Public Board meeting

Thu 07 December 2023, 09:30 - 13:15

Pinewood House Education Centre

NHS Stockport NHS Foundation Trust

Agenda

09:30 - 09:30
0 min

1. Apologies for absence

09:30 - 09:30
0 min

2. Declaration of Interests

09:30 - 09:35
5 min

3. Patient Story

Information

09:35 - 09:35
0 min

4. Minutes of Previous Meeting - held on 5 October 2023

Decision *Tony Warne*

04 - Public Board Minutes - 5 October 2023.pdf (10 pages)

09:35 - 09:40
5 min

5. Action Log

Discussion *Tony Warne*

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

09:40 - 09:50
10 min

6. Chair's Report

Discussion *Tony Warne*

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

09:50 - 10:00
10 min

7. Chief Executive's Report

Discussion *Karen James*

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

STRATEGY & PLANNING

10:00 - 10:45
45 min

8. One Stockport: One Future

Discussion *Caroline Simpson, Chief Executive, Stockport MBC*

08a - One Stockport One Future - Front Sheet - December 2023.pdf (3 pages)

08b - One Stockport One Future.pdf (13 pages)

10:45 - 11:00
15 min

9. Transformation

Discussion *Angela Brierley*

9.1. Continuous Improvement Strategy

09a - Continuous Improvement Strategy - December 23.pdf (27 pages)

9.2. NHS IMPACT Assurance Report

09b - NHS Impact Assurance Report - December 23.pdf (6 pages)

11:00 - 11:15
15 min

10. Digital Strategy Progress Report

Discussion *Peter Nuttall*

10a - Digital Strategy Progress Report - Front Sheet - December 2023.pdf (6 pages)
10b - Digital Strategy Progress Report - December 2023.pdf (13 pages)

11:15 - 11:30
15 min

11. Communications & Engagement Strategy Progress Report

Discussion *Helen O'Brien*

11a - Communications Strategy Progress Report - Froint Sheet - December 2023.pdf (2 pages)
11b - Communications Strategy Progress Report.pdf (8 pages)

11:30 - 11:40
10 min

COMFORT BREAK

PERFORMANCE

11:40 - 12:00
20 min

12. Integrated Performance Report

Discussion *Karen James / Executive Directors*

- Quality
- Operational Performance
- Workforce
- Finance

12a - IPR Front Sheet - December 2023.pdf (2 pages)
12b - Integrated Performance Report (Oct23 data).pdf (23 pages)

12:00 - 12:15
15 min

13. Mid-Year Review: Corporate Objectives Outcome Measures

Discussion *Karen James*

13 - Corporate Objectives Mid Year Progress 2023-24.pdf (9 pages)

12:15 - 12:30
15 min

14. Board Confirmation of Trust Response to NHS England operational guidance letter: Addressing the significant financial challenges created by industrial action

Decision *Jackie McShane*

14 - Trust Response to Operational Guidance Letter - November 2023.pdf (9 pages)

FINANCE

12:30 - 12:35
5 min

15. Quarter 4 Revenue PDC Support Submission to NHS England

Decision *John Graham*

15 - Q4 Revenue Support Application 2023-24 - December 2023.pdf (8 pages)

QUALITY

12:35 - 12:45
10 min

16. Annual EPRR Report - Core Standards and Statement of Compliance

Discussion *John Graham*

16a - EPRR Annual Report - December 2023.pdf (2 pages)
16b - EPRR Annual Report 2023-24.pdf (18 pages)

12:45 - 12:55
10 min

17. Safer Care Report

Discussion *Nicola Firth / Andrew Loughney*

17a - Safer Care Report - Front Sheet - November 2023.pdf (2 pages)
17b - Safer Care Report - November 2023.pdf (24 pages)

PEOPLE

12:55 - 13:05
10 min

18. Guardian of Safe Working Annual Report

Discussion *Tom Finnigan / Andrew Loughney*

18 - Guardian of Safe Working Annual Report.pdf (7 pages)

STANDING COMMITTEE REPORTS

13:05 - 13:15
10 min

19. Board Committees - Key Issues Reports

Discussion *Non-Executive Director Committee Chairs*

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

19.1. Finance & Performance Committee

19.1.1 - F&P Committee Key Issues Report - Oct 2023.pdf (3 pages)
19.1.2 - F&P Committee Key Issues Report - Nov 2023.pdf (4 pages)

19.2. People Performance Committee

19.2 - PPC Key Issues Report - Nov 2023.pdf (3 pages)

19.3. Quality Committee

- 19.3.1 - Quality Committee Key Issues Report - Oct & Nov 2023.pdf (5 pages)
- 19.3.2 - Appendix 1 - Maternity Services Highlight Report - November 2023.pdf (3 pages)
- 19.3.3 - Appendix 2 - Annex A Maternity Service Highlight Report - November 2023.pdf (34 pages)
- 19.3.4 - Appendix 3 - PMRT Report - November 2023.pdf (8 pages)
- 19.3.5 - Appendix 4 - ATAIN Tool & Audit.pdf (5 pages)
- 19.3.6 - Appendix 5 - App 1 Transitional Care Action Plan.pdf (2 pages)
- 19.3.7 - Appendix 6 - App 2 - ATAIN Action Plan.pdf (2 pages)
- 19.3.8 - Appendix 7 - Ockenden - Kirkup Return Front Sheet - November 2023.pdf (4 pages)
- 19.3.9 - Appendix 8 - Annex A - STOCKPORT Ockenden-Kirkup Return October 2023.pdf (11 pages)
- 19.3.9 - Appendix 9 - Maternity Workforce Bi-Annual Staffing Report.pdf (14 pages)

19.4. Audit Committee

- 19.4 - Audit Committee Key Issues Report - Nov 2023.pdf (3 pages)

CLOSING MATTERS

13:15 - 13:15
0 min

20. Any Other Business

DATE, TIME & VENUE OF NEXT MEETING

13:15 - 13:15
0 min

21. Thursday, 1 February 2024, 9.30am, Pinewood House Education Centre

13:15 - 13:15
0 min

22. Resolution:

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

NHS Stockport NHS Foundation Trust

STOCKPORT NHS FOUNDATION TRUST
Minutes of a meeting of the Board of Directors held in public
Held on Thursday 5 October 2023, at 9.30am in Pinewood House Education Centre, Stepping Hill Hospital

Members Present:

Prof Tony Warne	Chair
Dr Samira Anane	Non-Executive Director
Mr Anthony Bell	Non-Executive Director
Mrs Amanda Bromley	Director of People & Organisational Development
Mrs Nicola Firth	Chief Nurse
Mrs Beatrice Fraenkel	Non-Executive Director
Mr John Graham	Chief Finance Officer / Deputy Chief Executive
Mr David Hopewell	Non-Executive Director
Mrs Karen James	Chief Executive
Dr Andrew Loughney	Medical Director
Mrs Jackie McShane	Director of Operations
Mrs Mary Moore	Non-Executive Director
Dr Louise Sell	Non-Executive Director
Mr Meb Vadiya	Associate Non-Executive Director *

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

Quorate: Yes

In attendance:

Mrs Soile Curtis	Deputy Trust Secretary
Ms Nesta Featherstone	Associate Nurse Director IPC *(for item 128/23)*
Mr Paul Featherstone	Director of Estates & Facilities *(for item 124/23)*
Mrs Rebecca McCarthy	Trust Secretary
Ms Nadia Walsh	Freedom to Speak Up Guardian *(for item 130/23)*

Observing:

Mrs Sue Alting	Lead Governor
Ms Kathryn Dore	Graduate Trainee
Ms Karen Lynas	Karen Lynas Consulting

Apologies:

Mrs Caroline Parnell	Director of Communications & Corporate Affairs*
Dr Marisa Logan-Ward	Non-Executive Director / Deputy Chair

** indicates a non-voting member*

REF No/Yr.	ITEM	ACTION OWNER
117/23	**Apologies for Absence** The Chair welcomed everyone to the meeting. Apologies for absence were noted as above.	

118/23	**Declarations of Interest** There were no declarations of interest.	
119/23	**Patient Story** The Board of Directors watched a patient story relating to a patient's carer who had been subjected to domestic abuse. The Board of Directors acknowledged the importance of ensuring that all staff were compliant with statutory and mandatory training, and commended the actions taken by the Corporate and Ward Teams in supporting the carer. **The Board of Directors received and noted the Patient Story.**	
120/23	**Minutes of Previous Meeting** The minutes of the previous meeting held on 3rd August 2023 were agreed as a true and accurate record.	
121/23	**Action Log** The action log was reviewed and annotated accordingly.	
122/23	**Chair's Report** The Chair presented a report reflecting on recent activities within the Trust and the wider health and care system. The Board of Directors received an update on external partnerships, Trust activities and strengthening Board oversight. The Board of Directors commended the recent Transformation Services Celebration event and the Research & Innovation showcase, noting that it was pleasing to see all the transformational achievements achieved during a very challenging time. In response to a question from Mrs Beatrice Fraenkel, Non-Executive Director, about transformational change reporting to the Board, the Chief Executive confirmed that the Board received a twice-yearly Transformation Programme Report. **The Board of Directors received and noted the Chair's Report.**	
123/23	**Chief Executive's Report** The Chief Executive presented a report providing an update on local and national strategic and operational developments. She briefed the Board on the content of the report and highlighted the following areas: • Industrial Action • Trust response to verdict in the trial of Lucy Letby • Greater Manchester (GM) Integrated Care System • Awards The Board of Directors acknowledged the significant impact of the industrial action and thanked all staff for their hard work during this difficult time. In response to a question from Mrs Beatrice Fraenkel, Non-Executive Director, the Chief Executive, Medical Director and Director of Operations	

	briefed the Board on actions taken locally and nationally to minimise the risk to patient safety during industrial action, noting the attempted derogations for maternity and P2 pathways. Dr Louise Sell, Non-Executive Director, confirmed that the Quality Committee received a quarterly Patient Safety Incident Report, which enabled the Committee to have an appropriate line of sight in this area. Mrs Mary Moore, Non-Executive Director, referred to a recent discussion with the Trust's Scheduling Team, noting that further work was required to ensure the Trust has the correct contact details for patients to improve communications. **The Board of Directors received and noted the Chief Executive's Report.**	
124/23	**Reinforced Autoclaved Aerated Concrete (RAAC) Briefing** The Director of Estates & Facilities presented a report outlining work undertaken to ensure the Trust was managing RAAC concerns robustly, including detailed survey information regarding the hospital estate, and reports on the assurances provided by third party landlords for a number of properties occupied by the Trust. The Board heard that an inspection had identified RAAC in one area of the Trust, in the boiler house roof panels, with a solution for the eradication of RAAC identified. In response to a question from Mrs Beatrice Fraenkel, Non-Executive Director, regarding funding for the necessary works, the Chair confirmed that this would be considered as part of the Private Board discussions. In response to a question from Dr Samira Anane, Non-Executive Director, querying the impact of RAAC in other GM organisations, the Director of Estates & Facilities advised that this was being considered at a monthly meeting of GM Directors of Estates, ensuring a system-wide approach where appropriate. **The Board of Directors received and noted the RAAC Briefing.**	
125/23	**Integrated Performance Report** The Chief Executive introduced the Integrated Performance Report (IPR), which included exception reports for areas of most significant note. **Operational** The Director of Operations presented the operational performance section of the IPR and highlighted challenges and mitigating actions regarding Emergency Department (ED) performance, patient flow, diagnostics, cancer, Referral to Treatment (RTT), outpatient efficiency, and theatre efficiency metrics due to under-achievement in month. The Director of Operations reported that current performance against the ED 4-hour standard continued to benchmark well across GM, with Stockport ranking third for type-1 performance at 66.16% year to date. The Board noted, however, the significant impact of the increased numbers of ED attendances. The Board heard that 12-hour waits were reduced and robust processes for managing, reviewing and providing assurance for assessment	

of harm relating to the delays were fully embedded within the service.

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

The Director of Operations advised that diagnostic performance remained above target thresholds, and whilst capacity had been challenged by industrial action, endoscopy and imaging were showing much improved positions. The Board heard that ECG capacity remained the greatest area of concern and improvement trajectories were being developed.

The Director of Operations reported that cancer performance remained extremely challenged and it was anticipated that performance would continue to be impacted by industrial action in the coming months. She highlighted a continued focus on patients waiting for 63+ days, and advised that the Trust had successfully achieved its backlog trajectory target for July and August.

In response to a question from Mr Meb Vadiya, Associate Non-Executive Director, who queried if the general negative performance trends were due to the impact of the industrial action, the Director of Operations noted that certain trajectories, including cancer, had been directly impacted by the industrial action. She advised that RTT performance was also notably impacted by the increased demand and lack of mutual aid in GM. The Medical Director supported the comments made by the Director of Operations, noting that the total capacity across GM was insufficient.

In response to a question from Dr Louise Sell, Non-Executive Director, querying the change to the cancer waiting time standard and associated risks, the Director of Operations advised that there were no significant risks to the Trust in this area, and that while the requirement for the 2-week wait target had been removed, the Trust would continue to track performance against this as it was a leading indicator to other cancer targets.

In response to a question from Mr David Hopewell, Non-Executive Director, regarding the increased ED attendances, the Director of Operations confirmed that Stockport was an outlier regarding the high number of ED attendances, but there was no consequent increase to income given the current financial regime. The Board heard that an analysis had highlighted increased attendances in the paediatric and elderly and frail patient cohorts, with a significant increase in complex cases. It was noted that the Trust was working with GM as part of the financial performance recovery programme regarding financial impact including in relation to out of area discharges.

Quality

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

In response to a question from Mrs Mary Moore, Non-Executive Director, regarding incident reporting, the Chief Nurse confirmed that whilst incident reporting had increased, the levels of harm had decreased.

	People The Director of People & Organisational Development (OD) presented the people section of the IPR and highlighted performance and mitigating actions around agency costs, workforce turnover, appraisal and mandatory training rates due to under-performance in month. In response to questions from Mr Tony Bell, Non-Executive Director, and Mr Meb Vadiya, Associate Non-Executive Director, the Director of People & OD briefed the Board on focused work around recruitment and retention, including the apprenticeship programme. **Finance** The Chief Finance Officer presented the finance section of the IPR and advised that the Trust had submitted a plan with an expected deficit of £31.5m for the financial year 2023/24. He advised that the deficit assumed delivery of an efficiency target of £26.2m, of which £10.3m was recurrent. The Chief Finance Officer reported that at month 5, the Trust position was a deficit of £13.6m, which was £1.3m adverse to plan. The Board heard that this was a deterioration of £0.5 in month, and that the adverse variance was driven by the impact of industrial action by junior doctors and consultants, undelivered efficiency savings, open escalation wards, enhanced staffing levels to support the high level of ED attendances, the elective recovery fund estimated penalty in Quarter 1, and the cost of the pay award for 2023/24 over and above expected funding. The Chief Finance Officer reported that the Trust's efficiency plan for 2023/24 was £26.2m (£10.3m recurrent) and at month 5 the Trust was £1.0m behind plan. He highlighted work ongoing to identify additional recurrent schemes. The Chief Finance Officer confirmed that the Trust had maintained sufficient cash to operate in August 2023, but noted risks in this area and the assumption that the Trust would require revenue support in Quarter 3 or 4 2023/24. It was noted that the Capital plan for 2023/24 was £62.7m, but this was subject to confirmation as the GM position remained oversubscribed. The Board heard that at month 5, expenditure was behind plan by £3.5m, however this would be re-profiled into future months. In response to a question from Mrs Beatrice Fraenkel, Non-Executive Director, regarding risks relating to the financial plan delivery, the Chair noted that this formed part of the conversations with the Integrated Care Board and the PwC Turnaround Team as part of a series of Finance & Performance Recovery meetings. **The Board of Directors received and noted the Integrated Performance Report.**	
126/23	**Elective Care:** • **Referral to Treatment Self-Certification: Confirmation of Submission** The Director of Operations presented a report providing a detailed background to the request from NHS England to provide assurance against a set of activities to drive the recovery of outpatients at pace. It was noted that the Trust had been required to complete a self-certification	

	against these activities by 30 September 2023, and given the timing of the submission date, the Board had delegated the detailed analysis to the Finance & Performance Committee. The Board heard that the Finance & Performance Committee had completed this task at its meeting on 21 September 2023. The Director of Operations advised that the review had concluded that full assurance could not be provided on all measures, and an associated action plan was being developed with regional colleagues, particularly in relation to the capacity to deliver first appointments to all patients by 31 October 2023. The Board heard that the action plan would be monitored through the Performance Review Meetings, and updates provided to the Finance & Performance Committee via the Operational Performance Report. **The Board of Directors received and noted the report and endorsed the decision of the Finance & Performance Committee to sign off the RTT Board Self Certification.**	
127/23	**Public Dividend Capital (PDC) Revenue Support 2023/24** The Chief Finance Officer presented a report informing the Board of the 2023/24 Revenue Support PDC arrangements from the Department of Health & Social Care. He advised that Revenue Support PDC was available to the Trust to support its revenue expenditure as part of a robust and defined process by the Capital and Cash Team at NHS England. The Chief Finance Officer noted that the Trust's anticipated requirement for cash support was included in the Annual Plan 2023/24 submission. He advised that the Board must approve any PDC Revenue Support request by the Trust in the form of a Board Resolution, and the report sought formal approval of the resolution (at Appendix 1) in preparation for future monthly PDC Revenue Support, in line with the Trust's Annual Plan and cashflow forecasts. In response to a question from Dr Louise Sell, Non-Executive Director, the Chief Finance Officer provided further clarity on the implications of drawing down cash in the context of medium term financial planning, and confirmed that the Trust would continue with defensive measures to protect and maximise the cash position. **The Board of Directors received and noted the report and ratified the Board Resolution attached in Appendix 1.**	
128/23	**Annual Infection Prevention Control Report 2022/23** The Associate Nurse Director Infection Prevention Control (IPC) presented the Annual Infection Prevention & Control Report 2022/23 and an associated presentation. She presented a summary of the mandatory reporting and IPC activities from the previous year, key achievements, and key challenges. The Board of Directors were informed that several IPC targets had not been achieved in year, noting the challenges and actions to implement learning in 2023/24. The Associate Nurse Director IPC presented benchmarking data for 2023/24, alongside confirmation of the Healthcare Acquired Infections (HCAI) thresholds for 2023/24.	

	In response to a comment from the Chief Finance Officer about the challenging Trust estate, the Associate Nurse Director IPC acknowledged that the old estate was not conducive from an IPC perspective. The Chief Nurse commented that the lack of a decant ward added to the challenges, and she paid tribute to the IPC team for their hard work in the challenging circumstances. In response to a question from the Chief Executive about the specialist nurse provision, the Associate Nurse Director IPC and the Chief Nurse advised that work was ongoing to establish how the specialties could support the specialist nurse to ensure annual leave and sickness cover. In response to a question from the Chair about lessons learned from Covid, the Associate Nurse Director IPC and the Chief Nurse highlighted the importance of the vaccination programme and IPC precautions, noting that all GM providers were adhering to national guidance in this area. **The Board of Directors received and noted the Annual Infection Prevention Control Report 2022/23.**	
129/23	**Safer Care Report** The Chief Nurse and Medical Director presented a report providing assurances and risks associated with safe staffing and the actions in progress to mitigate the risks associated with patient safety and quality, based on patients' needs, acuity, dependency and risks. The Board acknowledged the ongoing high levels of operational demand within the acute and community services, which was having an impact on patient and staff experience. It was noted that demands within the ED remained significant, impacted by large numbers of patients who no longer required a hospital bed, and that this demand was being operationally managed by senior teams and on-call colleagues with continual dynamic risk assessments conducted. The Board also acknowledged the impact and associated challenges of the continued industrial action. In response to a question from Dr Louise Sell, Non-Executive Director, who queried the reason for pausing engagement with the NHS England international nurse recruitment programme, the Chief Nurse advised that the programme would finish after this year, and she and the Director of People & OD briefed the Board on focused work around nurse recruitment. The Board heard that this included helping existing health care assistants who are registered nurses in their country of origin to complete their nurse registration. In response to a question from Dr Louise Sell, Non-Executive Director, about Healthroster compliance, the Chief Nurse advised that the reporting would be reviewed to support provision of a continuous picture. **The Board of Directors received and noted the Safer Care Report.**	
130/23	**Freedom to Speak Up Report** The Freedom to Speak Up (FTSU) Guardian presented a report providing an overview of the proactive efforts of the FTSU Guardian in increasing visibility and engagement with staff, including training compliance, awareness	

	campaigns, culture and cases. She noted that the recent Lucy Letby trial had prompted specific actions, which were included in the report. The FTSU Guardian stated that, due to the small number of cases raised to date, there were no specific themes or trends to report. It was noted, however, that some staff had shared their hesitance to speak up due to a perception of unsupportive management and fear of detriment, and the Board heard that the FTSU Guardian was liaising with various teams to triangulate this information. The Medical Director referred to the actions following the Lucy Letby verdict and queried if the Trust had mechanisms in place to support those staff who may have cultural barriers to speaking up. The FTSU Guardian highlighted the importance of psychological safety and having an open and transparent culture in the Trust to encourage people to speak up and noted the ongoing recruitment of FTSU champions to provide further routes for people to raise issues. In response to a question from Mrs Beatrice Fraenkel, Non-Executive Director, the FTSU Guardian confirmed that she felt well supported in her role and had a route through which to raise concerns regarding capacity. In response to a comment from Mr Meb Vadiya, Associate Non-Executive Director, who highlighted the importance of having various avenues available for staff to raise concerns, the FTSU Guardian acknowledged the comment and noted that speaking up was everyone's responsibility. She reiterated the importance of psychological safety to nurture an open culture. In response to a follow up comment from the Chair about the avenues available for speaking up and capturing the interactions, Mrs Beatrice Fraenkel, Non-Executive Director, noted that the People Performance Committee had highlighted the importance of ensuring that staff were aware of the various different routes for speaking up. The Director of People & OD advised that a report on the mechanisms for staff to raise concerns was considered by the Audit Committee annually, and noted that the staff survey helped capture feedback from staff. **The Committee received and noted the Freedom to Speak Up Report.**	
131/23	**Board Assurance Framework 2023/24 – Quarter 2** The Chief Executive presented the Board Assurance Framework (BAF) 2023/24 as at the end of Quarter 2, noting that all BAF risks were regularly reviewed by relevant Board Committees. She briefed the Board on the report and the principal risks and associated mitigations. Furthermore, a heat map and gap analysis between current and target risk score was provided. The Board heard that operational performance, finance, workforce, and estates related risks remained as the Trust's most significant scoring risks. Mr Tony Bell, Non-Executive Director, queried how risks were monitored, particularly based on the size of the gap between the risk score and target score. The Chief Executive advised that the risk review process included review of controls and mitigations in the context of the target risk score. The Chief Finance Officer stated that the challenge process was undertaken at the	

	Risk Management Committee, where individual divisions, directorates and corporate services presented the risks and associated progress updates. He added that any individual issues would consequently be referred to the relevant Board Assurance Committees for further review as necessary. In response to a question from Mrs Beatrice Fraenkel, Non-Executive Director, about triangulation of risks between Board Committees, Mr David Hopewell, Chair of Audit Committee/Non-Executive Director, noted that triangulation took place at Audit Committee where the Risk Management Committee Report was presented and all Board Committee Chairs had the opportunity to explain and highlight issues from their respective Committees. **The Board of Directors reviewed and approved the Board Assurance Framework 2023/24 as at Quarter 2, including action proposed to mitigate risks.**	
132/23	**Board Committees – Key Issues Reports** **Finance & Performance Committee** The Chair of Finance & Performance Committee (Mr Tony Bell, Non-Executive Director) presented the key issues report from Finance & Performance Committee meeting held on 21 September 2023. He briefed the Board on the content of the report and detailed key financial and operational issues considered, noting triangulation of the key risks with the Board Assurance Framework and Risk Register. **The Board of Directors reviewed and confirmed the Finance & Performance Committee Key Issues Report, including actions taken.** **People Performance Committee** The Chair of People Performance Committee (Mrs Beatrice Fraenkel, Non-Executive Director) presented the key issues report from the People Performance Committee meeting held on 15 September 2023. She briefed the Board on the content of the report and detailed key people related issues considered, noting ongoing work to ensure clear and focused reporting. **The Board of Directors reviewed and confirmed the People Performance Committee Key Issues Report, including actions taken.** **Quality Committee** The Chair of Quality Committee (Mrs Mary Moore, Non-Executive Director) presented thea key issues report from the Quality Committee meeting held on 26 September 2023. She briefed the Board on the content of the report and detailed key quality related issues considered at the meeting. **The Board of Directors:** • **Reviewed and confirmed the Quality Committee Key Issues Report, including actions taken.** • **Reviewed and confirmed the Maternity Services Highlight Report.** **Audit Committee (including Audit Committee Terms of Reference)** The Chair of Audit Committee (Dr David Hopewell, Non-Executive Director) presented the key issues report from the Audit Committee meeting held on 19 September 2023. He briefed the Board on the content of the report, and	

	advised that the Committee recommended the updated Audit Committee Terms of Reference to the Board of Directors for approval, following minor changes proposed in relation to the Committee's role in the appointment process of the internal and external auditors. **The Board of Directors:** • **Reviewed and confirmed the Audit Committee Key Issues Report, including actions taken.** • **Approved the updated Audit Committee Terms of Reference.**	
133/23	**Any Other Business** There was no other business.	
134/23	**Date and Time of Next Meeting** Thursday, 7 December 2023, 9.30am, Pinewood House Education Centre.	
135/23	**Resolution** *"To move the resolution that the representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to commercial interests, sensitivity and confidentiality of patients and staff, publicity of which would be premature and/or prejudicial to the public interest".*	

Signed:_____Date:_____

BOARD OF DIRECTORS PUBLIC MEETING ACTION TRACKER

Action Log Ref No/Yr.	Meeting Date	Minute Ref	Item	Action	Responsible	Status
01/22	1 Dec 2022	199/22	Freedom to Speak Up Toolkit	The Board of Directors agreed that a workshop / group maybe established to further consider and progress the toolkit prior to bringing it back to the People Performance Committee and Board if required. **Update February 2023** – Date to be confirmed. **Update March 2023** – Freedom to Speak Up Report, including update regarding Action Plan to progress recommendations from toolkit to be presented at PPC in May 2023, and determine if requirement for further workshop. **Update June 2023** – Discussed via PPC and agreed to defer establishing a working group at this time. Further action to be determined as required. **Update October 2023** – Further review of toolkit and action plan agreed to be presented to PPC in March 2024 – Confirmed on PPC Work Plan. The Board agreed to keep the action open as the toolkit would require Board sign off once it had been through PPC.	Director of People & OD / Director of Communications & Corporate Affairs	April 2024
01/23	3 Aug 2023	94/23	Integrated Performance Report – Workforce	The Board requested quantitative information on the cost of sickness absence and bank and agency usage above target, and what the financial savings would be if the Trust was able to reduce to the target.	Chief Finance Officer	January 2024

Action Log Ref No/Yr.	Meeting Date	Minute Ref	Item	Action	Responsible	Status
				Update December 2023: Discussed at Finance & performance Committee, November 2023. Work underway to review. Agreed to be presented to Finance & performance in January, and onward to Board.		

On agenda
Not due
Overdue
Closed

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

Meeting date	7 December 2023	**Public**	X	**Confidential**	
Meeting	Board of Directors				
Report Title	Chair's Report				
Presented by	Prof. Tony Warne, Chair	**Author**	Prof. Tony Warne, Chair		

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

This paper relates to the following Annual Corporate Objectives

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

The paper relates to the following CQC domains

	Safe		Effective
	Caring		Responsive
X	Well-Led		Use of Resources

This paper relates to the following Board Assurance Framework risks

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

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

Where issues are addressed in the paper

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

Executive Summary

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

1. PURPOSE OF THE REPORT

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

2. EXTERNAL PARTNERSHIPS

The invasion and war in Ukraine continues' and as I write this report, we are on day 640 of this ongoing conflict. Since I last reported to the Board, the news from the Middle East is equally troubling. The conflict between Israel and Hamas is now on day 50. The origins of both these conflicts are many years old, and resolution for both appears a long way off. However, I'm certain that standing together, love and not hate will eventually triumph. Until then we should keep all those caught up in these conflicts around the world, in our thoughts and prayers.

Since I last reported to the Board, I took two weeks off on holiday to visit India and Nepal, so was unable to do some of the things I would normally hope to do here at the Trust. However, I was pleased to be able to attend the NHS Providers Annual conference in November. There were nearly 900 delegates on each of the two days, and there was a full programme of presentations from leading health and care professionals, commentators and politicians.

Following a Cabinet reshuffle immediately before the conference Victoria Atkins, was promoted to Secretary of State for Health and Social Care - the fifth in the last two years. She couldn't attend in person but had sent a pre-recorded video. Resolving the doctors' industrial action was something she absolutely saw as a critical first task, which was very encouraging to hear. She also acknowledged there was much more that requires addressing. The NHS is contending with significant pressures from all sides. A tired and often burnt-out workforce, with massive vacancies still to fill (125,000); increasing demands across all services (October saw more than 2.2 million people attending A&E departments); a post-pandemic long waiting list legacy (nearly eight million people); and of course, continuing financial pressures (including a need to revolutionise capital funding across the whole NHS).

Victoria also noted that she would need to work across the various government departments, if health inequalities are to be addressed and thus reduce the demand on health care services. Likewise, the acute sector must find ways to shift more of its resources to primary and community care, so that people can be better supported in more appropriate settings and ideally closer to, or in their own home.

Amanda Pritchard, Chief Executive of NHS England also gave a keynote speech. She was passionate but challenging, well-informed and quoted, by name, many folk that she had met over the past year who were doing incredible things in making a difference to others. It was a stellar performance by someone demonstrating the

leadership qualities so needed in a world challenged by so many inter-related and seemingly intractable problems.

Wes Streeting, the Shadow Secretary of State for Health and Social Care, speaking after Amanda, cautioned us that if we keep increasing the funds for the NHS, and the NHS continues to push the boundaries of what a healthcare system should be doing, the rest of the public sector is likely to suffer. Every £1 extra for the NHS is £1 less for education, defence, the police and so on. He wanted to see transformation and reform, but wasn't referring about more structural reform, so ICS are here to stay. His reform ideas were about making a greater investment in primary and community services and tackling social care provision.

Finally, from the conference was a speaker who spoke about the interrelated concepts of '*wilful blindness*', '*organisational conformance*', '*whistleblowing*' and why the NHS appears unable to learn from the mistakes of others, even when these are set out clearly in extensive reviews. It was compelling challenge. She was the wonderfully straight-talking Margaret Heffernan. You can gain a sense of her presentation here, from a similar key-note paper a year ago. Her talk starts at 09.30 mins into this film - https://youtu.be/PPJYGqpaBak?si=9Vwj4mSv52L6DGY9

Closer to home, I visited St Annes Hospice, both to visit the service and also to meet with other Chairs from Sector 3, Mastercall, Viaduct, Pennine Care, Health Watch, and Stockport Homes to continue our discussions on working more closely together across Stockport.

Like all NHS provider organisations within the Greater Manchester ICS, we have been working with Price Waterhouse Cooper, colleagues in examining and exploring how to improve our financial position as a system and more effectively lean into the elective recovery programme challenge. These have been challenging meetings and have required a great deal of extra work from Executive Director colleagues and their teams. They have also been very valuable in helping us better understand the drivers contributing to our deficit budget. This programme of work will continue into the new year.

The GM Chairs met during November, and Mark Fisher, CEO GM ICB, joined the meeting to discuss some of the current issues facing provider organisations and the ICB. I chaired my first North West Region NHS Providers meeting for chairs and CEO's at which Julian Hartley, CEO of NHS Providers, presented their latest views of health policy, politics, and challenges – it was an interesting insight into the full presentation he made a week later at the National Conference.

I was able to attend the Stockport Health and Wellbeing Board. It was a packed agenda. As well as reports on Safeguarding, the Annual Health Watch Report there were two extremely comprehensive reports that looked back (Covid 19 – Stockport

Experience) and looked forward (the Stockport Food Plan). Both were very powerful accounts, but the food plan was the one that stood out for me. It covered everything from growing and consuming food, obesity, waste, food poverty and provided an evidence-based approach to tackling each of these aspects. It was a great example of how a multi-agency and multi-professional approach has to be the way we develop future health and wellbeing promoting services across Stockport. Both these reports, and others, can be found here:

https://democracy.stockport.gov.uk/documents/g29219/Public%20reports%20pack%2029th-Nov-2023%2014.00%20Health%20Wellbeing%20Board.pdf?T=10

3. TRUST ACTIVITIES

It was very sad to hear of the loss of two great supporters of SFT. John Pantall sadly passed away after a brief illness and stay in the hospital he gave so much to over many years. He was an appointed Governor and then an elected Governor for many years. Like many of us, I will miss his observational challenges, always evidence based and hearing from his wonderful store of stories.

The other sad loss was of Imelda Mounfield. Imelda had been a patient here and at the Christie. With her husband, Gary 'Mani' Mounfield former bassist with the rock band the Stone Roses, they staged an auction of pop and rock memorabilia raising an incredible £100,000, half of which was donated to our Stockport NHS Charity. A swell as raising this incredible sum, the event also raised awareness of bowel cancer and early detection. Both Mani and Imelda were able to join us at this year's Making a Difference Awards and it was great to be able to publicly acknowledge their generosity and support for the Trust.

The night of celebration and recognition was held in the sumptuous and magnificent Stockport Town Hall Ballroom. Over 300 colleagues took part, and although not everyone got an award, every nomination showcased some incredible activities, and or people, all of whom had made a difference to others. The icing on the cake for me was the singing waiters – I'm not sure how that gets topped next year!

I spent a fascinating 2 hours attending the current round of Civility Saves Lives training – great facilitators and a very interactive session. I would urge all colleagues to sign up for one of the future sessions.

I have been able to get out and about and visiting colleagues since I last reported to the Board. The first visit was to our Fracture Liaison Service. Simply brilliant, proactive health care at its best. The very small team make such a difference to the lives of women (and men) at risk of future fractures due to disease, age or trauma.

I also spent an afternoon with our School Nursing colleagues. Part of my time with them was spent observing the Crucial Crew afternoon. For 15 minutes at a time groups of 9,10 and 11-year-olds sat with a range of agencies that helped them understand how to stay safe on the railways, water, on buses and so on. Our School Nurses were there discussing the dangers of vaping. I was impressed by the enthusiasm, knowledge, and confidence of the young children. Another brilliant example of working upstream in maintaining people's health and wellbeing. It was also a fun event too.

I chaired three Consultant appointment panels, and we were able to appoint to all posts: one in Paediatrics; one in Gastroenterology; and two in Histopathology.

Finally, I would like to acknowledge and thank colleagues for the response they were able to make to the closure of Outpatient B facilities. The business continuity plans was activated, but it was the generosity of spirit, the flexibility in approach and the creativity of colleagues that really did make the difference in a difficult situation. Pride is sometimes an over used word, but as events unfolded following the decision to close the building, I could not have been prouder of the colleagues we work with. A magnificent effort, thank you to all those involved.

4. STRENGTHENING BOARD OVERSIGHT

We were able to hold our second externally facilitated Board Development event. The session focussed on how we interact as a Board in a Board meeting. The data were illuminating. There are two more sessions planned over the next six months.

Meeting date	7 December 2023	**Public**	X	**Confidential**	
Meeting	Board of Directors				
Report Title	Chief Executive's Report				
Presented by	Karen James, Chief Executive	**Author**	Director of Communications & Corporate Affairs		

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

This paper relates to the following Annual Corporate Objectives

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

The paper relates to the following CQC domains

	Safe		Effective
	Caring		Responsive
X	Well-Led		Use of Resources

This paper relates to the following Board Assurance Framework risks

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

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

Where issues are addressed in the paper

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

Executive Summary

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

- Addressing financial challenges
- New Secretary of State
- RAAC capital scheme
- Outpatients B closure
- New laboratory information system
- Martha's Rule
- Innovation bid
- Cadets and student nurses
- Menopause clinic
- MADE awards
- LGBT Champion
- AHP of the Year
- Unsung Hero

1. PURPOSE OF THE REPORT

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

2. NATIONAL NEWS

2.1 Addressing financial challenges

NHS England has written to every Integrated Care Board and provider trust to clarify the funding and actions the NHS has been asked to take to manage the financial and performance pressures resulting from recent industrial action.

It is estimated that industrial action has cost the NHS around £1 billion as well as significant loss of elective activity.

All systems were asked to complete a rapid exercise to agree actions for the remainder of the financial year to:

- achieve financial balance
- protect patient safety
- prioritise emergency performance and capacity while protecting urgent care, high priority elective and cancer care.

To try to address the position NHSE has agreed with the government to:

- allocate £800m from a combination of existing national budgets and some new funding
- reduce the elective activity target for the remainder of 2023-24 to a national average of 103% above pre-pandemic levels of activity
- discontinue the holding back of the Elective Recovery Fund (ERF) for the rest of the year and allocate systems their full ERF monies.

Systems were asked to agree the actions needed to live within their financial allocations and plans were to reflect the impact of a reduced elective activity goal, based on the assumption there will be no further industrial action.

2.2 New Secretary of State

Victoria Atkins was named as the new Secretary of State for Health and Care in the recent Cabinet re-shuffle.

She takes over the role from Steve Barclay, and she was previously financial secretary to the Treasury. The MP for Louth and Horncastle in Lincolnshire has had a number of other ministerial roles including leading on prisons and probation, Afghan resettlement, and women.

3. TRUST NEWS

3.1 RAAC capital scheme

The Trust has received confirmation from NHS England of an award of £1.8m PDC for the eradication of reinforced aerated autoclaved concrete (RAAC) capital scheme.

The allocation has been approved by the National RAAC Programme Board. Our Board of Directors has previously formally approved the business case to proceed with the scheme to eradicate RAAC from the boiler house on our hospital site, which will be delivered by March 2024.

3.2 Outpatient B Closure

Unfortunately, due to a further deterioration on the Outpatient B infrastructure, we had to make a difficult decision to close the department. The Clinical and Operational Teams worked extremely hard to maintain temporary clinical capacity in other locations, whilst longer-term options continue to be developed.

3.3 New laboratory information system

Our hospital pathology service will soon be joining a new laboratory information system (LIMS) that will enable colleagues to work more collaboratively and improve services for both patients and clinicians.

We have has joined with three other trusts in the Greater Manchester Pathology Network - Bolton, Tameside and Glossop, and the Northern Care Alliance - to introduce the new LIMS system, which is set to improve the way medical information is shared, leading to faster diagnosis and treatment for patients.

It is one of the largest pathology networks in England, serving an estimated 2.8 million people from a total of seven NHS trusts which together conduct more than 71.4 million tests every year. Our pathology service alone carries out over four million tests.

The new LIMS will offer a standardised system at each organisation and a standard interface across GM, so services will be able to view patient results in the Greater Manchester Care Record from all electronic patient records.

As well as reducing variation in the way tests are carried out and reported the new system should also make it easier for clinicians to see if a patient has previously had a test taken so they can avoid repeating the test, or use the results to reach a faster diagnosis or treatment decision. We hope that our pathology service will be fully using the system in 2024-25.

3.4 Martha's rule

Last month we began a pilot of Martha's Rule – the first to run in GM.

Martha's Rule is a new change that is set to be implemented in the NHS across England and Wales and it will give patients and their next of kin the legal right to a second medical opinion in the same hospital if they believe concerns are not being taken seriously.

Our pilot is running in AMU and Treehouse and gives individuals the opportunity to contact the nurse in charge or matron to request a second opinion about a deteriorating patient. Learning from the pilot will inform the roll out of the rule across the Trust.

3.5 Innovation bid

We have joined forces with Tameside & Glossop Integrated Care NHS Foundation Trust to make a successful bid for NHSE innovation funding.

The joint bid, which was led by our Associate Nurse Director for Cancer, will fund a project to support nurses from BME backgrounds to develop skills in cancer care with a view to gaining skills to join the cancer workforce of the future.

3.6 Cadets and student nurses

We have welcomed 27 new cadets who have joined the Trust at the start of their NHS careers.

They are now working in clinical services across the organisation, as are a group of student nurses from Hong Kong who joined the Trust last month for clinical placements as part of their training. We hope that many of them will want to return to Stockport once they are fully qualified nurses.

3.7 Menopause clinic

We have launched a new dedicated clinic to support colleagues experiencing the menopause.

The clinic is one of the first of its kind for the country and it is thanks to the Trust's charity that we have been able to set up the clinic as an addition to the range of health and wellbeing support we provide to colleagues through our occupational health service.

As a supportive employer with a significant female workforce, we have introduced a range measures to help staff with the menopause, including optional lighter uniforms, a recently launched menopause café that offers a safe space for people to share their experiences, and a new menopause themed Facebook group that has more than 200 members.

As well as supporting colleagues we are hoping that our efforts will be recognised with 'Menopause Friendly' accreditation.

3.8 MADE awards

We are hugely proud of the work of all of our colleagues, and it is important that we recognise and celebrate all they are achieving for our patients and local population.

Last month 300 of our colleagues gathered at Stockport Town Hall for our annual Making a Difference Everyday Awards ceremony. Thanks to the support of the Trust's charity and a number of external sponsors celebrated individuals and teams nominated by patients and colleagues for a series of awards linked to our values and key objectives.

The winners this year were:

- Greta Harrison – Volunteer of the Year
- Bethany Suggitt – Rising Star Award
- Bramhall & Woodford Rotary Club, Imelda Mounfield, and the organisers of Noah's golf day – Fundraisers of the Year
- Jo Black – Inspirational Leader Award
- Phillipa Caldwell – Non-clinical Rising Star Award
- Helen Blane – Clinical Rising Star Award
- Outpatient booking team – Non-Clinical Team of the Year
- Stockport community neuro-rehabilitation team – Clinical Team of the Year
- Rachel Black – Improvement, Innovation and Efficiency Award
- Laurel Suite team – Patient Choice Award
- Sarah Varey – Chair's Special Commendation.

3.9 LGBT champion

Joe O'Brien, our matron for critical care, has received an award of excellence from the LGBT Foundation for her commitment to inclusion.

Joe, who runs our hospital's intensive care unit, was awarded the title of Gold Champion for showing excellence in her commitment to creating an environment of lesbian, gay, bisexual and trans inclusion, for both colleagues and patients.

We are committed to being an inclusive employer and care provider. We were one of the first NHS trusts in the region to sign up to the All Equals Charter supporting LGBT equality across Greater Manchester, and we also have an active staff network for our LGBT colleagues.

3.10 AHP of the Year

Hannah Fenton, a pharmacist with our specialist pain team was recently named the Allied Healthcare Professional of the Year by the National Acute Pain Symposium (NAPS), the forum for acute pain clinical specialists from across the UK.

Hannah was recognised for the invaluable contributions she has made to the team and using her pharmaceutical expertise to ensure the safest possible care for patients. She is currently working on a pilot project for pre-operative patients on high dose opioids, looking to improve their pain outcomes after surgery.

3.11 Unsung hero

Nadia Kardahji-Bould is in the running for an Unsung Hero award from the Health Care Supply Association (HCSA), as part of their annual Procurement for Healthcare Awards, which celebrate ensuring the efficient distribution of supplies to provide quality healthcare.

Nadia is a supplies contract manager in our procurement team. She joined the team in 2019 as a procurement assistant, and quickly worked her way up to her current position.

She has provided a range of specialist support to clinical services including helping to make sure suction catheters were available for the community complex oxygen team, despite there being a national shortage. She was able to support them using her contacts with both suppliers and other trusts to request mutual aid, ensuring the service did not run out of these vital products.

3.12 Emergency Preparedness Resilience and Response (EPRR)

The Trust has undertaken its annual self-assessment against the EPRR Core Standards Assessment 2023 which is now being discussed with the ICB team.

4. RECOMMENDATION

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

Meeting date	7th December 2023	**Public**	X	**Confidential**	
Meeting	Board of Directors				
Report Title	One Stockport: One Future				
Director Lead	N/A	**Author**	Caroline Simpson, Chief Executive, Stockport Metropolitan Borough Council		

Paper For:	**Information**	**X**	**Assurance**		**Decision**	
Recommendation:	This report is to update the Board of Directors on the One Stockport: One Future work and engage in a discussion on the main elements.					

This paper relates to the following Annual Corporate Objectives

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

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	PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus

Where issues are addressed in the paper

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Financial impacts if agreed/not agreed	
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Executive Summary

Background

The One Stockport Borough Plan was launched in March 2021 following intensive engagement with partners, local business, the Voluntary, Community, Faith and Social Enterprise (VCFSE) sector and local people. Stockport Foundation Trust played an active role in it's development.

The Borough Plan sets out a collective vision for Stockport in 2030, so that together we can create a place that works for everyone. These shared ambitions comprised of 'One Heart, One Home, and One Future'.

The One Stockport Borough plan represents a significant accomplishment and we are well on the way to delivering remarkable things together as a Borough. However, we know there is much more to do. The pandemic has exacerbated inequalities and the cost of living crisis is having a huge impact on local communities. This alongside the increased demand on public services and financial pressures means that we need to think further ahead.

Purpose

One Stockport, One Future marks the next phase of our Borough Plan. It is focussed on the 'One Future' element of the plan and concentrates on change and action over the long term, 15 years.

We have identified 5 big things that will transform Stockport and have amplifying effects across many other areas. By working together collectively we can achieve our vision to be best place in the UK to live happy and healthy lives.

The 5 big things include:

- Jobs and Homes
- Best place to grow up
- The Best health and Care
- Thriving Neighbourhoods
- Clean, Green Transport

These are underpinned by two key themes. The first is our ambition to be a fair and inclusive borough where inequalities are addressed and everyone can thrive. The second is climate action and for Stockport to be carbon neutral by 2038

One Stockport, One Future is a 'call to action', asking partners, local people, businesses and VCFSE sector to work together to deliver the 5 big things. It also acts as a proposition to external organisations and central government showing that Stockport has a 'recipe' for success and is a place for partnership and investment.

One Health and Care Plan

The One Health and Care Plan is Stockport's locality plan and health and wellbeing strategy. It is currently being refreshed in the context of One Stockport: One Future. The six health and care delivery programmes outlined in this plan will be part of the route map to this 15 year vision.

The plan is being revised through engagement with the public and the health and care workforce. This engagement work will also influence One Stockport, One Future. The One Health and Care Plan will be presented to the One Health and Care Board in December and Health and Wellbeing Board

Engagement and Key Dates

The development of One Future: One Stockport is being done collaboratively with our partners and stakeholders across the borough.

- **Over November 2023 - January 2024** we will be having two- way conversations and dialogue with key partners and stakeholders
- **Between February - March 2024 -** We will draw on this feedback to refine the final document and supporting communications materials.
- **March 2024 -** Launch of One Stockport: One Future

ONE STOCKPORT

ONE STOCKPORT – ONE FUTURE – 5 BIG THINGS

Caroline Simpson

Chief Executive, Stockport Council

ONE HEART

ONE HOME

ONE FUTURE

McCarthy Rebecca
06/12/2023 11:30:02

ONESTOCKPORT
ONEFUTURE
Delivering 5 big things together

One Stockport, One Future

- This is the next phase of our borough plan, a **call to action** over the next 10-15 years
- Outline's "5 Big Things" that that we will supercharge to make Stockport the best place in the UK to live **happy and healthy lives**
- They do not cover all our activity across the borough but are the things have **amplifying effects** across many other areas.
- Demonstrates why Stockport has a **'recipe' for success** and will make Stockport **stand out** as one of the best places in the country
- A pitch to partners, government and investors

ONESTOCKPORT
ONEFUTURE
Delivering 5 big things together

ONE STOCKPORT: ONE FUTURE - FILM

With Climate Action Now and fair and inclusive running across all areas

McCarthy Rebecca 06/12/2023 11:30:25

ONESTOCKPORT
ONEFUTURE
Delivering 5 big things together

GOOD JOBS AND HOMES

ONESTOCKPORT
ONEFUTURE
Delivering 5 big things together

The ambitions for this big thing might be as follows...

1. **Building more homes in the town and district centres using already developed land**
2. **Ambitious plans for the east of our Town Centre and will create accessible and affordable housing so everyone can live and succeed in a community they can be proud of**
3. **Creating 1500 new businesses and getting an additional 6500 people in employment**
4. **Creating and producing jobs in growing industries such as - the green economy, digital, construction, health and care and transport**

What are your thoughts? Further suggestions?

THE BEST PLACE TO GROW UP

The ambitions for this big thing might be as follows...

1. **Having excellent schools right across the borough for everyone, with every child included in their success**
2. **Easy access to top-quality early years support for all 0–5-year-olds, helping to narrow inequalities**
3. **Young people being involved in shaping the future of Stockport**

What are your thoughts? Further suggestions?

ONESTOCKPORT
ONEFUTURE
Delivering 5 big things together

THE BEST HEALTH AND CARE

The ambitions for this big thing might be as follows...

1. The development of a brand-new hospital and health-hub at the heart of the town centre,
2. Services delivered in our neighbourhoods, providing better access to joined up health and care services close to where you live
3. Everyone living independently, in their own homes for as long as possible

ONESTOCKPORT
ONEFUTURE
Delivering 5 big things together

The One Health and Care Plan is part of the roadmap to delivering One Stockport: One Future

THRIVING NEIGHBOURHOODS

The ambitions for this big thing might be as follows...

1. **Unleashing even more community spirit by having brilliant community spaces and things to do that connect people with each other and with the place they live**
2. **Continuing to support our thriving local businesses, and vibrant voluntary, community, and social enterprise sector.**
3. **Joining up public services, working together, alongside local people as a single team**

What are your thoughts? Further suggestions?

ONESTOCKPORT
ONEFUTURE
Delivering 5 big things together

ONESTOCKPORT
ONEFUTURE
Delivering 5 big things together

CLEAN, GREEN TRANSPORT

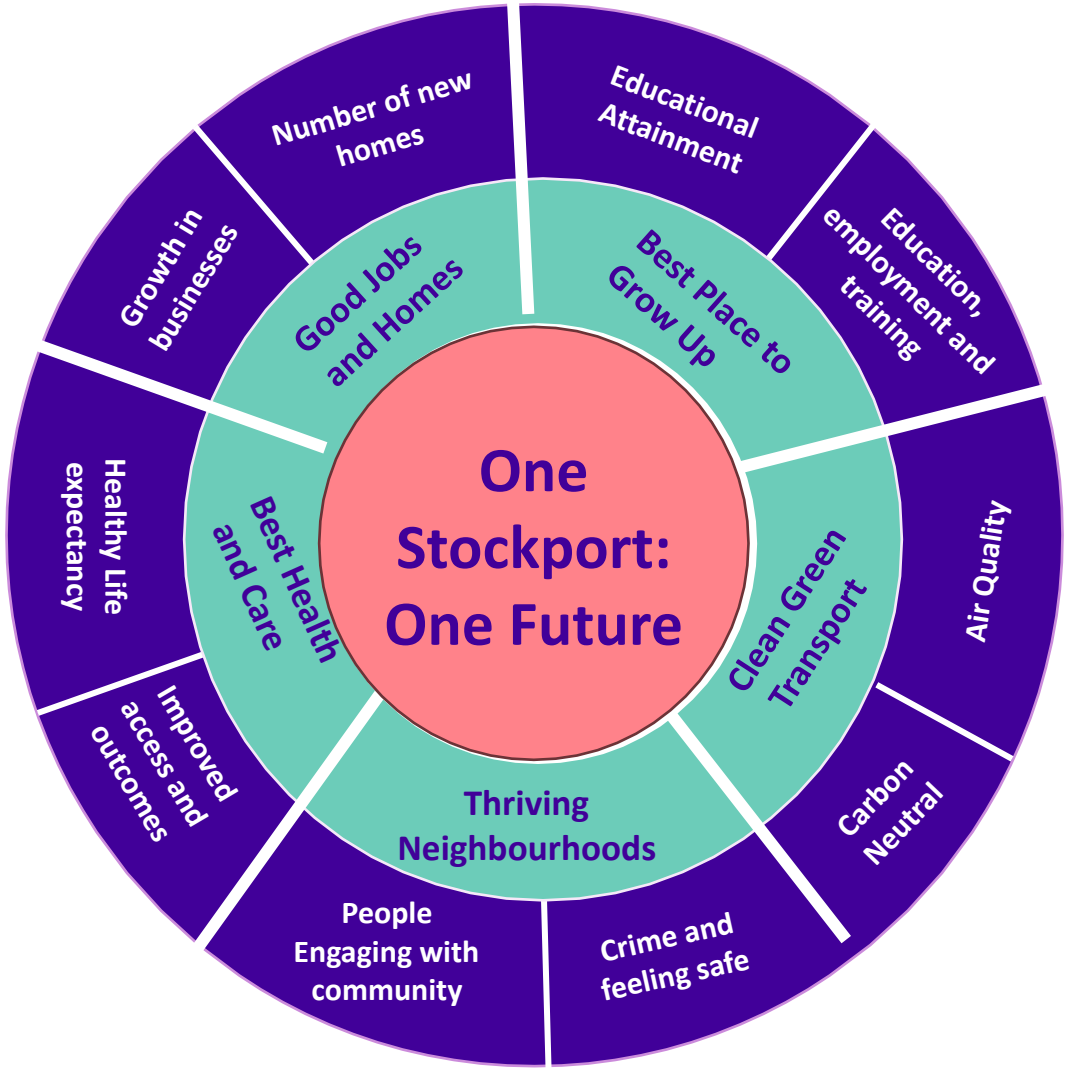
The ambitions for this big thing might be as follows...

1. **Bringing the Metrolink to Stockport, providing residents with another fast and efficient public transportation option.**
2. **Facilitating a zero-emission bus network which connects all our neighbourhoods, including the introduction of the Bee network across our Borough.**
3. **Securing further national investment in Stockport Railway Station to maintain its status as one of the best-connected stations in the North.**

What are your thoughts? Further suggestions?

The impact we will have

These are the key areas where we want to improve our performance to be the best we can be. We will do this with our key partners in each area



ONESTOCKPORT
ONEFUTURE
Delivering 5 big things together

Engagement on One Stockport, One Future

- It will be developed in collaboration
- Over November 2023 – January 2024 we will be having two- way conversations and dialogue with key partners and stakeholders
- This will shape the plan before a March 2024 launch

ONESTOCKPORT
ONEFUTURE
Delivering 5 big things together

Prompt questions:

- What are your thoughts?
- What are the key areas we need to focus on?
- Do you think there is anything missing?

How can you support the achievements of these ambitions?

ONESTOCKPORT
ONEFUTURE
Delivering 5 big things together

Meeting date	7th December 2023	**Public**	**X**	**Confidential**	
Meeting	Board of Directors				
Report Title	Continuous Improvement Strategy				
Director Lead	Angela Brierley, Director of Transformation	**Author**	Hannah Silcock, Head of Transformation		

Paper For:	**Information**		**Assurance**		**Decision**	X
Recommendation:	The Trust Board is asked to approve the new Continuous Improvement Strategy for Stockport NHS Foundation Trust.					

This paper relates to the following Annual Corporate Objectives

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

The paper relates to the following CQC domains

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

This paper relates to the following Board Assurance Framework risks

X	PR1.1	There is a risk that the Trust does not deliver high quality care to service users
	PR1.2	There is a risk that patient flow across the locality is not effective
	PR1.3	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan
	PR2.1	There is a risk that the Trust is unable to sufficiently engage and support our people's wellbeing
	PR2.2	There is a risk that the Trust's services do not fully support neighbourhood working
X	PR3.1	There is a risk in implementing the new provider collaborative model to support delivery of Stockport ONE Health & Care (Locality) Board priorities
	PR3.2	There is a risk that the Trust does not deliver a joint clinical strategy with East Cheshire NHS Trust
X	PR4.1	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to

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

Where issues are addressed in the paper

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

Executive Summary

The purpose of this paper is to ask the Board to approve the new draft Continuous Improvement Strategy for Stockport NHS Foundation Trust & Tameside & Glossop Integrated Care NHS Foundation Trust, to support both organisations to build an improvement culture of continuous improvement.

This strategy sets out our shared ambitions over the next 3 years, guiding our priorities to make the best use of our resources. It aims to embed a culture of continuous improvement and provide our workforce with the skills, knowledge and support required to continue to deliver cutting edge services. In doing so, we will facilitate a culture of continuous improvement that directly improves outcomes for our patients, our workforce, the organisations as a whole, and for our populations.

NHS
Tameside and Glossop
Integrated Care
NHS Foundation Trust

NHS
Stockport
NHS Foundation Trust

Our Joint Strategy for Continuous Improvement

2024 – 2027

Stockport NHS Foundation Trust

&

Tameside & Glossop Integrated Care NHS Foundation Trust

Our Joint Strategy for Continuous Improvement

2024 – 2027

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Foreword

Stockport NHS Foundation Trust (SFT) and Tameside & Glossop Integrated Care Foundation Trust (TGICFT) are committed to delivering the best possible care for our populations.

Healthcare is constantly evolving, with new treatments, techniques and systems developed every day. To ensure that our trusts continue to deliver high quality services, supporting and promoting continuous improvement is a vital function of our leadership team.

Both Stockport and Tameside have a strong history of implementing strategic change to improve services and meet local needs. Over recent years we have seen the benefits of taking a collaborative approach to transformation, sharing knowledge, skills, and resources to improve the local service offer for the communities we serve.

This strategy sets out our shared ambitions over the next 3 years, guiding our priorities to make the best use of our resources. It aims to embed a culture of continuous improvement and provide our workforce with the skills, knowledge and support required to continue to deliver cutting edge services. In doing so, we will facilitate a culture that directly improves outcomes for our patients, our workforce, the organisations as a whole, and for our populations.

Karen James OBE
Chief Executive Officer

Angela Brierley
Director of Transformation

1. Context

1.1 About the Trusts

Stockport NHS Foundation Trust (SFT) and Tameside and Glossop Integrated Care NHS Foundation Trust (TGICFT) aim to be well-led organisations delivering safe, high quality care for local people.

Our Strategic Plans were developed in collaboration with our workforce and patients, setting out clear visions for the future.

Figure 1 - Trust Strategies

Our Trusts:	NHS Stockport NHS Foundation Trust	NHS Tameside and Glossop Integrated Care NHS Foundation Trust
Our Mission:	***Making a difference every day***	***Beyond Patient Care to Population Health***
Our Values:	• We Care • We Respect • We Listen	• Safety • Care • Respect • Communication • Learning
Our Strategic Objectives:	• A great place to work • Always learning, continually improving • Helping people live their best lives • Investing for the future by using our resources well • Working with others for our patients and communities	• Support local people to remain well • Provide high quality integrated services • Develop and retain a workforce fit for the future • Work with partners to innovate, transform and integrate care provision • contribute to the delivery of financial sustainability

1.2 Alignment of plans

Our long-term Trust strategies are delivered through a range of medium-term business strategies, which set out the detail of how we will achieve our ambitions across our clinical divisions and enabling functions such as workforce, informatics, and estates.

Each year, the Trusts develop annual operational plans for in-year priorities, which align to national policy and delivery of our strategic objectives. This hierarchy of plans is set out in the figure to the right.

This document sits among our business strategies, detailing our medium-term plans to deliver the Trust's vision.

Figure 2 - Hierarchy of plans

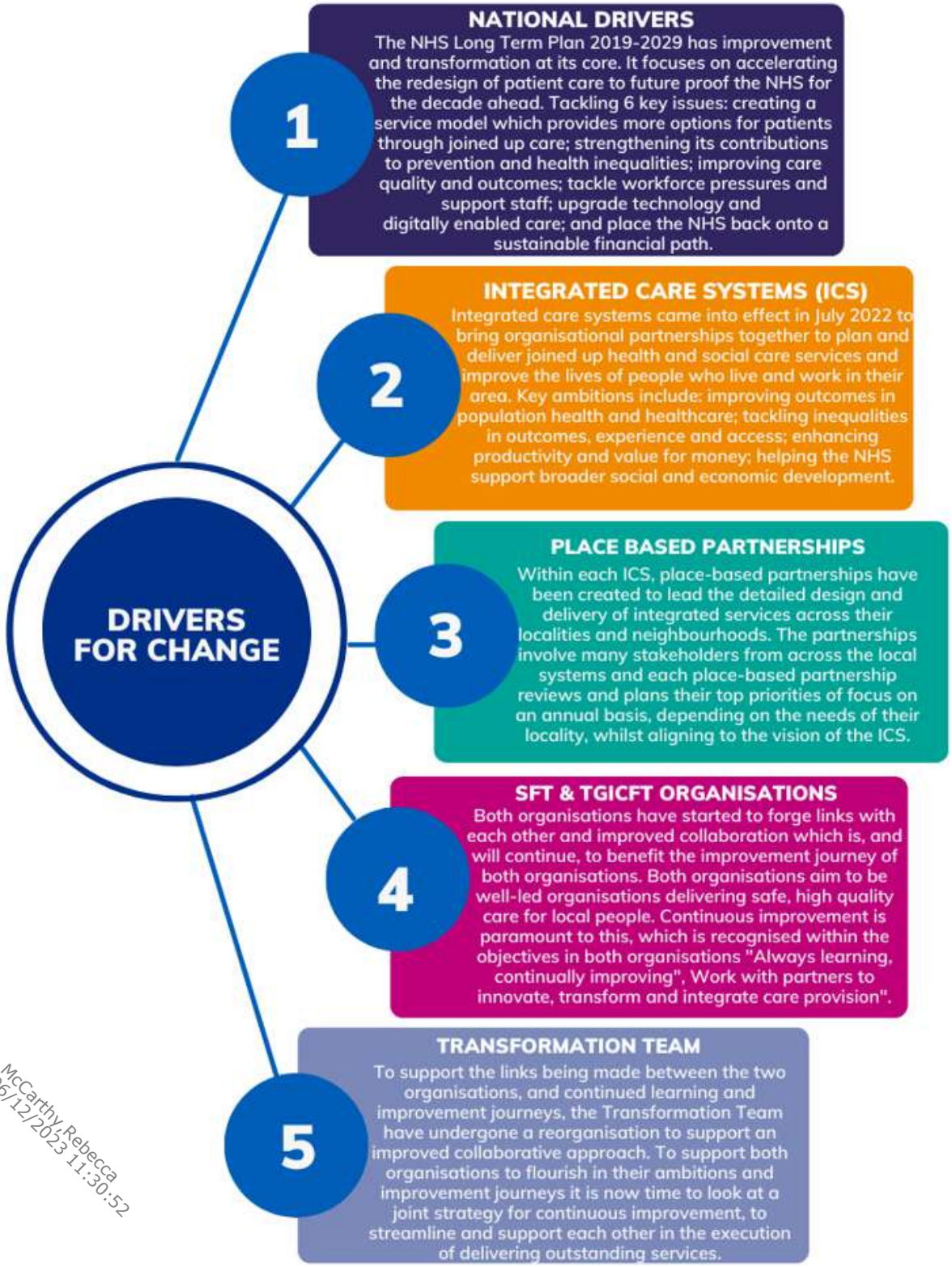
Trust Strategy

2. Healthcare Improvement Agenda

2.1 Drivers for Change

The five key drivers of change are set out in the diagram below:

Figure 3- Drivers for Change



3. Introduction

Continuous improvement is an ongoing process of identifying, analysing and making incremental improvements to systems, processes, products or services.

Continuous improvement is paramount to our service quality for our patients and workforce as we navigate these complexities and redesign our services to improve efficiencies and productivity through more streamlined services, without compromising care. We need to deliver improvements at scale, and at pace, while improving the capacity and capability of the services to improve over time.

The transformation work taking place across Stockport and Tameside, already demonstrates how embedding a culture of continuous improvement in our Trusts can facilitate better outcomes for patients, staff, the organisation as a whole, and our population.

This strategy sets out our ambitions over the next 3 years, building on previous successes, and working in partnership with our NHS, university and industry partners to overcome shared challenges and realise our full potential in a cross sector, integrated care system (ICS)-allied approach. This strategy will guide our priorities and decisions for 2022-2027, but it is important to note that the transformation landscape is constantly changing, so our approach will need to be flexible and agile to account for this.

3.1 Developing our strategy

In 2021, a number of changes occurred in the senior leadership teams across our organisations, with a single Chief Executive Officer taking responsibility for leadership across both trusts, followed by a number of joint appointments at director level, and the initiation of Board-to-Board meetings to promote the collaborative ethos required within the new NHS landscape of Integrated Care Systems.

Within the Transformation team, we felt it was a timely opportunity to review our improvement activities across the two organisations, reflect on successes and gaps and determine a new direction of collaborative working to mirror the changes taking place regionally and improve services for our population.

We have a dedicated transformation team on both sites, however, to truly achieve our potential in both organisations, we need to think bigger and wider and embed this into the mindset of all who support our services.

Engagement with our staff has been integral to the development of our strategy. Seeking the opinions and voices of our workforce on various key matters that will support us to develop a culture of continuous improvement across the organisations. Through this co-production, we can ensure we are building a strategy we can implement and embed. Through this engagement key themes emerged which have helped shape our vision.

At all times, the strategy under development kept in mind the overarching trust strategies and objectives, alongside the wider context regionally and nationally, to ensure we remain aligned to these key priorities.

3. Our Journey

Over recent years, SFT and TGICFT have delivered significant achievements on their improvement journeys, advancing evidence-based knowledge in a clinical setting and directly benefitting our patient populations. This has been achieved through our transformation approach, where we recognise improvement. To support this, we acknowledge one-size does not fit all, and we have a plethora of tools and techniques for improvement.

Our journey accelerated as we brought the SFT and TGICFT Transformation Teams under one management structure in 2020. This strengthened our knowledge and experience as a team, and increased the skill set we were able to pass on to the workforces within our trusts. Both teams are a corporate support function, rather than providing individual alignment to divisions. This helps us see and respond effectively to interdependencies between improvement programmes, reducing the impact of siloed working.

To date, our transformation approach has been underpinned by 4 key areas:

Figure 4 - Transformation Approach

LEADERSHIP & ENGAGEMENT

PRIORITISATION

GOVERNANCE & ASSURANCE

SUSTAINABILITY

The Transformation Teams are now a corporate support function across both organisations. This helps us see and respond effectively to improvements, increasing the breadth of knowledge and experience across the trusts. We provide training and engage with our workforces at different stages of their career, to support the improvement agenda, led by our Executive Team.

We have a robust request process for those who require more support in delivering their improvements through the Transformation Team. This ensures that divisional teams can set and prioritise their improvements and through our Executive-led Service Improvement Group (SIG), organisational and system priorities can be aligned.

Both organisations hold a strong governance & assurance approach to improvement through SIG. Trust priority schemes are reported on a monthly basis to the group and additional divisional improvement work is reported bi-annually. A Transformation Event then showcases the improvement work from across the organisation on an annual basis.

To create long-lasting, sustainable change, we cannot be reliant on one team to support the vast array of improvements. We have therefore been training staff in a range of tools to support improvement, recognising that when it comes to improvement, one size does not fit all, therefore increasing our capacity to support continuous improvement.

4. Our ambition

Our strategic aim is to adopt continuous improvement across both organisations and facilitate a culture that directly improves outcomes for our patients, workforce, the organisations as a whole and our populations.

Improvement-led delivery is a long-term approach that facilitates stronger organisational governance, productivity and positive cultural change over time.

To achieve this, we have set 5 key ambitions under our "ADOPT" model:

Figure 5 – ADOPT Continuous Improvement Strategic Model

Align
to our strategic ambitions

Develop
a continuous improvement culture

Organisational Partnerships
to deliver sustainable change

People
placed at the heart of our plans and engagement

Train
our people to deliver improvement

5. Delivering our strategy

Our ambitions will be delivered through 16 objectives, which will enable our workforce to “ADOPT” Continuous Improvement.

Ambition	Objective	
	1.1	Ensure we remain aligned to organisational, regional and national strategies and objectives.
	2.1	Provide the tools to support change and improvement.
	2.2	Develop an improvement hub, providing support and coaching to individuals and teams in implementing an improvement initiative.
	2.3	Promote improvement initiatives and share learning widely, celebrating successes through a range of avenues.
	2.4	Develop a forum for improvement ideas to be submitted and reviewed.
	3.1	Collaboration within and across both organisations to share good practice and areas for learning.
	3.2	Engage with system-wide partners to implement and embed sustainable change for the benefits of the people living in our localities.
	3.3	Work with our partners to support improved prevention and early identification for our local population.
	4.1	Create opportunities for people to suggest improvements.
	4.2	Co-produced improvement with our staff and service users and those with lived, and living, experience.
	4.3	Person-centred approaches underpins all improvement work we carry out.
	4.4	Effective, visible leadership to support improvement.
	4.5	Grow a network of Improvement Champions.
	5.1	Develop an in-house improvement training programme for people across all levels.
	5.2	Provide training opportunities in an array of media.
	5.3	Provide drop-in sessions for people, and teams, leading their own improvements.
	5.4	Provide bite-size improvement education sessions for people to attend.

Ambition 1: Align to our strategic intentions

Align
to our strategic ambitions

Whilst building a continuous improvement culture, it is vital our ambitions are aligned to national, regional, local and organisational priorities.

This ensures we stay focused on improving the areas that matter most to our staff and patients.

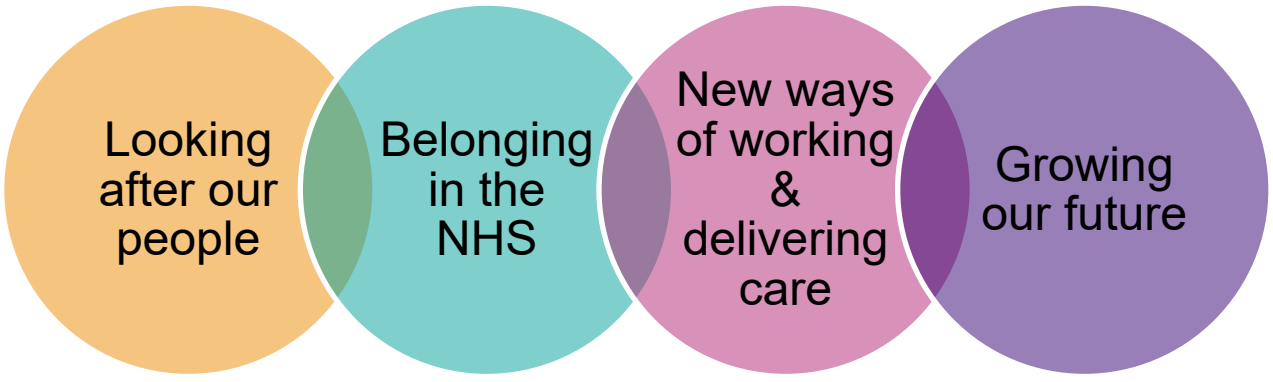
Objective 1.1: Ensure we remain aligned to organisational, regional and national strategies and objectives.

The NHS Long Term Plan set ambitions to ensure that in 10 years the NHS will still be fit for the future. This ambitious plan sets the improvement objectives at a national level that we must respond to.

Additionally, the NHS People Plan, provides a clear workforce strategy for the NHS.

It focuses on actions to support transformation across the NHS, with focus on training our people and working together differently to deliver patient care through the aims highlighted below. In our continuous improvement strategy, we have placed people as a core ambition, acknowledging improvement, and the culture we seek to create, cannot occur without placing people.

Figure 6 - Pillars of the NHS People Plan



Through the 2022 Health and Care Act, a legislative framework was established that supports collaboration and partnership-working to integrate services. The Integrated Care System in Greater Manchester (GM) includes all health and care partners working within GM and is responsible for the health and care for 2.8 million people across 10 'Places'. GM's main challenges include: significant health inequalities; performance challenges; and financial challenges. The Greater Manchester Integrated Care Partnership developed a Joint Forward Plan with six missions:

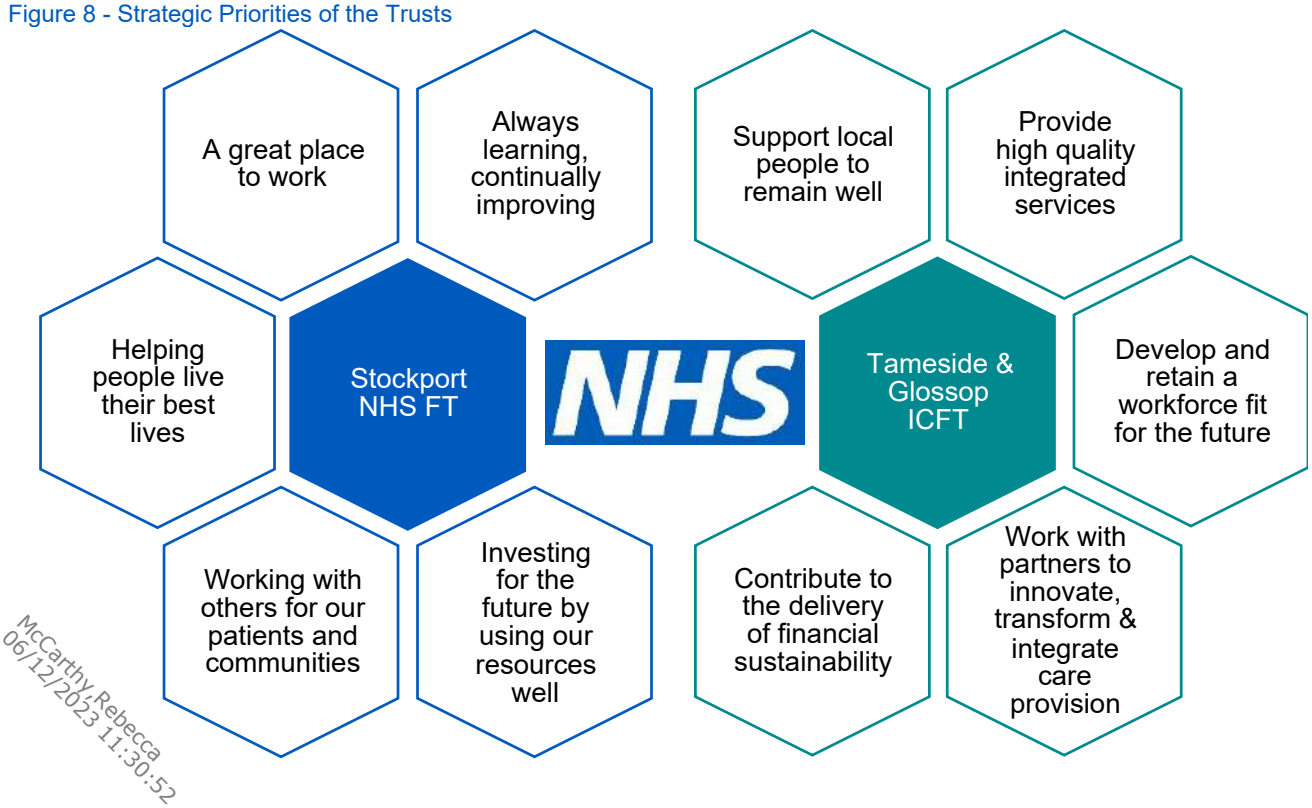
Figure 7 - Greater Manchester Integrated Care Partnership's missions

1. Strengthening our communities
2. Helping people get into, and stay in, good work
3. Recovering core NHS and care services
4. Helping people stay well and detecting illness earlier
5. Supporting our workforce and our carers
6. Achieving financial sustainability

The expectation is that Places will lead on transformation programmes in response to the GM ICS Forward Plan. Locally, Stockport and Tameside Places have developed their locality plans.

Finally, as a continuous improvement strategy to serve our organisations, we need to ensure alignment to our trusts' strategic objectives.

Figure 8 - Strategic Priorities of the Trusts



Ambition 2: Develop a continuous improvement culture

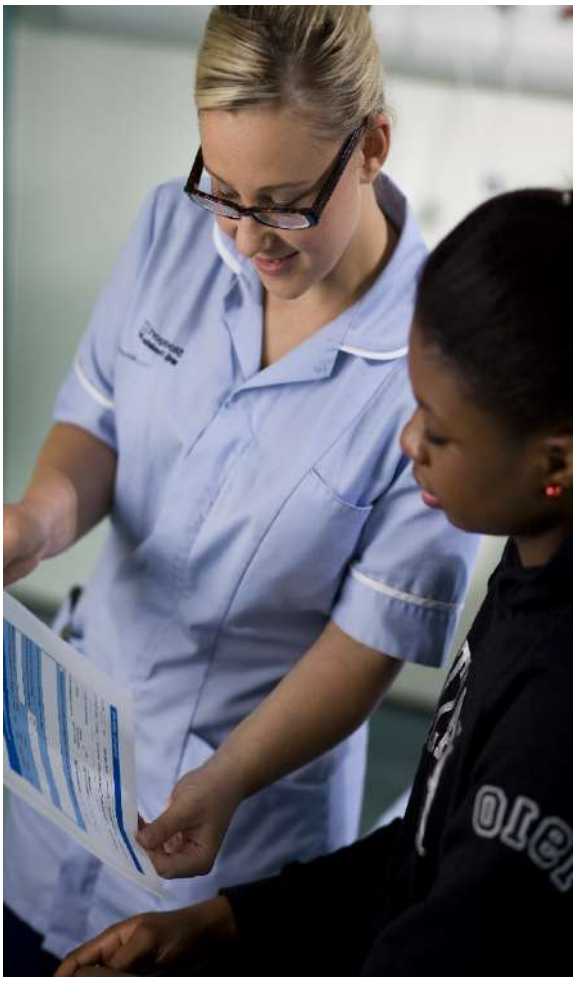
Develop
a continuous improvement culture

Healthcare is an ever-changing environment, and consequently, we need to continually be able to respond to change. Improvement must be a golden thread throughout our organisations and workforce. By creating an improvement culture, we are advocating a curious mindset, where there is confidence to explore opportunities for meaningful and lasting improvements; opportunities to celebrate and encourage success and innovation; scope for recognising and learning from past errors; whilst being willing to constantly explore and consider new, exciting practices. Culture is not easy to change, however, to enable this, we will:

Objective 2.1: Provide the tools to support change and improvement

We acknowledge that one size does not fit all when it comes to improvement. Therefore, we will:

- Develop a core catalogue of improvement tools and techniques that can be used in a wide array of scenarios, across the whole improvement cycle.
- Provide opportunities for people to explore these tools through masterclasses and drop-in sessions provided by the Transformation Team.
- Develop digital and interactive materials for self-service transformation tools.
- Support people to understand how to use data to make and track changes.



Objective 2.2: Develop an improvement hub, providing support and coaching to individuals and teams in implementing an improvement initiative

To support those implementing improvement initiatives, we will:

- Create an improvement hub supported by the Transformation Team as a drop-in space for individuals and teams to discuss the initiatives, progress, successes and frustrations.
- Support people to develop their ideas, apply the tools or work through their challenges of leading an improvement.

Objective 2.3: Promote improvement initiatives and share learning widely, celebrating successes through a range of avenues

To develop a culture of continuous improvement, it is important to learn from improvement initiatives that occur across the organisations, alongside celebrating these improvements. We will:

- Use a range of media including storyboards, posters, videos and animations.
- Utilise trust communication pathways to ensure improvement initiatives and outcomes are shared widely.
- Engage in cross-sector learn and share sessions between both SFT & TGICFT.
- Work with our health and care partners in the locality, Greater Manchester and nationally to engage with and facilitate learning and sharing events.

Objective 2.4: Develop a forum for improvement ideas to be submitted and reviewed

Acknowledging that those working within, or using, our services are the experts in understanding where we may be able to make improvements, we will:

- Provide a forum for people to submit improvement ideas, including anonymously.
- Create a panel to review the improvements submitted, which will include leaders from the relevant divisions/services, and finance colleagues, to consider our future opportunities.

Ambition 3: Organisational partnerships to deliver sustainable change

Organisational Partnerships
to deliver sustainable change

We cannot deliver change that is sustainable in isolation. It is imperative we work together as individual organisations, with our wider system partners and as a sector. This will ensure any improvements we make will lead to sustainable change.

Objective 3.1: Collaboration within and across both organisations to share good practice and areas for learning

As the Transformation Team are a corporate team, rather than divisionally aligned, they are well placed to support the sharing of good practice, across the organisation and sector. We will:

- Provide opportunities for good practice and areas of improvement to be shared across the organisation and sector through specific learn and share sessions.
- Continue to ensure divisional representation at the relevant Service Improvement Groups across both sites.

Objective 3.2: Engage with system-wide partners to implement and embed sustainable change for the benefits of the people living in our localities

We acknowledge that as Foundation Trusts, we cannot work in isolation, and working with our partners is vital to support the delivery of the NHS Long term Plan, Greater Manchester Joint Forward Plan as well as our local wider health economy. We will:

- Engage with all key stakeholders in our improvement programmes, including health, social and voluntary sector organisations.
- Ensure that we are engaged as key partners in the work occurring across our systems including through our place-based partnerships and working.

Objective 3.3: Work with our partners to support improved prevention and early identification for our local population

We understand that prevention is better than cure, and that for those who do receive a health diagnosis, the earlier this is identified, for many this will lead to improved outcomes. Consequently, working with our partners to support improved prevention and early identification for our local population is paramount. We will:

- Ensure we understand the health inequalities within our localities, and where targeted interventions are required.
- Acknowledge that prevention and early identification needs to be a key essential workstream for many of our improvement programmes, and work with our partners to support the prevention and early identification agenda.
- Support place-based approaches and communication campaigns aimed to tackle the social determinants of health.

Ambition 4: People placed at the heart of our plans and engagements

People
placed at the heart of our plans and engagement

Co-production is about people working together using their lived and living experience and expertise to, equally, responsibly, inclusively and creatively find solutions to tricky problems. It is vital that as we go on this continuous improvement journey, we do so with all stakeholders, including those who work within, and those who access our services, alongside those who live within our local communities.

Objective 4.1: Create opportunities for people to suggest improvements

When considering this objective, it is important to note that this voice is open to all who work within, or access, our services. By encouraging an inclusive approach to improvement and empowering people to make suggestions, we are encouraging a cycle of continuous improvement and acknowledging that our services should not remain static, and anyone can help make a difference to how we shape our future. We will:

- Develop a process for patients and carers to suggest improvements.
- Develop a process for our workforce to suggest improvements, including anonymous submissions.
- Develop a robust review process for submissions.

Objective 4.2: Co-produced improvement with our staff and service users and those with lived, and living, experience

Those working within, or accessing our services are the experts. We will:

- Co-design and co-produce with service users and people with lived experience of our services and pathways.
- Provide opportunities for various levels of partnership in our transformation programmes.
- Seek to ensure that a diverse range of perspectives are sought and considered, mirroring the diversity of those accessing our services.
- Improve our offer back to those who provide their time to support our improvement programmes by offering high-level improvement training and mentoring which will support them when sitting on our programme boards.

Objective 4.3: Person-centred approaches underpins all improvement work we carry out

A one-size-fits-all health and care system simply cannot meet the increasing complexity of people's needs and expectations. A person-centred approach is based on 'what matters to people' and their individual strengths and needs. We will:

- Ensure a person-centred approach underpins all our improvement programmes of work.
- Gain a range of perspectives on our improvement journeys, to widen the voice and understanding to the work that we carry out.
- Ensure our pathways remain flexible enough to support a person-centred approach to the care we provide to our patients.

Objective 4.5: Grow a network of Improvement Champions

We have dedicated Transformation Teams on both sites, but to grow the continuous improvement culture, we need champions to take this forward and grow the movement. We will:

- Grow a network of improvement champions, built from those with an interest and desire to improve services.
- Provide support and a range of resources to the improvement champions to support them on their improvement journeys.
- Provide training to the improvement champions with an expectation of wider dissemination through a train the trainer approach.
- Support career and personal development pathways for staff and improvement activists at all stages.

Objective 4.4: Effective, visible leadership to support improvement

A focus on instilling behaviours that enable improvement throughout organisations and systems, role-modelled consistently by leaders at all levels within our organisation. We will:

- Ensure continuous improvement is part of our leadership training programmes across both organisations.
- Ensure a clear Senior Responsible Officer, Operational and Clinical Lead is identified on our Transformation schemes run as an organisation and ensure the people undertaking these roles have received any relevant training.
- Ensure improvement is featured within the job descriptions of our leaders and managers across the organisations.
- Provide opportunities at all levels for where leadership to support improvement occurs as visualised below:

Ambition 5: Train our people to deliver improvement

Train
our people to deliver improvement

To embed a continuous improvement culture, it is important to ensure that our workforce feel adequately skilled and confident to implement and monitor improvements. Training is an essential component of this. To support this ambition, it is important to acknowledge that people have varied preferences when it comes to learning, and there are many different methods to train people

Objective 5.1: Develop an in-house improvement training programme for people across all levels

To increase the access to improvement training that our people can receive, we will:

- Utilise the ADOPT Continuous Improvement branding to develop an in-house training programme based on a Stockport & Tameside methodology
- Communicate widely to make our workforce aware of the training packages available.

Objective 5.2: Provide training opportunities in an array of media

It is important to acknowledge that people learn in many ways, and as one-size does not fit all when it comes to improvement, nor does it when it comes to training. Consequently, we will:

- Review opportunities across a range of media to facilitate training, including podcasts; face-to-face sessions; virtual sessions; and self-help guides.

Objective 5.3: Provide drop-in sessions for people, and teams, leading their own improvements

Generic training will not always support people when on their improvement journeys. Therefore, we will:

- Provide bespoke opportunities for individuals and teams to access coaching to support them whilst carrying out improvement work.
- Provide frequent drop-in sessions, where individuals, and teams, can attend to discuss a change initiative, gain understanding on tools available to support them and share learning and areas of good practice and those of learning.

Objective 5.4: Provide bite-size improvement education sessions for people to attend

A curious mind may need space to explore ideas with others to understand opportunities or tools that may be available to support their services and the improvements they are looking to make. We will:

- Hold frequent drop-in sessions run by the Transformation Team, where any individual or team can attend to build their continuous improvement knowledge and gain understanding on tools through bite-size sessions.

6. Key indicators of success

The Trusts are committed to ensuring transparency by actively monitor the effectiveness of our plans. The following indicators will be used to assess progress.

Ambition	Objective		Success indicator
Align	1.1	Ensure we remain aligned to organisational, regional and national strategies and objectives.	Meet the key milestones set out in the NHS Long Term Plan and operational planning guidance.
			Key stakeholders supporting the GM Integrated Care Partnership 6 missions.
Develop	2.1	Provide the tools to support change and improvement	"ADOPT" Continuous Improvement Methodology embraced across both organisations.
			Interactive materials and self-help guides created and available to all, to introduce improvement tools and their use.
			Increased number of people accessing available materials.
	2.2	Develop an improvement hub, providing support and coaching to individuals and teams in implementing an improvement initiative	Frequent drop-in clinics available.
			Increased number of people accessing sessions
	2.3	Promote improvement initiatives and share learning widely, celebrating successes through a range of avenues	Embedded joint working model for improvement across the two organisations with leadership infrastructure to enable this.
			Annual Transformation event to be held at both Trusts to celebrate their improvement work.
			Increased number of "Learn and Share" sessions between the 2 organisations to be held.
			Combined annual report to be published showcasing the transformation work occurring.
			Increased involvement in regional and national webinars, showcasing both organisations as at the forefront of improvement and transformation.
			Increased number of award nominations.
	2.4	Develop a forum for improvement ideas to be submitted and reviewed.	Mechanisms developed for people to submit their ideas for improvement, and their review.
			Increased number of improvement initiatives that may contribute to financial/efficiency/quality improvements received.
			Feedback loop developed to update those who have suggested improvements.

Ambition	Objective		Success indicator
Organisational Partnerships	3.1	Collaboration within and across both organisations to share good practice and areas for learning	Increased number of "Learn and Share" sessions between the 2 organisations to be held.
			Maintained levels of engagement through Service Improvement Groups at both organisations.
	3.2	Engage with system-wide partners to implement and embed sustainable change for the benefits of the people living in our localities	Stakeholder checklist, including all parties, included in all transformation schemes.
			Attendance as providers at all relevant meetings to improve our localities.
	3.3	Work with our partners to support improved prevention and early identification for our local population	Increased features of health inequalities within improvement schemes.
			Prevention and early identification workstreams to feature within all long-term health improvement schemes.
			Increased campaigns to improve prevention and early identification.
People	4.1	Create opportunities for people to suggest improvements	Increased opportunities for patients and carers to submit improvement ideas.
			Increased opportunities for our workforce to submit improvement ideas.
	4.2	Co-produced improvement with our staff and service users and those with lived, and living, experience	Increased visibility of patients and carers views in improvement schemes
			Increased training for people with lived and living experience who support our transformation meetings.
	4.3	Person-centred approaches underpins all improvement work we carry out	Increased number of EIA and QIA completed for improvement initiatives.
			Increased number of improvements have considered and documented person-centred approaches.
	4.4	Effective, visible leadership to support improvement	All senior leader job descriptions to include improvement.
			All senior leaders have accessed improvement training.
			All transformation schemes to have an operational lead and clinical lead.
	4.5	Grow a network of Improvement Champions	Increased number of improvement champions.
			Increased number of services with an improvement champion.

Ambition	Objective		Success indicator
Train	5.1	Develop an in-house improvement training programme for people across all levels	Increased number of people accessing training packages.
	5.2	Provide training opportunities in an array of media	Increased methods of accessing training.
			Increased number of people accessing resources and training across the platforms.
	5.3	Provide drop-in sessions for people, and teams, leading their own improvements	Frequent drop-in clinics available.
			Increased access to coaching opportunities for improvement.
	5.4	Provide bite-size improvement education sessions for people to attend	Frequent drop-in clinics available.
			Increased number of people accessing sessions.

6.1 Risks

Effective management of risks will be key to achieving our digital strategy. Risks will be managed via a risk register in accordance with Trust risk management arrangements and reported to the Service Improvement Group.

Risk	Mitigation	Impact	Likelihood	Score
Operational pressures in an uncertain climate due to ongoing industrial action.	Service Improvement Group will oversee priorities and address conflicts	4	3	12
Conflicting priorities and ongoing operational challenges don't allow time for improvement	Service Improvement Group will oversee priorities and address conflicts	4	3	12
Lack of capacity and inability to allocate time for improvement delivery work	Executive recognition of demands of business as usual activities	4	3	12

6.2 Impact Assessment

In line with the Trusts' governance procedures, any change programme will be assessed for potential impact on quality of services, equality of access and outcomes, and impacts on privacy.

7. Find out more

For more information, contact us at:

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NHS
Stockport
NHS Foundation Trust

NHS
Tameside and Glossop
Integrated Care
NHS Foundation Trust

APPENDIX 1

Tameside and Glossop Integrated Care NHS Foundation Trust

Stockport NHS Foundation Trust

NHS IMPACT AND THE CONTINUOUS IMPROVEMENT STRATEGY

NHS IMPACT FOCUSEIS THE NEW, SINGLE, SHARED NHS IMPROVEMENT APPROACH LAUNCHED IN 2023. IT HAS 5 COMPONENTS FORMING THE 'DNA' OF ALL EVIDENCE-BASED IMPROVEMENT METHODS

BUILDING A SHARED PURPOSE

The continuous improvement strategy sets a shared vision and purpose. for both organisations.

Following collaboration with our staff on both sites, we have ensured it meets the needs of our people.

It aims to build a culture, underpinned by our core values, and places our people, both workforce and the local population, at the heart of the strategy.

INVESTING IN PEOPLE & CULTURE

Developing a culture of improvement is at the heart of the strategy, acknowledging that improvement needs to be everyone's business.

The strategy implementation will provide opportunities for people to develop their skills in improvement, providing them with the confidence to enable improvements in their day-to-day operations.

Idea generation through a "hub" and providing opportunities for improvement coaching is paramount in the strategy.

DEVELOPING LEADERSHIP BEHAVIOURS

Effective, visible leadership to support improvement is a key objective of the strategy.

It aims to ensure continuous improvement is part of our leadership training programmes and that those leading transformation schemes have had adequate training.

Leadership occurs at all levels, and the strategy capitalises on this to ensure we are building leadership behaviours for improvements across all of these levels, including through access to our training programmes.

BUILDINIG IMPROVEMENT CAPABILITY & CAPACITY

Through this strategy with have developed a methodology based on "ADOPT" Continuous Improvement.

This training package will be rolled out to all as part of our 3 year implementation plan.

We have also acknowledged the importance of those with lived and living experience. with co-production a key ambition of all improvement work going forward.

EMBEDDING IMPROVEMENT INTO MANAGEMENT SYSTEMS & PROCESSES

We have robust processes in place across both organisations through our Executive-led Service Improvement Groups (SIG) to respond to system and national priorities.

This group enables oversight of continuous improvement work, alongside clear escalation plans for risks and issues that are occurring that may limit improvement.

Meeting date	7th December 2023	**Public**	**X**	**Confidential**	
Meeting	Board of Directors				
Report Title	NHS IMPACT Framework 2023 - Assurance Report				
Director Lead	Angela Brierley, Director of Transformation	**Author**	Hannah Silcock, Head of Transformation		

Paper For:	**Information**		**Assurance**	X	**Decision**	
Recommendation:	The Board of Directors is asked to note the content of this assurance report in relation to the guiding principles of the NHS IMPACT Framework 2023.					

This paper relates to the following Annual Corporate Objectives

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

The paper relates to the following CQC domains

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

This paper relates to the following Board Assurance Framework risks

X	PR1.1	There is a risk that the Trust does not deliver high quality care to service users
	PR1.2	There is a risk that patient flow across the locality is not effective
	PR1.3	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan
	PR2.1	There is a risk that the Trust is unable to sufficiently engage and support our people's wellbeing
	PR2.2	There is a risk that the Trust's services do not fully support neighbourhood working
	PR3.1	There is a risk in implementing the new provider collaborative model to support delivery of Stockport ONE Health & Care (Locality) Board priorities
	PR3.2	There is a risk that the Trust does not deliver a joint clinical strategy with East Cheshire NHS Trust
	PR4.1	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to

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

Where issues are addressed in the paper

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

Executive Summary

The purpose of this report is to provide assurance to the Board in relation to the new universal NHS IMPACT Framework (Improving Patient Care Together) which was produced by NHS England in September 2023. (This is available on the NHS IMPACT website).

The National Improvement Board strongly encourages organisations, and their Boards, to engage in the creation of a development strategy, applying an organisational approach to improvement to embed the five components of NHS IMPACT:

- Building a shared purpose and vision
- Investing in people and culture
- Developing leadership behaviours
- Building improvement capability and capacity
- Embedding improvement into management systems and processes

NHS IMPACT states that when these five components are consistently used organisations create the right conditions for continuous improvement and high performance, delivering better care for patients and better outcomes.

This report highlights how we will meet the five principles across Stockport NHS Foundation Trust and Tameside & Glossop ICFT through our newly developed Continuous Improvement Strategy.

1. Purpose

1.1 The purpose of this paper is to highlight the NHS IMPACT (Improving Patient Care Together) approach to improvement that has been developed by NHS England and to provide an update on our current position against the 5 guiding principles.

2. Introduction / Background

2.1 In 2023, a new NHS Impact approach to improvement was launched, aiming to align and develop an integrated approach to improvement delivery and capability building across NHS provider organisations and integrated care systems (ICS's). The approach outlines 5 guiding principles with associated recommendations.

2.2 The 5 guiding principles are:

- Building a shared purpose and vision
- Investing in people and culture
- Developing leadership behaviours
- Building improvement capability and capacity
- Embedding improvement into management systems and processes

3. Our Current Position

3.1 <u>Building a shared purpose and vision:</u>

3.1.1 This principle focuses on creating a vision and shared purpose, driven by the executive leadership team, with input from all stakeholders, including those with lived experience. It requires all improvement work to align to the shared purpose and vision. And encourages organisations to start by focusing on current NHS priorities and pressures the organisation is facing. The shared purpose and vision should allow staff to understand the importance of their work and to see it from the service user's perspective. Celebrating and sharing good practice where possible.

EXAMPLE OF WHERE THIS IS HAPPENING IN PRACTICE

Stockport NHS FT and Tameside & Glossop ICFT:

Improvement is one of the core objectives of both organisations. Both organisations also have clear strategic priorities, alongside those set out through the Long Term Plan. At both organisations, all requests for Transformation Team support into improvement work is prioritised against these priorities. Requests for improvement support is managed through the Service improvement Group on both sites.

Both organisations also hold an annual Transformation Event to celebrate the improvement work that has occurred and have had a new Marketing role introduced to help the Trusts celebrate improvement successes.

See Continuous Improvement Strategy pages 11-12 for how this will develop moving forward.

3.2 Investing in people and Culture:

3.2.1 This principle promotes working with people in healthcare roles, alongside those with lived experience to design and implement improvements based on what matters to them. It encourages horizon scanning and visiting other systems and organisations to understand different ways of working. Through investing and supporting our staff, it will enable them to make improvements on their day-to-day operations. This principle encourages a coaching style to leadership in areas where improvement is required and to encourage idea generation and PDSA (plan, do, study, act) cycles regularly, encouraging the use of measurements to capture improvement.

EXAMPLE OF WHERE THIS IS HAPPENING IN PRACTICE

Stockport NHS FT:

Stockport FT have been on a journey of experience-based co-design for their service improvements over the last 2 years. This has seen the model for pain management services redesigned with people who access our services. This project and way of working has received recognition through awards and funding being awarded through the Q Exchange to support the next phase of improvements. This is a model we will continue with where appropriate across both Stockport and Tameside.

Tameside & Glossop ICFT:

The Digital Health Team have been supporting out-of-hospital care across Tameside & Glossop since 2017. Since being established, through a series of PDSA cycles they have been continually measuring the effectiveness of a number of pilot schemes involving the use of digital technology, working in collaboration with system partners and people with lived experience to continually develop new services to the local population. Evidence suggests that this is versatile service model, which is well accepted by users, in a range of settings and can be delivered at scale across the Greater Manchester footprint.

See Continuous Improvement Strategy pages 13-14 & 17-18 for how this will develop moving forward.

3.3 Developing Leadership Behaviours:

3.3.1 This principle advocates for a clear leadership development strategy which outlines capability requirements and access to training. It talks to building leaders across the system that respond to the values and behaviours of the organisation, including holding leaders to account for behaviours, not just improvement. It advocates for support to be in place to empower people to improve their own services and carry out test improvement projects, alongside training/development opportunities for everyone who has a formal leadership role, to provide them with the skills and experience to deliver improvements.

EXAMPLE OF WHERE THIS IS HAPPENING IN PRACTICE

Stockport NHS FT:

Acknowledging that leadership occurs at all levels, Stockport has a robust preceptorship training programme, with dedicated modules and sessions for improvement throughout the preceptorship cycle. This model encourages improvement from early in peoples careers. Individuals are supported to run their own improvement projects as part of their preceptorship.

Tameside & Glossop ICFT:

Tameside have developed and delivers the ASPIRE leadership programme. As part of this a full day session on quality improvement and development is delivered, encouraging our leaders to run their own improvement project as part of the programme. This provides the foundations for our senior leaders in the organisation, to support them in delivering and advocating for improvement within their teams.

See Continuous Improvement Strategy pages 18-19 for how this will develop moving forward.

3.4 Building improvement capability and capacity:

3.4.1 This principle focuses on the use of an improvement methodology to use across the organization, ensuring a local way of practicing improvement. To support this, it promotes access to improvement training for all, so that everyone can run improvement projects and continuously improve their work. This includes how to measure success and utilise data to track changes, alongside ensuring co-production with people who use our services. This domain advocates a training strategy to increase improvement capability.

EXAMPLE OF WHERE THIS IS HAPPENING IN PRACTICE

Stockport NHS FT and Tameside & Glossop ICFT:

Both organisations recognise the importance of flexibility within their improvement approach, recognising that one size does not fit all. Therefore, we have a range of methodologies within our improvement toolbox. As part of our Continuous Improvement Strategy, we have built a methodology that will support flexibility to meet our organisational needs.

Access to training and co-production has been present to date in both organisations. However, we recognise a need to increase this as an underpinning ethos to improvement across all areas.

See Continuous Improvement Strategy page 19 for how this will develop moving forward.

3.5 Embedding into management systems and processes:

3.5.1 This principle encourages the development of a management system to align with the strategy, vision and purpose of the organisation, from board to all workforce structures and functions. This aims to monitor early warning signs and quality risks, with clear processes of how to respond. The goal is to build a coherent system allowing easy adaptation to national priorities, facilitated by a committed Board utilising the approach for day-to-day operations and ensuring transparent, trackable progress.

EXAMPLE OF WHERE THIS IS HAPPENING IN PRACTICE

Stockport NHS FT & Tameside & Glossop ICFT:

Both organisations hold a strong governance & assurance approach to improvement through their respective Service Improvement Groups (SIG). Trust priority schemes are reported on a monthly basis to the group and additional divisional improvement work is reported bi-annually. Both SIG's track and monitor improvement and respond to risks and blockages that are present within the organisations.

See Continuous Improvement Strategy pages 11-12 for how this will develop moving forward.

4. Recommendations

This paper recommends the implementation of the newly developed Continuous Improvement Strategy to support both organisations in building a culture for improvement, alongside strengthening our areas for improvement outlined within the NHS IMPACT Framework.

Meeting date	7 December 2023	**Public**	X	**Confidential**	
Meeting	Trust Board of Directors				
Report Title	Digital Strategy 2021-26 Delivery Report: No. 3				
Presented by	Peter Nuttall, Director of Informatics	**Author**	Helen Bennett, Chief Information Officer		

Paper For:	**Information**		**Assurance**	X	**Decision**	
Recommendation:	The Board of Directors is requested to review the content of the report and confirm progress against the Digital Strategy 2021-26.					

This paper relates to the following Annual Corporate Objectives

x	1	Deliver personalised, safe and caring services
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	4	Develop a diverse, talented and motivated workforce to meet future service and user needs
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X	Well-Led	X	Use of Resources

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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

Following approval of the Trust's Digital Strategy in December 2021, the attached report provides the third update on the delivery of this Strategy. The first update was provided to the Board in October 2022 and the second in June 2023.

The report follows the same format as the overall strategy and focuses upon the Trust's seven digital ambitions as detailed in the diagram below.

1. Introduction

1.1 The aim of this report is to update the Board of Directors with work that has been undertaken in the last six months to deliver the Trust's Digital Strategy. Detailed below are the key highlights from the report.

2. DIGITISE patient care

2.1 Work is progressing slowly on the Joint EPR Programme with Tameside. The Stockport and Tameside Boards approved a decision to progress to formal procurement (subject to all external approvals). It was recognised at this stage that the OBC presented an affordability gap. Although this position was accepted by GM, the OBC has not yet been supported by the regional team and, therefore, has not been submitted to the national team for final approval. Over the last 6 months, there has been significant reprofling of the financial schedules of both Trusts including reviewing of cash releasing benefits to improve the overall affordability gap.

2.2 Work on replacing of the Trust's laboratory system (Telepath) is well underway with the new solution (called Winpath supplied by Clinisys). The Trust team is working with three other Trusts in GM to develop a standardised build that will support future GM pathology networking. An anticipated go live date is planned for June 2024.

2.3 A new blood tracking solution (Haemonetics) is due to go live on 28th November and will be rollout across the Trust. This digital system will remove the risks associated with the current paper-based processes.

2.4 Three projects have now been formally handed over to BAU: Ophthalmology EPR, Theatreman and PATRON (clinical system access portal); and the rollout out of in- house developed CLIO (e clinic outcome form) has commenced across acute specialities.

3. EMPOWER our patients

3.1 The main focus of activities in the last six months, is a review in the use of the Trust's virtual consultation platform (Attend Anywhere [AA]). This review is to assess whether this functionality is required, once external funding expires in March 2024. The use in the national solution provided to Trusts during the Covid pandemic, has declined as outpatient services returned to the pre- pandemic position, with non- face- to- face appointments being delivered generally by phone. Paediatrics is the largest user, with some use in 12 other services/community teams. An option appraisal paper is currently being drafted for executive team consideration.

4. SUPPORT our staff

4.1 Our Digital Nursing team, in conjunction with our digital technology and support staff, continues to support wards and clinical departments with 'digital ward rounds' to ensure that all digital kit is well maintained so that that staff have

devices readily available at the point of care. The digital skills team continues to enhance the Trust's digital e learning offering with on- line Haemonetics training for nursing staff to be released, and new on- line training being finalised for staff moving from 'green screen' PAS to Patientcentre later in the year. A programme for updating all on- line training packages for staff using the Community EPR is also underway.

4.4 INVEST in our infrastructure

4.1 Rollout of the new replacement wireless infrastructure and network cabinet refresh programme is underway with a third of network cabinets now replaced. With major issues raised around the Trust's two server rooms cooling systems, a small investment is required in Aspen House and an option appraisal has commenced to review potential solutions to replace the current Beech House server room. This includes consideration for an adjacent new build or installation of a server room pod.

4.2 Work continues on security patching of our systems and infrastructure to keep the Trust safe from ever- increasing cyber-attacks. A new cyber solution, called Palo Alto, is now live to provide assurance of cyber safety of medical devices connected to the Trust's network.

5. ENGAGE our clinical leaders to improve quality

5.1 Work is continuing on engaging clinical staff in the Trust's digital programmes including the potential future EPR. Workshops have been held with a range of clinical teams in developing demonstration scripts to support the formal EPR procurement. Led by Chief Clinical Information Officer, this process ensures that clinicians feel engaged in this major transformation programme. Plans have commenced on developing a formal digital champion network that will be supported by training and awareness of the full digital agenda.

5.2 Clinical coding is also progressing with its modernisation programme. Working collaboratively with Tameside, a full staff consultation has been held with Stockport team, which that has included the appointment of a joint head of service and a cross organisational training team.

6. ENHANCE our performance

6.1 Optimisation of the Trust's data warehouse continues. Data from the Trust warehouse now feeds into high- profile NHS England improvement programmes, including Model Hospital, GIRFT and Faster Data Flows, as well as to the Integrated Care System supporting their System Control Centre, the new OPEL framework, and locality board reporting.

6.2 The team continues to support Trust service improvements and their day-case dashboard was shortlisted for this year's Health Service Journal (HSJ) Patient Safety Award. This dashboard provides analysis against national benchmarking data, and was designed collaboratively with surgeons to be used in analysing where improvements could be made in moving patients' treatment to day-case rather than with an overnight stay.

7 COLLABORATION with our partners

There is ongoing engagement with digital partners both in Stockport and GM. The delivery of Tquest (electronic requesting of radiology exams by GPs) is due to go live at the end of November.

Meetings continue to be held with Mid and East Cheshire as they progress with their EPR programme.

8 Recommendations

The Board is asked to note the content of this paper and supporting Digital Strategy; Delivery Update: No 3 report.

Digital & Informatics Team

NHS Stockport NHS Foundation Trust

Digital Strategy 2021-2026

Delivery Update: No 3

Trust Board of Directors

November 2023

CONTENTS

1. INTRODUCTION

This is the third update report on the delivery of Trust's Digital Strategy (2021-2026). The Strategy was approved by the Trust Board of Directors in December 2022 and two update reports have been received in October 2022 and May 2023.

The delivery of the strategy is the responsibility of the Digital and Informatics Teams with oversight from the Digital & Informatics Group. This Group meets on a bi-monthly basis and is chaired by the Director of Informatics. Key Issues & Assurance Reports are presented to the Finance and Performance Committee.

2. REVIEW OF AMBITIONS

The report is structured around the seven key ambitions of the strategy (see diagram below) and provides an update on the actions listed against each of the ambitions in the strategy document.

3 FUNDING OPPORTUNITIES

The digital and informatics department have been successful in securing additional external capital funding including £9.9 million in 2021/22 and c £8 million 2022/23. This has enabled investment in a new LIMS solution, ophthalmology EPR, blood tracking system, improved digital dictation, mobile devices for acute/community and significant investment a replacement acute wireless solution and supporting network cabinet refresh programme.

4 OVERALL PROGRESS ON DELIVERY

In the past 6 months, the teams have continued to progress with the delivery of the digital strategy in parallel with managing all BAU activities.

DIGITISE
patient
care delivery

OUR DIGITAL AMBITIONS – 2021-2024

WHAT HAVE WE DELIVERED?

Acute EPR (Electronic Patient Record)

Stockport & Tameside digital teams continue to work on the preparation activities for the formal procurement and implementation of a joint EPR solution. A joint Outline Business Case was supported by both Trust Boards in Jan/Feb 2023. The Boards recognised the affordability gap in the case, but wished to see progression to the formal procurement stage where exact costs would be finalised. This position was supported by GM ICS and the case was submitted to the Regional Team in May 2023. There has been significant remodelling on the financial schedules to improve the Trusts' positions. This work is nearing conclusion, and it is anticipated that the OBC will be submitted to the national team for its 8- week approval phase in late Nov/early Dec. Current estimates are that, if approved, formal procurement will commence in Feb 2024.

Laboratory Information Management System (LIMS)

The LIMS (Telepath replacement) programme is progressing well and is now planned to go live in June 2024, in a sequence of go lives with Bolton, NCA, and Tameside. For Stockport, the LIMS programme forms part of a bigger Pathology Digital Programme which also includes the implementation of an electronic blood tracking system, which is due to go live at end of Nov 2023, and GM digital pathology which is technically live but operationally delayed as a result of pressures and vacancies in cellular pathology.

Optimising existing systems and maximise capabilities.

The Digital Nursing Team has delivered advanced functionality within Patientrack including partial observations, strikethrough of incorrect data entry, leave- and- return recording capabilities, MUST nutrition and hydration assessment, and Sepsis 6 assessment. This work not only has an impact on patient safety, but also enables more accurate BI reporting on patient acuity and nursing intervention. The team continues to develop the system as requested to support key patient safety initiatives and plan to introduce falls/bed- rail assessment modules and Purpose T skin integrity assessments in this financial year.

Maximising the benefits of Community EPR

New developments in the community EPR solution include the introduction of non-medical prescribing, working with the Tameside Digital Health Team in the establishment of virtual wards and also making enhancements to the system to support the Discharge to Assess Service.

Expanded system integration and data sharing

Working with Stockport Locality and GMSS colleagues, we have undertaken a review of access profiles within the Greater Manchester Care Record (GMCR) for Trust staff to facilitate a relaunch of Electronic Palliative Care Coordination Systems (EPaCCS). EPaCCS is used to record and share an individual's care preferences and key details about their care at the end of life. Towards the end of November there will be a locality communication campaign to support the relaunch, which will include signposting to training for those who will be creating and editing EPaCCS documentation.

Explore use of AI/VR & NLP

Enhanced digital dictation allows the clinician to dictate their letters but instead of providing medical secretaries with voice files from which to type the associated letter, a text file is provided for the secretary to review and then send. Following a successful pilot, enhanced digital dictation has been implemented across all clinical specialities apart from Obstetrics and Gynaecology. Date for go live still to be confirmed. The benefits of this solution are reduction in turnaround times for letters being sent to GPs.

Digital Clinical Safety

A robust governance structure and process have been implemented to track and progress the organisation's compliance with DCB standards to ensure the clinical safety of digital systems is assured prior to implementation. A Digital Clinical Safety Group has been established with multi-disciplinary representation and a series of templates and support packages established to enable project teams to achieve compliance. A network of Clinical Safety Officers is being established.

COMPLETED PROJECTS

Specialist Ophthalmology EPR;
Optimise Theatreman solution;
PATRON – single point of clinical- system access.

NEW PROJECTS COMMENCED

CLIO – E clinical outcome forms (in house development to replace green paper RTT forms) to improve data quality and patient tracking for patients on RTT pathways.

OUR DIGITAL AMBITIONS – 2021-2024

WHAT HAVE WE DELIVERED?

Delivery of a patient portal

Comprehensive patient- portal functionality will be procured as part of an acute EPR solution; however, using a current Trust system supplier, a basic patient portal has been established allowing patients to read their outpatient appointment letters and receive messages to confirm their requirement for an appointment if there are long wait times. Having secured £75K from the national Wayfinder programme, work is nearing completion on the Trust's portal to the NHS App link to enable patients to view their appointment. In addition, a proof- of- value exercise is underway to ascertain whether the costs of sending clinical letters to patients via the Trust portal/NHSApp is a more cost-effective approach than via post.

Support increased use of video consultation

External funding provided as result of pandemic for Attend Anywhere [AA] (video consultation platform) will cease in March 2024. Usage in AA has dropped significantly over the last 2 years with the majority of face-to-face consultations being held by telephone; however, Paediatrics and Occupational Health find the solution very helpful. A detailed options paper on the way forward is being finalised in readiness for submission to the Executive Team in November.

Support introduction of patient applications

As part of a GM Elective Recovery Programme, the Trust piloted the 'My Recovery' application. This supports patients cared for by Trauma & Orthopaedics in completing questionnaires to enable the team to track pre- and post- operative patients.

Delivery of the digital maternity record

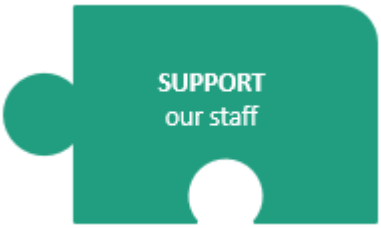
Progress in building system enhancements into Euroking has been slow due to ongoing supplier capacity issues. This has been exacerbated by a national issue with Euroking that has caused clinical risk in some Trusts but only data-quality issues at Stockport. A detailed internal investigation was held, and all mitigations put in place. A 2nd digital midwife has now been appointed.

Explore virtual visiting platform

No updates.

Investigate options for telemedicine and telehealth

No updates.



OUR DIGITAL AMBITIONS – 2021-2024

WHAT HAVE WE DELIVERED?

Embed flexible digital training model

E- learning training continues to be revised to split training into smaller modules to allow flexibility when completing digital training. There are currently ninety-two individual digital courses with sub videos available on Moodle, the Trust's digital training platform, which can be accessed by staff on site or at home. The team is currently working on nurse training for the new blood tracking solution (Haemontics) and Patientcentre training for outpatient staff/ medical secretaries moving from old 'green PAS' to Patientcentre. Work is also underway to refresh Community EPR modules as well as Solus Cardiology to support the major system upgrade. The Digital Nursing Team also has a standing session at the new Clinical Staff Induction Programme to signpost and support new members of staff with the use of Trust clinical digital systems.

Clinical equipment investment and replacement programme

The Digital Nursing Team conducted a Trust wide audit to ensure all existing kit is working as expected, staff have the equipment they need to fulfil their clinical roles and responsibilities, and arranged fixes and replacements as required. The Team is continuing to roll out new devices including ePMA trolleys, dual- screen ward- round trollies and single screen desktops on wheels, across all clinical areas, to support changes in ways of working and care delivery. There are approx. thirty devices left to be distributed. Work has also been undertaken to remind staff in clinical areas how to report issues with broken IT equipment to ensure that they can be fixed as soon as possible. Weekly Digital Clinical Ward Rounds have been established in partnership with the Digital Nursing Team and IT to further support timely resolution of problems with equipment.

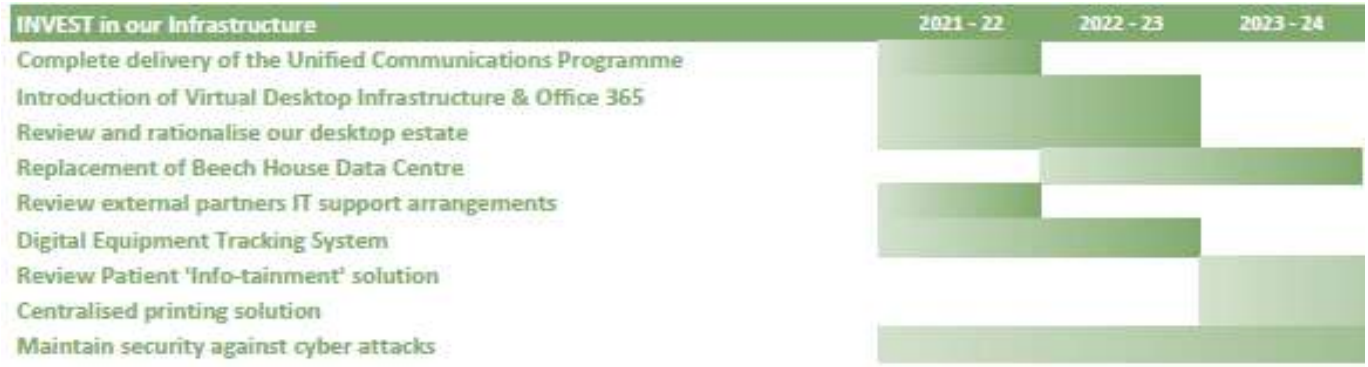
BOYD/UYOD (Bring/ Use Your Own Devices)

No updates.

COMPLETED PROJECTS

Support agile working;
Deliver and refine PATRON.

OUR DIGITAL AMBITIONS – 2021-2024



WHAT HAVE WE DELIVERED?

Complete delivery of Unified Communications Programme

Programme completed in Sept 2022. Due to the speed of deployment part during the pandemic, the team is currently working with all divisions to review handset requirements and original configuration.

Introduction of Virtual Desktop Infrastructure (VDI) and Office 365

Following completion of rollout of the new VDI solution across all community locations, the acute rollout has now commenced but will be aligned with the mandatory deployment of Windows 11. Estimated completion is Q1 – 2024/25.

Review and rationalise desktop estate

Once the VDI programme is complete, a full desktop/laptop rationalisation programme will commence.

Replacement of Beech House data centre

Due to significant challenges with the current 'end of life' cooling systems for the Beech House Server Room and the overall deterioration of the Beech House building, a task & finish group has been established. This includes members of Estates & Facilities, Digital Technology & Support, and the Trust Planning Team who are supporting the development of an options appraisal paper in readiness for review.

Review external partners IT support arrangements

GM Support Services continue to provide support the Trust's connectivity and wifi to all community locations. Work has recently been finalised that would enable the Trust to take this support in house in the future. An options paper on the way forward, considering, costs and service quality will be prepared in early 2024 for consideration.

Digital equipment tracking system

No updates.

Review patient 'infotainment' system

No updates.

Centralised printing solution

Following the rollout of centralised printing across community sites, the acute programme is underway with a planned completion of Q4 2023/4. This programme will replace all printers across community and acute sites with larger, more capable MFDs (Multi- Function Devices) that includes scanning and copying.

Maintain security against cyber- attacks

On 13.10.2024, following a recent penetration test where ¼ of staff passwords were cracked, staff were advised on further strengthening of passwords and avoiding the use of common words. In May 2023, Palo Alto was installed as a more enhanced and adaptive cyber-security capability to keep up with the ever-evolving cyber- threat. This solution also tracks all medical devices connected to the network and highlights any potential threats. With terms of reference drafted, plans are underway to establish a Cyber Security Governance Group in early 2024. This Group will oversee the establishment of an internal Security Operations Centre (SOC) and development of a Cyber Security Strategy.

Replace acute wireless infrastructure

The current programme is now progressing with a third of all network cabinets replaced. Due to challenges with power requirements and fire and lighting standards, there is an overall delay, with an estimated completion date of Q2 2024/5.

NEW ACTIVITIES

Infrastructure replacement/enhancement 5-year Investment Plan

Work is nearing completion on a clear 5-year investment plan for the Trust's digital technology infrastructure. This will ensure that there is ongoing awareness of the need for continual investment to avoid both infrastructure failure and risk of cyber threat.

OUR DIGITAL AMBITIONS – 2021-2024

WHAT HAVE WE DELIVERED?

Establish a robust clinical engagement framework

Work is currently underway to engage clinical teams across both the acute and community sites in preparation for the procurement of an EPR. Clinical Teams have been engaged through workshops, forums and 1:1 discussions to inform creation of demonstration scripts. Once the EPR programme is confirmed, the foundation building work completed to date will inform the establishment of an engagement framework that will underpin digital clinical safety, IT development prioritisation, and EPR procurement/implementation. Efforts are currently underway to design a Trust Digital Champions Programme that increase the presence and impact of digitally enthused clinicians across the organisation to promote pipeline projects and to garner momentum and interest in the digital and informatics specialties.

Digital comorbidity to capture to improve clinical data quality

This development is currently on hold due to staffing pressures in the Trust's Digital Development & Integration Team. This initiative will be reviewed in Q4 2023/4.

Modernise our clinical coding department and raise its profile

To further support the modernisation of the clinical coding department, the Trust is working collaboratively with Tameside. A full staff consultation with the Stockport team has just closed and included the appointment of a joint head of service and a cross- organisational training team. This reorganisation also includes a resource to help deliver the department's improvement and engagement programme, working with clinicians to raise awareness and improve processes in order to ensure clinical coding is accurate and fully representative of the patient population and the level of care being provided by the Trust.

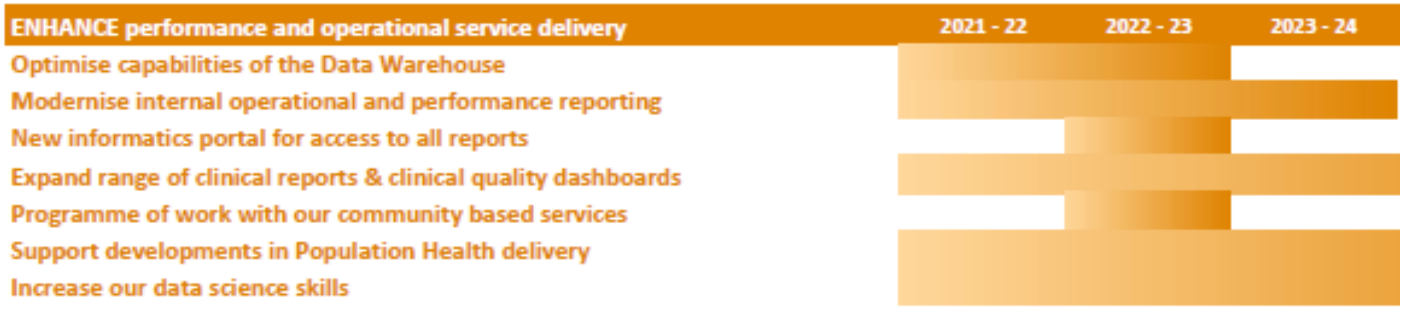
Clinical coders working more closely with clinical teams

See previous point.

Data provision for clinical audit and research teams

To support improved access to data for clinical audit and research in the future, the following detail has been included in the draft EPR output based specification and will be a requirement of a future EPR supplier.
'*The EPR solution must also allow for effective clinical audit by providing functionality to easily identify cohorts of patients, and subsequently supply a standard set of information and ad hoc reports to assess clinical practice. A combination of specific clinical audit reports and alerts are expected to be provided by the bidder to support the clinical audit function for each discipline.'*

OUR DIGITAL AMBITIONS – 2021-2024



WHAT HAVE WE DELIVERED?

Optimise capabilities of the data warehouse

The Trust's Data Warehouse centralises data from lots of different systems and sources. The warehouse now contains data from seventeen different clinical systems. Having data in one central place makes reporting, analytics, and external data submissions easier and more comprehensive. Work continues to refine the underlying data models and to develop new reporting layers in order to decommission legacy reporting tables, supporting the move to a "single version of the truth". Data from the Trust warehouse now feeds into high profile NHS England improvement programmes, including Model Hospital, GIRFT and Faster Data Flows, as well as to the Integrated Care System supporting their System Control Centre, the new OPEL framework, and locality board reporting. This data is driving decision-making so particular attention is played to data quality with an established Trust Data Quality Review Group providing assurance and recommending improvements to ensure that data quality remains consistently high.

Modernise internal operational and performance reporting

The Business Intelligence (BI) team continues to work closely with the operational teams to develop and improve internal reporting, including providing more predictive analytics. Using Tableau, the team has developed a new ED Live dashboard and a bed- modelling dashboard, both of which predict demand into ED, expected conversion into admissions, and, therefore, bed demand. This enables the operational teams to assess the likely bed requirements over the weeks ahead. The team continues to support Trust service improvements and the day-case dashboard was shortlisted for this year's Health Service Journal (HSJ) Patient Safety Award. This dashboard provides analysis against national benchmarking data, was designed collaboratively with surgeons and is used in analysing where improvements could be made in moving patients' treatment to daycase rather than with an overnight stay.

New informatics portal for access to all reports

The BI team has started to develop centralised menus within Tableau for access to groups of similar reports. The new ED reporting portal has recently been deployed.

Expand range of clinical reports and clinical quality dashboards

Continued attendance by BI analysts at the Deteriorating Patient Group to provide data to support a range of clinical measures and improvements including NEWS2, missed/batched patient observations, safety medications, and auto bleeping. Engagement in the Palliative Care & End of Life Group has commenced where data will be required to support improvements in service delivery.

Programme of work with our community- based services

Work continues on transitioning community data into the new data warehouse, developing the underlying reporting structure and rebuilding national reporting for community waiting times. Re-development of local reporting will follow once the underlying structure is in place. The review process for operational reporting requirements with the community service teams has commenced.

Support developments in population- health delivery

The BI team continues to support the work of the Integrated Care System with the development of risk stratification tools that aid the localities population health and health inequalities agendas.

Increase data- science skills

No updates.

OUR DIGITAL AMBITIONS – 2021-2024

WHAT HAVE WE DELIVERED?

Link closely with Tameside digital teams

Where opportunities have arisen, the teams continue to work closely together, including the use of resource from Tameside to support current interfacing requirements, and establishing a collaborative clinical coding organisational structure. Stockport and Tameside continue to work closely on a joint EPR Programme.

Digitally support the joint clinical strategy with East Cheshire

The digital teams will be engaged once required to participate. Regular meetings are held between CIOs and CCIOs for shared learning and lessons learnt with the East/ Mid Cheshire EPR Programme.

Explore options for joint digital working

No updates.

Review internal and external technical interoperability capabilities

No updates.

Alignment of ambitions with Stockport and Greater Manchester

The Trust's Chief Information Officer (CIO) and Chief Clinical Information Officer (CCIO) attend the Stockport Digital Leaders meeting on a monthly basis. Currently primary care and the Trust are working together to finalise plans for a go live of Tquest radiology on 19 November. This solution will allow GPs to order radiology examinations electronically using the same system they currently use for pathology requesting.

The CIO also attends the weekly meeting of GM Provider CIOs. Both forums ensure that Stockport's ambitions and delivery plans are aligned to external plans.

SUMMARY

Delivery of the Digital Strategy is continuing to progress well, supported by the significant external investment that the team has managed to secure. In addition, the Trust's major digital ambition of a new EPR solution is also progressing, which is a positive step for the Trust, although there are delays in the external approval processes due to issues with affordability. The team is, however, working hard to keep procurement and preparedness activities on track and ensure close collaboration with Tameside. It should also be acknowledged that the Digital and Informatics Team continues to deliver the day- to- day activities highlighted in the diagram below (e.g. answering helpdesk calls; maintaining, and enhancing, digital systems; securing clinical engagement; ensuring good data governance; and responding to ad hoc data requests).

Meeting date	7 December 2023	**Public**	X	**Confidential**	
Meeting	Board of Directors				
Report Title	Communications & Engagement Strategy Update				
Presented by	Director of Communications & Corporate Affairs	**Author**	Director of Communications & Corporate Affairs		

Paper For:	**Information**		**Assurance**	X	**Decision**	
Recommendation:	The Board of Directors is requested to review the content of the report and confirm progress against the Communications Strategy.					

This paper relates to the following Annual Corporate Objectives

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

The paper relates to the following CQC domains

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

This paper relates to the following Board Assurance Framework risks

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

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

Where issues are addressed in the paper

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

Executive Summary

The purpose of this report is to provide an update to the Board of Directors on the delivery of the Communications & Engagement Strategy 2023 – 2026.

The report sets out some of the key achievements in delivering the 2023-24 annual plan since the last update to the Board in June 2023.

It also highlights the operational pressures and unforeseen demand for support that are impacting on the ability of the communications team to fully deliver its annual plan for 2023-24.

As a result for the remainder of the year the communications team will be focusing on maintaining existing trusts communication channels and delivering the re-development of the Trust website – a significant piece of work and a key priority for the organisation.

Due to the impact of unforeseen demand for communications support some activities the team had scheduled to deliver in 2023-24 will now be taken forward in 2024-2025

NHS
Stockport
NHS Foundation Trust

COMMUNICATIONS AND ENGAGEMENT STRATEGY

2023 - 2026

Progress update
December 2023

Making a DIFFERENCE every day

Introduction

In November 2022 the Board of Directors approved a communications strategy to guide the organisation's communications and engagement activities for 2023-2026.

This report provides an update on progress in delivering the communications strategy since the last update to the Board in June 2023.

Objectives

The communication strategy was developed to support delivery of the Trust's overarching strategy, and was aligned with the organisation's values in that:

We care about the views of our stakeholders,

We listen to what our stakeholders tell us,

We respect them, their views, and what they tell us.

The strategy set out seven principles that underpin how the Trust communicates and engages with its stakeholders:

1. We enthusiastically instigate, maintain and learn from engaging two-way conversation with our internal and external stakeholders.
2. Our communication and engagement activities recognise and embrace the diversity of the communities we serve, the colleagues who provide our services, and the partners we work with.
3. The way we communicate and engage with our stakeholders is shaped by feedback from our conversations, and is rooted in insight and developed in response to evaluation.
4. We concentrate our resources on communication and engagement tools and methods that are proven to be the most effective and meet the shared needs of our stakeholders.
5. Our communications are open, honest, warm and friendly, clear and simple, factual, consistent, timely and accessible.
6. We actively embrace effective engagement with all stakeholders and clearly demonstrate how their feedback influences how we work.
7. The language and tone of voice we use in our communication methods and engagement activities reflects our values as a caring, confident, innovative and forward thinking organisation striving to deliver excellent services.

The strategy recognised the Trust's commitment to ensuring that everyone who is in contact with us – as a colleague, patient or partner – has a positive experience, and communication and engagement activities aim to support that by:

- developing a compelling narrative about our ambitions, aspirations and the significant progress we are making on our improvement journey;
- sharing the narrative clearly and consistently across all our proven communication and engagement tools;
- supporting and enabling colleagues to effectively share the narrative.

It also set out our approach to communicating and engaging with:

- internal colleagues,
- patients and their families, who may also be carers;
- partners, including regulators and MPs;
- the public, including traditional media.

The strategy contained a high level first action year plan for 2023-24 and the appendix demonstrates progress to date in delivering that plan.

Delivery

Significant progress has been made in delivering the plan for 2023-24 since the last update to the Board in June 2023:

- Organised and supported range of activities to celebrate NHS 75th anniversary with associated publicity
- Supported staff through the development and maintenance of a menopause Facebook page, drafting blogs for Board's menopause lead and instigating the menopause focused Swartz Round.
- As part of our ongoing development of social media embedded use of Next Door as one of the ways we inform and engage local communities, reviewed the use of X (Twitter) and registered to use the new Threads social media site.
- Worked with colleagues at East Cheshire NHS Trust and external consultants to gather views of Stockport patients, carers and public in latest round of engagement work to support development of joint clinical strategy.
- Worked with corporate affairs colleagues to mark Members Week with events and regular social media posts, and supported annual members meeting.

- Increased positive media coverage of the Trust and its services.
- Attracted 70% more entries for 2023 MADE awards, co-ordinated judging panels and planned for delivery of awards celebration evening on 3 November 2023.
- Developed a Covid memorial art project in partnership with local authority colleagues that will contribute to Stockport's Town of Culture celebrations.

These activities have been delivered by the communications team in addition to its usual workload. While delivery of the strategy is led by the communication team it relies on the capacity of both clinical and non-clinical colleagues to be fully implemented.

The communication team is experiencing a high level of unplanned demand for support, often at short notice, and coupled with industrial action, this has impacted on the capacity of the team to focus on proactive activities and some of the new developments outlined in the annual plan.

For the remainder of 2023-24 the team will have to focus on effectively maintaining existing communication methods and delivering key Trust priorities, including re-development of the website which is a significant piece of work for the small team.

As a result the plan has been reviewed and some activities that the team had hoped to deliver in 2023-24 will now be addressed in 2024-25.

Summary

The communication team has made significant progress in delivering the first year of the 2023-26 communication strategy, despite unforeseen operational pressures.

The annual plan that underpins delivery of the strategy is reviewed on a six monthly basis and due to the high level of unplanned demand for communication support some developments will now be delivered in 2024-25.

Great place to work

Support delivery of organisational development strategy	• Organised successful Making a Difference Awards in October 22 and November 23 - now planning 2023 event • Supported promotion of health and wellbeing events via Trust Update, Trust Talk and staff Facebook	
Develop a communication & engagement handbook to support managers	Handbook developed – roll out paused due to operational pressures	Q4
Work with HR/OD colleagues to ensure new website & recruitment materials markets Trust as employer of choice	Research phase complete, build phase underway	Q4
Develop colleague magazine to foster Team Stockport ethos	Trust Talk introduced July 2022, primarily as an e-newsletter with some paper copies for staff rooms • Positive feedback about the newsletter, with staff regularly requesting additional print copies to read	
Grow staff Facebook group and explore other social media platforms	• Current figures: 3,100 members • Menopause staff private group: 225 members	
Support internal staff network to recognise and celebrate diversity	• Regular networks slide in team brief, • Regular posts in the weekly update to all staff. • Support for awareness days and events as required	Q1 2024-25
Develop staff app	Initial discussions with app provider and future development scheduled	Q4

Investing for the future by using our resources well

Focus on evaluation to target resources to most impactful methods	Quantitative and qualitative evaluation built into all methods as appropriate	
Roll out corporate identity	Operational pressure and resources has delayed development	Q1 2024-25
Support services to evaluate their communication & engagement tools	Part of communications & engagement handbook	Q4
Rationalise on-site messaging to maximise impact	Ongoing consistent approach	

Helping people live their best lives

Maximise opportunities to amply public health messaging	• National and regional campaign material shared across all comms mediums • Specific communication plans developed and rolled out for key Trust activities eg CURE, annual vaccinations	
Adopt strategic management approach to social media messaging to share health and well being campaigns	• Annual messaging schedule developed to tie in with national campaigns and awareness days • Supplemented with regional messaging eg Choose well linked to Bank Holidays • Adoption of new social media platforms to reach neighbourhoods	
Develop a new Trust website to share information	Research phase complete, build phase underway	Q4
Support impactful delivery of key trust campaigns and ambitions	• Specific communication plans developed and rolled out for key Trust activities eg CURE, annual vaccinations, delivery of Green Plan. • Regular comms rep at key planning meetings eg Green Plan	

Always learning continually improving

Maximise sharing of improvement narrative across communication tools	Ongoing consistent approach	
Recruit and train cohort of experts to contribute to media coverage	On hold while funding for media training, or free resource identified	Q4
Ensure 90/10 ratio of positive to negative coverage	Positivity ratio currently above 90%. Number of proactive media stories increased by more than a third since last update	
Develop style guide to support services in communication with patients & families	Operational pressure and resources has delayed development	Q1 2024-25
Develop social media guide	Complete and also available in handbook	
Learn from neighbouring organisations to develop staff app	T&G shared insights which will be incorporated into development	
Expand comms & engagement capacity & skills by sharing learning with south sector partners	• Three workshops held with communications colleagues from T&G and EC – third deferred due to operational pressures. • Ongoing informal sharing and learning on regular basis	
Shape an engagement toolkit to support teams	Operational pressure has delayed development	Q1 2024-25

Working with others for patients & communities

Play active role in national, GM, South sector and Stockport comms & engagement networks	• Attend national professional and Confed network meetings • Attend regular GM and Stockport meetings • Workshops and informal networks with South sector colleagues	
Work with Place colleagues to develop & deliver approach to comms & engagement	• Weekly comms meetings with Place colleagues to develop approach	
Maximise positive messaging opportunities & joint campaigns	• Support Place, GM and national campaign materials across all Trust communication methods • Contribute expertise & knowledge to campaign planning eg winter	
Support clinical colleagues to ensure patient & carers info needs are met	• Operational pressure has delayed development • Adhoc request supported where possible	Q1 2024-25
Ensure effective comms &engagement support to joint clinical strategy work with East Cheshire Trust	• Jointly chair comms & engagement group • Comms link to project governance group • Worked closely with external support to ensure latest phase of patient, carer and public engagement completed	
Support delivery of membership engagement & patient engagement strategies	• Promote patient and members engagement activities through social media and internal comms methods • Support corporate affairs team in the organisation of members events	
Develop annual plan of visits, events & activities to engagement external stakeholders	On hold due to operational pressures	Q4

Meeting date	7th December 2023	**Public**	x	**Confidential**	
Meeting	Board of Directors				
Report Title	Integrated Performance Report				
Director Lead	Chief Executive	**Author**	Peter Nuttall, Director of Informatics		

Paper For:	**Information**	x	**Assurance**	x	**Decision**	x	
Recommendation:	The Board is asked to note and discuss performance against the reported metrics. This includes the described issues that are affecting performance and any mitigating actions to improve performance that are described in the exception reports.						

This paper relates to the following Annual Corporate Objectives

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

The paper relates to the following CQC domains

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

This paper relates to the following Board Assurance Framework risks

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

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

Where issues are addressed in the paper

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

Executive Summary

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

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

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

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

Integrated Performance Report

Reporting Period 01/10/2023

Integrated Performance Report - Introduction

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

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

The Trust is performing well against the Timely Recognition of Sepsis metric and back close to target levels. Antibiotic administration within timescales continues to be challenging. Key themes include delayed sepsis screening, and failure by clinician to complete Sepsis6.

Reported infection rates for C.diff and E.coli continue to be significantly higher than the thresholds set by the UKHSA. C.diff themes from the avoidable cases are linked with antibiotic appropriateness, course length, and course numbers which appear to have increased following the COVID pandemic.

Numbers of hospital- acquired category-2 pressure ulcers are now within target thresholds. Community-acquired pressure ulcers continue to be a challenge, with patient decision- making as a primary theme following a review. Work streams currently in development to support community nurses in their communication with patients.

Maternity has seen a slight increase in the number of registrable stillbirths and neonatal deaths. The Maternity Unit was placed on temporary divert a total of 10 times between July and October.

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

Current performance against the 4-hour standard continues to benchmark well across Greater Manchester, with Stockport ranking 3rd for type-1 performance at 63.59% year-to-date. 12-hour waits are reduced and robust processes for managing, reviewing, and providing assurance for assessment of harm in respect of the delays, are fully embedded within the service.

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

Diagnostic performance is still above the target and, although capacity has been challenged by industrial action in recent weeks, endoscopy and imaging are showing much improved positions. ECG capacity continues to be an area of concern, although support from the CDC has greatly improved the current position.

Cancer performance has been challenged in recent months due to the impact of industrial action and the sustained increase in demand. Divisional teams have revised improvement trajectories across these standards assuming no further industrial action, and considering the changes that will come into effect within individual services. The current forecast indicates that the Trust will achieve both the 28-day standard and the 63+- backlog target by year end, with 62- day performance increasing to 75%.

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

Sickness Absence is above target for October, although an increase was expected due to seasonal illness. The Trust continues to focus on improvements, and recently the Deputy Director of People attended attendance management review meetings with all the Divisions with the intention to challenge and support the escalation of difficult cases. The Trust will also be promoting the services of Maximus which is an external company offering a free support service for staff experiencing mental health issues. Mental health is one of the main contributors to staff not being in work.

Agency costs are lower than average for the fifth month running, reporting 4.7% for October.

Although still above the target, workforce turnover is also reported as significantly improved for a second consecutive month with 14./1% for October.

Mandatory training is showing significant improvements, with reported performance of above 94% for the last several months.

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

At month 7, the Trust position is £2.0m adverse to plan – a deficit of £20.7m. This is a deterioration of £0.2m in month.

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

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

The CIP plan for 2023-24 is £26.2m (£10.3m recurrent). The CIP plan for month 7 is £14.7m; at this point, the Trust is ahead of plan by £0.4m due to a one off non-recurrent benefit in month 6. The majority of the CIP delivered is non-recurrent. Further work continues to take place to identify additional recurrent schemes.

The Trust has maintained sufficient cash to operate during October.

The Capital plan for 2023-24 is £62.7m as per the latest plan submission, which is subject to final confirmation with GM ICS. At month 7, expenditure is behind plan by £5.3m; however, this spend will be reprofiled into future months.

Integrated Performance Report - Scorecard

	Reporting Period	Target 23/24	Actual YTD	6-mth Trend	Actual Month	Current Period	1-mth Forecast
Quality Scorecard							
Mortality: SHMI	Jul-22 to Jun-23	≤ 100		↑	96	●	●
Sepsis: Timely recognition	Nov-22 to Oct-23	≥ 90%		↑	97.4%	●	●
Sepsis: Antibiotic administration	Nov-22 to Oct-23	≥ 90%		↓	74.3%	▲	▲
C.diff infection rate	Nov-22 to Oct-23	≤ 17.63		↘	60.84	▲	▲
Covid-19 infection rate	Nov-22 to Oct-23	≤ 4.27		↑	2.07	●	●
MRSA infection rate	Nov-22 to Oct-23	≤ 0		↓	2.68	▲	▲
E. coli infection rate	Nov-22 to Oct-23	≤ 20.27		↓	121.24	▲	▲
Medication incident rate	May-23 to Oct-23	≤ 4.64		↓	5.8	▲	▲
Patient safety incident rate	May-23 to Oct-23	≤ 69.24		↓	82.54	▲	▲
STEIS reportable incidents	Oct-23	≤ 4	33	→	8	▲	▲
Stroke: Overall SSNAP Level	Jun-23	≥ C		→	A	●	●
Falls rate	Oct-23	≤ 3.51	3.08	→	3.28	●	●
Falls due to lapses in care	Oct-23	≤ 425	174	→	19	●	●
Falls causing moderate+ harm	Oct-23	≤ 22	4	→	1	●	●
Pressure Ulcers: Hospital, Cat 2	Oct-23	≤ 79	32	↑	6	●	●
Pressure Ulcers: Hospital, Cat 3&4	Oct-23	≤ 8	7	→	0	●	▲
Pressure Ulcers: Community, Cat 2	Oct-23	≤ 114	82	→	11	▲	▲
Pressure Ulcers: Community, Cat 3&4	Oct-23	≤ 38	31	→	5	▲	▲
Complaints: Written Complaints Rate	Oct-23	≤ 7.9	7.96	↓	13.17	▲	▲
Complaints: Timely response	Oct-23	≥ 95%	91.4%	↗	97.4%	●	●
Early Neonatal Deaths	Oct-23	≤ 0	2	↘	1	▲	▲
Registrable Stillbirths	Oct-23	≤ 0	2	↓	1	▲	▲
Registrable Stillbirth Rate	Oct-23	≤ 0	1.18	↘	4.24	▲	▲
Smoking In Pregnancy	Oct-23	≤ 10%	6.3%	↘	8.7%	●	●
Maternity Diverts	Oct-23	≤ 0	10	↓	4	▲	▲

	Reporting Period	Target 23/24	Actual YTD	6-mth Trend	Actual Month	Current Period	1-mth Forecast
Operational Scorecard							
Ambulance handover delays	Mar-23	≤ 5%	23%	→	22.6%	▲	▲
4hr Standard	Oct-23	≥ 76%	64.5%	↘	58.6%	▲	▲
Patients in department over 12 hrs	Oct-23	≤ 2%	7.4%	↘	12.5%	▲	▲
No criteria to reside (NCTR)	Oct-23	≤ 73	663	↑	82	▲	▲
Discharge ready	Oct-23		80.4%	↗	81.3%		
Delayed discharges	Oct-23		4.2%	↗	4.1%		
Diagnostics: 6 Week Standard	Oct-23	≤ 5%	13.5%	→	10.8%	▲	▲
62-day standard	Oct-23	≥ 85%	48.2%	→	55.3%	▲	▲
28-day standard (FDS)	Oct-23	≥ 75%	63.7%	↘	61.8%	▲	▲
14-day standard (2WW)	Oct-23	≥ 93%	96.8%	↘	95.7%	●	●
Incomplete pathways 18-week %	Oct-23	≥ 92%		↓	49.7%	▲	▲
52-week breaches	Oct-23	≤ 3814		↗	3923	▲	▲
65-week breaches	Oct-23	≤ 0		↘	1295	▲	▲
Activity vs. Plan: Elective	Oct-23	≥ 100%	101.8%	→	103.8%	●	●
Activity vs. Plan: Outpatient	Oct-23	≥ 100%	99.5%	↗	102.9%	●	▲
Activity vs. Plan: ED Attendances	Oct-23	≤ 100%	100%	↗	102.5%	▲	▲
Outpatient DNA rate	Oct-23	≤ 6.3%	7.8%	→	7.8%	▲	▲
Outpatient clinic utilisation	Oct-23	≥ 90%	89.3%	→	89.2%	▲	▲
Patient initiated follow up (PIFU)	Oct-23	≥ 4.35%	3.5%	↗	4%	▲	▲
Capped Touch Time Utilisation	Oct-23	≥ 85%	70.6%	→	70.9%	▲	▲
Average cases per 4-hour session	Oct-23	≥ 2.8	2.75	↗	2.84	●	●
Workforce Scorecard							
Substantive Staff-in-Post	Oct-23	≥ 90%	91.3%	↘	92.9%	●	●
Sickness Absence: Monthly Rate	Oct-23	≤ 6%	5.8%	↘	6.4%	▲	▲
Workforce Turnover	Oct-23	≤ 12.5%	14.6%	↑	14.1%	▲	▲
Staff Retention Rate	Oct-23		98.8%	→	98.9%		
Appraisal Rate: Overall	Oct-23	≥ 95%	89.8%	↗	90.5%	▲	▲
Mandatory Training	Oct-23	≥ 95%	93.9%	↗	94.5%	▲	▲
Agency Costs %	Oct-23	≤ 3.7%	5.5%	↗	4.7%	▲	▲
Finance Scorecard							
Capital Expenditure	Oct-23	≤ 10%		↑	-42%	●	●
Cash Balance	Oct-23			→	23.9		
CIP Cumulative Achievement	Oct-23	≥ 0%		↗	3.1%	●	●
Financial Controls: I&E Position	Oct-23	≤ 0%		→	10.5%	▲	▲

Legend

1-month Forecast

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

Current Period

- ● target achieved
- ▲ target not achieved

6-month Trend

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

Integrated Performance Report - Exception

Quality: Sepsis

		Target	Actual	6-month Trend	Previous Performance	1-month Forecast
Sepsis: Timely recognition	The number of patients who are screened for sepsis, as a percentage of those eligible patients audited.	>= 90%	97.4%	↑	● ● ● ● ● ●	●
Sepsis: Antibiotic administration	The number of patients who received IV antibiotics within agreed timescales for sepsis patients, as a percentage of eligible patients audited and found to have sepsis.	>= 90%	74.3%	↓	▲ ▲ ▲ ▲ ▲ ▲	▲

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

Timely Recognition

- 100% timely recognition in October.
- 12- month rolling figure now 97%, ahead of national target of 90%.

Key Actions November

- Trial AQ audit alongside current audit to commence this month.
- Attend senior nurse meeting for all divisions to engage ward managers regarding sepsis screening tools and Sepsis6 compliance.
- Medical Education supporting the Sepsis6 teaching sessions.
- Toolbox focus- night staff.

Antibiotic Administration

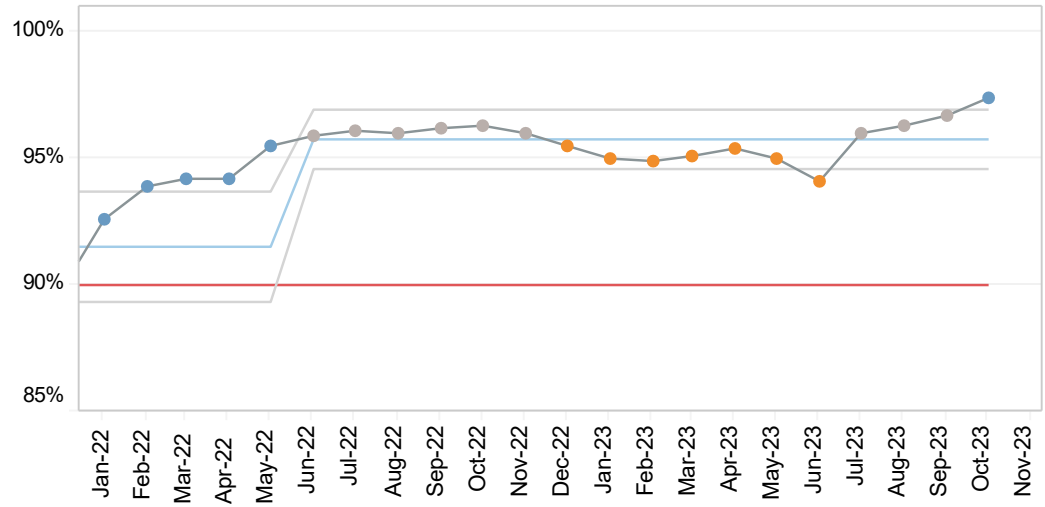
- October compliance 81%.
- 12- month rolling figure now 74%, below national target of 90%.
- 17/21 patients treated for sepsis received antibiotics in accordance with trust guidelines.
- 2 fails occurred in Surgery and 2 within Division of Medicine.
- Only 1 fail occurred out of hours. 2 fails occurred during strike action of junior doctors/ consultants.
- 3/4 fails occurred due to delayed nurse administration of antibiotics, 1 fail was a result of delayed prescribing. In three of the fails there was delayed sepsis screening assessment and in all fails Sepsis6 wasn't completed by the clinician. A further theme cited was poor communication.
- Average delay of 81 minutes.
- Harm not identified.

Key Actions November

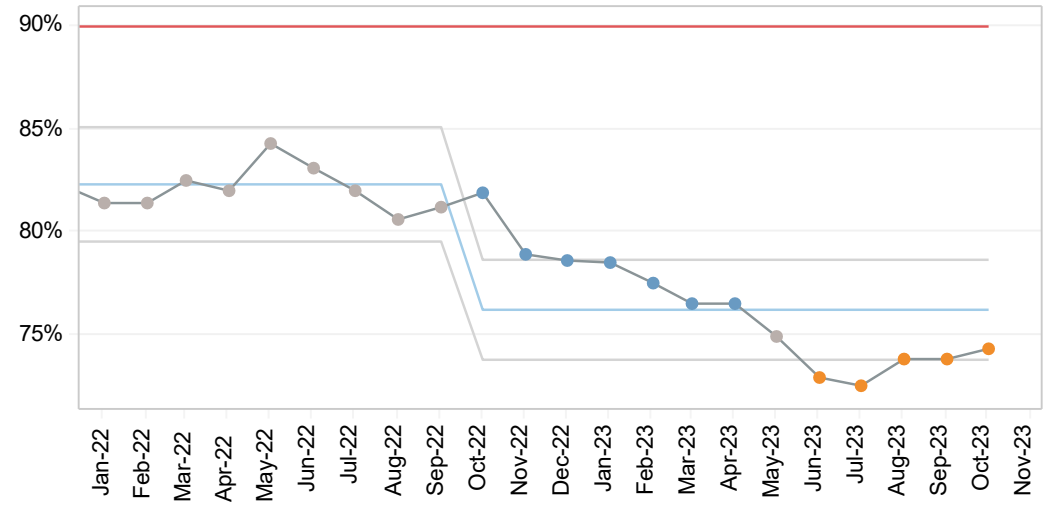
- Trial AQ audit alongside current audit to commence this month.
- Attend senior nurse meeting for all divisions to engage ward managers regarding sepsis screening tools and Sepsis6 compliance.
- Medical Education supporting the Sepsis6 teaching sessions.
- Toolbox focus- night staff.

Signed off by	Emily Abdy
Executive Lead	Nicola Firth

Performance for Sepsis: Timely recognition



Performance for Sepsis: Antibiotic administration



Integrated Performance Report - Exception

Quality: Infection Rates

		Target	Actual	6-month Trend	Previous Performance	1-month Forecast
C.diff infection rate	The number of hospital-onset C: Difficile (C. diff) infections per 100,000 bed days for patients aged 2 years and older.	<= 17.63	60.84			
Covid-19 infection rate	The number of Covid-19 infections per 1,000 bed days.	<= 4.27	2.07			

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

C.diff

There were 5 HOHA (hospital onset) and 2 COHA (community onset) cases in October, totalling 54 YTD. The Trust is over the projected threshold of 23 for the end of October and over the 2023-24 threshold of 40 cases for the year.

50 cases have been presented to the HCAI Panel. 8 Cases have been deemed Avoidable and 41 cases deemed Unavoidable. 1 case requires further investigation after panel review and 4 cases await panel review in November.

The latest national figures (August 2023) rates Stockport third out of the seven GM Trusts.

Themes from the avoidable cases are linked with antibiotic appropriateness, course length, and course numbers which appear to have increased following the Covid pandemic. The IPC team is presenting themes associated with community prescribing at the Stockport quality improvement collaborative group in November.

Covid-19

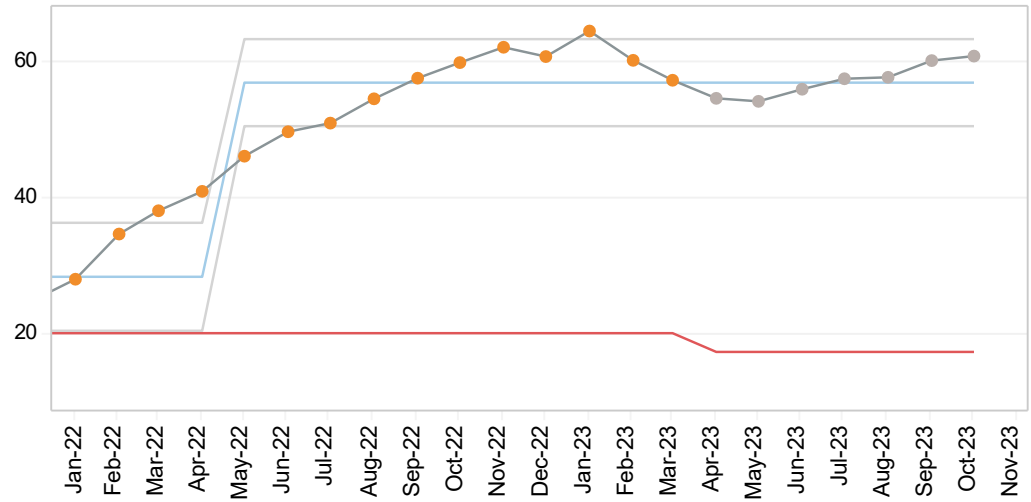
The Trust reported 21 Covid positive cases in October, of which 8 were nosocomial. This is an increase of 8 positive case and 3 HOC case numbers on the previous month. The Trust currently has a rate of 38% against a Northwest rate of 43%. The HOC rate remains unchanged from last month; however, there is an increase in the Northwest rate by 1%.

Collaboration work on winter planning and respiratory escalation triggers has commenced between IPC and operational teams.

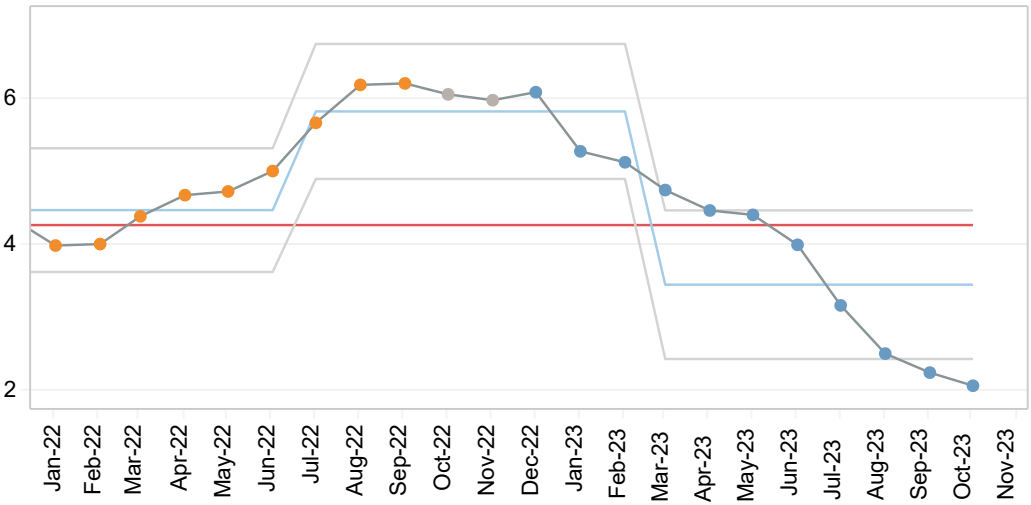
McCarthy Rebecca 06/12/2023 11:30:52

Signed off by	Christine Glynn
Executive Lead	Nicola Firth

Performance for C.diff infection rate



Performance for Covid-19 infection rate



Integrated Performance Report - Exception

Quality: Infection Rates (continued...)

		Target	Actual	6-month Trend	Previous Performance	1-month Forecast
E. coli infection rate	The number of Escherichia Coli (E. coli) bacteraemia infections per 100,000 bed days.	<= 20.27	121.24	↓	▲ ▲ ▲ ▲ ▲ ▲	▲
MRSA infection rate	The number of hospital-onset Methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemia infections per 100,000 bed days.	<= 0	2.68	↓	▲ ▲ ▲ ▲ ▲ ▲	▲

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

MRSA

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

Monitoring of MRSA screening continues and is reported monthly to divisions at the IP&C operational group.

Monitoring of ANTT compliance continues through the IP&C operational group, with a focus on medics ANTT.

E.Coli

There were 3 HOHA and 3 COHA cases in October, totalling 43 cases YTD. The Trust is over the projected threshold of 26 for the end of October.

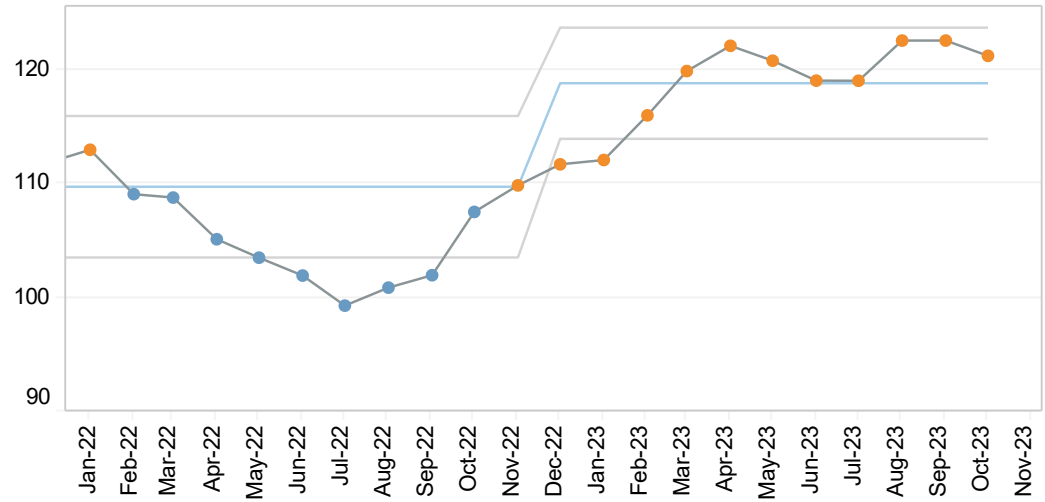
The Trust is supporting the national UTI campaign to raise awareness.

A full review of the urinary catheter care and management across the Trust is currently underway to standardise practice.

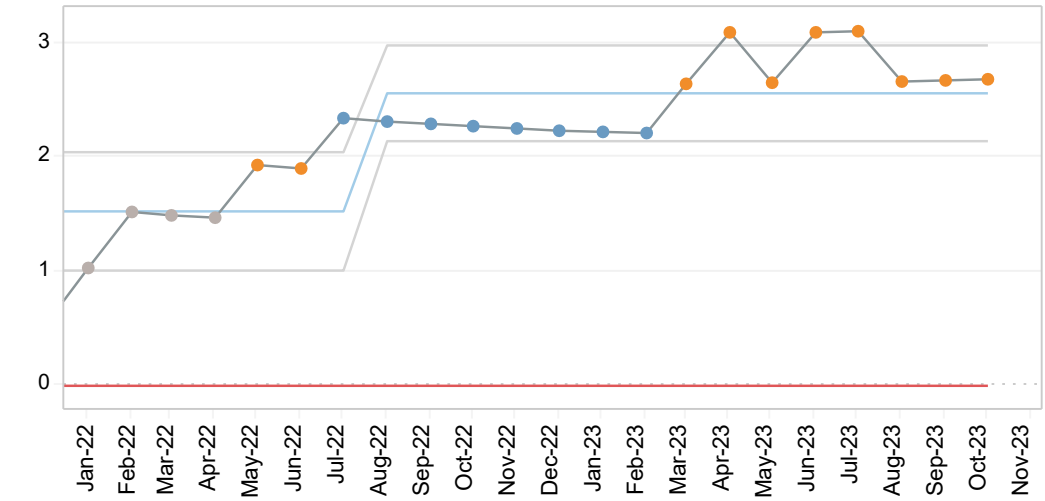
McCarthy Rebecca 06/12/2023 11:30:52

Signed off by	Christine Glynn
Executive Lead	Nicola Firth

Performance for E. coli infection rate



Performance for MRSA infection rate



Integrated Performance Report - Exception

Quality: Incidents

		Target	Actual	6-month Trend	Previous Performance	1-month Forecast
Medication incident rate	The number of medication incidents, calculated as an incidence rate for every 1000 bed days. This average is calculated on a rolling 6- month basis.	<= 4.64	5.8	↓	● ▲ ▲ ▲ ▲ ▲	▲
Patient safety incident rate	The number of patient safety incidents, calculated as an incidence rate for every 1000 bed days. This average is calculated on a rolling 6- month basis.	<= 69.24	82.54	↓	▲ ▲ ▲ ▲ ▲ ▲	▲
STEIS reportable incidents	The total number of STEIS reportable incidents. Target/benchmark based on the median performance for 2021/22 financial year.	<= 4	8	→	● ● ▲ ● ▲ ▲	▲

Medication Incidents

There are no issues related to medication incidents to report.

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

Patient Incidents

There are no issues related to patient incidents to report.

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

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

STEIS

There were 8 serious incidents declared and submitted to StEIS in October 2023:

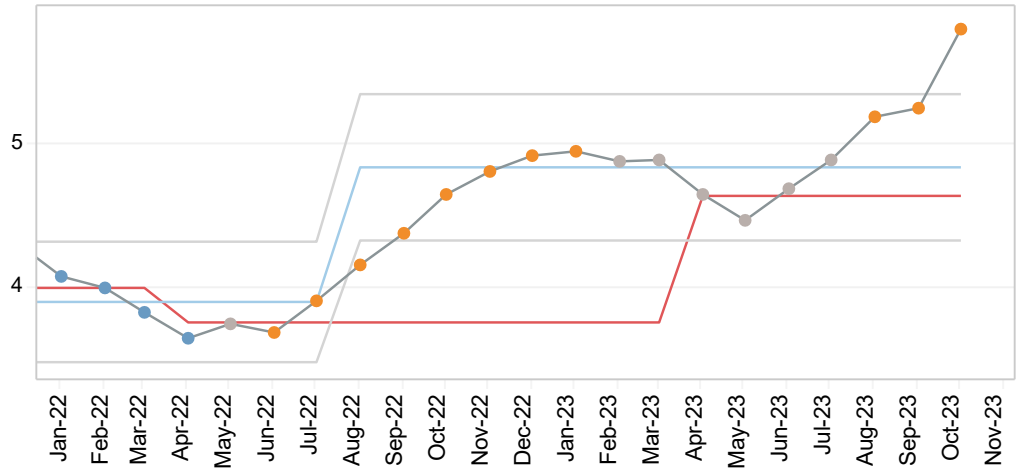
- Safeguarding allegation about staff member (de-escalated);
- Intrapartum stillbirth;
- 3 x maternity divert (de-escalated);
- Delayed thrombo-prophylaxis;
- Audiology service and care provided (4 cases);
- Baby transferred for therapeutic cooling.

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

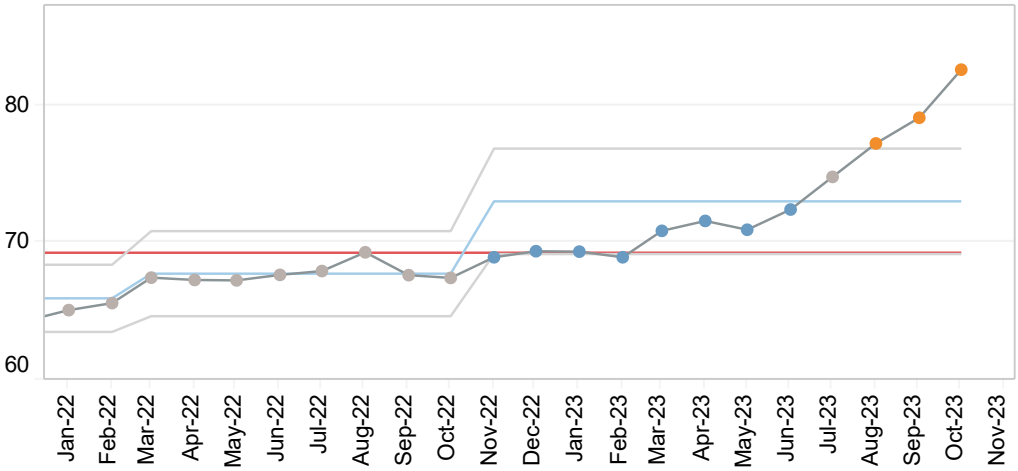
McCarthy Rebecca 08/12/2023 11:30:52

Signed off by	Natalie Davies
Executive Lead	Nicola Firth

Performance for Medication incident rate



Performance for Patient safety incident rate



Integrated Performance Report - Exception

Quality: Pressure Ulcers		Target	Actual	6-month Trend	Previous Performance	1-month Forecast
Hospital, Category 2	Total number of category- 2 pressure ulcers in a hospital setting - includes device-related pressure ulcers.	<= 6	6	↑	● ● ▲ ● ● ●	●
Hospital, Category 3&4	Total number of category- 3 and category- 4 pressure ulcers in a hospital setting - includes device-related pressure ulcers.	<= 0	0	→	▲ ▲ ▲ ▲ ▲ ●	▲
Community, Cat 2	Total number of category- 2 pressure ulcers in a community setting.	<= 9	11	→	▲ ● ▲ ▲ ▲ ▲	▲
Community, Category 3&4	Total number of category- 3 and category- 4 pressure ulcers in a community setting - includes device-related pressure ulcers.	<= 3	5	→	▲ ▲ ● ▲ ▲ ▲	▲

Hospital

The Trust has set a target to reduce the overall number of hospital- acquired pressure ulcers by 5% for year April 2023- April 24. This month the Trust reported 6 category- 2 pressure ulcers, 2 of which were as a result of a medical device. This is a slight increase from previous months; however, the Trust remains on trajectory to meet the reduction target.

The main work streams in progress now are:

- Developing the 'purpose t' pressure- ulcer risk assessment tool into digital version (using Patient track).
- Reviewing the training provision and role-specific requirements.
- Increased engagement and training has taken place with allied health professionals (physios, OT, social workers, and discharge co-coordinators) with further sessions planned.
- Additional toolbox training sessions are being developed with the CPF teams across all divisions to promote pressure- ulcer- prevention awareness.
- The annual pressure relieving mattress audit is taking place this month.

Community

The Trust has set a target to reduce the overall number of community- acquired pressure ulcers by 10% for year April 2023- April 24. This month the Trust reported 11 category- 2 pressure ulcers. The community is currently over trajectory to meet the reduction target.

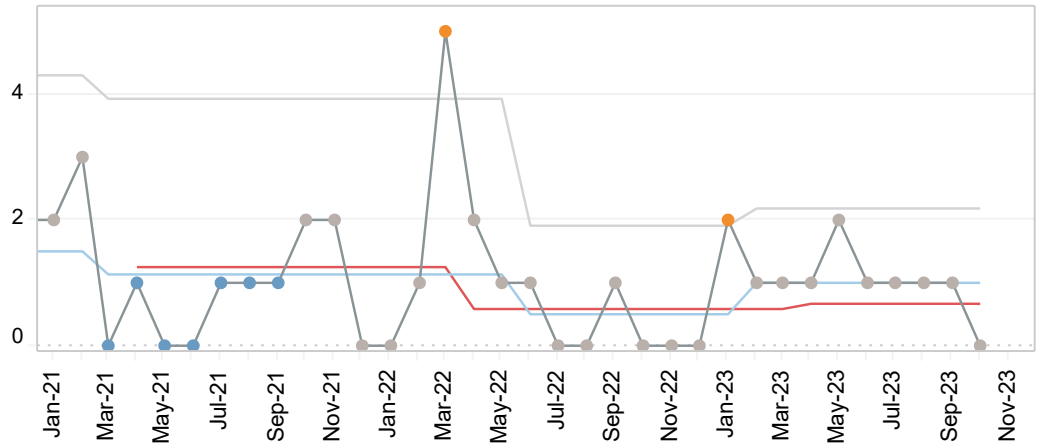
Trend analysis is ongoing in the community but there are few incidents that identify missed opportunities or lapses- in- care.

This month there have been 5 category- 3 or 4 pressure ulcers in the community. There continues to be high numbers of patients developing category- 3 or 4 pressure ulcers in the community. Each individual investigation has shown no lapses- in- care provided

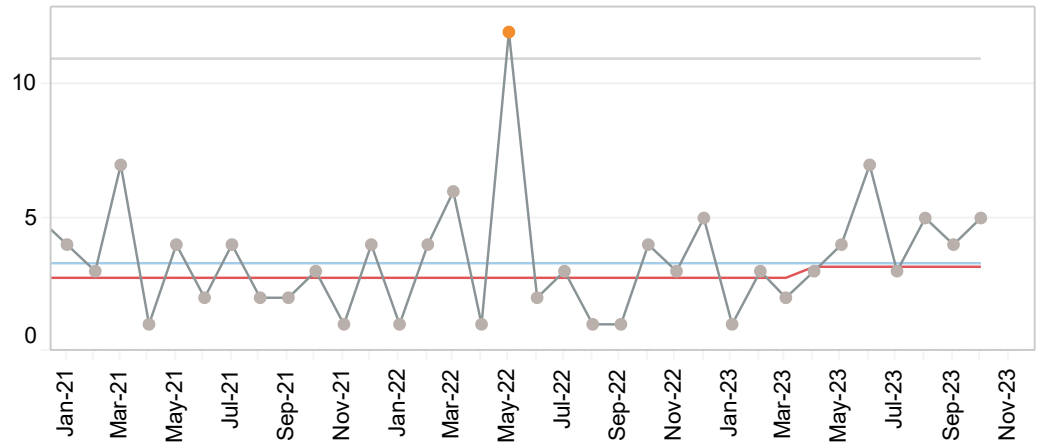
A thematic review of all category- 3 or 4 pressure ulcers occurring in community patients over the last 6 months has been undertaken. The primary theme has shown decision making by the patient as the main factor. Work streams are in development to help our community nurses in their communication with patients, and providing information to patients to help them make informed decisions.

Signed off by	Lisa Gough
Executive Lead	Nicola Firth

Performance for Pressure Ulcers: Hospital, Cat 3&4



Performance for Pressure Ulcers: Community, Cat 3&4



Integrated Performance Report - Exception

Quality: Complaints

		Target	Actual	6-month Trend	Previous Performance	1-month Forecast
Timely response	The total number of formal complaints responded to within agreed timescales, as a percentage of all formal complaints responded to.	>= 95%	97.4%			
Written Complaints Rate	Number of formal written complaints received, calculated as an incidence rate for every 1000 whole time equivalent staff in post.	<= 7.9	13.33			

In October 2023 we received the highest number of formal complaints in month for the year to date. 72 formal complaints were received in October - Integrated Care = 5, Medicine = 14, Surgery = 22, Women & Children = 11, Corporate = 0, Estates & Facilities = 0, Emergency Department and Clinical Decision Unit = 12 and Clinical Support Services = 8.

The PALS & Complaints Team continues to focus on resolving concerns informally where appropriate, but we are seeing an increase in both informal complaints & enquiries (287 cases) and formal complaints (72).

Top five themes for formal complaints in October 2023 were as follows:

- Communication;
- Staff values and behaviours;
- Clinical treatment;
- Patient care;
- Admissions and discharges.

Top five themes for informal concerns in October 2023 were as follows:

- Appointments;
- Communication;
- Administration procedures and record management;
- Patient care;
- Waiting times.

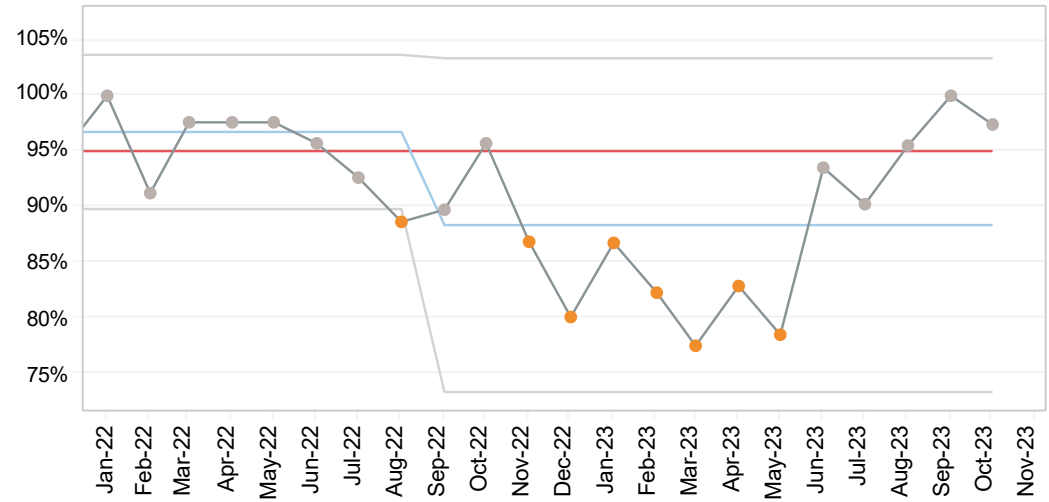
37 of the 38 responses sent in October 2023 were sent within the agreed timeframe, resulting in a 97.4% response rate.

A response rate of 97.4% is a good achievement considering the ongoing pressures at the Trust and increased workload.

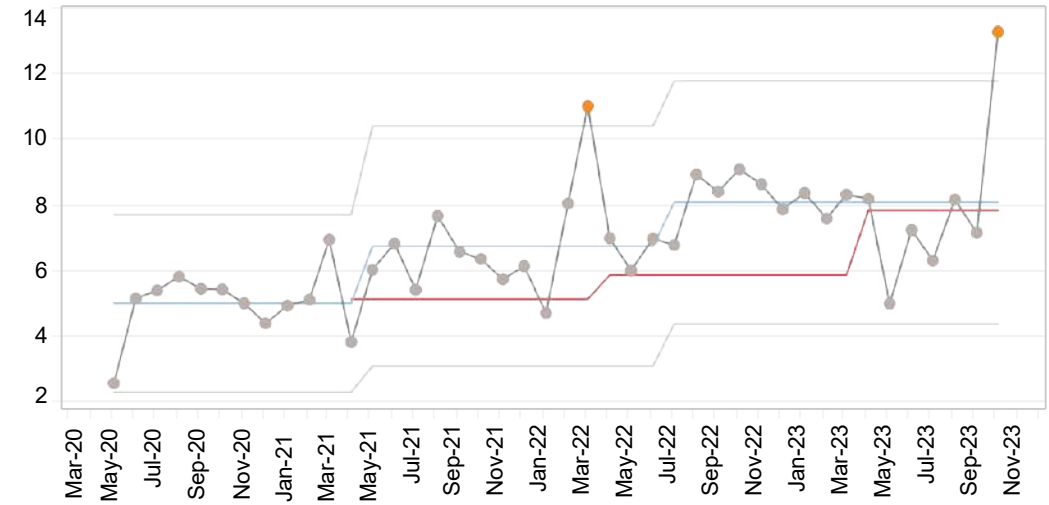
When it becomes clear we will not meet the expected timeframe, the case officer will contact the complainant to keep them informed and, if necessary, agree a new timescale.

Signed off by	Natalie Davies
Executive Lead	Nicola Firth

Performance for Complaints: Timely response



Performance for Complaints: Written Complaints Rate



Integrated Performance Report - Exception

Quality: Maternity

		Target	Actual	6-month Trend	Previous Performance	1-month Forecast
Early Neonatal Deaths	The number of babies born with signs of life, that have died with within the first 7 completed days of life.	<= 0	1			
Registrable Stillbirths	The number of babies born without signs of life due to stillbirth or termination of pregnancy that occurs after a gestation of 24 weeks (168 days) or more.	<= 0	1			
Registrable Stillbirth Rate	The number of babies born without signs of life due to stillbirth or termination of pregnancy that occurs after a gestation of 24 weeks (168 days) or more. .	<= 0	4.24			
Smoking In Pregnancy	The number of women known to be smokers at the time of delivery, as a percentage of all deliveries in the month.	<= 10%	8.7%			
Maternity Diverts	The total number of occasions the maternity unit has been unable to admit women during the reporting period.	<= 0	4			

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

Early Neonatal Deaths
There was 1 baby born over 24 weeks who died within 7 days of birth in October. This case is currently being reviewed by the MDT using the Perinatal Mortality Review Tool (PMRT).

Registrable Stillbirths
There was 1 registerable stillbirth reported in October where a woman presented in advanced labour, unable to auscultate a foetal heartbeat. Currently being investigated by MNSI, previously known as HSIB.

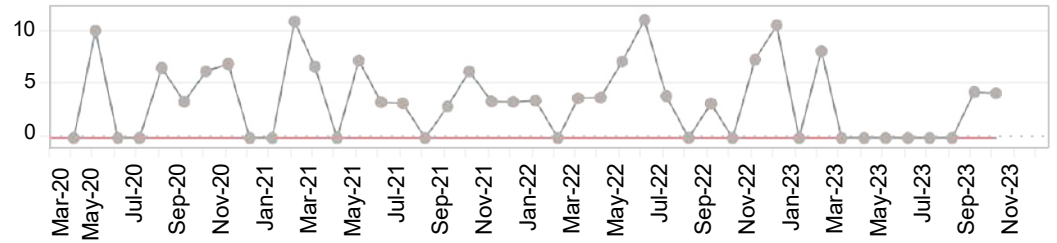
Smoking in Pregnancy
The percentage of women who were smoking at the time of delivery in October was 8.7% (19 out of 228). This is an increase from September, which was 6.3% (14 out of 233). To improve performance, an additional B4 post is being recruited to, enabling additional contacts and support within the team. The team has increased their capacity for face-to-face visits. With the additional Maternity Tobacco Dependency Advisor, it is the expectation that the service will see an improvement with the SATOD rates.

Maternity Unit Diverts
The Maternity Unit was placed on temporary divert on 4 occasions in October, compared to 1 occasion that was reported in September. The rationale for the divert was insufficient staffing due to vacancy and short-term/last- minute sickness. No harm was caused as a result of the diverts.

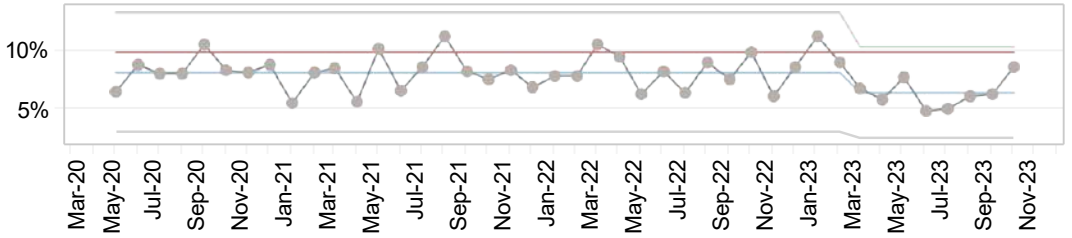
Rapid reviews are undertaken for any divert and presented at serious incident review group, an audit form is also completed and returned to the local maternity and neonatal (LMNS) system for shared learning. All maternity unit temporary diverts are StEIS reported.

Signed off by	Rachel Alexander-Patton
Executive Lead	Nicola Firth

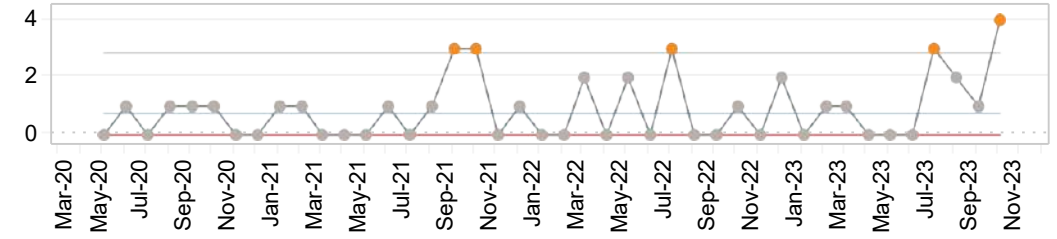
Performance for Registrable Stillbirth Rate



Performance for Smoking In Pregnancy



Performance for Maternity Diverts



Integrated Performance Report - Exception

Operations: ED

		Target	Actual	6-month Trend	Previous Performance	1-month Forecast
Ambulance handover delays	The number of ambulance handovers delayed by 30 minutes or more, as a percentage of all ambulance handovers.	<= 5%	22.6%	→	▲ ▲ ▲ ▲ ▲ ▲	▲
4hr Standard	The number of patients who were admitted, discharged, or leave A&E within 4 hours of their arrival, as a percentage of all patients attending A&E.	>= 76%	58.6%	↘	▲ ▲ ▲ ▲ ▲ ▲	▲
Patients in department over 12 hrs	The number of patients spending 12 hours or more in department, as a percentage of all patients attending the emergency department.	<= 2%	12.5%	↘		▲

October's performance against the UEC 4hr standard saw a decrease to 58.6% compared to 61.5% in September 2023.

October saw an increase in attendances from 9,623 in September to 9,802 in October 2023

Overall performance benchmarks well across GM. Stockport's ED YTD performance is currently 63.59% ranking 3rd in GM for type- 1 4hr performance (excluding RMCH).

October saw a sharp increase in 12- hour waits for admission in ED to 330 compared to 134 in September. This led to long delays for ambulances crews being released to the community.

Robust processes for managing, reviewing, and providing assurance for assessment of harm in respect to 12hr breaches are fully embedded within the service.

The service continues to focus on ensuring that long waits are reduced by reviewing the ED workforce model and improving triage & navigations times (initial assessment).

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

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

E-triage transformation piece of work continues to focus on front- door streaming and decongestion of department, with aim of soft launch in November 2023.

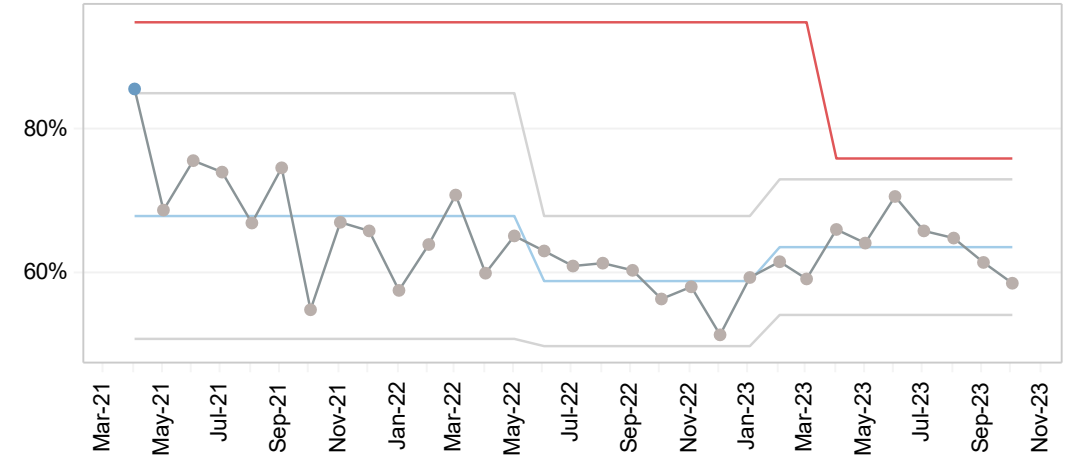
Admission avoidance collaborative working with Mastercall, Virtual Ward & Age UK.

Programme of flow works continues including ward MDTs.

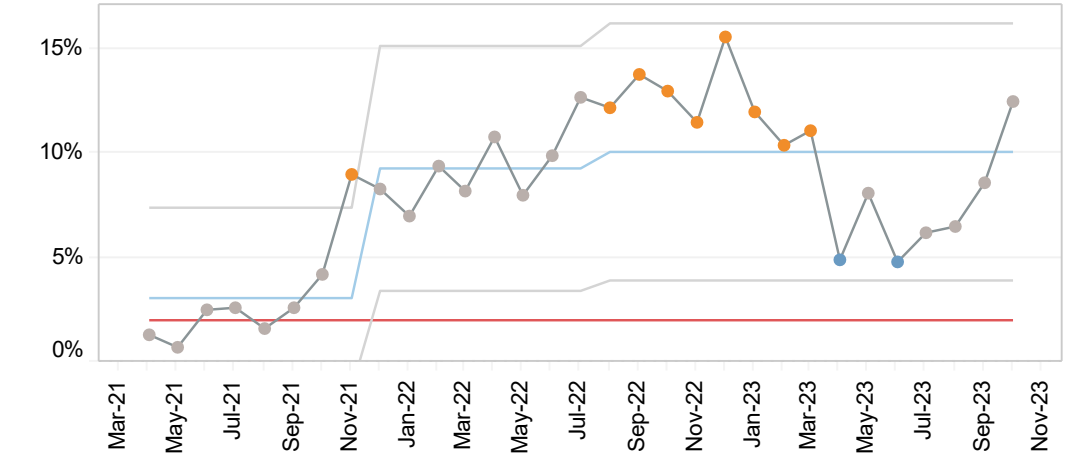
McCarthy,Rebecca 06/12/2023 11:30:52

Signed off by	Catherine Cotton
Executive Lead	Jackie McShane

Performance for 4hr Standard



Performance for Patients in department over 12 hrs



Integrated Performance Report - Exception

Operations: Patient Flow

		Target	Actual	6-month Trend	Previous Performance	1-month Forecast
No criteria to reside (NCTR)	Number of patients with "No Criteria to Reside". This metric is a mean average per day for each month.	<= 73	82	↑	▲ ▲ ▲ ▲ ▲ ▲	▲
Discharge ready	The number of patients discharged from hospital on the same day as their 'discharge ready date', as a percentage of all patient discharges.		81.3%	↗		
Delayed discharges	The number of patients discharged from hospital 7 days or more after their 'discharge ready date', as a percentage of all patient discharges.		4.1%	↗		

Discharge Ready

The Discharge Ready metrics are new to the report this month. There are not currently any national or GM targets for these metrics and we will review this in time for the next report in order to set local thresholds for performance monitoring. The national rate for the 'discharge ready' metric is 86.4% for September.

No Criteria to Reside

The number of patients with no criteria to reside in month remains higher than the target level with challenges continuing with the NCTR numbers for patients who reside outside of Stockport; however, we have seen a slight decrease which is encouraging. Work continues to embed and improve operational system and processes within the wards and system partners, to improve discharges across all pathways.

The challenges of accessing timely care home beds has severely impacted on the Trust's ability to discharge/transfer patients with a NCtR in a timely manner. Increased number of patients being discharged on Pathway 1 as opposed to Pathway 2 is encouraging; however, those patients truly requiring Pathway 2 care home beds are more dependent, requiring increased support. Care homes are increasingly declining these patients due to their complexity, which results in longer lengths of stay within the acute trust, impacting on flow through acute and community D2A beds. System partners are reviewing the community bed location and contracts to ensure that the right beds are commissioned.

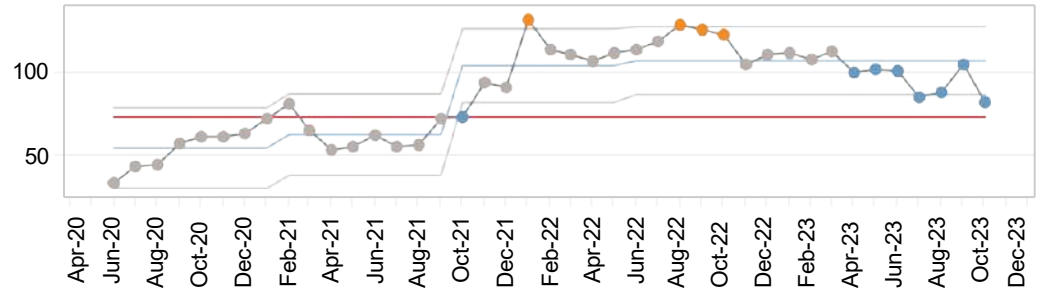
System partners are meeting weekly to collaborate on a system- wide response to safe and timely discharge and have established task and finish groups to facilitate focussed work on key areas of discharge; system operating model, individual pathways, community beds, and out of area. The focus on home- care provision continues, and the group is currently reviewing the in house SMBC Reablement Team (REACH) capacity as well as the commissioned care from private providers. Facilitating timely discharges on the day remains a focus of this work. A system executive oversight meeting to review long length of stay within community beds takes place weekly to support effective patient flow.

The number of out-of-area patients remains high with other localities struggling to access community capacity within their areas, which is impacting on the ability to discharge / transfer patients to their local area. ICB is meeting with North Derbyshire weekly to support out- of- area partners to escalate and enable improved flow out of the hospital.

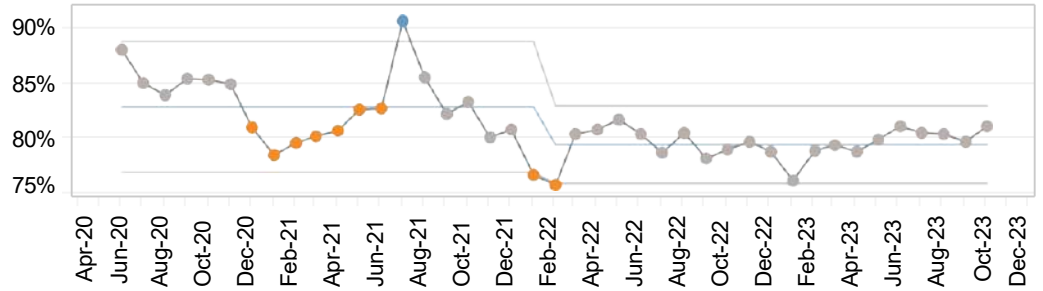
System tactical meetings have increased in frequency to support flow and the Programme of Flow is continuing to review all LLOS patients including those who have NCtR.

Signed off by	Margaret Malkin
Executive Lead	Jackie McShane

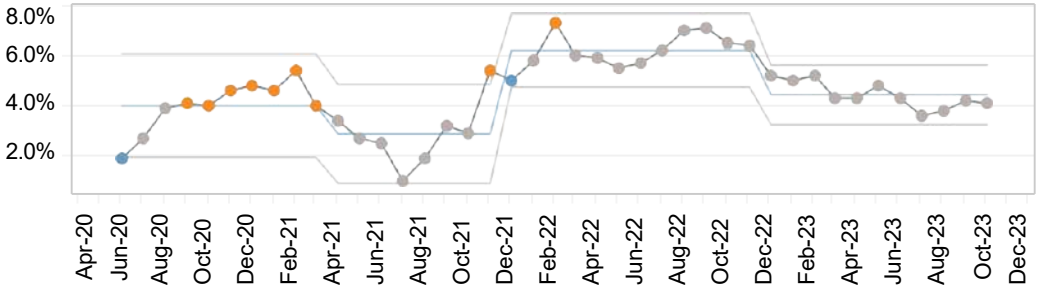
Performance for No criteria to reside (NCTR)



Performance for Discharge ready



Performance for Delayed discharges



Integrated Performance Report - Exception

Operations: Diagnostics

		Target	Actual	6-month Trend	Previous Performance	1-month Forecast
Diagnostics: 6 Week Standard	The percentage of patients referred for diagnostic tests who have been waiting for more than 6 weeks.	<= 5%	11.9%	→	▲ ▲ ▲ ▲ ▲ ▲	▲

The diagnostic backlog has steadily decreased over the last 3 consecutive months, with 707 patients now waiting over 6 weeks.

Endoscopy

The endoscopy backlog has decreased to 108 patients waiting over 6 weeks, maintaining the downward trajectory. Pressure on endoscopy remains, as a result of increased colorectal suspected cancer referrals, the impact of industrial action and return/repeat second procedures. The combined impact has meant that the trajectory for achievement of the 95% standard has been pushed back to March 24.

Imaging

The imaging backlog has increased to 32 patients waiting over 6 weeks. The majority of these waits are due to patient choice or other clinical reasons for delay. Although most imaging modalities remain DM01 compliant, non-obstetric ultrasound was impacted by industrial action and a peak- leave period reducing lists.

Echocardiology (ECG)

The ECG backlog has decreased to 567 patients waiting over 6 weeks. The service has now started working with In-Health as part of the CDC programme and the plan is to create an additional 130 slots per month; however, due to lack of facilities i.e. (room availability) an increase of 90 slots per month has been delivered thus far. A potential sixth room has been stepped down because the location, and the room itself, was deemed not to be appropriate.

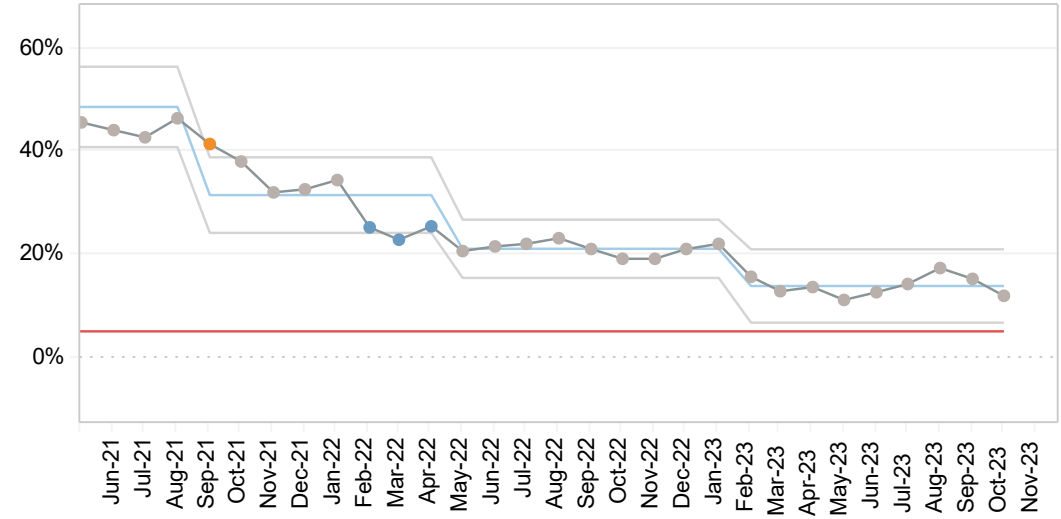
ECG staffing remains a pressure. With the recent conversion of the vacant physiologist post to a trainee position, recruitment to this new role is still underway. It should be noted that additional activity from successful recruitment to the trainee post will not support the recovery of our backlog position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

It is estimated that The Trust will be meeting the 6-week DMO1 target for routine Echo by February 2024.

McCarthy Rebecca 06/12/2023 11:30:52

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

Performance for Diagnostics: 6 Week Standard



Integrated Performance Report - Exception

Operations: Cancer

		Target	Actual	6-month Trend	Previous Performance	1-month Forecast
62-day standard	The percentage of patients on a cancer two-week-wait pathway that have received their first treatment within 62 days of GP referral.	>= 85%	55.3%	→	▲ ▲ ▲ ▲ ▲ ▲	▲
28-day standard (FDS)	The percentage of patients that are notified whether or not they have cancer within 28 days from the date of referral.	>= 75%	61.8%	↘	▲ ▲ ▲ ▲ ▲ ▲	▲
14-day standard (2WW)	The percentage of patients on a cancer pathway that have attended their first outpatient appointment within 14 days of their GP referral.	>= 93%	95.7%	↘	● ● ● ● ● ●	●

Cancer performance has been challenged in recent months due to the impact of industrial action and the sustained increase in demand.

The final 62-day performance for September was 44.6 %, with 28-day FDS (Faster Diagnosis Standard) performance showing an improvement from the previous month at 61.8%.

The 63+ backlog was 119 at the end of October, an increase of 2 from the September position.

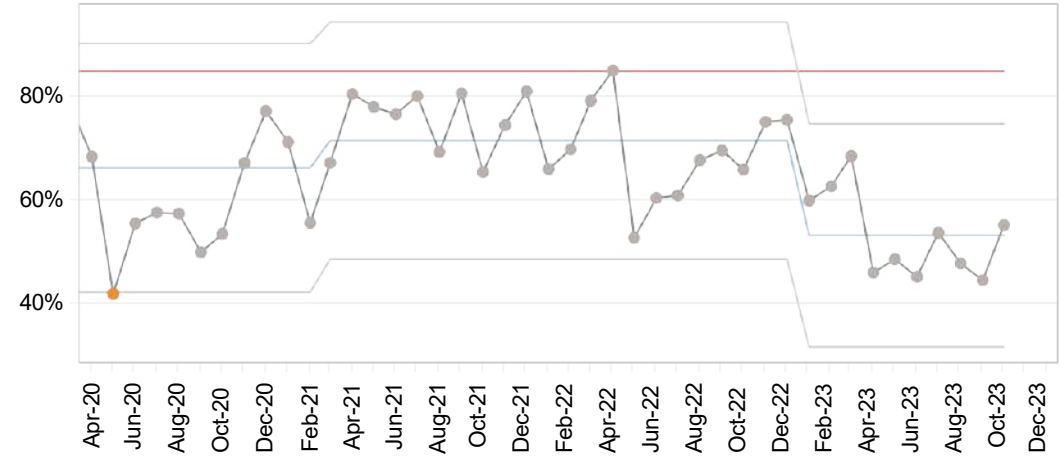
Divisional teams have revised improvement trajectories across these standards assuming no further industrial action, and considering the changes that will come into effect within individual services. The current forecast indicates that the Trust will achieve both the 28- day standard and the 63+ backlog target by year end, with 62- day performance increasing to 75%.

Additionally, the organisation is being supported by both the national team and the regional Cancer Alliance in terms of identifying mutual aid, referral optimisation, and potential access to fixed- term funding to enable demand to be met and waiting times reduced.

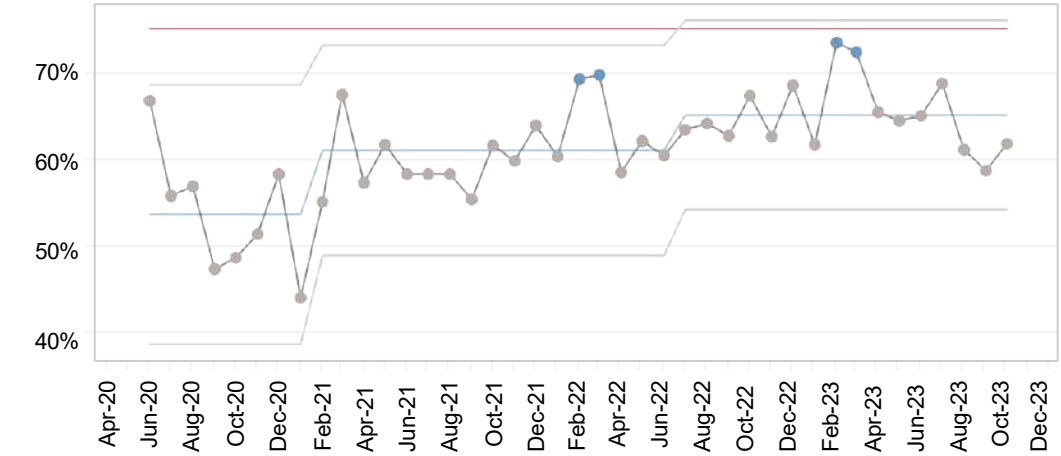
McCarthy Rebecca
06/12/2023 11:30:52

Signed off by	Jo Pemrick
Executive Lead	Jackie McShane

Performance for 62-day standard



Performance for 28-day standard (FDS)



Integrated Performance Report - Exception

Operations: Referral to Treatment (RTT)

		Target	Actual	6-month Trend	Previous Performance	1-month Forecast
Incomplete pathways 18-week %	Referral to treatment, the number of patients on an open pathway, whose clock period is less than 18 weeks, as a percentage of all patients on an open pathway.	>= 92%	49.7%	↓	▲ ▲ ▲ ▲ ▲ ▲	▲
52-week breaches	Referral to treatment, the total number of patients whose pathway is still open and their clock period is greater than 52 weeks at month end.	<= 3814	3923	↗	▲ ▲ ▲ ▲ ▲ ▲	▲
65-week breaches	Referral to treatment, the total number of patients whose pathway is still open and their clock period is greater than 65 weeks at month end.	<= 0	1295	↘	▲ ▲ ▲ ▲ ▲ ▲	▲

The number of patients waiting 65+ weeks to commence treatment decreased in month due to a concentrated effort to date as many patients as possible and the Trust has also seen a reduction in 52+ week waits and the overall waiting list size due to the utilisation of the independent sector and waiting- list validation text messages.

The Trust has 2 patients waiting 104 + weeks - patients where choice and clinical complexity are factors. These patients have treatment plans being arranged for November.

The 78 week wait position has remained a challenge due to the significant effect of the BMA industrial action & the lack of mutual aid & independent sector support for long waiters has negatively impacted on our recovery and this led to end of September breaches. However the trusts position for October has improved to 175 patients who are 78+ weeks, we continue to strive towards reducing this number to zero.

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

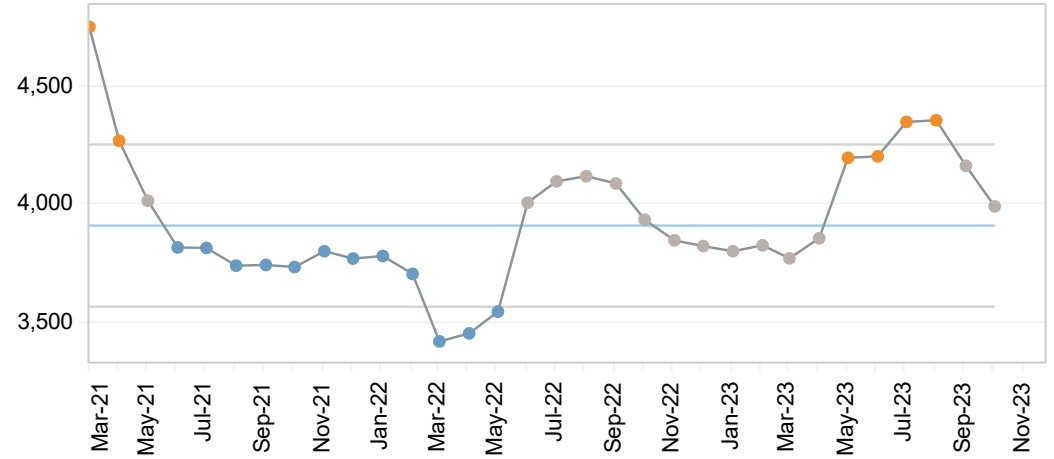
The levels of urgent and suspected cancer referrals remain high, resulting in extended waits for routine referrals in some services.

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

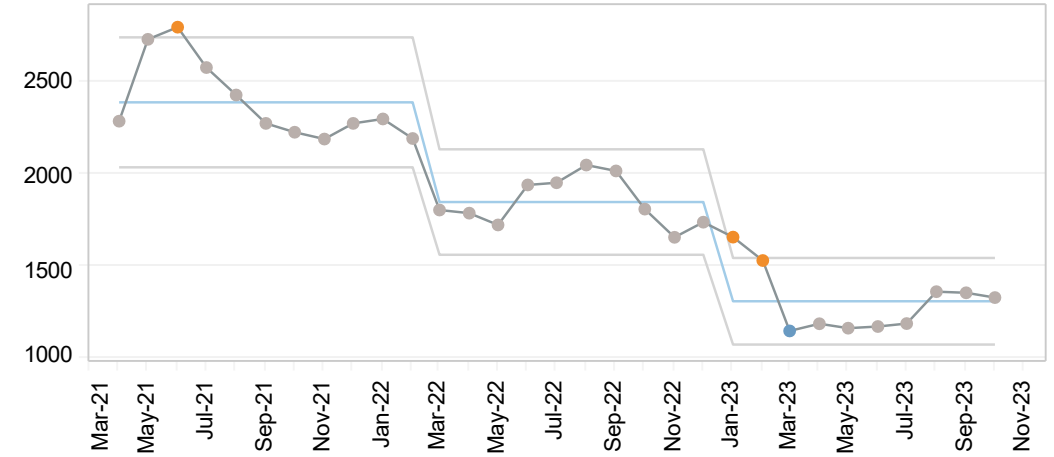
Trust elective performance meetings continue to focus on progressing patient pathways and eliminating long waits. The focus is on eliminating all patients who are waiting over 78 weeks at each month end and those waiting over 65 weeks by end March 2024.

Signed off by	Dan Riley
Executive Lead	Jackie McShane

Performance for 52-week breaches



Performance for 65-week breaches



Integrated Performance Report - Exception

Operations: Outpatient Efficiencies

		Target	Actual	6-month Trend	Previous Performance	1-month Forecast
Outpatient DNA rate	The number of appointments where the patient did not attend, as a percentage of all booked appointments.	<= 6.3%	7.8%	→	● ▲ ▲ ▲ ● ▲	▲
Outpatient clinic utilisation	The number of outpatient appointment slots booked, as a percentage of all outpatient appointment slots planned. Excludes cancelled clinic templates.	>= 90%	89.2%	→	▲ ▲ ▲ ▲ ▲ ▲	▲
Patient initiated follow up (PIFU)	The number of patients moved to a PIFU pathway as a result of an outpatient attendance, as a percentage of all outpatient attendances.	>= 4.35%	4%	→	▲ ▲ ▲ ▲ ▲ ▲	▲

DNA

'Nudge' reminder texts were rolled out to all specialties at the end of September. There will be ongoing monitoring of this until December.

Reminder and waiting- list validation text wording has been reviewed and letter portal notification will also be reviewed.

The Trust has reached out to peer trusts outside of GM, and Tameside, with lower DNA rates to review their processes. Piloting of contacting patients for short- notice slots commenced in October.

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

The development of speciality-specific action plans for those with highest DNAs has commenced.

Clinic Utilisation

Clinics managed by the Centralised Booking Team are at 92% utilisation. Clinics managed by the services themselves are at 85% utilisation. Meeting with areas with issues are to take place in November.

Detailed information of utilisation has been shared with the Divisions, CDs, and DMs. This has also been discussed at the Trust Performance and Elective Care Forum. Development of speciality- specific action plans for those with lowest clinic utilisation .

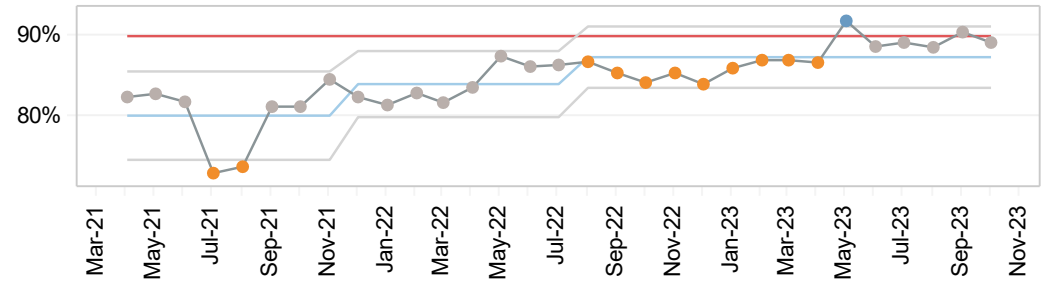
Patient Initiated Follow Up (PIFU)

Performance has improved to 4%, which is the highest level in GM. Speciality- based benchmarking data has been shared to look for further opportunities to improve use. Specialities are continuing to utilise GIRFT guidance to identify opportunities for further roll out of PIFU.

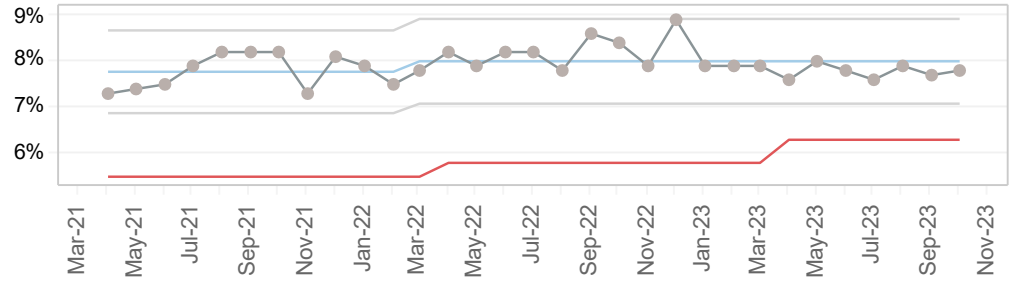
McCarthy Rebecca 07/12/2023 11:30:52

Signed off by	Mike Allison
Executive Lead	Jackie McShane

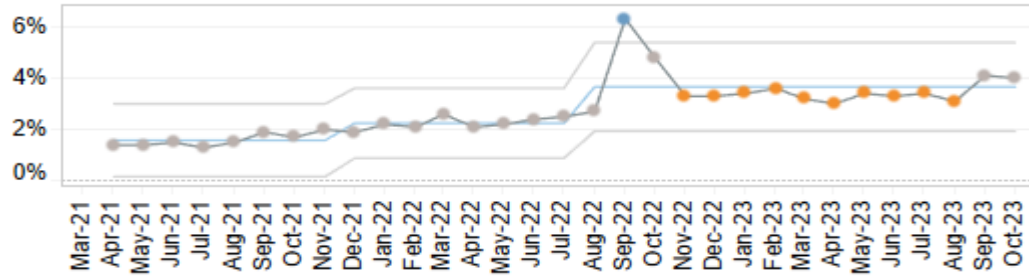
Performance for Outpatient clinic utilisation



Performance for Outpatient DNA rate



Performance for Patient initiated follow up (PIFU)



Integrated Performance Report - Exception

Operations: Theatre Utilisation

		Target	Actual	6-month Trend	Previous Performance	1-month Forecast
Capped Touch Time Utilisation	The overall time spent operating, calculated as a percentage of the overall planned session time. Session overrun time is excluded from the calculation of this measure.	>= 85%	70.9%	→	▲ ▲ ▲ ▲ ▲ ▲	▲
Average cases per 4-hour session	The total number of completed cases, calculated as a rate per 4-hour session equivalent. Excludes emergency and trauma sessions.	>= 2.8	2.84	↗	▲ ▲ ● ▲ ▲ ●	●

Touch-time Utilisation

Performance on capped touch time utilisation has remained static; however, uncapped touch time utilisation performance continues to benchmark well against peers and nationally.

Weekly additional theatre booking and utilisation meetings continue to have a positive impact, with good engagement across all surgical specialities, demonstrating a slight increase in ACPL (average cases).

Nursing vacancies and skill- mix is improving with bespoke recruitment events being held. Anaesthetic medical workforce remains a key area of concern and is impacting on the optimisation of some theatre lists. Focused operational management enables the prioritisation of patients but can result in late changes to lists. A six- monthly deep dive/review into the anaesthetic workforce is currently being undertaken.

A shift in the direction of the theatre programme has been introduced to focus on productivity and efficiency, with a case drafted to support the increase in pre-operative assessment capacity. A theatres' 'share and learn' session has taken place with TGH.

Average cases per 4-hour session

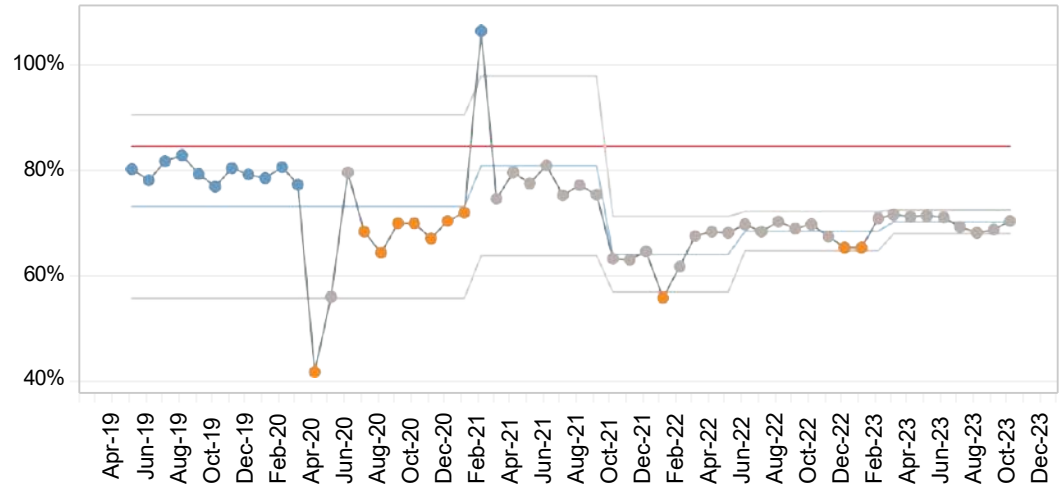
ACPL has shown a slight improvement. The temporary conversion of daycase and elective orthopaedic ward has impacted on this.

A revised theatre efficiency programme and trajectory is in development to re-focus the performance and will be supported by the national GIRFT programme

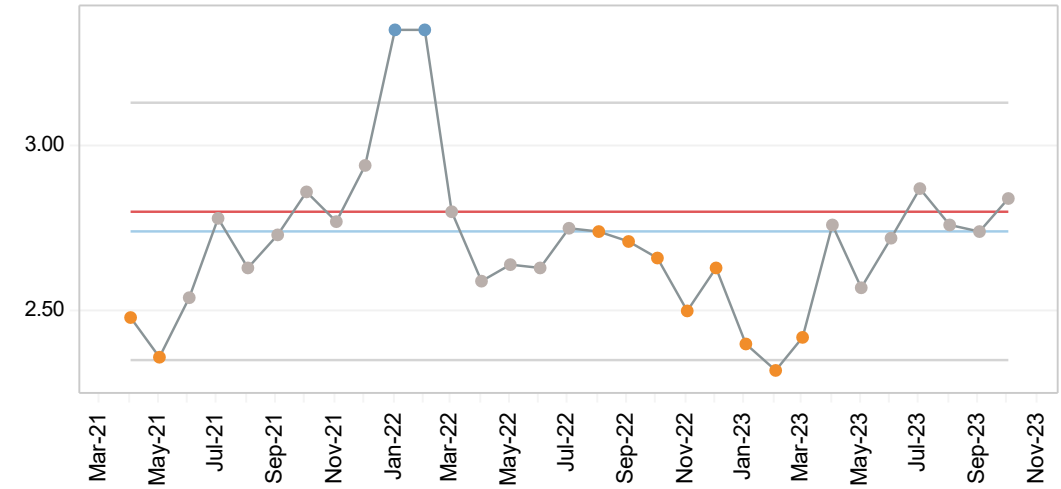
McCarthy Rebecca 06/12/2023 11:30:52

Signed off by	Karen Hatchell
Executive Lead	Jackie McShane

Performance for Capped Touch Time Utilisation



Performance for Average cases per 4-hour session



Integrated Performance Report - Exception

Workforce: Sickness Absence		Target	Actual	6-month Trend	Previous Performance	1-month Forecast
Sickness Absence: Monthly Rate	The total number of staff on sickness absence, calculated as a percentage of all staff-in-post whole time equivalent.	<= 6%	6.4%			

Attendance remains above target at 94.16%, although has decreased in October as expected due to seasonal illnesses.

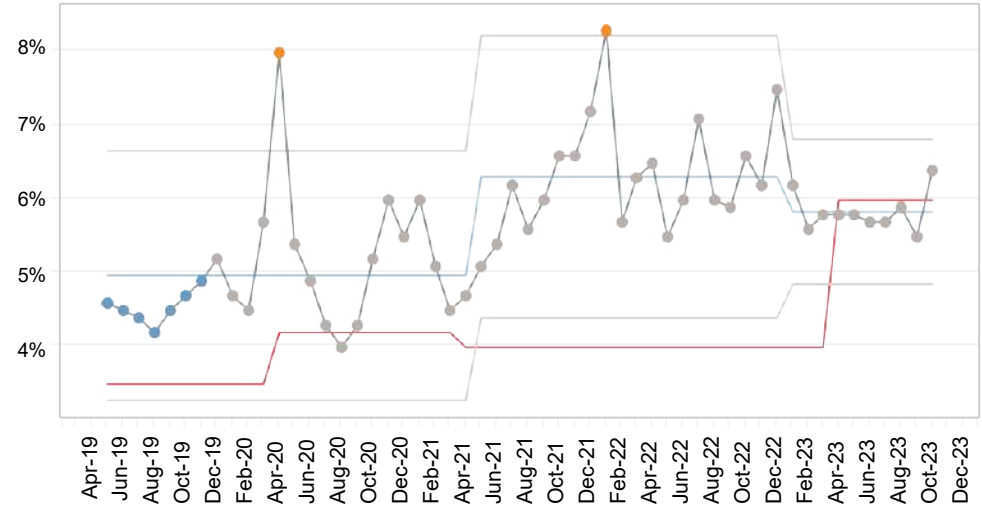
The Trust continues to focus on improvements and recently the Deputy Director of People attended attendance management review meetings with all the Divisions, with the intention to challenge and support the escalation of difficult cases. The People & OD Department has co-ordinated an attendance management summit to discuss areas of improvement and support. An action plan is being produced which includes awareness raising for manager and the production of an all-encompassing wellbeing leaflet to identify the support available.

The Trust will also be promoting the services of Maximus, which is an external company offering a free support service for staff experiencing mental health issues. Mental health is one of the main contributors to staff not being in work.

McCarthy Rebecca 06/12/2023 11:30:52

Signed off by	Kaiser Chowdhury
Executive Lead	Amanda Bromley

Performance for Sickness Absence: Monthly Rate



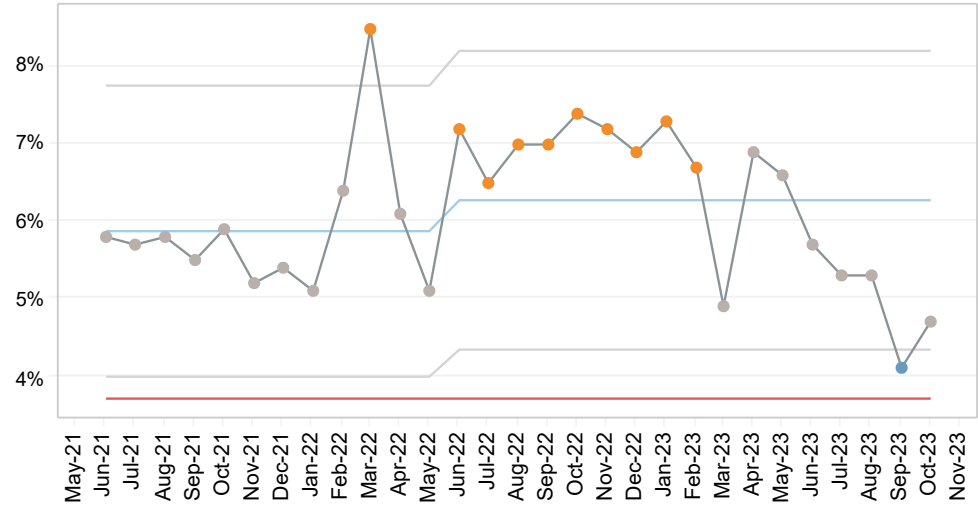
Integrated Performance Report - Exception

Workforce: Agency Costs		Target	Actual	6-month Trend	Previous Performance	1-month Forecast
Agency Costs %	Total agency costs, as a percentage of total PAY costs.	<= 3.7%	4.7%			

The total bank and agency spend in October 2023 was £4.06M, which represents 15.5% of the total pay bill within the month and is 84K lower than September 2023. The Division with the highest bank & agency spend in October was Medicine (£1.30M).

McCarthy Rebecca 06/12/2023 11:30:52

Performance for Agency Costs %



Signed off by	Kaiser Chowdhury
Executive Lead	Amanda Bromley

Integrated Performance Report - Exception

Workforce: Turnover		Target	Actual	6-month Trend	Previous Performance	1-month Forecast
Workforce Turnover	The percentage of employees leaving the Trust and being replaced by new employees.	<= 12.5%	14.1%			

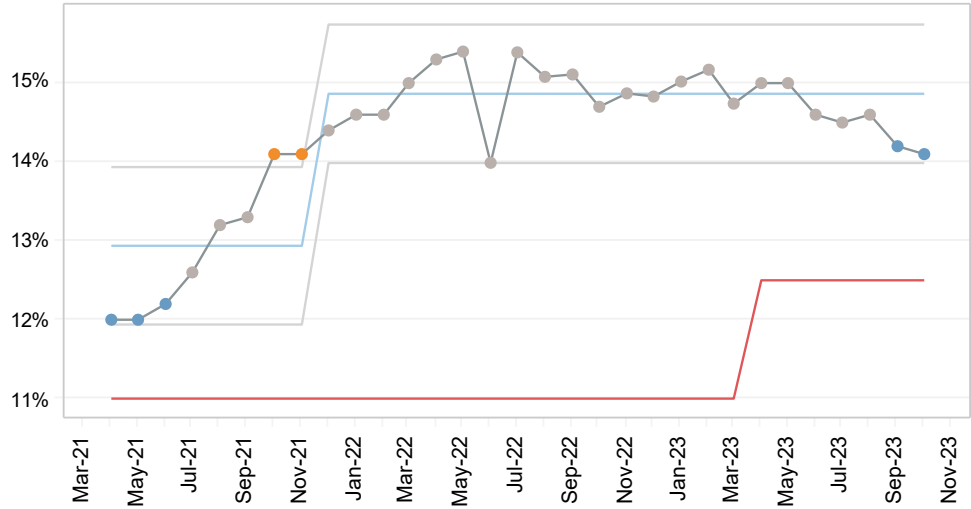
The Trust's 12- month turnover rate up to October 23 was 14.1%, a slight decrease from the September figure of 14.2%.

Integrated Care has the highest turnover rate of 18.74%, followed by Emergency Department (17.96%). Corporate Services has the lowest turnover rate (11.75%).

The top known reason for leaving for the 12 months to August was 'Voluntary Resignation' for:
– Work Life Balance - 12.71%;
– Relocation - 11.78%;
– Promotion - 9.92%.

McCarthy Rebecca 06/12/2023 11:30:52

Performance for Workforce Turnover



Signed off by	Kaiser Chowdhury
Executive Lead	Amanda Bromley

Integrated Performance Report - Exception

Workforce: Appraisals		Target	Actual	6-month Trend	Previous Performance	1-month Forecast
Appraisal Rate: Overall	The percentage of overall staff that have been appraised within the last 15 months. Includes both medical staff and non-medical staff.	>= 95%	90.5%			

Consolidated appraisal compliance for the organisation currently stands at 90.8%, which is below the Trust target of 95%.

Clinical Support Services remain above target at 95.10%.

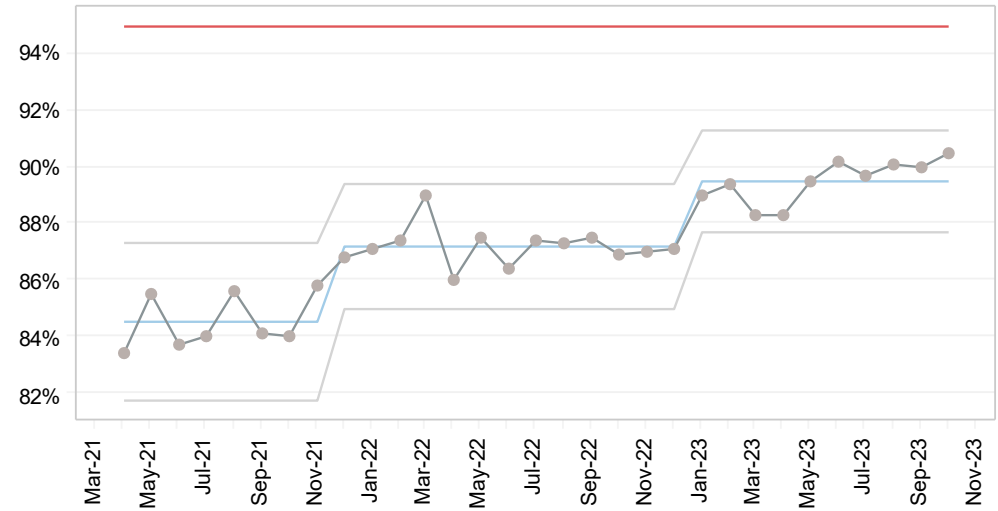
Appraisal performance is now addressed within monthly performance review meetings and divisions are supported by the Education and OD Teams to improve compliance.

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

McCarthy Rebecca 06/12/2023 11:30:52

Signed off by	Kaymo Jammeh
Executive Lead	Amanda Bromley

Performance for Appraisal Rate: Overall



Integrated Performance Report - Exception

Workforce: Mandatory Training		Target	Actual	6-month Trend	Previous Performance	1-month Forecast
Mandatory Training	The percentage of statutory & mandatory training modules showing as compliant.	>= 95%	94.5%			

Mandatory training is currently at 94.49% for the organisation which is very close to the Trust target. Teams have been working hard to improve compliance across the Trust.

Clinical Support Services, Corporate Services, E&F, Integrated Care, and Women's and Children's are above target.

Medical and Dental is the lowest performing staff group, and we are engaging with colleagues to improve this position with a trajectory in place.

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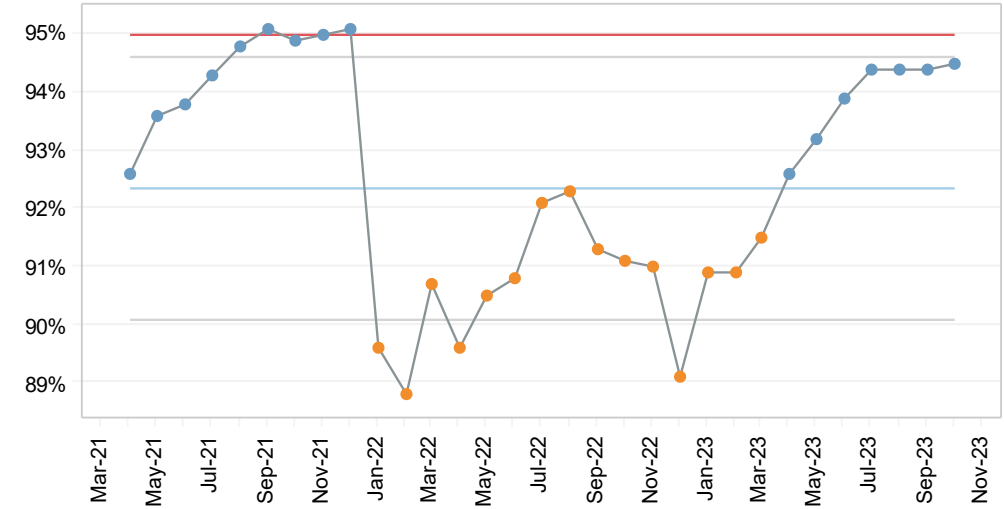
Performance for Mandatory Training



Signed off by	Kaymo Jammeh
Executive Lead	Amanda Bromley

Integrated Performance Report - Exception

Finance		Target	Actual	6-month Trend	Previous Performance	1-month Forecast
Capital Expenditure	The actual capital expenditure, as a percentage of the planned capital expenditure. Performance is displayed as a percentage variance from the planned amount.	<= 10%	-42%			
Cash Balance	The amount of cash balance in Trust accounts. Figures displayed are millions per month.		23.9			
CIP Cumulative Achievement	The value of the actual CIP achievement, displayed as a percentage variance from the planned CIP achievement.	>= 0%	3.1%			
Financial Controls: I&E Position	The actual financial position, displayed as a percentage variance from the planned financial position.	<= 0%	10.5%			

Risks

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

The cost of industrial action was not included in the planning process. The gross cost of the industrial action to date is £2.1m, which does not include the cost of providing additional capacity to replace lost activity. No further industrial action dates have been confirmed after October.

The risk of non-delivery of activity in accordance with ERF is still not clear, but in line with GM values, the Trust has reported a £1.2m risk to month 7.

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

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

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

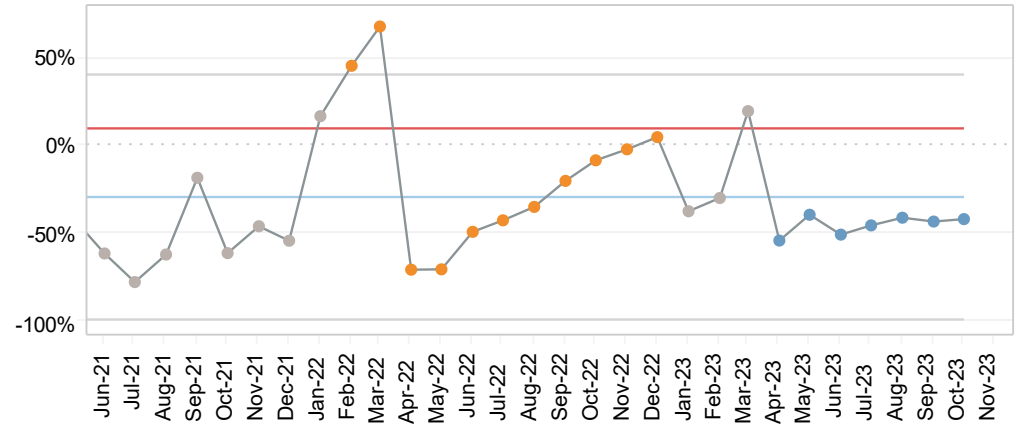
There is an increasing cost of acuity in the Trust for enhanced care for patients. This also links to the number of no criteria to reside patients who have complex needs and for whom CHC external placements cannot be found.

Offsetting the risks, is the announcement of additional funding to support the costs of industrial action and this will be clarified in the Month 8 financial position.

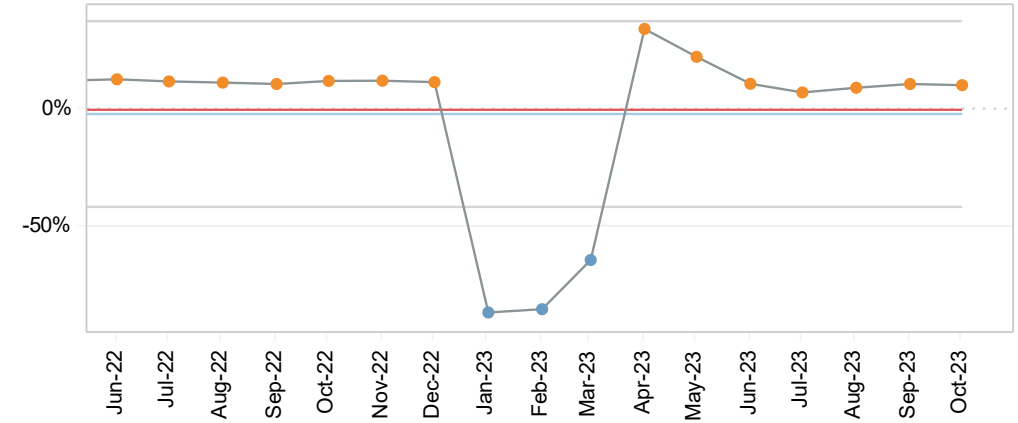
McCarthy Rebecca 06/12/2023 11:30:52

Signed off by	Kay Wiss
Executive Lead	John Graham

Performance for Capital Expenditure



Performance for Financial Controls: I&E Position



NHS
Stockport
NHS Foundation Trust

Meeting date	7 December 2023	**Public**	X	**Confidential**	
Meeting	Board of Directors				
Report Title	Trust Objectives & Key Outcome Measures 202/24 – Mid Year Progress Report				
Presented by	Karen James, Chief Executive	**Author**	Andy Bailey, Deputy Director of Strategy & Partnerships Angela Dawber, Head of Strategy and Partnerships		

Paper For:	**Information**		**Assurance**	X	**Decision**	
Recommendation:	The Board of Directors is requested to is asked to note progress in delivery of Trust Objectives.					

This paper relates to the following Annual Corporate Objectives

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

The paper relates to the following CQC domains

	Safe		Effective
	Caring		Responsive
X	Well-Led		Use of Resources

This paper relates to the following Board Assurance Framework risks

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

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

Where issues are addressed in the paper

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

Executive Summary:

This paper provides a high-level overview of progress made over the first six months of the year against the Objectives and Key Outcome Measures for 2023/24, with the more detailed objectives being reviewed by the Chief Executive and Team on a regular basis.

The Board will note that papers discussed at Board and its Committees are aligned with the corporate objectives. The key outcome measures relating to the Corporate Objectives for 2023/24 will be familiar to Trust Board members as these are discussed at the relevant Trust Board Committees.

The Trust Board is asked to note good progress towards the corporate objectives, with a number of actions completed ahead of schedule. The report includes examples of progress and exceptions.

Our Objectives for 2023/24

Stockport NHS Foundation Trust

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

Our Vision

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

Our Values & Our Mission

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

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

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

Our Mission
Making a difference every day.

Corporate Objectives 2023/24 We Will:	Key Outcome Measures *How will we know we will have achieved our objectives?*	RAG Rating	Mid-Year Progress
1 - Deliver personalised, safe and caring services.	Deliver national waiting time / performance requirements, including: • 76% seen within 4hrs in ED by March 2024	🔴	The trust did not meet the four-hour emergency care standard in October 2023, with a performance of 66.3%. Performance also fell short of the target set in the NHSI/E plans (64.9% for October) A revised trajectory to meet the 76% standard by March 2024 is being developed in line with recent letter on national planning expectations.
	• 97% G&A bed occupancy by Mar 24 and Critical Care bed occupancy at 92%	🟢	Year to date bed occupancy was 95.2% in October 2023
	• Eliminate waits of over 65 weeks for elective care by Mar 24	🔴	Latest position for October 2023 is 1,409 over 65 weeks. A revised trajectory has been submitted to GM anticipating 1,543 65-week waits by year end. We have continued to seek mutual aid to support reduction of our backlog, however there is a lack of available capacity across the system.
	• Reduce NCtR to 73 by Mar 24	🔴	Current daily average for NCtR is 97. In October 2023 there were 88 patients with No Criteria to Reside against a target of 73. Total of 476 NCtR YTD. The average number of days in an acute bed with NCtR is currently 7.74 days
	• 100% ambulance handovers within 60 mins.	🔴	23% of ambulance handovers take place within 60 minutes YTD
	• < 82 cancer patients waiting over 62 days by Mar 24	🟡	48.5% of cancer patients waiting over 62 days. Latest 63-day standard is currently reported at 41.6%. Latest position as at 26/11/23 is a backlog of 90 against revised trajectory of 128 for the end of November. The Trust anticipates delivery of plan by year end.
	• 75% performance against cancer faster diagnosis standard by Mar 24	🟡	57.2% in September 2023. 64.8% performance against cancer faster diagnosis standard YTD. The trust anticipates 75.4% performance by March 2024.
	• 90% of diagnostic tests in under 6 weeks by Mar 24	🟡	13.7% of patients waited longer than 6 weeks YTD for diagnostic tests. YTD colonoscopy activity is 22.8% below plan, Gastroscopy is 20% below plan, Echo is 24.3% below plan, CT is 13.8% below plan, MR is 12.6% below plan. NOUS is 4.7% below plan. Flexi Sigmoid is 2.3% above plan
	• 80% Virtual Ward beds occupancy by Mar 24	🔴	Currently averaging 18 occupied beds at 8am with 2 admissions per day. This equates to a bed occupancy rate of 36%, with an average length of stay 8.3 days.

Corporate Objectives 2023/24 We Will:	Key Outcome Measures *How will we know we will have achieved our objectives?*	RAG Rating	Mid-Year Progress
	• 85% Theatre Utilisation	🟡	Uncapped touch time utilisation is 83.5%. Capped touch time utilisation is 74.8% YTD
	• Move 5% of outpatient attendances to PIFU by Mar 24	🟡	In October 2.9% of outpatients were discharged on a PIFU pathway. 3.1% of patients currently moved onto PIFU pathway YTD. Local Target 4.1%
	• 70% of Urgent community responses <2 hours	🟢	The Trust continues to deliver above the standard with the current rate at 96%.
	Secure a local Ophthalmology service through a partnership with Tameside & Glossop Integrated Care NHS FT	🟡	Work is ongoing to develop a business case with GMICS
	New incident reporting system (PSIRF) is embedded across the organisation.	🟢	The Patient Safety Incident Response Framework will be implemented across the NHS in the autumn. A Serious Incident Review Group (SIRG) meets 3 times a week with Chief Nurse and Medical Director present. This is in addition to the Incident Review Group (IRG) which looks at all incidents with harm moderate and below. Both groups have been established to oversee moderate and serious harm incidents. Close working with the coroner will be key for the new framework - the Chief Nurse has already met with the coroner and will continue to do so throughout the transition.
	Improve the quality and safety of our services through delivery of the Quality and Safety Strategy Objectives for 2023/24.	🟢	In June 2023, the board received an update on the delivery of the quality strategy. Board receives regular updates against quality strategy. In 2023/24 targets focus on pressure ulcers, falls and infection prevention with monthly updates provided to board.
	Meet maternity safety standards and CNST maternity requirements.	🟢	In August 2023, Board received a report noting the trust achieved full compliance of all 10 safety standards in year 4. Year 5 submission to take place in February 2024
	Enhance and embed the end-of-life care model.	🟢	The Palliative & End of Life Care (PEOLC) Steering Group meetings chaired by Dr Tushar Mahambrey (DMD) with Margaret Malkin and Helen Howard commenced in October 2022. TOR have been ratified. Comfort observations, work plan for divisions and work streams are being finalised. BI will be supporting to track improvements.

Corporate Objectives 2023/24 We Will:	Key Outcome Measures *How will we know we will have achieved our objectives?*	RAG Rating	Mid-Year Progress
			Bi-monthly meetings will be to feed into Stockport wide PEOLC meeting as key issues report and then onwards into PSG.
	Continue the roll out of the STARS Accreditation Programme, improving the number of areas achieving 'green' status.	●	Trust overall combined STARS achievement was 60% at end of Q2. During April- Oct 23, 39 assessments were completed across the trust. A Blue STARS procedure was set up to recognise consistent achievement of quality standards.
	SIs are reporting within 48 hours and a software system for all SIs is embedded across the organisations.	●	An Incident review Group meets every Tuesday, chaired by the Deputy Director of Quality & Governance and attended by corporate teams and senior clinical leads it reviews incidents reported in the previous week and shared lessons learnt via the weekly Risky Business newsletter.
	Complete a well led assessment against key lines of enquiry.	●	Well Led Self-Assessment reviewed by Board in March 2023, to support well led review. Considering financial pressures, determined to utilise internal audit to undertake 'Well Led Position Statement' to be completed by Q4. To be reported to Audit Committee.
2 - Support the health and wellbeing needs of our community and colleagues	Reduce sickness and absence levels through the roll out of the Trust's new Health and Wellbeing Policy.	●	YTD 5.8%. Below the target of 6%
	The Locality Provider Collaborative has established programmes to improve primary/secondary health and wellbeing outcomes through evidence-based interventions.	●	One Stockport Locality collaborative continues to meet and workstreams have been agreed with the provider partnership and a work plan in place.
3 -Develop effective partnerships to address health and wellbeing inequalities. McCarthy Rebecca 06/12/2023 11:30:52	In collaboration with partners and stakeholders, a Locality Plan is developed which is aligned with the GM ICP Strategy.	●	The ONE Stockport locality plan is being refreshed with partners and aligns to both the Trust and ICS forward view.
	Begin to integrate corporate functions across Tameside and Stockport which includes HR, BI, IT, Strategy and Estates.	●	The Strategy team is already working across both Trusts. As part of the PWC work, a review of scope for integration has been assessed with Execs.
	Continue to explore areas for collaboration across clinical services across Tameside & Glossop and Stockport Trusts.	●	Clinical Partnership Group between the two Trusts continues to meet with collaboration reviews underway on Gastroenterology, diagnostics, pathology, urology, ENT, DEXA. Work is also beginning to review Frailty models across the Trusts.

Corporate Objectives 2023/24 We Will:	Key Outcome Measures *How will we know we will have achieved our objectives?*	RAG Rating	Mid-Year Progress
	To progress the agreed plan to support a centralised model for Stockport's Intermediate Care Bed Base.	🔴	A collaborative approach with system partners is looking to establish a centralised bed base as a future model – this is likely to be the development on the St Thomas' site. In the interim, commissioners are reviewing the immediate bed requirements and what is required going forward. There remains a significant risk of further community beds being decommissioned by the end of 23/24.
	The Trust Strategy is refreshed during 2023/24 financial year (Q4).	🟢	Initial scoping paper has been to Exec Team and work with be undertaken in Q4 to refresh the plan
	The Trust Planning round is undertaken and completed in Q3-Q4 2023/24.	🟢	Operational Planning is underway, with the intention of bringing a draft plan to Board in January 2024.
4 - Develop a diverse, talented and motivated workforce to meet future service and user needs	Increase integrated workforce models through the development of Trust outcomes.	🟢	Senior leadership events facilitated to explore team dynamics and establish better ways of working and enhance leadership skills. Roll out of Civility Saves lives programme to commence from Nov 2023
	Complete a Medical Workforce Plan for those difficult to recruit specialties.	🔵	The Medical WFP action is complete and is included in overall strategic WFP document approved via PPC. Currently reviewing the divisional WFPs which feed into the Trust overarching plan and are linked into the operational plan discussions
	Implement the Trust's Equality, Diversity and Inclusion Strategy objectives for 2023/24.	🟢	Board receives regular updates on EDI strategy
	Improve retention and reduce bank and agency usage in accordance with the Trust improvement trajectories.	🟢	Staff retention rate YTD is 98.8%, with turnover at 14.4%. Turnover reduced by 4% over first half of the year. Agency usage has reduced to 89.79 WTE, though bank usage has increased by 88.24 WTE. Combined bank and agency usage is at 11% of staffing
	Respond to staff survey feedback to demonstrate improvements.	🟢	Current Staff Survey overall response rate as of 16th November is just below 40%.
5 - Drive service improvement through high quality research, innovation and transformation.	Develop locality-wide research programmes through facilitation of system wide trials.	🟢	In August, board received an update on delivery of research strategy. Trust was 8th highest recruiting trust for clinical trials.
	Implement the Trust Research and Development Strategy objectives for 2023/24.	🟢	Delivery of R&D strategy continues.
	To deliver, in partnership, the Community Diagnostic Centre, to the agreed specification and within Q4 2023/24.	🟡	Business case has been signed off by NHS England and work is underway to agree pathways and processes.

Corporate Objectives 2023/24 We Will:	Key Outcome Measures *How will we know we will have achieved our objectives?*	RAG Rating	Mid-Year Progress
	Complete an update of the Trust's website.	🟢	Progress on the new website is ongoing, expected completion by the end of Q4 (March 2024)
6 - Use our resources efficiently and effectively.	Deliver the Trust's Financial, Revenue and Capital Plan.	🔴	Over the first half of the year the trust has a deficit position of £18.2 million which is £1.8million adverse to plan. £1.7 million of this relates to costs of covering industrial action.
	Deliver the Trust's financial efficiency programme (STEP/CIP).	🟡	Board receives monthly finance report updating on efficiency delivery. We have seen good progress on some recurrent schemes, however there remains a shortfall against the recurrent target in year.
	Complete the final accounts for the year end which receive a compliant audit report.	🟢	On track to deliver as planned
	Achieve greater productivity and efficiency levels in endoscopy, outpatients, theatre, day cases, LoS, to achieve upper quartile performance levels (model hospital).	🟡	96% utilisation since May 23. DNA rate in Oct 1.9%. Diagnostic backlog reduced to 108 patients waiting over 65 weeks. Nurse led consent has been implemented which has helped reduce turnaround time. Last minute cancellation process in place to maximise cancelled slots and fill with appropriate patients, helping reduce lost capacity. Recruited to full establishment, improved retention and seen a reduction in staff sickness.
7 - Develop our Estate and Digital infrastructure to meet service and user needs.	Deliver the Emergency Department (ED) expansion scheme.	🔴	Completion of main building structure done. External cladding and internal mechanical and electrical fittings taking place. • Meetings held with regional team regarding project completion dates - now anticipated as Q3/4 24/25. • Trust must spend full PDC award in 23/24 and manage any remaining impact via CDEL in 24/25
	An EPR Business Case and recruitment process is completed across both Tameside and Stockport Foundation Trusts	🟡	Joint Stockport & Tameside EPR Outline Business Case was supported by Trust Boards earlier in the year, recognising an affordability gap. Following review by GM, the case was submitted to the Regional Team where further work is continuing prior to submission to the national team. The Trusts' teams continue preparing procurement documentation including demonstration scripts in readiness for final approval of OBC and progression to formal EPR system procurement. System have asked the Trust to accept a PDC award of

Corporate Objectives 2023/24 We Will:	Key Outcome Measures *How will we know we will have achieved our objectives?*	RAG Rating	Mid-Year Progress
			£3.56m in 23/24 despite no deliverable spend plan in place.
	The rollout of the new digital Laboratory Information System is completed.	🟡	LIMS implementation programme currently working towards a go-live date Q2 2024/2025. On premise infrastructure and High-Level Design complete for all disciplines. Lab teams are currently working on detailed Low-Level Design with system build progressing in line with standardisation piece with GM pathology network. Risk around pressures on the staff resources supporting the project.
	Complete the Meadows PFI hand back process.	🟡	Formal notice has been provided to Project Co that the Trust intends to exercise the option of purchasing the facility. • A survey of the facilities has been undertaken and the Trust is overseeing rectification works • A draft Transition Plan is being compiled Actions remain to: • Determine source of capital for the transaction • Draft Heads of Terms for an agreement between Trusts to determine post-hand back conduct and finances • Develop an FM services transition plan
	Develop and implement a Way Finding Strategy.	🟡	The trust is using the opportunity presented by the new ED development to review way finding opportunities. Once completed a wider site-based approach will be progressed.
	Deliver the Trust's Green Plan objectives for 2023/24.	🟢	Introduced first electric community ambulance, supporting a reduction in carbon emissions.
	Continue the delivery of the PFI optimisation work and complete the PFI DRP process.	🟢	PFI Optimisation work continues, with updates provided to executives.
	Continue to engage key stakeholders in the development of the new hospital OBC and to complete a transition plan for the hospital site to address the poor capital stock which will include Outpatients B and Pathology.	🟡	Our funding application for inclusion in the national New Hospital programme was unsuccessful – conversations have since taken place with GM/Locality leads to agree next steps. Progress with of the site development strategy has been via introduction of an Estates Strategy Steering Group, membership includes external stakeholders from SMBC Active conversations are taking place with SMBC regarding re-provision of OPD B as a priority.

Meeting date	07 December 2023	**Public**	**X**	**Confidential**	
Meeting	Board of Directors				
Report Title	Response to NHS England Operational Guidance Letter: Addressing the significant financial challenges created by industrial action.				
Director Lead	Jackie McShane, Director of Operations	**Author**	Angela Dawber, Head of Strategy and Partnerships		

Paper For:	**Information**		**Assurance**	X	**Decision**	X
Recommendation:	The Board of Directors is asked to ratify the Trust response to the NHS England Operational Guidance Letter *'Immediate actions to address significant financial challenges",* following delegated approval to the Trust Chair and Chief Executive to sign off the response, thereby enabling submission to NHS England by the required deadline.					

This paper relates to the following Annual Corporate Objectives

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

The paper relates to the following CQC domains

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

This paper relates to the following Board Assurance Framework risks

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

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

Where issues are addressed in the paper

	Section of paper where covered
Equality, diversity and inclusion impacts	Section 4
Financial impacts if agreed/not agreed	Section 3
Regulatory and legal compliance	Throughout
Sustainability (including environmental impacts)	N/A

Executive Summary

On the 8th November, Integrated Care Systems received operational guidance relating to the impact of industrial action on forecast delivery of 2023/24 plans. A rapid two-week exercise was initiated, requiring ICS' and Trust Boards to sign-off and submit key finance, performance and capacity commitments to NHS England by 22nd November 2023.

The attached paper provides an update on the submission made to Greater Manchester ICS and NHS England, which recommits the Trust to:

- Deliver our financial plan for 2023/24
- Prioritise delivery of the 4hr A&E standard by March 2024
- Deliver planned reductions in the 62-day cancer backlog.

It also highlights the following changes:

- revised trajectory of 75.4% for the Faster Diagnosis Standard
- reduction of 8 G&A beds due to the re-phasing of the EUCC build
- revised forecast of 1,543 65-week waits by year end
- revised forecast of 351 78-week waits.

Acknowledging the Trust response would not be reviewed by the Trust Board ahead of the 22nd November submission deadline, the Board of Directors virtually approved delegated authority for sign off by Chair and Chief Executive to ensure timely submission, with an acknowledgement that the response would be

presented for ratification at the Board meeting in December.

1. Purpose

1.1 This report sets out the Trust's submission to NHS England with regard to delivery of operational plans 2023/24.

2. Introduction / Background

2.1 On the 8th November Integrated Care Systems (ICS) received operational guidance[1] addressing the significant financial challenges created by industrial action in 2023/24. A rapid two-week exercise was initiated, requiring ICS' and Trust Boards to sign-off key finance, performance and capacity commitments by the 22nd November.

2.2 GM ICS asked providers to submit their position by 16th November for collation into a system position.

2.3 The priority now is to deliver the Trust's financial plans, urgent care and cancer performance.

3. Trust Submission

3.1 Stockport NHS Foundation Trust has confirmed to GM ICS and NHS England that it **will**:

- Deliver the financial plan 2023/24
- Prioritise delivery of the 4hr A&E standard by March 2024
- Deliver planned reductions in the 62-day cancer backlog

3.2 The Trust's submission recognises the following **change** to plan:

- revised trajectory of 75.4% for the Faster Diagnosis Standard
- reduction of 8 G&A beds due to the re-phasing of the EUCC build.

3.3 See submission in Appendix 1.

3.4 The Trust response remains consistent with the final operational plan submission approved by the Board in June 2023, which included confirmation that key metrics within the plan were subject to several assumptions, without which metrics would not be achieved. The Board of Directors were fully sighted on the development of the operational plan and decision-making regarding approval.

3.5 Furthermore, the Trust response is consistent with the recent Board declaration to NHS England relating to 'Protecting and Expanding Elective Capacity', reviewed by Finance & Performance Committee, and approved by Board of Directors in October 2023. The declaration included confirmation that management of clinical risk in relation to timely access was in place; with a

[1] NHS England » Addressing the significant financial challenges created by industrial action in 2023/24, and immediate actions to take

series of reports provided to Quality Committee to support review of patient safety matters and clinical risk in relation to poor patient flow/timely access.

3.6 **Additional GM ICS Submission**

In addition, GM ICS asked Trusts to provide an updated position on waiting times (see submission in Appendix 2). As a result of significant increases in urgent cancer referrals, a lack of regional mutual aid in those specialties; and the significant loss of capacity caused by industrial action, the Trust anticipates:

- 1,543 65-week waits by year end; and
- 351 78-week waits by year end.

3.7 The Trust remains committed to eliminating 104-week waits and foresees no change to the overall waiting list position.

3.8 Finance & Performance Committee considered operational performance trajectories, assumed as part of operational planning for 2023/24, at its meeting in November 2023. High level information of the key actions to achieve the trajectories, including underlying assumptions, will be presented as part of the Operational Performance Report going forward to provide assurance regarding achievement.

3.9 As per the approved operational and financial plan, the delivery of the trajectory is predicated on a number of caveats relating to:

- Ability to maintain elective operating all year – not impacted by further non-elective pressures
- Q4 improvements based on consolidation of community bed base and success of length of stay improvement work
- The success of locality work around safe and timely discharges
- No further industrial action
- All of our services having access to available independent sector and mutual aid capacity.

4. Impact Assessment

4.1 The Board has continued to discuss the importance of quality impact assessing decisions / actions taken in response to significant financial challenges, as set out within the minutes of the Board of Directors meetings.

4.2 The Trust response to NHS England remains consistent with the approved operational and financial plan, with agreed focus on urgent care, emergency cancer referrals, and prioritising long-waits to minimise negative impacts on patient safety and quality outcomes. The Trust continues to validate waiting lists and prioritise, on the basis of need, with systems in place to review the management of clinical risk associated with delivery of timely care and quality impact assessment of business cases & cost improvement programmes

overseen by the Chief Nurse, Medical Director and Director of People & Organisational Development.

4.3 The Trust continues to work with colleagues across the North West to attempt source mutual aid in those specialties where there is the greatest risk of long-waits due to workforce capacity.

5. Next Steps

5.1 The Trust has initiated planning for 2024/25.

5.2 Sessions were held with each Division to review delivery against activity, workforce and financial plans over the first half of the year and anticipated that will impact on forecast outturn. This will be developed into a draft capacity plan in anticipation of national planning guidance by the end of the year.

5.3 A high level timeline can be found in appendix 3, though this will be subject to change when NHS planning guidance is released.

5.4 The Board is asked to receive the update on the planning process.

Appendix 1 – SFT section of GM Submission

Acute – RJW
STOCKPORT NHS FOUNDATION TRUST

The trust board confirms its commitment to:	Confirmation (Y/N)	If not confirmed, provide a brief explanation including the basis for a revised proposed plan	Actuals		Plans				
			Period	Value	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Headline objectives									
The 4 hour system A&E performance as described in the winter plan	Y		Sep-23						
The March 2024 cancer 62 day backlog position set out in the 2023/24 operational plan	Y		Sep-23						
The March 2024 cancer Faster Diagnosis Standard performance set out in the 2023/24 operational plan	N	75.4% as per revised trajectory	Aug-23						
Key enablers									
Core G&A bed capacity growth committed to within the winter plan	N	Minus 8 beds due to the re-phasing of the EUCC capital build.	Sep-23	631	649	649	649	644	644
Escalation capacity committed to within the winter plan	Y				0	0	0	0	0
An ambulance handover average delay trajectory, that is consistent with the overall system-level trajectory, has been agreed by the trust Board	Y								
Discharge									
A discharge ready date metric was published for the Trust in November, and the trust Board is regularly reviewing this metric as part of a performance dashboard to drive improvement	Y	To be added to the December IPR at Board							

Sign off	
The return must be signed off by the trust Chair and CEO on behalf of the trust board. In signing off the return the trust Chair and CEO are providing assurance that the trust Board has considered the quality impact assessment of plans and assured itself of appropriate clinical involvement in decision making.	

Appendix 2 - GM Supplementary Elective Template

The trust board confirms its commitment to:	Confirmation (Y/N)	If not confirmed, provide a brief explanation including the basis for a revised proposed plan	Actuals		Plans				
			Period	Value	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Total waiting list	Y		Sep-23	46459	52938	52643	52857	53340	53900
65 week waits	N	We now anticipate **1,543** 65 week waits by year end, due to the impact of: increased cancer/urgent demand in certain specialties; lack of regional mutual aid in those specialties for the level / type required; and the significant loss of capacity caused by industrial action.	Sep-23	1353	392	301	195	94	0
78 week waits	N	We now anticipate **351** 78 week waits	Sep-23	185	0	0	0	0	0
104 week waits	Y		Sep-23	4	0	0	0	0	0

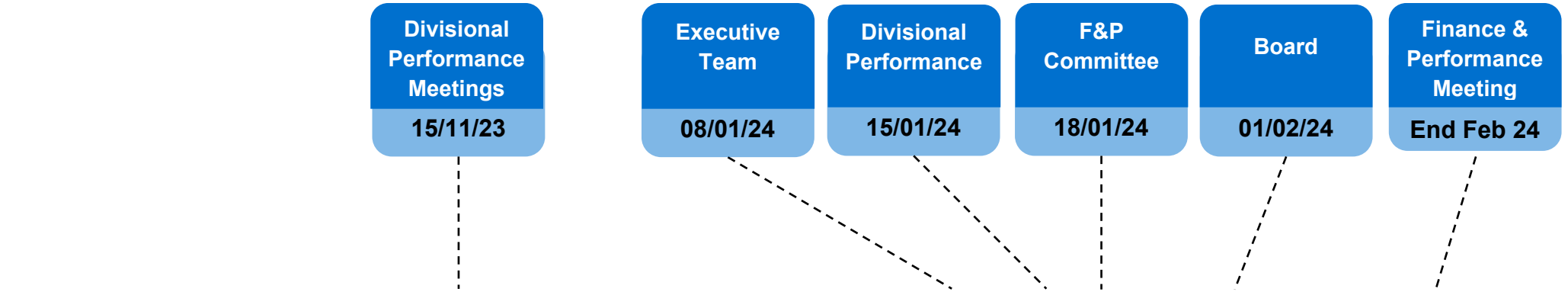
Revision to RTT Trajectories

Total incomplete RTT pathways		April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
Stockport	Plan	47,525	48,970	50,154	51,106	51,734	52,698	53,956	54,821	54,761	55,210	55,929	56,724
	Actual	46,282	47,007	47,617	46,778	47,500	46,381	44,546	44,588	44,630	44,672	44,714	44,754
	Variance to plan	-1243	-1963	-2537	-4328	-4234	-6317	-9410	-10233	-10131	-10538	-11215	-11970
	% variance	-3%	-4%	-5%	-8%	-8%	-12%	-17%	-19%	-19%	-19%	-20%	-21%

65 week waits		April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
Stockport	Plan	1,114	1,018	912	811	705	604	498	392	301	195	94	0
	Actual	1,237	1,180	1,233	1,242	1,349	1,418	1,293	1,343	1,393	1,443	1,493	1,543
	Variance to plan	123	162	321	431	644	814	795	951	1,092	1,248	1,399	1,543
	% variance	11%	16%	35%	53%	91%	135%	160%					

52 week waits		April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
Stockport	Plan	2,311	2,327	2,414	2,672	2,961	3,295	3,873	4,518	4,860	5,354	5,898	6,607
	Actual / Trajectory	3,850	4,222	4,340	4,458	4,443	4,340	3,923	3,855	3,787	3,719	3,651	3,583
	Variance to plan	1539	1895	1926	1786	1482	1045	50	-663	-1073	-1635	-2247	-3024
	% variance	67%	81%	80%	67%	50%	32%	1%	-15%	-22%	-31%	-38%	-46%

Appendix 3 – High Level Planning Timeline



October 2023	November 2023	December 2023	January 2024	February 2024	March 2024
Baseline • M01-06 • Plan v actual • Performance • Forecast outturn	**Forecast** • Divisional plans • Workforce changes • Known service changes • STEP plans	**Draft Plan** • Activity • Performance • Workforce • Finance • Capital • STEP	**Governance** • Review with Divisions • *National guidance?* • ET approval • F&P • Board	**Confirm & Challenge** • FPPM review • GM process • Draft submission to national team	**Final Plan** • Final amends • Review with Divisions • ET – F&P – Board • Final submission • Budget sign-off

NHS Stockport NHS Foundation Trust

Meeting date	7th December 2023	**Public**	X	**Confidential**	
Meeting	Board of Directors				
Report Title	Board Ratification - Revenue Support Public Dividend Cash Application				

Director Lead	John Graham Chief Finance Officer	**Author**	Lisa Byers Associate Director of Finance – Financial Services

Paper For:	**Information**		**Assurance**		**Decision**	X
Recommendation:	Further to the Board Resolution approving the Revenue Support Application process and in accordance with NHS England (NHSE) requirement for challenge to plans, the Board of Directors is asked to ratify the virtual approval of the application for £16 million PDC revenue support in Quarter 4 of 2023-24. The Board application was submitted prior to the 1st December 2023 deadline.					

This paper relates to the following Annual Corporate Objectives

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

The paper relates to the following CQC domains

	Safe		Effective
	Caring		Responsive
	Well-Led	X	Use of Resources

This paper relates to the following Board Assurance Framework risks

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

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

Where issues are addressed in the paper

	Section of paper where covered
Equality, diversity and inclusion impacts	X
Financial impacts if agreed/not agreed	£16 million cash support
Regulatory and legal compliance	Whole Paper
Sustainability (including environmental impacts)	X

Executive Summary

At the 31st October 2023 the Trust has a cash balance of £23.9 million; a reduction of £23.2 million from the 1st April 2023. It is forecast that by the 31st March 2023, without cash support, the Trust will dip below its minimum cash balance by £907k in February 2024 and will have a cash deficit of £4.3 million by the 31st March 2024 including capital creditors outstanding of £8.2 million.

Provider Revenue Support is available to all cash distressed providers with the provision of public dividend capital through a defined process. This process requires a forecast submission in December 2023 for revenue support PDC requests for January to March 2024.

The Trust has a minimum cash balance set at £1.746 million by NHSE for operational revenue purposes which is two days of operating expenditure. Above this the closing balance may also include cash balances for capital expenditure (internal depreciation and capital PDC awards). Revenue Support PDC requests can only be made to support revenue expenditure and cannot be used for capital expenditure. In practice this means that capital PDC awards drawn cannot be used for revenue purposes. However, internal depreciation funding will be allowed for use in the short term.

Before submitting the formal revenue support request the Trust is required to evidence that the cash position has been discussed, the plans challenged, and that the requested amount of Revenue Support

PDC has been approved by the Board. In preparation for borrowing the Board approved a resolution in October 2023 that multiple requests for PDC revenue support totalling £20,000,000 are taken. The Board also authorised the Director of Finance to execute and authorise all Finance documents on behalf of the Trust.

The attached paper was presented to the Finance and Performance Committee on 16th November to review and discuss the Trust cash forecast and liquidity management strategies. Based on this discussion the Committee supported the application for cash support and recommend for virtual approval by the Board the application for Revenue Support Public Dividend Capital at £16 million for Quarter 4 January to March 2024.

The Finance and Performance Committee also reviewed the Trust's Treasury Management Policy at its meeting on the 16th November 2023.

To ensure the application for £16 million PDC Revenue Support could be submitted by the 1st December 2023 deadline, following review and support by Finance & Performance Committee, the Board of Directors virtually approved the application, noting ratification by the Board of Directors at its meeting on 7th December.

1. Purpose

1.1 This paper sets out the process for the Trust to access cash through revenue support Public Dividend Capital (PDC) from the Department of Health and Social Care (DHSC), the process for applying and the conditions the Trust must meet and upon which revenue support PDC will be granted.

1.2 The Board of Directors is asked to review the Trust cash forecast and cash management strategies to April 2024 and approve the application for revenue support PDC of £16 million in quarter 4 2023-24 in accordance with the Board resolution agreed in October 2023.

2. Introduction

2.1 Provider Revenue Support PDC is available for all cash-distressed Providers. Four types of Revenue Support PDC requests can be submitted to the NHS England (NHSE) Provider Revenue Support Team.

- **Deficit Support -** To make a request, a Provider must be in a cumulative deficit position in the financial year. The request amount cannot exceed the deficit**;**
- **Intra ICS Cash Transfers -** Requests can be made to transfer cash between two Providers within the same ICS through repaying and drawing PDC via DSHC**.** Whilst this option is being considered by Greater Manchester Integrated Care System it is not yet agreed and not an option for the application this paper is proposing;
- **Working Capital (by Exception) -** Distressed Providers can make Revenue Support PDC working capital requests by exception (e.g.to pay down prior year creditors aged over 90 days); and
- **In-Quarter Requests (by Exception) -** Providers can make new or additional deficit or working capital Revenue Support requests monthly within the quarterly cycle, on an exception only basis.

2.2 Revenue Support PDC is available to support revenue expenditure only and is available to the Trust for necessary and essential expenditure to protect continuity of patient services. PDC support for capital expenditure follows a separate process and capital PDC should not be used for revenue expenditure.

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

2.4 The Trust must demonstrate its revenue cash requirements to NHSE through a defined process and timetable. This includes a daily cashflow forecast including one month proceeding and one month after the application period request. It also requires a commentary of the Trust's liquidity management strategies, any mitigating factors, evidence of Board and Finance & Performance Committee approval for revenue support and that the cash position has been discussed.

3. Matter under consideration

3.1 The Trust cash forecast to the 30th April 2024 is presented below.

Trust Name	Stockport NHS Foundation Trust				
Trust Code	RWJ				
	£000	£000	£000	£000	£000
	Dec-23	**Jan-24**	**Feb-24**	**Mar-24**	**Apr-24**
Opening Balance	**19,642**	**14,222**	**8,268**	**3,499**	**10,814**
Monthly Income					
NHS Receipts	30,231	32,071	31,731	29,070	31,365
Non NHS Receipts	2,424	3,143	2,744	3,273	1,708
Receipts for Capital	5,031	3,253	3,330	10,995	1,519
TOTAL	**37,685**	**38,467**	**37,805**	**43,337**	**34,592**
Monthly Payments					
Payroll Payments	- 28,584	- 29,269	- 29,065	- 28,823	- 29,132
Non NHS Payments	- 10,050	- 10,256	- 10,001	- 13,737	- 9,910
Capital Payments	- 3,724	- 4,791	- 4,139	- 5,256	- 8,231
Loan Payments	- 622	- 0	- 184	- 0	- 0
PDC Dividend Payments	-	-	-	- 3,200	-
Other Payments	- 125	- 105	- 92	- 81	- 267
Total	**- 43,106**	**- 44,421**	**- 43,481**	**- 51,098**	**- 47,540**
Balance	**14,222**	**8,268**	**2,592**	**- 4,262**	**- 2,134**
Revenue Support PDC Receipts	**-**	**-**	**907**	**15,076**	**4899***
Adjusted Balance	**14,222**	**8,268**	**3,499**	**10,814**	**2,765**

* 2024-25 Quarter 1 Revenue Support applications will be submitted in a separate application in March 2024.

3.2 The cash forecast above highlights a closing 2023-24 cash balance of £4.3 million deficit without revenue PDC support. Capital creditors at the 31st March 2024 are forecast to be £8.2 million based on Capital Plan projections. Behind the above summary a daily forecast has been prepared covering the period from the 1st December 2023 to the 30th April 2024.

3.3 NHSE have set the Trust minimum cash balance at £1.746 million (two days operating expenditure based on March 2020 calculations). This balance must be hit for each month in the draw period. The daily cash forecast pinpoints where the minimum cash balance falls below this limit in the period before the revenue support draw dates - between the 11th to 15th of the month and this informs the amounts drawn. The balance at the end of the month will be higher than the minimum balance where it includes capital PDC and revenue funding to meet expenditure in the following month before further income and revenue support PDC receipt.

3.4 To meet the minimum cash balance in each month in Quarter 4 2023-24 the Trust will require total revenue deficit support PDC of £16 million in 2023-24.

In February 2024 the minimum cash balance is forecast to fall to £839k on the 27th February requiring the first draw of revenue support of £907k.

3.5 In March 2024 the Trust cash balance will fall to a £5 million deficit on the 27th March and further to £13.3 million in April 2024 before receipt of contract income. To reach the minimum cash balance of £1.7 million revenue support of £15 million is required in March. The closing balance of £10.8 million includes £3.9m of PDC drawn for capital schemes and, in accordance with NHSE rules, is not to be utilised for revenue purposes. This will be used for capital creditor payments in April 2024.

3.6 At the 31st March 2024 the cumulative Trust income and expenditure forecast position is £31.8 million deficit. This meets the terms for applying for deficit support as set out at point **2.1** above.

3.7 **Liquidity Management Strategies**

3.8 The Trust Plan deficit position of £31.8 million in 2023-24 is worse than in 2022-23 by £8 million (2022-23 £23.8 million Plan deficit). This is a combination of inflationary pressures, costs of capacity and capital and a reduction in Covid funding. There is a CIP requirement of £26.2 million. Within the Annual Plan the Trust forecast a requirement to access revenue support of £20 million. In 2022-23 the Trust received system cash support of £21 million to reduce its planned deficit but this was non-recurrent income.

3.9 The 2023-23 Annual Plan deficit contributing to the worsening cash position is as follows:

	£m
2022/23 Planned Deficit	**(23.1)**
Pressures - cost of capacity	(3.0)
2022/23 underlying position	**(26.1)**
Add back	
Non-recurrent CIP delivered 2022/23	(12.2)
NR income and FYE of changes 2022/23	(3.2)
2023/24 contract income changes	
Inflation Funding	9.4
Inflation Efficiency requirement	(3.6)
Covid System funding	(11.2)
ERF	5.0
Growth, GM Contracts & other	6.3
Inflation	
Inflation costs	(12.2)
Pressures	
Cost of capital	(4.1)
Cost of capacity	(3.3)
Income risk	(0.9)
Other developments	(1.3)
CIP requirement 2023/24	25.5
2023/24 Planned Deficit	**(31.8)**

3.10 The Trust cash position forecast to March 2024 is presented monthly to the Finance and Performance Committee along with the key drivers of the Trust financial position and capital programme progress against plan.

3.11 The Trust's cash position is included as a significant risk on the Trust risk register and is monitored monthly by the Risk Management Committee. The Risk Management Committee updates the Audit Committee bi-monthly and Finance and Performance Committee monthly to provide assurance that appropriate oversight is given of the risk.

3.12 The Trust manages its treasury activities and liquidity through the Financial Services team. The roles and responsibilities of the Board, Chief Finance Officer and Finance department are set out in the Treasury Management Policy.

3.13 There is a monthly Cashflow Monitoring Group consisting of members of the Financial Services, Financial Management, Contract Income and Procurement teams. The Group is responsible for monitoring the cash levels of the organisation in the short, medium and longer term.

3.14 The Group will ensure delivery of actions to improve the forecast liquidity and to preserve cash by:

- Review of the Trust's short term cash flow ensuring the Trust retains sufficient cash to fulfil its obligations;
- Review of key cash related KPIs and taking appropriate action;
- Improved cash planning and cash awareness across the organisation;
- Identification and implementation of cash preservation schemes;
- Ensure the procurement team manage all supplier negotiations in line with Better Payment Practice requirements and cash management needs;
- Ensure compliance with the Trust's No Purchase Order No Pay Policy;
- Reduced debtors and accrued debt and prompt settlement of invoices;
- Approving the Trust's Debt Collection Policy;
- Escalation of invoice payment delays and issues;
- Reduced stock levels;
- Reduced prepayments;
- Ongoing monitoring of creditors payment terms;

3.15 There is a separate Debt Reduction Group to specifically review the Trust Aged Debt and escalate actions for outstanding invoices. Capital Plan forecasts are tracked through the Capital Planning Management Group (CPMG) and significant schemes such as the Emergency and Urgent Care Campus have separate cashflow monitoring meetings.

3.16 The Trust Better Payment Practice Performance is monitored on a monthly basis with an analysis of each payment run by listing of all invoices outside of payment terms by Division to escalate poor performance.

3.17 The outcomes and recommendations of the PWC Trust Grip and Control Review was designed to inform actions to preserve the Trust's cash balances and minimise the need for further revenue support requests. The Trust has scored highly against the recommended grip and control actions. It should be noted that the release of balance sheet flexibility to improve the bottom line financial position has little impact on the Trust's cash position.

3.18 The Trust has highlighted the risks to its cash position with the GM ICS since the start of the financial year. After further escalation, in November it was agreed that the Trust contract income would be paid on the 1st instead of the 15th of the month and has assumed the continuation of this for the remainder of the financial year. The Finance team is also monitoring weekly the receivable and payable balances with other GM and local providers.

3.19 Cash management discussions have begun at a GM wide level at Director of Finance and Deputies meetings to discuss the strategies system wide for managing cash levels. These include:

- Defensive cash management tactics;
  Payment terms management, treasury function
- Apply for temporary loans;
  External view of GM cash balance whilst borrowing
- ICB maximise payments and timings;
  Allocations management and agreed changes to payment dates
- Mutual aid across GM;
  Incentives and Unintended consequences

3.20 GM will also increase its governance and monitoring with detailed review and scrutiny via a new Capital and Cash Group with Trust Senior Accountant participation. The Trust is actively engaging in discussions with GM to inform these new processes. Preparations are underway for the formation of this group but it is yet to meet.

4. Recommendations

4.1 The Board of Directors is asked to review the Trust cash forecast and liquidity management strategies.

4.2 The Board of Directors is asked to virtually approve the Quarter 4 Revenue Support PDC application for £16 million to the Board for submission to NHS England on the 1st December 2023.

Meeting date	7 December 2023	**Public**	X	**Confidential**	
Meeting	Trust Board Meeting				
Report Title	Annual Report for EPRR				
Director Lead	John Graham, Chief Finance Officer &	**Author**	Ava da Costa Maia Head of EPRR		

Paper For:	**Information**		**Assurance**		**Decision**	X
Recommendation:	The Board of Directors is asked to approve the EPRR Annual Report, including compliance position with core standards.					

This paper relates to the following Annual Corporate Objectives

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

The paper relates to the following CQC domains

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

This paper relates to the following Board Assurance Framework risks

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

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

Where issues are addressed in the paper

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

Executive Summary

The Annual Report for EPRR has been developed to ensure that the Trust Board is sighted on the improvements that have been made in emergency preparedness, as well as the action that is required to ensure that the Trust achieves full compliance with our core standards by April 2024.

The Annual Report describes the regional Core Standards Assurance Process and our compliance with the standards we are expected to attain.

The report provides details of the training and exercises that we have been involved in over the past 12 months, as well as the learning we have gained from incidents. We have made significant progress over the past year, updating plans and policies and implementing standard operating procedures.

We have declared ourselves Partially Compliant with our core standards, and the Annual Report contains details of the gaps in our assurance that we will be closing over the next few months until we can declare full compliance.

Stockport
NHS Foundation Trust

ANNUAL REPORT

Emergency Planning, Response and Resilience

December 2022 – December 2023

Stockport NHS Foundation Trust is committed to ensuring that services are resilient, minimising the risk of disruption to services.

This document was approved by the EPRR Group on 31 October 2023 by Chair's Action

Contents

Foreword from the Accountable Emergency Officer

I am pleased to present the EPRR Annual Report for the year ending December 2023.

It has been a very challenging time for Stockport NHS Foundation Trust over the past couple of years with regard to resilience and business continuity. We will all be cognisant of the impact of COVID-19 and how much the quality of preparedness can impact on how well we as an NHS provider and an employer can respond to incidents that threaten to disrupt our services.

An internal audit that took place late last year highlighted to us that we had some gaps in our arrangements, and advised us that we had not been dedicating enough resource to ensuring that we are resilient. With that in mind we appointed an interim Head of EPRR who has been leading the improvement plan for resilience. We intend to recruit substantively to an EPRR Manager role to ensure that our progress remains steady and we are as prepared as we can be for major incidents or business disruptions.

Our responsibilities under the Civil Contingencies Act, the Health and Social Care Act and a number of other pieces of legislation remain unchanged and we are working towards being fully compliant with these. In addition, we also must ensure that we are compliant with our Core Standards and our NHS Standard Contract, and this year the assessment process has been more detailed than it has been in previous years. We have welcomed the opportunity to assess once more how much progress we have made, and this has also informed our work plan going forward.

Whilst we recognise that we have had a lot of work to do, it has been gratifying to see the commitment from our Divisions to contribute to the EPRR Group which was refreshed late last year to steer and support the improvement work. This has clearly worked well, resulting in the development and ratification of several guidance documents, which have been developed to describe and develop our response arrangements to a range of contingencies. These can be found on the EPRR microsite, and in the predetermined Major Incident Control Room resource packs.

Due to the recovery phase of COVID-19 and the industrial action periods that have taken place this year, it has not been appropriate or possible for us to have a Trust wide live exercise or command post exercise. However, we have used the opportunity to learn in formal and informal ways from the incident responses that we have done over the year.

Our Command and Control structures are well established and we have been able to demonstrate effective response to these incidents.

We have had the opportunity to learn from a Disaster Recovery Exercise hosted by our IT Team in which, again, valuable learning was identified for us and the improvements we have made as a result were tracked through the EPRR Group.

We will always have to maintain a state of preparedness for major incidents and crises that could affect our ability to deliver services. I would therefore like to take this opportunity to thank our staff from every division who have worked tirelessly through recent very challenging times to ensure that we continue to deliver safe services. It is clear that there is consistent and excellent effort across the Trust to rise to the challenges, for which we at Stockport FT are very grateful. I would also like to thank the members of the EPRR Group for their support, expertise and effort in achieving the very significant progress that we have made over the past 12 months in our EPRR arrangements.

John Graham
Accountable Emergency Officer
Stockport NHS Foundation Trust

December 2023

Executive Summary

Stockport NHS Foundation Trust aspires to full compliance with our NHSE Core Standards for EPRR, as this will demonstrate our resilience and ability to respond to emergency situations.

This report outlines our compliance journey, indicating how much we have progressed and highlighting our priorities for the coming year with regard to resilience.

We have focused on compliance with the core standards as these provide a comprehensive framework for us to monitor our own actions and set our priorities.

For the 2023/24 Core Standards Framework, there are 61 standards applicable to the Trust across 10 domains and our self assessment shows that we are partially compliant. We have work to do on mass fatality planning, lockdown planning and training.

Domain	Number of Standards	Full Compliance
1. Governance	**6**	6
2. Duty to Assess Risk	**2**	2
3. Duty to Maintain Plans	**10**	5
4. Command and Control	**2**	2
5. Training and Exercising	**4**	1
6. Response	**7**	5
7. Warning and Informing	**4**	4
8. Cooperation	**4**	4
9. Business Continuity	**10**	10
10. CBRN	**12**	10
Total	**61**	**48**

In addition to an overall assessment of our resilience and response capability across these domains, we also are required to undertake a deep dive into our training capability for EPRR. We have been able to carry out training for major incident loggists, strategic command in a crisis and business continuity for divisions. We have much room for improvement with regard to how we deliver, monitor and record training and this will be a focus for the next year.

Overall, we are pleased to be able to report significant progress in our resilience and the assurance we are able to produce to demonstrate our arrangements. We are keen to ensure that this progress continues into next year and beyond so that we are able to maintain our aspiration to provide the safest and highest quality services despite disruptive challenges.

Introduction

EPRR is an essential part of ensuring that our services are safe and well-led. In order to assess our capabilities, we have undertaken a self assessment of our compliance with our NHSE Core Standards for EPRR.

At Stockport NHS Foundation Trust, we are committed to ensuring that we can respond effectively to a disruptive incident. This includes both arrangements for the response itself, as well as ensuring the continuity of our core business while we are responding to the situation.

The self-assessment process is an in-depth enquiry into the arrangements that we have in place across several domains which examine every part of our business.

The Core Standards Self-Assessment is a useful tool to help us examine our arrangements and identify any gaps that exist so we can work on improving our resilience.

We do this as part of our compliance with legislation. We are a Category 1 responder under the Civil Contingencies Act, which sets out a number of duties with which we must comply.

These include our duty to:

- Assess the risk of emergencies occurring and use this to inform contingency planning
- Put in place emergency plans
- Put in place robust Business Continuity Management arrangements
- Put in place arrangements to warn and inform the public in the event of an emergency
- Share information with other local responders to enhance co-ordination
- Cooperate with other local responders to enhance coordination and efficiency.

We carry out these duties as part of the Greater Manchester health economy by taking part in the Local Health Resilience Partnership, which is a network of local providers feeding into a single point of contact facilitated by our local NHSE colleagues.

Working with other local partner organisations in this way means that, should there be a major incident that affects the health economy, resources can be made available and managed across the community and our resilience therefore increased when we experience challenging situations.

This means that, not only are we more likely to be able to manage situations better by drawing on a wider pool of resources, but we are also able to recover faster by distributing demand across the wider economy too.

We can also participate in community planning, risk assessment and resilience preparedness, ensuring that our arrangements are current and congruent with other organisations.

It is important that all organisations in the area respond in a way that is compatible with other organisations so that partners such as ambulance, police and fire and rescue services are able to work effectively and collaboratively between providers.

We continue to focus on joint priorities such as information sharing, safeguarding, mass casualty management, CBRN (Chemical, Biological, Radiation and Nuclear) management and mass fatalities. We can also share training and exercising, and, where appropriate, procure resources collectively.

EPRR Overview

Stockport NHS Foundation Trust previously managed EPRR as part of compliance responsibilities within the Estates and Facilities Team. It became clear as a result of last year's Core Standards Self Assessment, and a comprehensive internal audit, that the function required more robust resource than was possible.

An interim Head of EPRR was appointed to transform the resilience function within the year with a view to having robust arrangements in place to hand over at the point of substantive recruitment into an EPRR management role. Recruitment has been challenging, however, with several rounds of advertisement and interview not resulting in appointment.

We are pleased to note, however, that progress has been steady and effective. This year's Core Standards assurance process has been far more exhaustive than in previous years, with the standard of evidence required increasing significantly. We welcome the opportunity to identify any gaps in the arrangements that we have, and aspire to achieve full compliance within the coming months.

We have drafted, developed and ratified a raft of new documents including

- Major Incident Plan
- Business Continuity Plan
- Mass Casualty Plan
- Heat Wave Plan
- Communicating in a Crisis Plan
- Evacuation and Shelter Plan

Our winter planning arrangements are our next priority, and this includes a new pandemic infection plan, lockdown plan and mass fatalities plan.

We have identified as part of our self assessment that we have gaps in our formalization of training arrangements and we will be addressing these to ensure that the quality of our training offer to staff can be formally demonstrated.

We have also reinvigorated our EPRR Group, which has representation from all Divisions and has been well supported through the year. This commitment from all Divisions has made the progress we have made possible, for which we thank all involved.

EPRR Leads

The only way we can deliver our responsibilities in EPRR is with the strong engagement and commitment of all of our Divisions at a senior level.

We have been supported well through the year by our corporate and operational colleagues, which has meant that we have been able to deliver significant progress in EPRR for which we are very grateful.

The EPRR Divisional Leads contributing to the EPRR Group for 20222/23 have been consulted on the work undertaken through the year, and have been generous with their expertise, support and guidance.

This has enabled us to ensure that the documents we have produced to describe our resilience arrangements are fit for purpose.

Speciality	EPRR Lead
Chair	*John Graham*
Head of EPRR	*Ava da Costa Maia*
Non Executive Director	*Catherine Anderson*
Clinical Support Services	*Glenn Ellis*
Clinical Support Services	*Mike Allison*
Contracts	*Susan Rigby*
Emergency Department	*Phillipa Oliver*
Emergency Department	*Ash Challinor*
Emergency Department	*Zak Warburton*
Estates and Facilities	*Dan Reason*
Estates and Facilities (Matron)	*Claire Gibson*
Estates and Facilities	*Jennifer Kilheeney*
Estates and Facilities	*Maggie Thwaites*
Human Resources	*Tracey Etchells*
Infection Prevention and Control	*Nesta Featherstone*
Information and IT	*Helen Bennett*
Information and IT	*Rebecca Mayers*
Integrated Care	*Jane Ankrett*
Integrated Care	*Margaret Malkin*
IT	*Peter Hughes*
Medicine and Clinical Support	*Nadine Armitage*
Nursing	*Carol Sparks*
Operational Support Team	*Cathy Lloyd*
Pathology	*Mark Gordon*
Pharmacy	*James Baker*
Pharmacy	*Paul Buckley*
Procurement	*Tracy Stockwell*
Radiology and Endoscopy	*Stuart Cooper*
Surgical, GI and Critical Care	*Christopher O'Loughlin*
Surgical, GI and Critical Care	*Karen Hatchell*
Surgical, GI and Critical Care	*Kerry Byrne*
Women, Children and Diagnostics	*Kelly Curtis*
Women, Children and Diagnostics	*Zoe Turner*

Training and Exercising

Training and exercising is a vital part of ensuring that we are prepared for emergency situations. Without fully exercising our arrangements, it is not possible to identify any planning gaps or incorrect assumptions.

We have trained a number of major incident loggists through the year, and we now have 12 major incident loggists who have been recently trained. We will be offering training again to ensure that we can increase the number of available loggists, as well as update people who were previously trained. We have delivered training for our Executive Team, focusing on the Gold Command role in a major incident. This received good feedback. Similar training for senior managers who could be called upon to be Silver Commanders was completed in November.

We have also carried out a business continuity tabletop exercise for the Medical Division, which offered some valuable learning about communication, assumptions about capabilities and identified some gaps in dispersal planning.

Decontamination testing and training is carried out by our EPRR leads in the Emergency Department, who ensure that the equipment is functioning well and staff are familiar with procedures for its use.

We carried out a Disaster Recovery exercise for IT which was very effective at demonstrating our IT recovery procedures and capabilities, as well as highlighting a number of areas in which we are reliant on resources being available online, which would present a challenge in a real IT service failure. We have not been able to schedule an appropriate time for a command post exercise as we would have wished to because of our continued response to COVID-19 and other operational pressures. However, we have practiced our command and control procedures as we responded to industrial action, IT outages and the heat wave this year. These responses have provided us with assurance that our command and control arrangements are robust and well rehearsed.

We have held debriefs following incidents, exercises and training, which have helped us to identify:

- Improved cancelling and rescheduling of elective outpatient activity to minimise impact on patients
- Bottlenecks in patient flow priorities which can be foreseen and resources deployed to minimise these
- Ways to improve communication with staff and patients
- Gaps in local arrangements that rely on resources that we may need to redeploy
- Protecting the wellbeing of staff is one of our highest priorities
- Challenges in communication with patients particularly when rescheduling elective activity
- The need to ensure swift response to alerts and increased risks
- The need to improve LHRP engagement and participation
- Gaps in our training administration of EPRR
- The need to think more sustainably and more robustly about heat wave planning

Resilience Risk Assessment

The Civil Contingencies Act (2004) places a legal duty on responders to undertake risk assessments and publish risks. We do this through our partnership in the Local Resilience Forum. Our Trust Risk Register is required to reflect the risks to resilience that could impact on our staff and services, and there is a community risk register that is prepared annually for us to refer to.

The Greater Manchester Community Risk Register reassures the community that the risk of potential hazards has been assessed, and that preparation arrangements are undertaken. The Trust's EPRR risk register mirrors the risks identified on the Community Risk Register that could impact our services or our staff.

The major risks that have been identified in the Greater Manchester Community Risk Register include:

- Widespread flooding
- Emerging infections or pandemic
- Largescale industrial accident
- Pollution
- Adverse weather
- Loss of essential infrastructure
- Terrorism
- Transport emergencies
- Cybersecurity issues
- Antimicrobial resistance

We have assessed these risks and, where analysis shows that there may be an impact on the Trust, we have included them and our mitigations in our Trust risk register. We are committed to ensuring that our services are of as safe and high quality as possible, and managing risk is an essential part of horizon scanning and preparedness for disruptive incidents.

The risks that were identified as being relevant to our Trust Risk Register were:

- Risk that services will be disrupted due to loss of infrastructure or essential services such as power, water or heating.
- Risk of emerging or pandemic infection affecting large numbers of people, therefore causing pressure on services and absence among staff
- Risk of a mass casualty incident as a result of malicious threat, largescale accident or deliberate or accidental release of hazardous material
- Risk of disruption due to adverse weather
- Risk of cyber attack leading to denial of IT service, loss of data and disruption to patient care

The EPRR Risk Register will be managed in the same way as all Trust risk registers. Oversight of the risks and associated actions will be through the EPRR Group, who will track progress and escalate risks where these have the potential to become more challenging.

Some risks will be more pertinent at different times of the year or under different circumstances. For instance, risk of heat wave increases and decreases with summer weather.

The risk of adverse weather increases the risk of disruption due to hazardous travelling conditions, increased staff absence due to winter illness, planned holiday absence and outbreaks of winter illness leading to increased demand on services.

As with all our emergency preparedness work, we should approach risk identification and mitigation as a collaborative health economy. Using command and control structures both internally as our Trust manages incidents and as part of the Greater Manchester Local Health Resilience Partnership means that resources and risks are managed across the whole locality.

Of course, we must still maintain preparedness for incidents that have a very high impact but are thankfully very rare. The Manchester Arena bombing is an example of this kind of incident, and we have looked at the public enquiry following the incident, as well as our own response, and ensured that we encapsulate that learning into our risk actions to ensure we are as prepared as we can be for such an unprecedented occurrence.

We have plans in place to mitigate our EPRR risks, and we will monitor the effectiveness of our plans and procedures through regular review by the EPRR Group.

Core Standards Self Assessment and Assurance

This year, we have been required to produce assurance of our self assessment for our Core Standards for EPRR. This is a change from previous years, and has offered us the opportunity to examine the plans we had in place and ensure that they are in line with current best practice and reflect updated arrangements within the Trust.

Although we have made significant progress, we are still only partially compliant and we have an action plan in place to ensure that we continue to work towards full compliance.

FULLY COMPLIANT The organisation is 100% compliant with all core standards they are expected to achieve.	**SUBSTANTIALLY COMPLIANT** The organisation is 89-99% compliant with the core standards and there is a Board approved action plan to meet compliance within the next 12 months
PARTIALLY COMPLIANT The organisation is 77-88% compliant with core standards and there is a Board approved action plan to meet compliance within 12 months.	**NONCOMPLIANT** The organisation is 76% or less compliant with core standards.

For our 2023/24 Core Standards, our self assessment was as follows:

Domain	Full	Substantial	Partial	Non Compliant
Governance (6)	6			
Duty to Assess Risk (2)	2			
Duty to Maintain Plans (11)	5		2	4
Command and Control (2)		2		
Training and Exercising (4)	1	1		2
Response (7)	5		2	
Warning and Informing (4)	4			
Cooperation (5)	4			1
Business Continuity (10)	10			
CBRN (13)	11	2		
Total No of Standards	48	5	4	7

We will work towards achieving full compliance within the next 12 months. Our action plan has identified that we need to focus on our administration and management of training for EPRR, formalising and testing our newly drafted plans and ensuring that we hold 6 monthly communication tests.

We also need to ensure that we are represented and contribute to the Local Health Resilience Partnership so that we can make sure that our priorities are considered within the context of the Greater Manchester health economy with regard to resilience.

Learning and Improving

We have had to rise to a number of challenges this year with regard to resilience. These include a small number of IT outages, some telecommunications failures and more notably, a series of industrial action periods and a heat wave. This has been on top of the pressure brought by the COVID 19 pandemic, from which the NHS as a whole has not yet recovered.

COVID-19

The pandemic brought significant learning for us as a Trust in addition to the learning that the NHS as a whole was able to identify. We became adept and skillful at using command and control structures and are able to adopt these easily and effectively. We also adapted our ways of working to include remote working, which has significantly increased our resilience, allowing people to work from home when they are infectious but not unwell. This also means that more people are able to work remotely as their business as usual, which alleviates some pressure on parking and office accommodation and also limits the disruptive impact of transport challenges or adverse weather.

We matured and tested our internal communications, using new platforms such as WhatsApp to create leaner and swifter communications between teams. We became more effective at responding to pressure points and redeployment of people or resources to alleviate that pressure earlier.

There are still some challenges that we need to address, such as fit testing for face masks. These challenges will be tracked through the EPRR Group action monitoring. We also need to ensure that we maintain an ongoing focus on the well-being of our staff, who worked consistently and unfailingly hard throughout the pandemic under the most challenging of circumstances.

IT Outages

We have had a small number of IT outages through the year, and we have learnt from these that it is invaluable to have other means of communication as an option when our telecommunication or email systems are not operational. The use of mobiles and WhatsApp has become more embedded and this is effective and helpful. Our IT and information teams work hard to ensure that systems are robust and resilient, as well as comprehensively backed up in case of any outages, and this works well. As a Trust we have learnt from these outages that we need to debrief all teams involved as a collective so we can understand the impact and ensure that our preparedness arrangements include all functions. These incidents also tested the response of our IT teams and showed them to be swift and effective in identifying and addressing issues. Our staff were able to revert to paper systems and recover from the outages, clearing backlogs, and we should continue to ensure that our staff know that their work in this regard is acknowledged and appreciated.

Heat Wave

There were two periods of exceptionally warm weather this year, namely in May and September 2023. During these periods of time there were inpatient areas of the Trust where the internal temperature exceeded 31°C. We have a small number of mobile air conditioning units but these are limited in their function, and can only cool a small enclosed area, which means that cooling for our larger areas remains a challenge. We have a newly drafted Heat Wave Plan in place which outlines the actions we should take to respond to an imminent heat wave, but the guidance for heat wave advises that we consider longer term, more sustainable planning to cool the site naturally as this is both more effective and more in line with the Green Agenda, and we are considering the most appropriate options for doing this.

Industrial Action

During the periods of industrial action, we were able to fine tune our responses to the periods of impact by understanding more about the timing of rescheduling activity, which areas became pressure points more swiftly and redeploying people to areas of high demand effectively. There was significant pressure on staff, however, and this included administrative staff who bore the brunt of the distress felt by patients when their episode of care was rescheduled. We recognise the importance of continuing to ensure that our staff feel supported and appreciated, as they continue to work hard to meet these challenges.

Specific Contingency Plans

There are some specific contingency plans that we are required to have in place under our "Maintaining plans" duty. These include generic plans such as the Major Incident Plan, Business Continuity Plan and Evacuation and Shelter Plan.

Some more specific plans have been developed to cover other contingencies in line with our risk assessments and the Greater Manchester Community Risk Register.

Mass Casualty Plan

This plan sets out the arrangements we would carry out both as a receiving hospital, and also as a business continuity response. In other words, while we would need to maintain preparedness to accept a sudden large influx of casualties, we would also have to, at the same time, continue to provide services for people we are already treating. This sort of incident causes severe pressure and the Mass Casualty Plan therefore outlines important initial actions that are designed to relieve the pressure as much as possible. It is important to note that all of these specific contingency plans must be used in conjunction with the arrangements set out in the Major Incident Plan.

Heat Wave Plan

This plan, which has been referenced earlier in this report, outlines arrangements for the immediate response to a heat wave including establishment of command and control, a list of priorities to consider at the time and arrangements for the use of designated areas on the Stepping Hill site as cool refuges. These measures have limited impact at the time of the heat wave and our focus must remain on long term planning to limit the impact of hot weather by sustainable means that are more effective.

Communication in a Crisis Plan

Communication will be a major determinant of the outcome of any incident. Where communication is effective and timely, this will have a positive impact. Principles outlined in the Communication in a Crisis Plan include an intention to ensure that staff are kept up to date as much as possible, and certainly should be informed about situations before the information is available to the public.

The plan also describes arrangements for management of the media and our communication with the press. It is important that this is done in a planned way so that messages that are released are done so in a managed manner that supports the people affected by the incident, maintains their confidentiality and protects the reputation of the Trust.

Shelter and Evacuation Plan

This plan is written and to be used in conjunction with the Trust's longstanding fire safety plans. It describes the use of existing evacuation kit and circumstances under which an evacuation of a part of the hospital might be required. It is important to note that any evacuation would be managed in line with the Major Incident Plan, and this plan is a subsidiary plan that highlights specific concerns. The most important principle is that any hospital evacuation would have a severe and widely felt impact across the health economy, and we should be sure to communicate clearly, swiftly and effectively with the Local Health Resilience Partnership to secure safe transfers for any patients who would have to be transferred to other providers. It would not be effective for us to try and secure placements ourselves. That priority should be managed as a collaborative.

Core Standards Assurance Process Outcome

There was a change in approach for this year's NHSE Core Standards assessment process. In previous years, we were expected to assess our own preparedness and then submit a spreadsheet reporting our findings, and a statement of compliance to summarise our state of compliance with EPRR standards. This self assessment would then form the basis for an action plan for the following year to help us to identify areas in which we needed to improve. This year, we were required to submit our evidence to support our self assessment into a central repository of information, and those submissions were assessed by the national NHSE EPRR team with regard to fitness for purpose and current best practice.

In 2022/23, we undertook the self assessment process and found ourselves to be substantially compliant with some gaps. An internal audit highlighted a number of areas that required improvement, and it was determined that a lack of resource dedicated to EPRR was at the root of the gaps in compliance, and that it would not be possible to close those gaps without additional resources. An interim Head of EPRR was appointed to create a work plan and implement measures to improve, while a substantive recruitment process was undertaken. The interim Head of EPRR remains in post at the time of writing this annual report, as the recruitment process has not yet resulted in appointment.

Significant progress has been made this year, which includes the development of major EPRR documents, reinvigoration of the EPRR Group, training and strengthening our collaborative relationships with the Local Health Resilience Partnership, whilst we have also had to respond to the challenges of the year such as industrial action, high demand for services during COVID-19 recovery and heat wave.

Despite our progress, in the light of the more stringent requirements for this year, we assessed ourselves as Partially Compliant, and we have a clear plan in place for improving that to Full Compliance within a very short period of time. The gaps that we have identified include the need for a new Pandemic Infection Plan, clearer arrangements for lockdown, plans for management of celebrity visits and a need to formalise our training management of EPRR in line with the published Skills for Justice Minimum Occupational Standards for professionals involved in emergency preparedness and response.

The regional assessment of our EPRR self assessment was not in agreement with our findings, and a number of elements of our assurance were subject to challenge. Our review of our self assessment has increased our confidence that our initial assessment of partially compliant, with a planned trajectory of improvement delivering full compliance in April 2024, is robust. Engagement with the LHRP and other Trusts has made it clear that we are in a similar position to other Trusts, who have decided to follow a similar process.

A resubmission confirming our findings will be completed in December 2023.

We are looking forward to being able to declare full compliance with our EPRR standards by April 2024.

Abbreviations and Glossary

EPRR- Emergency Planning, Resilience and Response
The formal set of arrangements, frameworks and command and control structures created to manage major incidents.

CBRN – Chemical, Biological, Radiation and Nuclear
This descriptor refers to the deliberate or accidental release of hazardous material that causes a risk to human or environmental health by means of chemical, biological, radiation or nuclear harm.

CCA – Civil Contingencies Act
The primary Act of Law that governs respond to major incidents, and sets out our responsibilities. It also defines NHS Acute Provider Trusts as Category 1 responders, which places a set of 6 duties on us. These duties are the focus of all of our EPRR activities.

LRF – Local Resilience Forum
The collaborative set up in response to our duties under the Civil Contingencies Act to enable us to work together with other responders to create an effective emergency response.

LHRP – Local Health Resilience Partnership
The LRF has many subgroups to manage specific areas of planning, such as flooding, terrorism, civil unrest and so forth. The LHRP is the subgroup that represents the interests, risks and priorities of NHS and other health care providers within the LRF.

SFT – Stockport Foundation Trust
NHS Foundation Trust which runs Stepping Hill Hospital and other specialist centres, as well as community health services for Stockport.

Appendix 1: Core Standards Self-Assessment Gaps in Compliance

The Core Standards self-assessment is a spreadsheet toolkit which examines our preparedness arrangements. The areas in which we are non compliant are summarised below. Once we have completed the actions below we will be substantially compliant. We will then be able to work on formalising our management of EPRR training, testing and exercising and completing the contingency plans we require to achieve full compliance within the project period ending April 2024. The areas in which we declared non compliance are as follows:

Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (not compliant)	Action to be taken
Duty to maintain plans	**Infectious disease**	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Acute providers should ensure their arrangements reflect the guidance issued by DHSC in relation to FFP3 Resilience in Acute setting incorporating the FFP3 resilience principles. https://www.england.nhs.uk/coronavirus/secondary-care/infection-control/ppe/ffp3-fit-testing/ffp3-resilience-principles-in-acute-settings/	Infectious Disease Outbreak Plan	Non compliant	Novel infectious outbreak plan
Duty to maintain plans	**New and emerging pandemics**	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Infectious Disease Outbreak Plan	Non compliant	Novel infectious outbreak plan
Duty to maintain plans	**Counter-measures**	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Mass Countermeasure arrangements should include arrangements for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements. Commissioners may be required to commission new services to support mass countermeasure distribution locally, this will be dependant on the incident.	Infectious Disease Outbreak Plan	Non compliant	Novel infectious outbreak plan

Duty to maintain plans	**Excess fatalities**	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Arrangements should be: • current • in line with current national guidance in line with DVI processes • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Mass Casualty Plan	Non compliant	Mass Fatalities plan
Training and exercising	**EPRR Training**	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	Evidence • Process explicitly described within the EPRR policy or statement of intent • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff	EPRR Policy Training needs analysis Training records Training materials Exercise portfolios and senior training records	Non compliant	TNA
Training and exercising	**Responder training**	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	Evidence • Training records • Evidence of personal training and exercising portfolios for key staff	Training records	Non compliant	TNA

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Meeting date	7th December 2023	**Public**	X	**Confidential**	
Meeting	Board of Directors				
Report Title	Safer Care Report				
Director Lead	Nic Firth, Chief Nurse Andrew Loughney, Medical Director	**Author**	Helen Howard, Deputy Chief Nurse		

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

This paper relates to the following Annual Corporate Objectives

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

The paper relates to the following CQC domains

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

This paper relates to the following Board Assurance Framework risks

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

	PR3.2	There is a risk that the Trust does not deliver a joint clinical strategy with East Cheshire NHS Trust
X	PR4.1	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit and retain the optimal number of staff, with appropriate skills and values
X	PR4.2	There is a risk that the Trust's workforce is not reflective of the communities served
	PR5.1	There is a risk that the Trust does not implement high quality transformation programmes
	PR5.2	There is a risk that the Trust does not implement high quality research & development programmes
	PR6.1	There is a risk that the Trust does not deliver the annual financial plan
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Where issues are addressed in the paper

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

Executive Summary

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

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

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

NHS
Stockport
NHS Foundation Trust

Safer Care Report – November 2023

Report of: Nic Firth, Chief Nurse
Dr Andrew Loughney, Medical Director

Contents

Stockport NHS Foundation Trust

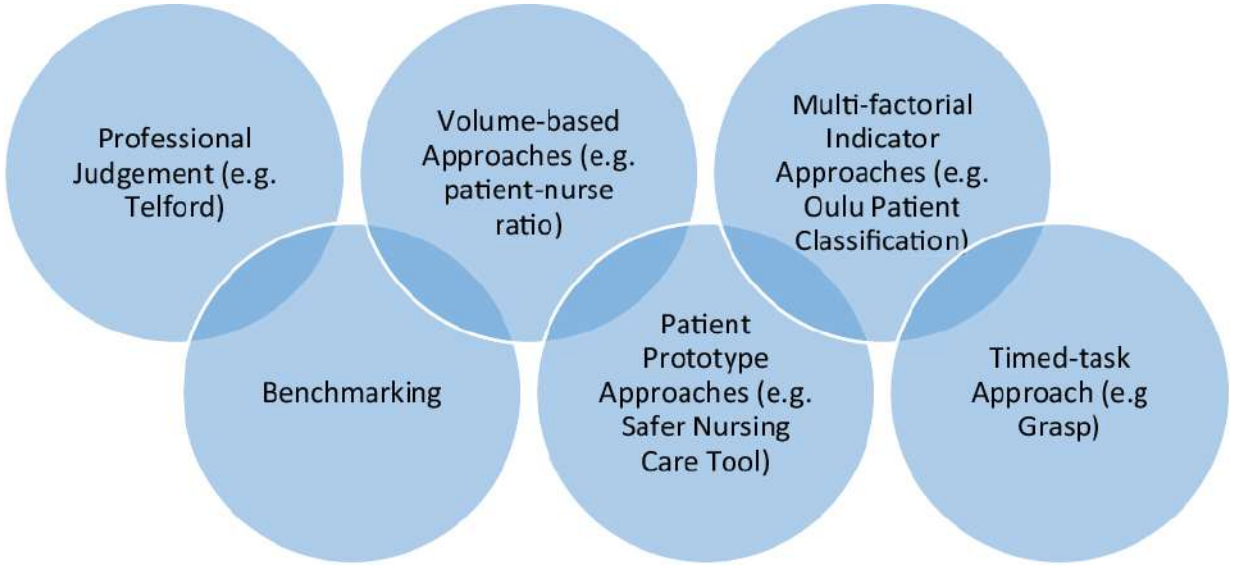
1. Introduction

NHS Stockport NHS Foundation Trust

The Safer Care Report provides the Board of Directors with an update on the following:

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

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



1. Introduction

Stockport NHS Foundation Trust

Safe staffing is a fundamental part of getting care and support right for individuals. Across the organisation it is essential that there is the right quantity of skilled staff to meet the needs of the service. Evidence based decision making on safe and effective staffing is a requirement for all NHS organisations. We continue to focus on patient safety and patient experience, in relation to safer staffing utilising a triangulated approach.

Safer Nursing Care Tool

The Safer Nursing Care Tool (SNCT) is a NICE endorsed evidence based tool currently used in the NHS and includes tools for the following settings:

- adult inpatient wards in acute hospitals (updated 2023)
- adult acute assessment units (updated 2023 – all previous versions of the tool are no longer valid)
- children and young people's inpatient wards in acute hospitals
- mental health inpatient wards
- emergency departments

Primarily used by the nursing workforce, the development of these tools has been led by a core group of experienced professional leaders and leading academics.

These tools support chief nurses to determine optimal nurse staffing levels helping NHS hospital staff measure patient acuity and/or dependency to inform evidence based decision making on staffing and workforce. The tools can also support organisations to deliver evidence based workforce plans to support existing services or to develop new services.

2. Vacancies (September 2023)

Divisions	Actual WTE	Variance WTE	Post Recruited to in TRAC WTE
Clinical Support Services	94.60	-11.25	5
Corporate Services	102.80	-0.40	71
Emergency Department	112.57	-41.28	14
Integrated Care	422.68	-65.49	53
Medicine & Urgent Care	391.12	-41.69	11
Surgery & GI	461.85	-32.57	30
Women, Children & Diagnostics	444.51	-55.73	54
Grand Total	2030.14	-248.42	238

The above data above covers the positions of registered nurses and midwives, nursing associates and staff awaiting PINS (newly qualified nurses and international nurses who have passed the OSCE).

The Trust policy is that all nursing students completing a placement at Stockport NHS Foundation Trust are eligible to apply for a permanent job. Once successful at interview and going through the recruitment process their application is recorded within the "Corporate Services" division on Trac. When the student has been allocated to their ward of choice, their application will be moved to the appropriate division within Trac.

Obtaining accurate information on the number of vacancies within the Trust has proved difficult, and this is an ongoing issue, as data is provided from a number of sources such as Finance and Workforce (from Trac and ESR) and the figures do not match. A piece of work is currently being undertaken to ensure that this issue does not continue.

3. Nursing & Midwifery Turnover – Healthroster

Stockport NHS Foundation Trust

The Trust uses SCNT at the daily staffing meetings to review staffing levels in conjunction with acuity levels of patients. The census is completed 3 times per day.

Roster period - 11 September - 8 October 2023								Roster period 17 July - 13 August 2023	
Business Division	Annual Leave %	Roster Approval (Full) Lead Time Days	Total Unavailability %	% Changed Since Approval	Unused Hours (4 week period)	Over contracted Hours (4 week period)	Total Hours balance	Additional Duties in hours (Total Hours)	Safecare % compliance across 3 Census periods (average)
ED	17.1%	43.5	26.7%	25.5%	460.4	333.4	127.1	221.75	0
IC	12.8%	55.56	21.2%	28.3%	1162.6	662.6	500.0	3232.72	58.10%
Medicine	12.1%	52.11	23.5%	40.4%	2101.4	1328.8	772.6	4421.64	60.07%
S&CC	13.0%	58.25	27.4%	33.4%	1908.1	1073.9	834.2	4050.29	46.00%
W&C	16.0%	36.46	41.3%	15.3%	790.2	586.7	203.4	347	28.00%
CSS	9.4%	32	11.90%	11.1%	237.25	116.47	120.78	425	0
Total					6660	4102	2558	12698.4	48.04%

Processes for improving the Key Performance Indicator (KPI) :

- The Rostering Team send weekly email reminding Matrons to approve rosters promptly
- During the Roster Challenge Meetings/forms hours are reviewed and all anomalies are discussed with the relevant Ward Manager/Matron
- The process to create additional duties has been tightened to only allow the Matrons/professional cover to be able to create additional tiles
- The reasons for creating additional duties has been streamlined to ensure information can be triangulated with levels of absences, vacancies etc
- A video on how to use Safecare is currently being created by the Rostering Team and will be cascaded to ward managers for new starters
- KPIs are always discussed with the Matrons during the Nursing and Midwifery Staffing Meeting

Data provided by The Rostering Team

4. NHS Professionals (July – September 2023)

NHS Stockport NHS Foundation Trust

The information below illustrates the % of shifts picked up by staff in July, August and September compared to the demand that was sent out.

	July 2023			August 2023			September 2023		
Nursing	**Day**	**Night & Saturday**	**Sunday & Bank Holiday**	**Day**	**Night & Saturday**	**Sunday & Bank Holiday**	**Day**	**Night & Saturday**	**Sunday & Bank Holiday**
Band 2	68.30%	93.40%	94.40%	66.80%	93.90%	95.30%	66.50%	95.20%	97.40%
Band 3	67.60%	96.50%	92.00%	79.20%	94.20%	97.70%	69.90%	97.50%	97.00%
Band 4 & 5	77%	94.90%	96.80%	67.20%	94.10%	94.50%	69.40%	91.60%	94.00%
Band 6 & 7	62.90%	58.50%	83.30%	53.60%	57.10%	76.50%	55.30%	58.80%	69.90%

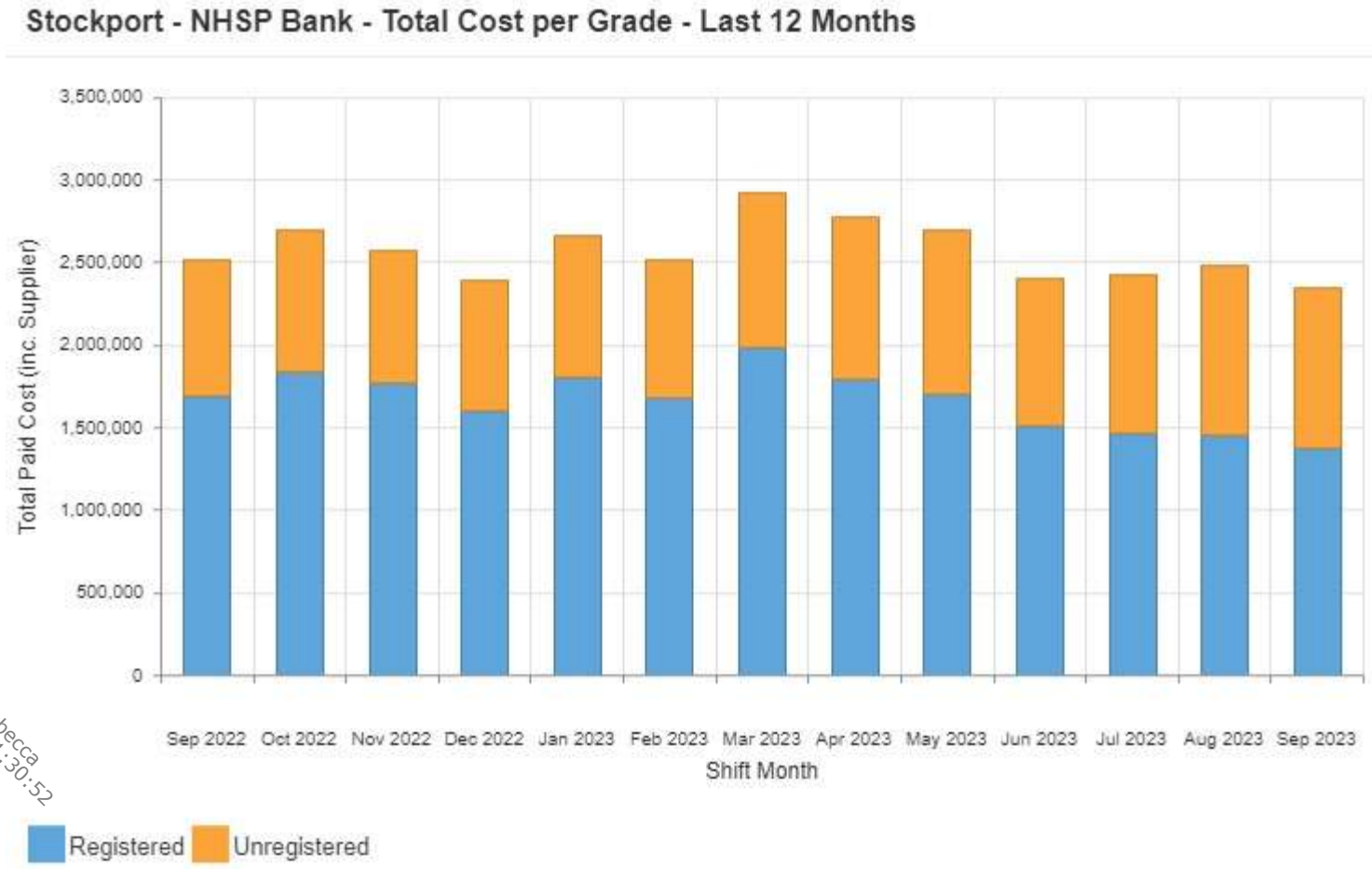
	July 2023			August 2023			September 2023		
Maternity Triage, Maternity 2, Maternity 3	**Day**	**Night & Saturday**	**Sunday & Bank Holiday**	**Day**	**Night & Saturday**	**Sunday & Bank Holiday**	**Day**	**Night & Saturday**	**Sunday & Bank Holiday**
Band 2	81.90%	91%	95.20%	65.50%	96.50%	96.40%	60.50%	97.10%	100%
Band 3	0	0	0	0	0	0	0	100%	0
Band 4 & 5	0	0	100%	0	0	0	0	0	0
Band 6 & 7	13.50%	39.20%	58.80%	28.20%	26.60%	52.70%	25%	37.50%	45%

Data provided by NHS Professionals

5. Nursing & Midwifery Temporary Staffing

Stockport NHS Foundation Trust

The figures below illustrates the cost 'month on month' cost to the Trust of temporary staffing for registered nurses and midwives, and health care assistants



McCarthy Rebecca 06/12/2023 11:30:52

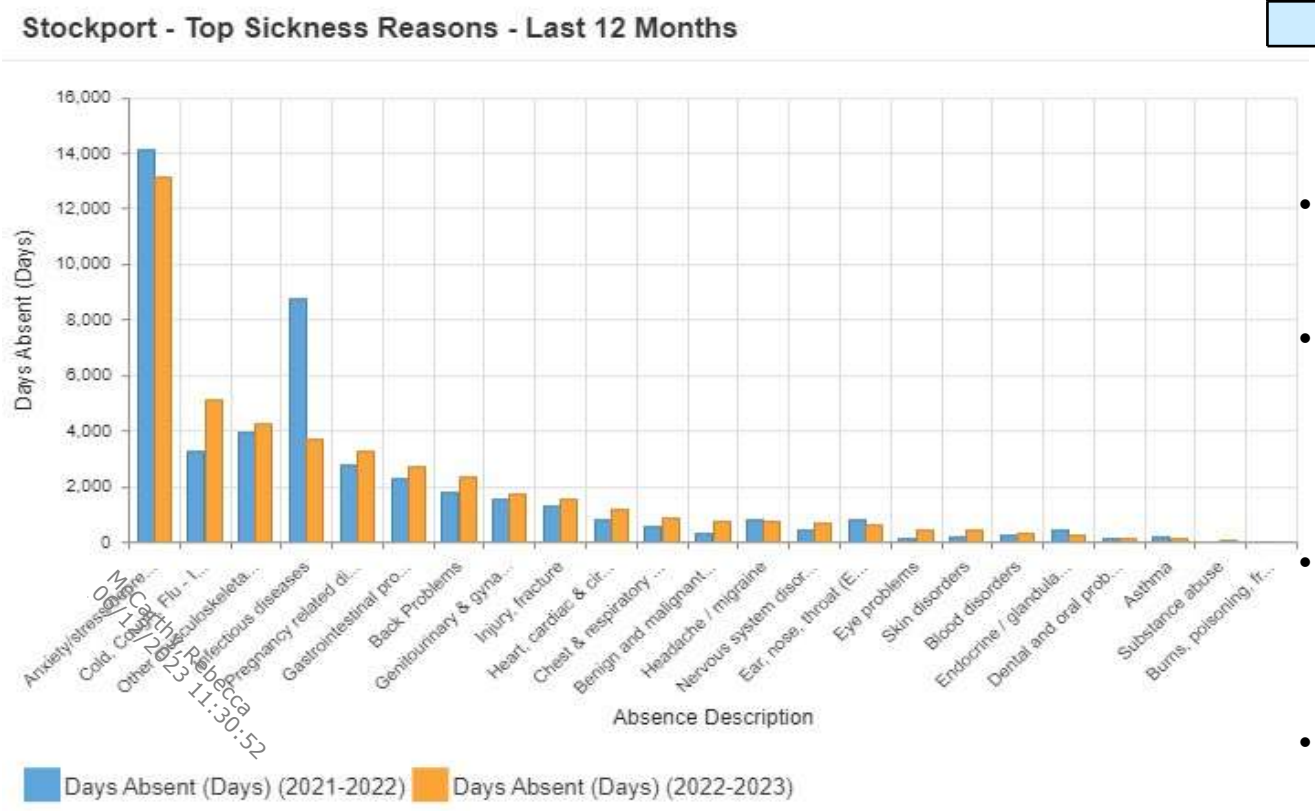
Data provided by Peoples Analytic

6. Nursing & Midwifery Absences (September 2023)

Stockport NHS Foundation Trust

Figures reported in September 2023, indicate absences for Registered Nurses and Midwives at 6.82% and Allied Health Professionals at 4.51%

Division / Role	Sickness %
Allied Health Professionals	4.51%
Registered Nurses & Midwives	6.82%
Students	0.15%



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

Data provided by Peoples Analytic & Workforce

7. Nursing & Midwifery Risk Highlights

NHS Stockport NHS Foundation Trust

The Trust encourages staff to report incidents caused by staffing shortfalls via Datix.

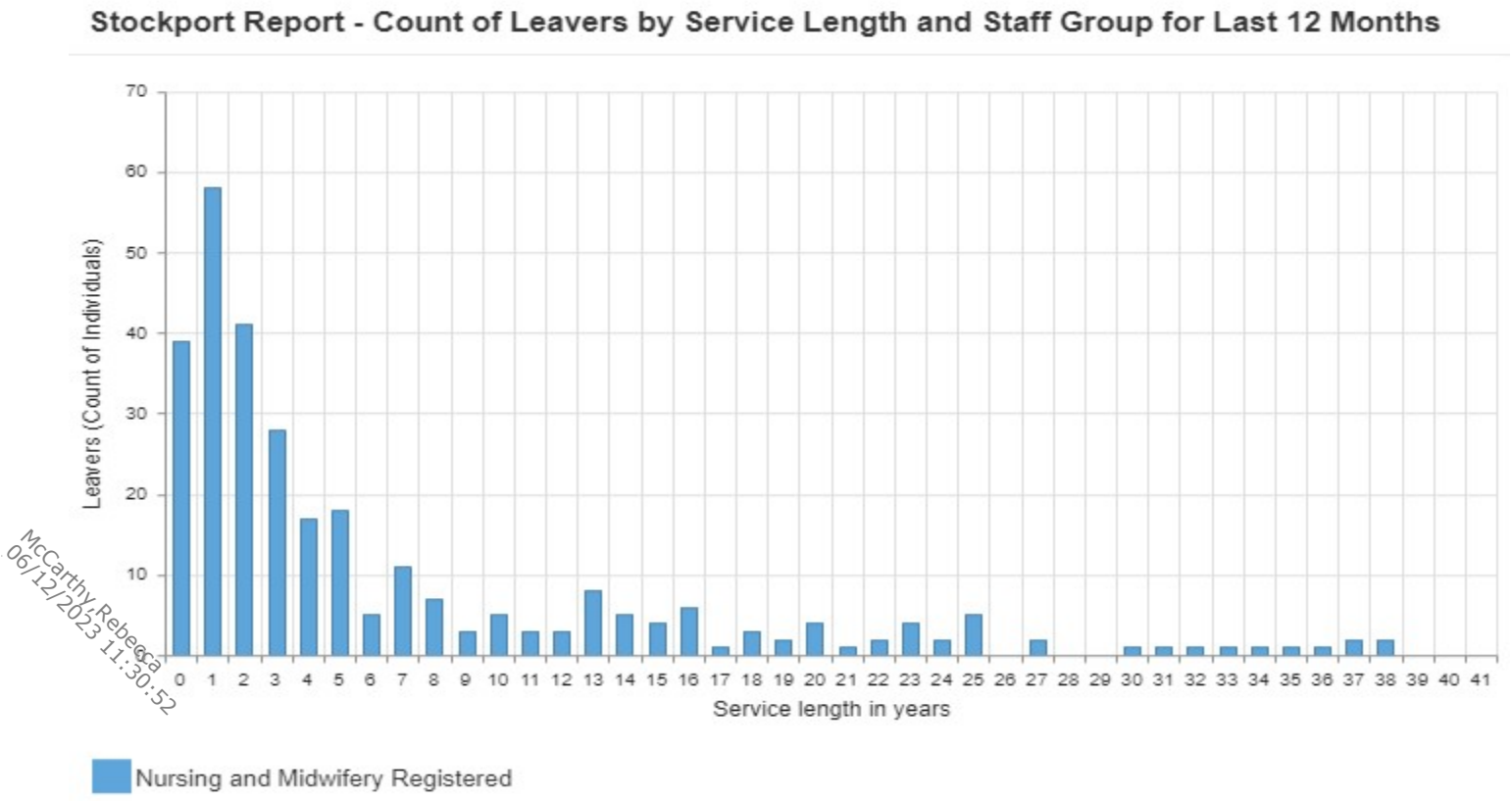
The graph illustrates the number of 'month on month' incidents. The increase in reporting staffing shortfalls is a positive indicator of staff feeling confident to escalate their concerns appropriately.

Data provided by Datix

8. Nursing & Midwifery Retention

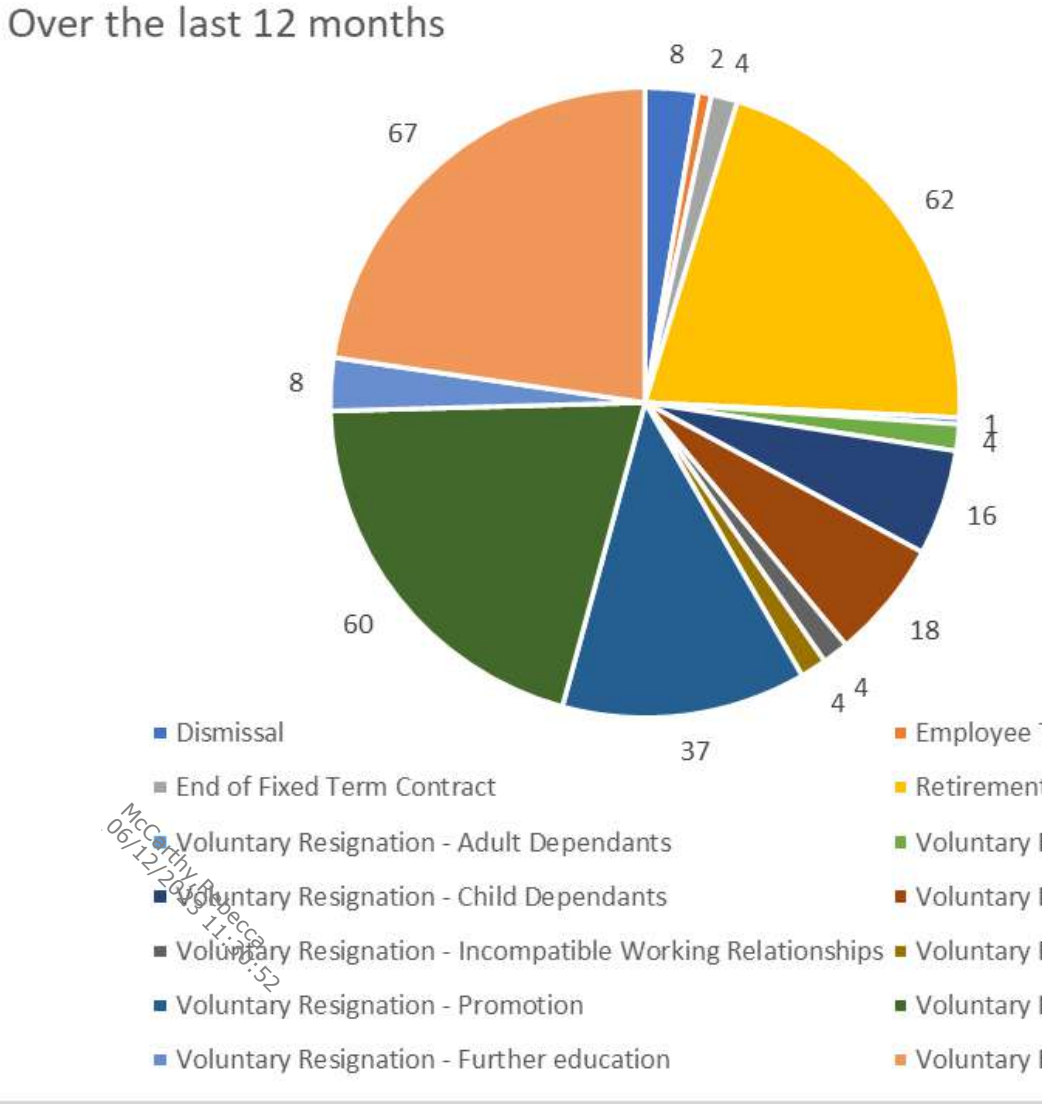
Stockport NHS Foundation Trust

Funding has been obtained for the role of Band 6 Pastoral Care Nurse (18 month secondment). Within the role they will be involve in supporting new starters throughout their recruitment process and their initiation on the wards, international HCAs throughout their OSCE process and representing the Trust at recruitment events. The role will also include managing the Grow and Retain our Workforce (GROW) pathway which enables registered nurses to internally transfer. The focus of this role is the retention of staff



Data provided by Peoples Analytic

9. Nursing & Midwifery – Reason for Leaving



- The number of staff applying for the Professional Nurse Advocate (PNA) programme has increased, this investment will have a positive impact on supporting staff and increase in retention
- To enhance retention the role of a Pastoral Care Lead has been created to provide emotional and practical support for new starters, international educated nurses and healthcare assistants. This is a Band 6 temporary contract for 18 months

Data provided by Peoples Analytic

10. Nursing & Midwifery Recruitment

NHS Stockport NHS Foundation Trust

Recruitment

- Theatres held a successful event on the 21st October, and Women & Children's are holding their first Maternity recruitment event on the 18th November. Both events are held in the speciality areas so the areas with guided tours show casing the working environment.

- Workforce Matron & Matron for Medicine to visit University of Salford on the 7th December to discuss careers opportunities at the Trust with the 3rd nursing students

- The International Educated Nurses (IENs) recruitment programme has now finished. The focus is now on the IENs who are currently employed as Health Care Assistants (HCAs) in the Trust and to support them through the Objective Structured Clinical Examination (OSCE) process. Monies has been allocated to fund 10 HCAs through the OSCE with training provided by the OSCE Team, Pinewood House.

- Midwifery now have 3 International Educated Midwives (IEMs) working at the Trust, 2 more will be joining within the next few months.

11. Nursing Recruitment Pathways

To make the role of nursing more accessible the Trust has looked at alternative, more affordable and with more flexibility different pathways for staff to qualify as a registered nurse or senior healthcare practitioner, instead of the traditional route via university. These opportunities re-enforce the Trust's policy on supporting staff development.

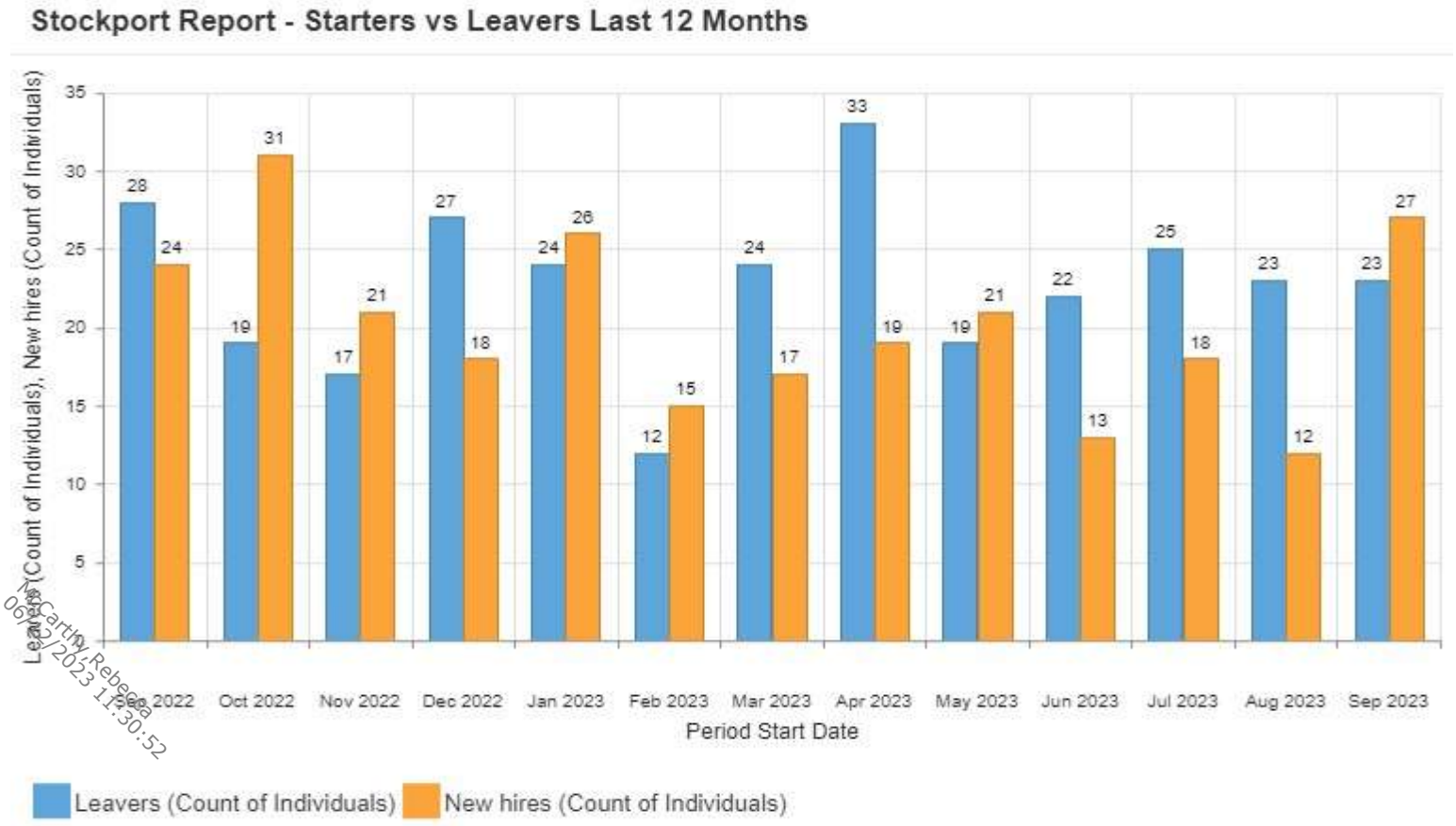
Nursing Cadet Scheme
The Trust is working in collaboration with Trafford College to support learners on a healthcare programme who are aged 16 and up. The Cadets are on placement at the Trust on Thursdays and Fridays (term time only) and rotate placement areas every 12 weeks.

Trainee Nursing Associates
In September, 7 Trainee Nursing Associates (TNAs) started at the Trust.

Registered Nursing Degree Apprenticeship (RNDA)
The Nursing Associates (NA) and Assistant Practitioners (AP) can apply for the RNDA study Adult Nursing at Bolton University. On completing 18 months the NAs, and 2 years for the APs, they will obtain a BSc in Adult Nursing. There are currently 8 on the programme, with 4 starting in February 2024.

12. Nursing & Midwifery Starters & Leavers

- Data from Peoples Analytic estimate that 92 members of staff are approaching retirement age, “retirement age” is perceived as aged 55 years onward although staff may retire early due to ill health
- For reassurance due to successful recruitment events 80 newly qualified nurses are joining the Trust between September – December 2023



Data provided by Peoples Analytic

13. Nursing & Midwifery Celebrations & Awards

Stockport NHS Foundation Trust

Angel Rose Cheruvathoor Ouseph joined the Trust in September 2022. She obtained her PIN and qualified as a Band 5 registered nurse in November 2022.

Angel has been invited to the reception hosted by His Majesty The King to celebrate the contribution of Nurses and Midwives (notably International Nurses and Midwives) working in the UK's Health and Social Care Sector on Tuesday 14th November, from 4pm at Buckingham Palace.

On Friday 3rd November 2023 the Trust is hosted its annual awards ceremony at Stockport Town Hall, the categories were :

Volunteer of the Year
Fundraisers of the Year
Unsung hero - non clinical
Unsung hero – clinical
Clinical Team
Rising Star
Inspirational Leader
Patient's Choice
Improvement, Innovation and Efficiency
Non-clinical team

14. Midwifery Update

Stockport NHS Foundation Trust

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

Current Maternity position

	WTE Actual	Number of WTE Vacancies	Post WTE Recruited to TRAC
Registered Midwives	160.48 (Including B8 & above)	Vacancy 10.41 Maternity Leave 6.2	1

14. Midwifery Update

Obstetrics cover

- 24/7 Consultant obstetric cover on delivery suite
- 2/day 7 day/week Consultant ward rounds in place

Challenges

- Current registered vacancy inclusive of Inpatient and Outpatient area's 10.41 WTE, in addition to this there is currently a gap of 6.2 WTE on Maternity leave (due back April 24 – June 24). This equates to a total deficit of 16.61 WTE

Actions

- Weekly planned roster scrutiny meetings/E.Roster training sessions - continue
- Rolling advert for Band 5/6 midwives
- Recruitment day planned 18th November 2023

Assurance

- All shift coordinators have supernumerary status.
- September data showed we achieved 97.8% one to one care in labour (1BBA, 1 fully dilated on admission. 1 precipitate birth)
- Maternity Red Flags monitored and reported through division
- Fully engaged with Maternity support workers framework working group – Agreed uplift for B2 to B3 Maternity assistants for those who meet the competency framework (August 23)
- Funding extended until 23/24 for Recruitment and Retention Midwife
- Engaged with the International Educated Midwifery (IEM) recruitment programme, three IEMs recruited in 1st wave. 3 commenced in post, The Trust has applied for further funding for 2 IEMs to be appointed to Stockport NHS Foundation Trust.
- Recruited to x2 Housekeeper, 4 MA roles, ward clerk recruitment ongoing

Maternity Update – Red Flags

NHS Stockport NHS Foundation Trust

Maternity Red Flags

Maternity red flag events are events that are immediate signs that something may require action to stop the situation getting worse. Action includes escalation to the senior midwife in charge of the service, and the response may include allocating additional staff to the ward or unit.

Maternity red flags are monitored by the Maternity manager of the day and the shift coordinators out of hours. Red flags are triggered by insufficient staffing levels resulting in the following:

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

14. Maternity Update – Red Flags

Stockport NHS Foundation Trust

During October 2023 there were 12 maternity red flags reported via Datix

Datix 107408 – Reduced staffing across the unit resulting in delay in care.

Datix 106408– Delay in midwives receiving breaks to staffing.

Datix 106917 –Unable to provide 1:1 care in labour.

Datix 107191 – Delay in care for induction of labour.

Datix 107357 – Delay in care for induction of labour

Datix 107399 - Delay in midwives receiving breaks to staffing

Datix 107404 – Delay in care for Induction of labour

Datix 107418 - Delay in care for Induction of labour

Datix 107585 – Delay in care and midwife unable to take break

Datix 107654 - Delay in care for Induction of labour

Datix 107807 – Midwives' unable to take break

Datix 108438 - Delay in care for Induction of labour

15. Medical Staffing (September 2023)

NHS Stockport NHS Foundation Trust

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

Tier 3: Expert clinical decision makers.

Clinicians who have overall responsibility for patient care, in the Medical Workforce these are our Consultants.

Tier 2: Senior clinical decision makers.

Clinicians who are capable of making a prompt clinical diagnosis and deciding the need for specific investigations and treatment. For the medical grades this is largely SAS Doctors and Senior Clinical Fellows.

Tier 1: Competent clinical decision makers.

Clinicians who are capable of making an initial assessment of a patient. For the medical grades this is largely Foundation Doctors and Junior Clinical Fellows.

Medical Staff	FTE Budgeted	FTE Actual	Variance FTE
Tier 3	253.18	227.22	-25.96
Tier 2	76.64	64.9	-11.74
Tier 1	114.619	146.65	32.03
Total	**444.44**	**438.77**	**-5.67**

The Trust is also a host employer on behalf of the Lead Employer, St Helens and Knowsley NHS Trust, for specialty, core and general practice trainees and host 165 Trainee Doctors who work across our specialties.

Data provided by Medical Staffing

15. Medical Staffing (September 2023)

NHS Stockport NHS Foundation Trust

Consultant Recruitment

Medical Staffing continue to work with divisions to target recruitment campaigns in advance of when Doctors in Training are set to become eligible to work as Consultants. This has seen recent success with the appointment of a Consultant in Occupational Health, this speciality has previously proved difficult to fill.

We are currently actively working with divisions regarding the recruitment of Consultants in Medicine, Gastro, Microbiology, Pathology and Paediatrics.

CESR

Medical Staffing and Dr Shashidhara North West CESR Lead are continuing a review of Doctors pursuing the CESR route to become Consultants, and will be presenting a paper to the Medical Workforce Group in November 2023 regarding how current and future Doctors undertaking CESR will be managed to enable good workforce planning.

The Trust has supported Dr Tokala in obtaining his Specialist Register registration through the CESR route, and he has now been appointed as a Substantive Consultant in Spinal Surgery.

Safe care functionality

A phased role out commenced in December 2022, and this will demonstrate the minimum medical staffing requirement per area alongside the actual staff available each day. This will better aid the movement of Doctors between areas to ensure that safe staffing is maintained.

15. Medical Staffing – International Recruitment

MTI Scheme

Medical Staffing work with divisions to utilise the MTI scheme to secure International Doctors.

Respiratory Medicine have fed back that the new Tier 2 Doctor have recently joined and are adding value to the specialty.

International Medical Recruitment

Dr Shashidhara is currently in Dubai and India as part of the Trust's recruitment campaign for Tier 1 and Tier 2 international Doctors. He has linked in with specialities with regards to establishing what their needs are with the aim of appointing to all posts.

Medical Staffing met with the GMC to explore whether it is viable and beneficial for the Trust to become a GMC Sponsoring Organisation in order to help with employing Doctors from this group in a more seamless way. An options paper will be presented to the next Medical Workforce Group in November 2023.

Safe care functionality - A phased role out commenced in December 2022, and this will demonstrate the minimum medical staffing requirement per area, alongside the actual staff available each day. This will better aid the movement of Doctors between areas to ensure that safe staffing is maintained.

16. Going forward

Stockport NHS Foundation Trust

- Recruitment of Pastoral Care Lead Band 6 temporary contract for 18 months fixed term contract to support new starters joining the Trust, international nurses and HCAs
- Workforce Matron and Matron for Medicine to visit University of Salford on the 7th December to discuss careers opportunities at the Trust with the 3rd nursing students
- Identification of a role with the skillset to promote recruitment campaigns and the Trust as an employer of choice (previously managed by social media company Just-R)
- Introduction and promotion of retention initiative the GROW pathway
- Ward allocation for nursing students qualifying in December 2023/January 2024
- Formalise the pathway for international nurses working as HCAs to qualify as Band 5 registered nurses
- Taking photographs for recruitment campaigns
- Interviewing and filming staff – provided films
- Promoting events on social media platforms
- Contacting individuals who had registered an interest in attending the events
- Manage #supportteamstockport Facebook page & @stockportnursing twitter account

Meeting date	07 December 2023	**Public**	x	**Confidential**	
Meeting	Board of Directors				
Report Title	Guardian of Safe Working Report				
Director Lead	Andrew D. Loughney Medical Director	**Author**	T Finnigan Guardian of Safe Working		

Paper For:	**Information**	x	**Assurance**	x	**Decision**	
Recommendation:	The Board of Directors is asked to review the report and confirm that junior medical staff are safe and able to work, including any associated risks and actions.					

This paper relates to the following Annual Corporate Objectives

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

The paper relates to the following CQC domains

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

This paper relates to the following Board Assurance Framework risks

x	PR1.1	There is a risk that the Trust does not deliver high quality care to service users
	PR1.2	There is a risk that patient flow across the locality is not effective
	PR1.3	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan
x	PR2.1	There is a risk that the Trust is unable to sufficiently engage and support our people's wellbeing
	PR2.2	There is a risk that the Trust's services do not fully support neighbourhood working
	PR3.1	There is a risk in implementing the new provider collaborative model to support delivery of Stockport ONE Health & Care (Locality) Board priorities
	PR3.2	There is a risk that the Trust does not deliver a joint clinical strategy with East Cheshire NHS Trust
x	PR4.1	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to

		recruit and retain the optimal number of staff, with appropriate skills and values
	PR4.2	There is a risk that the Trust's workforce is not reflective of the communities served
	PR5.1	There is a risk that the Trust does not implement high quality transformation programmes
	PR5.2	There is a risk that the Trust does not implement high quality research & development programmes
	PR6.1	There is a risk that the Trust does not deliver the annual financial plan
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Where issues are addressed in the paper

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

Executive Summary

This report provides the Board with an update on the work of the Guardian of Safe Working (GOSW)

1. Purpose

1.1 It is important that junior doctors are fully trained and work in ways that are safe and fair. This is reflected in the 2016 terms and conditions of service (TCS) for doctors and dentists in training which references the role of the Guardian of Safe Working.

1.2 The role of the Guardian of Safe Working is to:

- ensure that doctors are confident that their concerns will be addressed
- require improved working hours and rotas for doctors in training where necessary
- provide Boards with assurance that junior medical staff are safe and able to work
- identify risk and advise Boards on the required response
- ensure fair distribution of financial penalty income to the benefit of doctors in training.

1.3 There is also a requirement for the Guardian of Safe Working to submit a report to the Board at least annually.

2. Background and Links to Previous Papers

2.1 GOSW is now not having to get involved in as many individual reports as we see more engagement from Educational Supervisors

2.2 As with previous trends, we are still seeing the majority of Trainees request and be given TOIL for their reports

2.3 I have been able to provide a more detailed breakdown on areas in which reports are being generated

2.4 I have continued to review and attend when possible the regional GOSW meetings that take place monthly

2.5 I attended the national BMA Guardian meeting which is a good forum to discuss all matters relating to reporting.

3. High level data Q1-3 2023/24

Number of doctors / dentists in training in the Trust (total):	186
Number of doctors / dentists in training on 2016 TCS:	186
Amount of time available in job plan for GOSW:	1 PAs
Admin support provided to the guardian (if any):	0 WTE
Job-planned time for educational supervisors:	0.08 PAs per trainee

4. Matters Under Consideration

Exception reports (with regard to working hours)

Exception Reports (ER) over past quarter	
Reference period of report	02/07/23 - 02/11/23
Total number of exception reports received	32
Number relating to immediate patient safety issues	3
Number relating to hours of working	26
Number relating to pattern of work	3
Number relating to educational opportunities	0
Number relating to service support available to the doctor	3

***Note**: Within the system, an exception relating to hours of work, pattern of work, educational opportunities and service support has the option of specifying if it is an Immediate Safety Concern (ISC). ISC is not an exception type by itself.*

Immediate Safety Concerns

There were no immediate safety concerns.

Outcomes

ER outcomes: resolutions	
Total number of exceptions where TOIL was granted	31
Total number of overtime payments	2
Total number of work schedule reviews	0
Total number of reports resulting in no action	1
Total number of organisation changes	0
Compensation	0
Total number of resolutions	**34**
Total resolved exceptions	**36**

Specialty and Grade

Reasons for exception reports over last quarter by specialty & grade				
ER relating to:	Specialty	Grade	No. ERs raised	No. ERs closed
Relating to immediate patient safety issues	Acute Medicine	CT1	1	0
	Trauma & Orthopaedics	ST3 *	2	0
Total			**3**	**0**
Relating to hours/pattern of work	Accident and emergency	ST3	1	1
	Acute Medicine	CT1	1	0
	Cardiology	ST4	0	1
	General medicine	FY1 *	0	3
	General medicine	FY1	5	1
	General medicine	FY2	0	1
	General surgery	FY1	0	5
	General surgery	FY1	4	5
	General surgery	FY1 *	0	2
	General surgery	FY2 *	0	0
	Geriatric medicine	FY1	1	1
	Obstetrics and gynaecology	FY2	2	3
	Obstetrics and gynaecology	ST1	5	3
	Obstetrics and gynaecology	ST2 *	1	1
	Obstetrics and gynaecology	ST5	5	0

	Psychiatry	FY2	0	2
	Trauma & Orthopaedic Surgery	FY1	0	1
	Trauma & Orthopaedic Surgery	FY2 *	0	0
	Trauma & Orthopaedic Surgery	ST3 *	4	0
	Urology	FY1	0	5
Total			**29**	**35**

Relating to educational opportunities	Obstetrics and gynaecology	FY2	0	1
Total			**0**	**1**

Relating to service support available	Acute Medicine	FY2	2	0
	General surgery	FY1	1	0
Total			**3**	**0**

Work schedule review

I have requested one work schedule review in which it was raised that cover over the weekend for surgery was understaffed, resulting in the generation of several exception reports. Will conclude findings in next quarter.

Comment

As is the trend year on year we have seen a jump in the number of reports in the first quarter of the year. A pattern that we've seen repeated particularly in August when we have a new cohort of juniors starting work and further juniors who are more familiar with the reporting system moving into the middle grades of surgical training and core medical training. We see the same steady numbers of reports with FY1/FY2. This quarter we have seen a slight increase in ST1, 2 & 3. I believe that this will be an ongoing trend as the juniors that have grown with this system, move into the more senior trading roles.

Vacancies

I've not been made aware of any significant vacancies in any specialty or level.

Fines

No fines issued by me. No areas where fine has been warranted. We haven't had any fines since June 2019, that balance –£328.16 There is to be updated guidance issued at National meeting regarding what generates a fine and how much to fine.

5. Areas of Risk & Issues Arising

Thanks go to Spencer McKee as we have a significant improvement in ensuring trainees receive their rotas in an acceptable time period and we have had no further issues from the BMA on this part.

The Junior strikes are ongoing. We await further guidance from the BMA with regard ongoing strikes and there is a new ballot at the start of November. Certainly, the strikes have not had any negative impact with regards to number reports that have been issued or immediate safety concerns and I would expect this trend to continue if further strike action was announced.

In my last report, presented to the Board, I'd raised notification about coming to the end of my tenure as Guardian of Safe Work. I'm sorry to say that I am now going to action that, so that I can start the process of formally changing over to a new Guardian of Safe Working. I feel that I've achieved everything that I had hoped to within this role over the past years and feel it's now time for a fresh face.

I would like to pass my thanks onto Dr David Baxter and Nicole Beveridge for their continual support over the years and providing a first class service to the juniors that we have. My thanks to Dr Colin Wasson, who appointed me, and Dor Andrew Loughney, who supported my ongoing role, and believing in it. My thanks to the Board, for engaging in the process of exception reporting and the role of GOSW work and taking significant interest ultimately providing a better environment for all our doctors in Stockport.

I would hope that's the formal transfers process to the new Guardian of Safe Work would have been completed by the next Board report at the end of either Q2 or Q3.

6. Recommendations from Q1,2 & 3

Board to accept report.
Continue engagement of educational supervisors and Juniors
Restart the regular meetings of LNC and Junior Doctors forum
Start the process of recruiting a new GOSW for which I will aid the handover.

Meeting date	7th December 2023	**Public**	X	**Confidential**	
Meeting	Board of Directors				
Report Title	Board Committee Assurance – Key Issues Reports				
Director Lead	Committee Chairs	**Author**	Soile Curtis, Deputy Company Secretary Rebecca McCarthy, Trust Secretary		

Paper For:	**Information**		**Assurance**	X	**Decision**	X
Recommendation:	The Board of Directors is asked to: – Review the key issues and matters for escalation provided via the Board Committees – Receive the Maternity Services Report as reviewed and confirmed by Quality Committee, including matters for escalation highlighted within the Quality Committee Key Issues Report.					

This paper relates to the following Annual Corporate Objectives

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

This paper relates to the following CQC domains

	Safe		Effective
	Caring		Responsive
X	Well-Led		Use of Resources

This paper relates to the following Board Assurance Framework risks

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

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

Where issues are addressed in the paper

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

Executive Summary

The Board of Directors has established the following Committees:

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

The Committees have no executive powers, other than those specifically delegated within their Terms of Reference, but they can make recommendations to the Board of Directors for approval. The Committees are to report to the Board of Directors by means of a Key Issues Report summarising business conducted by the Committee together with key actions and/or risks.

A summary is provided for the Board of Directors of the key matters and decisions from the meetings of the Finance & Performance Committee, People Performance Committee, Quality Committee and Audit Committee held during October and November 2023.

KEY ISSUES REPORT	
Name of Committee/Group	Finance & Performance Committee
Chair of Committee/Group	Mr Anthony Bell, Non-Executive Director
Date of Meeting	19 October 2023
Quorate	Yes

The Finance & Performance Committee draws the following key issues and matters to the Board's attention:

Item	Key issues and matters to be escalated
Operational Performance Report	The Committee received the Operational Performance Report, including performance against the strategic core operating standards, benchmarking of performance against the four key standards (A&E 4-hour standard, Cancer 62-day standard, 18-week Referral to Treatment (RTT) standard, and Diagnostic 6-week wait standard), and key Productivity, Efficiency & Transformation programmes. The Committee acknowledged the continued operational pressures and the action being taken to improve performance. The Committee heard that the Trust continued to perform below the national target against all of the core operating standards, however it was acknowledged that the Trust's performance compared favourably against GM peers for Emergency Department (ED) and Diagnostic performance. The Committee acknowledged the impact of the BMA industrial action, with significant adverse impact particularly around cancer and elective performance, with over 5,000 elective appointments cancelled to date. The Committee heard mitigating actions around cancer performance, including the establishment of an Executive-led Patient Tracking List meeting. It was noted that all divisions had been asked to provide an improvement trajectory and the Trust was liaising with well-performing peer trusts to seek learning. With regard to Urgent & Emergency Care, the Committee noted the continued high attendance levels and challenges to flow, and issues around no criteria to reside, particularly for out of area patients. The Committee heard that the internal Programme of Flow work was having a positive impact on performance. The Committee noted challenges around Diagnostic performance, with Echocardiology remaining the biggest area of concern, and the Committee heard that outsourcing to the Community Diagnostic Centre capacity was being explored. The Committee discussed the robustness of the forecast information and in conclusion, the Committee requested further clarity on the forecast from now to year-end; underlying assumptions and mitigating actions (including resource requirements) in sufficient detail to enable the Committee to test the robustness of the forecast; and the implications to the Trust and the rest of the GM if we failed to hit those targets.

Finance Report	The Committee received an update regarding key financial performance indicators for Month 6 2023/24. The Committee heard that overall, the Trust position at month 6 was adverse to plan by £1.8m, with a planned year-end deficit of £31.5m, which was in line with the annual plan for 2023/24. It was noted that the key reasons for the variance to plan in month related to strike action, pay award, open escalation wards, elective recovery fund (ERF) estimated penalty for Q1 as calculated by GM, drugs income under-performance, enhanced staffing levels to support the high level of ED attendances and cover for vacancies and sickness absence. The Director of Finance advised that £2.0m was offset by other budget underspends and non-contract income above plan. It was noted that the Stockport Trust Efficiency Programme (STEP) plan for 2023/24 was £26.2m (£10.3m recurrent), and that the plan for month 6 had been delivered (non-recurrently) and was ahead of target by £0.5m. The Committee noted a continued focus on recurrent delivery. It was noted that that ERF had been reported at month 6 in line with national guidance, with an estimated underperformance of £1.0m in month 6. The Committee heard that the Trust had maintained sufficient cash to operate during September, but noted risks in this area and the assumption that the Trust would require revenue support in Quarter 4 2023/24. The Director of Finance advised that the cash risk for the Trust scored at 15 and was included on the significant risk register. It was noted that the Cashflow Monitoring Group continued to closely monitor the cash position. Good performance was noted against the Better Payment Practice Code standard. It was noted that the Capital Plan for 2023/24 was £62.7m, but subject to confirmation, and at month 6 expenditure was behind plan by £3.9m. The Committee reviewed and noted the financial position as at Month 6, and acknowledged the significant risk around the delivery of the financial plan.
Greater Manchester (GM) Financial Position Update	The Committee received a verbal update on the plans and actions being covered ahead of the next GM Finance & Performance Recovery Meeting on 25 October 2023. It was noted that a report would be provided to the Private Board meeting on 2 November 2023, including a summary from the GM Finance & Performance Recovery meeting. The Committee heard that the corporate risk relating to the finance and procurement team's ability to meet service demands remained on the Trust Risk Register, with a risk score of 15.
Procurement Contracts for Approval McCarthy Rebecca 06/12/2023 11:30:52	The Committee received a report detailing procurement processes in progress over £750K. **Action:** The Committee recommended the award of the contract extension for the Blood Science Managed Service for up to 12 months to the Board of Directors for approval.

Standing Committees	The Committee received and noted the following key issues reports: • Capital Programmes Management Group • Estates Strategy Steering Group (ESSG) The Committee received the draft ESSG work plan, noting that the dates on the work plan still needed to be populated before it could be approved by the Committee.

KEY ISSUES REPORT	
Name of Committee/Group	Finance & Performance Committee
Chair of Committee/Group	Mr Anthony Bell, Non-Executive Director
Date of Meeting	16 November 2023
Quorate	Yes

The Finance & Performance Committee draws the following key issues and matters to the Board's attention:

Item	Key issues and matters to be escalated
Operational Performance Report and Performance Trajectories	The Committee received the Operational Performance Report, including performance against the strategic core operating standards, performance against the four key standards (A&E 4-hour standard, Cancer 62-day standard, 18-week Referral to Treatment (RTT) standard, and Diagnostic 6-week wait standard), and key Productivity, Efficiency & Transformation programmes. The Committee acknowledged the continued operational pressures and the action being taken to improve performance. The Committee noted the change in the report format to enable alignment with the Board Integrated Performance Report and Quality Committee reporting. The Committee welcomed the consistency of the data in the new reporting, but requested more far reaching trajectories and the re-inclusion of GM/national benchmarking to be included in future reports. The Committee heard that the Trust continued to perform below the national target against all of the core operating standards, however it was acknowledged that the Trust's performance compared favourably against GM peers for Emergency Department (ED) performance. The Committee acknowledged the impact of the BMA industrial action, with significant adverse impact particularly around cancer and elective performance, with over 6,500 elective appointments cancelled to date, and noted the need to work with GM regarding mutual aid. With regard to Urgent & Emergency Care, the Committee noted challenges in this area due to continued high attendance levels, higher acuity of patients and challenges to flow, and issues around no criteria to reside (NCTR), particularly for out of area patients. It was noted, however, that there had been a slight decrease in the numbers of NCTR which was encouraging, and the Committee heard that the internal Programme of Flow work continued. The Committee heard that cancer performance had been challenged in recent months due to the impact of industrial action and the sustained increase in demand. It was noted that all divisions had revised improvement trajectories across the cancer standards in light of no further industrial action planned to date, with the current forecast indicating that the Trust would achieve both the 28-day standard and the 63+ backlog target by year-end, and 62-day performance increasing to 75%. The Director of Operations advised that the Trust was being supported by both the National Team and the regional Cancer Alliance in identifying mutual aid, referral optimisation and

	potential access to fixed term funding to enable demand to be met and waiting time reduced. The Committee received a separate report providing an update on the overall Trust performance against the following trajectories assumed as part of operational planning for 2023/24: • 4-hour performance and ED activity • Bed occupancy and no criteria to reside • Long length of stay patients • Non-elective admissions • Cancer performance and trajectory • Diagnostics performance and trajectory The Committee discussed the need for the Committee to receive the appropriate level of information to provide assurance rather than reassurance, and in conclusion it was suggested that future Operational Performance Reports should include high level information of the key actions in place to move the dial to meet the trajectories, including underlying assumptions and implications if the targets were not met. The Committee reviewed and noted the Operational Performance Report and the updated performance trajectory information providing additional reassurance, noting that data providing more assurance was awaited.
Finance Report	The Committee received an update regarding key financial performance indicators for Month 7 2023/24. The Committee heard that overall, the Trust position at month 7 was adverse to plan by £2.0m, with a planned year-end deficit of £31.5m, which was in line with the annual plan for 2023/24. It was noted that the key reasons for the variance to plan in month related to strike action, pay award, open escalation wards, elective recovery fund (ERF) estimated penalty up to Month 7 as calculated by GM, drugs income under-performance, enhanced care for patients with dementia and other continuing healthcare needs, and enhanced staffing levels to support the high level of ED attendances and cover for vacancies and sickness absence. The Director of Finance advised that £2.4m was offset by other budget underspends and non-contract income above plan. It was noted that the Stockport Trust Efficiency Programme (STEP) plan for 2023/24 was £26.2m (£10.3m recurrent), and that the plan for Month 7 had been delivered (non-recurrently) and was ahead of target by £0.4m. The Committee noted a continued focus on recurrent delivery. It was noted that that ERF had been reported at Month 7 in line with national guidance, with an estimated underperformance of £1.2m. The Committee heard that the Trust had maintained sufficient cash to operate during October, but noted risks in this area and the assumption that the Trust would require revenue support in Quarter 4 2023/24. The Director of Finance advised that the cash risk for the Trust scored at 15 and was included on the significant risk register, and it was noted that the Cashflow Monitoring Group continued to closely monitor the cash position. Good performance was noted against the Better Payment Practice Code standard.

	It was noted that the Capital Plan for 2023/24 was £62.7m, but subject to confirmation, and at Month 7 expenditure was behind plan by £5.3m. The Committee heard that on 8 November 2023, NHS England had sent a letter to trusts addressing the significant financial challenges created by the industrial action. It was noted that ICSs were required to confirm back by 22 November 2023 that the 2023/24 financial and operational plans could now be achieved given the additional investment. It was noted that the Trust was currently forecasting delivery of the financial plan, albeit this assumed that 3 key risks (industrial action, ERF and GM depreciation) were offset centrally or by GM. It was also noted that risks relating to discharge to assess and out of area discharges required a resolution. The Committee acknowledged that, due to timings, the Trust response would not be reviewed at Board ahead of the submission deadline; therefore, sign off by Chair and Chief Executive to ensure timely submission would be required, with an acknowledgement that the response would be presented for ratification at the Board meeting in December. The Committee were informed that the response would remain consistent with the narrative and position reported via the Finance & Performance Committee and Board over recent months. The Committee reaffirmed that quality and safety was paramount in the context of the GM turnaround work. The Committee concluded that it did not yet have full assurance regarding the financial outturn, with an acknowledgement that this was being addressed by the GM ICS turnaround review. It was noted that internally, the Trust was continuing to look at every possible flexibility in this area.
Greater Manchester (GM) Finance & Performance Recovery	The Committee noted that as part of the GM turnaround process by PWC, one of the key actions was a review of balance sheets across the nine provider organisations, to be consolidated into an overarching report to provide transparency and constituency. While the full report was awaited, the Trust had received a draft PWC report on the Trust's balance sheet for factual accuracy checking. The Committee heard that the Trust had engaged positively with the PWC team throughout the review and had discussed the recommendations at length. The Committee noted the requirement for an action plan to address the recommendations in the report, which would be reviewed by the Audit Committee and considered at the GM Finance & Performance Recovery meetings. The Committee reaffirmed that its work plan could continue to flex to support the requirements of the GM Finance & Performance Recovery meetings.
Quarter 4 PDC Revenue Submission to NHS England	The Committee noted that at the Board meeting in October, a Board Resolution, in preparation for the planned revenue support PDC submissions for 2023/24, was approved. The Committee reviewed the application for £16m PDC revenue support in Quarter 4 of 2023/24. The Chief Finance Officer highlighted the daily defensive cash measures taken by the Trust. The Committee reviewed the application for £16m PDC revenue support in Quarter 4

	2023/24 and recommended it for virtual approval by the Board to enable submission of the application by 1 December 2023.
Annual Review of Treasury Management Procedures	The Committee received a report including an updated Treasury Management Policy to reflect the current financial regime in 2023/24 and current arrangements in place to manage the cash position. The Committee suggested some minor amendments to the wording in the policy to ensure clarity. The Committee received and noted the report and agreed that confirmation of the governance route for approval of the Treasury Management Policy was required.
Digital Strategy Progress Report	The Committee received a report providing an update on the delivery of the Trust's Digital Strategy, which was approved by the Board in December 2021. The Committee heard that overall, the delivery of the Digital Strategy was progressing well, albeit slow progress was noted with regard to the EPR programme. The Committee thanked the Chief Information Officer for all her work over the years and wished her the very best in her retirement.
Standing Committees	The Committee received and noted the following key issues reports: • Capital Programmes Management Group • Digital & Informatics Group

KEY ISSUES REPORT	
Name of Committee/Group	People Performance Committee
Chair of Committee/Group	Mrs Beatrice Fraenkel, Noon-Executive Director
Date of Meeting	9 November 2023
Quorate	Yes

The People Performance Committee draws the following key issues and matters to the Board of Directors' attention:

Item	Key issues and matters to be escalated
People Integrated Performance Report	The Committee received the People Integrated Performance report, which provided an update on attendance, appraisals, mandatory training, turnover, time to hire and agency expenditure. The Committee confirmed performance in relation to attendance was within target, with all other metrics below target. It was noted, however, that performance had improved from last month for turnover and contingent spend as a percentage of total payroll and agency spend. The Committee acknowledged the adverse impact of the operational pressures and industrial action on the metrics.
Industrial Action Briefing	The Committee received a report providing a summary of the industrial action of consultants and junior doctors and the approach taken by the Trust in managing and mitigating the impact. The Committee heard about the Trust's response and emergency preparedness, industrial action summary including financial impact, post action review, derogations and future steps. The Committee noted significant assurance regarding the approach being taken to minimise the impact of future industrial action.
Equality, Diversity & Inclusion (EDI) Strategy	The Committee received a report providing progress against each of the EDI targets set out within the EDI Strategy relating to workforce, culture, assurance & compliance and health inequalities. The Committee noted positive progress made against the delivery of the EDI Strategy, as supported by the latest EDI performance metrics, albeit acknowledging that culture change would take some time to embed. The Committee noted the intention to review the EDI action plan in light of the new NHS EDI Improvement Plan and the NW Anti-Racism Framework Self-Assessment, with a view to presenting the consolidated and re-prioritised plan to the Committee in January 2024.
Guardian of Safe Working McCarthy Rebecca 06/12/2023 11:30:52	The Committee received a Guardian of Safe Working report and heard that no immediate safety concerns or patient harm had been identified during the reporting period. Further to the decision taken by the Guardian of Safe Working to not continue in the role, the Committee thanked Mr Tom Finnigan for all his work as the Guardian of Safe Working.

Item	Key issues and matters to be escalated
Health & Wellbeing Plan	The Committee received a draft Health & Wellbeing Plan 2024, acknowledging alignment with the national NHS Health & Wellbeing Framework. It was noted that the plan had been developed in consultation with the Staff Health & Wellbeing Steering Group, People Engagement & Leadership Group and the Wellbeing Guardian. The Committee reviewed and approved the Health & Wellbeing Plan 2024.
Employee Relations & Exclusions Activity	The Committee received a report providing a summary of employee relations case activity for Q1 and Q2 2023/24, including information regarding: • Employee relation cases by type and division • Employment tribunals • Safeguarding allegations The Committee acknowledged the Trust's focus on EDI and attendance management and noted a reduction in the number of employment tribunals. The Committee heard that the Trust was continually learning from the employee relation cases and noted the establishment of a Conduct Review Panel to ensure fairness and consistency.
Widening Participation	The Committee received a report providing an update on the Widening Participation and Vocational Learning offer aligned to the Trust's People Plan and the NHS People Plan. The Committee noted collaborative work with system partners to build relationships, remove barriers and overcome challenges to offer work experience and career opportunities for people in Stockport, particularly those in underrepresented areas.
NHS Staff Survey 2023	The Committee received a report outlining actions taken to promote this year's Staff Survey and encourage participation. The Committee heard about actions in place to encourage participation, including Trust-wide incentives, targeted approach with divisions and staff groups, alongside a comprehensive communications campaign, whilst acknowledging the challenges around improving response rates in the context of increasing service demands and staff shortages. It was noted that the initial results would be received in December 2023, with the full management report expected at the end of January 2024 (embargoed until March 2024). It was anticipated that the results would be presented to the Committee in March 2024. The Committee acknowledged the importance of turning the results into positive action to help better engage, develop and retain our workforce. Furthermore, it was noted that this in turn would help improve patient care, organisational performance and culture and improve attendance.
Sexual Safety in the Workplace – Organisational Charter	The Committee heard that NHS England had launched its first NHS Sexual Safety Charter on 4 September 2023, emphasising the importance of NHS taking a systematic zero tolerance approach to sexual conduct and violence, protecting the safety of patients and staff. The Committee received a report detailing the 10 principles of the Charter, the support currently provided by the Trust and further actions required to achieve a zero tolerance approach in this area.

Item	Key issues and matters to be escalated
	The Committee noted next steps, with a view for the Board to formally sign up to the Charter and working towards full implementation by July 2024. The Committee acknowledged the action plan detailing the actions required to ensure the Trust builds upon existing arrangements to achieve compliance with the 10 principles of the Charter.
Safe Care (Staffing) Report	The Committee received a report providing assurances and risks associated with safe staffing, alongside actions to mitigate the risks to patient safety and quality, based on patients' needs, acuity, dependency and risks. The Committee acknowledged the ongoing high levels of operational demand within the acute and community services, which was having an impact on patient and staff experience. It was noted that demands within the Emergency Department remained significant, impacted by large numbers of patients who no longer require a hospital bed, and that this demand was being operationally managed by senior teams and on-call colleagues with continual dynamic risk assessments conducted. The Committee also acknowledged the impact and associated challenges of the industrial action.
Standing Committees	The Committee received and noted the following key issues report: • People, Engagement & Leadership Group The Committee heard that the supporting narrative accompanying the key issues report template would be reviewed to provide further guidance to the report authors to ensure consistency. It was noted that the purpose of the key issues reports was to highlight any escalations from the reporting groups to the Committee, with assurance provided through the various reports included on the Committee work plan.

KEY ISSUES REPORT	
Name of Committee/Group	Quality Committee
Chair of Committee/Group	Mary Moore, Chair of Quality Committee / Non-Executive Director
Date of Meeting	24th Oct 2023 & 28th November 2023
Quorate	Yes

The Quality Committee draws the following key issues and matters to the Board's attention:

Item	Key issues and matters to be escalated
Learning from Deaths Report (Oct 2023)	The Medical Director presented the Learning from Deaths Quarterly Report Q1 2023/24, including information regarding the process undertaken and number of deaths reviewed in line with the policy The timely administration of antibiotics is a theme. The committee continues to monitor the timely administration of antibiotics through metrics contained elsewhere. This remains consistently below target, although much improved to previous years as measured in the IPR. Patients should, where possible, remain with the same clinical team after admission to the hospital's bed base as this aids consistent and rapid decision-making and helps with effective communication with families. Despite reductions in the number of patients with no clinical criteria to reside and reductions in patients with a long length of stay, poor flow through the hospital remains a problem and is associated with a poor quality of care. The Quality Committee reviewed the Learning from Deaths Report including processes that the Trust has in place that allow it to learn from deaths and key themes identified during Q1 2023/24.
StARS Progress Report – Q2 2023/24 (Oct 2023)	The Deputy Chief Nurse presented the StARS quarterly report including confirmation of assessments completed and current assessment ratings at the end of Q2 2023-24 by division and area. Decision had been taken to suspend the accreditation programme during the doctor's industrial action which had impacted on the overall number of assessments undertaken this quarter. The process continues to evolve with a role out to Maternity, theatres and Community services. The accreditation is maturing to recognise sustained improvement with the awarding of 'Blue Stars' to those areas maintaining the highest level of 'Green stars' award. M2 continued to be rated as 'red'. The Deputy Chief Nurse confirmed a change in ward leadership had been implemented, with additional corporate support being provided to address standards requiring improvement. E3 which has been a concern on a number of issues including requiring a deep dive

	for higher mortality rates (reported elsewhere) is now accredited Green. General areas for improvement being supported by Corporate Nursing noted as standards of documentation, especially relating to those patients that required additional support with their needs, care of the dying and medication management standards.
Quality & Safety Integrated Performance Report (Oct & Nov 2023)	**Quality & Safety Integrated Performance Report (IPR)** Quality Committee reviewed the Integrated Performance Report, which included specific update on quality and safety metrics that were not achieving target, alongside areas of sustained improvement and that were not covered elsewhere on the agendas. The HSMR was re-introduced to monitor our position as an outlier within GM. This shows a now improving position into the amber zone from red. Work continues on effective coding for end of life care. The Medical Director confirmed sepsis: antibiotic administration remained below target and reaffirmed the improvement work underway with AQUA Cdiff continued to be above threshold, with the Trust part of a GM ICS collaborative to improve shared learning and ensure joined up system approach, particularly around antibiotics and community prescribing. In both Oct and November there continues with a rise in incidents reported whilst the number of incidents with harm remained within control limits. Novembers committee considered the range of metrics and how they are presented (%, numbers, rates) the Deputy Director of Governance agreed to consider future reporting of incident reporting to align all metrics recognising that activity has increased in many areas and denominators are not recognised with metrics.
External Visits & Inspections Register Report (Nov 2023)	External Visits & Inspections Register Report The Deputy Director of Quality Governance presented the External Visits & Inspections Register Report highlighting visits that had taken place during May – October 2023, including associated risks, and high-level outcome where available. This inaugural report collated a range of regulatory activity and the outcomes: eg CQC, MHRA, ISO. acknowledging the report is iterative. Further engagement was agreed to incorporate medical and other professional education bodies for formal planned or unannounced external assessment, accreditation or inspection. The trust awaits formal written feedback on the Maternity CQC inspection earlier in the year following positive verbal feedback at the time.
Maternity Services Report (Nov 2023)	Update received on key maternity improvement work streams including: Maternity Services • CNST Year 5 • Saving Babies Lives Care Bundle V3 • Midwifery Continuity of Carer pathway (MCOC) • Ockenden Reports (2020/2022) • East Kent Report (2022) • Three year delivery plan for maternity and neonatal services (2023) • Pregnancy Loss review (July 2023)

	Perinatal Mortality Review Tool (PMRT) Q2 2023/24 ATAIN) Tool and Audit Proforma LMNS Return (Ockenden - Kirk Up Report) Maternity Workforce Biannual Staffing Report Compliance with all the above or on track for compliance with mandated time line assured. CQC report is awaited following positive verbal feedback. Areas highlighted for improvement were discussed and had already been actioned. The CQC verbally stated that they observed professional challenge and a positive culture A comprehensive position of midwifery workforce covering the period May 2023 to October 2023, including staff in post and recruitment and retention plans were discussed along with the triangulation to People Performance Committee. **All Maternity Services Reports were reviewed and recommended to the Board of Directors in line with reporting requirements (Appendix 1-8).** Our CNST declaration of compliance is due on 1st February 2024, it requires sign off by Board (Who meet that day) LMNS and the ICB. Agendas have been arranged to facilitate this.
Quality Strategy Progress Report (Nov 2023)	The Assistant Chief Nurse presented progress against Year 3 2023-2024 targets of the Trust Quality Strategy 2021-2024. Progress was highlighted in relation to: • Start well – Improve the first 1,000 days of life • Live well – Reduce avoidable harm • Age well – Reduce avoidable harm • Die well with dignity – Improve the last 1,000 days of life The report demonstrated progress made and actions taken, The Committee agreed that RAG rating did not necessarily reflect impact or metrics achieved. The strategy to be reviewed through the Steering Group – (to review to demonstrate clarity on metrics and whether achieved not.
Discharge Deep Dive (Nov 2023)	The Directorate Manager Operational Support provided a deep dive into work taking place to support discharges from hospital. The team now present information to the Discharge Concerns Panel and attend Long Length of Stay ward rounds. Successful transition of team from Integrated Care to Corporate services has resulted in more involvement with in-patient flow. This has resulted in more patient centred challenges in respect of discharge planning. Dr Tushar is the clinical champion and team feel well supported. Length of stay reduced by 1 day

Key Issues Reports (Oct & Nov 2023)	Regular key issues reports received, reviewed and confirmed/noted. Many of the exceptions from the subcommittees are explored in detail during the main agenda of the Quality Committee. **Health & Safety Joint Consultative Group (JCG) – Key Issues Report** Training compliance 92.42% Slight increase and decrease in incidents reporting within control limits, two Riddor reported incidents. **Patient Safety Group Key Issues Report** - Serious Incident Related to Patient Safety - Data Review of Neonatal Deaths - Quarterly Medical Examiners Report - VTE Prevention Report - Point of Care Testing (POCT) Report - Chief Pharmacist Report – including Medicines Optimisation Group and Safe Medicines Practice Group Reports - Maternity Services Report - Nutrition and Hydration Update – Coronial Concerns - Nutrition and Hydration Report - Pressure Ulcer Report - Quarterly Patient Safety Report (July – September 2023) - Notification of serious incidents - Audiology is seeing a lower than expected referral of children to the service, a review is underway to establish cause and develop an action plan. This will come to PSG and QC for monitoring and assurance. **Patient Experience Group Key Issues Report** Quality Committee reviewed and confirmed the Patient Experience Key Issues Report - PALS & Complaints Report – October 2023 - Walkabout Wednesday - Patient Experience Q2 Report - Q2 Voluntary Services - National Cancer Patient Survey - Q2 Chaplaincy and Spiritual Care Report A summary of Walkabout Wednesday was provided to précis activity undertaken during the reporting period. This is to provide a mechanism for escalation of identified risks and quality concerns. **Trust Integrated Safeguarding Group (TISG) Key Issues Report.** Quality Committee reviewed and confirmed the TISG Key Issues Report - Safeguarding Training Strategy - Dementia Plan 2023-2026 - Divisional Safeguarding Assurance Report - Neonatal Assurance Action Plan - Adult Safeguarding Integrated Report - Adult Safeguarding Operational Meeting KIR - Safeguarding Children KIR - Looked After Children KIR - Maternity Safeguarding Activity Report

	- Public Health Nursing Governance & Safeguarding KIR - Dementia Steering Group - Stockport Accreditation & Recognition Scheme (StARS) Update - Security Report - PREVENT - SAR/DHR/Rapid Review/CSPR Update - GM Safeguarding Assurance Action Plan - Risk Register - Feedback from Local SAB and SCP - Guidance on suspected birth marks including 'blue grey birthmarks' (congenital dermal melanocytosis) - Learning Disability FOI Our Head of Safeguarding is now vacant following the promotion of the previous incumbent to another organisation. Recruitment is underway.

Meeting date	28th November 2023	**Public**	√	**Confidential**	
Meeting	Quality Committee				
Report Title	Maternity Services Update				
Director Lead	Andrew Loughney, Medical Director Nic Firth, Chief Nurse	**Author**	Sharon Hyde, Divisional Director of Midwifery Rachel Alexander-Patton, Deputy Head of Midwifery		

Paper For:	**Information**		**Assurance**	X	**Decision**	
Recommendation:	Quality Committee is asked to review the Maternity Services Highlight Report and confirm progress against each programme the service is working towards, including action being taken to ensure compliance where this is required, and provide confirmation to the Board of Directors.					

This paper relates to the following Annual Corporate Objectives

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

The paper relates to the following CQC domains

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

This paper relates to the following Board Assurance Framework risks

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

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

Where issues are addressed in the paper

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

Executive Summary

The Maternity Services highlight report incorporates an update on a number of the elements the service is currently working towards, including:

- CNST Year 5

  As required in Safety Action 9 (a,b) and Safety Action 10 (a, b + c)

- Saving Babies Lives Care Bundle V3 as required for Safety Action 6
- Midwifery Continuity of Carer pathway (MCOC)
- Ockenden Reports (2020/2022)
- East Kent Report (2022)

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

The update also includes an overview of Stockport's performance across GMEC using the quality surveillance toolkit, ongoing work with the Maternity Voice Partnership (MVP), midwifery staffing, overview of incidents, harm and risk, equality and equity plan, perinatal mental health, StARS and maternity and perinatal safety champions.

Annex A is a summary presentation of progress under each area of the plan.

The report will be presented on a bi-monthly basis to Patient Safety Group, Quality Committee and appended to the Quality Committee Key Issues Report to the Board of Directors including confirmation of key assurances and matters for escalation.

Maternity Services Highlight Report

Quality Committee
28th November 2023

Maternity Services Highlight report

NHS Stockport NHS Foundation Trust

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

- CNST Year 5
- Saving Babies Lives Care Bundle V3
- Midwifery Continuity of Carer pathway (MCOC)
- Ockenden Reports (2020/2022)
- East Kent Report (2022)
- Three year delivery plan for maternity and neonatal services (2023)
- Pregnancy Loss review (July 2023)
- Perinatal quality surveillance dashboard highlight reports

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

MIS CNST Year 5

Stockport NHS Foundation Trust

Year 5

- Information published 31 May 2023 (Archived)
- Updated version circulated July 23, and additional update for Safety action 1 and 8 was circulated October 23
- Continue to incentivise the 10 maternity safety actions from year 4 with some further refinement
- CNST Assurance check point presentation for LMNS/ICB to include evidence – Completed 17th October
- Completed board declaration to be submitted to NHSR by **12 noon** on **1 February 2024**

Stockport NHS Foundation Trust

Board Reporting

- There is an ask that the below reports relating to safety actions from CNST Year 5 are reported to board monthly or quarterly, it is the exception that if board meetings are held bi monthly then this is sufficient to meet the standards.
  - Safety Action 1 – PMRT quarterly audit report – Presented to Quality Committee quarterly as part of the Maternity Services Report
  - Safety Action 9 - All six requirements of principle 1 of the Perinatal Quality Surveillance model
  - Safety Action 9 - To use a locally agreed dashboard to include, as a minimum:
    1. Findings of review of all perinatal deaths
    2. Findings of review all cases eligible for referral to MSNI
    3. Number of incidents logged as moderate or above
    4. Report on training compliance in line with core competency framework
    5. Minimal staffing overview
    6. Service User Voice feedback
    7. Staff feedback from frontline champions and walk about
    8. MSNI/NHSR/CQC or other organisation with a concern or request for action directly with trust
    9. Coroner Reg 28 made directly to Trust
  - Safety Action 10 – Evidence that 100% of qualifying cases have been reported to MSNI, including evidence that families have received information on the role of HSIB and EN scheme, and duty of candour.

Safety Action 9 - Perinatal Quality Surveillance model
Six requirements to strengthen and optimise board oversight for maternity and neonatal safety

Stockport NHS Foundation Trust

Six Requirements	Where reported	RAG
To appoint a non-executive director to work alongside the board-level perinatal safety champion to provide objective, external challenge and enquiry.	Maternity and Women's Health governance + Risk Women's and Children's Quality Group Patient Safety Group Quality Committee	
That a monthly review of maternity and neonatal safety and quality is undertaken by the trust board.	Maternity and Women's Health governance + Risk Women's and Children's Quality Group Patient Safety Group Quality Committee	
That all maternity Serious Incidents (SIs) are shared with trust boards and	Maternity and Women's Health governance + Risk Women's and Children's Quality Group Patient Safety Group Quality Committee	
To use a locally agreed dashboard, drawing on locally collected intelligence to	Maternity and Women's Health governance + Risk Women's and Children's Quality Group Patient Safety Group Quality Committee	
Having reviewed the perinatal clinical quality surveillance model in full, in collaboration with the local maternity system (LMS) lead and regional chief midwife, formalise how trust-level intelligence will be shared to ensure early action and support for areas of concern or need.	Meetings in place to support information sharing between LMNS/regional board/ICB – working collaboratively with the LMNS/ICB	
To review existing guidance, refreshed how to guides and a new safety champion toolkit to enable a full understanding of the role of the safety champion, including strong governance processes and key relationships in support of full implementation of the quality surveillance model.	Maternity and Perinatal safety champions meetings and walk rounds held BI-monthly in line with guidance. Staff feedback in place in the form of posters, Bi –monthly walk rounds. Process from safety champions to be reviewed in line with CNST YR 5	

Safety Action 9
1) Findings of review of all perinatal deaths using the real time monitoring tool

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Case ID	Date of birth	Date of death	Standard 1a All cases to be reported within 7 days.	Standard 1b 95% of parents should have been advised of the review and perspectives of care sought.	Standard 1c Review started within 2 months of reporting.	Standard 1c a minimum of 60% of multi-disciplinary reviews should be completed to the draft report stage within four months of the death	Standard 1c Final report to be published within six months.
88004	18/06/2023	18/06/2023	Reported day 1	Review not supported as Termination of pregnancy	N/A	N/A	N/A
88292	08/07/2023	08/07/2023	Reported day 1	Standard Met	Standard Met	Due 08/11/2023	Due 08/01/2024
88525	18/07/2023	20/07/2023	Reported day 2	Standard Met	Standard Met	Due 20/11/2023	Due 20/01/2024
88715	29/07/2023	29/07/2023	Reported day 3	Review not supported as Termination of pregnancy	N/A	N/A	N/A
88988	20/08/2023	20/08/2023	Reported day 0	Review not supported as Termination of pregnancy.	N/A	N/A	N/a
89534	22/09/2023	22/09/2023	Reported Day 2	Standard Met	Standard Met		

McCarthy,Rebecca 06/12/2023 11:30:52

- Quarterly PMRT audits and action plans are undertaken and are shared through Maternity and Women's health governance and risk meeting, Women and Children's Quality Group, Patient Safety Group and Quality Committee

Safety Action 9
2) Findings of review all cases eligible for referral to Maternity & Newborn Safety Investigations (MSNI)

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HSIB cases reported from the introduction of MSNI to 17th October 2023

Cases at 17 October 2023	
Total referrals	19
Referrals / cases rejected	5
Total investigations to date	14
Total investigations completed	11
Current active cases	3

Current investigations

Case number	Referral date	Category	Current status	Next steps
MI-030216	20 July 2023	Neonatal death	Staff interviews in progress. Awaiting PM report	Internal QA
MI-034605	4 October 2023	Intrapartum stillbirth	Records uploaded, thank you	Family conversation
MI-035331	18 October 2023	HIE/Cooling	New referral	Speak to Trust

Stockport NHS Foundation Trust

Safety Recommendations to date

In total to date the Trust have received 18 safety recommendations from 11 completed MSNI investigations.

The categories include:

- Documentation
- Clinical attendance and guidance
- Clinical assessment and guidance
- Escalation
- Quality assurance

Two reports did not have any safety recommendations.
All safety recommendations have been addressed by a multi-disciplinary agreed action plan.
All actions are closed, the last report was received in September 2023 with 0 safety recommendations

Safety Action 9
3) Number of incidents logged as moderate or above

NHS Stockport NHS Foundation Trust

Hospital	Stockport NHS Foundation Trust		
Reporting Period (Month/Year)	September 2023		
Total Number of Moderate or above (Level 3) Incidents validated. *(Use an * next to the number If any are unvalidated).*	0	Diverts - • Number of diverts. • Number of women affected. • Any serious incidents reported due to the divert Deflections - • Number of deflections • Number of women affected. • Any serious incidents due to the deflection	1 3 0 0
Stillbirths	1 – antepartum stillbirth	Babies Born <27 weeks gestation in < level 3 unit. *Include gestation and reason for birth outside NICU*	0
Neonatal Death	0	Number of Babies born at home midwife not present	1 - Unbooked concealed pregnancy
Total number of StEIS Incidents (for month)	1 Maternity Divert	Number of babies born in other location midwife not present How many outstanding incidents do you have? Do you have any delays in processing moderate and serious incidents?	0 64 incidents reported in September 2023. 17 incidents awaiting review on the 3rd October 2023

McCarthy Rebecca 06/12/2023 11:30:52

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Lessons learnt/themes from any StEIS/72-hour report for sharing.

Lessons learnt/themes from any StEIS/72-hour report for sharing.

Please use this section to describe learning/themes from any of your StEIS incidents that could be useful across the GMEC Maternity providers:

Temporary Maternity Divert.
4th September 2023 – 72-hour rapid review. **StEIS reportable.**
Rationale for temporary maternity divert insufficient staffing. There was a deficit of five midwives on the night shift. This was as a result of a high level of sickness currently being experienced within the midwifery establishment in addition to a number of vacancies.
At the time of the divert in total there were 13 women on the delivery suite, 3 women requiring 1:1 care in addition to 7 inductions of labour and 3 other women as inpatients on the delivery suite.
There were 3 women redirected to neighbouring units during the time of the divert.
The total time of the divert was 4 hours.

Recommendations from HSIB cases

Please use this section to describe learning from your incidents that could be useful across the GMEC Maternity providers from HSIB cases:

Draft report received – awaiting final report following family comments.

Safety Action 9
3) Number of incidents logged as moderate or above

NHS Stockport NHS Foundation Trust

Grade of incident	Description of incident Please include information on Birth centile, fetal abnormalities	Stillbirth, neonatal death, maternal death other	Ethnicity including any issues with understanding and speaking English	Maternal Medicine Complexities	Deprivation index	List issues and themes in care, including incidental findings.	Actions/Learning / Proposed audits to assess effectiveness
No Harm	29+1 week gestation ambulance admission, placental abruption	Antenatal Stillbirth	Any other ethnic group	FGR risk identified a booking - previous baby BW centile >3rd and <10 Allergies (emergency OC)? PCOS Smoker at booking - quit during pregnancy History of laparoscopy for ruptured cyst and fluid removal November 2016 Result of last smear - inflammatory changes - taken within the last 3 years Depression past treatment (mood stable and not on medication); generalised anxiety disorder History of renal problems - (recurrent infection, last year had UTI's X 4, admitted for treatment) - noted had antibiotics in pregnancy for a UTI at booking Family history - father has had 2 aneurisms, under treatment; Mother Schizophrenia Past history of gastrointestinal problems - heartburn - regular medication for omeprazole, now settled with diet. Under investigations re wrists - query carpal tunnel syndrome	2	Booked as high risk – previous baby low birth weight centile and smoker. PPH 3100ml	Rapid review undertaken PMRT in process and supported by the Bereaveent lead midwife

Safety Action 9
3) Number of incidents logged as moderate or above

NHS Stockport NHS Foundation Trust

Incident Category	Description of incident & number of incidents in this category	Actions/learning/ QI work to target themes
Maternity Care	Maternity triggers remain one of the themes of obstetric related incidents. The main theme within maternity care for September was delays in care, including delays in IOL, this was as a result of staffing issues experienced during September.	All delays in care have been reviewed and there was no harm caused as a result of a delay in progressing with the induction of labour process.
Workplace stressors/demands	During September there were a number of incidents submitted with regards to workplace stressors, this was as a result of staffing levels being below the recommendation of safe staffing on a number of shifts. These incidents are recorded as maternity red flag incidents.	All maternity red flag incidents are escalated to Trust board via the governance process. The current staffing situation has been added to the risk register. There is currently a high sickness rate within the maternity unit and a number of vacancies. There are 11 new starters due to commence employment in September/October 2023 which will increase the midwifery establishment.
Environmental Conditions	There were a number of incidents reported in September with regards to excessive temperatures within the Maternity unit due to hot weather conditions.	Temperatures were escalated to the Estates and Facilities team, and a risk has been added to the Risk Register regarding potential for increased medical interventions due to exposure to extreme temperatures. Staff undertaking interventions where deemed appropriate for patients.

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There are 9 risks on the obstetric risk register reported moderate or above

Capacity and Demand	3
IT Systems	1
Security	1
Medication related	1
Equipment	1
Staffing	1
Information Governance	1

There is one risk on the register which scores 12 – there is a risk of not being able to meet the recommendations of safe staffing within the maternity unit.

Safety Action 9
3) Number of incidents logged as moderate or above

NHS Stockport NHS Foundation Trust

2572	Divisional Risk	Capacity and Demand	Obstetric	Mrs Jane O'Brien	Mrs Jane Armstrong	Women and Children	This is a risk assessment for the unavailability of inpatient DSNs to review patients within maternity.	31/07/2023	31/10/2023	Moderate Risk	9	Moderate Risk	6	New Risk	Marie Dooley 06/09/2023 09:23:01
2565	Divisional Risk	Staffing	Obstetric	Mrs Sharon Hyde	Mrs Sharon Hyde	Women and Children	There is a risk of not being able to meet the recommendations of safe staffing within the maternity unit.	27/07/2023	06/12/2023	Moderate Risk	12	Moderate Risk	6	New Risk	Mrs Catherine Anne Toksoy 27/09/2023 15:57:02
2558	Divisional Risk	Information Governance Risk	Obstetric	Stephanie Bray	Rachel AlexanderPatton	Women and Children	This is an information governance risk assessment for the functionality and data quality of Euroking.	12/07/2023	30/11/2023	Moderate Risk	6	Low Risk	4	New Risk	Stephanie Bray 31/10/2023 12:06:51
2326	Divisional Risk	Equipment	Obstetric	Miss Sarah McManus	Mrs Sharon Hyde	Women and Children	This is a risk assessment regarding the manufacturing issue with fetal fibronectin cassettes.	09/12/2022	12/04/2024	Moderate Risk	6	Low Risk	3		Miss Sarah McManus 11/10/2023 11:17:50
2323	Divisional Risk	Medication Related	Obstetric	Miss Sarah McManus	Mrs Sharon Hyde	Women and Children	This is a risk assessment for uterotonics not stored in a locked cupboard or fridge as per trust drug storage policy	29/11/2022	29/11/2023	Moderate Risk	6	Moderate Risk	6	New Risk	Marie Dooley 05/09/2023 13:54:10
2262	Divisional Risk	IT Systems	Obstetric	Stephanie Bray	Mrs Sharon Hyde	Women and Children	Document export from MIS to Advantis and out to GP/Health visiting service. ("search for" and duplicates)	30/08/2022	02/01/2024	Moderate Risk	9	Low Risk	3		Stephanie Bray 31/10/2023 11:55:24
2016	Divisional Risk	Security (including Lone Worker, Security Audit, Violence & Aggression)	Obstetric	Matron Louise Burns	Mrs Sharon Hyde	Women and Children	staff within the Women's and Children's Division on occasion being a lone worker	24/09/2021	23/09/2024	Moderate Risk	6	Moderate Risk	6	No Change in Risk Score	Marie Dooley 27/09/2023 16:15:38
1977	Divisional Risk	Capacity and Demand	Obstetric	Miss Sarah McManus	Mrs Sharon Hyde	Women and Children	This is a risk assessment for being unable to complete all Newborn and Infant Physical Examinations within the recommended 72hrs	22/07/2021	11/12/2023	Moderate Risk	6	Low Risk	3	No Change in Risk Score	Miss Sarah McManus 11/09/2023 15:27:02
893	Divisional Risk	Capacity and Demand	Obstetric	Miss Sarah McManus	Mrs Sharon Hyde	Women and Children	This is a risk of poor quality and unsafe care provision relating to delayed induction due to the increased induction rate.	02/01/2019	13/01/2024	Moderate Risk	9	Moderate Risk	6	No Change in Risk Score	Marie Dooley 11/10/2023 11:48:15

Safety Action 9
4) Report on training compliance in line with core competency framework

Stockport NHS Foundation Trust

Core Competency Number	Core Competency	Type of Training	May - August 2023 (Submit to LMNS by 29.9.23)
1	SBL		**Percentage of staff compliant**
	Element 1 : Smoking	Face to face training	Midwives 64% Obstetricians 84%
		NCSCT E-learning	Midwives 85% Obstetricians 45%
		Risk Perception Training for ANC staff	Training TBA
	Element 2 : Fetal Growth Surveillance	E-learning for Health Module	Midwives 85% Obstetricians 45%
		Serial Fundal Height Face to face training and competency	Midwives 76% Obstetricians 100%
		Face to face training	Midwives 94% Obstetricians 93%
	Element 3: Reduced Fetal Monitoring	E-learning for Health module	Midwives 85% Obstetricians 45%
		Face to face training	Midwives 94% Obstetricians 93%
	Element 4: Fetal monitoring	see Core Competency 2	
	Element 5 : Preterm Birth	E-learning for Health module	Midwives 85% Obstetricians 45%
		face to face training	Midwives 94% Obstetricians 93%
	Element 6 : Diabetes in Pregnancy	Face to face training	Midwives 83%
2	Fetal Monitoring GMEC Package: Full day Fetal monitoring training to include CTG, Antenatal and Intermittent Auscultation	Face to face training	Midwives 94% Obstetricians 93%
	CTG competency	GMEC Competency document	Midwives 93% Obstetricians 66%
	Intermittent Auscultation Competency	GMEC Competency document	Midwives 55% Obstetricians NA
3	Maternity Emergencies - Multidisciplinary Team - Full day	Face to face training	Midwives 91% Obstetricians 97% Anaesthetics 84% Other 86%
4	Equality, Equity and Personalised Care	Face to face training	Midwives 91% Obstetricians 97% Other 86%
5	Care during Labour and Immediate Postnatal Period	Face to face training	Midwives 91% Obstetricians 97% Other 86%
6	Neonatal Basic Life Support	Face to face training	Midwives 91%

Safety Action 9
5) Minimal staffing overview

NHS Stockport NHS Foundation Trust

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

Current Maternity position

	WTE Actual	Number of WTE Vacancies	Post WTE Recruited to TRAC
Registered Midwives	160.48 (Including B8 and above)	Vacancy 10.41 Maternity Leave 6.2	1.0wte

Obstetrics cover

- 24/7 Consultant obstetric cover on delivery suite
- 2/day 7 day/week Consultant ward rounds in place

Challenges

- Current registered vacancy inclusive of Inpatient and outpatient area's 10.41wte, in addition to this there is currently a gap of 6.2 wte on Maternity leave (due back April 24 – June 24). This equates to a total deficit of 16.61wte.

Actions

- Weekly planned roster scrutiny meetings/E.Roster training sessions - continue
- Rolling advert for Band 5/6 midwives
- Recruitment day planned 18th November 2023

Assurance

- All shift coordinators have supernumerary status.
- September showed we achieved 97.8% one to one care in labour (1BBA, 1 fully dilated on admission. 1precipitate birth)
- Maternity Red Flags monitored and reported through division
- Fully engaged with Maternity support workers framework working group – Agreed uplift for B2 to B3 Maternity assistants (August 23)
- Funding extended until 23/24 for Recruitment and Retention Midwife
- Engaged with the International Educated Midwifery (IEM) recruitment programme, three IEMs recruited in 1st wave. 3 commenced in post, The Trust has applied for further funding for 2 IEMs to be appointed to Stockport NHS Foundation Trust.
- Recruited to x2 Housekeeper, 4 MA roles, ward clerk recruitment ongoing

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MVNP Engagement

- New MVNP Chair appointed April 2023
- Monthly 1:1 with Deputy HOM
- MNVP Quarterly meetings represented by Exec and Non Exec Safety Champions, Maternity, Obstetric and Neonatal safety champions.
- Face to Face MVNP meeting planned for September 23
- MVNP Chair invited to Maternity and Perinatal safety champions meetings as standing agenda item and HSIB quarterly meetings
- Minutes or Patient Experience Group shared with MVNP chair

Working in Collaboration

- Inpatient welcome to ward leaflet/ antenatal aromatherapy leaflet – co produced
- Maternity Infographic shared monthly
- 15 Steps action plan ongoing – 15steps follow up walk round date to be confirmed
- Meetings with community matron to prioritise hearing the voices of women from Black, Asian and Minority ethnic backgrounds and women living in area's with high deprivation.
- Planning to meet with the neonatal ward manager to hear the voices of women and families of babies requiring support from the neonatal unit/team
- Explore opportunity to have a MVNP padlet which is accessible to all service users

Safety Action 9
7) Staff feedback from frontline champions and walk about

The Maternity and Perinatal Safety Champions walk rounds take place Bi-monthly. The next one is due to take place on Friday 3rd November 2023

Andrew Loughney under took the walk round on Thursday 10th August 23
Area's visited

- Maternity and Neonatal unit visited excluding community
- Met with various Midwives and neonatal nurses
- M2 – Met with the ward manager

Discussions held regarding:

- Staffing challenges
- Everyone welcomed the discussions
- Environmental improvements recognised
- Use of space on M2

Andrew Loughney (MD) and Mary Moore (NED) are both registered to the FutureNHS workspace to access: *Safety Culture - Maternity & Neonatal Board Safety Champions - FutureNHS Collaboration Platform workspace*

Safety Action 9

Stockport NHS Foundation Trust

8) HSIB/NHSRCQC or other organisation with a concern or request for action made directly with the trust

- No reports for July/August

9) Coroner Regulation 28 made directly to the Trust

- No reports for July/August

Saving Babies Lives Care Bundle V3 (SBLCBv3)

NHS Stockport NHS Foundation Trust

Background

- The Saving Babies' Lives Care Bundle provides evidence based best practice, for providers and commissioners of maternity care across England to reduce perinatal mortality.
- Version 3 of the SBLCB was released on 1 June 2023, and builds on the SBLCBv1 (March 2016) and SBLCBv2 (March 2019)
- Stockport Maternity services successfully implemented all **5** elements of the SBLCBv2.
- Version 3 of the SBLCB builds on the achievements of previous iterations and includes a refresh of all existing elements, drawing on national guidance such as from NICE or RCOG Green Top Guidelines, and frontline learning to reduce unwarranted variation where the evidence is insufficient for NICE and RCOG to provide guidance.
- Version 3 includes a new, additional element on the management of pre-existing diabetes in pregnancy based upon data from The National Pregnancy in Diabetes (NPID) Audit. There are now 6 elements of care:

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

SBLCBv3 also sets out a number of important wider principles to consider during implementation. These are not mandated by the care bundle but reflect best practice care and are recommended to be followed in conjunction with the 6 elements.

Saving Babies Lives Care Bundle V3 (SBLCBv3)

NHS Stockport NHS Foundation Trust

- Each element in SBLCB v3 has been reviewed to include actions to improve equity, including for babies from Black, Asian and mixed ethnic groups and for those born to mothers living in the most deprived areas, in accordance with the NHS equity and equality guidance.

- As part of the Three Year Delivery Plan for Maternity and Neonatal Services, NHS Trusts are responsible for **implementing** SBLCBv3 by **March 2024**

- Integrated Care Boards (ICBs) are responsible for agreeing a local improvement trajectory with providers, along with overseeing, supporting, and challenging local delivery.

- LMNS have launched the SBLCBv3 Implementation tool on NHS Future platform to provide assurance against the compliance of all 6 elements and CNST YR 5 – First submission completed on 15th September

- To achieve CNST year 5 providers are required to demonstrate implementation of 70% of interventions across all 6 elements overall and implementation of 50% of interventions in each individual element.

- 1ST Quarterly LMNS SBLCB V3 assurance meeting held 3rd October 2023

Draft LMNS report shared

- Significant assurance received – action plan in place to support improved compliance
- Overall compliance across all 6 elements 69% validated by the LMNS
- 5 out of 6 elements have over 50% of interventions fully implemented
- Element 4 – Fetal monitoring achieved less than 50% areas of improvement highlighted include audit outcomes for risk assessment at the onset of labour and hourly review and escalation in labour, training compliance met across all specialities but improved compliance against competency assessment required

CQC Feedback

- CQC inspection took place over 2 days on 29th + 30th September 2023
- Preliminary feedback session was held on 5th October 2023 with the Divisional director of Midwifery and Nursing, Divisional Director, Chief Nurse, Executive Director and Deputy Director of Quality Governance

Overview of findings

Positives

- We saw effective team working (confident and appropriate relationships with professional challenges).
- The service has recognized vulnerabilities and were working towards reducing inequalities throughout their maternity services
- We saw a positive culture with holistic positive person-centered care focusing on the needs of the woman, birthing people, and babies

Issues of potential concern and actions taken

Staff shortages.

Since September we have appointed and in post 12.88wte midwives across inpatient and outpatient areas, with an additional 1 wte Midwife to commence in post. There is a planned recruitment day to be held on 18th November for B5/6 midwives.

There was a lack of audit and monitoring around risk assessments in triage, a lack of audit and assurance regarding MEOWS.

In response to this an SBAR audit has been added to AMAT and is undertaken monthly across all inpatient area's and will be monitored through Maternity & Women's Health Governance & Risk Group. A MEOWS audit has been undertaken and the proforma is currently being added to AMAT

High Dependency on delivery suite, clarity required as some refer to it as Enhanced Care and others as HDU. Concerns not all staff are appropriately trained / competent to provide high dependency care on the delivery suite

The Care of the Critically ill woman in childbirth guideline has been updated to address the concerns raised, consistent terminology has been used throughout the document and has been ratified through labour ward forum

Midwifery Continuity of Carer (MCoC) Update November 2023

NHS Stockport NHS Foundation Trust

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

IN THE ABSENCE OF NATIONAL MCOC TARGETS THE STOCKPORT OFFER :

- Established model of AN and PN continuity for all women and families including named Midwife
- Low risk offer for intrapartum care utilising the birth centre for suitable women
- A successful home birth service led from community and utilising an on-call system
- The increase in choice for place of birth at home also includes an increasing number of requests for birth outside of guidance and accompanying personalised plans of care to this effect
- Enhanced MCOC offer to the most vulnerable families including young parents and asylum seekers
- Building on the challenges experienced within the previous enhanced (CORA) model, this is no longer confined within a specific team and is spread across the community.
- A small team providing enhanced MCoC to asylum seekers & Young parents specifically, also provide intrapartum support according to availability. The team plan their roster around the needs of their woman and families including on call for birth to increase the potential for MCOC throughout the pregnancy and postnatal period.

Midwifery Continuity of Carer (MCoC)

- The enhanced team currently consists of 3 WTE CMWS and a band 4 as support for early help & intervention and attendance at birth. There are plans to build the assistant practitioner capacity to support MCoC and the team

- Data is being collated to illustrate the positive affect this has begun to have on MCoC and moreover birth experience for both groups.

Local data

	July	August	September
Total Bookings	273	301	263
% Women in receipt of full MCOC	6%	1%	4%
Homebirths With MW in attendance With no MW in attendance	3.43% 2 3	1.71%	0.87%

Vision

- The current transformation towards Family Hubs in Stockport, provides an opportunity for further development of smaller community based MCoC teams. The teams will provide an enhanced offer to those most likely to benefit from coordinated and relational care (MCoC) This is within an integrated early years approach that begins in pregnancy.
- Early adopter sites have been identified in Adswood, Brinnington and Offerton to this effect and plans have begun within community teams to align to the family hubs footprints. This is to enable both increased efficiency and more joined up and integrated care around vulnerable families within the community.
- Additional staffing resource to accommodate associated vulnerability within the team caseloads would enable MCoC including intrapartum care and advocacy, to be utilised as a key enabler to improving outcomes for high-risk families within the family hubs agenda.

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

Stockport NHS Foundation Trust

The aim of the plan is to improve maternity outcomes and experiences for those women and people using maternity and neonatal services in GMEC who face inequality on the basis of their circumstances or protected characteristics, such as ethnicity, faith, belief, sexual orientation and disability.

- In response to national guidance the LMNS and GMEC developed The Maternity Equity & Equality Action Plan 2022-2027, we have commenced the process of benchmarking ourselves against the 5 priorities and inclusive recommendations, the action plan is currently being updated to reflect the changes.

  - Restore NHS services, following COVID pandemic
  - Mitigate against digital exclusion
  - Ensure datasets are complete and timely
  - Accelerate preventative programmes that engage those at greatest risk of poor health outcomes
  - Strengthen leadership

Progress so far

- In June 2022 we produced a Standing Operating Procedure (SOP) titled 'Reducing inequality in Black Asian and minority Ethnic communities during the perinatal period'
- Our service collects data on a monthly basis through the maternity data set system which enables mapping in relation to local deprivation utilising postcodes – to be reported on from October 23
- We have a community team leader taking the lead on equity & equality
- We have a Midwife working specifically and providing enhanced care to with asylum seeker families. The needs of these particularly vulnerable families is inclusive to the cultural & Diversity training for Midwifery which incorporates tackling unconscious bias, cultural sensitivity, and trauma informed care.
- We have recruited 3 International educated midwives, with funding to recruit a further two

Perinatal Mental Health

NHS Stockport NHS Foundation Trust

Service offer

- Perinatal Mental Health Lead Midwife and Lead Obstetric Consultant supported by B6 midwife and B4 Midwifery Assistant. The perinatal service is aligned to infant parent service within Stockport family.
- Stockport NHS Foundation trust have adopted the GMEC Perinatal Mental Health Guideline
- A screening tool comprising of a series of questions known as PHQ4 (Patient health questionnaire) is a universal offer within the booking procedure to identify current maternal depression & anxiety.
- Partners of women booked with poor mental health are signposted to Dad Matters or Stockport Talking therapies for additional psychological support.
- Families are prioritised within Stockport talking therapies for psychological support in the perinatal period
- Stockport fall within cluster 1 of the development of the specialist Community MH services which ensures complex need is managed appropriate
- Women have personalised plans
- The perinatal mental health team were recently recognised with a chief-nurse award for their 'Walk into wellbeing' initiative
- As a result of recent PN survey for dads there are plans in place to develop collaborative initiatives with dad matters that support the MH of partners, attachment relationships and bonding. This is part of the 1001 critical days initiative and will be focused on the most vulnerable families in the family Hubs early adopter areas

Collaborative working

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

Ockenden/East Kent Reports/Three year delivery plan

NHS Stockport NHS Foundation Trust

Ockenden Interim report (2020)

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

Regional Insights assurance visit (May 2022)

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

Final Ockenden report (2022)

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

East Kent Report (2022)

- 4 Key areas for action

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

Three-year delivery plan (March 2023)

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

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

North West Regional Maternity Strategy 2023-25

Stockport NHS Foundation Trust

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

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

Aim

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

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

Pregnancy Loss Review

NHS Stockport NHS Foundation Trust

Aim

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

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

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

Recommendations

The review has published 73 recommendations , which cover:

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

Pregnancy Loss Review

NHS Stockport NHS Foundation Trust

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

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

Future Plan

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

Gynaecology matron attended the Association of Early Pregnancy Units (APEU) conference with a focus on the Pregnancy loss review, following the outcome of the conference the division have commenced a review with an associated action plan.

Maternity Update – Maternity Red Flags

NHS Stockport NHS Foundation Trust

Maternity Red Flags

Maternity red flag events are events that are immediate signs that something may require action to stop the situation getting worse. Action includes escalation to the senior midwife in charge of the service, and the response may include allocating additional staff to the ward or unit.

Maternity red flags are monitored by the Maternity manager of the day and the shift coordinators out of hours. Red flags are triggered by insufficient staffing levels resulting in the following:

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

Maternity Update – Maternity Red Flags

NHS Stockport NHS Foundation Trust

During October 2023 there were 12 maternity red flags reported via Datix

Datix 107408 – Reduced staffing across the unit resulting in delay in care.

Datix 106408– Delay in midwives receiving breaks to staffing.

Datix 106917 –Unable to provide 1:1 care in labour.

Datix 107191 – Delay in care for induction of labour.

Datix 107357 – Delay in care for induction of labour

Datix 107399 - Delay in midwives receiving breaks to staffing

Datix 107404 – Delay in care for Induction of labour

Datix 107418 - Delay in care for Induction of labour

Datix 107585 – Delay in care and midwife unable to take break

Datix 107654 - Delay in care for Induction of labour

Datix 107807 – Midwives' unable to take break

Datix 108438 - Delay in care for Induction of labour

Maternity StARS overview

Stockport Accreditation & Recognition System (StARS) is designed to measure the quality of care provided by individuals and teams throughout the Trust. It incorporates key clinical indicators and supports the standards in providing evidence for the Care Quality Commission's Fundamental Standards.

The framework considers 14 standards with each standard subdivided into the following 3 categories Environment, Care and Leadership.

Maternity inpatient areas have been included in the accreditation programme from November 2022 following the development of maternity specific standards. the results are highlighted below.
The number signifies the first, second and third assessment overall result;

MATERNITY	Nov 22	Jan/Feb 23	May/June 23	August/Sept 23
M1 (DS)		1	2	3
M2	1	2	3	4
M3 (BC)		1	2	3

Actions

- Action plans are in place for each area, overseen by the Divisional Director of Midwifery and the Deputy Head of Midwifery.
- Weekly divisional oversight meeting in place to review action plans, share progress and support each other.
- Action plans shared and discussed at directorate and divisional meetings.

Greater Manchester and Eastern Cheshire Strategic Clinical Network
Maternity Quality Surveillance

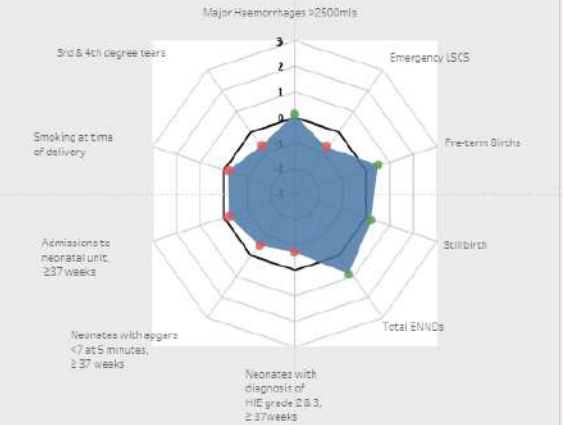
NHS Stockport NHS Foundation Trust

Maternity Quality Surveillance | Updated: 22/08/23 | Provider Choice: Stockport

Lastest 12 months | Jul, 2022 to Jun, 2023

Stillbirth (per 1,000): 3.119
Early Neonatal Deaths (per 1,000): 0.313
HIE (per 1,000): 1.038
Maternal Deaths (per 1,000): 0.000

Further Maternity data available here



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	GM Avg	
Stillbirths		3.119
Total ENNDs		0.313
Maternal Deaths		0.000
Neonates with a diagnosis of HIE Grade 2 and ...		1.04
Apgars <7 at 5 minutes, ≥ 37 weeks		14.54
Major haemorrhages >2500mls		4.10
3rd & 4th degree tears		3.03
Admissions to neonatal unit, ≥37 weeks		5.12
Emergency LSCS		25.86
Pre-Term Births		9.58
Women smoking at time of delivery		7.83

Greater Manchester Integrated Care Partnership

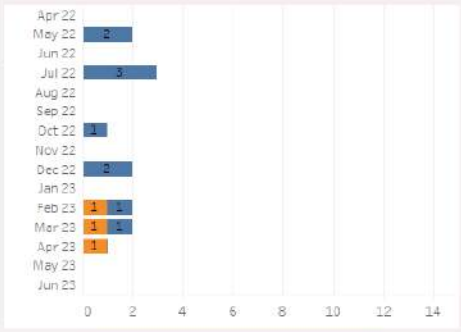
% Compliant:

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

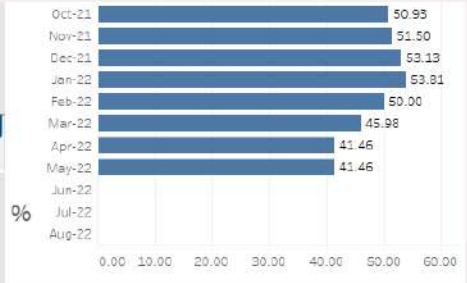
NHS Improvement

STEIS and Diverts
Total number of diverts
Total number of STEIS excluding diverts
Total: 10 / 3

No. of StEIS/Divert INCIDENTS:



CONTINUITY OF CARER



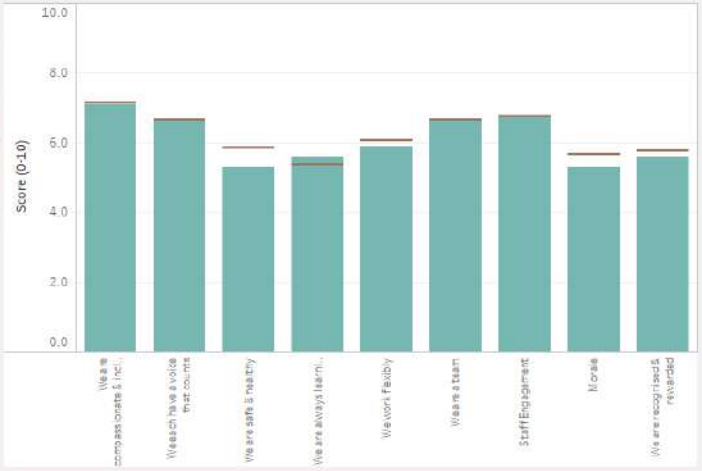
Care Quality Commission: Requires Improvement

NHS Resolution
CNST MIS Status
10

SURVEYS

Breakdown | Your Org

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



	We are compassionate & inclu..	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	We are recognised & rewarded
Breakdown	7.1	6.7	5.3	5.6	5.9	6.7	6.8	5.3	5.6
Your Org	7.2	6.7	5.9	5.4	6.1	6.7	6.8	5.7	5.6
Responses	726	722	727	707	723	727	726	726	724

GMC National Training Survey (2022) Overall Satisfaction (published March 2023): 69%

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

GMEC CQC Maternity Survey

The Start of Your Care During Pregnancy	Antenatal Check-Ups	During Your Pregnancy	Your Labour and Birth	Staff Caring for You	Care in Hospital After Birth	Feeding Your Baby	Care at Home After Birth	Overall average
5.46	8.66	8.61	7.43	8.08	7.89	8.19	8.[illegible]	[illegible]

Meeting date	28th November 2023	**Public**	√	**Confidential**	
Meeting	Quality Committee				
Report Title	Perinatal Mortality Review Tool (PMRT) July-September 2023 (Q2)				
Director Lead	Zoe Turner Director of Women and Children Division	**Author**	Amanda Lightbown Lead Bereavement Specialist Midwife Nicola Kempson Bereavement Specialist Midwife		

Paper For:	**Information**		**Assurance**	X	**Decision**	
Recommendation:	Quality Committee is asked to receive the quarterly Perinatal Mortality Review Tool (audit) as assurance that the Trust are meeting the standards set out in safety action 1 of the Maternity Incentive Scheme Year Five, and provide confirmation of progress to the Board.					

This paper relates to the following Annual Corporate Objectives

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

The paper relates to the following CQC domains

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

This paper relates to the following Board Assurance Framework risks

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

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

Where issues are addressed in the paper

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

Executive Summary

Due to the recommendation that all supported reviews are completed within six months of reporting, the Perinatal Mortality Review Tool report which is generated by MBRRACE will report that no reviews have been completed within the quarter this report relates to

During this quarter we have reported 5 cases to MBRRACE.

1. 08.07.23 - Late fetal loss diagnosed at 23+4 weeks gestation (24+0 weeks gestation at delivery).

2. 20.07.23 - Early NND (day 2), 37+3 weeks gestation at delivery.

3. 29.07.23 - Termination of pregnancy for fetal abnormalities at 24+3 weeks gestation.

4. 20.08.23 - Termination of pregnancy for fetal abnormalities at 23+5 weeks gestation.

5. 22.09.23 - Stillbirth (antepartum) at 29+1 weeks gestation.

The notifications were completed within the requirement of 7 working days.

Surveillance and PMRT review is not supported for 2 cases following notification of termination of pregnancy.

Surveillance completed for 3 cases within the requirement of 1 month.

PMRT review started with parent perspectives & factual questions for the 3 cases within the requirement of 2 months.

1. Purpose

This paper provides evidence that the division are monitoring standards against safety action 1 of the Maternity Incentive Scheme Year Five.

The paper provides assurance to the Trust Board that all reportable fetal losses are notified to MBRRACE and reviewed by a multi-disciplinary team using the national standardised Perinatal Mortality Review Tool (PMRT)

2. Introduction / Background

Safety action 1 of the Maternity Incentive Scheme – year five asks:
Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

Required standard

a) All eligible perinatal deaths from should be notified to MBRRACE-UK within seven working days. For deaths from 30 May 2023, MBRRACE-UK surveillance information should be completed within one calendar month of the death.
b) For 95% of all the deaths of babies in your Trust eligible for PMRT review, parents should have their perspectives of care and any questions they have sought from 30 May 2023 onwards.
c) For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from 30 May 2023. 95% of reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed to the draft report stage within four months of the death and published within six months.
d) Quarterly reports should be submitted to the Trust Executive Board from 30 May 2023.

3. Matter under consideration

In view of the timing of the MBRRACE reports, each Trust quarterly report will include the report from the previous quarter for information. The following reports provide a summary and are generated directly from the PMRT data base following the mortality review.

PMRT - Perinatal Mortality Reviews Summary Report

This report has been generated following mortality reviews which were carried out using the national Perinatal Mortality Review Tool

Stockport NHS Foundation Trust

Report of perinatal mortality reviews completed for deaths which occurred in the period:

1/7/2023 to 30/9/2023

There are no published reviews for Stockport NHS Foundation Trust in the period from 1/7/2023 to 30/9/2023

During this quarter 5 cases have been reported to MBRRACE.

1. 08.07.23 - Late fetal loss diagnosed at 23+4 weeks gestation (24+0 weeks gestation at delivery).
2. 20.07.23 - Early NND (day 2), 37+3 weeks gestation at delivery.
3. 29.07.23 - Termination of pregnancy for fetal abnormalities at 24+3 weeks gestation.
4. 20.08.23 - Termination of pregnancy for fetal abnormalities at 23+5 weeks gestation.
5. 22.09.23 - Stillbirth (antepartum) at 29+1 weeks gestation.

All notifications were completed within the requirement of 7 working days.

Surveillance and PMRT review is not supported for 2 cases following notification of termination of pregnancy.

Surveillance completed for 3 cases within the requirement of 1 month.

PMRT review started with parent perspectives & factual questions for the 3 cases within the requirement of 2 months.

The late fetal loss case at 23+4 weeks has a PMRT MDT meeting planned for 31.10.23.

The early NND case (day2/37+3 weeks at delivery) has been reported to MNSI (HSIB). MNSI report awaited. PMRT due to be completed by 20.11.23, provisional date for review 8.11.23, plan to invite MNSI as external reviewers.

The antepartum stillbirth case at 29+1 weeks is due for review by 22.01.24.

This is in comparison to 2 cases reported in the same quarter in 2022, 1 case of antepartum stillbirth at 36+5 weeks gestation, 1 case of termination of pregnancy for fetal abnormalities at 27+0 weeks gestation.

The Princess Royal Hospital, The Shrewsbury and Telford Hospital NHS Trust reported one case to MBRRACE where the mother booked at Stockport NHS FT. Late NND on 19.08.23 of baby born at 40+4 weeks gestation via spontaneous vaginal delivery on 29.07.23. The booking, antenatal, intrapartum and postnatal information has been completed by the Stockport NHS FT bereavement midwives and obstetric consultant as required and returned to the reporting hospital. Notification of a date for a joint MDT PMRT meeting is awaited to review and grade the care.

To conclude of the cases reported during quarter 2 there are three reviews which require an MDT PMRT review. Two cases are not supported for a review in view of them not meeting the criteria as they are terminations of pregnancy. There is one late neonatal death review which Stockport NHS Foundation Trust are responsible for reviewing jointly with The Princess Royal, The Shrewsbury and Telford Hospital NHS Trust as the mother had antenatal, intrapartum and postnatal care at Stockport NHS FT.

In view of the timing of the MBRRACE reports, each Trust quarterly report will include the report from the previous quarter for information

PMRT - Perinatal Mortality Reviews Summary Report

This report has been generated following mortality reviews which were carried out using the national Perinatal Mortality Review Tool

Stockport NHS Foundation Trust

Report of perinatal mortality reviews completed for deaths which occurred in the period:

1/4/2023 to 30/6/2023

There are no published reviews for Stockport NHS Foundation Trust in the period from 1/4/2023 to 30/6/2023

For this quarter the 3 reported cases were not supported for review as they did not meet the criteria.

In summary during quarter 1 2023/2024 there were 3 deaths reported to MBRRACE. This is in comparison to 8 cases (4 termination of pregnancy, 1 NND, 3 antepartum stillbirth) reported in the same quarter the previous year. For this quarter the 3 cases were not supported for review due to being termination of pregnancies at 23+0, 24+3 & 23+3 weeks gestation.

A joint PMRT was undertaken with Royal Oldham Hospital (ROH) as planned on 06.07.23 for the case of a NND on 05.04.23 of baby born at 24+4 weeks gestation on 23.03.23 at ROH. Primigravida booked for low risk care, referred to FMU Manchester following 20 week anatomy scan following identification of enlarged cystic kidney, enlarged heart and atypical shaped head. Attended Stockport NHS FT triage at 22+5 wks gestation with rupture of membranes, admitted to delivery suite and transferred to ROH. Stable and discharged from ROH at 24+1 with a plan to deliver at MFT with care at ROH until 28weeks. 24+4 attended triage with pain and spotting, in labour and proceeded to delivery.

Cause of death -

1a. Multi Organ Failure

1b. Extreme Prematurity Left multicystic dysplastic kidney, right cystic kidney, pulmonary hypoplasia

2. Preterm prelabour rupture of membranes

PM declined. Placental histology: Acute Chorioamniontis with maternal inflammatory response of Stage 3 grade 2. Features of maternal vascular under perfusion.

Grading of care of the mother and baby up to the point of birth of the baby:

B - The review group identified care issues which they considered would have made no difference to the outcome for the baby.

Grading of care of the baby from birth up to the death of the baby:

B - The review group identified care issues which they considered would have made no difference to the outcome for the baby.

Grading of care of the mother following the death of her baby:

A - The review group concluded that there were no issues with care identified for the mother following the death of her baby.

Additional comment in the narrative regarding grading of care

Care of the mother and baby up to the point of the birth of the baby: Stepping Hill Grade A. ROH Grade B.

No issues and actions identified for Stockport NHS FT.

4. Recommendations

4.1 Quality Committee is asked to note the contents of the report and the trusts progress against Safety action 1of the Maternity Incentive Scheme Year Five.

Meeting date	28th November 2023	**Public**	X	**Confidential**	
Meeting	Quality Committee				
Report Title	Quarterly Report of Transitional Care pathway and Avoidable term admissions to Neonatal Unit (ATAIN) 1st July to 30th September 2023 (Q1 2023/24)				
Director Lead	Zoe Turner Divisional Director Women and Children's	**Author**	Sharon Hyde Divisional Director of Midwifery and Nursing		

Paper For:	**Information**		**Assurance**	X	**Decision**	
Recommendation:	Quality Committee is asked to receive the quarterly Report of Transitional Care pathway and Avoidable term admissions to Neonatal Unit 1st July – 30th September 2023 (Q2 2023/24) as required in Safety Action 3, Year 5 Maternity Incentive Scheme The Quality Committee is asked to note the outcome and actions from the audit to support continued improvement.					

This paper relates to the following Annual Corporate Objectives

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

The paper relates to the following CQC domains

X	Safe		Effective
	Caring		Responsive
	Well-Led		Use of Resources

This paper relates to the following Board Assurance Framework risks

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

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

Where issues are addressed in the paper

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

Executive Summary

This paper provides a quarterly update to Quality Committee, as required by Maternity Incentive Scheme (MIS) Year 5 to comply with Safety Action 3 (sections b, e, f and g),

ATAIN (Avoiding Term Admissions into Neonatal units) is an NHS England Quality Improvement programme to reduce the admissions of full-term babies to neonatal care.

Transitional Care (TC) services support care of babies within the maternity setting to reduce avoidable admissions to neonatal services and minimise separation of mothers and their babies.

It is a requirement for services to undertake robust reviews and learn lessons to reduce the number of mothers and babies who are separated after birth.

1. Purpose

1.1 This paper provides a quarterly update to Quality Committee, as required by Maternity Incentive Scheme (MIS) Year 5 to comply with Safety Action 3 (sections b, e, f and g), and is submitted to Maternity and Women's Risk and Governance meeting, Women and Children's Quality Group meeting and Maternity and Perinatal Safety Champions Meeting

2. Background

2.1. ATAIN (Avoiding Term Admissions into Neonatal units) is an NHS England Quality Improvement programme to reduce admission of full-term babies to neonatal care.

2.2. Transitional Care (TC) services support care of vulnerable babies within the maternity setting to reduce avoidable admissions to neonatal services and minimise separation of mothers and their babies.

2.3. Stockport NHS Foundation Trust provides transitional care activity in accordance with the British Association of Perinatal Medicine (BAPM) principles, to meet the standard set by NHS Resolution Maternity Incentive Scheme Year 5.

2.4. Stockport NHS Foundation Trust has a TC guideline which was jointly developed by the Maternity and Neonatal teams and met Safety Action 3 (section a) on MIS Year 4.

3. Matters under consideration

Audits of Transitional Care Provision from 01.07.2023 to 30.09.2023 (Q2)

3.1. As required by Year 5 MIS Safety Action 3, this quarterly review details the number of admissions to the neonatal unit which met current Transitional Care (TC) admissions criteria but were admitted to the neonatal unit.

3.2 There were 25 babies in Quarter 2 that were eligible for TC.

3.3. There were 9 babies who met current TC admission criteria but did not receive TC, due to parental choice and safeguarding reasons. These babies were admitted to the neonatal unit and received special care.

3.4. Out of the 25 eligible babies, 16 babies were admitted from Delivery Suite for Intensive, High Dependency or Special Care. These babies all received Transitional Care, after 'Stepping Down' from Special Care on the Neonatal unit.

4. Recommendations

Transitional Care (Q2)

4.1. Themes identified include:

- Requirement for improved education with regards to TC and the use of the short-term observation pathway
- Improve knowledge of pathways for reducing separation at birth

4.2. The Transitional Care Model is currently being reviewed. The division have successfully appointed 2 Transitional Care Band 6 Leads, who will be overseen by Neonatal Unit Matron. TC Guidelines are also being reviewed, with a plan to re-launch Transitional Care across Maternity and Neonatal Services. Reducing Separation will be primary focus along with staff engagement and education.

4.3. An overall TC action plan, as required by MIS year 5 Safety Action 3 (section c) is provided in Appendix 1.

5. Audits of ATAIN from 01.07.2023 to 30.09.2023 (Q2)

5.1 The ATAIN programme aims to reduce admissions to the Neonatal Unit by identifying and acting upon practice issues promptly to demonstrate improvements in care. Focusing on:

- Respiratory conditions
- Hypoglycaemia
- Jaundice
- Asphyxia (perinatal hypoxia-ischaemia
- Hypothermia

5.2 Documentation audits occur biweekly by ATAIN champions and compliance is monitored on a quarterly basis at Maternity and Women's Risk and Governance meeting, Women and Children's Quality Group meeting and Maternity, Neonatal and Board level safety champions. This meets MIS year 5 Safety Action 3 (sections b and c).

5.3 A bi-weekly multidisciplinary review of unexpected admissions to the neonatal unit occurs which highlights themes, actions, learning and whether the admission could have been avoided.

5.4 In the period 1st July 2023 to the 30th September 2023 (Q2) there were 32 term admissions, 13 of these admissions were considered avoidable following the multidisciplinary review.

5.5 Out of the 32 admissions 20 were from delivery suite and 12 were from the inpatient postnatal ward.

5.5 On review of specific ATAIN metrics, of the 13 avoidable admissions to the Neonatal Unit:

- 7 babies were admitted due to respiratory conditions.
- 2 babies due to hypoglycaemia
- 0 babies due to early onset jaundice
- 0 babies due to perinatal hypoxia-ischaemia
- 0 babies due to hypothermia.
- 4 were due to safeguarding.

5.6 Themes identified:

- Not following short term observation policy on delivery suite and the ward
- Inappropriate transfer to NNU – Required enhanced observations or TC care
- Lack of consideration for the use of terbutaline
- Admissions to the unit for safeguarding requirements and plans

5.7 Any themes that continue to generate specific actions is recorded on the shared action plan in the ATAIN review file and presented at the Maternity and Women's Risk and Governance meeting.

5.8. Further review is then applied at the Women and Children's Quality Group meeting and Maternity and Perinatal Safety Champions Meeting.

6 Action Plan

6.1 An overall ATAIN action plan, as required by MIS year 5 Safety Action 3 (section c) is provided in Appendix 2.

7. Conclusion

7.1. Following approval at Quality Committee, this paper will be submitted for Board Level review and approval.

7.2. Following approval, this paper will be shared with Greater Manchester and Eastern Cheshire Local Maternity and Neonatal System (GMEC LMNS) and onwards to Integrated Care Board (ICB). This meets MIS year 5 Safety Action 3 (section c).

Action Plan – Transitional Care

Organisation:	Stockport NHS Foundation Trust
Lead Officer:	Helen Large Emma Kirk
Position:	Neonatal Ward Manager Paed & Neonatal Governance Lead
Tel:	0161 419 5530
Email:	Helen.large@stockport.nhs.uk Emma.kirk@stockport.nhs.uk
Address:	

Version	Date
V1	*13/10/23*

Status Key	
1	Not complete / no progress reported/ timescales not met by more than 6 months/ no evidence provided
2	Actions partly or mostly achieved / timescales not met by 3- 6 months / some evidence outstanding
3	All actions complete but awaiting evidence / timescales within 3 months
4	All actions completed and good supporting evidence provided

Ref	Standard	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (document or hyperlink)	Current Status 1 2 3 4
1	Review and restructure of TC	1) Review and update Guideline for management of Neonates requiring transitional care. 2) Appointment of Band 6 Transitional Care leads. 3) Changes and updates to guideline to be communicated to all staff.	Carrie Heal & Helen Large Helen Large Helen Large, TC Leads & Neonatal Governance Lead	31/12/23 01/10/23 31/12/23		
2	TC Leads and Education Practitioner to support education on use of short-term observation pathway.	1) Re launch short term observation policy. 2) MDT Staff engagement and education session on use of the guidelines, scenario based learning, case studies sharing findings from reviews, escalation process. 3) Education sessions for midwives – obtaining observations on neonates, obtaining blood sugars on neonates.	Nicola Owen/Zita Gregory	31/12/23		

		4) Learning resources for staff – Information board 5) Link in with DS &PNW team for shared learning.				
3	TC Leads to support mothers and staff on delivery suit and post natal ward to prioritise reduction of separation.	1) TC Leads to be formally introduced to Maternity and Neonatal Teams and role of TC lead to be communicated. 2) TC leads to introduce daily DS & PN ward reviews to establish relationship with staff and parents and identify early case priorities for the reduction of mother and baby separation.	TC Leads	31/12/23		

Action Plan Sign Off

Name: … …… **Date**: ……

Action Plan – ATAIN

Organisation:	Stockport NHS Foundation Trust
Lead Officer:	Attain Review Team
Position:	DS ward manager/ Fetal monitoring Lead/ Obstetric & Paediatric consultant Leads/ NNU ward manager/ Maternity & Neonatal Governance.
Tel:	0161 419 5530
Email:	Stacey.longworth@stockport.nhs.uk Helen.large@stockport.nhs.uk
Address:	

Version	Date
V1	*31/10/2023*

Status Key	
1	Not complete / no progress reported/ timescales not met by more than 6 months/ no evidence provided
2	Actions partly or mostly achieved / timescales not met by 3- 6 months / some evidence outstanding
3	All actions complete but awaiting evidence / timescales within 3 months
4	All actions completed and good supporting evidence provided

Ref	Standard	Key Actions	Lead Officer(s)	Deadline for action	Progress Update Please provide supporting evidence (document or hyperlink)	Current Status 1 2 3 4
1	Short Term Observations	1. Re launch of the STO policy 2. Education with Doctors and midwives. 3. Case review sharing from MDT attain review 4. Interactive learning board. 5. Hot topics.	• Delivery Suite Manager • Inpatient ward Manager • Neonatal Unit Ward Manager • Fetal Monitoring lead	18/12/2023		
2	Use of terbutaline	1. Information around use of Terbutaline – • As an in utero resuscitation for the baby • Not solely for use in cases of Hyper stimulation 2. Audit the use of Terbutaline to ascertain the no of cases it is being used where contractions are hyperstimulated and if this is due to Induction process or use of IV Oxytocin	• Fetal Monitoring lead • Delivery Suite Manager • Fetal Monitoring lead	23/12/2023 4/1/2024 23/12/2023		

		3. Sharing cases with the team 4. Add to learning interactive board. 5. Education around terms (hyperstimulation / tachysystole) and use of terbutaline	• Delivery Suite Manager • Fetal Monitoring lead	23/12/2023 23/12/2023		
3	Safeguarding	1. Sharing of admissions for Safeguarding indications 2. Include Safeguarding team.	• Delivery Suite Manager • Inpatient ward Manager • Safeguarding Midwife	06/12/2023	Already learnt from previous quarter. New case this quarter. Full MDT including social services. Baby admitted with foster parents to ward. Discharges within 12 hours. Successful admission	

McCarthy Rebecca
06/12/2023 11:30:52

Action Plan Sign Off

Name: … …… **Date**: ……

Meeting date	28th November 2023	**Public**	√	**Confidential**	
Meeting	Quality Committee				
Report Title	Local Maternity and Neonatal System (LMNS) Safety Assurance Return.				
Director Lead	Zoe Turner Divisional Director Women and Children's	**Author**	Sharon Hyde Divisional Director of Midwifery and Nursing		

Paper For:	**Information**	**X**	**Assurance**	**X**	**Decision**	
Recommendation:	Quality Committee are asked to receive the quarterly safety assurance return as is required to be submitted to the LMNS, and confirm progress with Ockenden, East Kent and the single plan recommendations.					

This paper relates to the following Annual Corporate Objectives

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

The paper relates to the following CQC domains

	Safe		Effective
	Caring		Responsive
	Well-Led		Use of Resources

This paper relates to the following Board Assurance Framework risks

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

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

Where issues are addressed in the paper

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

Executive Summary

The Trust is required to update the LMNS on progress with Ockenden, East Kent and the single plan recommendations.

The LMNS has a responsibility to improve oversight and safety assurance across Maternity Services in in Greater Manchester and East Cheshire (GMEC), as recommended by the National Quality Board on Systems Group and the revised Perinatal Quality Surveillance Model, to ensure that safer outcomes for pregnant women/Birthing people and babies are achieved.

The system has introduced a quarterly Safety Progress and Performance Special Interest Group (SPP SIG) to demonstrate that these principles are implemented into the LMNS governance structure.

Annex A Is the Ockenden - Kirkup return 2023 demonstrating the Trusts level of implementation to date.

1. Purpose

1.1 The purpose of this paper is to give an overview of the requirements of the LMNS from the Trust in providing assurance against the progress of Ockenden, East Kent and the proposed single plan.

2. Background

2.1 The Local Maternity and Neonatal System (LMNS) has a responsibility to improve oversight and safety assurance across Maternity Services in Greater Manchester and East Cheshire (GMEC), as recommended by the National Quality Board on Systems Group and the revised Perinatal Quality Surveillance Model, to ensure that safer outcomes for pregnant women/Birthing people and babies are achieved.

2.2 The LMNS as a result has developed a Safety Progress and Performance Special Interest Group (SPP) where Trusts are required to provide a quarterly update on progress against recommendations and actions from the national reports.

2.3 This paper links with the information provided in the quarterly maternity services update report to Quality Committee, which includes progress and actions in relation to the national reports.

3. Matters under consideration.

3.1 This is the 4th data return where the trust will share progress with the LMNS against the Ockenden and Kirkup recommendations and immediate and essential actions.

3.2 The trust has declared full compliance against the recommendations in the Kirkup report, apart from full compliance against questions 28;

- Ensure that staff undertaking incident investigations have received appropriate education and training to undertake this effectively
    - All consultants to have completed RCA training.
    - Develop a local record of staff who have completed RCA training and the investigations undertaken (including dates)

- The trust had previously declared full compliance with this question. It has been acknowledged that as Trusts are moving towards the Patient Safety Incidence Response Framework (PSIRF) for responding to patient safety incidents, this question is no longer relevant. Consultants will complete PSIRF training and a local record of staff who have completed PSIRF training will be developed to monitor compliance.

3.3 The trust has declared full compliance against 48 of the 49 questions relating to the 7 immediate and essential actions from the initial Ockenden report (Appendix A has the full breakdown of all questions).

The remaining 1 question is currently not compliant. A summary of this question with associated actions is outlined in the table below

IEA	Question	Evidence Required	RAG Rating	Action/Info
WF	Q48	More Consultant midwives		There are currently no plans for a consultant midwife

Completion Guidance:		
Please complete each tab demonstrating your level of implementation at the time of reporting		
Tab:		
1	**Submission Overiew**	Please complete in full
2	**Ockenden return**	This mirrors earlier returns and requires updating on progress up to the date of competion - Please report on your percentage of compliance. It will RAG rate automatically.
3	**Kirkup return**	Please note some recommendations have been greyed out – these do not require completion as they are superseded by information in the Ockenden recommendations.
4	**Kirkup recommendations**	Details the Kirkup recommendations as a helpful reminder – this doesn't require any completion.

Internal trust governance

	Confirmation of / or planned Public Trust Board update on progress against the Ockenden action plan	Date of Public Board update	Executive sign off of this return		
	Yes/No	please insert date	**Date**	**Name**	**Role**
Stockport NHS FT	Y	06/04/2023	02/03/2023	Nicola Firth	Chief Nurse
Stockport NHS FT	Y	06/06/2023	22/05/2023	Nicola Firth	Chief Nurse
Stockport NHS FT	Y	03/08/2023	11/07/2923	Nicola Firth	Chief Nurse
Stockport NHS ft	Y		11/10/2023	Nicola Firth	Chief Nurse

Submission dates	**Meeting Dates**
11-Oct-23	18-Oct-23
10-Jan-23	17-Jan-23
10-Apr-24	17-Apr-24
10-Jul-24	17-Jul-24
09-Oct-24	16-Oct-24

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	Initial Self Report with % of compliance Report to LMNS by 11th October 2023	Details of action to be taken if partially or not compliant
IEA1 Enhanced Safety	Q1	Are maternity dashboards a formal item on LMNS agendas at least every 3 months?	Dashboard to be shared as evidence.	100%	100%		100%		100%		100%		100%	
			Minutes and agendas to identify regular review and use of common data dashboards and the response / actions taken.	100%	100%		100%		100%		100%		100%	
			SOP required which demonstrates how the trust reports this both internally and externally through the LMS.	100%	100%		100%		100%		100%		100%	
			Submission of minutes and organogram, that shows how this takes place.	100%	100%		100%		100%		100%		100%	
		Maternity Dashboard to LMS every 3 months Total		**100%**	**100%**		100%		100%		100%		100%	
	Q2	External clinical specialist opinion for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death	Audit to demonstrate this takes place.	0%	100%		100%		100%		100%		100%	
			Policy or SOP which is in place for involving external clinical specialists in reviews.	100%	100%		100%		100%		100%		100%	
		External clinical specialist opinion for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death Total		**50%**	**100%**		100%		100%		100%		100%	
	Q3	Maternity SI's to Trust Board & LMS every 3 months	Individual SI's, overall summary of case, key learning, recommendations made, and actions taken to address with clear timescales for completion	100%	100%		100%		100%		100%		100%	
			Submission of private trust board minutes as a minimum every three months with highlighted areas where SI's discussed	100%	100%		100%		100%		100%		100%	
			Submit SOP	0%	100%		100%		100%		100%		100%	
		Maternity SI's to Trust Board & LMS every 3 months Total		**67%**	**100%**		100%		100%		100%		100%	
	Q4	Using the National Perinatal Mortality Review Tool to review perinatal deaths	Audit of 100% of PMRT completed demonstrating meeting the required standard including parents notified as a minimum and	100%	100%		60%		100%		100%		100%	
			Local PMRT report. PMRT trust board report. Submission of a SOP that describes how parents and women are involved in the PMRT process as per the PMRT guidance.	100%	100%		100%		100%		100%		100%	
		Using the National Perinatal Mortality Review Tool to review perinatal deaths Total		**100%**	**100%**		60%		100%		100%		100%	
	Q5	Submitting data to the Maternity Services Dataset to the required standard	Evidence of a plan for implementing the full MSDS requirements with clear timescales aligned to NHSR requirements within MIS.	100%	100%		100%		100%		100%		100%	
		Submitting data to the Maternity Services Dataset to the required standard Total		**100%**	**100%**		100%		100%		100%		100%	
	Q6	Reported 100% of qualifying cases to HSIB / NHS Resolution's Early Notification scheme	Audit showing compliance of 100% reporting to both HSIB and NHSR Early Notification Scheme.	100%	100%		100%		100%		100%		100%	
		Reported 100% of qualifying cases to HSIB / NHS Resolution's Early Notification scheme Total		**100%**	**100%**		100%		100%		100%		100%	
	Q7	Plan to implement the Perinatal Clinical Quality Surveillance Model	Full evidence of full implementation of the perinatal surveillance framework by June 2021.	100%	100%		100%		100%		100%		100%	
			LMS SOP and minutes that describe how this is embedded in the ICS governance structure and signed off by the ICS.	100%	100%		100%		100%		100%		100%	
			Submit SOP and minutes and organogram of organisation's involved that will support the above from the trust, signed of via the trust governance structure.	0%	100%		100%		100%		100%		100%	
		Plan to implement the Perinatal Clinical Quality Surveillance Model Total		**67%**	**100%**		100%		100%		100%		100%	
	Q8	**Same as Q3**												
IEA1 Total				**81%**										
	Q9	N/A												
	Q10	N/A												
	Q11	Non-executive director who has oversight of maternity services, (Is there an allocated Non-Executive at Board level who works collaboratively with the maternity safety champions?)	Evidence of how all voices are represented:	100%	100%		100%		100%		100%		100%	
			Evidence of link in to MVP; any other mechanisms	100%	100%		100%		100%		100%		100%	
			Evidence of NED sitting at trust board meetings, minutes of trust board where NED has contributed	100%	100%		100%		100%		100%		100%	
			Evidence of ward to board and board to ward activities e.g. NED walk arounds and subsequent actions	100%	100%		100%		100%		100%		100%	
			Name of NED and date of appointment	100%	100%		100%		100%		100%		100%	
			NED JD	100%	100%		100%		100%		100%		100%	
		Non-executive director who has oversight of maternity services Total		**100%**	100%		100%		100%		100%		100%	
	Q12	**Same as Q4**												
	Q13	Demonstrate mechanism for gathering service user feedback, and work with service users through Maternity Voices Partnership to coproduce local maternity services	Clear co-produced plan, with MVP's that demonstrate that co production and co-design of service improvements, changes and developments will be in place and will be embedded by December 2021.	100%	100%		100%		100%		100%		100%	
			Evidence of service user feedback being used to support improvement in maternity services (E.G you said, we did, FFT, 15 Steps)	100%	100%		100%		100%		100%		100%	

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IEA2 Listening to Women and Families	Q13		Please upload your CNST evidence of co-production. If utilised then upload completed templates for providers to successfully achieve maternity safety action 7. CNST templates to be signed off by the MVP.	100%	100%		100%		100%		100%		100%	
		Demonstrate mechanism for gathering service user feedback, and work with service users through Maternity Voices Partnership to coproduce local maternity services Total		**100%**	100%		100%		100%		100%		100%	
	Q14	Trust safety champions (Midwifery and Obstetrician) meeting bimonthly with Board level champions	Action log and actions taken.	100%	100%		100%		100%		100%		100%	
			Log of attendees and core membership.	100%	100%		100%		100%		100%		100%	
			Minutes of the meeting and minutes of the LMS meeting where this is discussed.	100%	100%		100%		100%		100%		100%	
			SOP that includes role descriptors for all key members who attend by-monthly safety meetings.	0%	100%		100%		100%		100%		100%	
		Trust safety champions meeting bimonthly with Board level champions Total		**75%**	**100%**		100%		100%		100%		100%	
	Q15	Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services.	Clear co produced plan, with MVP's that demonstrate that co-production and co-design of all service improvements, changes and developments will be in place and will be embedded by December 2021.	100%	100%		100%		100%		100%		100%	
		Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services. Total		**100%**	**100%**		100%		100%		100%		100%	
	Q16	Non-executive director support the Board maternity safety champion	Evidence of participation and collaboration between ED, NED and Maternity Safety Champion, e.g. evidence of raising issues at trust board, minutes of trust board and evidence of actions taken	0%	100%		100%		100%		100%		100%	
			Name of ED and date of appointment	100%	100%		100%		100%		100%		100%	
			Role descriptors	100%	100%		100%		100%		100%		100%	
		Non-executive director support the Board maternity safety champion Total		**67%**	**100%**		100%		100%		100%		100%	
IEA2 Total				**88%**	**100%**									
IEA3 Staff Training and working together	Q17	Multidisciplinary training and working occurs. Evidence must be externally validated through the LMNS, 3 times a year via TNA Template.	A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	100%	100%		100%		100%		100%		100%	
			LMNS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data.	0%	50%		100%		100%		100%		100%	
			Submit evidence of training sessions being attended, with clear evidence that all MDT members are represented for each session.	100%	100%		100%		100%		100%		100%	
			Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements.	100%	100%		100%		100%		100%		100%	
			Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place.	100%	100%		100%		100%		100%		100%	
		Multidisciplinary training and working occurs. Evidence must be externally validated through the LMS, 3 times a year. Total		**80%**	**100%**		100%		100%		100%		100%	
	Q18	Twice daily consultant-led and present multidisciplinary ward rounds on the labour ward.	Evidence of scheduled MDT ward rounds taking place since December, twice a day, day & night, 7 days a week (e.g. audit of compliance with SOP)	100%	75%		75%		100%		100%		100%	
			SOP created for consultant led ward rounds.	0%	100%		100%		100%		100%		100%	
		Twice daily consultant-led and present multidisciplinary ward rounds on the labour ward. Total		**50%**	**75%**		75%		100%		100%		100%	
	Q19	External funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only	Confirmation from Directors of Finance	0%	100%		100%		100%		100%		100%	
			Evidence from Budget statements.	100%	100%		100%		100%		100%		100%	
			Evidence of funding received and spent.	100%	100%		100%		100%		100%		100%	
			Evidence that additional external funding has been spent on funding including staff can attend training in work time.	100%	100%		100%		100%		100%		100%	
			MTP spend reports to LMS	0%	100%		100%		100%		100%		100%	
		External funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only Total		**60%**	**100%**		100%		100%		100%		100%	
	Q20	N/A												
	Q21	90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session	A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	100%	100%		100%		100%		100%		100%	
			Attendance records - summarised	100%	100%		100%		100%		100%		100%	
			LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data. Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place.	0%	50%		100%		100%		100%		100%	
		90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session Total		**67%**	**100%**		100%		100%		100%		100%	

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	Q22	Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.	Evidence of scheduled MDT ward rounds taking place since December 2020 twice a day, day & night; 7 days a week (E.G audit of compliance with SOP)	100%	75%		75%		100%		100%		100%	
		Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week. Total		**100%**	**75%**		75%		100%		100%		100%	
	Q23	Is MDT schedule for training in place?	A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	100%	100%		100%		100%		100%		100%	
			LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation described as checking the accuracy of the data.	0%	50%		100%		100%		100%		100%	
		The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place Total		**50%**	**100%**		100%		100%		100%		100%	
IEA3 Total				**67%**					100%		100%		100%	
	Q24	Links with the tertiary level Maternal Medicine Centre & agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre	Audit that demonstrates referral against criteria has been implemented that there is a named consultant lead, and early specialist involvement and that a Management plan that has been agreed between the women and clinicians	0%	100%		100%		100%		100%		100%	
			SOP that clearly demonstrates the current maternal medicine pathways that includes: agreed criteria for referral to the maternal medicine centre pathway.	100%	100%		100%		100%		100%		100%	
		Links with the tertiary level Maternal Medicine Centre & agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre Total		**50%**	**100%**		100%		100%		100%		100%	
	Q25	Women with complex pregnancies must have a named consultant lead	Audit of 1% of notes, where all women have complex pregnancies to demonstrate the woman has a named consultant lead.	100%	100%		100%		100%		100%		100%	
			SOP that states that both women with complex pregnancies who require referral to maternal medicine networks and women with complex pregnancies but who do not require referral to maternal medicine network must have a named consultant lead.	100%	100%		100%		100%		100%		100%	
		Women with complex pregnancies must have a named consultant lead Total		**100%**	**100%**		100%		100%		100%		100%	
IEA4 Managing Complex Pregnancy	Q26	Complex pregnancies have early specialist involvement and management plans agreed	Audit of 1% of notes, where women have complex pregnancies to ensure women have early specialist involvement and management plans are developed by the clinical team in consultation with the woman.	100%	100%		100%		100%		100%		100%	
			SOP that identifies where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the teams.	100%	100%		100%		100%		100%		100%	
		Complex pregnancies have early specialist involvement and management plans agreed Total		**100%**	**100%**		100%		100%		100%		100%	
	Q27	Compliance with all five elements of the Saving Babies' Lives care bundle Version 2	Audits for each element.	100%	100%		100%		100%		100%		100%	
			Guidelines with evidence for each pathway	100%	100%		100%		100%		100%		100%	
			SOP's	100%	100%		100%		100%		100%		100%	
		Compliance with all five elements of the Saving Babies' Lives care bundle Version 2 Total		**100%**	**100%**		100%		100%		100%		100%	
	Q28	All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.	SOP that states women with complex pregnancies must have a named consultant lead.	100%	100%		100%		100%		100%		100%	
			Submission of an audit plan to regularly audit compliance	100%	100%		50%		50%	Currently undertaking Audits adhoc. Robust audit plan due for completion and implemenation end of May 2023	100%	Audit plan now in place	100%	Audit plan now in place
		All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place. Total		**100%**	**100%**		50%		50%		100%		100%	
	Q29	Do you have agreed maternal medicine specialist centre?	Agreed pathways	100%	100%		100%		100%		100%		100%	
			Criteria for referrals to MMC	100%	100%		100%		100%		100%		100%	
			The maternity services involved in the establishment of maternal medicine networks evidenced by notes of meetings, agendas, action logs.	100%	100%		100%		100%		100%		100%	
		Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres Total		**100%**	**100%**		100%		100%		100%		100%	
IEA4 Total				**93%**	**100%**									
	Q30	All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional	How this is achieved within the organisation.	100%	100%		100%		100%		100%		100%	
			Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above.	100%	100%		50%		50%	Currently undertaking Audits adhoc. Robust audit plan due for completion and implemenation end of May 2023	100%	Audit plan now in place	100%	Audit plan now in place
			Review and discussed and documented intended place of birth at every visit.	100%	100%		100%		100%		100%		100%	
			SOP that includes definition of antenatal risk assessment as per NICE guidance.	0%	100%		100%		100%		100%		100%	
			What is being risk assessed.	0%	100%		100%		100%		100%		100%	

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IEA5 Risk assess throughout pregnancy		**All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional Total**		**60%**	**100%**		75%		80%		100%		100%	
	Q31	Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.	Evidence of referral to birth options clinics	100%	100%		100%		100%		100%		100%	
			Out with guidance pathway.	100%	100%		100%		100%		100%		100%	
			Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above.	100%	100%		50%		50%	Currently undertaking Audits adhoc. Robust audit plan due for completion and implemenation end of May 2023	100%	Audit plan now in place	100%	Audit plan now in place
			SOP that includes review of intended place of birth.	0%	100%		100%		100%		100%		100%	
		Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture. Total		**75%**	**100%**		75%		75%		100%		100%	
	Q32	**Same as Q27**												
	Q33	A risk assessment at every contact. Include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance.	Example submission of a Personalised Care and Support Plan (It is important that we recognise that PCSP will be variable in how they are presented from each trust)	100%	100%		100%		100%		100%		100%	
			How this is achieved in the organisation	100%	100%		100%		100%		100%		100%	
			Personal Care and Support plans are in place and an ongoing audit of 5% of records that demonstrates compliance of the above.	100%	100%		50%		50%	Currently undertaking Audits adhoc. Robust audit plan due for completion and implemenation end of May 2023	100%	Audit plan now in place	100%	Audit plan now in place
			Review and discussed and documented intended place of birth at every visit.	100%	100%		100%		100%		100%		100%	
			SOP to describe risk assessment being undertaken at every contact.	0%	100%		100%		100%		100%		100%	
			What is being risk assessed.	0%	100%		100%		100%		100%		100%	
		A risk assessment at every contact. Include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance. Total		**67%**	**100%**		83%		83%		100%		100%	
IEA5 Total				**67%**	**100%**									
IEA6 Monitoring Fetal Wellbeing	Q34	Appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring	Copies of rotas / off duties to demonstrate they are given dedicated time.	0%	100%		100%		100%		100%		100%	
			Examples of what the leads do with the dedicated time E.G attendance at external fetal wellbeing event, involvement with training, meeting minutes and action logs.	100%	100%		100%		100%		100%		100%	
			Incident investigations and reviews	100%	100%		100%		100%		100%		100%	
			Name of dedicated Lead Midwife and Lead Obstetrician	100%	100%		100%		100%		100%		100%	
		Appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring Total		**75%**	**100%**		100%		100%		100%		100%	
	Q35	The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on elements of fetal health	Consolidating existing knowledge of monitoring fetal wellbeing	100%	100%		100%		100%		100%		100%	
			Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported e.g clinical supervision	0%	100%		100%		100%		100%		100%	
			Improving the practice & raising the profile of fetal wellbeing monitoring	0%	100%		100%		100%		100%		100%	
			Interface with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.	0%	100%		100%		100%		100%		100%	
			Job Description which has in the criteria as a minimum for both roles and confirmation that roles are in post	100%	100%		100%		100%		100%		100%	
			Keeping abreast of developments in the field	0%	100%		100%		100%		100%		100%	
			Lead on the review of cases of adverse outcome involving poor FHR interpretation and practice.	100%	100%		100%		100%		100%		100%	
			Plan and run regular departmental fetal heart rate (FHR) monitoring meetings and training.	0%	100%		100%		100%		100%		100%	
		The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on elements of fetal health Total		**38%**	100%		100%		100%		100%		100%	
	Q36	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	Audits for each element	100%	100%		100%		100%		100%		100%	
			Guidelines with evidence for each pathway	100%	100%		100%		100%		100%		100%	
			SOP's	100%	100%		100%		100%		100%		100%	
		Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2? Total		**100%**	100%		100%		100%		100%		100%	
	Q37	Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MBRRACE three in December 2019?	A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	100%	100%		100%		100%		100%		100%	
			Attendance records - summarised	100%	100%		100%		100%		100%		100%	
			Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements.	100%	100%		100%		100%		100%		100%	

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		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 MNS war three in December 20192 Total		**100%**	100%		100%		100%		100%		100%	
	Q38	**Same as 35**												
IEA6 Total				**67%**	**100%**									
	Q39	Trusts ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery	Information on maternal choice including choice for caesarean delivery.	100%	**100%**		100%		100%		100%		100%	
			Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites.	100%	**100%**		100%		100%		100%		100%	
		Trusts ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery Total		**100%**	**100%**		100%		100%		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 domain	100%	**100%**		100%		100%		100%		100%	
			Demonstration of the information service users can access for evidence based information in all	100%	**100%**		100%		100%		100%		100%	
			MVP review of information	100%	**100%**		100%		100%		100%		100%	
		Do you have Do you have accessible information to enable accurate evidence based information including all care AN, Intrapartum & PN? Total		**100%**	**100%**		100%		100%		100%		100%	
	Q41	Women must be enabled to participate equally in all decision-making processes	An audit of 1% of notes demonstrating compliance.						50%	Currently undertaking Audits adhoc. Robust audit plan due for completion and implemenation end of May 2023	100%	Audit plan now in place	100%	
			CQC survey and associated action plans						100%		100%		100%	
			SOP which shows how women are enabled to participate equally in all decision making processes and to make informed choices about their care. And where that is recorded						25%	SOP in development	50%	SOP continues to be developed	100%	SOP continues to be developed
		Women must be enabled to participate equally in all decision-making processes Total							50%		66%		100%	
	Q42	Women's choices following a shared and informed decision-making process must be respected	An audit of 5% of notes demonstrating compliance, this should include women who have specifically requested a care pathway which may differ from that recommended by the clinician during the antenatal period, and also a selection of women who request a caesarean section during labour or induction.	0%	100%		50%		50%	Currently undertaking Audits adhoc. Robust audit plan due for completion and implemenation end of May 2023	100%	Audit plan now in place	100%	
			SOP to demonstrate how women's choices are respected and how this is evidenced following a shared and informed decision-making process, and where that is recorded.	100%	100%		100%		100%		100%		100%	
		Women's choices following a shared and informed decision-making process must be respected Total		**50%**	**100%**		50%		50%		100%		100%	
	Q43	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?	Clear co produced plan, with MVP's that demonstrate that co production and co-design of all service improvements, changes and developments will be in place and will be embedded by December 2021.	100%	100%		100%		100%		100%		100%	
			Evidence of service user feedback being used to support improvement in maternity services (E.G you said, we did, FFT, 15 Steps)	100%	100%		100%		100%	IOL survry	100%		100%	
			Please upload your CNST evidence of co-production. If utilised then upload completed templates for providers to successfully achieve maternity safety action 7. CNST templates to be signed off by the MVP.	100%	100%		100%		100%		100%		100%	
		Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services? Total		**100%**	**100%**		100%		100%		100%		100%	
	Q44	Pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website.	Co-produced action plan to address gaps identified	100%	100%		100%		100%		100%		100%	
			Gap analysis of website against Chelsea & Westminster conducted by the MVP	100%	100%		100%		100%		100%		100%	
			Information on maternal choice including choice for caesarean delivery.	100%	100%		100%		100%		100%		100%	
			Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites.	100%	100%		100%		100%		100%		100%	
		Pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. Total		**100%**	**100%**		100%		100%		100%		100%	
IEA7 Total				**93%**	**100%**				100%		100%		100%	
	Q45	Demonstrate an effective system of clinical workforce planning to the required standard	Consider evidence of workforce planning at LMS/ICS level given this is the direction of travel of the people plan	100%	100%		100%		100%		100%		100%	
			Evidence of reviews 6 monthly for all staff groups and evidence considered at board level.	100%	100%		100%		100%		100%		100%	
			Most recent BR+ report and board minutes agreeing to fund.	100%	100%		100%		100%		100%		100%	
		Demonstrate an effective system of clinical workforce planning to the required standard Total		**100%**	**100%**		100%		100%		100%		100%	

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	Initial Self Report with % of compliance Report to LMNS by 11th October 2023	Details of action to be taken if partially or not compliant
WF	Q46	Demonstrate an effective system of midwifery workforce planning to the required standard?	Most recent BR+ report and board minutes agreeing to fund.	100%	100%		100%		100%		100%		100%	
		Demonstrate an effective system of midwifery workforce planning to the required standard? Total		**100%**	**100%**		100%		100%		100%		100%	
	Q47	Director/Head of Midwifery is responsible and accountable to an executive director	HoM/DoM Job Description with explicit signposting to responsibility and accountability to an executive director	100%	100%		100%		100%		100%		100%	
		Director/Head of Midwifery is responsible and accountable to an executive director Total		**100%**	**100%**		100%		100%		100%		100%	
	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%		100%		100%		100%	
			Gap analysis completed against the RCM strengthening midwifery leadership: a manifesto for better maternity care	100%	100%		75%		100%		100%		100%	
			1. A Director of Midwifery in every trust and health board, and more Heads of Midwifery across the service						100%	Divisional Director of Midwifery in post with a Deputy Head of Midwifery.	100%		100%	
			2. A lead midwife at a senior level in all parts of the NHS, both nationally and regionally						100%		100%		100%	
			3. More Consultant midwives						0%	Currently no Consultant Midwife	0%	No Consultant midwife plans currently	0%	No Consultant midwife plans currently
			4. Specialist midwives in every trust and health board						100%		100%		100%	
			5. Strengthening and supporting sustainable midwifery leadership in education and research						100%		100%		100%	
			6. A commitment to fund ongoing midwifery leadership development						100%		100%		100%	
			7. Professional input into the appointment of midwife leaders						100%		100%		100%	
		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%		100%		100%		100%	
			Evidence of risk assessment where guidance is not implemented.	0%	100%		100%		100%		100%		100%	
			SOP in place for all guidelines with a demonstrable process for ongoing review.	0%	100%		100%		100%		100%		100%	
		Providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Total		**33%**	**100%**		100%		100%		100%		100%	
WF Total				**80%**	**100%**				92%		92%		92%	

Kirkup report recommendations
Regional Update

Key :

RAG Rate : Green = Complete.
Amber = Partial compiant
Red = Not compliant

Those that are greyed out are superseded by Ockenden and do not need completing on this tab.

Kirkup Action no.	Relating to Kirkup Recommendation (see Kirkup Recommendations tab for further information)	Action	Suggested documents that may support Trust assurance.	GMEC STOCKPORT NHS FOUNDATION TRUST	Report to LMNS by 27th February 2023	Report to LMNS by 19th April 2023	Report to LMNS by 19th July 2023	Report to LMNS by 11 October 2023
6	R2	Obtain feedback from midwives and nurses who have recently completed a preceptorship programme to identify any improvements that can be made to the programme	Utilise PMA feedback	Green	Green	Green	Green	Green
7	R2, R3	Review the skills of Band 6 midwives to identify and address any training needs to ensure a competent and motivated workforce	Develop a robust support package for new band 6 midwives	Green	Green	Green	Green	Green
			Completion of the Mentoring module	Green	Green	Green	Green	Green
			Suturing competency	Green	Green	Green	Green	Green
			IV therapy competency	Green	Green	Green	Green	Green
			Care of women choosing epidural anaesthesia.	Green	Green	Green	Green	Green
8		Review the current induction and orientation process for midwives and nurses joining the organisation at Band 6 to ensure they are competent and confident to provide care	Practice educator reports and feedback	Green	Green	Green	Green	Green
11	R2	Review the provision of maternal AIMS courses and ensure that all places are allocated appropriately and staff attend the session.	Practice educator meeting notes, discussion with DoMS/HoMs	Green	Green	Green	Green	Green
12	R2	Review the educational opportunities available for staff working in postnatal areas to increase their understanding of the compromised neonate, including consideration of bespoke educational sessions and HEI courses e.g. Care of the compromised baby module at University of Salford	Practice educator reports and feedback	Green	Green	Green	Green	Green
13	R2	Improve staff knowledge, response time and escalation processes in relation to a woman's deteriorating condition	Incident review and feedback, related lessons learnt, training opportunities	Green	Green	Green	Green	Green
14	R2	Implement a process for cascading learning points generated from incidents or risk management in each clinical area e.g. email to staff, noticeboard, themed week / message of the week, core huddles, NICU news	Weekly Safety Huddles, Hot Topics, Governance Boards, Monthly Governance updates	Green	Green	Green	Green	Green
17	R3	Review the support provided when staff are allocated to a new clinical area and what supernumerary actually means in order to manage staff expectations		Green	Green	Green	Green	Green
18	R3	Offer opportunities to other heads of service for staff from other trusts to broaden their experience by secondment or supernumerary status						
19	R5	Develop a list of current MDT meetings and events and share with staff across the directorate						
20	R8	Develop and implement a recruitment and retention strategy specifically for the obstetric directorate	Employment of a Recruitment and Retention Midwife	Green	Green	Green	Green	Green
21		Review the current midwifery staffing establishment to ensure appropriate staffing levels in all clinical areas						
22		Ensure that all staff who leave are offered an exit interview with a senior member of staff and use the information gained from these interviews to inform changes aimed at improving retention		Green	Green	Green	Green	Green
23		Provide Staff Forum meetings where staff are encouraged to attend and discuss concerns	Ward Meetings, Professional Midwifery Advocates drop in sessions and clinical supervision	Green	Green	Green	Green	Green
24	Only applicable to multi-site trusts.	Improve working relationships between the different sites located geographically apart but under the same organization.						
25	R9	Reiterate to all staff via email and team meetings the roles and responsibilities of the consultant obstetrician carrying the hot week bleep.						
26	R11, R12	Ensure that staff receive education during their induction regarding the incident reporting process including the process for reporting incidents, the incidents that should be reported and the rationale for learning from incidents.		Green	Green	Green	Green	Green
27	R11, R12	Including a review of the processes for disseminating and learning from incidents						
28		Ensure that staff undertaking incident investigations have received appropriate education and training to undertake this effectively	All consultants to have completed RCA training	Green	Amber	Amber	Amber	Amber
			Identified midwives to have completed RCA training	Green	Green	Green	Green	Green
			Staff who have completed RCA training undertake an investigation within 1 year and regularly thereafter in order to maintain their skills	Green	Green	Green	Green	Green
			Develop a local record of staff who have completed RCA training and the investigations undertaken (including dates)	Green	Amber	Amber	Amber	Amber
29	R12	Ensure that the details regarding staff debriefing and support are completed on the Trust incident reporting system for all level 4 and 5 incidents						
30	R12	Ensure that all Serious Incidents (SI's)are fedback to the staff						
31	R12	Identify ways of improving attendance of midwives at SI's feedback sessions						
32	R13	Maternity Services Liaison Committee involvement in complaints	Collation of complaints reports					
33	R14	Review the current obstetric clinical lead structure						
34	R15	Review past SI's and map common themes	Thematic reviews					
35	R23	Ensure that maternal deaths, late and intrapartum stillbirths and unexpected neonatal deaths are reported, reviewed and an investigation undertaken where appropriate	Maternal deaths, stillbirths and early neonatal deaths reports					
36	R26	Ensure that all staff are aware of how to raise concerns	Whistle blowing staff policy/FTSU guardian	Green	Green	Green	Green	Green
37	R31	Provide evidence of how we deal with complaints		Green	Green	Green	Green	Green
38	R31	Educate staff regarding the process for local resolution and support staff to undertake this process in their clinical area	Identifying situations where local resolution is required	Green	Green	Green	Green	Green
39	R32	Develop a plan to maintain a supervision system beyond the decommissioning of the LSAs once national recommendations have been agreed.	Implementation of the A-AQUIP model					
40	R38	Ensure that all perinatal deaths are recorded appropriately	Sending the completed form to the Deputy Director of Nursing/ Head of Midwifery and the Divisional Clinical Effectiveness Manager					
41	R39	Ensure that Confidential Enquiry reports are reviewed following publication and that an action plan is developed and monitored to ensure that high standards of care are maintained	MBRRACE action plan	Green	Green	Green	Green	Green

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

Meeting date	28th November 2023	Public	√	Confidential	
Meeting	Quality Committee				
Report Title	Maternity Workforce Bi-Annual Staffing Report				
Director Lead	Zoe Turner Divisional Director Women and Children's	**Author**	Sharon Hyde Divisional Director of Midwifery and Nursing		

Paper For:	Information		Assurance	X	Decision	
Recommendation:	Quality Committee is asked to review and confirm action being undertaken to ensure the provision of a midwifery workforce in line with safer staffing. Quality Committee will receive the maternity workforce report 6 monthly.					

This paper relates to the following Annual Corporate Objectives

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

The paper relates to the following CQC domains

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

This paper relates to the following Board Assurance Framework risks

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

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

Where issues are addressed in the paper

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

Executive Summary

The Trust is required to demonstrate an effective system is in place for midwifery workforce planning and safer staffing in line with the requirements of NICE guideline for safer midwifery staffing NG4 and NHS Resolution (NHSR) Maternity Incentive scheme (MIS) Clinical Negligence Scheme for Trusts (CNST) Year 5, safety action 5.

The report covers the period of May 2023 to October 2023.

NHS
Stockport
NHS Foundation Trust

Maternity Workforce Bi-Annual Staffing Report

May-October 2023

1. Introduction

The following paper sets out the position against the context of national professional staffing standards and the national midwifery challenges.

This bi-annual midwifery staffing report, covering the period of May 2023 to October 2023, is to provide assurance that there is an effective system to ensure that maternity services at Stockport NHS Foundation Trust have the workforce they require.

The NHS Resolution (NHSR) Maternity Incentive Scheme Safety Action 5 requires that trusts demonstrate an effective system of midwifery workforce planning using the following standards:

a	A systematic, evidence-based process to calculate midwifery staffing establishment is completed
b	Trust Board to evidence midwifery staffing budged reflects the establishment as calculated in a) above
c	The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service
d	All women in active labour receive one-to-one midwifery care
e	Submit a midwifery oversight report that covers staffing / safety issues to the Board every 6 months during the maternity incentive scheme year 5 reporting period

Utilising the Birthrate plus report for Stockport, February 2023, and in line with NICE guidance for Safe Midwifery Staffing for Maternity Settings (NICE, 2015) the plan outlines how the Trust will continue to develop the maternity workforce in line with national policy.

Due to the fluctuating position in maternity care, it is essential that there is adequate staffing in all areas to provide safe, high-quality care by staff who have the necessary skills and knowledge. Regular and ongoing monitoring of the activity and staffing is vital to identify trends and causes for concern, which must be supported by a robust policy for escalation in times of high clinical acuity or low staffing numbers.

2. Current Position

2.1 Birth rate Plus

The February 2023 Birthrate Plus recommends a total midwifery establishment of 167.83 wte inclusive of the clinical midwives, specialist midwives and management roles.

Summary of results:

Current Funded wte Clinical, Specialist and Management Roles wte	Birth Rate Plus wte	Variance +/- wte
178.77	166.63	12.14
178.77	With midwifery sonographers 167.83	10.94

The Birth Rate Plus findings showed that there is positive variance of 12.14 wte clinical midwives comparing the current clinical wte with Birth Rate Plus wte. However, the 1.23 wte midwifery sonographers in post are not funded, when removed result in a positive variance of 10.94 wte midwives.

The Womens & Childrens Division has recently realigned budgets following the receipt of recurrent funding from Ockenden and the LMNS, and to align with the Birthrate plus recommendations from the 2023 report including specialists' posts.

2.2 Midwifery Workforce

An overarching review of all staffing establishments in order to align both inpatient and outpatient clinical areas with safe registered and unregistered staff has been undertaken.

The main drivers for the establishment review included:

- Aligning all specialist midwifery roles with the Ockenden and saving babies lives care bundle (SCLCB) recommendations, with the exception of the consultant midwife role.
- To ensure safe staffing levels in all clinical areas as outlined in Birth rate plus and recommendations from the regional team insights visit in May 22, which included an additional midwife to be based on the inpatient ward at night.
- The requirement to align MSW Band 2 to 3 changes, as the nature of work satisfies the core competency criteria that was undertaken for the wider

organisation unfortunately the MSWs were not included in this trust wide review, therefore it is the divisional proposal to fund the uplift as required.

- To increase the administrative establishment available to support Maternity triage and the antenatal day unit, enabling registered staff to undertake timely role specific activities.
- To create housekeeper roles to ensure ward areas are maintained in line with ward accreditation standards and CQC.

The funding allocated for SBLCBv2 was used to enhance the existing teams by increasing the WTE within each element, the outcome of this review has resulted in strengthened leadership, visibility and accessibility to the leads associated with each of the elements.

In addition to the SBLCB roles the Specialist Midwife roles have been benchmarked across GM to ensure the roles are appropriately remunerated, without this there was a risk of midwives leaving the organisation to undertake the same role at neighbouring organisations on a higher band or increased hours.

The current midwifery establishment is as below.

Posts	Current WTE	Proposed WTE	WTE Movement from Proposal	Saving Babies Lives Funding	TOTAL Maternity Establishment	WTE Movement from Proposal & SBL
Band 8a+	5.00	5.00	-		**5.00**	-
Band 6-7	155.48	152.55	(2.93)	6.14	**158.69**	3.21
Assistant Practitioners	6.87	7.07	0.20	2.00	**9.07**	2.20
Band 2 MSW	24.64	0.00	(24.64)		**0.00**	(24.64)
Band 3 MSW	0.00	34.57	34.57		**34.57**	34.57
NHSP Sickness Cover	3.22	4.44	1.23	0.06	**4.50**	1.29
Ward Clerks	5.87	8.02	2.15		**8.02**	2.15
Housekeepers	0.00	2.00	2.00		**2.00**	2.00
Other Admin	1.80	1.80	-	1.00	**2.80**	1.00
TOTAL	**202.88**	**215.45**	**12.57**	**9.20**	**224.65**	**21.77**

Total Clinical Establishment (to include in Birth Rate +)	**153.16**
Total Management Establishment (to include in Birth Rate +)	**21.60**
Total Establishment Outside of Birth Rate +	**49.89**
TOTAL	**224.65**

**Does not include additional band 3 MSW, band 6 preceptorship midwife and continuity of carer band 4 non-recurrently funded in 22/23. Awaiting confirmation of recurrent funding (also affects bereavement and R&R)*

Birthrate plus determined that Stockport Maternity services had a positive variance of 10.94 wte midwives, in view of this and the requirement to align with the HEE Maternity Support Worker Framework, the workforce review resulted in a reduction of 2.93wte midwives to fund the uplift between Band 2 to Band 3 and an increase in headcount of 9.93wte MSW's.

The overall benefits of implementing the revised workforce plan.

Benefits
Specialist Roles - Improved patient safety and prevent increase in maternal and neonatal Mortality & morbidity.
Specialist roles - Ensure compliance with national maternity drivers such as SBLCBv2 and Ockenden recommendations. As a result, continually improving quality and safety and provide service with a good reputation within the LMNS footprint.
All Staff - Increased staff morale, having the correct staff in the correct roles will provide better job satisfaction leading to improved morale in the workplace and reduce turnover.
All Staff - Improved efficiency by correct staff undertaking correct roles.
Improved patient experience, it is well documented that improved staff morale is closely linked with a better patient experience.
Ensure MSWs are in line with the trust wide & GM band 2/band 3 review.
Within W&C budget - The changes to the maternity rosters are within current budgeted establishment.
An increase in establishment of MSWs will result in reduction in NHSP spend.
Compliance against Birmingham Symptom Specific obstetric triage system (BSOTS) states that we are required to have an MSW observing women in the waiting area at all times
Risk of non-compliance with regard to intentional rounding
MSW will provide admin support to ANDU and the midwife sonographers which will enable women to leave antenatal clinic with a scan appointment (a risk which was flagged as part of the antenatal improvement programme) and will reduce DNA for scan.

2.3 Training

Our current training programme is aligned to the LMNS core competency framework and is led by the PBE team. Protected time is given to all registered and non-registered staff to attend all mandatory training. This is reported quarterly as part of the LMNS TNA submission. Local training is monitored through the division alongside the divisions HR business partner, and a monthly assurance meeting is held by the Divisional director.

An annual TNA request is submitted to the organisation to support ongoing Registered and non-registered CPD. This is monitored through the PBE team with full oversight from the Divisional Director of Midwifery and Nursing.

2.4 MSW workforce.

In March 2023 the maternity service commenced a review regarding the role of Band 2 and Band 3 clinical support workers and committed to aligning job roles with the HEE Maternity Support Worker Framework.

The first stage of this workstream involved meeting all Band 2 Clinical Support Workers to review their current role and assess their existing clinical skills and knowledge. During this meeting a discussion regarding career development was held and each member of staff was informed that Stockport would support career development to a Band 3 Maternity Support Worker if the member of staff desired this. This phase was completed in March 23.

The second stage of this workstream formalised this discussion and each member of staff were asked to confirm if they wished to remain as a Band 2 or progress to a Band 3 position as a Maternity Support Worker. The formal outcomes of their decisions are now being received.

The third stage of this workstream was to amend the existing job descriptions for Band 2 and Band 3 Clinical Support Workers to align with the HEE Maternity Support Worker Framework. The Band 3 job description was reviewed and has been approved by the AFC panel on 18th September 23. The Band 2 role is awaiting review.

The fourth stage of this workstream is to develop and implement a local programme to support the development of all Band 2 support staff who have chosen to progress to a Band 3 role and implement this. Clinical skills training for those staff who have confirmed that they wish to progress to a Band 3 has now commenced.

The final stage of this workstream will be to recruit to any Band 2 and Band 3 vacancy. This process has begun however will not be finalised until all existing employees have confirmed their career choice.

The current establishments are 24.64 for Band 2 support workers, 0 WTE for Band 3 support workers and 6.87 WTE for Band 4 clinical support. Following the completion of this workstream the establishments will be altered to 2 WTE Band 2 Maternity Housekeepers, 34.57WTE Band 3 Maternity Support Workers and 7.07 WTE Band 4 Clinical Support Workers.

2.5 Obstetric Workforce

The Trust currently has 14 consultants in post and are able to maintain consultant presence until 20:00 hrs Monday to Friday and from 08:30 – 20:30 for 6 out of 7 weekends.

On the 7th weekend when there is no resident cover the on-call consultant attends the unit to undertake the twice daily ward rounds in line with Ockenden recommendations. This provides 365 days twice daily ward rounds including bank holidays.

The strategy going forward is to recruit an additional consultant to enable resident cover 7 out of 7 weekends.

2.6 Neonatal Workforce

The current medical workforce requires 2WTE junior doctors to support the rota for dedicated SHO cover for NNU as per BAPM guidance. A business case is currently being considered by the executive team and being worked through to achieve BAPM standards, all other areas of the medical workforce are compliant to BAPM for the Trust LNU service.

The neonatal unit is developing an AHP workforce as per network recommendations, and has dedicated support from Physio, SLT, Psychology and dietetics which forms part of the workforce development program.

The neonatal workforce from a nursing perspective meets BAPM standards, has an integrated transitional care service to minimise separation and provide the extra support required.

The neonatal unit has a robust operational infrastructure in place, with clear escalation and guidance for day-to-day operational management relating to both medical and nurse staffing.

3. Internationally Educated Midwives (IEM)

Stockport NHS FT agreed to support five internationally educated midwives to join the Trust between October 2022 and December 2023.

Three of these midwives successfully passed their OSCEs and joined Stockport as Band 4 supernumerary practitioners until they received their NMC Registration and PIN. All three have recently received their NMC PIN's and are now preceptee midwives with a bespoke programme to support their development.

The remaining two midwives are in the process of preparing to reside in the country and preparing for their OSCEs at the earliest will be January 2024.

The programme to support the development of the international midwives is intensive and requires an extended programme of supernumerary time of between 6 and 12 months to develop and consolidate the required skills and knowledge to

practice effectively. Because of this Stockport NHS FT does not intend recruit any further international midwives during 2024; this time will be sent support the existing international midwives to consolidate their skills and knowledge to become autonomous practitioner.

4. Apprenticeship levy

Stockport does not currently have any staff undertaking midwifery apprenticeships, that said it is something that may be considered in the future.

5. Midwifery recruitment and retention

The division has a rolling recruitment programme for Band 5 and 6 midwives including a broader range of posts being advertised, including the traditional rotational post, flexible working, role specific posts, core positions.

The division also holds recruitment days at the Trust where interviews will be undertaken on the day. The next planned recruitment day is Saturday 18 November.

All third year students are offered post as Band 5 preceptee midwives. The division has recently had the following new starters in post or due to commence in post between September and October:

Week commencing 11th September 2023 – 1B5 Midwife (1.0wte)

Week commencing 2nd October 2023 – 3 B5 Midwives (3wte) and 1 B6 Midwife (1wte)

Week commencing 9th October 2023 – 2 B5 Midwives (1.80wte)

Week Commencing 16th October 2023 – 2 B5 Midwives (2wte)

Week Commencing 23rd October 2023 – 1 B5 Midwife (1wte) and 1 B6 Midwife (0.8wte)

Week Commencing 30th October 2023 – 1 B5 Midwife (1wte)

1 B5 Midwife is awaiting course completion (0.64wte)

Included in the recruitment are 3wte IEM who are now in receipt of their NMC pin, this gives us 15.24wte new starters.

The breakdown of this is given below:

	Number of staff	WTE
Band 5	14	13.44 (Inclusive of IEM)
Band 6	2	1.8
Band 7	0	0
Band 8A	0	0

The division employed a 1.0 WTE supernumerary recruitment and retention midwife whose focus is to co-ordinate the support offered to newly qualified midwives who join the Trust, and also facilitate support for student midwives within the trust. This post holder also provides early intervention and support for those members of staff who have expressed an intention to seek alternative employment. The recruitment and retention midwife offers to meet all members of staff who have resigned to undertake an exit interview; the information that is gained from these interviews will be used to inform and support the development of the Stockport NHS FT maternity workforce strategy.

Between April 23 and September 23, 22 midwives left their employment with the division. This is an average of 3.6 midwives (3.03 WTE) per month.

Reason for leaving	**Number of midwives**	**WTE**	**Band**
Employment gained as a midwife in a Trust in region	4	4.56	6
Employment gained as a midwife in a Trust out of region	1	1	6
Retirement	8 (2 retired and returned)	6.13	6/7
Alternative Career Path	4	2.2 0.92	7 6

Agency Work / Left Midwifery	5	3.4	6

As part of our recruitment and retention plan we are continuously identifying ways in which we recognise the exceptional work undertaken by the Maternity workforce. These peer nominated schemes are supported by the PMA's and senior leadership team. Examples include.

- Bee positive awards
- Star in the car
- Goodwill on the hill
- Monthly newsletters from the specialist midwives

6. Safe staffing

6.1 Manager of the Day (MOD)

At Stockport Maternity services we have a manager of the day rota 7 days a week, who undertake 4 hourly walk rounds of the unit. Within the manager of the day structure there is an inpatient MOD and a community MOD, the MOD will escalate any concerns to the inpatient matron and community matron as deemed appropriate.

The Divisional Director of Midwifery and Nursing and Deputy head of Midwifery and Nursing have oversight of the report and any escalation throughout the day. Alongside the MOD a sitrep is completed by the shift coordinator at every shift handover, ensuring activity is captured over a 24hour period.

A monthly safe staffing report is submitted and presented at Divisional Quality Group this is also captured on the Maternity highlight report which is presented to Quality Committee Bimonthly. The report is also submitted quarterly to trust board as part of the wider trust safe staffing report.

6.2 Red Flag Events

NICE (2015) outlines what is considered a midwifery staffing red flag and the division encourage the team to support these via datix. Local intelligence has identified that 'red flag' incidents are not always submitted therefore this data is likely not to be accurate. As mitigation the manager of the day will be assessing each ward for 'red flags' at least four times a day and submitting incident reports as required once they have rectified the concern.

The table below indicates the numbers of red flags which have been submitted via datix.

	Labour Ward Coordinator not supernumerary	Unable to provide 1:1 care in labour	Other staffing red flags	Total red flags
Aug 23	0	3	9	12
Sep 23	0	1	4	5

6.3 Roster Management

The rosters are monitored through e-roster KPI's, ensuring safe staffing is maintained across all clinical areas. The rosters are completed by the ward managers and final approval is sought from the Divisional Director of Midwifery and Nursing.

A weekly health roster review meeting is held by the deputy chief nurse to provide additional oversight and management of the divisional roster KPI's.

6.4 Bank / Agency Midwives

The division aims to fill all vacant clinical midwifery shifts using bank midwives through NHSP. Shifts are put out to NHSP through health roster when rosters are created, providing a robust oversight of staffing levels.

The division are planning to begin the use of safe care live within health roster in the new year to allow for real time oversight of midwifery staffing.

The division do not currently use Agency midwives to fill vacancy clinical shifts.

Due to Stockport Maternity units' current vacancy rate a review was undertaken to benchmark ourselves against NHSP rates across GMEC. It was recognised by the organisation that Stockport pays one of the lowest rates within GMEC. In response to this the organisation has agreed a temporary enhanced rate until the end of November in anticipation for the new starters to commence in post.

7. Summary

It is recognised that there are midwifery staffing challenges nationally. The service is working to reduce vacancies and become an employer of choice focusing on opportunities for career development and maximising recruitment opportunities.

8. Conclusion

The Quality Committee are asked to receive this paper and note progress of the work undertaken to address the midwifery vacancy position.

NHS Stockport NHS Foundation Trust

KEY ISSUES REPORT	
Name of Committee/Group	Audit Committee
Chair of Committee/Group	David Hopewell, Non-Executive Director
Date of Meeting	23rd November 2023
Quorate	Yes

The Audit Committee draws the following key issues and matters to the Board of Directors' attention:

Item	Key issues and matters to be escalated
Risk Management Committee Report	The Committee received: • a report on the work of the Risk Management Committee • a list of significant risks at September and October 2023. The Committee received additional information on the financial risk to the Trust of providing care and support to vulnerable asylum seeking families. The risk was based on information from Stockport MBC regarding increasing number of asylum seekers placed within the local authority area. The Committee were updated on Risk 2465 regarding an escalation of the environmental conditions in Outpatients B that had come to light following a structural engineer survey of the building. In addition to the immediate concerns, it was raised that there would also be a need to quantify the financial risk of this. A query was raised on the evaluation of shared risk across the committee structure and how this was received in Board reporting. The Trust Secretary highlighted that this was co-ordinated through the Board Assurance Framework, with delegation of the principal risks to respective Committees, alongside, the Audit Committee review of the Risk Management Committee Report and the standing agenda item on feedback from Board Committees.
Feedback from Board Committees.	The Committee received verbal reports on the key risks from the Chairs of the Board Committees: • Finance and Performance Committees • Quality Committee • People Committee Within the updates an example of the shared evaluation of risk with respect to No Criteria to Reside, which had been referred to the Quality Committee by the Finance and Performance Committee.
Internal Audit 2023/24 Plan Progress Report	The Committee received: • Internal Audit Plan Progress Report • Internal Audit Reports • Follow up Tracker Update The Committee were assured that the Internal Audit Plan was progressing to plan and

	performance indicators all rated green. The Plan has been updatedas agreed with the Chair and Chief Finance Officer, to incorporate a Well Led (Supporting Position) review replacing planned days relating to the Provider Collaboratives Review and the Risk Management Review. Follow up actions on recommendations related largely to the IT Audit report and are being tracked by the IT auditor. There are no concerns on progress. The Committee received the final report in Stock Management which received Limited Assurance. The review was requested following incidents of missing items in both the IT and Estates departments. 10 departmental areas reviewed, high or substantial assurance was received in five areas (Trust Pharmacy, Pathology Laboratories, Medical Devices/EBME, Receipt & Distribution Centre and Catering Stock). However, the remaining areas (Governance, Theatres Stocks, Estates Materials and Equipment, Linen and Staff Uniforms and the Trust retail outlets) received limited assurance. Overall lack of consistency in approach to stock control and procedures after purchase reported The Committee noted one recommendation, to set up a task and finish group to consider the 27 individual recommendations, will prioritise the development of terms of reference and timescales. Audit Committee requestedupdate on progress in February 2024. Mazars provided assurance that the external audit will review the risks on stocks and increase the challenge in the Value for Money report. The Committee were informed that the Theatre stocks were specifically being addressed by the Procurement team as a pilot for a theatre inventory management system alongside an early stock count in Quarter 3 of 2023-24. The Committee were assured by the allocation of MIAA Plan days to the stock review as it arose from weaknesses identified and highlighted the focus on areas of concern.
Anti-Fraud Progress Report	The Committee received the Anti-Fraud Progress Report and were assured it was progressing as planned. It received an update on the status of current investigations. The Committee were given assurance that the Trust had not incurred any financial losses on Fraud Prevention notices issued during September – November 2023.
External Audit Progress Report	The Committee received an External Audit Progress Report for 2023/24. It was noted that the interim planning visit would begin in February 2024 when sufficient data would be available to allow for substantial testing. The Committee received assurance that the Charity Independent Examination work was complete and the final report from the Independent Examiner was due shortly. The Committee confirmed the Strategy Memorandum for the 2023-24 Annual Accounts and Report would be presented to the February 2024 Audit Committee.
Waivers	The Committee received a report of waivers for the period April 2023 to September 2023. The Committee received assurance that all waivers were issued in accordance with Standing Financial Instructions. The Committee received confirmation that the increased number of waivers requested

	by Estates and Facilities department was being addressed with a training session on their use and a pro-active contract review to remove the need for waivers in the future. The Committee requested assurance that the procedures and processes for off-framework awards was robust, mirroring on framework awards. The Chief Finance Officer confirmed that MIAA would be requested to look at this in a combined review of Stockport and Tameside & Glossop FTs.
Any Other Business	The Committee received an update on the next stage in the procurement route for the award of the external audit tender that is due for renewal by the 1st October 2024. It received assurance that the recommendations made are in accordance with statutory obligations and the Deputy Head of Procurement had confirmed the process complied with procurement rules.