decisions deemed urgent may proceed within the absence of a quorum with any actions from that meeting being confirmed at the next full meeting.

3.4 Notice of meeting

3.4.1 Before each meeting, a notice of the meeting specifying the business proposed to be transacted and supporting papers for the business expected shall be sent by electronic mail to the usual place of business of each member, to be available at least five clear days before the meeting.

3.4.2 The Chair of the Committee may, at their discretion, allow additional agenda items and papers to be circulated after the notice of the meeting.

3.5 Frequency of meetings

3.5.1 The Committee shall meet at least 6 times per year.

3.5.2 The Chair may at times convene additional meetings of the Committee and/or request business that requires urgent attention is considered via email, for majority decision making by members. All decisions made via email will be confirmed at the next full meeting.

3.6. Administration

3.6.1 The Company Secretary will ensure appropriate administrative arrangements are in place and that minutes are recorded, confirmed and appropriately archived from each meeting.

4. DELEGATED AUTHORITY

4.1 The People Performance Committee is authorised by the Board to investigate any matter within these terms of reference.

4.2 Seek information from any Director, officer, or employee; and all Directors, officers and employees are directed to extend the fullest co-operation to the Committee in the discharge of its functions.

4.3 Within the procedures approved by the Board, obtain independent legal or other professional advice where required, including the attendance of independent advisers at meetings of the Committee.

5. RESPONSIBILITIES

The responsibilities of the Committee are to:

5.1 Seek assurance on the effectiveness of systems and processes that exist in relation to delivery of the Trust's people related strategies and plans to support of achievement of related corporate objectives.

5.2 Review the levels of assurance provided from key people performance related metrics and monitor action/s to address any adverse trends against the agreed plans.

5.3 Receive and review the outcomes of staff surveys, including the annual NHS staff survey and surveys of staff undertaken by professional registration bodies, and associated action/s.

5.4 Review the effectiveness of arrangements in place relating to equality, diversity and inclusion in the Trust's workforce, including oversight of statutory reporting requirements and make recommendation to the Board.

5.5 Review compliance with statutory registration requirements for members of staff and make recommendation to the Board.

5.6 Review current cases of exclusion of staff from working at the Trust.

5.7 Oversee the development of people related strategies and plans and recommend to the Board.

5.8 Review the findings of major investigations or reviews (internal or external to the Trust) relevant to people, as delegated by the Board, or on the Committees initiatives and consider management's response.

5.9 Review people related risks from the Board Assurance Framework and associated significant risks from the Corporate Risk Register and ensure that mitigations are appropriately actioned.

5.10 Review and approve the Work Plans and Terms of Reference of any group that reports directly to the Committee.

5.11 Undertake or consider on behalf of the Chairman or the Board such other related tasks or topics as the Chairman or the Board may from to time entrust to the Committee.

The Committee will work in partnership with other Committees of the Board to address matters that impact on the responsibilities of several Committees.

6. RELATIONSHIP WITH THE BOARD OF DIRECTORS

6.1 The Committee will report to the Board by means of a Key Issues Report summarising business conducted by the Committee together with key actions and/or risks.

6.2 The Key Issues Report will be forwarded to the Board following each Committee meeting.

6.3 Minutes of all Committee meetings will be available to all members of the Board on request.

7. RELATIONSHIP WITH OTHER GROUPS

7.1 The Committee shall have the power to establish sub-committees for the purpose of addressing specific tasks or areas of responsibility. In accordance with the Trust's Standing Orders, the Committee may not delegate powers to a sub-committee unless expressly authorised by the Trust Board.

7.2 The Committee will receive reports, in the form of Key Issues Reports, from the following:
- Equality, Diversity & Inclusion Group
- People, Engagement & Leadership Group
- Educational Governance Group

7.3 For the purpose of providing assurance regarding the controls in place for the management and mitigation of risks recorded on the Board Assurance Framework, the Committee (through its Chair) reports regularly to the Audit Committee.

8. REVIEW

8.1 The Committee will review its terms of reference and membership annually and recommend any changes to the Board for approval.

8.2 The Committee will review the effectiveness and performance of the Committee on an annual basis and report the outcome to the Board.

NHS Stockport NHS Foundation Trust

Quality Committee Annual Review 2022/23

1. Introduction

1.1 The Quality Committee considered and confirmed the outcome of the Committee Annual Review, including the revised Terms of Reference and Work Plan 2023/24 at its meeting in March 2023. The review is recommended to the Board of Directors for approval.

2. Background

2.1 Section 8.1 of the current Quality Committee Terms of Reference states that *"The Committee will evaluate its own membership and review the effectiveness and performance of the Committee on an annual basis".*

2.2 Furthermore, the Terms of Reference require that the Terms of Reference of the Quality Committee are reviewed by the Board of Directors annually.

3. Compliance with Terms of Reference 2022/23

3.1 The Quality Committee has an annual work plan, which sets out the matters to be considered by the Committee to fulfil its broad responsibilities:

- Oversight and assurance on matters relating to delivery of the Trust's quality related strategies and plans to support achievement of corporate objectives
- Support the Board in the development of quality related strategies and plans

Appendix 1 details key matters and standard reports considered by the Quality Committee during 2022/23. In addition, the Committee also considered:

- Transfusion Deep Dive
- Falls Deep Dive
- Patient Initiated Follow Up Deep Dive
- Divisional Governance Project Implementation Report
- External Visits & Inspections Process
- Response to NHS England Quality & Safety of Mental Health, Learning Disability & Autism Inpatient Services
- Patient Experience Strategy
- Mental Health Plan
- Joint Stockport NHS Foundation Trust & Tameside & Glossop Integrated Care NHS Foundation Trust Research, Development & Innovation Strategy 2022-27

3.2 Attendance at 2022/23 Quality Committee meetings is provided in Appendix 2. The Committee has (to date) met on ten occasions and all meetings were quorate. The attendance for the March meeting will be updated before the Committee Annual Review is presented to the Board of Directors.

4. Committee Effectiveness

4.1 Effective sub-committees can provide significant benefits to the board, enabling the board to make informed decisions and meet their wide-ranging governance and regulatory responsibilities. Likewise, sub-committees should play a key role in supporting directors in their strategic and oversight roles.

4.2 An informal review of committee effectiveness is led by the Chair of the Committee as part of the meeting arrangements. This enables members to provide real-time feedback regarding what has worked well and areas for improvement.

4.3 Furthermore, Quality Committee members held a workshop on 17th March to review committee effectiveness considering:

- What is working well
- What could be improved
- Draft Committee Work Plan 2023/24 and Sources of Assurance based on:
  - Does the work plan enable oversight of the effectiveness of systems and controls in place to deliver related strategies/plans and achieve corporate objectives
  - Does the work plan facilitate a proportionate assurance approach, enabling strategic discussion and periodic consideration of either areas facing particular challenges or emerging areas of change.

Key discussion included:

What has worked well?

- Positive and open & honest challenge at meetings, with interaction between all attendees.
- Coverage of all areas of 'quality' within the remit of the committee – no gaps.

What could be improved?

- Volume of information and frequency of reporting can bring about shift from board level assurance to operational discussion.
- Potential to rationalise frequency of specific reports e.g., Serious Incident Report. Alongside opportunity to rationalise subgroup key issue reports to ensure appropriate level of information and reduce duplication.
- Potential to re-structure agenda to support meeting flow.
- When considering additional reviews/deep dives, ensure appropriate time to enable this to take place, and/or if this may be reported via subgroup.
- Ensure balance of positive and negative patient stories.
- Explore explicit triangulation between subgroups of Quality Committee via introduction of 'Chair's Notes' on each agenda. This could also be utilised for Board Committees.

Any other comments

- Members considered reintroducing face to face meetings and/or a hybrid solution and the pros & cons of different options. It was determined that this would be considered further at mid-year point, noting forementioned improvement opportunities to be implemented.

4.4 Consideration of the above, and compliance with the terms of reference, confirms the effective operation of the committee throughout 2022/23, with opportunities for ongoing improvement to be taken forward.

5. Committee Work Plan 2023/24

5.1 The Work Plan 2023/24 (Appendix 3) has also been developed in line with discussion and outcome of the Quality Committee workshop and Chair of Quality Committee.

5.2 Reports detailed within the Work Plan should be action-driven and practical, containing enough data and information to enable the committee to reach an evidence-based and auditable conclusion.

5.3 The Committee will remain alert to approval of the Trust's Annual Plan - Corporate Objectives and Outcome Measures for 2023/24. Following approval, a further review of the Work Plan will take place to ensure the Committee remains connects to the Board objectives and outcome measures that fall within its remit.

5.4 Board to Ward – Governance Alignment

5.4.1 The Operational Divisions Performance Review Framework (PRF) supports the Trust to assure delivery of the annual corporate objectives, providing a connection from Board to Ward. The PRF is based on 6 domains:

- Operational Excellence
- Quality of Care
- People & Leadership
- Finance
- Service Transformation & Innovation
- Strategy

Each domain is measured by oversight metrics based on regulatory frameworks, national targets and the outcome measures identified within the Trust's annual plan – and is reflected within the key sources of assurances considered via respective Board Committees.

6. Terms of Reference

6.1 A review of the Committee Terms of Reference has been conducted as part of the review of committee effectiveness. The revised Terms of Reference are included at Appendix 5 of the report for Committee review, prior to presentation to the Board of Directors for approval.

6.2 Key revisions to the terms of reference relate to:

- Director of Operations included within membership.

Appendix 1: Key Matters considered by Quality Committee 2022/23

Topic	Apr 2022	May 2022	Jun 2022*	Jul 2022	Sept 2022	Oct 2022	Nov 2022	Jan 2023	Feb 2023	Mar 2023
Patient Story	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Quality & Safety Integrated Performance Report	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Key Issues & Assurance Reports:										
Patient Safety Group		✓	✓	✓	✓	✓	✓	✓	✓	✓
Clinical Effectiveness Group	✓	✓	✓	✓	✓	✓		✓	✓	✓
Patient Experience Group	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Health & Safety Joint Consulting Group	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Trust Integrated Safeguarding Group	✓		✓		✓	✓		✓	✓	
CQC Update	✓				✓					
Notification of Serious Incidents	✓	✓	✓	✓	✓	✓		✓	✓	✓
Patient Safety Report					✓			✓		
Learning from Deaths						✓			✓	
Waiting List Harms (including harms associated with patient flow)			✓				✓		✓	
Maternity Services Report	✓	✓	✓		✓		✓	✓		✓
Infection Prevention Control Report				✓		✓		✓		
National Inpatient Survey Results						✓				
Annual Safeguarding Report			✓							
Annual Clinical Audit Report				✓						
Annual Patient Experience Report				✓						
Annual Research & Innovation Report		✓								
Annual Infection Prevention Control Report			✓							
Annual Health & Safety Report		✓								
Draft Quality Accounts		✓								
Board Assurance Framework and Aligned Significant Risks	✓	✓		✓			✓	✓		✓
Informal Review of Meeting Effectiveness	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Quality Committee Work Plan	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

*Extraordinary Quality Committee meeting held on 17th June 2022 to consider Mental Health Plan.

Appendix 2: Quality Committee 2022/23 Attendance Register

Member	Name	Apr 22	May 22	Jun 22	Jun 22	Jul 22	Sept 22	Oct 22	Nov 22	Jan 23	Feb 23	Mar 23
Core Members												
Chair of Quality Committee/Non-Executive Director	Mary Moore	Y	Y	Y	Y	Y	Y	Y	Y	A	Y	Y
Non-Executive Director	Samira Anane						Y	Y	Y	Y	Y	A
Non-Executive Director	Marisa Logan-Ward	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Non-Executive Director	Louise Sell	Y	Y	A	Y	Y	Y	Y	Y	Y	Y	Y
Medical Director	Andrew Loughney	Y	Y	Y	Y	Y	Y	Y	Y	A	Y	Y
Chief Nurse	Nic Firth	Y	A	Y	Y	A	A	Y	Y	Y	Y	Y
Regular Attendees												
Deputy Chief Nurse	Helen Howard	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Deputy Director of Quality Governance	Natalie Davies	Y	Y	Y	A	Y	Y	A	Y	Y	Y	Y
Trust Secretary	Rebecca McCarthy	Y	Y	A	Y	Y	Y	Y	Y	Y	Y	Y
Head of Midwifery	Sharon Hyde	A	A	A	N/A	N/A	A	N/A	Y	A	N/A	Y
Deputy Head of Midwifery	Rachel Alexander-Patton	A(D)	A	A(D)	N/A	N/A	A(D)	N/A	-	A(D)	N/A	N/A
Head of Safeguarding	Thomas Parker Evans	Y	N/A	Y	N/A	N/A	Y	A	N/A	Y	Y	Y
Was meeting quorate?		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Key												
Y	= Present											
A	= Apologies											
A(D)	= Attended as Deputy											
N/A	= No Report											

Appendix 3: Quality Committee Work Plan 2023/24

			2023									2024		
	Items		**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
		Lead	**Q1**			**Q2**			**Q3**			**Q4**		
1.	**Patient Story**	Deputy Chief Nurse	●	●	●	●		●	●	●		●	●	●
Deep Dives														
2.	**End of Life Care**		●											
Quality Performance														
3.	**Quality & Safety Integrated Performance Report**	Medical Director / Chief Nurse	●	●	●	●		●	●	●		●	●	●
Regulatory Compliance														
4.	**CQC Update**	Chief Nurse / Deputy Director Quality Governance			●							●		
5.	**External Visits & Inspections Register Report**	Deputy Director Quality Governance	●						●					
Assurance and Oversight Requirements														
6.	**Learning from Deaths**	Medical Director	●			●			●			●		
7.	**Patient Safety Report including Serious Incidents**	Deputy Director Quality Governance	.	.●				●		●			●	
8.	**Maternity Services Report** *(Additional reports/frequency to be revised in line with external reporting submissions)*	Chief Nurse / Head of Midwifery			●			●		●				●
9	**Infection Prevention and Control Strategy Progress Report** *(Annual Report in June)*	Chief Nurse										●		
10.	**StARS Progress Report**	Deputy Chief Nurse	.●	.		●			●			●		
11.	**Quality Strategy Progress Report**	Deputy Chief Nurse		●						●				
12.	**Patient, Family & Carer Experience Strategy Progress Report**	Deputy Chief Nurse			●							●		
13.	**Annual National In-Patient Survey Report and Action Plan**	Deputy Chief Nurse						●						
14.	**Patient Flow Associated Harms Report**	Deputy Medical Director				●				●				●

15.	**Mental Health Plan Progress Report**	Deputy Chief Nurse / Medical Director						•						•
Standing Committees														
16.	**Safeguarding Group Key Issues Report**	Chief Nurse	•		•			•	•			•	•	
17.	**Patient Experience Group Key Issues Report**	Chief Nurse	•	•	•	•		•	•	•		•	•	•
18.	**Health and Safety JCG Key Issues Report**	Deputy Director Quality Governance	•	•	•	•		•	•	•		•	•	•
19.	**Clinical Effectiveness Group Key Issues Report** *(Consolidated quarterly report in line with quarterly cycle of Clinical Effectiveness Group business)*	Medical Director	•		•			•				•		•
20.	**Patient Safety Group Key Issues Report**	Medical Director	•	•	•	•		•	•	•		•	•	•
Annual Reports														
21.	**Annual Health & Safety Report**	Deputy Director Quality Governance		•										
22.	**Annual Research & Innovation Report**	Medical Director				•								
23.	**Annual Clinical Audit Report & Forward Programme**	Medical Director			•									
24.	**Annual Complaints Report**	Deputy Director Quality Governance				•								
25.	**Annual Infection Control Report**	Chief Nurse			•									
26.	**Annual Safeguarding Report**	Deputy Chief Nurse			•									
27.	**Annual Quality Account**	Deputy Director Quality Governance		•										
Strategic Developments														
28.	**Patient Safety Incident Response Framework & Plan**	Deputy Director Quality Governance				•								
Risks														
29.	**BAF & Aligned Significant Risks**	Company Secretary				•		•				•		•
Committee Business														

30.	Review and approve of **Terms of Reference**	Chair												●
31.	Review and approve of **Annual Work Plan**	Chair												●
32.	Review and approve **Quality Committee Subgroup Terms of Reference & Annual Work Plan**	Chair	●											
33.	Informal Review of Committee Effectiveness	Led by Chair	●	●	●	●		●	●	●		●	●	●
34.	Formal Committee Evaluation	Chair												●

Schedule as required:

- Major investigations or reviews (internal of external to the Trust) relevant to quality of care.
- Development of quality related strategy, prior to recommendation to Board

Appendix 4: Quality Committee Terms of Reference

NHS Stockport NHS Foundation Trust

QUALITY COMMITTEE

TERMS OF REFERENCE

1. CONSTITUTION

1.1. The Board of Directors (the Board) hereby resolves to appoint a Committee, to be known as the Quality Committee.

1.2 The Quality Committee shall have terms of reference and powers delegated by the Board and is subject to such conditions, such as reporting to the Board, in accordance with any legislation, regulation or direction issued by the Trust.

1.3 Save where otherwise provided in these Terms of Reference, the Standing Orders of the Board apply to the proceedings of this Committee.

1.4 The Quality Committee's activities will support the development and delivery of the Trust's Strategy and Annual Plan.

2. PURPOSE OF THE COMMITTEE

The overarching purpose of Quality Committee is to:

2.1 Provide oversight and assurance regarding the operation of systems and processes to ensure the quality of care, encompassing patient safety, clinical effectiveness, and experience, provided to users of the Trust's services.

2.2 Support the Board in the development of strategy related to quality of care.

2.3 Ensure any associated risks, identified in relation to the above, are managed in accordance with the Trust's assurance framework and risk management arrangements.

2.4 To have oversight into the Trust's quality-related work with locality and system partners.

3. COMPOSITION & CONDUCT OF THE COMMITTEE

3.1 Membership

3.1.1 Membership will comprise:

- Three named Non-Executive Directors, one of whom shall be the Chair
- Chief Nurse
- Medical Director
- Director of Operations

3.1.2 All statutory Directors are authorised to attend and take part in meetings of the Committee, when they judge appropriate.

3.1.3 There is an expectation that members will attend all meetings during the financial year. Individual attendance levels will be monitored by the Chair of the Committee who will take appropriate measures should attendance be less than 75%.

3.1.4 Nominated deputies may attend in the absence of any member; however, this shall be in an advisory capacity only and attendance of a deputy shall not count towards the attendance level set out in 3.1.3.

3.1.5 The following shall also attend Committee meetings on a regular basis:
- Deputy Director of Quality Governance
- Deputy Chief Nurse
- Head of Midwifery
- Maternity Safety Champion
- Head of Safeguarding
- Company Secretary

3.1.6 The Committee will invite other senior leaders to support specific matters, as required.

3.2. Chair

3.2.1 The Chair of the Committee will be a Non-Executive Director.

3.2.2 Another Non-Executive Director will deputise as the Chair of the Committee in the Chair's absence.

3.3 Quorum

3.3.1 A quorum will consist of three core committee members, provided that at least two of the attendees are Non-Executive Directors. Deputies in attendance do not count towards the quorum.

3.3.2 Members withdrawing from the meeting owing to a conflict of interest shall no longer count towards a quorum.

3.3.3 However, at the discretion of the Chair, matters and decisions deemed urgent may proceed within the absence of a quorum with any actions from that meeting being confirmed at the next full meeting.

3.4 Notice of meeting

3.4.1 Before each meeting, a notice of the meeting specifying the business proposed to be transacted and supporting papers for the business expected shall be sent by electronic mail to the usual place of business of each member, so as to be available at least five clear days before the meeting.

3.4.2 The Chair of the Committee may, at their discretion, allow additional agenda items and papers to be circulated after the notice of the meeting.

3.5 Frequency of meetings

3.5.1 The Committee shall meet at least 10 times per year.

3.5.2 The Chair may at times convene additional meetings of the Committee and/or request business that requires urgent attention is considered via email, for majority decision making. All decisions made via email will be confirmed at the next full meeting.

3.6. Administration

3.6.1 The Company Secretary will ensure appropriate administrative arrangements are in place and that minutes are recorded, confirmed, and appropriately archived from each meeting.

4. DELEGATED AUTHORITY

The Quality Committee is authorised by the Board to:

4.1 Investigate any matter within these terms of reference.

4.2 Seek information from any Director, officer, or employee; and all Directors, officers and employees are directed to extend the fullest co-operation to the Committee in the discharge of its functions.

4.3 Within the procedures approved by the Board, obtain independent legal or other professional advice where required, including the attendance of independent advisers at meetings of the Committee.

5. RESPONSIBILITIES

The responsibilities of the Committee are to:

5.1 Seek assurance on the effectiveness of systems and processes that exist to ensure quality of care, including patient safety, clinical effectiveness and patient & service user experience.

5.2 Review the levels of assurance provided from key performance indicators in relation to quality of care and monitor action/s to address any adverse trends.

5.3 Have oversight of compliance with the Care Quality Commission registration requirements and identify any risks that may prevent this, ensuring mitigations are in place and delivered.

5.4 Review compliance with statutory and regulatory requirements and make recommendation / confirmation to Board as appropriate with respect to:
- infection prevention and control
- safeguarding
- maternity services
- health and safety

5.5 Ensure effective systems for learning are in place to drive change and support improvement in quality of care.

5.6 Review the delivery of clinical audit programmes and the implementation of learning resulting from such programmes.

5.7 Review the delivery of activities in place to actively seek feedback from people using services and ensure feedback supports service improvement.

5.8 Receive and review the outcomes of national and local patient surveys and associated actions.

5.9 Oversee the development of quality related strategies and recommend to the Board.

5.10 Oversee preparation of the statutory Quality Accounts and any associated matters as required by the regulator (in association with Audit Committee).

5.11 Review the findings of major investigations or reviews (internal of external to the Trust) relevant to quality of care, as delegated by the Board or on the Committees initiative and consider management's response.

5.12 Review quality related risks from the Board Assurance Framework and associated significant risks from the Significant Risk Register and ensure that mitigations are appropriately actioned.

5.13 Review and approve the Work Plans and Terms of Reference of any group/committee that reports directly to the Committee.

5.14 Undertake or consider on behalf of the Chairman or the Board such other related tasks or topics as the Chairman or the Board may from to time entrust to the Committee.

The Committee will work in partnership with other Committees of the Board to address matters that impact on the responsibilities of several Committees.

6. RELATIONSHIP WITH THE BOARD OF DIRECTORS

6.1 The Committee will report to the Board by means of a Key Issues Report summarising business conducted by the Committee together with key actions and/or risks.

6.2 The Key Issues Report will be forwarded to the Board of Directors following each Committee meeting.

6.3 Minutes of all Committee meetings will be available to all members of the Board on request.

7. RELATIONSHIP WITH OTHER GROUPS

7.1 The Committee shall have the power to establish sub-committees for the purpose of addressing specific tasks or areas of responsibility. In accordance with the Trust's Standing Orders, the Committee may not delegate powers to a sub-committee unless expressly authorised by the Trust Board.

7.2 The Committee will receive reports, in the form of Key Issues Reports, from the following:

- Patient Safety Group
- Clinical Effectiveness Group
- Patient Experience Group
- Health & Safety Joint Consultative Group
- Integrated Safeguarding Group

7.3 For the purpose of providing assurance regarding the controls in place for the management and mitigation of risks recorded on the Board Assurance Framework, the Committee (through its Chair) reports regularly to the Audit Committee.

8. REVIEW

8.1 The Committee will review its terms of reference and membership annually and recommend any changes to the Board for approval.

8.2 The Committee will review the effectiveness and performance of the Committee on an annual basis and report the outcome to the Board.

Stockport NHS Foundation Trust

Meeting date	6 April 2023	X	Public		Confidential	Agenda item
Meeting	Board of Directors					
Title	Board Committee Assurance – Key Issues & Assurance Reports					
Lead Director	Committee Chairs	Authors	Soile Curtis, Deputy Company Secretary			

Recommendations made / Decisions requested:

The Board of Directors is asked to:

- **Review and confirm the key issues and assurance provided in the Board Committee Reports.**
- **Review and support the Local Maternity and Neonatal Systems (LMNS) Submission as recommended by Quality Committee**
- **Approve the Policy for the Approval of Non-Audit and Additional Services by the Trust's External Auditors as recommended by Audit Committee**

This paper relates to the following Corporate Annual Objectives-

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

The paper relates to the following CQC domains-

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

This paper is related	x	**PR1.1**	There is a risk that the Trust does not deliver high quality of care to service users, which may lead to suboptimal patient safety, effectiveness and/or experience and failure to meet regulatory standards
	x	**PR1.2**	There is a risk that patient flow across the locality is not effective which may lead to potential harm,

to these BAF risks			suboptimal user experience, and inability to achieve national standards for urgent and elective care
	x	**PR1.3**	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan which may lead to suboptimal patient safety, outcomes and user experience and inability to achieve national standards for planned care
	x	**PR2.1**	There is a risk that the Trust fails to sufficiently engage and support our people, which may lead to low morale, higher turnover & sickness absence and gaps in the workforce that may impact on delivery of high-quality care
	x	**PR2.2**	There is a risk that the Trust's community services do not fully support neighbourhood working which may lead to suboptimal improvement in neighbourhood population health
	x	**PR3.1**	There is a risk in approving and implementing a new Provider Collaborative model to support delivery of priorities/objectives of the Stockport's ONE Health & Care (Locality) Board which may lead to a delay in delivery of models of care which support improvements in population health and operational recovery following the pandemic
	x	**PR3.2**	There is a risk that the Trust does not deliver a joint Clinical Strategy with East Cheshire NHS Trust (ECT), which may lead to suboptimal pathways of care and/or limited service resilience across the footprint of both Trusts
	x	**PR4.1**	There is a risk that the Trust does not implement high quality research & transformation programmes which may lead to suboptimal service improvements
	x	**PR5.1**	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit the optimal number of staff, with appropriate skills and values, which may lead to suboptimal staff and patient experience
	x	**PR5.2**	There is a risk that the Trust fails to have a workforce that is reflective of the communities served which may lead to staff with a protected characteristic having a suboptimal staff experience (career progression, turnover) and a poorer patient experience
	x	**PR6.1**	There is a risk that the Trust does not deliver the 2022/23 financial plan which may lead to a poor use of resources and increased regulatory intervention
	x	**PR6.2**	There is a risk that the Trust does not develop and agree with partners a multi-year financial recovery plan, optimising opportunities for financial recovery through system working, which may lead to a lack of financial sustainability
	x	**PR7.1**	There is a risk that the Trust does not implement the Digital Strategy designed to ensure a resilient and responsive digital infrastructure which may lead to inability to support improvements in quality of care and compromise of data/information
	x	**PR7.2**	There is a risk that the estate is not fit for purpose and/or meets national standards which may lead to inefficient utilisation of the estate to support high quality of care and increased health & safety incidents
	x	**PR7.3**	There is a risk that the Trust does not materially improve environmental sustainability which may lead to suboptimal support to locality ambitions and the NHS commitment to carbon reduction
	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 which may lead to an adverse long term impact on the Trust's capability to deliver modern and effective care

Where issues are addressed in the paper-

	Section of paper where covered
Equality, diversity and inclusion impacts	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 & Assurance 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 held during February and March 2023. In addition, a summary of key matters and decisions from the Audit Committee held on 9th February 2023 is provided, included recommendation to Board regarding approval of the

NHS Stockport NHS Foundation Trust

KEY ISSUES AND ASSURANCE REPORT
Finance & Performance Committee
16 February 2023

The Finance & Performance Committee draws the following matters to the Board of Director's attention-

Issue	Committee Update	Assurance received	Action	Timescale
Operational Performance Report	The Director of Operations presented the Operational Performance Report, including performance at the end of January 2023 against the strategic core operating standards, benchmarking of performance against the four key standards (A&E 4-hour standard, Cancer 62-day standard, 18-week Referral to Treatment (RTT) standard, and Diagnostic 6-week wait standard), and Productivity, Efficiency & Transformation. The Director of Operations highlighted the continued operational pressures and the impact of the various industrial actions taken place in January, including by the North West Ambulance Service (NWAS). The Director of Operations briefed the Committee on key pieces of work to address the issue of no criteria to reside (NCTR), including winter schemes and work around the community bed base offering. It was noted that approx. 25-30% of the Trust's NCTR cases related to local authorities outside of GM and that discussions were ongoing in this area.	The Committee reviewed and noted the Operational Performance Report for Month 10. The Committee heard that the Trust continued to perform below the national target against all of the core operating standards. Despite the continued operational challenges, the Committee heard that the Emergency Department (ED) performance had improved in January with reduced attends and better flow out of the department. With regard to forecast diagnostic performance, the Committee noted a small deterioration in month with Endoscopy and Echo remaining areas of concern. It was noted that the 62-day cancer performance remained at an improved level and the 18-week performance remained relatively unchanged, although the longest waits continued to reduce. The Director of Operations advised that the focus for the final quarter of the year was to eliminate all waits over 78 weeks by the end of March 2023.		
Finance Report	The Chief Finance Officer and Director of Finance provided an update on financial	The Committee received and noted the financial position as at Month 10.		

Issue	Committee Update	Assurance received	Action	Timescale
	performance for Month 10 2022/23. They advised that overall, the Trust's position at month 10 was £16.5m favourable to plan. The Committee heard that the year-end forecast was a deficit of £3.3m which was £19.7m favourable to plan, and that the positive movement from month 9 was due to additional system funding.	The Committee noted the bridge of the non-recurrent changes which had been agreed to as part of the GM position. The Chief Finance Officer advised that the allocation of the additional funding would be cash backed and therefore a significant improvement to this year's cash position, but highlighted a risk to cash flow for next year and beyond due to uncertainty in this area. The Committee heard that the Trust was still managing risks to achieve the revised year-end deficit of £3.3m due to issues such as high energy costs and other inflationary pressures, but noted that there was grip and control in place to manage these risks to ensure delivery.		
Procurement Update Report	The Director of Finance presented the Procurement Update Report.	The Committee noted the procurement exercises in progress over £750k and recommended the award of the Workforce Transformation Services contract to the Board of Directors for approval.	Contract award to the Board for approval	March 2023
Trust Planning	The Director of Strategy & Partnerships and Director of Finance provided a planning progress update presentation and the Committee heard that the final submission was due to GM on 16 March 2023. It was noted that the Board would be asked to approve the final submission.	The Committee noted the presentation and heard that a further update would be provided to the March Board meeting. The Committee received assurance that the Trust had a robust process in place to ensure the plans remained realistic.	An update to be provided to the Board	March 2023
Community Diagnostic Centre Update	The Director of Strategy & Partnerships provided a Community Diagnostic Centre (CDC) Update presentation. The Committee heard that the primary aims of the CDC was to improve population health outcomes, increase diagnostic capacity, improve productivity and efficiency, reduce health inequalities, deliver a better and more personalised diagnostic experience, and support integration of care.	The Committee noted the presentation and the ongoing work to establish a joint CDC across Stockport and Tameside.		

Issue	Committee Update	Assurance received	Action	Timescale
Standing Committees	• **Capital Programme Management Group (CPMG)** In response to a question about delays to the PM5 Panel Scheme due to the finding of asbestos, the Chief Finance Officer agreed to clarify the significance, consequence and whether the action had been completed and report back to the next meeting. • **Digital and Informatics Group**	The Committee received and noted the key issues and assurance reports.	With regard to the delays to the PM5 Panel Scheme due to the finding of asbestos, the Chief Finance Officer agreed to confirm the significance and whether the action had been completed and report back to the next meeting.	March 2023
Any Other Business	• **Committee Scheduling** The Committee noted that a number of the final performance figures were not available for the meeting and the Trust Secretary agreed to liaise with the Executive leads about the timing of Committee meetings going forward.		Discussion to be held about the timing of Committee meetings going forward with a recommendation to be brought back to the Committee.	March 2023

NHS Stockport NHS Foundation Trust

KEY ISSUES AND ASSURANCE REPORT
Finance & Performance Committee
16 March 2023

The Finance & Performance Committee draws the following matters to the Board of Director's attention -

Issue	Committee Update	Assurance received	Action	Timescale
Finance & Performance Committee Annual Review	The Finance & Performance (F&P) Committee considered the Committee Annual Review 2022/23, including revised Terms of Reference and Work Plan.	The Committee considered and confirmed the positive outcome of the F&P Committee Annual Review 2022/23, including the revised Terms of Reference and Work Plan 2023/24, and recommended them to the Board of Directors for approval subject to minor amendments.	Committee Annual Review 2022/23 to the Board of Directors for approval	April 2023
Approval of Terms of Reference and Work Plans for Subgroups	The Committee considered and approved the Terms of Reference and Work Plans for the Capital Programme Management Group and Digital and Informatics Group.	It was agreed that the Subgroup Annual Reports would be presented to the April Committee meeting.	Include Subgroup Annual Reports on the Committee Work Plan for April	April 2023
Operational Performance Report	The Director of Operations presented the Operational Performance Report, including performance at the end of February 2023 against the strategic core operating standards, benchmarking of performance against the four key standards (A&E 4-hour standard, Cancer 62-day standard, 18-week Referral to Treatment (RTT) standard, and Diagnostic 6-week wait standard), and Productivity, Efficiency & Transformation. The Director of Operations highlighted the continued operational pressures and described action to improve performance. The ongoing and significant challenge with out of area discharges, specifically to	The Committee reviewed and noted the Operational Performance Report for Month 11. The Committee heard that the Trust continued to perform below the national target against all of the core operating standards. It was noted that the operational performance would remain significantly challenged until further action to resolve no criteria to reside and bed occupancy position, particularly for out of area patients in Derbyshire, could be resolved. With regard to forecast diagnostic performance, the Committee noted a small deterioration in month with Endoscopy and Echocardiography remaining areas of concern. It was noted that the 62-day cancer performance remained at an	Highlight potential adverse impact of delayed discharge on quality of care and experience to Quality Committee. The ongoing and significant challenge with out of area discharges to be escalated to the Board.	April 2023 April 2023

Issue	Committee Update	Assurance received	Action	Timescale
	Derbyshire, was highlighted, noting the adverse impact on the no criteria to reside (NCTR) position. It was noted that further action and escalation was required to address the adverse impact on activity performance, finance and patient experience. In response to a discussion about the adverse impact of the delayed discharges on the quality of patient care and patient experience, it was suggested that this issue was highlighted to the Quality Committee.	improved level and the 18-week performance remained relatively unchanged. Albeit the longest waits continued to reduce, with continued focus on eliminating all long waits over 78 weeks by the end of March 2023, the Committee noted this would be challenging to achieve. Committee noted all patients waiting over 104 weeks had either chosen to wait or were unfit/clinically complex.		
Finance Report	The Chief Finance Officer and Director of Finance provided an update on financial performance for Month 11 2022/23. The overall Trust position at Month 11 was £18.3m favourable to plan. The Committee heard that the year-end forecast was a deficit of £3.3m which was £19.7m favourable to plan, and that the positive movement from Month 9 was due to additional system funding.	The Committee received and noted the financial position as at Month 11. As a result of the additional funding from the Greater Manchester ICS, the Committee has increased assurance regarding the Trust's full year financial outturn. The Committee noted challenges around capital expenditure, with options to fully utilise available resources being explored prior to year-end. It was noted that the Trust had maintained sufficient cash to operate during February, and noted cash forecast for next year remained a risk. The Committee noted the Greater Manchester (GM) position for 2023/24, with a current shortfall to achieve a balanced position, and further iterations of financial plans to improve financial performance required, including potential for increased efficiency requirements.		
Capital Programme 2023/24	The Director of Strategy & Partnerships presented a report providing a summary of the Trust's Capital Plan for 2023/24, reflecting the submission made to GM as part	The Committee noted the report, including prioritisation process in place to determine the capital programme, and supported recommendation to Board for approval of the	Capital Programme 2023/24 to the Board of Directors for approval	April 2023

Issue	Committee Update	Assurance received	Action	Timescale
	of the annual planning process. The Committee heard that the Capital Programme reflected committed business cases and development schemes, essential critical estate infrastructure and IT / digital upgrades, essential equipment replacement which the Trust had not been able to accelerate, and planning contingencies to take account of unforeseen failures or remedial works.	Capital Programme 2023/24. The Committee felt the paper would have provided greater assurance via clear link between programmes to the Board Assurance Framework / Strategic Risk Register and Corporate Objectives.		
Trust Planning	The Director of Strategy & Partnerships delivered a presentation providing a progress update on the updated plan, as delegated to the Executive Team, for submission to GM.	The Committee received and noted the planning presentation and current activity, workforce and financial position.		
Green Plan Progress Report	The Associate Director of Estates & Facilities presented a report providing an update on progress made against the Green Plan approved by the Board of Directors in February 2022. He briefed the Committee on progress made against the objectives of the Green Plan and actions being taken in order to reach net zero by 2040.	The Committee received and noted the report, confirming progress against the Green Plan during the first year of implementation.		
Board Assurance Framework (BAF) and Aligned Significant Risks	The Trust Secretary presented a report detailing the current position of the principal risks assigned to the Finance & Performance Committee.	The Committee reviewed and approved the 11 finance and performance related principal risks to be scheduled within the Board Assurance Framework 2022/23 to be presented to the Board of Directors in April 2023.	BAF 2022/23 to be presented to the Board of Directors for approval	April 2023
Standing Committees	• **Capital Programme Management Group (CPMG)** In response to a comment from the F&P Committee Chair regarding challenges in ensuring capital expenditure by year-end, the Chief Finance Officer provided an overview of the associated processes in place utilising best practice guidance and	The Committee received and noted the key issues and assurance reports.		

Issue	Committee Update	Assurance received	Action	Timescale
	noted discussion with External Audit colleagues in this area.			

NHS Stockport NHS Foundation Trust

KEY ISSUES AND ASSURANCE REPORT
People Performance Committee
9 March 2023

The People Performance Committee (PPC) draws the following matters to the Trust Board's attention-

Issue	Committee Update	Assurance received	Action	Timescale
Industrial Action	The Committee received an update about the continued application of processes to respond to industrial action across several staff groups.	Positive assurance that the systems and processes in place are appropriate whilst noting the uncertainty about the potential action in the weeks to come and likely escalation of the impact of strikes.		
People Integrated Performance Report	The Committee considered the People Performance Report and received an update on the following areas: sickness absence, statutory and mandatory training, safeguarding & resuscitation training, role specific training, appraisals, retention and vacancies, pay expenditure, recruitment pipeline and divisional profiles.	The Committee noted an improved sickness absence position in January 2023 and heard that the most common reason for sickness remained anxiety, stress and depression. The Committee acknowledged the improvement in sickness absence, which was particularly commendable given the significant operational pressures, and thanked staff for their commitment and hard work. The Committee heard that Freedom to Speak Up training compliance had been added this month as part of Role Specific compliance rate, which had impacted the overall compliance as anticipated. The Committee noted that actions were in place to improve the position. The Committee received positive assurance about reduced turnover with divisions focusing on recruiting to establishment and reducing vacancies. It was noted that bank and agency usage remained high as the		

Issue	Committee Update	Assurance received	Action	Timescale
		Trust continued to experience operational challenges with escalation beds remaining open. The Committee acknowledged the adverse impact of the industrial action and operational pressures on appraisal and mandatory training compliance whilst patient safety and care was prioritised. The Committee welcomed the improvements in safeguarding and resuscitation training.		
Annual Workforce Equality Monitoring Report	The Committee considered the Annual Workforce Equality Monitoring Report which provided information on the Trust's workforce demographic during 2022 segregated between protected characteristics.	The Committee received information about the Trust's areas of focus, including increasing Black, Asian and Minority Ethnic (BAME) representation at senior leadership positions.	The Committee considered the Trust's compliance with the Equality Duty and approved the Annual Workforce Equality Monitoring Report for publication on the Trust's website.	March 2023
Gender Pay Gap Report 2021/22	The Committee considered a Gender Pay Gap Report 2021/22, which trusts were required to publish on an annual basis.	The Committee heard that the Trust's mean gender pay gap had reduced by nearly 1% from last year, with the median pay gap increasing slightly. It was noted that the recruitment, retention and progression priorities in the Equality, Diversity & Inclusion Strategy sought to address the disparity. It was noted that addressing the widening of the gap between men and women receiving bonuses was also a focus for the Trust.	The Committee approved the report for publication to the UK Government's Gender Pay Gap reporting portal and the Trust's website.	March 2023

Issue	Committee Update	Assurance received	Action	Timescale
Staff Survey	The Committee considered the results of the 2022 National Staff Survey and heard that the survey had been sent to 5,906 staff members, with a response rate of 42.4%.	The Committee was advised that 3 questions had scored significantly better and 9 questions significantly worse compared to the previous year's survey. It was noted that the Trust had scored better than the sector benchmark for 24 questions and significantly worse for 9 questions. The Committee was advised that following the publication of the final national results with benchmarking data, results would be shared sequentially with the Executive Team, the Board of Directors, Divisional Leaders and local leadership teams. Divisions would be required to identify 3 areas for celebration and 3 areas for improvement from their divisional staff survey results and prepare activity to celebrate and/or improve scores over the next 12 months, with plans to be monitored through the People Engagement and Leadership Group. A robust internal communications plan would be implemented to ensure that the workforce are made aware of the survey results and to engage staff in co-designing the solutions that will make the Trust a great place to work.		

Issue	Committee Update	Assurance received	Action	Timescale
Board Assurance Framework (BAF) and Aligned Significant Risks	The Committee reviewed the Board Assurance Framework and aligned significant risks.	Positive assurance about the alignment of the Committee work plan and agenda with the relevant risks.	The Committee reviewed and approved the people related principal risks to be included within the Board Assurance Framework 2022/23 to be presented to the Board of Directors in April 2023.	April 2023
Annual Review	• **2023/24 People & Organisational Development (OD) Directorate Priorities** The Committee reviewed the 2023/24 People & OD priorities relating to the OD plan, Equality, Diversity & Inclusion (EDI), Place Based Programmes, Collaboration, Medical Staffing / Agency Expenditure and Sickness Absence.	The Committee received and noted the 2023/24 People & Organisational Development Directorate Priorities and their alignment with Staff Survey results, People Plan and EDI Strategy.		
	• **People Performance Committee Annual Review (including review of Terms of Reference and Work Plan 2023/24)** The Committee reviewed the People Performance Committee Annual Review 2022/23.	The Committee reviewed and supported recommendation of the following to the Board of Directors for approval: - People Performance Committee Annual Review confirming the effective operation of the Committee in line with its Terms of Reference - People Performance Committee Terms of Reference - People Performance Committee Work Plan 2023/24	The Committee recommended the Annual Review (including Terms of Reference and Work Plan) to the Board of Directors for approval.	April 2023

Issue	Committee Update	Assurance received	Action	Timescale
Subgroup Terms of Reference for Approval	The Committee reviewed and approved the following subgroup Terms of Reference: • People Engagement & Leadership Group • Educational Governance Group • Equality, Diversity & Inclusion Group			
Policy Report	The Committee approved the following policies: • Performance Improvement Policy • Policy on Claiming Expenses • Policy on Term Time Working • Freedom to Speak Up Policy			
Key Issues and Assurance Reports	The Committee received and noted the following key issues and assurance reports: • People, Engagement & Leadership Group • Equality, Diversity & Inclusion Group • Educational Governance Group			

Assurance gained includes the Committee receiving evidence that:

i. The extent of the issue has been quantified;
ii. The impact is included in all internal and external reporting
iii. There are processes in place to learn from the occurrence, and measures have been put into place to prevent them happening again

KEY ISSUES AND ASSURANCE REPORT ***Quality Committee*** ***28th February 2023 & 28th March 2023***				
The Quality Committee draws the following matters to the Board of Director's attention-				
Issue	**Committee Update**	**Assurance received**	**Action**	**Timescale**
Patient Story February & March 2023	The Committee heard a patient story, the objective of which was to remind us why we are here and the values we have.	Positive assurance on: • The introduction of Quiet Rooms in response to patient and staff experiences • Gift Boxes for patients in Acute Frailty Unit comprising of donated gifts to support safe discharge home		
Action Log February & March 2023	All outstanding actions for February and March 2023 were reviewed, with updates on progress or completion or on the agenda.	Positive assurance that actions are being undertaken and progressed. Awaiting national guidance regarding imminent changes to Deprivation of Liberty Safeguards (DOLS) processes.	Update on DOLS awaiting national guidance	TBC
BAF Principal Risks & Aligned Significant Risks March 2023	The Trust Secretary presented the two principal risks from the Board Assurance Framework 2022-23.	Assurance sought that the committee remained cognisant of the current pressures in the Trust and wider system in assessing the risk score for Principal Risk 1.2 relating to quality of care. Board Assurance Framework for 2023/24 to be developed in line with Corporate Objectives, with relevant risks to be developed via Quality Committee.	Consider disaggregation of Principal Risk 4.1 relating to transformation and research & development for 2023/24	Q1 2023/24
Mental Health Plan Progress	The Medical Director and Deputy Chief Nurse presented the Mental Health plan update on the	Positive assurance that much activity is being undertaken training package	Training Needs Analysis to	Q2 2023

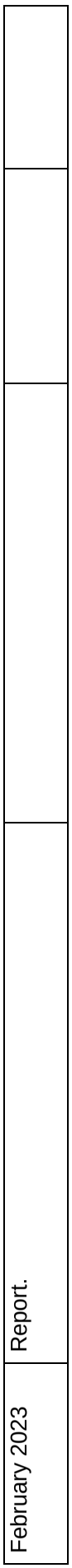
Report March 2023	following objectives: Mental Health Awareness: 90% of all staff will be trained to improve the experience of service users with mental health needs by 31st December 2024 Learning from experience: Pathways of care for service Users Collaboration: Improving the service user experience	sourced via eLearning for Healthcare for Maternity, Emergency Medicine and Healthcare Professionals. The Committee look forward to receiving assurance regarding compliance and uptake of training packages along with TNA's	commence with planned go-live of training package date of Q2 2023. Update on metrics for training and TNA's	September 2023
Patient Flow Associated Harms Review – February 2023	The Medical Director presented the Patient Flow Associated Harms Review, supplementing the 'Waiting Lists Harms' report presented on a regular basis to Quality Committee.	Quality Committee recognised the potential wide-ranging scope of patient flow associated harms including safety, effectiveness, and experience (both patients and staff) and surveillance beyond the Emergency Department and noted the reporting process would be an iterative one. A range of metrics reviewed relating to flow in ED. No significant harm reported, and further assurance considered.	Patient harm review under consideration for triangulation and incorporation across regular Quality Committee reports ahead of next update. StARS, IPR, KIR from subgroups etc.	June 2023
Maternity Services Reports: Maternity Improvement Plan Progress Report	The Divisional Director of Midwifery & Nursing presented the Maternity Service Report incorporates all improvement/action plans the service was currently working towards including: - CNST Year 4 - Saving Babies Lives (SBL) - Continuity of Carer pathway (COC) - Maternity Safety Support Programme (MSSP) - Ockenden Report - East Kent Report - Kirkup	A comprehensive assurance based report was received. Positive assurance by way of gap analysis in respect of the East Kent report, Ockenden report and Kirkup Report (national reports with recommendations for improvement and safety. Where gaps, none or partial compliance	Reports to be presented to the Quality Committee on a quarterly basis	June 2023

	- Maternity Voices Partnership (MVP) - Maternity and Perinatal Safety Champions	was noted there was evidence of progress to compliance and action being undertaken, alongside the timescale prescribed. Positive assurance on the work and engagement of Safety Champions. It was noted that East Cheshire NHS, plan for the return of Maternity Services from SFT in July 2023, with impact on staffing and service delivery to SFT considered and significant concerns identified.		
Local Maternity and Neonatal Systems (LMNS) Submission March 2023	The Divisional Director of Midwifery & Nursing presented the quarterly submission to the Local Maternity and Neonatal Systems (LMNS) in Greater Manchester and East Cheshire (GMEC), including progress with Ockenden, East Kent, and the single plan recommendations when published (Appendix 1 & 2)	Committee confirmed the position as detailed within the return against the Ockenden and Kirkup recommendations and immediate and essential actions as below: The Trust has declared full compliance against the recommendations in the Kirkup Report, apart from full compliance against question 28 - Ensure that staff undertaking incident investigations have received appropriate education and training to undertake this effectively The trust has declared full compliance against 40 of the 48 questions relating to the 7 immediate and essential actions from the initial Ockenden Report. Associated actions to achieve full	Quality Committee recommend the quarterly safety assurance return as required to be submitted to the LMNS, to be reported to the Board of Directors	April 2023

		compliance where not yet confirmed considered by Committee and determined as appropriate.		
Notification of Serious Incidents February & March 2023	Notification of Serious Incidents (SI) Report The Deputy Director of Quality Governance presented the Notification of Serious Incidents Report including update on serious incidents (as defined within the 2015 Serious Incident Framework) and inquests, concerning Stockport NHS Foundation Trust, during February 2023.	Positive assurance received, Serious Incidents remain within control limits. In February 2023: 3 serious incidents were declared to the ICB via StEIS Compliance with Duty of Candour, by letter, sent within 10 days was 100% There were no overdue reports to the ICB 4 investigations were completed and signed off through the Serious Incident Review Group. Actions identified to reduce the likelihood of the same incident happening again are in the process of being implemented. There were 0 de-escalation requests made to the ICB. There was 1 outstanding serious incident action plan The Trust received no new PFD notice from the Coroner in February 2023	Iterative review of report format in line with the introduction of PSIRF	Ongoing
Integrated Performance Report – Quality & Safety	The IPR Report was presented, reviewed, and noted. Assurance was reviewed and agreed, and further actions and focus agreed.	The Committee identified that the IPR triangulates with assurances on performance identified throughout the meeting, with remaining metrics considered by exception. This reporting period continues to see no improvement Hospital Standard Mortality rate with SFT continuing to remain outside the control limit. One of only two	IPR escalated to Board as part of Trust IPR	April 2023

		GM Trusts in the 'red zone'. Clinical audit of UTI and Neck of Femur undertaken, with general adherence to standards, and further consideration of clinical coding required. Negative assurance for the anticipated improvement for C-difficile anticipated following a change in prescribing. Whilst antimicrobial vigilance was continued in an inpatient setting a high incidence of prescribing in the community did not support the improvement. There was limited assurance that the Trust would achieve its pressure ulcer reduction by end of Q4. Negative assurance to impact No Criteria to Reside. Positive assurance on achieving target % decrease in falls. Positive assurance that a good number of quality metrics remained on track		
Patient Safety Group Key Issues & Assurance Report – February & March 2023	The Medical Director presented the Patient Safety Group Key Issues & Assurance Report (KI&AR)	Patient Safety Group Limited assurance in relation to provision of cervical screening services including colposcopy and histopathology. Limited assurance was provided regarding oxygen prescribing – where a snapshot audit had identified supplemental oxygen was not being	Monitored via the Clinical Effectiveness Group. Group is being set up to look at ways of improving	June 2023

		prescribed as required. Positive assurance provided regarding the ongoing work relating to quality and safety improvement with continued attention and focus required upon sustaining improvement in pressure ulcer reductions Positive assurance provided regarding on-going work to reduce falls across the organisation. Trust target is a 10% reduction in overall falls and falls with moderate or above harm with the Trust on track to meet target. Escalation of the medical staffing in microbiology. Mitigated by short term locums with future plans required.	oxygen prescribing.	
Health & Safety JCG Key Issues & Assurance Report – February & March 2023	The Deputy Director of Quality Governance presented the Health & Safety Key Issues & Assurance Report including update on:	Positive assurance was received from groups reporting into the HSJCG during March 2023. Partial assurance on re engagement with Staff Side. RCN Rep. present. Full assurance from divisional safety and performance monitoring and RIDDOR Reporting.		
Patient Experience Group Key Issues & Assurance Report –	The Deputy Chief Nurse presented the Patient Experience Group Key Issues & Assurance Report including update on the following: Quality Committee reviewed and confirmed the Patient Experience Group Key Issues & Assurance	Quality Committee was assured on progress and actions taken.		


February 2023
Report.

Meeting date	28th March 2023	√	Public		Confidential	Agenda item
Meeting	Quality Committee					
Title	Local Maternity and Neonatal System (LMNS) safety assurance return.					
Lead Director	Andrew Loughney, Medical Director Nic Firth, Chief Nurse		Author	Divisional Director of Midwifery & Nursing / Deputy Head of Midwifery/ Business Planning Manager		

Recommendations made / Decisions requested.

Quality Committee is asked to receive the quarterly safety assurance return as required to be submitted to the LMNS and provide confirmation of progress to the Board.

This paper relates to the following Corporate Annual Objectives-

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

The paper relates to the following CQC domains-

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

This paper is related to these BAF risks	x	**PR1.1**	There is a risk that the Trust does not deliver high quality of care to service users, which may lead to suboptimal patient safety, effectiveness and/or experience and failure to meet regulatory standards
		PR1.2	There is a risk that patient flow across the locality is not effective which may lead to potential harm, suboptimal user experience, and inability to achieve national standards for urgent and elective care
		PR1.3	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan which may lead to suboptimal patient safety, outcomes and user experience and inability to achieve national standards for planned care
		PR2.1	There is a risk that the Trust fails to sufficiently engage and support our people, which may lead to low morale, higher turnover & sickness absence and gaps in the workforce that may impact on delivery of high-quality care
		PR2.2	There is a risk that the Trust's community services do not fully support neighbourhood working which may lead to suboptimal improvement in neighbourhood population health
		PR3.1	There is a risk in approving and implementing a new Provider Collaborative model to support delivery of priorities/objectives of the Stockport's ONE Health & Care (Locality) Board which may lead to a delay in delivery

			of models of care which support improvements in population health and operational recovery following the pandemic
		PR3.2	There is a risk that the Trust does not deliver a joint Clinical Strategy with East Cheshire NHS Trust (ECT), which may lead to suboptimal pathways of care and/or limited service resilience across the footprint of both Trusts
		PR4.1	There is a risk that the Trust does not implement high quality research & transformation programmes which may lead to suboptimal service improvements
		PR5.1	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit the optimal number of staff, with appropriate skills and values, which may lead to suboptimal staff and patient experience
		PR5.2	There is a risk that the Trust fails to have a workforce that is reflective of the communities served which may lead to staff with a protected characteristic having a suboptimal staff experience (career progression, turnover) and a poorer patient experience
		PR6.1	There is a risk that the Trust does not deliver the 2022/23 financial plan which may lead to a poor use of resources and increased regulatory intervention
		PR6.2	There is a risk that the Trust does not develop and agree with partners a multi-year financial recovery plan, optimising opportunities for financial recovery through system working, which may lead to a lack of financial sustainability
		PR7.1	There is a risk that the Trust does not implement the Digital Strategy designed to ensure a resilient and responsive digital infrastructure which may lead to inability to support improvements in quality of care and compromise of data/information
		PR7.2	There is a risk that the estate is not fit for purpose and/or meets national standards which may lead to inefficient utilisation of the estate to support high quality of care and increased health & safety incidents
		PR7.3	There is a risk that the Trust does not materially improve environmental sustainability which may lead to suboptimal support to locality ambitions and the NHS commitment to carbon reduction
		PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus which may lead to an adverse long term impact on the Trust's capability to deliver modern and effective care

Where issues are addressed in the paper-

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

Executive Summary

The Trust is required to update the LMNS on progress with Ockenden, East Kent and the single plan recommendations when published.

The LMNS has a responsibility to improve oversight and safety assurance across Maternity Services in in Greater Manchester and East Cheshire (GMEC), as recommended by the National Quality Board on Systems Group and the revised Perinatal Quality Surveillance Model, to ensure that safer outcomes for pregnant women/Birthing people and babies are achieved.

The system has introduced a quarterly Safety Progress and Performance Special Interest Group (SPP SIG) to demonstrate that these principles are implemented into the LMNS governance structure.

Annex A Is the Ockenden - Kirkup return 2023 demonstrating the Trusts level of implementation to date.

The data return will be presented on a quarterly basis to Quality Committee and onward to the Board of Directors via the Quality Key Issues Report.

1. Purpose

1.1 The purpose of this paper is to give an overview of the requirements of the LMNS from the Trust in providing assurance against the progress of Ockenden, East Kent and the proposed single plan.

2. Background and Links to Previous Papers

2.1 The Local Maternity and Neonatal System (LMNS) has a responsibility to improve oversight and safety assurance across Maternity Services in Greater Manchester and East Cheshire (GMEC), as recommended by the National Quality Board on Systems Group and the revised Perinatal Quality Surveillance Model, to ensure that safer outcomes for pregnant women/Birthing people and babies are achieved.

2.2 The LMNS as a result has developed a Safety Progress and Performance Special Interest Group (SPP) where Trusts are required to provide a quarterly update on progress against recommendations and actions from the national reports.

2.3 This paper links with the information provided in the quarterly maternity services update report to Quality Committee, which includes progress and actions in relation to the national reports.

3. Matters under consideration.

3.1 This is the first quarterly data return where the trust will share progress with the LMNS against the Ockenden and Kirkup recommendations and immediate and essential actions.

3.2 The trust has declared full compliance against the recommendations in the Kirkup report, apart from full compliance against questions 28;

- Ensure that staff undertaking incident investigations have received appropriate education and training to undertake this effectively
    - All consultants to have completed RCA training.
    - Develop a local record of staff who have completed RCA training and the investigations undertaken (including dates)

- The trust had previously declared full compliance with this question. It has been acknowledged that as Trusts are moving towards the Patient Safety Incidence Response Framework (PSIRF) for responding to patient safety incidents, this question is no longer relevant. Consultants will complete PSIRF training and a local record of staff who have completed PSIRF training will be developed to monitor compliance.

3.3 The trust has declared **full compliance** against **40** of the **48** questions relating to the 7 immediate and essential actions from the initial Ockenden report (Appendix A has the full breakdown of all questions).

3.4 The remaining **8** questions are currently **partially compliant.** A summary of these questions with associated actions is outlined in the table below.

IEA	Question	Evidence required	RAG rating	Action/Info
IEA 1. Enhanced Safety	**Q4.** Using the National Perinatal Mortality Review Tool to review perinatal deaths	Audit of 100% of PMRT completed demonstrating meeting the required standard including parents notified as a minimum and external review		2 out of 5 baby reviews did not meet the requirement for an element of standard 1 of the PMRT. This was identified as a technical error with regard to the timeframe for completion of factual questions and corrected immediately, with no adverse effects to families. The trust is complaint with all other aspects of the PMRT and submitted a mitigation letter to be considered by NHSR when reviewing compliance.
IEA 3. Staff training and working together.	**Q 18.** Twice daily consultant-led and present multidisciplinary ward rounds on the labour ward. **Q22.** Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.	Evidence of scheduled MDT ward rounds taking place since December, twice a day, day & night. 7 days a week (e.g. audit of compliance with SOP) Evidence of scheduled MDT ward rounds taking place since December 2020 twice a day, day & night; 7 days a week (e.g. audit of compliance with SOP)		Audits in place, showing compliance 5 days per week and 6 out of 8 weekends. This will be fully compliant from April following the commencement of our 2nd Consultant.
IEA 4. Managing complex pregnancy	**Q28.** All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.	Submission of an audit plan to regularly audit compliance		Audits undertaken adhoc.currently. Quarterly audit schedule in development, to be accessible via AMaT from April 2023, therefore will be fully compliant.
IEA 5. Risk assess throughout pregnancy	**Q30.** All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional. **Q31.** Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture. **Q33.** A risk assessment at every contact. Include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PCSP). Regular audit	Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above.		Audits undertaken adhoc currently. Quarterly audit schedule in development, to be accessible via AMaT from April 2023, therefore will be fully compliant.

	mechanisms are in place to assess PCSP compliance**.**			
IEA 7. Informed consent	**Q42.** Women's choices following a shared and informed decision-making process must be respected	An audit of 5% of notes demonstrating compliance, this should include women who have specifically requested a care pathway which may differ from that recommended by the clinician during the antenatal period, and also a selection of women who request a caesarean section during labour or induction.		Audits undertaken adhoc currently. Quarterly audit schedule in development, to be accessible via AMaT from April 2023, therefore will be fully compliant.

Completion Guidance:		
Please complete each tab demonstrating your level of implementation at the time of reporting		
Tab:		
1	**Submission Overiew**	Please complete in full
2	**Ockenden return**	This mirrors earlier returns and requires updating on progress up to the date of competion - Please report on your percentage of compliance. It will RAG rate automatically.
3	**Kirkup return**	Please note some recommendations have been greyed out – these do not require completion as they are superseded by information in the Ockenden recommendations.
4	**Kirkup recommendations**	Details the Kirkup recommendations as a helpful reminder – this doesn't require any completion.

Internal trust governance

	Confirmation of / or planned Public Trust Board update on progress against the Ockenden action plan	Date of Public Board update	Executive sign off of this return		
	Yes/No	please insert date	**Date**	**Name**	**Role**
Stockport NHS FT	Y		02/03/2023	Nic Firth	Chief Nurse
Insert Trust Name					
Insert Trust Name					
Insert Trust Name					

Submission dates	**Meeting Dates**
Monday 27th February 2023	Tuesday 7th March 2023
Wednesday 19th April 2023	Wednesday 26th April 2023
Wednesday 19th July 2023	Wednesday 26th July 2023
Thursday 19th October 2023	Wednesday 25th October 2023
Wednesday 24th January 2024	Friday 19th January 2024

Ockenden Initial report recommendations

IEA	Question	Action	Evidence Required	GMEC August 2021 Submission - STOCKPORT NHS FOUNDATION TRUST	GMEC March 2022 - STOCKPORT NHS FOUNDATION TRUST	Isight Visit Date of insight visit to populate	Self Report with % of compliance Report to LMNS by 27th February 2023	Details of action to be taken if partially or not compliant	Self Report with %of compliance Report to LMNS by 19th April 2023	Details of action to be taken if partially or not compliant	Initial Self Report with % of compliance Report to LMNS by 19th July 2023	Details of action to be taken if partially or not compliant
IEA1 Enhanced Safety	Q1	Are maternity dashboards a formal item on LMNS agendas at least every 3 months?	Dashboard to be shared as evidence.	100%	100%		100%					
			Minutes and agendas to identify regular review and use of common data dashboards and the response / actions taken.	100%	100%		100%					
			SOP required which demonstrates how the trust reports this both internally and externally through the LMS.	100%	100%		100%					
			Submission of minutes and organogram, that shows how this takes place.	100%	100%		100%					
		Maternity Dashboard to LMS every 3 months Total		**100%**	**100%**		100%					
	Q2	External clinical specialist opinion for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death	Audit to demonstrate this takes place.	0%	100%		100%					
			Policy or SOP which is in place for involving external clinical specialists in reviews.	100%	100%		100%					
		External clinical specialist opinion for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death Total		**50%**	**100%**		100%					
	Q3	Maternity SI's to Trust Board & LMS every 3 months	Individual SI's, overall summary of case, key learning, recommendations made, and actions taken to address with clear timescales for completion	100%	100%		100%					
			Submission of private trust board minutes as a minimum every three months with highlighted areas where SI's discussed	100%	100%		100%					
			Submit SOP	0%	100%		100%					
		Maternity SI's to Trust Board & LMS every 3 months Total		**67%**	**100%**		100%					
	Q4	Using the National Perinatal Mortality Review Tool to review perinatal deaths	Audit of 100% of PMRT completed demonstrating meeting the required standard including parents notified as a minimum and external review.	100%	100%		60%					
			Local PMRT report. PMRT trust board report. Submission of a SOP that describes how parents and women are involved in the PMRT process as per the PMRT guidance.	100%	100%		100%					
		Using the National Perinatal Mortality Review Tool to review perinatal deaths Total		**100%**	**100%**		60%					
	Q5	Submitting data to the Maternity Services Dataset to the required standard	Evidence of a plan for implementing the full MSDS requirements with clear timescales aligned to NHSR requirements within MIS.	100%	100%		100%					
		Submitting data to the Maternity Services Dataset to the required standard Total		**100%**	**100%**		100%					
	Q6	Reported 100% of qualifying cases to HSIB / NHS Resolution's Early Notification scheme	Audit showing compliance of 100% reporting to both HSIB and NHSR Early Notification Scheme.	100%	100%		100%					
		Reported 100% of qualifying cases to HSIB / NHS Resolution's Early Notification scheme Total		**100%**	**100%**		100%					
	Q7	Plan to implement the Perinatal Clinical Quality Surveillance Model	Full evidence of full implementation of the perinatal surveillance framework by June 2021.	100%	100%		100%					
			LMS SOP and minutes that describe how this is embedded in the ICS governance structure and signed off by the ICS.	100%	100%		100%					
			Submit SOP and minutes and organogram of organisations involved that will support the above from the trust, signed of via the trust governance structure.	0%	100%		100%					
		Plan to implement the Perinatal Clinical Quality Surveillance Model Total		**67%**	**100%**		100%					
	Q8	**Same as Q3**										
IEA1 Total				**81%**								
	Q9	**N/A**										
	Q10	**N/A**										
	Q11	Non-executive director who has oversight of maternity services, (Is there an allocated Non-Executive at Board level who works collaboratively with the maternity safety champions?)	Evidence of how all voices are represented:	100%	100%		100%					
			Evidence of link in to MVP; any other mechanisms	100%	100%		100%					
			Evidence of NED sitting at trust board meetings, minutes of trust board where NED has contributed	100%	100%		100%					
			Evidence of ward to board and board to ward activities e.g. NED walk arounds and subsequent actions	100%	100%		100%					
			Name of NED and date of appointment	100%	100%		100%					
			NED JD	100%	100%		100%					
		Non-executive director who has oversight of maternity services Total		**100%**	100%		100%					

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IEA2 Listening to Women and Families	Q12	Same as Q4										
	Q13	Demonstrate mechanism for gathering service user feedback, and work with service users through Maternity Voices Partnership to coproduce local maternity services	Clear co-produced plan, with MVP's that demonstrate that co production and co-design of service improvements, changes and developments will be in place and will be embedded by December 2021.	100%	100%		100%					
			Evidence of service user feedback being used to support improvement in maternity services (E.G you said, we did, FFT, 15 Steps)	100%	100%		100%					
			Please upload your CNST evidence of co-production. If utilised then upload completed templates for providers to successfully achieve maternity safety action 7. CNST templates to be signed off by the MVP.	100%	100%		100%					
		Demonstrate mechanism for gathering service user feedback, and work with service users through Maternity Voices Partnership to coproduce local maternity services Total		**100%**	100%		100%					
	Q14	Trust safety champions (Midwifery and Obstetrician) meeting bimonthly with Board level champions	Action log and actions taken.	100%	100%		100%					
			Log of attendees and core membership.	100%	100%		100%					
			Minutes of the meeting and minutes of the LMS meeting where this is discussed.	100%	100%		100%					
			SOP that includes role descriptors for all key members who attend by-monthly safety meetings.	0%	100%		100%					
		Trust safety champions meeting bimonthly with Board level champions Total		**75%**	**100%**		100%					
	Q15	Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services.	Clear co produced plan, with MVP's that demonstrate that co-production and co-design of all service improvements, changes and developments will be in place and will be embedded by December 2021.	100%	100%		100%					
		Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services Total		**100%**	**100%**		100%					
	Q16	Non-executive director support the Board maternity safety champion	Evidence of participation and collaboration between ED, NED and Maternity Safety Champion, e.g. evidence of raising issues at trust board, minutes of trust board and evidence of actions taken	0%	100%		100%					
			Name of ED and date of appointment	100%	100%		100%					
			Role descriptors	100%	100%		100%					
		Non-executive director support the Board maternity safety champion Total		**67%**	**100%**		100%					
IEA2 Total				**88%**	**100%**							
	Q17	Multidisciplinary training and working occurs. Evidence must be externally validated through the LMNS, 3 times a year via TNA Template.	A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	100%	100%		100%					
			LMNS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data.	0%	50%		100%					
			Submit evidence of training sessions being attended, with clear evidence that all MDT members are represented for each session.	100%	100%		100%					
			Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements.	100%	100%		100%					
			Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place.	100%	100%		100%					
		Multidisciplinary training and working occurs. Evidence must be externally validated through the LMS, 3 times a year. Total		**80%**	**100%**		100%					
	Q18	Twice daily consultant-led and present multidisciplinary ward rounds on the labour ward.	Evidence of scheduled MDT ward rounds taking place since December, twice a day, day & night. 7 days a week (e.g. audit of compliance with SOP)	100%	75%		75%					
			SOP created for consultant led ward rounds.	0%	100%		100%					
		Twice daily consultant-led and present multidisciplinary ward rounds on the labour ward. Total		**50%**	**75%**		75%					
		External funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only	Confirmation from Directors of Finance	0%	100%		100%					
			Evidence from Budget statements.	100%	100%		100%					
			Evidence of funding received and spent.	100%	100%		100%					

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IEA3 Staff Training and working together	Q19		Evidence that additional external funding has been spent on funding including staff can attend training in work time.	100%	100%		100%					
			MTP spend reports to LMS	0%	100%		100%					
		External funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only Total		**60%**	**100%**		100%					
	Q20	**N/A**										
	Q21	90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session	A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	100%	100%		100%					
			Attendance records - summarised	100%	100%		100%					
			LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data. Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place.	0%	50%		100%					
		90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session Total		**67%**	**100%**		100%					
	Q22	Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.	Evidence of scheduled MDT ward rounds taking place since December 2020 twice a day, day & night; 7 days a week (E.G audit of compliance with rota	100%	75%		75%					
		Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week. Total		**100%**	**75%**		75%					
	Q23	Is MDT schedule for training in place?	A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	100%	100%		100%					
			LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation described as checking the accuracy of the data.	0%	50%		100%					
		The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in		**50%**	**100%**		100%					
IEA3 Total				**67%**								
IEA4 Managing Complex Pregnancy	Q24	Links with the tertiary level Maternal Medicine Centre & agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre	Audit that demonstrates referral against criteria has been implemented that there is a named consultant lead, and early specialist involvement and that a Management plan that has been agreed between the women and clinicians	0%	100%		100%					
			SOP that clearly demonstrates the current maternal medicine pathways that includes: agreed criteria for referral to the maternal medicine centre pathway.	100%	100%		100%					
		Links with the tertiary level Maternal Medicine Centre & agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist		**50%**	**100%**		100%					
	Q25	Women with complex pregnancies must have a named consultant lead	Audit of 1% of notes, where all women have complex pregnancies to demonstrate the woman has a named consultant lead	100%	100%		100%					
			SOP that states that both women with complex pregnancies who require referral to maternal medicine networks and women with complex pregnancies but who do not require referral to maternal medicine network must have a named consultant lead.	100%	100%		100%					
		Women with complex pregnancies must have a named consultant lead Total		**100%**	**100%**		100%					
	Q26	Complex pregnancies have early specialist involvement and management plans agreed	Audit of 1% of notes, where women have complex pregnancies to ensure women have early specialist involvement and management plans are developed by the clinical team in consultation with the woman.	100%	100%		100%					
			SOP that identifies where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the teams.	100%	100%		100%					
		Complex pregnancies have early specialist involvement and management plans agreed Total		**100%**	**100%**		100%					
	Q27	Compliance with all five elements of the Saving Babies' Lives care bundle Version 2	Audits for each element.	100%	100%		100%					
			Guidelines with evidence for each pathway	100%	100%		100%					

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			SOP's	100%	100%		100%					
		Compliance with all five elements of the Saving Babies' Lives care bundle Version 2 Total		**100%**	**100%**		100%					
	Q28	All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.	SOP that states women with complex pregnancies must have a named consultant lead.	100%	100%		100%					
			Submission of an audit plan to regularly audit compliance	100%	100%		50%					
		All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place. Total		**100%**	**100%**		50%					
	Q29	Do you have agreed maternal medicine specialist centre?	Agreed pathways	100%	100%		100%					
			Criteria for referrals to MMC	100%	100%		100%					
			The maternity services involved in the establishment of maternal medicine networks evidenced by notes of meetings, agendas, action logs.	100%	100%		100%					
		Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres Total		**100%**	**100%**		100%					
IEA4 Total				**93%**	**100%**							
	Q30	All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional	How this is achieved within the organisation.	100%	100%		100%					
			Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above.	100%	100%		50%					
			Review and discussed and documented intended place of birth at every visit.	100%	100%		100%					
			SOP that includes definition of antenatal risk assessment as per NICE guidance.	0%	100%		100%					
			What is being risk assessed.	0%	100%		100%					
		All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional Total		**60%**	**100%**		75%					
	Q31	Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.	Evidence of referral to birth options clinics	100%	100%		100%					
			Out with guidance pathway.	100%	100%		100%					
			Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above.	100%	100%		50%					
			SOP that includes review of intended place of birth.	0%	100%		100%					
		Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture. Total		**75%**	**100%**		75%					
	Q32	**Same as Q27**										
	Q33	A risk assessment at every contact. Include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance.	Example submission of a Personalised Care and Support Plan (It is important that we recognise that PCSP will be variable in how they are presented from each trust)	100%	100%		100%					
			How this is achieved in the organisation	100%	100%		100%					
			Personal Care and Support plans are in place and an ongoing audit of 5% of records that demonstrates compliance of the above.	100%	100%		50%					
			Review and discussed and documented intended place of birth at every visit.	100%	100%		100%					
			SOP to describe risk assessment being undertaken at every contact.	0%	100%		100%					
			What is being risk assessed.	0%	100%		100%					
		A risk assessment at every contact. Include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance. Total		**67%**	**100%**		83%					
IEA5 Total				**67%**	**100%**							
	Q34	Appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring	Copies of rotas / off duties to demonstrate they are given dedicated time.	0%	100%		100%					
			Examples of what the leads do with the dedicated time E.G attendance at external fetal wellbeing event, involvement with training, meeting minutes and action logs.	100%	100%		100%					
			Incident investigations and reviews	100%	100%		100%					

IEA5 Risk assess throughout pregnancy

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IEA6 Monitoring Fetal Wellbeing			Name of dedicated Lead Midwife and Lead Obstetrician	100%	100%		100%					
		Appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring Total		**75%**	**100%**		100%					
	Q35	The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on elements of fetal health	Consolidating existing knowledge of monitoring fetal wellbeing	100%	100%		100%					
			Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported e.g clinical supervision	0%	100%		100%					
			Improving the practice & raising the profile of fetal wellbeing monitoring	0%	100%		100%					
			Interface with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.	0%	100%		100%					
			Job Description which has in the criteria as a minimum for both roles and confirmation that roles are in post	100%	100%		100%					
			Keeping abreast of developments in the field	0%	100%		100%					
			Lead on the review of cases of adverse outcome involving poor FHR interpretation and practice.	100%	100%		100%					
			Plan and run regular departmental fetal heart rate (FHR) monitoring meetings and training.	0%	100%		100%					
		The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on elements of fetal health Total		**38%**	100%		100%					
	Q36	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	Audits for each element	100%	100%		100%					
			Guidelines with evidence for each pathway	100%	100%		100%					
			SOP's	100%	100%		100%					
		Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2? Total		**100%**	100%		100%					
	Q37	Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?	A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	100%	100%		100%					
			Attendance records - summarised	100%	100%		100%					
			Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements.	100%	100%		100%					
		Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019? Total		**100%**	100%		100%					
	Q38	**Same as 35**										
IEA6 Total				**67%**	**100%**							
	Q39	Trusts ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery	Information on maternal choice including choice for caesarean delivery.	100%	**100%**		100%					
			Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites.	100%	**100%**		100%					
		Trusts ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery Total		**100%**	**100%**		100%					
	Q40	Do you have Do you have accessible information to enable accurate evidence based information including all care AN, Intrapartum & PN?	Demonstration of the information service users can access for evidence based information in all formats	100%	**100%**		100%					
			Demonstration of the information service users can access for evidence based information in all	100%	**100%**		100%					
			MVP review of information	100%	**100%**		100%					
		Do you have Do you have accessible information to enable accurate evidence based information including all care AN, intrapartum & PN?		**100%**	**100%**		100%					
		Women must be enabled to participate equally in all decision-making processes	An audit of 1% of notes demonstrating compliance.									
			CQC survey and associated action plans									

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	Q41		SOP which shows how women are enabled to participate equally in all decision making processes and to make informed choices about their care, and where that is recorded.									
		Women must be enabled to participate equally in all decision-making processes Total										
	Q42	Women's choices following a shared and informed decision-making process must be respected	An audit of 5% of notes demonstrating compliance, this should include women who have specifically requested a care pathway which may differ from that recommended by the clinician during the antenatal period, and also a selection of women who request a caesarean section during labour or induction.	0%	100%		50%					
			SOP to demonstrate how women's choices are respected and how this is evidenced following a shared and informed decision-making process, and where that is recorded.	100%	100%		100%					
		Women's choices following a shared and informed decision-making process must be respected Total		**50%**	**100%**		50%					
	Q43	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?	Clear co produced plan, with MVP's that demonstrate that co production and co-design of all service improvements, changes and developments will be in place and will be embedded by December 2021.	100%	100%		100%					
			Evidence of service user feedback being used to support improvement in maternity services (E.G you said, we did, FFT, 1S Steps)	100%	100%		100%					
			Please upload your CNST evidence of co-production. If utilised then upload completed templates for providers to successfully achieve maternity safety action 7. CNST templates to be signed off by the MVP.	100%	100%		100%					
		Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services? Total		**100%**	**100%**		100%					
	Q44	Pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website.	Co-produced action plan to address gaps identified	100%	100%		100%					
			Gap analysis of website against Chelsea & Westminster conducted by the MVP	100%	100%		100%					
			Information on maternal choice including choice for caesarean delivery.	100%	100%		100%					
			Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites.	100%	100%		100%					
		Pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. Total		**100%**	**100%**		100%					
IEA7 Total				**93%**	**100%**							
	Q45	Demonstrate an effective system of clinical workforce planning to the required standard	Consider evidence of workforce planning at LMS/ICS level given this is the direction of travel of the people plan	100%	100%		100%					
			Evidence of reviews 6 monthly for all staff groups and evidence considered at board level.	100%	100%		100%					
			Most recent BR+ report and board minutes agreeing to fund.	100%	100%		100%					
		Demonstrate an effective system of clinical workforce planning to the required standard Total		**100%**	**100%**		100%					
	Q46	Demonstrate an effective system of midwifery workforce planning to the required standard?	Most recent BR+ report and board minutes agreeing to fund.	100%	100%		100%					
		Demonstrate an effective system of midwifery workforce planning to the required standard? Total		**100%**	**100%**		100%					
	Q47	Director/Head of Midwifery is responsible and accountable to an executive director	HoM/DoM Job Description with explicit signposting to responsibility and accountability to an executive director	100%	100%		100%					
		Director/Head of Midwifery is responsible and accountable to an executive director Total		**100%**	**100%**		100%					
WF	Q48	Describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care:	Action plan where manifesto is not met	100%	100%		75%					
			Gap analysis completed against the RCM strengthening midwifery leadership: a manifesto for better maternity care	100%	100%		75%					
			1. A Director of Midwifery in every trust and health board, and more Heads of Midwifery across the service									

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			2. A lead midwife at a senior level in all parts of the NHS, both nationally and regionally									
			3. More Consultant midwives									
			4. Specialist midwives in every trust and health board									
			5. Strengthening and supporting sustainable midwifery leadership in education and research									
			6. A commitment to fund ongoing midwifery leadership development									
			7. Professional input into the appointment of midwife leaders									
		Describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care: Total		**100%**	**100%**		75%					
	Q49	Providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate.	Audit to demonstrate all guidelines are in date.	100%	100%		100%					
			Evidence of risk assessment where guidance is not implemented.	0%	100%		100%					
			SOP in place for all guidelines with a demonstrable process for ongoing review.	0%	100%		100%					
		Providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Total		**33%**	**100%**		100%					
WF Total				**80%**	**100%**							

Kirkup report recommendations
Regional Update

Key :

RAG Rate : Green = Complete. Amber = Partial compiant Red = Not compliant

Those that are greyed out are superseded by Ockenden and do not need completing on this tab.

Kirkup Action no.	Relating to Kirkup Recommendation (see Kirkup Recommendations tab for further information)	Action	Suggested documents that may support Trust assurance.	GMEC STOCKPORT NHS FOUNDATION TRUST	Report to LMNS by 27th February 2023	Report to LMNS by 19th April 2023	Report to LMNS by 19th July 2023
6	R2	Obtain feedback from midwives and nurses who have recently completed a preceptorship programme to identify any improvements that can be made to the programme	Utilise PMA feedback	Green	Green		
7	R2, R3	Review the skills of Band 6 midwives to identify and address any training needs to ensure a competent and motivated workforce	Develop a robust support package for new band 6 midwives	Green	Green		
			Completion of the Mentoring module	Green	Green		
			Suturing competency	Green	Green		
			IV therapy competency	Green	Green		
			Care of women choosing epidural anaesthesia.	Green	Green		
8		Review the current induction and orientation process for midwives and nurses joining the organisation at Band 6 to ensure they are competent and confident to provide care	Practice educator reports and feedback	Green	Green		
11	R2	Review the provision of maternal AIMS courses and ensure that all places are allocated appropriately and staff attend the session.	Practice educator meeting notes, discussion with DoMS/HoMs	Green	Green		
12	R2	Review the educational opportunities available for staff working in postnatal areas to increase their understanding of the compromised neonate, including consideration of bespoke educational sessions and HEI courses e.g. Care of the compromised baby module at University of Salford	Practice educator reports and feedback	Green	Green		
13	R2	Improve staff knowledge, response time and escalation processes in relation to a woman's deteriorating condition	Incident review and feedback, related lessons learnt, training opportunities	Green	Green		
14	R2	Implement a process for cascading learning points generated from incidents or risk management in each clinical area e.g. email to staff, noticeboard, themed week / message of the week, core huddles, NICU news	Weekly Safety Huddles, Hot Topics, Governance Boards, Monthly Governance updates	Green	Green		
17	R3	Review the support provided when staff are allocated to a new clinical area and what supernumerary actually means in order to manage staff expectations		Green	Green		
18	R3	Offer opportunities to other heads of service for staff from other trusts to broaden their experience by secondment or supernumerary status					
19	R5	Develop a list of current MDT meetings and events and share with staff across the directorate					
20	R8	Develop and implement a recruitment and retention strategy specifically for the obstetric directorate	Employment of a Recruitment and Retention Midwife	Green	Green		
21		Review the current midwifery staffing establishment to ensure appropriate staffing levels in all clinical areas					
22		Ensure that all staff who leave are offered an exit interview with a senior member of staff and use the information gained from these interviews to inform changes aimed at improving retention		Green	Green		
23		Provide Staff Forum meetings where staff are encouraged to attend and discuss concerns	Ward Meetings, Professional Midwifery Advocates drop in sessions and clinical supervision	Green	Green		
24	Only applicable to multi-site trusts.	Improve working relationships between the different sites located geographically apart but under the same organization.					
25	R9	Reiterate to all staff via email and team meetings the roles and responsibilities of the consultant obstetrician carrying the hot week bleep.					
26	R11, R12	Ensure that staff receive education during their induction regarding the incident reporting process including the process for reporting incidents, the incidents that should be reported and the rationale for learning from incidents.		Green	Green		
27	R11, R12	Including a review of the processes for disseminating and learning from incidents					
28		Ensure that staff undertaking incident investigations have received appropriate education and training to undertake this effectively	All consultants to have completed RCA training	Green	Amber		
			Identified midwives to have completed RCA training	Green	Green		
			Staff who have completed RCA training undertake an investigation within 1 year and regularly thereafter in order to maintain their skills	Green	Green		
			Develop a local record of staff who have completed RCA training and the investigations undertaken (including dates)	Green	Amber		
29	R12	Ensure that the details regarding staff debriefing and support are completed on the Trust incident reporting system for all level 4 and 5 incidents					
30	R12	Ensure that all Serious Incidents (SI's)are fedback to the staff					
31	R12	Identify ways of improving attendance of midwives at SI's feedback sessions					
32	R13	Maternity Services Liaison Committee involvement in complaints	Collation of complaints reports				
33	R14	Review the current obstetric clinical lead structure					
34	R15	Review past SI's and map common themes	Thematic reviews				
35	R23	Ensure that maternal deaths, late and intrapartum stillbirths and unexpected neonatal deaths are reported, reviewed and an investigation undertaken where appropriate	Maternal deaths, stillbirths and early neonatal deaths reports				
36	R26	Ensure that all staff are aware of how to raise concerns	Whistle blowing staff policy	Green	Green		
37	R31	Provide evidence of how we deal with complaints		Green	Green		
38	R31	Educate staff regarding the process for local resolution and support staff to undertake this process in their clinical area	Identifying situations where local resolution is required	Green	Green		
39	R32	Develop a plan to maintain a supervision system beyond the decommissioning of the LSAs once national recommendations have been agreed.	Implementation of the A-AQUIP model				
40	R38	Ensure that all perinatal deaths are recorded appropriately	Sending the completed form to the Deputy Director of Nursing/ Head of Midwifery and the Divisional Clinical Effectiveness Manager				
41	R39	Ensure that Confidential Enquiry reports are reviewed following publication and that an action plan is developed and monitored to ensure that high standards of care are maintained	MBRRACE action plan	Green	Green		

Recommendations from the published Kirkup report

1	The University Hospitals of Morecambe Bay NHS Foundation Trust should formally admit the extent and nature of the problems that have previously occurred, and should apologise to those patients and relatives affected, not only for the avoidable damage caused but also for the length of time it has taken to bring them to light and the previous failures to act. This should begin immediately with the response to this Report.
2	The University Hospitals of Morecambe Bay NHS Foundation Trust should review the skills, knowledge, competencies and professional duties of care of all obstetric, paediatric, midwifery and neonatal nursing staff, and other staff caring for critically ill patients in anaesthetics and intensive and high dependency care, against all relevant guidance from professional and regulatory bodies. This review will be completed by June 2015, and identify requirements for additional training, development and, where necessary, a period of experience elsewhere if applicable
3	The University Hospitals of Morecambe Bay NHS Foundation Trust should draw up plans to deliver the training and development of staff identified as a result of the review of maternity, neonatal and other staff, and should identify opportunities to broaden staff experience in other units, including by secondment and by supernumerary practice. These should be in place in time for June 2015.
4	Following completion of additional training or experience where necessary, the University Hospitals of Morecambe Bay NHS Foundation Trust should identify requirements for continuing professional development of staff and link this explicitly with professional requirements including revalidation. This should be completed by September 2015.
5	The University Hospitals of Morecambe Bay NHS Foundation Trust should identify and develop measures that will promote effective multidisciplinary team-working, in particular between paediatricians, obstetricians, midwives and neonatal staff. These measures should include, but not be limited to, joint training sessions, clinical, policy and management meetings and staff development activities. Attendance at designated events must be compulsory within terms of employment. These measures should be identified by April 2015 and begun by June 2015.
6	The University Hospitals of Morecambe Bay NHS Foundation Trust should draw up a protocol for risk assessment in maternity services, setting out clearly: who should be offered the option of delivery at Furness General Hospital and who should not; who will carry out this assessment against which criteria; and how this will be discussed with pregnant women and families. The protocol should involve all relevant staff groups, including midwives, paediatricians, obstetricians and those in the receiving units within the region. The Trust should ensure that individual decisions on delivery are clearly recorded as part of the plan of care, including what risk factors may trigger escalation of care, and that all Trust staff are aware that they should not vary decisions without a documented risk assessment. This should be completed by June 2015.
7	The University Hospitals of Morecambe Bay NHS Foundation Trust should audit the operation of maternity and paediatric services, to ensure that they follow risk assessment protocols on place of delivery, transfers and management of care, and that effective multidisciplinary care operates without inflexible demarcations between professional groups. This should be in place by September 2015.
8	The University Hospitals of Morecambe Bay NHS Foundation Trust should identify a recruitment and retention strategy aimed at achieving a balanced and sustainable workforce with the requisite skills and experience. This should include, but not be limited to, seeking links with one or more other centre(s) to encourage development of specialist and/or academic practice whilst offering opportunities in generalist practice in the Trust; in addition, opportunities for flexible working to maximise the advantages of close proximity to South Lakeland should be sought. Development of the strategy should be completed by January 2016.
9	The University Hospitals of Morecambe Bay NHS Foundation Trust should identify an approach to developing better joint working between its main hospital sites, including the development and operation of common policies, systems and standards. Whilst we do not believe that the introduction of extensive split-site responsibilities for clinical staff will do much other than lead to time wasted in travelling, we do consider that, as part of this approach, flexibility should be built into working responsibilities to provide temporary solutions to short-term staffing problems. This approach should be begun by September 2015.
10	The University Hospitals of Morecambe Bay NHS Foundation Trust should seek to forge links with a partner Trust, so that both can benefit from opportunities for learning, mentoring, secondment, staff development and sharing approaches to problems. This arrangement is promoted and sometimes facilitated by Monitor as 'buddying' and we endorse the approach under these circumstances. This could involve the same centre identified as part of the recruitment and retention strategy. If a suitable partner is forthcoming, this arrangement should be begun by September 2015.
11	The University Hospitals of Morecambe Bay NHS Foundation Trust should identify and implement a programme to raise awareness of incident reporting, including requirements, benefits and processes. The Trust should also review its policy of openness and honesty in line with the duty of candour of professional staff, and incorporate into the programme compliance with the refreshed policy.
12	The University Hospitals of Morecambe Bay NHS Foundation Trust should review the structures, processes and staff involved in investigating incidents, carrying out root cause analyses, reporting results and disseminating learning from incidents, identifying any residual conflicts of interest and requirements for additional training. The Trust should ensure that robust documentation is used, based on a recognised system, and that Board reports include details of how services have been improved in response. The review should include the provision of appropriate arrangements for staff debriefing and support following a serious incident. This should be begun with maternity units by April 2015 and rolled out across the Trust by April 2016.
13	The University Hospitals of Morecambe Bay NHS Foundation Trust should review the structures, processes and staff involved in responding to complaints, and introduce measures to promote the use of complaints as a source of improvement and reduce defensive 'closed' responses to complainants. The Trust should increase public and patient involvement in resolving complaints, in the case of maternity services through the Maternity Services Liaison Committee. This should be completed, and the improvements demonstrated at an open Board meeting, by December 2015.
14	The University Hospitals of Morecambe Bay NHS Foundation Trust should review arrangements for clinical leadership in obstetrics, paediatrics and midwifery, to ensure that the right people are in place with appropriate skills and support. The Trust has implemented change at executive level, but this needs to be carried through to the levels below. All staff with defined responsibilities for clinical leadership should show evidence of attendance at appropriate training and development events. This review should be commenced by April 2015.
15	The University Hospitals of Morecambe Bay NHS Foundation Trust should continue to prioritise the work commenced in response to the review of governance systems already carried out, including clinical governance, so that the Board has adequate assurance of the quality of care provided by the Trust's services. This work is already underway with the facilitation of Monitor, and we would not seek to vary or add to it, which would serve only to detract from implementation. We do, however, recommend that a full audit of implementation be undertaken before this is signed off as completed.
16	As part of the governance systems work, we consider that the University Hospitals of Morecambe Bay NHS Foundation Trust should ensure that middle managers, senior managers and non-executives have the requisite clarity over roles and responsibilities in relation to quality, and it should provide appropriate guidance and where necessary training. This should be completed by December 2015.
17 & 18	The University Hospitals of Morecambe Bay NHS Foundation Trust should identify options, with a view to implementation as soon as practicable, to improve the physical environment of the delivery suite at Furness General Hospital, including particularly access to operating theatres, an improved ability to observe and respond to all women in labour and en suite facilities; arrangements for post-operative care of women also need to be reviewed. Plans should be in place by December 2015 and completed by December 2017. 18. All of the previous recommendations should be implemented with the involvement of Clinical Commissioning Groups, and where necessary, the Care Quality Commission and Monitor. In the particular circumstances surrounding the University Hospitals of Morecambe Bay NHS Foundation Trust, NHS England should oversee the process, provide the necessary support, and ensure that all parties remain committed to the outcome, through an agreed plan with the Care Quality Commission, Monitor and the Clinical Commissioning Groups.
Recommendations for the wider NHS	
19	In light of the evidence we have heard during the Investigation, we consider that the professional regulatory bodies should review the findings of this Report in detail with a view to investigating further the conduct of registrants involved in the care of patients during the time period of this Investigation. Action: the General Medical Council, the Nursing and Midwifery Council.
20	There should be a national review of the provision of maternity care and paediatrics in challenging circumstances, including areas that are rural, difficult to recruit to, or isolated. This should identify the requirements to sustain safe services under these conditions. In conjunction, a national protocol should be drawn up that defines the types of unit required in different settings and the levels of care that it is appropriate to offer in them. Action: NHS England, the Care Quality Commission, the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives, the Royal College of Paediatrics and Child Health, the National Institute for Health and Care Excellence.

21	The challenge of providing healthcare in areas that are rural, difficult to recruit to or isolated is not restricted to maternity care and paediatrics. We recommend that NHS England consider the wisdom of extending the review of requirements to sustain safe provision to other services. This is an area lacking in good-quality research yet it affects many regions of England, Wales and Scotland. This should be seen as providing an opportunity to develop and promote a positive way of working in remote and rural environments. Action: NHS England.
22	We believe that the educational opportunities afforded by smaller units, particularly in delivering a broad range of care with a high personal level of responsibility, have been insufficiently recognised and exploited. We recommend that a review be carried out of the opportunities and challenges to assist such units in promoting services and the benefits to larger units of linking with them. Action: Health Education England, the Royal College of Obstetricians and Gynaecologists, the Royal College of Paediatrics and Child Health, the Royal College of Midwives.
23	Clear standards should be drawn up for incident reporting and investigation in maternity services. These should include the mandatory reporting and investigation as serious incidents of maternal deaths, late and intrapartum stillbirths and unexpected neonatal deaths. We believe that there is a strong case to include a requirement that
24	We commend the introduction of the duty of candour for all NHS professionals. This should be extended to include the involvement of patients and relatives in the investigation of serious incidents, both to provide evidence that may otherwise be lacking and to receive personal feedback on the results. Action: the Care Quality Commission, NHS England.
25	We recommend that a duty should be placed on all NHS Boards to report openly the findings of any external investigation into clinical services, governance or other aspects of the operation of the Trust, including prompt notification of relevant external bodies such as the Care Quality Commission and Monitor. The Care Quality Commission should develop a system to disseminate learning from investigations to other Trusts. Action: the Department of Health, the Care Quality Commission
26	We commend the introduction of a clear national policy on whistleblowing. As well as protecting the interests of whistleblowers, we recommend that this is implemented in a way that ensures that a systematic and proportionate response is made by Trusts to concerns identified. Action: the Department of Health.
27	Professional regulatory bodies should clarify and reinforce the duty of professional staff to report concerns about clinical services, particularly where these relate to patient safety, and the mechanism to do so. Failure to report concerns should be regarded as a lapse from professional standards. Action: the General Medical Council, the Nursing
28	Clear national standards should be drawn up setting out the professional duties and expectations of clinical leads at all levels, including, but not limited to, clinical directors, clinical leads, heads of service, medical directors, nurse directors. Trusts should provide evidence to the Care Quality Commission, as part of their processes, of appropriate policies and training to ensure that standards are met. Action: NHS England, the Care Quality Commission, the General Medical Council, the Nursing and Midwifery Council, all Trusts.
29	Clear national standards should be drawn up setting out the responsibilities for clinical quality of other managers, including executive directors, middle managers and non-executives. All Trusts should provide evidence to the Care Quality Commission, as part of their processes, of appropriate policies and training to ensure that standards are met. Action: NHS England, the Care Quality Commission, all Trusts.
30	A national protocol should be drawn up setting out the duties of all Trusts and their staff in relation to inquests. This should include, but not be limited to, the avoidance of attempts to 'fend off' inquests, a mandatory requirement not to coach staff or provide 'model answers', the need to avoid collusion between staff on lines to take, and the inappropriateness of relying on coronial processes or expert opinions provided to coroners to substitute for incident investigation. Action: NHS England, the Care Quality Commission.
31	The NHS complaints system in the University Hospitals of Morecambe Bay NHS Foundation Trust failed relatives at almost every turn. Although it was not within our remit to examine the operation of the NHS complaints system nationally, both the nature of the failures and persistent comment from elsewhere lead us to suppose that this is not unique to this Trust. We believe that a fundamental review of the NHS complaints system is required, with particular reference to strengthening local resolution and improving its timeliness, introducing external scrutiny of local resolution and reducing reliance on the Parliamentary and Health Service Ombudsman to intervene in unresolved complaints. Action: the Department of Health, NHS England, the Care Quality Commission, the Parliamentary and Health Service Ombudsman.
32	The Local Supervising Authority system for midwives was ineffectual at detecting manifest problems at the University Hospitals of Morecambe Bay NHS Foundation Trust, not only in individual failures of care but also with the systems to investigate them. As with complaints, our remit was not to examine the operation of the system nationally; however, the nature of the failures and the recent King's Fund review (*Midwifery regulation in the United Kingdom*) lead us to suppose that this is not unique to this Trust, although there were specific problems there that exacerbated the more systematic concern. We believe that an urgent response is required to the King's Fund findings, with effective reform of the system. Action: the Department of Health, NHS England, the Nursing and Midwifery Council.
33	We considered carefully the effectiveness of separating organisationally the regulation of quality by the Care Quality Commission from the regulation of finance and performance by Monitor, given the close inter-relationship between Trust decisions in each area. However, we were persuaded that there is more to be gained than lost by keeping regulation separated in this way, not least that decisions on safety are not perceived to be biased by their financial implications. The close links, however, require a carefully coordinated approach, and we recommend that the organisations draw up a memorandum of understanding specifying roles, relationships and communication. Action: Monitor, the Care Quality Commission, the Department of Health.
34	The relationship between the investigation of individual complaints and the investigation of the systemic problems that they exemplify gave us cause for concern, in particular the breakdown in communication between the Care Quality Commission and the Parliamentary and Health Service Ombudsman over necessary action and follow-up. We recommend that a memorandum of understanding be drawn up clearly specifying roles, responsibilities, communication and follow-up, including explicitly agreed actions where issues overlap. Action: the Care Quality Commission, the Parliamentary and Health Service Ombudsman.
35	The division of responsibilities between the Care Quality Commission and other parts of the NHS for oversight of service quality and the implementation of measures to correct patient safety failures was not clear, and we are concerned that potential ambiguity persists. We recommend that NHS England draw up a protocol that clearly sets out the responsibilities for all parts of the oversight system, including itself, in conjunction with the other relevant bodies; the starting point should be that one body, the Care Quality Commission, takes prime responsibility. Action: the Care Quality Commission, NHS England, Monitor, the Department of Health.
36	The cumulative impact of new policies and processes, particularly the perceived pressure to achieve Foundation Trust status, together with organisational reconfiguration, placed significant pressure on the management capacity of the University Hospitals of Morecambe Bay NHS Foundation Trust to deliver against changing requirements whilst maintaining day-to-day needs, including safeguarding patient safety. Whilst we do not absolve Trusts from responsibility for prioritising limited capability safely and effectively, we recommend that the Department of Health should review how it carries out impact assessments of new policies to identify the risks as well as the resources and time required. Action: the Department of Health.
37	Organisational change that alters or transfers responsibilities and accountability carries significant risk, which can be mitigated only if well managed. We recommend that an explicit protocol be drawn up setting out how such processes will be managed in future. This must include systems to secure retention of both electronic and paper documents against future need, as well as ensuring a clearly defined transition of responsibilities and accountability. Action: the Department of Health.
38	Mortality recording of perinatal deaths is not sufficiently systematic, with failures to record properly at individual unit level and to account routinely for neonatal deaths of transferred babies by place of birth. This is of added significance when maternity units rely inappropriately on headline mortality figures to reassure others that all is well. We recommend that recording systems are reviewed and plans brought forward to improve systematic recording and tracking of perinatal deaths. This should build on the work of national audits such as MBRRACE-UK, and include the provision of comparative information to Trusts. Action: NHS England.
39	There is no mechanism to scrutinise perinatal deaths or maternal deaths independently, to identify patient safety concerns and to provide early warning of adverse trends. This shortcoming has been clearly identified in relation to adult deaths by Dame Janet Smith in her review of the Shipman deaths, but is in our view no less applicable to maternal and perinatal deaths, and should have raised concerns in the University Hospitals of Morecambe Bay NHS Foundation Trust before they eventually became evident. Legislative preparations have already been made to implement a system based on medical examiners, as effectively used in other countries, and pilot schemes have apparently proved effective. We cannot understand why this has not already been implemented in full, and recommend that steps are taken to do so without delay. Action: the Department of Health.
40	Given that the systematic review of deaths by medical examiners should be in place, as above, we recommend that this system be extended to stillbirths as well as neonatal deaths, thereby ensuring that appropriate recommendations are made to coroners concerning the occasional need for inquests in individual cases, including deaths following neonatal transfer. Action: the Department of Health
41	We were concerned by the ad hoc nature and variable quality of the numerous external reviews of services that were carried out at the University Hospitals of Morecambe Bay NHS Foundation Trust. We recommend that systematic guidance be drawn up setting out an appropriate framework for external reviews and professional responsibilities in undertaking them. Action: the Academy of Medical Royal Colleges, the Royal College of Nursing, the Royal College of Midwives.
42	We further recommend that all external reviews of suspected service failures be registered with the Care Quality Commission and Monitor, and that the Care Quality Commission develops a system to collate learning from reviews and disseminate it to other Trusts. Action: the Care Quality Commission, Monitor.
43	We strongly endorse the emphasis placed on the quality of NHS services that began with the Darzi review, *High Quality Care for All* , and gathered importance with the response to the events at the Mid Staffordshire NHS Foundation Trust. Our findings confirm that this was necessary and must not be lost. We are concerned that the scale of recent NHS reconfiguration could result in new organisations and post-holders losing the focus on this priority. We recommend that the importance of putting quality first is re-emphasised and local arrangements reviewed to identify any need for personal or organisational development, including amongst clinical leadership in commissioning organisations. Action: NHS England, the Department of Health.

44	This Investigation was hampered at the outset by the lack of an established framework covering such matters as access to documents, the duty of staff and former staff to cooperate, and the legal basis for handling evidence. These obstacles were overcome, but the need to do this from scratch each time an investigation of this format is set up is unnecessarily time-consuming. We believe that this is an effective investigation format that is capable of getting to the bottom of significant service and organisational problems without the need for a much more expensive, time-consuming and disruptive public inquiry. This being so, we believe that there is considerable merit in establishing a proper framework, if necessary statutory, on which future investigations could be promptly established. This would include setting out the arrangements necessary to maintain independence and work effectively and efficiently, as well as clarifying responsibilities of current

NHS Stockport NHS Foundation Trust

KEY ISSUES AND ASSURANCE REPORT
Audit Committee
9th February 2023

The Audit Committee draws the following matters to the Board of Director's attention -

Issue	Committee Update	Assurance received	Action	Timescale
Internal Audit Progress Report	The Committee received a report of: • Progress against Plan • Internal Audit Reports • Follow up Tracker • Internal Audit Plan 2022/23	The Committee received assurance that a number of reviews have now been finalised. No changes to plan for 2022-23 are required. There were no significant issues to report on outstanding follow up actions. The IM&T Legacy/Unsupported Systems Review and Asset Management Review were presented to the Committee by the MIAA IM&T specialist. Both reports received limited assurance. The Committee noted the limited assurance reports. It received positive feedback that the IT department were engaged to learn the lessons from both reviews. The Committee noted the maturity of the IT department to request the Asset Management audit specifically to identify opportunities for improvement in this area. The Committee were assured that the Finance and Performance Committee will follow up on performance in these areas through its oversight of the Digital and Informatics Group. Further assurance was given that follow ups to these two specific reports were included in the draft Internal Audit Plan for 2023/2024.	Specific recommendations to be completed by the end of June 2023 after which the IT department will be asked to present to the Audit Committee where and how these have been embedded. MIAA to track follow up actions in 2023/2024.	June 2023 Q2 Draft 2023/24 Plan
	Internal Audit Reports: • HFMA Financial Sustainability	The Committee received high assurance from the Board Reporting – Provenance of Data Review. This report was a key element of the well led review and		

Issue	Committee Update	Assurance received	Action	Timescale
	• EPPR	gives assurance that there are strong processes and systems in place for the accuracy of data provided to the Board and its committees and that the metrics reported are, therefore, reliable. The Committee received the final HFMA Financial Sustainability Review having been given a verbal update of the conclusions at the November meeting. The review was now formally issued as complete and assurance was confirmed from MIAA that the financial control assessment is green rated. The EPPR Review received a limited assurance opinion. The Committee were assured that the findings of the report were in response to a request for the review by the Chief Finance Officer. A paper was also presented to Risk Committee where weaknesses were highlighted. Further assurance was given that resourcing had been put in place to address the actions and that MIAA were to meet with the EPPR Manager in the summer of 2023 to follow up actions and report back to Audit Committee in November 2023.	MIAA to follow up actions with EPPR Manager. MIAA to provide an update report to Audit Committee.	Q2 2023/24 November 2023
Internal Audit Plan 2023/24	The Committee received a report of: • Draft 2023/24 Internal Audit Plan	The Committee received the draft work programme for Internal Audit reviews in 2023/24. After discussion the Committee received assurance that the key priorities for Quarter 1 had been identified and approved with feedback for Q2 – Q4 to be provided to MIAA for agreement of the remaining plan.	The Committee to provide comments to MIAA on the draft plan.	Immediate
Anti-Fraud Progress Report and Anti-Fraud Plan 2023/24	The Committee received a report of: • Anti-Fraud Progress Report • Draft Anti-Fraud Plan 2023/24	The MIAA anti fraud report was received and progress against work plan noted and approved. The Committee received assurance that the Trust remained vigilant to fraud attempts. No financial losses had been incurred by the Trust from the 23		

Issue	Committee Update	Assurance received	Action	Timescale
		Fraud Prevention Check notices issued in this reporting period. The Committee discussed the draft Anti-Fraud Plan for 2023/24 and received assurance that it included pro-active programmes to address fraud in addition to planned days for investigations of alleged fraud. The Committee approved the anti-fraud plan for 2023/24.		
E-Rostering Report	The Committee received: • Briefing update on the financial savings associated with e-rostering.	In response to an action from September 2022 the Committee received a summary of the controls in place for e-rostering and a breakdown of a comparison of average shifts booked in 2020 to 2022. It was agreed to close the action and ask the Finance and Performance Committee to monitor this further through the Health Roster Report.		
External Audit Annual Report.	The Committee received: External Audit Progress Report	The Committee received assurance that the planning work for the 2022/23 external audit and other services was in progress. Mazars updated the Committee that there will be increased assessment of risk at the planning stage due to the implementation of a new auditing standard (ISA 315). The Committee received assurance that the Charity independent examination for 2021-22 was complete.	Interim Planning Audit for 2022/23	February 2023
Policy for the Approval of Non-Audit and Additional Services by the Trust's External Auditors	The Committee received a report from the Chief Finance Officer to review and recommend the policy to the Board of Directors.	The Committee received assurance that the policy had been updated to reflect the new Code of Governance issued in October 2022. The Committee were assured that there will be professional independence of the external auditor for such services with the update and renewal of this policy and the policy was in line with National Audit Office requirements.	Policy for the Approval of Non-Audit and Additional Services by the Trust's External Auditors (Appendix 1) to be presented for approval at the subsequent Board of Directors meeting. To notify the Council of Governors of the approval	April 2023

Issue	Committee Update	Assurance received	Action	Timescale
			of the Policy.	
Waiver Review	The Committee received an exceptional report for a waiver for the Maternity Roof Capital scheme. The Committee received a copy of the waiver form for P Bentley for catering supplies in response to a request for further information from the six month waiver report presented at the November 2022 meeting.	The Committee noted the report and that the value of the waiver of £300,000 was outside the normal delegated authority. The Committee approved the waiver and recommended it to the Board for formal ratification of the waiver as per Standing Financial Instructions. The Committee were assured of the reasons behind the waiver.	The Waiver Report on the Maternity Roof to be reported to the February Board meeting.	February 2023
Trust Committee updates	The Committee received verbal reports from the Chairs of key Board Committees.	The Committee noted the key risks identified in other Board Committees from the Chairs of the Finance and Performance, People Performance and Quality Committees.		

NHS
Stockport
NHS Foundation Trust

POLICY FOR THE APPROVAL OF NON-AUDIT AND ADDITIONAL SERVICES BY THE TRUST'S EXTERNAL AUDITORS

Approval of Non-Audit and Additional Services by the Trust's External Auditors Policy		Page:	Page 1 of 13
Author:	Kay Wiss, Director of Finance	Version:	2
Date of Approval:	DRAFT	Date for Review:	February 2026
To Note:	Printed documents may be out of date – check the intranet for the latest version.		

NHS Stockport NHS Foundation Trust

1. CONTENTS AND PAGE NUMBERS

12.1

NHS Stockport NHS Foundation Trust

2. EXECUTIVE SUMMARY

NHS Foundation Trust auditors are required to comply with the National Audit Office's Code of Audit Practice and the NHS Act 2006.

The statutory responsibilities and powers of the auditor are set out in the 2006 Act. In discharging these specific statutory responsibilities and powers, auditors are required to carry out their work in accordance with the Code.

The NHS Foundation Trust Code of Governance, 2022 states that ~~the Audit Committee should~~:

~~*"Develop and implement policy on the engagement of the external auditor to supply non-audit services, taking into account relevant ethical guidance regarding the provision of non-audit services by the external audit firm"*~~
"Legislation requires an NHS trust to have a policy on its purchase of non-audit services from its external auditor. An NHS foundation trust's audit committee should develop and implement a policy on the engagement of the external auditor to supply non-audit services"

This is based upon the requirement contained within the UK Corporate Governance Code published by the Financial Reporting Council. ~~The Code was revised in 2018, with the new Code applicable from 1 January 2019.~~

This ~~paper describes the~~ policy describes the framework the Trust will ~~adopt~~ utilise in agreeing any further additional services with its external auditor that falls outside its statutory audit responsibilities.

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NHS Stockport NHS Foundation Trust

3. PURPOSE

3.1 The purpose of this policy is to ensure compliance with the Revised Ethical Standard of 2016 for Audit and Assurance as issued by the Financial Reporting Council (FRC). This sets out principles covering non-audit and additional services provided by external auditors which are outside the scope of the statutory audit. This ethical standard has regard to the non-audit work undertaken by external auditors but also covers the subject of internal auditors and taxation or other services supplied, setting out what safeguards are required.

3.2 The ethical standard applies to all statutory external audit (or assurance) engagements; the purpose being to ensure the audit opinion (or assurance statement) is professionally sound and objective. This should in turn, enhance the credibility of information covered by the audit opinion (or assurance statement).

3.3 For NHS Foundation Trusts, the external auditors issue an audit opinion on the Statutory Accounts (Financial Statements) ~~and an opinion on the annual Quality Report~~. ~~These are~~This is a ~~r~~requirement~~s~~ of NHS ~~Improvement~~ England and ~~are~~ is linked to the Trust's licence to operate.

3.4 The standard limits the amount of non-audit work or services an external auditor can provide in order to avoid potential conflicts of interest from arising. Should a conflict of interest arise, this could create a potential risk that the external audit is unduly influenced by other factors. Further guidance is provided in the National Audit Office: 'Auditor Guidance Note 1 (AGN 01)'.

3.5 The users of the financial statements ~~or quality report~~ (including the general public) require confidence that the external auditor is independent of the Trust, impartial and unbiased. Whilst the audit firm in question may be satisfied itself that it is independent, given any particular condition or relationship with the client, the users of published information may draw a different conclusion.

3.6 The standard sets out the ethical rules and guidance necessary to ensure that the users of published information have the required assurance that the auditor is professionally independent.

NHS Stockport NHS Foundation Trust

4. STANDARD

4.1 The standard sets out that the fundamental objective of any audit engagement is that users trust, and have confidence, that the audit or assurance opinion is professionally sound and objective. This in turn should enhance the credibility to users of the information that the opinion covers. It should also enhance the intended users' understanding of the underlying 'subject matter'.

4.2 Users' interest in the audit engagement usually arises because they have an actual or prospective stake in an entity (e.g., patients, staff, governors, regulators or the general public) but do not have direct access to the subject matter.

4.3 Although auditors are reporting to users, they are engaged to do so by the Trust whose information they are reporting on. Accordingly, their 'contractual client' (the Trust) is different to their 'beneficial client' (users). These principal (the user) agent (Trust and auditor) relationships give rise to potential for conflicts of interest that need to be addressed if the user is to have trust and confidence in the audit process. Regulation and oversight of audit practitioners, including professional and ethical codes and standards, addresses the need for trust and confidence between users and practitioners.

4.4 The National Audit Office Guidance Note AGN 01 is the NAO's interpretation of the Ethical Standard as applied to the public sector. Links to this document, along with the FRC ethical standard are included at the end of this Policy. These provide more details on the specific requirements designed to achieve the confidence described above.

4.5 The ethical standard places various duties upon the external audit firm with regard to both the external audit itself and other services. These include:

- Rotation of audit partners after a maximum of 5 years
- Having a different partner (not the external audit partner) to lead any additional work
- No one from the external audit firm can have a key management position at the client (the Trust) or membership of the Audit Committee
- If any close family member of the engagement partner takes a role at the client this must be subject to review

4.6 The National Audit Office AGN 01 provides further guidance on the limits to non-audit services provided by the external auditor. It includes the prohibitions list in the ethical standard and prescribes a 70% cap on other permitted non-audit services.

4.7 Permitted non-audit services carried out by the external auditor are defined as work that is: *not relating to the financial statements and/or financial controls, is not integrated with the external audit work plan nor performed by the existing audit team.*

4.8 The external audit firm are prohibited from providing the following non-audit services:

- Tax services, including preparation of tax forms and the giving of tax advice

- Any services that include taking part in the key management decision making process of the audited entity
- Book keeping and preparation of accounting records
- Payroll services
- Designing or implementing internal controls
- Actuarial or litigation services
- The client entity's (the Trust) internal audit process
- Human resource services

Such non-audit services must be communicated to those charged with governance.

4.10 The NAO AGN 01 defines some exclusions from what is included in non-audit services; this includes audits of subsidiaries (as this is part of the external audit process)~~, the audit of the Quality Report (for the same reason)~~ and any other services required by law or the parent body (NHS ~~Improvement~~England).

4.11 The Audit Committee must be informed of any non-audit work to be carried out by the external auditor in order for it to be reviewed for compliance with the above standard. The cap is defined as: the total fees for non-audit services to the audited entity (the Trust and its controlled entities) in any one year should not exceed 70% of the total external audit fee (including subsidiaries~~ and quality report~~) for the same year.

4.12 The ethical standard also refers to internal auditors, by default these are not suppliers of the external audit, therefore they may supply other services, such as taxation services or consultancy advice, so long as separate partners lead those processes and there is no cap quantified. The ethical standard does place certain conditions and prohibitions on what the internal auditors can do: for example internal audit cannot be part of the key management decision making process of the entity (the Trust).

NHS Stockport NHS Foundation Trust

5. RESPONSIBILITIES

5.1 Responsibilities for the review and approval of non-audit services provided by auditors are outlined in the Trusts' Scheme of Reservation and Delegation and Standing Financial Instructions. To ensure the Trust and its appointed auditors continue to meet the ethical standards, more detailed responsibilities are set out below.

5.2 The Council of Governors

The Council of Governors will be notified of the policy, given that it is the Council which appoints the external auditors.

5.3 Board of Directors

Approve the overall policy regarding non-audit and additional services by the external auditor.

5.4 Audit Committee

Commissioning additional services from the external auditors by the Trust's Audit Committee, will be on the understanding that:

- the Audit Committee is responsible for agreeing additional work to be undertaken in line with compliance with the above standard;
- the Audit Committee considers whether external audit or another organisation is best placed to provide the service, based on such factors as relevant experience and expertise in that particular area;
- the Audit Committee confirms that the external auditor's ability to undertake its statutory responsibilities will not be compromised by the undertaking of this work;
- the Audit Committee agrees an Engagement Letter with the external auditor covering each piece of additional work, which will specify the scope of the work, timetable for delivery and fee. The Letter will also explain how the work does not compromise the independence of the external auditor;
- any additional work will be included in the Annual Report and the external auditor's Management Letter as reported to the Board of Directors and Council of Governors; and
- the Audit Committee will report to the Council of Governors as soon as possible following application of the policy, including if there are any matters arising from any such additional work, which raise significant concerns.

5.4 ~~Director of Finance~~Chief Finance Officer

The ~~Director of Finance~~Chief Finance Officer has responsibility for ensuring this policy is adhered to and for ensuring that the policy remains up to date and appropriate.

The ~~Director of Finance~~Chief Finance Officer will be informed of any proposed non-audit services or additional work before any further steps are taken. Subject to review via Audit Committee, the Chief Finance Officer is required to authorise any non-audit expenditure with the External Auditors.

12.1

Where required, the Chief Finance Officer will ensure compliance with the requirement for engagement with a management consultant over £50k being subject to approval from NHS England.

The Chief Finance Officer will maintain a log of all requests for non-audit services to record decision-making processes undertaken, enabling appropriate monitoring of compliance with this policy.

5.5 Budget holders and managers

All staff within Stockport NHS Foundation Trust are responsible for ensuring that the principles outlined within this policy are universally applied.

For the avoidance of doubt, the Audit Committee requires the business sponsor of the proposed work to obtain a proposed scope and fee estimate before the work commences.

The business sponsor should also seek written confirmation that the external auditor will be able to safeguard their independence in relation to the proposed work.

5.6 The External Auditor

Auditors must carry out their work with independence and objectivity. The auditors' opinions, conclusions and recommendations should both be, and be seen to be, impartial. Auditors and their staff should exercise their professional judgement and act independently of the NHS foundation trust.

They should ensure that they maintain an objective attitude at all times and that they do not act in any way that might give rise to, or be perceived to give rise to, a conflict of interest.

Auditors must provide written confirmation that proposed appointments adhere with the relevant ethical guidelines and do not compromise independence and objectivity prior to undertaking any non-audit work.

Stockport NHS Foundation Trust

6. IMPLEMENTATION & MONITORING

This policy and its associated procedures will be made available on the Trust intranet and will be disseminated to staff throughout the Trust.

Requests for non-audit services which are agreed by the ~~Director of Finance~~Chief Finance Officer will be reported to Audit Committee and the Council of Governors as described within the above 'Responsibilities' section.~~.~~

NHS Stockport NHS Foundation Trust

7. REFERENCES

This document is drafted with reference to the following guidance, including national and international standards:

- Financial Reporting Council Revised Ethical Standard 2016 - Audit and Assurance
- National Audit Office Auditor Guidance Note 01
- NHS Foundation Trust Code of Governance
- National Audit Office's Code of Audit Practice
- Audit Firm Governance Code 2016, Financial Reporting Council
- UK Corporate Governance Code 2018, Financial Reporting Council
- National Health Service Act 2006 (the 2006 Act)

NHS Stockport NHS Foundation Trust

8. EQUALITY IMPACT ASSESSMENT

Office Use Only	
Submission Date:	
Approved By:	
Full EIA needed:	Yes/No

To be completed by document author			
1	**Name of the Policy / SOP**	Policy for the Approval of Non-Audit and Additional Services by the Trust's External Auditors	
2	**Department / Business Group**	Finance/Corporate	
3	**Details of the Person responsible for the EIA**	**Name:** **Job Title:** **Contact Details:**	Rebecca McCarthy Company Secretary rebecca.mccarthy@stockport.nhs.uk
4	**What are the main aims and objectives of the Policy / SOP?**	The purpose of this policy is to ensure compliance with the Revised Ethical Standard of 2016 for Audit and Assurance as issued by the Financial Reporting Council (FRC). This policy describes the framework the Trust will utilise in agreeing any further additional services with its external auditor that falls outside its statutory audit responsibilities.	

For the following question, please use the EIA Guidance document for reference:		
5	**A) IMPACT** Is the policy / SOP likely to have a differential impact on any of the protected characteristics below? Please state whether it is positive or negative. What data do you have to evidence this? Consider: • What does existing evidence show? E.g. consultations, demographic data, questionnaires, equality monitoring data, analysis of complaints. • Are all people from the protected characteristics equally accessing the service?	**B) MITIGATION** Can any potential negative impact be justified? If not, how will you mitigate any negative impacts? • Think about reasonable adjustment and/or positive action • Consider how you would measure and monitor the impact going forward e.g. equality monitoring data, analysis of complaints. • Assign a responsible lead. • Produce action plan if further data/evidence needed • Re-visit after the designated time period to check for improvement.

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Age	No impact	
Carers	No impact	
Disability	No impact	
Race / Ethnicity	No impact	
Gender	No impact	
Gender Reassignment	No impact	
Marriage & Civil Partnership	No impact	
Pregnancy & Maternity	No impact	
Religion & Belief	No impact	
Sexual Orientation	No impact	
General Comments across all equality strands	No impact	

Action Plan

What actions have been identified to ensure equal access and fairness for all?

Action	Lead	Timescales	Review &Comments

EIA Sign-off	Your completed EIA and document should be sent to Equality, Diversity & Inclusion Manager for approval: equality@stockport.nhs.uk 0161 419 4784

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NHS Stockport NHS Foundation Trust

9. DOCUMENT INFORMATION

Type of Document:	Policy
Title:	Policy for the Approval of Non-Audit and Additional Services by the Trust's External Auditors
Version Number:	2
Recommended By:	Audit Committee
Approved By:	Board of Directors
Approval Date:	Policy Review Group: xx-xxx-xx Audit Committee: xx-xxx-xx Board of Directors: xx-xxx-xx
Next Review Date	xx-xxx-xx
Document Author:	Kay Wiss, Director of Finance
Document Director:	Chief Finance Officer
For use by:	All Trust employees
Specialty / Ward / Department (if local procedure document)	

Version	Date of change	Date of release	Changed by	Reason for change
2	February 2023		R McCarthy K Wiss	Review required

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