Stockport NHS
NHS Foundation Trust

COUNCIL OF GOVERNORS MEETING

23 MAY 2018

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Council of Governors Bundle - 23 May 2018

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NHS Stockport NHS Foundation Trust

Meeting of the Council of Governors
Wednesday, 23 May 2018

Held at 4.30pm in the Lecture Theatres, Pinewood House, Stepping Hill Hospital

AGENDA

Time			Enc	Presenting
1630	**1.**	Apologies for Absence		
	2.	Amendments to Declarations of Interests		
1635	**3.**	Minutes of previous meeting: • 6 December 2017 • 21 March 2018	✓	**A Belton**
1640	**4.**	Chair's Report - Appointment of Non-Executive Director	✓	**A Belton**
1650	**5.**	Chief Executive's Report & Integrated Performance Report	✓	**H Thomson**
1705	**6.**	Operational Plan 2018/19	✓	**H Mullen**
1720	**7.**	Quality Improvement Plan	✓	**A Lynch**
1735	**8.**	Governor Committee – Terms of Reference	✓	**P Buckingham**
1745	**9.**	Reports from Governor Committees: ▪ Governance & Membership Committee ▪ Patient Experience Committee ▪ Quality Standards Committee	✓	**Committee Chairs**
1800	**10.**	Lead Governor Communication	*Verbal*	**L Jenkins**
	11.	**DATE, TIME & VENUE OF NEXT MEETING**		

10.1 Wednesday, 18 July 2018, 6.00pm in the Lecture Theatres, Pinewood House.

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A TEN-MINUTE FORUM FOR PRE-RECEIVED QUESTIONS WILL FOLLOW AT THE CONCLUSION OF THE MEETING OF THE COUNCIL OF GOVERNORS.

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STOCKPORT NHS FOUNDATION TRUST
Minutes of a Council of Governors Meeting
Held on Wednesday 6 December 2017,
3.00pm in the Lecture Theatres, Pinewood House, Stepping Hill Hospital

Present:

Mr A Belton	Chair
Ms C Barton	Public Governor
Mrs E Brown	Public Governor
Dr R Catlow	Public Governor
Dr R Cryer	Public Governor
Mrs I Daniel	Staff Governor
Cllr L Dowson	Public Governor
Prof C Galasko	Public Governor
Mr A Gibson	Public Governor
Mr R Greenwood	Public Governor
Mrs M Harrison	Public Governor
Mr C Hudsmith	Staff Governor
Mr T Johnson	Public Governor
Mr R King	Public Governor
Dr T Kondratowicz	Public Governor
Mr L Jenkins	Public Governor
Ms C Mitchell	Staff Governor

In attendance:

Mrs C Anderson	Non-Executive Director
Mrs A Barnes	Chief Executive
Mrs C Barber-Brown	Non-Executive Director
Mr P Buckingham	Director of Corporate Affairs
Dr M Cheshire	Non-Executive Director
Mrs S Curtis	Membership Services Manager
Mrs A Lynch	Director of Nursing & Quality
Ms A Smith	Non-Executive Director
Mrs E Stimpson	Deputy Director of Workforce & OD
Mr M Sugden	Non-Executive Director
Mrs H Thomson	Interim Chief Executive (Designate)

ACTION

40/17 Apologies for absence

Apologies for absence were received from Mrs L Appleton, Mrs Y Banham, Mr F Patel, Mr R Driver, Cllr T McGee, Mr J Sandford, Mrs J Shaw, Mrs J Wragg, Mrs L Woodward and Mr G Wright.

The Chair welcomed Governors and colleagues in attendance to the meeting and made specific reference to Ms C Barton, Dr T Kondratowicz, Ms C Mitchell, Mrs H Thomson and Mrs A Lynch who were attending their first meeting of the Council of Governors.

41/17 Amendments to Declarations of Interests

There were no amendments made to the Register of Interests.

42/17 Minutes of the Previous Meeting

The minutes of the previous meeting held on 9 October 2017 were agreed as a true and accurate record of the meeting subject to an amendment to the final sentence of minute number 30/17 to be amended to read "He had been disappointed to note that *NHS Right Care* had not updated the relevant data….". The action log was reviewed and annotated accordingly.

43/17 Chair's Report

The Chair presented a report which had been presented to the Board of Directors on 30 November 2017. He advised that the report included information with regard to notable events, matters concerning the development of the Board, Chair engagements, any significant regulatory developments that the Chair had been involved in and a forward look to significant events or possible developments.

The Chair noted that this would be the final meeting of the Council of Governors to be attended by the Chief Executive prior to her retirement on 31 December 2017. The Chair, on behalf of the Council of Governors, wished the Chief Executive well for her retirement and acknowledged the tremendous service she had provided to the NHS generally, and this Trust in particular, throughout her extensive career with the health service.

The Council of Governors:

- Received and noted the Chair's Report.

44/17 Chief Executive's Report & Integrated Performance Report

The Chair noted that consideration of this agenda item provided Governors with a good opportunity to discharge their duty of holding the Non-Executive Directors to account by asking questions arising from the report and the attached Integrated Performance Report. The Chief Executive presented the report which provided an update on a number of strategic and operational developments. She briefed the Council of Governors on the content of the report and provided an overview on the following subject areas:

- Updated Single Oversight Framework
- Stakeholder Briefing: Winter Planning
- Integrated Performance Report.

The Director of Nursing & Quality introduced herself to the Council of

Governors and provided an overview of her role. She advised the Council of the development of a Quality Improvement Plan which would be underpinned by a new quality governance framework to provide assurance to the Board of Directors, the Council of Governors and regulators with regard to quality of care. The Director of Nursing & Quality advised that Governors would be invited to assist in the establishment of a quality improvement target and noted that a workshop would be held in January 2018 to consider this topic further. She also noted the development of a Patient Experience Strategy and briefed the Council on developments following the Care Quality Commission (CQC) inspections. The Director of Nursing & Quality noted the importance of ensuring that the CQC Action Plan was a transformational plan. **AL**

Dr M Cheshire noted that as Chair of the Quality Assurance Committee he felt confident that the Quality Improvement Strategy and associated quality metrics would help improve the Trust's Quality Agenda but commented that embedding the changes would take some time. The Chief Executive advised that the CQC were piloting whole system reviews and noted that Stockport was likely to be included in the process. She commented that the review would be led by the local authority and would focus on integration.

Mr L Jenkins queried whether the Trust was likely to benefit from the urgent care treatment centres referred to in the Greater Manchester Winter Planning briefing document attached to the report. The Chief Executive confirmed that this would be the case and advised that the ambulatory ill centre would become an urgent care treatment centre which would include more diagnostics. She also advised that the Trust was attempting to secure capital allocation to enlarge the site to enable inclusion of an on-site out of hours GP service. The Chief Executive noted, however, that the bid had not progressed yet as the Trust had not agreed its control total but commented on positive support received by partners. In response to a question from Cllr L Dowson regarding the Winter Planning briefing document, the Chief Executive briefed the Council on the Trust's links with High Peak and noted that escalation to East Cheshire and North Derbyshire was less robust due to a separate strategic footprint.

In response to a question from Prof C Galasko regarding the revised Single Oversight Framework (SOF) and the removal of emergency readmission rates from the list of quality indicators for acute providers, the Chief Executive advised that this aspect had only been removed from the regulator's view and noted that the Trust continued to report on it on a monthly basis. In response to a question from Mrs E Brown, the Chief Executive advised that Mrs C Griffiths, Improvement Director, had been appointed to support the Trust regarding the Quality Agenda and noted that her reporting line was through to the NHSI Medical Executive.

In response to a question from Mr L Jenkins regarding performance issues relating to Clinical Correspondence, the Deputy Director of

Workforce & OD provided an overview of mitigating actions in this area and advised that a clinical correspondence typing hub had been established to improve performance. Mrs C Barber-Brown noted that the Quality Assurance Committee had considered this issue and noted that the effectiveness of the typing hub would be evaluated. Dr M Cheshire commented that consideration was also being given to evaluate approaches used by different specialties to enable cascade of best practice. He also advised that that the Electronic Patient Record (EPR) would help improve performance in this area. The Director of Corporate Affairs advised that with regard to Clinical Correspondence, the Quality Assurance Committee had been concerned regarding the level of performance and had consequently requested an assurance report on the topic at the Committee meeting in January 2018.

Prof C Galasko commented on the reduction of elective income and queried why fewer theatre lists were going ahead if operations were being cancelled due to the lack of theatre time. Mr M Sugden briefed the Council on issues regarding the theatre lists and advised that the elective income of £1.9m was below plan. In response to a follow up question from Prof C Galasko, Mr M Sugden advised that the Finance & Performance Committee had requested further clarity with regard to the CCG's commissioning intentions for 2018/19 as part of the mid-contract review. The Chief Executive noted a compensatory increase in non-elective surgery admissions but commented that there was no evidence that commissioners were sending work elsewhere.

In response to a question from Mr T Johnson who noted a concern with regard to the Trust's and the whole Health-Economy's financial position, Mr M Sugden acknowledged the significant pressures with regard to financial targets and noted that the Finance & Performance Committee had reported low assurance regarding the Cost Improvement Programme and the overall financial target. He briefed the Council on mitigating actions relating to the 2017/18 and the 2018/19 targets. Mr M Sugden commented on the preparation of the Trust's Operational Plan which focused on sustainability and noted that the Trust was also preparing a Financial Recovery Plan to help regain financial balance.

In response to a question from Mr T Johnson, the Chief Executive advised that the £19m transformation monies received by Stockport were used for the integration of Health & Social Care and were not allocated to fund the provision of services. The Chair referred to the 'three legged stool' analogy of finance, quality and performance and noted that the financial aspect would take the longest to resolve. In response to a question from Mr T Johnson, the Chief Executive advised that the Greater Manchester Health & Social Care Partnership distributed funding to organisations whose bids met the required criteria. In response to a further question from Mr T Johnson, the Director of Corporate Affairs advised that the Council of Governors would receive a presentation regarding the Trust's medium-term Financial Strategy at the meeting on 16 April 2018. **FP**

Dr M Cheshire noted the complex challenges faced by the Trust in having to change the way clinical services were provided while at the same time improving safety and quality. He also commented on the significant local and national issue regarding medical and nursing recruitment and the consequent need to employ high cost agency staff. In response to a question from Mr L Jenkins regarding Chart 65 of the Integrated Performance Report, the Director of Finance noted that he was not yet in a position to confirm whether the Trust's Finance Use of Resource Metric would remain as a 3.

In response to a question from Mr L Jenkins regarding Chart 27 of the Integrated Performance Report, the Chief Executive advised that historically, neither the University Hospital of South Manchester NHS Foundation Trust nor the Central Manchester University Hospitals NHS Foundation Trust had commissioned 'UM Gold' to review their A&E data and the trusts were therefore not included in the chart. She noted, however, that the data from the two organisations would be included in the reports going forward. In response to a question from the Chair regarding actions that individuals could take to alleviate the pressure faced by the Emergency Department, the Interim Chief Executive Designate noted the importance of flu vaccinations and the Chief Executive noted the key messages outlined in the Greater Manchester Winter Planning briefing document attached at Annex B to the report. The Director of Nursing & Quality advised that the Trust's Twitter account included an 'at a glance' guide for using healthcare services and when it was appropriate to see a doctor.

The Council of Governors:

- Received and noted the Chief Executive's Report.

Mr L Jenkins left the meeting for the duration of the next agenda item.

45/17 Appointment of Lead Governor

The Director of Corporate Affairs presented a report, the purpose of which was to facilitate the appointment of a Lead Governor by the Council of Governors. He advised that the Council had appointed Mr L Jenkins as Lead Governor for a period of one year at its meeting held on 8 December 2016 and, consequently, the position was now due for annual review. The Director of Corporate Affairs noted that he had written to Governors on 16 November 2017 seeking expressions of interest for the role of Lead Governor with a deadline of 29 November 2017 for the submission of any expressions. In the event, an expression of interest had been received from the current Lead Governor, Mr L Jenkins, and the Director of Corporate Affairs advised that a copy of his supporting statement had been included for reference at Annex A of the report.

The Council of Governors:

- Appointed Mr L Jenkins as Lead Governor for a period of one year with effect from 1 January 2018.

Mr L Jenkins re-joined the meeting.

46/17 Governor Committee Arrangements

The Director of Corporate Affairs presented a report, the purpose of which was to present the outcome of a refresh of Governor Committee arrangements to the Council of Governors for approval. He referred the Council to s4 of the report and advised that Governors had been invited to submit expressions of interest to fill a current vacancy in the Nominations Committee membership and noted that one expression of interest had been received from Mr R Greenwood. The Council of Governors consequently approved the appointment of Mr R Greenwood as a Governor member of the Nominations Committee with effect from 6 December 2017.

The Director of Corporate Affairs noted that the report formalised the extensive discussion held at the Governors Ways of Working session on 24 July 2017 and the Council of Governors meeting held on 9 October 2017, during which the Council had agreed to revise its Committee arrangements to establish the following Committees:

- Governance & Membership Committee
- Patient Experience Committee
- Quality Standards Committee.

The Director of Corporate Affairs advised that draft Terms of Reference for the three Governor Committees had been included for reference at Annex A-C of the report. He noted that the content of the Terms of Reference was largely based on merging the functions of the previously separate Governance and Membership Committees and separating the functions of the previous Patient Safety & Quality Standards Committee. The Director of Corporate Affairs reported that the draft Terms of Reference for the Governance & Membership Committee had been considered at an initial meeting of the new Committee held on 20 November 2017 and were recommended for Council of Governors' approval. He advised that all three draft Terms of Reference had been circulated to Governors with the request for Committee membership preferences and comments had been received in relation to content.

The Director of Corporate Affairs referred the Council to s5.1 of the report which detailed the proposed membership of the three Governor Committees. He noted that the list indicated first and second preferences and advised that a "reserve list" would be compiled from the second preferences which would be used to fill any future vacancies. He also noted that any Governors yet to express an interest with regard to Committee membership still had the opportunity to do so. The Director of Corporate Affairs noted that the Terms of Reference included provision for Governors to attend any of the Committee meetings in an observer capacity. He also referred to the schedule of

meetings for 2018, included as Appendix 1 to the report, and noted an intention to hold initial Committee meetings in January 2018 to review the Terms of Reference, elect a Chair and Deputy Chair and consider Committee business prior to the scheduled meetings in March 2018.

Mr L Jenkins advised that he had discussed the Governor Committee arrangements with the Chair and the Director of Corporate Affairs and endorsed the recommendations outlined in the report and the proposal to hold initial meetings in January 2018. He made reference to the draft Terms of Reference of the Quality Standards Committee and proposed that consideration be given to include the Medical Director and the Director of Nursing & Quality in the list of Committee meeting invitees. Prof C Galasko endorsed this proposal. Mr L Jenkins also noted that a paragraph referring to the expectation of members attending all Committee meetings had been omitted from the Governance & Membership Committee Terms of Reference and should be included to ensure consistency with the other Committees' Terms of Reference.

Mr T Johnson commented that previous Committee Terms of Reference had included a stipulation to include at least one Staff Governor in the membership of the Governor Committees and proposed that this requirement be reinstated. The Director of Corporate Affairs noted that this was not an easy requirement to meet in practice and proposed that the issue be further considered at the Committee meetings in January 2018. Mr T Johnson also proposed Non-Executive Director attendance at Committee meetings, commented on the need to ensure adequate notice for meetings and requested that any meeting cancellations be approved by Committee members. The Director of Corporate Affairs referred to Appendix 1 of the report which provided dates of Council of Governors and Committee meetings and therefore provided sufficient notice of meetings for Governors. He also requested support from colleagues with regard to submission of reports to enable timely distribution of meeting packs.

In response to a comment from Mr T Johnson, Mr L Jenkins noted that he did not agree that there had been unnecessarily long gaps between Committee meetings as the establishment of the new Governor Committees had been awaiting Council approval at the December meeting. Mr R Greenwood endorsed the comments made by Mr L Jenkins and noted the need to recognise the pressures faced by the Trust, including in the context of suggested Non-Executive Director participation in Governor Committee meetings. Dr M Cheshire agreed that this required careful consideration as both Non-Executive and Executive Directors already had considerable time commitments.

In response to a comment from Mr L Jenkins, the Director of Corporate Affairs advised that an additional meeting of the Council of Governors was likely to be required in advance of the April meeting to consider an extension to a Non-Executive Director's term of office. In response to a question from Cllr L Dowson, the Director of Corporate Affairs confirmed that the membership numbers detailed in the Committee Terms of Reference would be further reviewed once the Committee

membership had been finalised. In response to a question from Cllr L Dowson, the Chair suggested that any further comments relating to the Committee Terms of Reference be emailed to the Director of Corporate Affairs. In response to a question from Mr A Gibson, the Director of Corporate Affairs noted the standard expectation of Committee members attending meetings but also acknowledged that this was not always possible.

The Director of Corporate Affairs thanked Governors for the helpful comments and requested approval of the draft Committee Terms of Reference with an understanding that further review would be undertaken at the Committee meetings to be scheduled for January 2018. The Council of Governors consequently approved the draft Terms of Reference.

The Council of Governors:

- Received and noted the report.
- Approved the Terms of Reference for Governor Committees as detailed at Annex A-C of the report.
- Approved the appointment of Mr R Greenwood as a Governor member of the Nominations Committee with immediate effect.
- Agreed initial membership for the revised Governor Committees and noted the meeting schedule for 2018.

47/17 Reports from Governor Committees

Mr L Jenkins presented a report from the Governance & Membership Committee meeting held on 20 November 2017 for noting. He commented that those Governors present had noted that the meeting had been held in advance of formal approval of relevant Terms of Reference and had agreed that Mr L Jenkins should Chair the meeting. Cllr L Dowson commented that he had attended the meeting and should therefore be included in the list of Governors present. In response to a question from Mrs E Brown, the Chair confirmed that Mrs H Thomson would formally assume the role of Interim Chief Executive with effect from 1 January 2018.

The Council of Governors:

- Received and noted the Governance & Membership Committee Report.

48/17 Lead Governor Communication

Mr L Jenkins advised the Council of Governors of his Lead Governor activities since the last meeting which included attendance at the Trust's Annual Members' Meeting; meetings with the Chair, the Chief Executive, the Interim Chief Executive Designate, Dr M Cheshire, Mr C Hudsmith and new Governors; a mentoring session with the Lead Governor of Bridgewater Community Healthcare NHS Foundation Trust;

attendance at the opening of the Trust's Surgical & Medical Centre; attendance at Board meetings; observation of meetings of the Quality Assurance Committee and People Performance Committee; and chairing the Membership & Governance Committee meeting. In response to a comment from Cllr L Dowson, the Council of Governors wished to thank Mr L Jenkins for everything he did in his role as Lead Governor, including his attendance at a considerable number of meetings.

Mr L Jenkins, on behalf of the Council of Governors, then paid tribute to the Chief Executive and wished her the very best in her retirement.

The Council of Governors:

- Received and noted the verbal report.

49/17 Date, time and venue of next meeting.

The next meeting of the Council of Governors was scheduled to be held on Monday, 16 April 2018, in the Lecture Theatres, Pinewood House, commencing at 6.00pm. It was noted, however, that an additional meeting of the Council of Governors was likely to be required in advance of the April meeting to consider an extension to a Non-Executive Director's term of office.

Signed: _____ Date: _____

COUNCIL OF GOVERNORS: ACTION TRACKING LOG

Ref.	Meeting	Minute Ref	Subject	Action	Responsible
05/16	8 Dec 16	53/16	Lead Governor Communication	*Cessation of 'Park & Ride' Service between Hazel Grove Park & Ride and Stepping Hill Hospital* - Mr L Jenkins agreed to liaise with Ms S Toal who would take the enquiry forward on behalf of the Trust. **Update 20 Apr 17** – Mr L Jenkins briefed the Council of the latest position and noted that correspondence between the Trust and Stagecoach representatives had not led to a satisfactory outcome. Cllr T McGee offered follow up the issue with Stagecoach. **Update 24 Jul 17** – Cllr T McGee noted that there was new management at Stagecoach and to date he had been unable to receive a satisfactory response. He advised the Council that he would contact Stagecoach again and ask them to reconsider the decision to cease the Park & Ride service to the hospital. **Update 9 Oct 17** – The Director of Support Services advised that as part of a wider engagement with the public regarding car parking at the hospital and surrounding areas, Stagecoach had indicated that no changes were anticipated to the Park & Ride arrangements at least until the Trust had prepared proposals in this area. **Update 6 Dec 17** – Mr L Jenkins reported that Cllr T McGee had been unable to make progress with Stagecoach with regard to the Park & Ride service issue. He wished to thank Cllr T McGee for his help with the matter and it was agreed to close this action.	L Jenkins / S Toal Cllr T McGee
03/17	9 Oct 17	32/17	CQC Report	The Interim Director of Nursing invited any interested Governors to take part in a mock CQC assessment which would be held on 24 October 2017 and agreed to circulate further information regarding the event to Governors. **Update 6 Dec 17** – Information had been circulated to Governors. Action complete.	R Holt (Interim Director of Nursing)

04/17	9 Oct 17	37/17	Reports from Governor Committees	In response to a question from Mrs L Woodward, the Interim Director of Nursing noted that Governors would be welcome to take part in the twice-weekly patient safety walkabouts and agreed to forward the dates to Governors. **Update 6 Dec 17** – Information had been circulated to Governors. Mr T Johnson encouraged Governors to take part in the patient safety walkabouts. Action complete.	R Holt (Interim Director of Nursing)
05/17	6 Dec 17	44/17	Report of the Chief Executive	The Director of Nursing & Quality advised that Governors would be invited to assist in the establishment of a quality improvement target and noted that a workshop would be held in January 2018 to consider this topic further.	A Lynch (Director of Nursing & Quality)
06/17	6 Dec 17	44/17	Report of the Chief Executive	In response to a question from Mr T Johnson, the Director of Corporate Affairs advised that the Council of Governors would receive a presentation regarding the Trust's medium-term Financial Strategy at the meeting on 16 April 2018.	F Patel (Director of Finance)

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STOCKPORT NHS FOUNDATION TRUST
Minutes of a Council of Governors Meeting
Held on Wednesday 21 March 2018
2.30pm in the Estates Conference Room, Stepping Hill Hospital

Present:

Mr A Belton	Chair
Mrs E Brown	Public Governor
Dr R Catlow	Public Governor
Dr R Cryer	Public Governor
Mrs I Daniel	Staff Governor
Mr R Greenwood	Public Governor
Mr C Hudsmith	Staff Governor
Mr T Johnson	Public Governor
Dr T Kondratowicz	Public Governor
Mr L Jenkins	Public Governor
Ms C Mitchell	Staff Governor
Mr T McGee	Appointed Governor
Mr R Driver	Public Governor
Mr G Wright	Public Governor
Mrs L Appleton	Public Governor
Mrs L Woodward	Public Governor

In attendance:

Mr M Sugden	Non-Executive Director
Mrs C Anderson	Non-Executive Director
Dr M Cheshire	Non-Executive Director
Mr P Buckingham	Director of Corporate Affairs
Mr H Mullen	Director of Support Services

ACTION

1/18 Apologies for absence

Apologies for absence were received from Ms C Barton, Mr L Dowson, Mrs M Harrison, Prof C Galasko, Mr R King, Mr A Gibson, Mrs H Thomson, Mr J Sandford, Mrs C Barber-Brown and Ms A Smith.

2/18 Amendments to Declarations of Interests

There were no amendments made to the Register of Interests.

3/18 Revised Trust Strategy - Presentation

Mr H Mullen delivered a presentation titled *'Refreshed Trust Strategy: A New Strategic View'* which covered the following subject areas:

- Introduction
- Why the Board requested a review of the Strategy
- Internal Environment – Drivers of Change
- External Environment – Drivers of Change

- What products required development
- Strategy 'Pyramid'
- Proposed Strategic View
- Next Steps

In response to questions from Dr R Catlow and Mr L Jenkins, Mr H Mullen provided an overview of the 'Model Hospital' and explained that the benchmark data provided allowed the Trust to identify areas where there were opportunities to improve efficiency. With regard to delays with Healthier Together implementation, Mr H Mullen advised that current delays related to approval of capital funding for necessary estate developments and noted that, once approved, the duration of interrelated build programmes would be approximately 65 weeks.

In response to a question from Mr G Wright, regarding potential hub and spoke arrangements as part of GM Theme 3 developments, Mr H Mullen advised that there would be no diminution of standards at spoke sites and noted work on a GM Pathology solution as an example. In response to a follow-up question from Mr T Johnson, Mr H Mullen also confirmed that patients at spoke sites would not experience delays in receiving test results. Mr R Driver commented on the efficient use of electronic processes. With regard to Pathology Services, Dr M Cheshire noted that the former Central Manchester Trust had created capacity which was capable of providing a service across Greater Manchester approximately five years ago.

Mr T Kondratowicz commented on organisations becoming increasingly dependent on technology and queried whether the Trust had robust IT security systems in place. Mr H Mullen confirmed that such arrangements were in place and noted the protection afforded by such systems during cyber-attacks which resulted in a global impact during 2017. He also advised that funding had been identified in the Trust's capital programme for 2018/19 to further enhance IT security measures.

With regard to integrated services, Mr T Johnson commented on a pilot programme which he believed had been run in the Marple area a number of years previously. He noted that little had been heard about this pilot since. Mr T McGee advised that the programme had been titled 'Stockport One' and noted that this had subsequently evolved as part of the Neighbourhood arrangements for Stockport Together. Mr H Mullen advised those present that the programmes in the Integrated Service Solution (ISS) were at varying stages of implementation.

Mr A Belton commented on the need for a clear set of system-level metrics to facilitate monitoring of ISS progress and there followed a discussion on the Stockport population with Mr T McGee advising that one in five of the population was over 65 years of age. Mr H Mullen noted an Enhanced Case Management (ECM) approach based on appropriate interventions at an individual level. Mr L Jenkins advised that, as a Marple resident, he was not aware of a 'Stockport One' programme but noted a poor level of primary care engagement. Mr R

Greenwood noted a recent example of a visit he had made to a local GP practice, where there appeared to be a lack of awareness of Stockport Together programmes, and queried the effectiveness of holding to account arrangements. Mr H Mullen acknowledged these comments and noted the importance of relevant metrics for monitoring purposes.

In response to a question from Mrs I Daniel, regarding the importance of common IT systems to ISS programmes, Mr H Mullen acknowledged the importance and noted that all Stockport GPs used the EMIS system and that the Community EPR was also EMIS-based. He also advised that a data-sharing pilot had recently been agreed. In response to a question from Ms C Mitchell, Mr H Mullen confirmed that relevant individuals had access to the summary care record.

Mr T Johnson commented on the importance of individuals having confidence in the effectiveness of services in the community. Mr H Mullen agreed and noted the importance of effective communication and engagement to raise awareness of the availability of community services. In response to a question from Mr G Wright, Mr H Mullen provided an overview of staff input to the Strategy review and noted that a series of engagement events had been held during the period July-October 2017.

On conclusion of the discussion, Mr H Mullen advised that Governors were welcome to provide any feedback on the revised strategy proposals to either himself or Mrs A Gaukroger, Director of Strategy & Planning, by 30 April 2018.

4/18 Draft Operational Plan 2018/19

Following an introduction from Mr A Belton, Mr M Sugden advised that the Draft Operational Plan 2018/19 had been submitted to NHS Improvement by the deadline of 8 March 2018. He advised that the Trust had originally planned to have a draft plan produced by 31 December 2017 but noted that the impact of winter pressures, clarity of commissioning intentions and the national planning timetable had impaired this aim.

Mr M Sugden informed Governors that the draft Plan document had been subject to review by the Finance & Performance Committee and advised that the Committee had requested a detailed implementation plan in April 2018 to provide assurance on Plan delivery. He noted that the Trust had received feedback from NHS Improvement requesting clarification on a number of areas of Draft Plan content and advised that the deadline for submission of the Final Operational Plan 2018/19 was 30 April 2018.

Mr H Mullen then briefed the Council on the content of a slide set which covered the following subject areas:

- Plan Overview
- Key Challenges 2018/19

- Link to Sustainability Plans & Transformational Plans
- Summary & Next Steps

There followed a discussion on the challenge faced by the Trust in delivering a cost improvement programme with a value of £15m. Mr H Mullen emphasised the importance of realising recurrent efficiency savings and, in response to questions, provided an explanation of the financial impact associated with funding to meet inflationary pressures. Mr R Greenwood noted the importance of integrated reporting and Mr H Mullen advised that this approach would be reflected in a revised Integrated Performance Report for 2018/19.

The Council of Governors:

- Received and noted the Draft Operational Plan 2018/19

Mr H Mullen left the meeting.

5/18 Non-Executive Director Appointment

Mr A Belton presented a report seeking approval for an extension to the Term of Office for Mr M Sugden. He briefed the Council on the content of the report and explained the rationale for seeking an extension to the Term of Office. He noted that the proposal had been considered by the Nominations Committee on 4 January 2018 and had been recommended for approval.

The Council of Governors:

- Approved an extension to the Term of Office for Mr M Sugden for a 12-month period commencing 1 April 2018.

6/18 Governor Committee Arrangements

Mr L Jenkins noted that revised arrangements for Governor Committees had been approved by the Council of Governors on 6 December 2017. He acknowledged that the arrangements remained a 'work in progress' but advised that some Governors felt that the arrangements were not working in relation to the number of members of Committees and, in particular, observer arrangements which prevented observers from participating in meetings. He iterated a view that observers should be allowed to take part and suggested that this would be manageable if meetings were chaired effectively. He suggested that Terms of Reference for Committees should be revised accordingly.

A number of differing views were expressed and it was noted that the matter should have been the subject of a formal proposal. It was agreed that the subject would be considered at the next Council of Governors meeting on 16 April 2018. **LJ**

7/18 Any Other Business

Mr A Belton invited Governors to forward any suggestions they may have of means of enhancing engagement and Governor understanding. He noted production of a monthly 'Governor Digest' as an example.

The Council of Governors agreed that, due to time constraints, business scheduled to have been conducted in private session would be carried forward to the next meeting.

8/18 Date, time and venue of next meeting.

The next meeting of the Council of Governors will be held on Monday, 16 April 2018, in the Lecture Theatres, Pinewood House, commencing at 6.00pm.

Signed: _____ Date: _____

COUNCIL OF GOVERNORS: ACTION TRACKING LOG

Ref.	Meeting	Minute Ref	Subject	Action	Responsible
05/16	8 Dec 16	53/16	Lead Governor Communication	*Cessation of 'Park & Ride' Service between Hazel Grove Park & Ride and Stepping Hill Hospital* - Mr L Jenkins agreed to liaise with Ms S Toal who would take the enquiry forward on behalf of the Trust. **Update 20 Apr 17** – Mr L Jenkins briefed the Council of the latest position and noted that correspondence between the Trust and Stagecoach representatives had not led to a satisfactory outcome. Cllr T McGee offered follow up the issue with Stagecoach. **Update 24 Jul 17** – Cllr T McGee noted that there was new management at Stagecoach and to date he had been unable to receive a satisfactory response. He advised the Council that he would contact Stagecoach again and ask them to reconsider the decision to cease the Park & Ride service to the hospital. **Update 9 Oct 17** – The Director of Support Services advised that as part of a wider engagement with the public regarding car parking at the hospital and surrounding areas, Stagecoach had indicated that no changes were anticipated to the Park & Ride arrangements at least until the Trust had prepared proposals in this area. **Update 6 Dec 17** – Mr L Jenkins reported that Cllr T McGee had been unable to make progress with Stagecoach with regard to the Park & Ride service issue. He wished to thank Cllr T McGee for his help with the matter and it was agreed to close this action.	L Jenkins / S Toal Cllr T McGee
03/17	9 Oct 17	32/17	CQC Report	The Interim Director of Nursing invited any interested Governors to take part in a mock CQC assessment which would be held on 24 October 2017 and agreed to circulate further information regarding the event to Governors. **Update 6 Dec 17** – Information had been circulated to Governors. Action complete.	R Holt (Interim Director of Nursing)

04/17	9 Oct 17	37/17	Reports from Governor Committees	In response to a question from Mrs L Woodward, the Interim Director of Nursing noted that Governors would be welcome to take part in the twice-weekly patient safety walkabouts and agreed to forward the dates to Governors. **Update 6 Dec 17** – Information had been circulated to Governors. Mr T Johnson encouraged Governors to take part in the patient safety walkabouts. Action complete.	R Holt (Interim Director of Nursing)
05/17	6 Dec 17	44/17	Report of the Chief Executive	The Director of Nursing & Quality advised that Governors would be invited to assist in the establishment of a quality improvement target and noted that a workshop would be held in January 2018 to consider this topic further.	A Lynch (Director of Nursing & Quality)
06/17	6 Dec 17	44/17	Report of the Chief Executive	In response to a question from Mr T Johnson, the Director of Corporate Affairs advised that the Council of Governors would receive a presentation regarding the Trust's medium-term Financial Strategy at the meeting on 16 April 2018.	F Patel (Director of Finance)
1/18	21 Mar 18	6/18	Governor Committee Arrangements	It was agreed that the subject of Committee membership and role of observers would be considered at the next Council of Governors meeting on 16 April 2018.	L Jenkins (Lead Governor)

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NHS
Stockport
NHS Foundation Trust

Report to:	Council of Governors	**Date:**	23 May 2018
Subject:	Appointment of Non-Executive Director		
Report of:	Chair	**Prepared by:**	P Buckingham

REPORT FOR APPROVAL

Corporate objective ref:	N/A	**Summary of Report** *Identify key facts, risks and implications associated with the report content.* The purpose of this report is to seek approval from the Council of Governors for the appointment of a Non-Executive Director.
Board Assurance Framework ref:	N/A	
CQC Registration Standards ref:	N/A	
Equality Impact Assessment:	☐ Completed X Not required	

Attachments:	Nil

This subject has previously been reported to:	☐ Board of Directors ☐ Council of Governors ☐ Audit Committee ☐ Executive Team ☐ Quality Committee ☐ F&P Committee	☐ PP Committee ☐ SD Committee ☐ Charitable Funds Committee ☐ Nominations Committee ☐ Remuneration Committee ☐ Joint Negotiating Council ☐ Other

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1. INTRODUCTION

1.1 The purpose of this report is to seek approval from the Council of Governors for the appointment of a Non-Executive Director.

2. BACKGROUND

2.1 A Non-Executive Director vacancy will arise when Mr J Sandford completes his Term of Office on 30 June 2018. The Nominations Committee met on 1 March 2018 to consider both the skill sets / competences required of a new Non-Executive Director and the approach for a recruitment and selection process. The Committee agreed the following specific skill set for the post:

- Significant Board level experience in a large, complex organisation
- Recent and relevant financial experience
- Audit Committee experience, preferably with experience as Chair of Audit Committee.

2.2 The Committee agreed that the Trust should engage external Recruitment Consultancy support to conduct the recruitment process and Gatenby Sanderson Ltd was subsequently appointed to provide this service.

3. INTERVIEW PROCESS

3.1 Interviews were held on 15 May 2018. A formal interview panel was constituted in accordance with the Nominations Committee Terms of Reference which comprised the Chair, Mr L Jenkins, Lead Governor, Mrs E Brown, Public Governor and Mr G Wright, Public Governor. Also present at the interviews in an advisory capacity was Ms E Pickup from Gatenby Sanderson. Ms Pickup did not play any part in the decision-making process.

3.2 All candidates participated in discussion prior to their formal interviews with a Focus Group comprised of a Governor, an Executive Director and a Senior Manager. The Interview Panel was provided with a summary of observations on candidates from the Focus Group on completion of the formal interviews. Following careful and considered deliberation, the Interview Panel unanimously recommended the following candidate for appointment:

3.3 **Mr David Hopewell.** David is a fellow of the Institute of Chartered Accountants and trained with Deloitte, Haskins and Sells before moving into industry with senior finance positions in Shell in both the UK and West Africa. He moved into the public sector in 1994 and was Corporate Director at Government Office for the North West (GONW) (1998-2006) where he was a Board Director with a portfolio including finance, partner audit, human resources, ICT, communications, governance and Ministerial business. After GONW closed he spent a short period as Director of

Resources and Company Secretary for Cheshire Peaks and Plains Housing Trust (2006-2007). Since 2007, David has had a portfolio carer working as a Resources Director for Retrak, a charity running projects for street children in Africa (2007-11), alongside Non-Executive appointments in a housing association (2009-12) and his current position as Non-Executive Director with Mid Cheshire Hospitals NHS Foundation Trust.

3.4 Confirmation of the ability of the recommended candidate to meet the time commitment required of the Non-Executive Director role was provided to the Interview Panel and no issues were identified with regard to compliance with the Fit & Proper Person requirements.

3.5 The recruitment process produced a strong field of candidates for the Non-Executive Director position and the Interview Panel was satisfied that the recommended candidate will prove to be highly effective in the role and will add value to the Board of Directors.

5. TERM OF OFFICE

5.1 It is proposed that the recommended candidate be appointed for a three year term with effect from 1 July 2018.

6. RECOMMENDATIONS

6.1 The Council of Governors is recommended to:

- Approve the appointment of Mr David Hopewell as Non-Executive Director in accordance with the term of office proposal set out at s5.1 of the report.

Stockport NHS Foundation Trust

Report to:	Council of Governors	**Date:**	23 May 2018
Subject:	Revised Integrated Performance Report		
Report of:	Interim Chief Executive	**Prepared by:**	Mr P Buckingham

REPORT FOR INFORMATION & DISCUSSION

Corporate objective ref:	All
Board Assurance Framework ref:	-----
CQC Registration Standards ref:	-----
Equality Impact Assessment:	☐ Completed ☒ Not required

Summary of Report

The purpose of the report is to present a revised Integrated Performance Report to the Council of Governors for information and discussion.

Attachments: Annex A – Integrated Performance Report

This subject has previously been reported to:	☒ Board of Directors	☐ PP Committee
	☐ Council of Governors	☐ SD Committee
	☐ Audit Committee	☐ Charitable Funds Committee
	☐ Executive Team	☐ Nominations Committee
	☐ Quality Committee	☐ Remuneration Committee
	☐ F&P Committee	☐ Joint Negotiating Council
		☐ Other

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1. INTRODUCTION

1.1 The purpose of the report is to present a revised Integrated Performance Report to the Council of Governors for information and discussion.

2. BACKGROUND

2.1 As part of work being undertaken to enhance Board and Committee oversight, the Board of Directors commissioned a review of the Integrated Performance Report which is considered at each Board of Directors meeting.

2.2 Work on the review, supported by best practice advice from Mrs C Griffiths, Improvement Director, was carried out during the period November 2017 - March 2018. Followers of Board meetings will have noted regular progress reports to the Board as the revised Integrated Performance Report has been developed.

3. CURRENT SITUATION

3.1 A first review of the revised Integrated Performance Report will be undertaken by the Board of Directors on 24 May 2018. While it is likely that further refinements to format and content will be made, the revised document is a vast improvement on previous reports and is the result of tremendous work carried out by the Performance and Informatics teams.

3.2 A copy of the revised Integrated Performance Report, which reflects April 2018 data, is included for reference at Annex A to this report. Feedback from Governors on this revised approach would be welcomed.

4. RECOMMENDATIONS

4.1 The Council of Governors is recommended to:

- Receive the Integrated Performance Report at Annex A for information and discussion.

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Report To:	Board of Directors	**Date:**	24 May 2018
Subject:	Trust Integrated Performance Report (Reporting Period: Month 1 2018/19)		
Report of:	Director of Support Services	**Prepared by:**	Information & Performance Teams

REPORT FOR ASSURANCE

Corporate Objective Ref:	☐ Completed ☑ Not Required	**Summary of Report** Trust Integrated Performance Report enclosed.
Board Assurance Framework Ref:	☐ Completed ☑ Not Required	
CQC Registration Standards Ref:	☐ Completed ☑ Not Required	
Equality Impact Assessment:	☐ Completed ☑ Not Required	

Attachments:

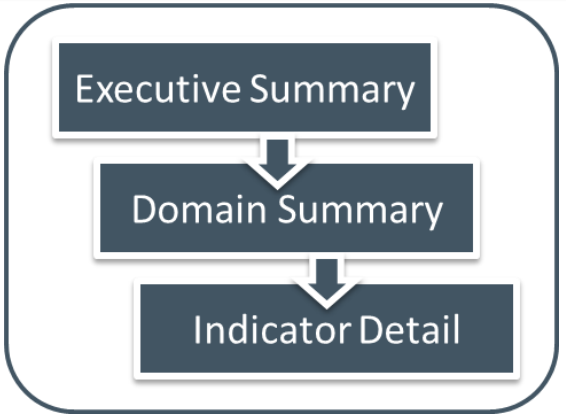
This subject has previously been reported to:	☐ Board of Directors	☐ SD Committee
	☐ Council of Governor	☐ Charitable Funds Committee
	☐ Audit Committee	☐ Nominations Committee
	☐ Executive Team	☐ Remuneration Committee
	☐ Quality Assurance Committee	☐ Joint Negotiating Council
	☐ F&P Committee	☐ Other
	☐ PP Committee	

Introduction

The Board report layout consists of three sections:

Executive Summary: Provides a high level summary of performance against the Trusts' Key Performance Indicators. The indicators are grouped by the Care Quality domains of Safe, Caring, Responsive, Effective and Efficient. The summary page reflects the Trusts' performance against the Single Oversight Framework indicators as monitored by NHS Improvement.

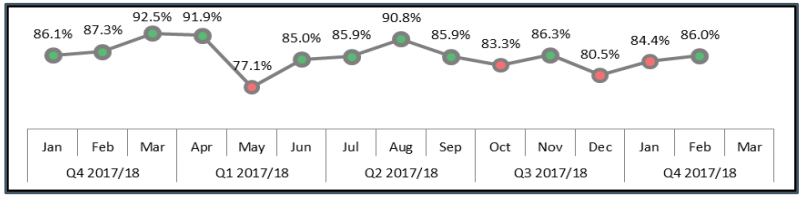
Domain Summary: Provides a summary of indicator level performance, arranged by Care Quality domain. For each indicator, performance against target is shown at Trust and Business Group level (where applicable). A grey marker reflects there is no target at this point in time. Page numbers on this level of the report advise where the detailed information for each indicator can be located.



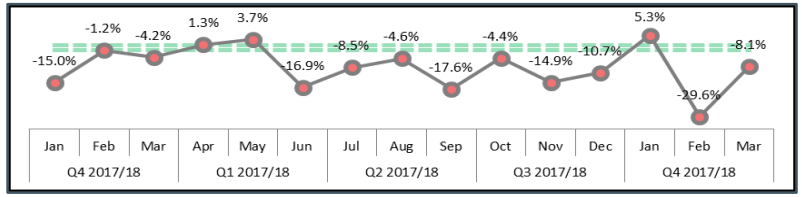
Indicator Detail: Provides detailed information for each indicator. This includes a chart representing the performance trend, and narrative describing the actions that are being undertaken in relation to performance. Specific Quality metrics will be reported a month in arrears as agreed by the Chief Nurse and Medical

Chart Summary

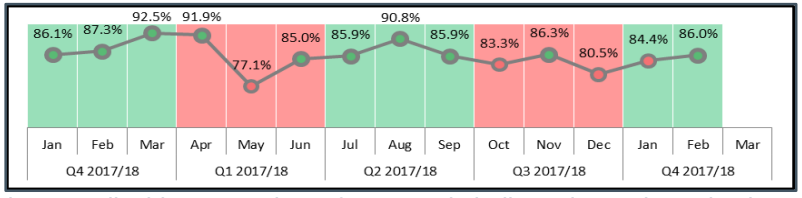
The following chart types are in use throughout the report:



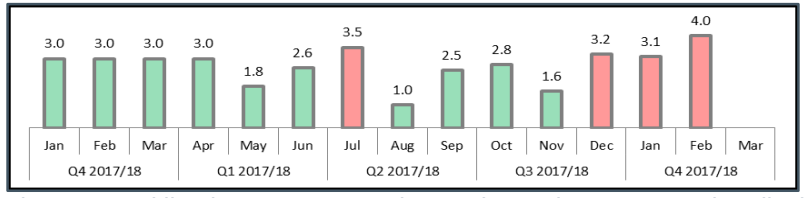
Trends are represented as a line where possible, with each monthly marker coloured to indicate achievement or non-achievement against target.



For indicators measured against a target variance, the green dotted lines indicate the target "safe-zone".



Where applicable, quarterly performance is indicated as coloured columns behind the main trend line.

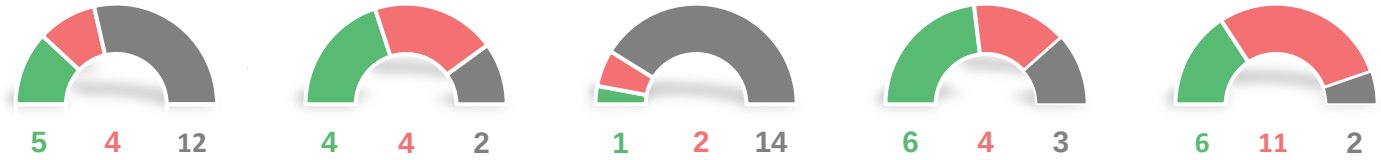


Where a trend line is not as appropriate, column charts are used to display information on indicator counts and totals.

Executive Summary

Stockport NHS Foundation Trust

Performance



Indicators

C.Diff Infection Count (lapses)	Bank & Agency Costs	Complaints Rate	A&E: 4hr Standard	Agency Spend: Cap
C.Diff Infection Rate	Emergency C-Section Rate	DSSA (mixed sex)	Cancer 62 Day Standard	I&E Position
E.Coli Infection Rate	HSMR Mortality Ratio	Friends & Family: A&E	Dementia: Finding Question	I&E Margin
MRSA Infection Rate	SHMI Mortality Ratio	Friends & Family: Inpatient	Diagnostics: 6 Week Standard	Financial Sustainability
MSSA Infection Rate	Never Events	Friends & Family: Maternity	RTT: Incomplete Pathways	Sickness Absence Rate
VTE Risk Assessment	Patient Safety Incident Rate	Patient Safety Alerts		Workforce Turnover

Key Changes to the indicators in this period are:
Safe:
Effective:
Caring:
Responsive:
Efficient:

Domain Summary

Indicator	Exec	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Safe													
C.Diff Infection Rate	CN&DQG	Mar-18		9.35							12.78		32
C.Diff Infection Count (lapses in care)	CN&DQG	Mar-18	<=17 *	0							4		32
MRSA Infection Rate	CN&DQG	Mar-18		0.89							0.40		33
MSSA Infection Rate	CN&DQG	Mar-18		8.46							7.87		33
E.Coli Infection Rate	CN&DQG	Mar-18		20.03							21.60		34
E.Coli Infection Count	CN&DQG	Mar-18	<=37 *	5							45		34
Falls: Total Incidence of Inpatient Falls	CN&DQG	Apr-18	<=115 *	120							120		35
Falls: Causing Moderate Harm and Above	CN&DQG	Apr-18	<=15 *	1							1		35
Pressure Ulcers: Hospital, Stage 2	CN&DQG	Mar-18		7							78		36
Pressure Ulcers: Hospital, Stage 3	CN&DQG	Mar-18		1							11		36
Pressure Ulcers: Hospital, Stage 4	CN&DQG	Mar-18		0							3		37
Pressure Ulcers: Community, Stage 2	CN&DQG	Mar-18		11							192		37
Pressure Ulcers: Community, Stage 3	CN&DQG	Mar-18		2							29		38

* Target calculated against Cumulative/YTD performance
** YTD figures related to 2017/18

Domain Summary

Indicator	Exec	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Safe													
Pressure Ulcers: Community, Stage 4	CN&DQG	Mar-18		1		↑					9	Δ	38
Safety Thermometer: Hospital	CN&DQG	Apr-18	>= *95%*	95.3%		↑					95.3%	Δ	39
Medication Errors: Overall	CN&DQG	Apr-18		64		↓					64		39
Medication Errors: Moderate Harm and Above	CN&DQG	Apr-18		3.1%		↑					3.1%		40
VTE Risk Assessment	CN&DQG	Mar-18	>= *95%*	96.5%		↓					96.3%		40
Clinical Correspondence	COO	Apr-18	>= *95%*	71.8%		↑					71.8%		41
Flu Vacination Uptake	DoW&OD	Mar-18	>= *70%*	78.6%		↑					71.1%	Δ	41
Discharge Summaries	MD	Apr-18	>= *95%*	85.3%		↑					85.3%		42

* Target calculated against Cumulative/YTD performance
** YTD figures related to 2017/18

Domain Summary

Indicator	Exec	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Effective													
Patient Safety Incident Rate	CN&DQG	Apr-18		47.22									20
Emergency C-Section Rate	CN&DQG	Apr-18	<= 15.4%	16.6%							16.6%		21
Never Event: Incidence	CN&DQG	Apr-18	<= 0	0							0		21
Duty of Candour Breaches	CN&DQG	Apr-18		0							0		22
Stranded Patients	COO	Apr-18	<= 35%	47.0%							47.0%		22
Delayed Transfers of Care (DTOC)	COO	Apr-18	<= 3.3%	2.1%							2.1%		23
Medical Optimised Awaiting Transfer (MOAT)	COO	Apr-18	<= 40	110							110		23
Bank & Agency Costs	DoW&OD	Apr-18	<= 5%	11.3%							11.3%		24
Mortality: HSMR	MD	Feb-18	<= 100	93.22									24
Mortality: SHMI	MD	Nov-17	<= 1	0.95									25

* Target calculated against Cumulative/YTD performance
** YTD figures related to 2017/18

Domain Summary

Indicator	Exec	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Caring													
Patient Safety Alerts: Completion	CN&DQG	Apr-18	>= 100%	80.0%							80.0%		12
DSSA (mixed sex)	CN&DQG	Apr-18	<= 0	0							0	Δ	12
Complaints Rate	CN&DQG	Apr-18		1.0%							1.0%		13
Complaints: Response Rate 25	CN&DQG	Apr-18		1.9%							1.9%		13
Complaints: Response Rate 45	CN&DQG	Apr-18		9.3%							9.3%		14
Complaints: Ombudsmen Cases	CN&DQG	Apr-18		0							0		14
Complaints Closed: Overall	CN&DQG	Apr-18		54							54		15
Complaints Closed: Upheld	CN&DQG	Apr-18		9							9		15
Complaints Closed: Partially Upheld	CN&DQG	Apr-18		25							25		16
Complaints Closed: Not Upheld	CN&DQG	Apr-18		20							20		16
Compliments	CN&DQG	Apr-18		2							2		17
Friends & Family Test: Response Rate	CN&DQG	Apr-18		28.3%							28.3%		17
Friends & Family Test: Inpatient	CN&DQG	Apr-18		95.0%							95.0%		18

* Target calculated against Cumulative/YTD performance
** YTD figures related to 2017/18

Domain Summary

Indicator	Exec	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Caring													
Friends & Family Test: A&E	CN&DQG	Apr-18		90.0%		↑					90.0%		18
Friends & Family Test: Maternity	CN&DQG	Apr-18		96.3%		↓					96.3%		19
Staff Friends & Family Test	CN&DQG	Mar-18		73.7%		↓					76.4%		19
Diabetes Reviews	MD	Apr-18	>= 90%	59.5%		↑					59.5%		20

* Target calculated against Cumulative/YTD performance
** YTD figures related to 2017/18

Domain Summary

Indicator	Exec	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Responsive													
Dementia: Finding Question	CN&DQG	Mar-18	>= 90%	93.3%							92.9%		25
Dementia: Assessment	CN&DQG	Mar-18	>= 90%	100.0%							92.2%		26
Dementia: Referral	CN&DQG	Mar-18	>= 90%	100.0%							98.1%		26
Serious Incidents: STEIS Reportable	CN&DQG	Apr-18		6							6		27
Litigation: Claims	CN&DQG	Apr-18		5							5		27
Litigation: Key Risk Claims Rate	CN&DQG	Apr-18		100.0%							100.0%		28
A&E: 4hr Standard	COO	Apr-18	>= 95%	80.2%							80.2%		28
A&E: 12hr Trolley Wait	COO	Apr-18	<= 0	7							7		29
Cancer 62 Day Standard	COO	Apr-18	>= 85%	88.6%							88.6%		29
Diagnostics: 6 Week Standard	COO	Apr-18	>= 99%	99.4%							99.4%		30
Referral to Treatment: Incomplete Pathways	COO	Apr-18	>= 92%	87.8%							87.8%		30
Outpatient Activity vs. Plan	COO	Apr-18	<= 1%	-0.5%							-0.5%		31
Elective Activity vs. Plan	COO	Apr-18	+/- 1%	-6.1%							-6.1%		31

* Target calculated against Cumulative/YTD performance
** YTD figures related to 2017/18

Domain Summary

Indicator	Exec	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Efficient / Well Led													
Financial Efficiency: I&E Margin	DoF	Apr-18	<= 2	4	🔴	→					4	△	42
Financial Controls: I&E Position	DoF	Apr-18	<= 1%	-2.3%	🟢	↑					-2.3%	△	43
Cash	DoF	Apr-18	+/- 1%	5.6%	🔴	↓					5.6%	△	43
Financial Use of Resources	DoF	Apr-18	<= 3	3	🟢	→					3	△	44
Elective Income vs. Plan	DoF	Apr-18	+/- 1%	-9.8%	🔴	↑	🔴	🔴	🔴	🔴	-9.8%	△	44
CIP Cumulative Achievement	DoF	Apr-18	+/- 1%	-53.2%	🔴	↓					-53.2%	△	45
Capital Expenditure	DoF	Apr-18	+/- 10%	-20.9%	🔴	↑					-20.9%	△	45
Financial Sustainability	DoF	Apr-18	<= 2	4	🔴	→					4		46
Sickness Absence Rate	DoW&OD	Apr-18	<= 3.5%	4.1%	🔴	↓	🔴	🔴	🟢	🔴	4.1%		46
Appraisal Rate: Non-medical	DoW&OD	Apr-18	>= 95%	95.1%	🟢	↑	🔴	🔴	🟢	🟢	95.1%	△	47
Appraisal Rate: Medical	DoW&OD	Apr-18	>= 95%	95.7%	🟢	↓	🔴	🔴	🟢	🟢	95.7%	△	47
Statutory & Mandatory Training	DoW&OD	Apr-18	>= 90%	91.3%	🟢	↑					91.3%	△	48
Workforce Turnover	DoW&OD	Apr-18	<= 13.94%	13.9%	🟢	↓	🔴	🔴	🟢	🟢		△	48

* Target calculated against Cumulative/YTD performance
** YTD figures related to 2017/18

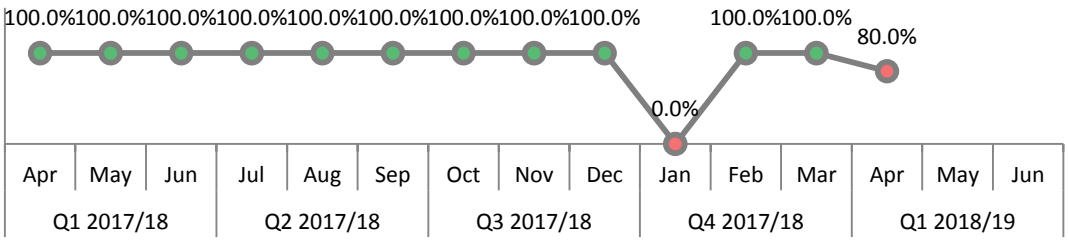
Domain Summary

Indicator	Exec	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Efficient / Well Led													
Staff in Post	DoW&OD	Apr-18	>= 90%	89.7%							89.7%		49
Agency Shifts Above Cap	DoW&OD	Apr-18	<= 0	783							783		49
Agency Spend: Distance from Cap	DoW&OD	Apr-18	<= 3%	14.6%							14.6%		50
Mortality: Deaths in ED or as Inpatient	MD	Apr-18		107							107		50
Mortality: Case Note Reviews	MD	Apr-18		33							33		51
Emergency Readmission Rate	MD	Feb-18	<= 7.9%	8.4%							8.6%		51

* Target calculated against Cumulative/YTD performance
** YTD figures related to 2017/18

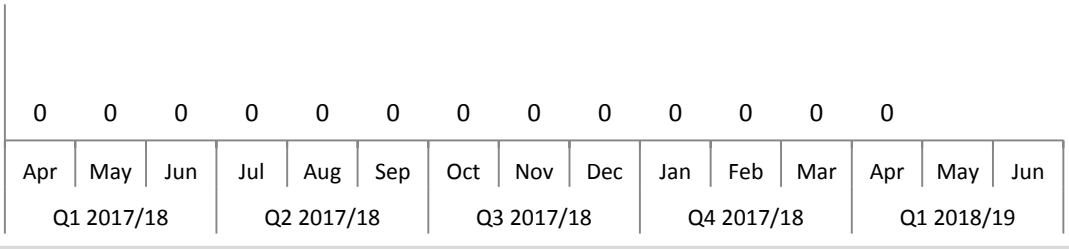
Indicator Detail

Apr-18	Patient Safety Alerts: Completion
1	The percentage of Patient Safety Alerts that are completed within their due date.
Target	In April 2018, 5 patient safety alerts were due to be closed with all actions taken. There was a delay in closing one alert.
>= 100%	



Actions
The CAS alert system is in use and this will prevent a reoccurrence of the delay of alerts being circulated.

Apr-18	DSSA (mixed sex)
0.0%	Total number of occasions sexes were mixed on same sex wards
Target	Our aim is to have no breaches of the delivery of single sex accommodation. There were no breaches in April 2018.
<= 0	

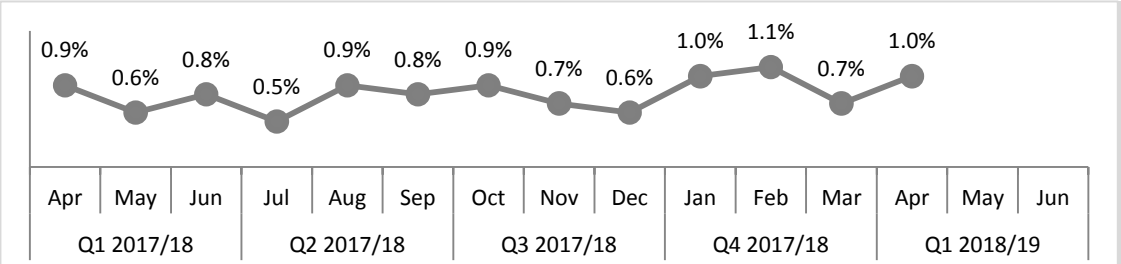


Actions
This standard is monitored through the patient experience group. There is no current actions required as we are meeting this standards.

Indicator Detail

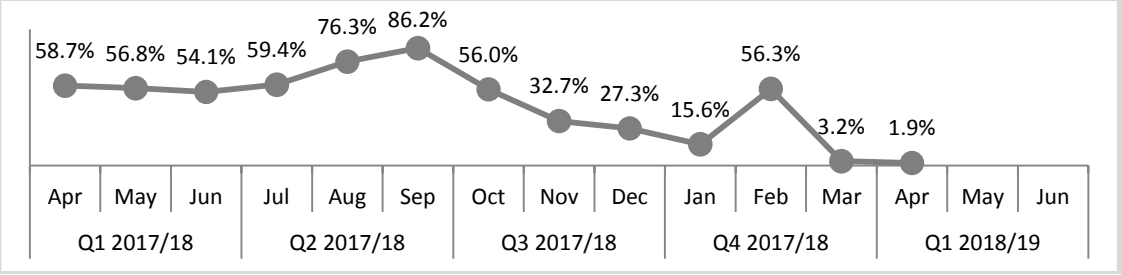
Apr-18	Complaints Rate
1.0%	The total number of formal written complaints received compared with the whole time equivalent staff.
Target	The management of complaints is under review and this has resulted in a delay in how efficiently complaints are being managed.

Actions
A full review of the complaints process is in progress.



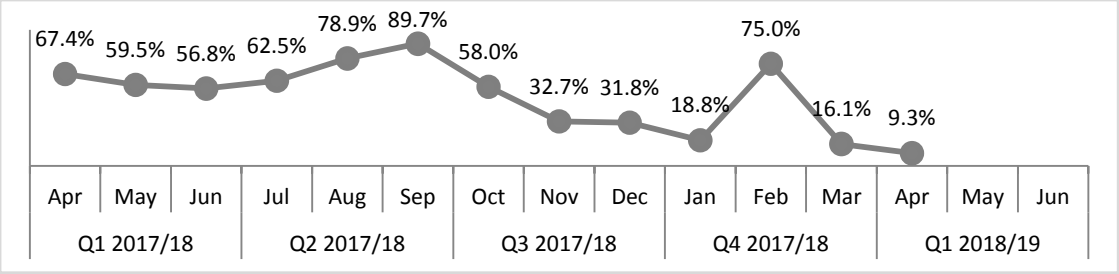
Apr-18	Complaints: Response Rate 25
1.9%	The percentage of formal complaints responded to within 25 days.
Target	Following discussions with our commissioners, there has been an agreement to change the timescales of formal complaints being handled within 25 days to 45 days.

Actions
These changes will be incorporated within the complaints policy which is currently under review.



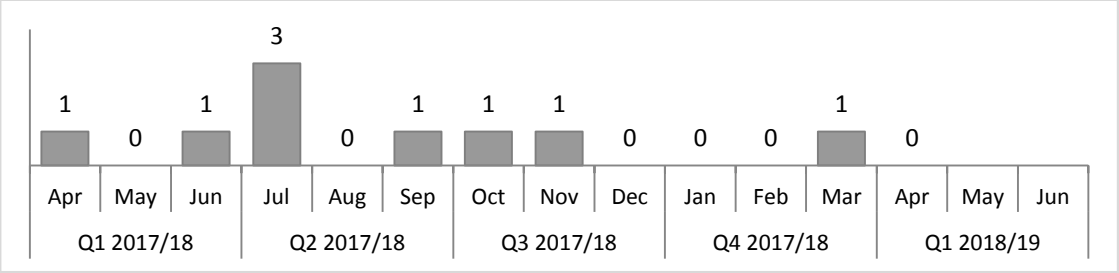
Indicator Detail

Apr-18	Complaints: Response Rate 45
9.3%	The percentage of formal complaints responded to within 45 days.
Target	The management of complaints is under review and this has resulted in a delay in how efficiently complaints are being managed.



Actions
During quarter 1 a trajectory will be developed to record and monitor improvements in complaint responses. The triangulation of data will enable us to give a thematic analysis of overall patient experience at the trust.

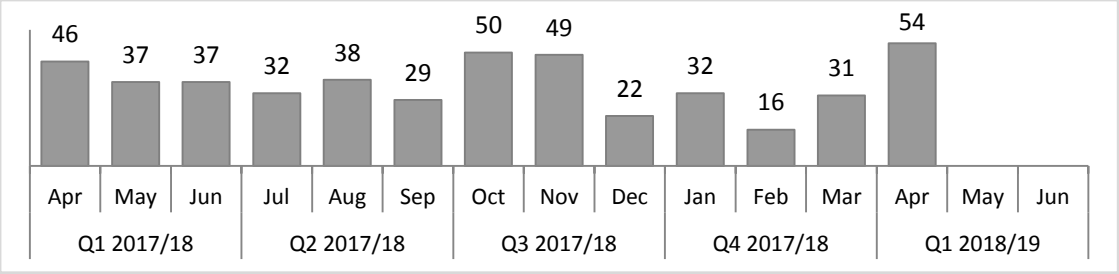
Apr-18	Complaints: Ombudsmen Cases
0	The total number of open Ombudsmen cases.
Target	The management of complaints is under review and this has resulted in a delay in how efficiently complaints are being managed.



Actions

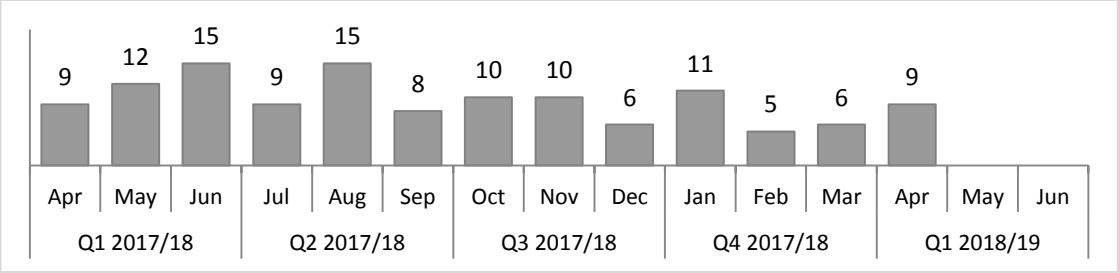
Indicator Detail

Apr-18	Complaints Closed: Overall
54	The total number of formal complaints that have been closed.
Target	The management of complaints is under review and this has resulted in a delay in how efficiently complaints are being managed.



Actions
During quarter 1 a trajectory will be developed to record and monitor improvements in compliant responses.

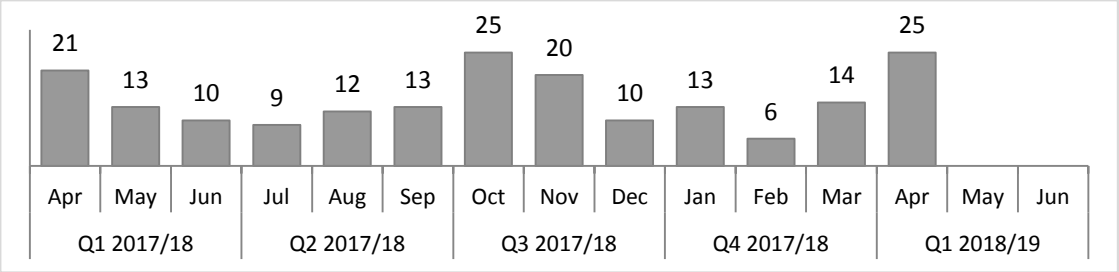
Apr-18	Complaints Closed: Upheld
9	The total number of upheld formal complaints that have been closed.
Target	The management of complaints is under review and this has resulted in a delay in how efficiently complaints are being managed.



Actions
We are developing a process whereby themes from closed complaints will available following the review of the complaints policy.

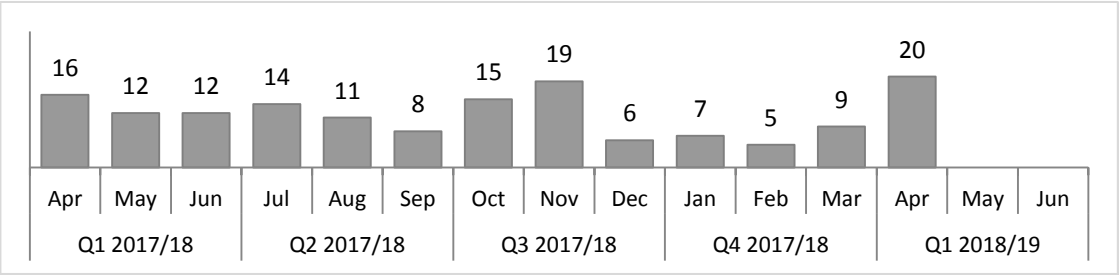
Indicator Detail

Apr-18	Complaints Closed: Partially Upheld
25	The total number of partially upheld formal complaints that have been closed.
Target	The management of complaints is under review and this has resulted in a delay in how efficiently complaints are being managed.



Actions
We are developing a process whereby themes from closed complaints will available following the review of the complaints policy.

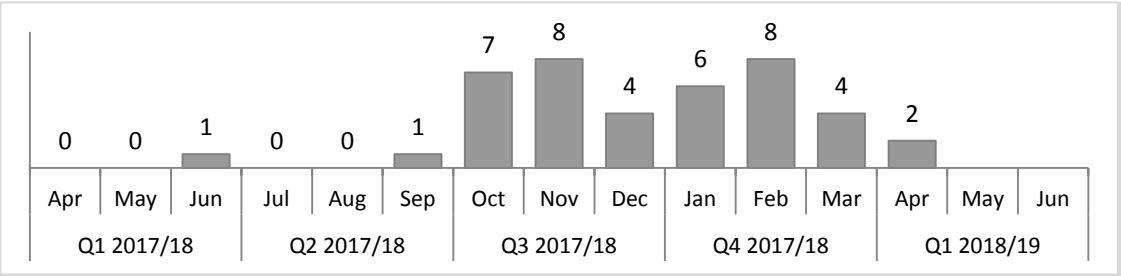
Apr-18	Complaints Closed: Not Upheld
20	The total number of not upheld formal complaints that have been closed.
Target	The management of complaints is under review and this has resulted in a delay in how efficiently complaints are being managed.



Actions
We are developing a process whereby themes from closed complaints will available following the review of the complaints policy.

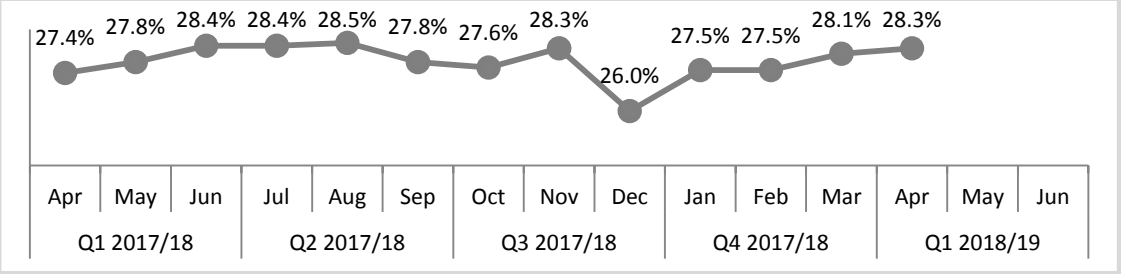
Indicator Detail

Apr-18	Compliments
2	Total number of compliments received.
Target	The collection of compliments is not a well established process currently.



Actions
The complaints policy is currently under review and will include the recording of compliments going forward.

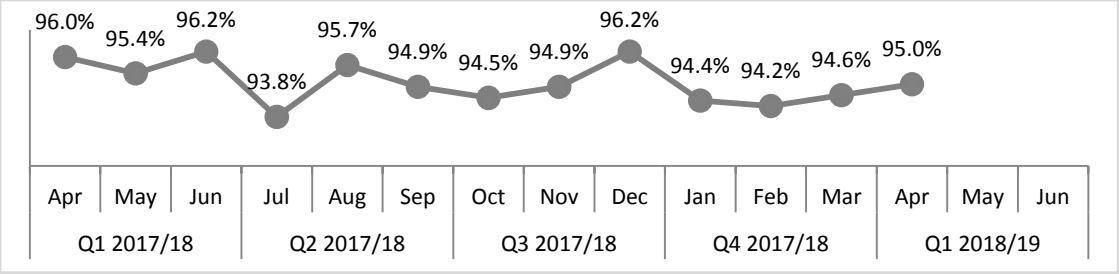
Apr-18	Friends & Family Test: Response Rate
28.3%	The percentage of eligible patients completing an FFT survey.
Target	There is not a required response rate for the Family and Friends Test for the organisation.



Actions
The importance of feedback from patients and relatives is crucial to supporting the quality improvement plan for the organisation. The patient experience strategy is in development and will outline the key areas of focus in line with the objectives of the quality improvement plan.

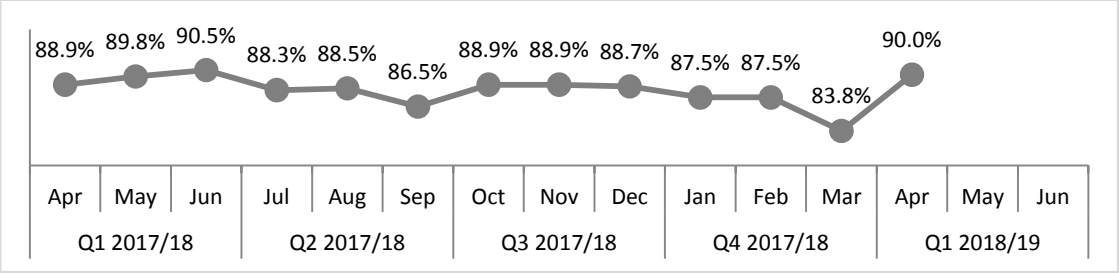
Indicator Detail

Apr-18	Friends & Family Test: Inpatient
95.0%	The percentage of surveyed inpatients who are extremely likey or likely to recommend the Trust for care.
Target	Positive comments received for inpatient areas were related to kind, friendly, professional staff. Negative comments continue to relate to the lack of nursing staff, poor cleanliness in some areas and poor communication.



Actions
Ensure feedback is provided to the teams involved in providing care. The triangulation of data related to patient experience is being developed to ensure the themes are captured and will be shared in the patient experience report going forward. The Trust is working with NHS Improvement to support the workforce strategy with a number of work streams developed. These include: Supporting staff to move ward areas Recruitment fairs and events International recruitment

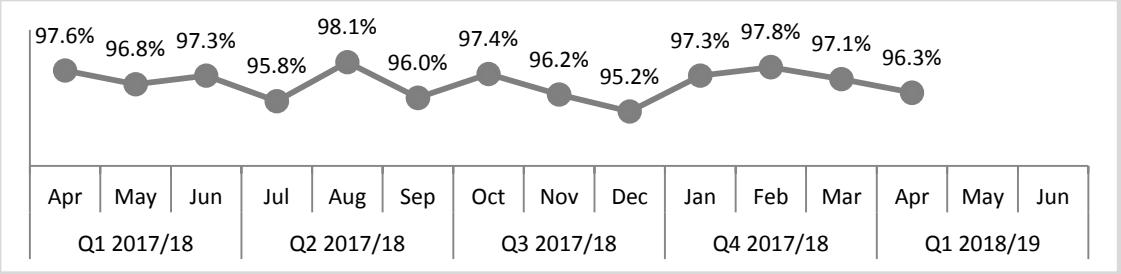
Apr-18	Friends & Family Test: A&E
90.0%	The percentage of surveyed A&E patients who are extremely likey or likely to recommend the Trust for care.
Target	Positive comments related to caring staff working extremely hard under challenging circumstances. Many positive comments related to friendly, cheerful staff. Negative comments continue to relate to long waiting times.



Actions
Ensure the positive feedback is received to the teams involved in providing care. The waiting times in the emergency department remain a challenge and there is a workstream associated with improving overall performance.

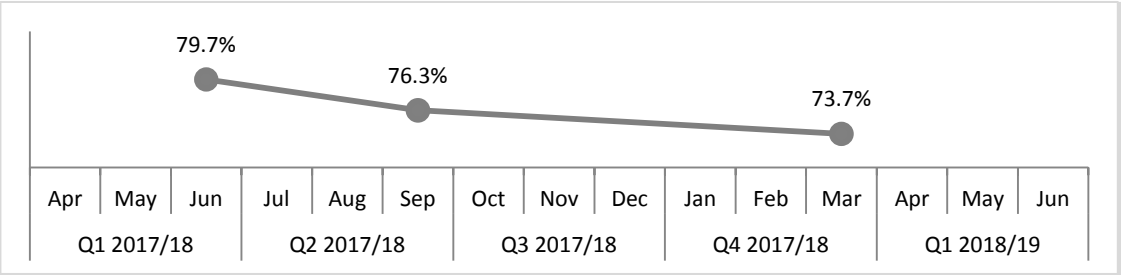
Indicator Detail

Apr-18	Friends & Family Test: Maternity
96.3%	The percentage of surveyed maternity patients who are extremely likey or likely to recommend the Trust for care.
Target	All comments continue to be positive and continue to be related to caring and compassionate staff. Many positive comments were made about the excellent advice and support given in relation to breastfeeding.



Actions
Ensure the feedback is received to the teams involved in providing care.

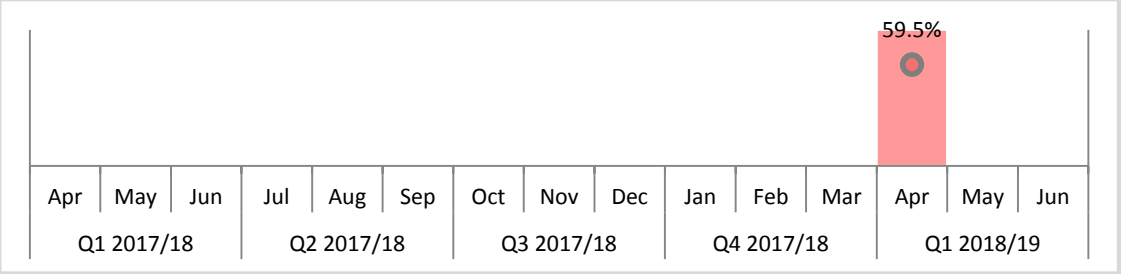
Mar-18	Staff Friends & Family Test
73.7%	The percentage of all surveyed staff who are extremely likely or likely to recommend the Trust for care.
Target	The survey is undertaken on a quarterly basis.



Actions

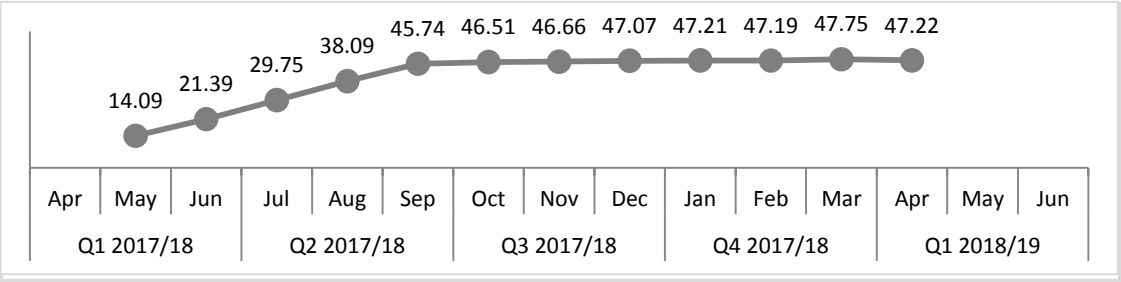
Indicator Detail

Apr-18	Diabetes Reviews
59.5%	The percentage of inpatients with known diabetes, on treatment and with a blood glucose of less than 3mmol/L, that have been reviewed by the diabetes team prior to discharge.
Target	This is a new metric, and represents a first attempt to summarise the management of clinically significant hypoglycaemia by the specialist diabetes team. 59.5% of Inpatients with clinically significant hypoglycaemia in the month of April 2018 were reviewed by a member of the Diabetes specialist team.
>= 90%	



Actions
We will continue to work on the collection of this data and the improvement in the performance against this metric.

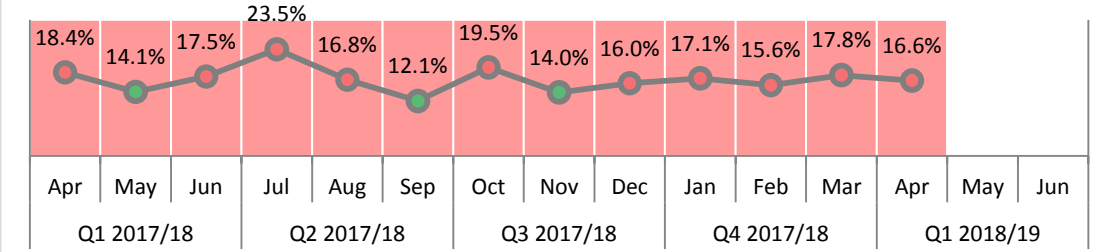
Apr-18	Patient Safety Incident Rate
47.22	Average number of patient safety incidents for every 1000 bed days, calculated using a rolling 6 month number of reported patient safety incidents compared to the rolling 6 month average number of bed days per 1000.
Target	There have been 810 incidents reported in April. The most common occurring incidents are those associated with Pressure Ulcers, followed by slips, trips and falls.



Actions
Incidents are reviewed in the business groups, with scrutiny and oversight provided by the weekly Patient Safety Summit. Lessons learned are immediately shared through the Patient Safety Summit update sent to all staff.

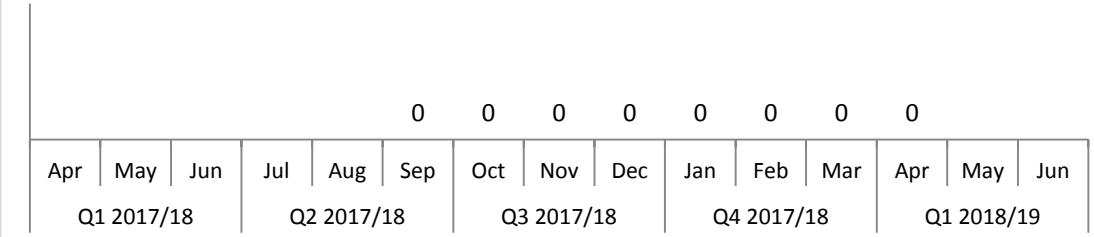
Indicator Detail

Apr-18	Emergency C-Section Rate
16.6%	The percentage of births where the mother was admitted as an emergency and had a c-section.
Target	
<= 15.4%	



Actions

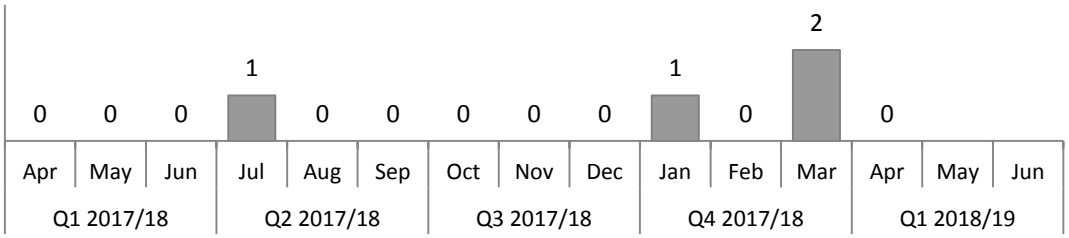
Apr-18	Never Event: Incidence
0	Total number of never events. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
Target	There have been no never events in month
<= 0	



Actions
The updated never events list can be found on the Trust Intranet. Information has been circulated through the newsletter "Risky Business" The trajectory for never events is 0

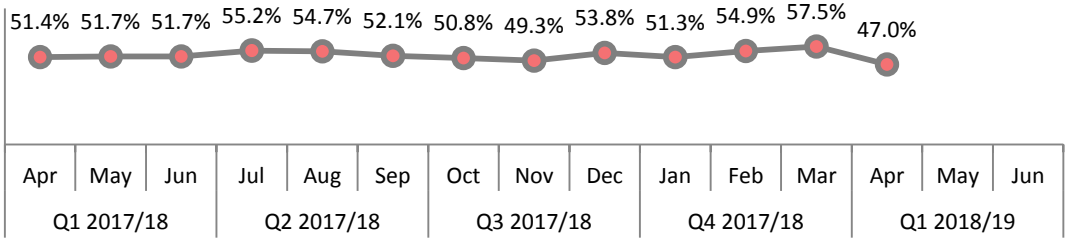
Indicator Detail

Apr-18	Duty of Candour Breaches
0	Total number of Duty of Candour breaches in month.
Target	There has been 1 incident during the month of April 2018 where Duty of Candour was required. This was completed by the Business Group



Actions
The process of Duty of Candour is recorded within the Datix system. Business Groups have been requested to ensure that Duty of Candour, both opening and closing, is accurately recorded within the datix system. Business Groups have also been requested to record 'being open' conversations with patients when an incident of moderate harm has occurred.

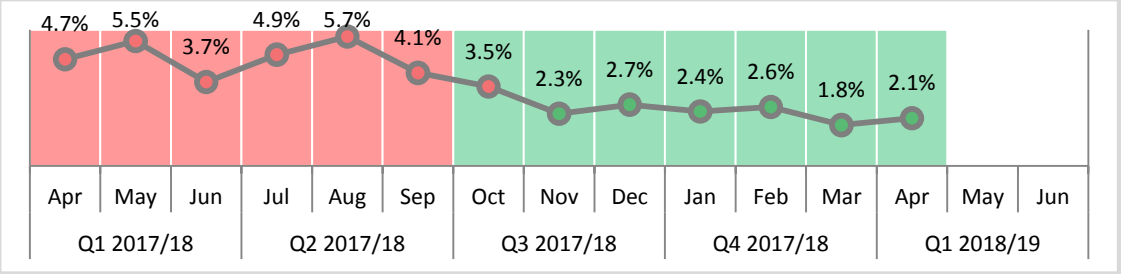
Apr-18	Stranded Patients
47.0%	The percentage of patient that have had a length of stay of 7 days or more. This is an average number calculated using daily snapshot data.
Target	The number of stranded patients has reduced significantly in month and has continued during May to date.
<= 35%	



Actions
To support further improvement on this position, the following actions are happening: Weekly 'Grand Rounds' are now taking place Advantis Ward is being further developed to enable daily reports for interrogation. Programmes of work are taking place around specific themes that have emerged.

Indicator Detail

Apr-18	Delayed Transfers of Care (DTOC)
2.1%	The percentage of patients that have remained in their hospital bed beyond their transfer of care date. This is an average number calculated using daily snapshot data.
Target	DTOC performance continues to meet the set standard.
<= 3.3%	

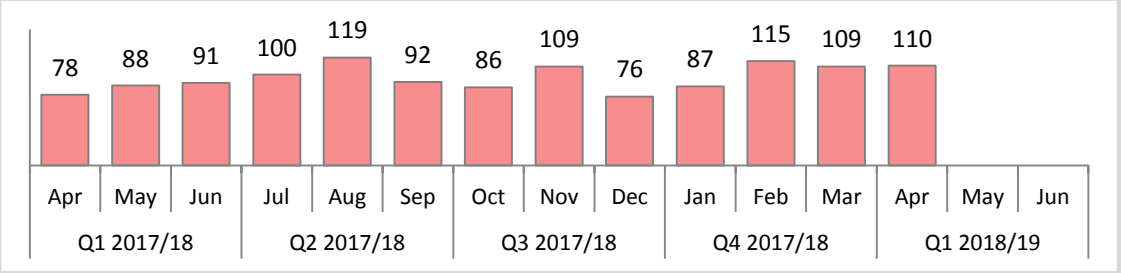


Actions

Early indications for May show an upward trend toward the upper limits of compliance.

Nursing Home Placements being the main concern. We are working with SMBC as lead commissioners to ensure this does not escalate further

Apr-18	Medical Optimised Awaiting Transfer (MOAT)
110	Total number of patients each day who have been medically optimised. This is an average number calculated using daily snapshot data. 'Medical optimisation' is the point at which care and assessment can safely be continued in a non-acute setting.
Target	The number of MOATs remain significant yet static with Nursing home placements and awaiting assessment being the major causes of delay
<= 40	



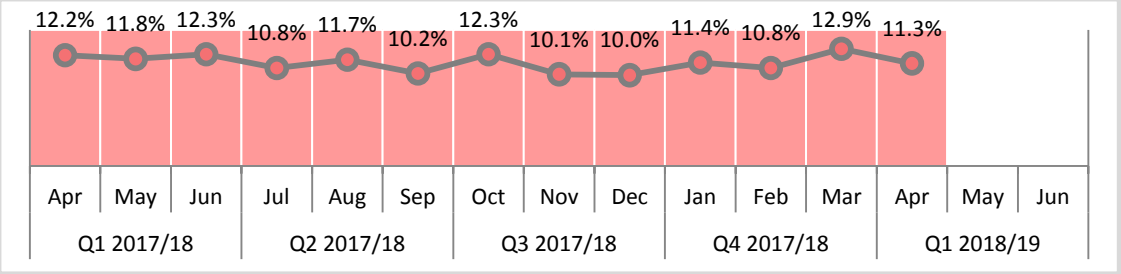
Actions

Actions are monitored through the Grand Rounds and Improving Patient Flow Steering group programmes of work:

- Red to Green
- AQuA project - Discharge Planning / Ward Round Checklist
- Fractured Neck of Femur Length of Stay
- Development of a Transfer to Assess Unit (Bluebell Ward)

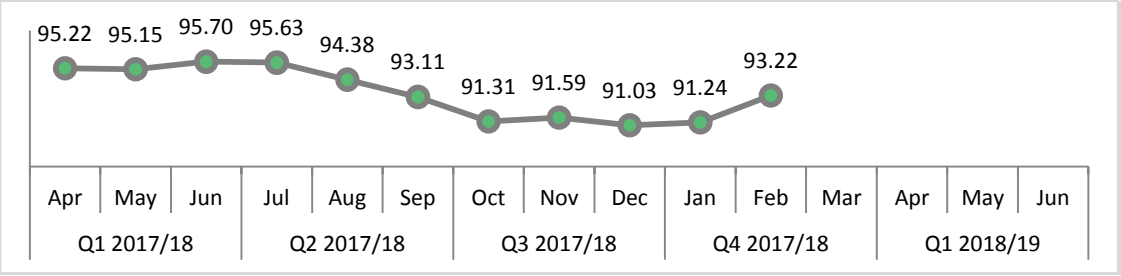
Indicator Detail

Apr-18	Bank & Agency Costs
11.3%	The total bank & agency cost as percentage of the total pay costs
Target	Bank and agency costs in April 2018 account for 11.28% (£2.81M) of the £18.510M total pay costs. This is a £0.72M increase from the position reported in March 2018 (£2.09M).
<= 5%	



Actions
Substantive recruitment from within the UK targeted at newly qualified professional groups. International recruitment to source professionals with appropriate qualifications to attract registration with an enhanced induction to the NHS. Development and growth of the bank. Increased booking and approval controls to ensure that agency staff are only used when essential. Retention strategies to address the core reason that substantive staff leave the Trust Job re-design to make hard to fill specialties more attractive, including rotations and joint specialty posts.

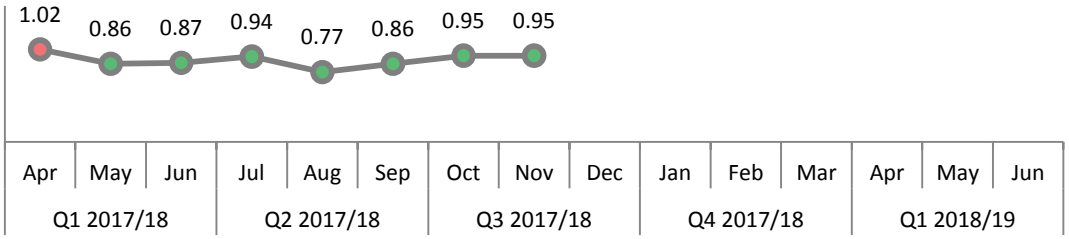
Feb-18	Mortality: HSMR
93.22	This is the ratio between the actual number of patients who either die while in hospital compared to the number of patients that would be expected to die based on whether patients are receiving palliative care, and socio-economic deprivation.
Target	This data represents a rolling twelve month mortality ratio. We need to ensure that our data is consistent with that published elsewhere, such that we do not get false reassurance from these results. Further clarity in next months report. Traditionally low levels of palliative care coding push our HSMR above average, but our SHMI below.
<= 100	



Actions
We need to triangulate these results with other sources to ensure consistent reporting.

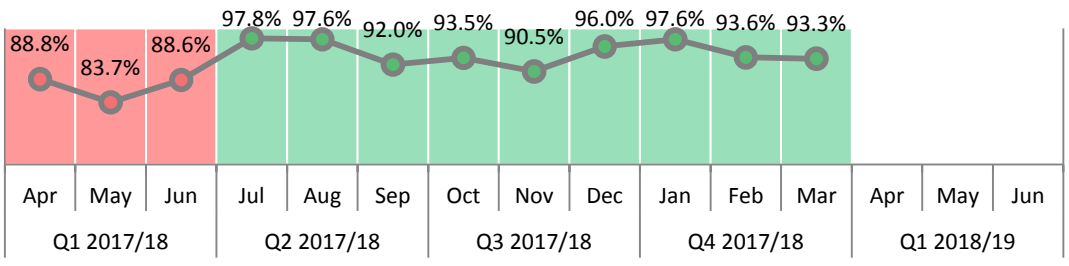
Indicator Detail

Nov-17	Mortality: SHMI
0.95	This is the ratio between the actual number of patients who either die while in hospital or within 30 days of discharge compared to the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated.
Target	We have been anticipating an increase in SHMI, following a change in our coding practice relating to pneumonia. Fortunately our SHMI remains above average, and the second best in the region. We anticipate a slight worsening over the first quarter, with recovery over the second quarter of the year.
<= 1	



Actions

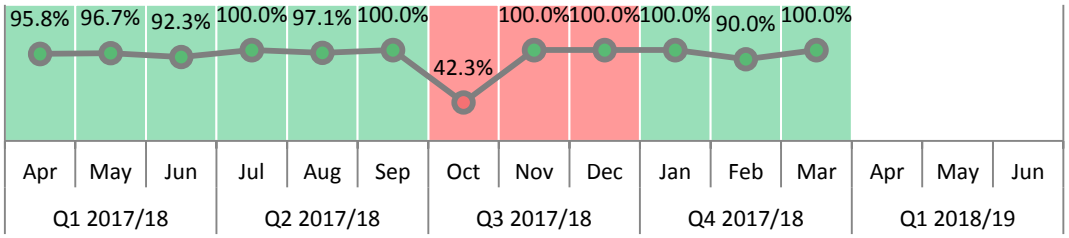
Mar-18	Dementia: Finding Question
93.3%	The percentage of eligible patients who have a diagnosis of dementia or delirium or to whom case finding is applied.
Target	The target has been achieved in month.
>= 90%	



Actions

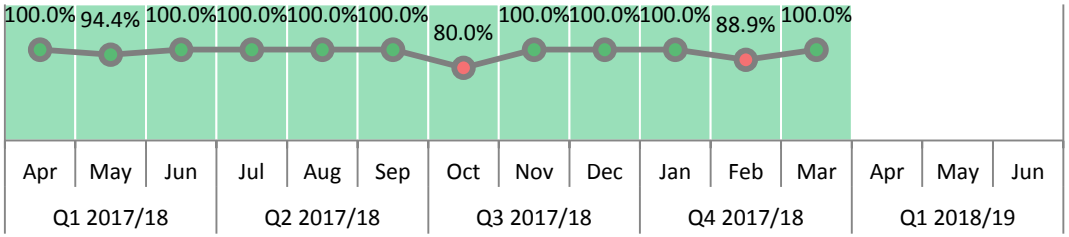
Indicator Detail

Mar-18	Dementia: Assessment
100.0%	The percentage of eligible patients who, if identified as potentially having dementia or delirium, are appropriately assessed.
Target	The target has been achieved in month
>= 90%	



Actions

Mar-18	Dementia: Referral
100.0%	The percentage of eligible patients where the outcome was positive or inconclusive, are referred on to specialist services.
Target	The target has been achieved in month.
>= 90%	

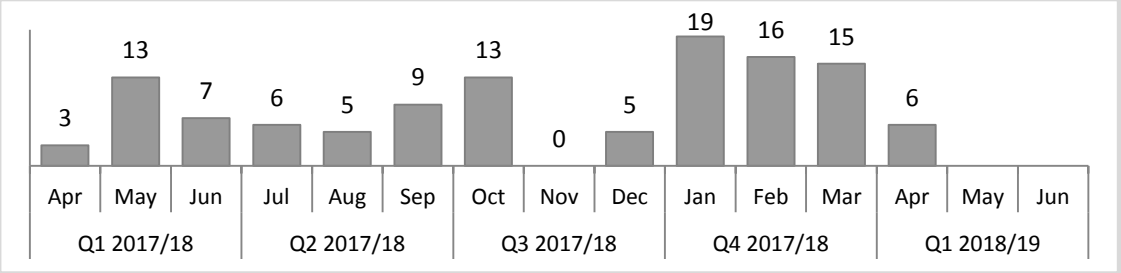


Actions

Indicator Detail

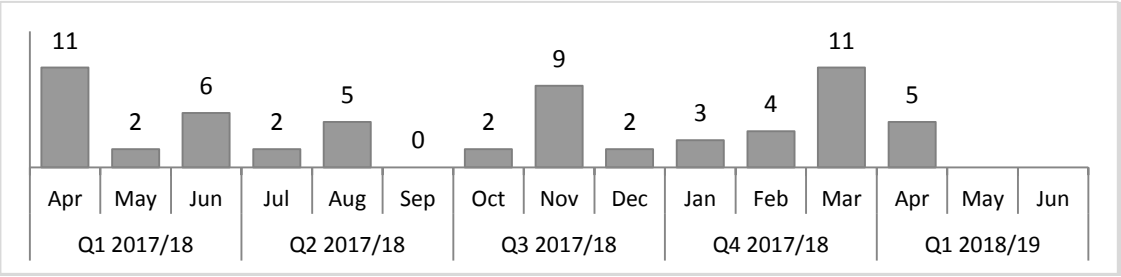
Apr-18	Serious Incidents: STEIS Reportable
6	The total number of STEIS reportable incidents.
Target	There have been 6 STEIS reportable incidents identified in month. 2 relating to a number of 12 hour breaches. 1 maternity divert. 1 patient death relating to treatment 1 delay in treatment

Actions
Each incident is subject to a Level 2 investigation.



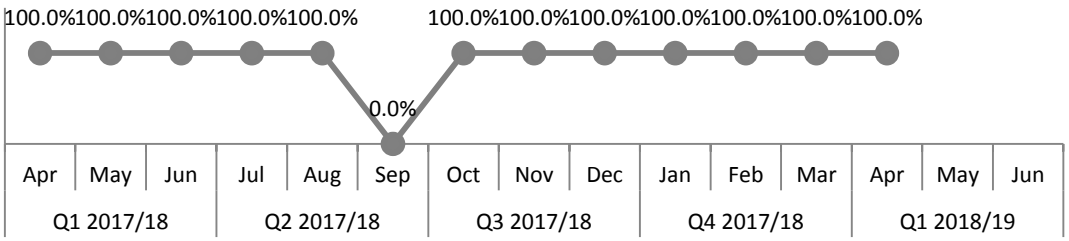
Apr-18	Litigation: Claims
5	Total number of claims opened in month.
Target	In April the Trust received 5 litigation claims, all were potential medical negligence claims.

Actions
The process for investigating the claims received has commenced.



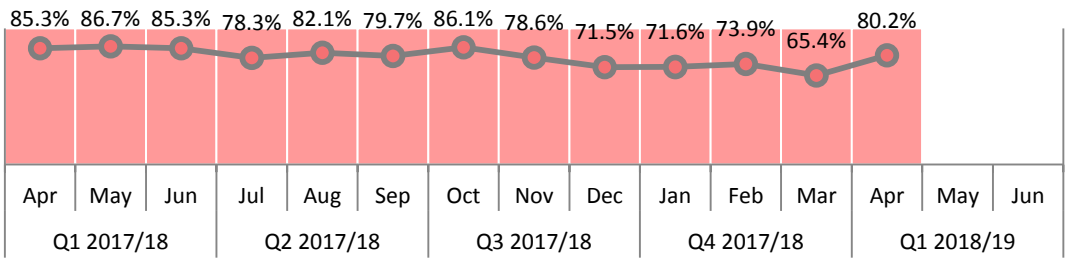
Indicator Detail

Apr-18	Litigation: Key Risk Claims Rate
100.0%	The percentage of claims opened in month that are related to key risk areas.
Target	5 litigation claims were received in April, all were potential medical negligence claims.



Actions

Apr-18	A&E: 4hr Standard
80.2%	The percentage of patients who were admitted, discharged, or leave A&E within 4 hours of their arrival.
Target	Performance against the 4hr standard significantly improved to 80.2% in April against the improvement trajectory of 78% for M1. Performance in May has continued to improve with the month to date position standing at 90.0%, at the time of writing against the 82% trajectory plan.
>= 95%	



Actions

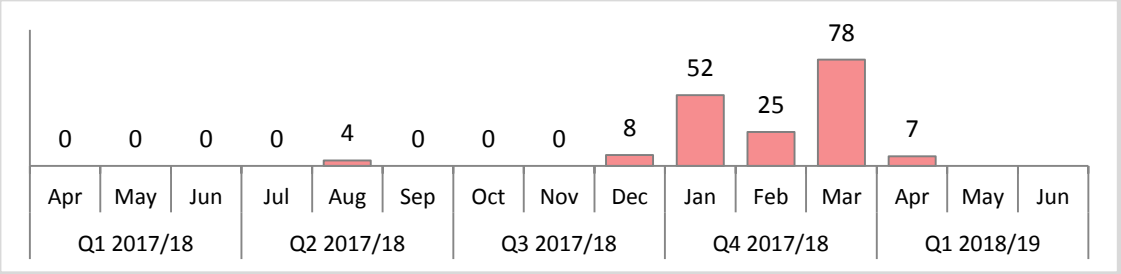
ED are focusing on an initiative called 'driving time to decide'. A set of metrics has been developed to help improve decision making time and ensure minimal delays at each stage of the patient pathway through the Emergency Department.

The Trust is also mindful of the need for a robust Winter plan, and as such Senior Executives are exploring innovative ways to flex and increase capacity and workforce to deal with inevitable seasonal demand.

In response to the Urgent Care pressures and workload, a Delivery Director has now been appointed, whose remit will be to operationally manage these daily pressures and processes.

Indicator Detail

Apr-18	A&E: 12hr Trolley Wait
7	Total number of patients whose decision to admit from A&E was over 12 hours from their actual admission.
Target	A significant improvement in the number of 12 hour trolley waits in April with none reported to date for May.
<= 0	

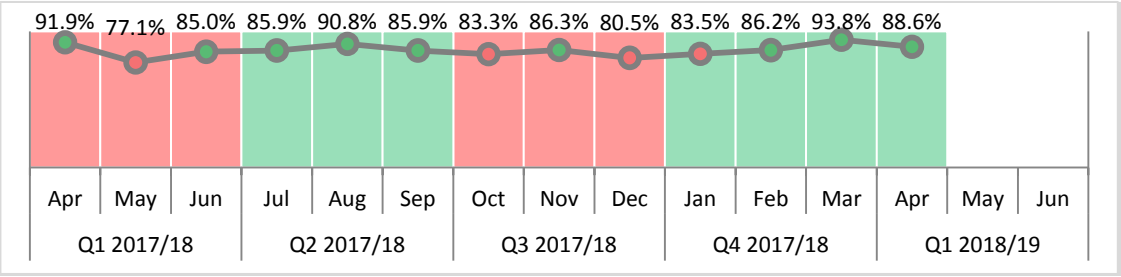


Actions

A root cause analysis is undertaken for each 12hr trolley wait.

To date, no patient harm events have been identified.
A review of the standard Operating procedure for recording 12 hour trolley waits is underway. This may see an increase in the number reported but will not adversely affect the patient journey and standard of care.

Apr-18	Cancer 62 Day Standard
88.6%	The percentage of patients on a cancer pathway that have received their first treatment within 62 days of their GP referral.
Target	The Trust is predicting to achieve the cancer standard for April. Whilst the position is not yet closed, the latest figures suggest a performance of 88.6%.
>= 85%	Waits for pathology reporting are generally increasing due to resource issues within the Clinical team.



Actions

Histopathology are outsourcing reporting in the short-medium term to minimise delays.

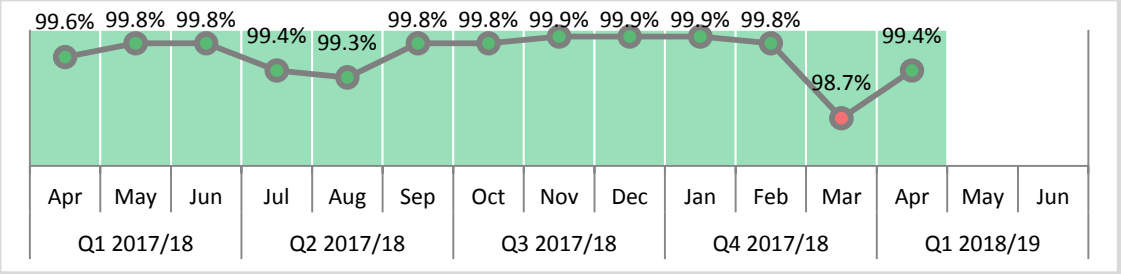
Colorectal are due to commence a "Straight to test" model.

More general themes of work across all tumour groups include:

- Clinically led review of pathways to facilitate the Faster Diagnosis Standard
- Increasing the number of patients being given an appointment by Day 7 of the pathway through daily monitoring and clinically-led prioritising of workload.

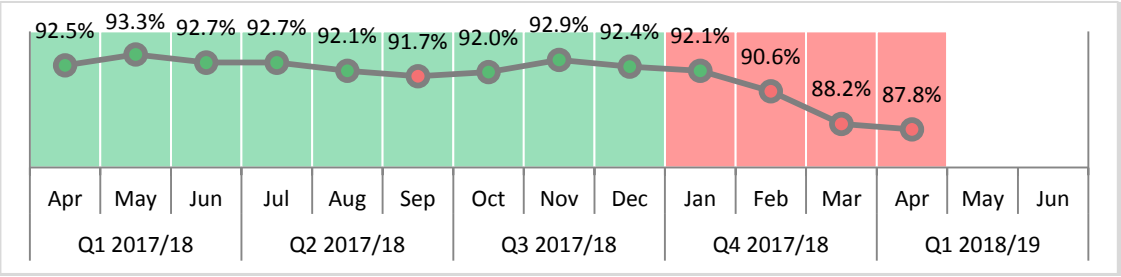
Indicator Detail

Apr-18	Diagnostics: 6 Week Standard
99.4%	The percentage of patients refered for diagnostic tests who have been waiting for less than 6 weeks.
Target	The Trust is predicting to achieve the diagnostic target in April, following a marginal fail in March which was due to capacity issues in Non-obstetric ultrasound and Echocardiography.
>= 99%	



Actions
Echocardiography is reliant on regular additional sessions in order to meet the 6 week standard. A capacity and demand piece of work is being undertaken, supported by the Transformation Team. An action plan will subsequently be compiled. Radiology have recently recruited to positions, and are undertaking a strategic service wide review of future capacity and resource requirements. The planned replacement of the Gamma Camera may adversely impact on the diagnostic standard for the next 12 weeks. Mitigation involves outsourcing to GM partners

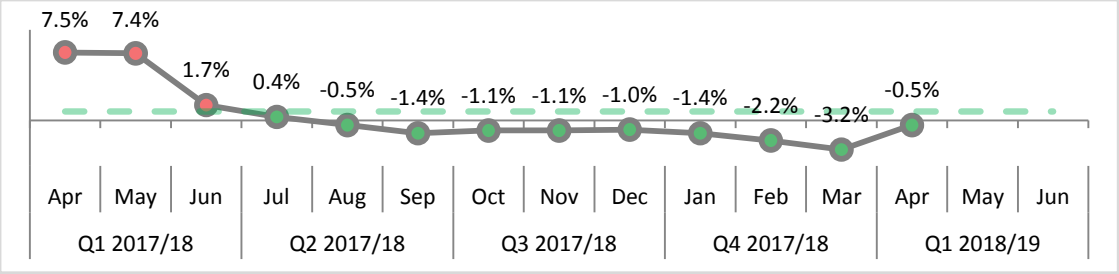
Apr-18	Referral to Treatment: Incomplete Pathways
87.8%	The percentage of patients whose pathway is still open and their clock period is less than 18 weeks.
Target	Although the Trust forecast non-compliance with the RTT standard throughout Q1, performance for April is below predicted levels. This is mainly due to the increased number of patients waiting beyond 18 weeks on a non-admitted pathway.
>= 92%	



Actions
The full elective operating programme resumed in April, which will start to impact on the admitted waiting list from May. Initial forecasts are looking positive for month end. The main areas of variance in the non-admitted waiting list are ENT, Urology, General Surgery and Cardiology. As resource issues in the Outpatient Booking Team are impacting on the ability to maximise clinic templates, a review of the processes and workload is due to be undertaken to ensure future resilience.

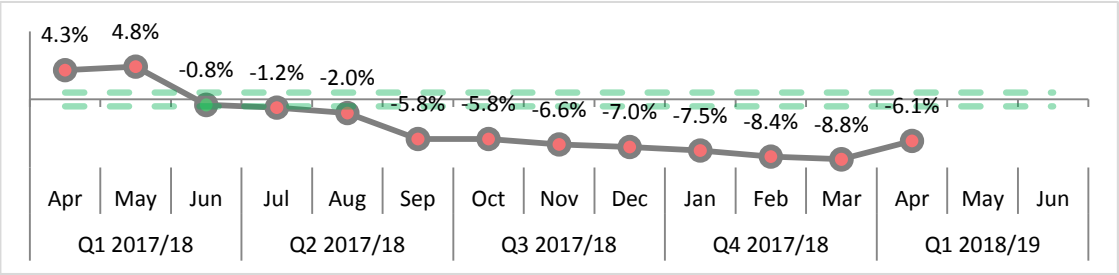
Indicator Detail

Apr-18	Outpatient Activity vs. Plan
-0.5%	The percentage variance between planned outpatient activity and actual outpatient activity.
Target	The Trust was 115 Outpatient attends adverse to plan in month 1 at aggregate level.
<= 1%	WC&D and IC over-performed against plan, whilst the Medicine and Surgical Business Groups under-performed.



Actions
Actions being undertaken in the main areas of negative variance are: Urology: renegotiating continued use of waiting list initiative sessions, as funded at out-turn. Oral surgery: reviewing the Service Level Agreement. The service is reliant on visiting Consultants maintaining monthly activity levels. Chest service: recruiting physiologists to strengthen lung function capacity which closely supports Out-Patient clinics General Surgery and Knees are expected to recover planned activity levels within Q1.

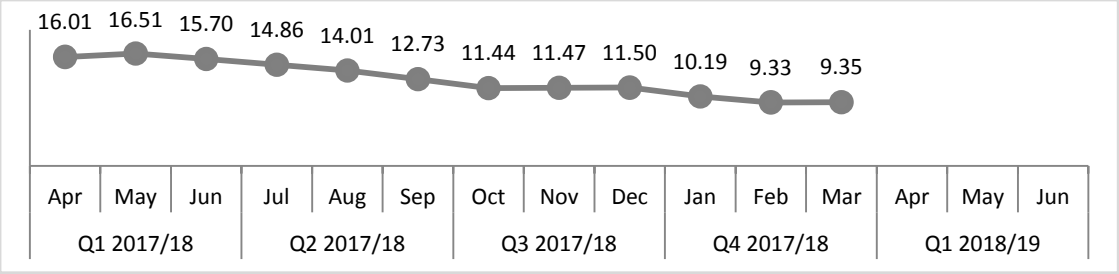
Apr-18	Elective Activity vs. Plan
-6.1%	The percentage variance between planned elective activity and actual elective activity.
Target	The Trust position for elective and day-case activity was 182 spells adverse to plan for month 1. The main areas negatively adverse to plan were Endoscopy, Urology, T&O and Oral Surgery.
+/- 1%	



Actions
The full elective programme resumed on 9th April, which will enable T&O to meet plan going forward. Other actions include: -An additional Nurse Endoscopist is being explored to increase nurse-delivered activity and help maximise throughput. -Additional HDU step-down capacity is being created to enable higher throughput of major cases. -T&O will be undertaking 4 joint replacements per operating list and adapting a senior Consultant job plan to accommodate an additional all day list. -Urology are looking to re-instate a locum Consultant post to maximise activity throughput.

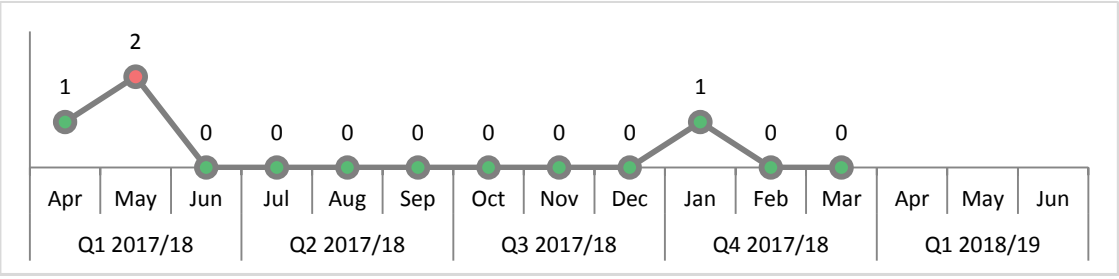
Indicator Detail

Mar-18	C.Diff Infection Rate
9.35	Average number of C.Diff infections for every 100,000 bed days, calculated using a rolling 12 month number of Trust-attributable C.Diff infections compared to the rolling 12 month average number of bed days per 100,000.
Target	The overall target set for Clostridium Difficile for 2017/18 was 39 cases in total with a target of 17 where lapses in care have been identified.



Actions
The target is monitored through the infection prevention committee.

Mar-18	C.Diff Infection Count (lapses in care)
0	Total number of C.Diff infections due to lapses in care.
Target	Clostridium difficile data represented within this section relates to March 2018 due to incident reporting timescales. In March 2018 there were zero cases where lapses in care were identified.
<=17 *	During 2017-18 there has been 4 cases of Clostridium difficile that were found to have

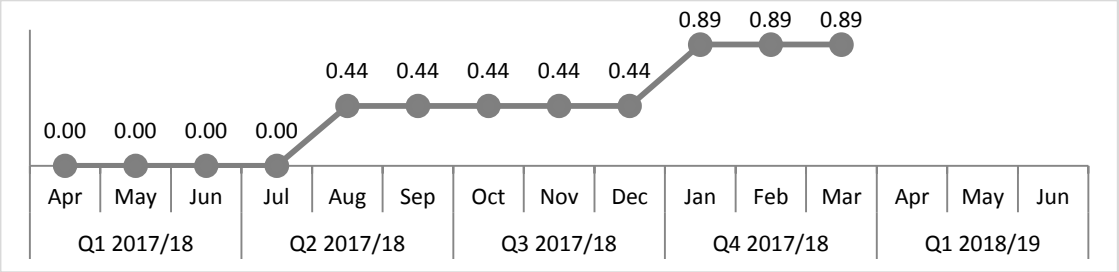


Actions
The Infection Prevention and Control Team are undertaking the following actions to reduce the number of cases where lapses in care have been identified, these include: * Reviewing the new NICE draft guidance to combat drug resistant UTI's with the antibiotic pharmacists and consultant microbiologist * Working with the new clinical site coordinator team in relation to isolation of patients

Indicator Detail

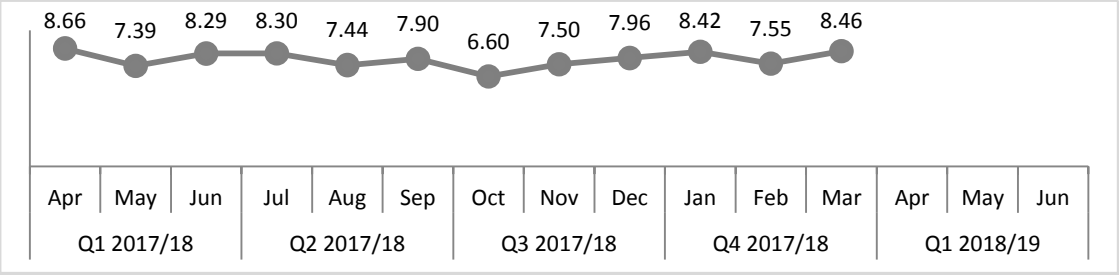
Mar-18	MRSA Infection Rate
0.89	Average number of MRSA infections for every 100,000 bed days, calculated using a rolling 12 month number of Trust-attributable MRSA infections compared to the rolling 12 month average number of bed days per 100,000.
Target	The target for MRSA cases remains zero for 2018/19.

Actions
The target is monitored through the infection prevention committee.



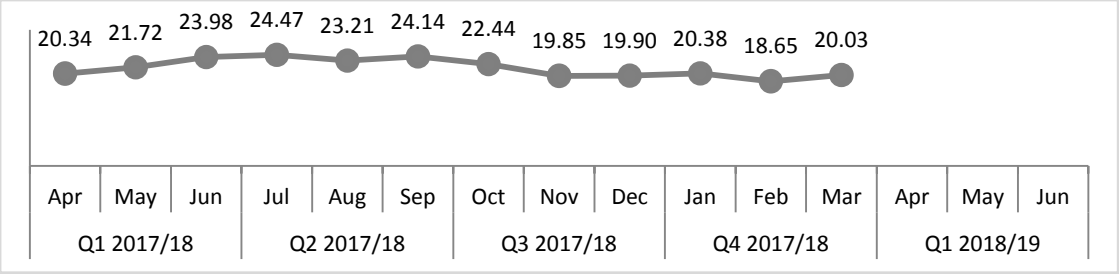
Mar-18	MSSA Infection Rate
8.46	Average number of MSSA infections for every 100,000 bed days, calculated using a rolling 12 month number of Trust-attributable MSSA infections compared to the rolling 12 month average number of bed days per 100,000.
Target	The MSSA infection rate is being viewed as a whole health economy rather than by individual trust.

Actions
This will remain an agenda item on the trusts infection prevention committee.



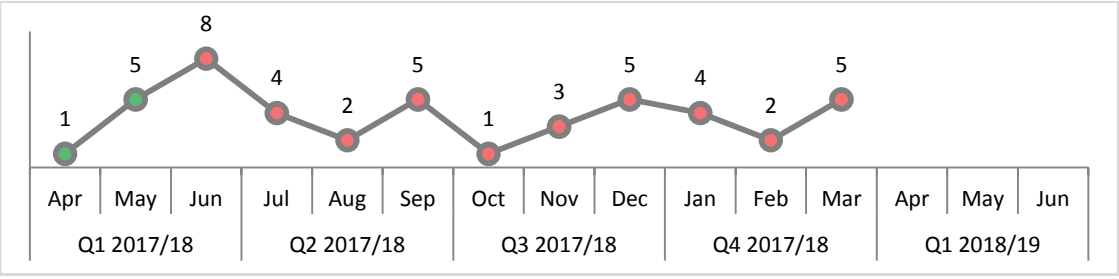
Indicator Detail

Mar-18	E.Coli Infection Rate
20.03	Average number of E.Coli infections for every 100,000 bed days, calculated using a rolling 12 month number of Trust-attributable E.Coli infections compared to the rolling 12 month average number of bed days per 100,000.
Target	Nationally there is an aim to reduce healthcare associated gram-negative blood stream infections by 50% by March 2021, firstly focusing on E coli infection as one of the largest groups.



Actions
This will be monitored through the infection prevention committee with a baseline being established during quarter 1 of 2018/19.

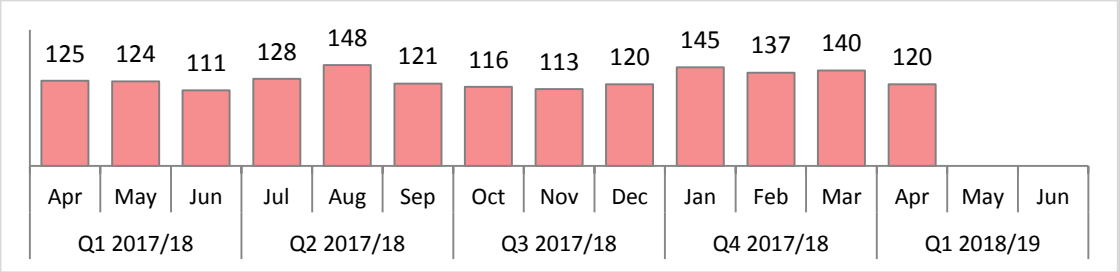
Mar-18	E.Coli Infection Count
5	Total number of E.Coli infections.
Target	Nationally there is an aim to reduce healthcare associated gram-negative blood stream infections by 50% by March 2021, firstly focusing on E coli infection as one of the largest groups.
<=37 *	



Actions
This will be monitored through the infection prevention committee with a baseline being established during quarter 1 of 2018/19.

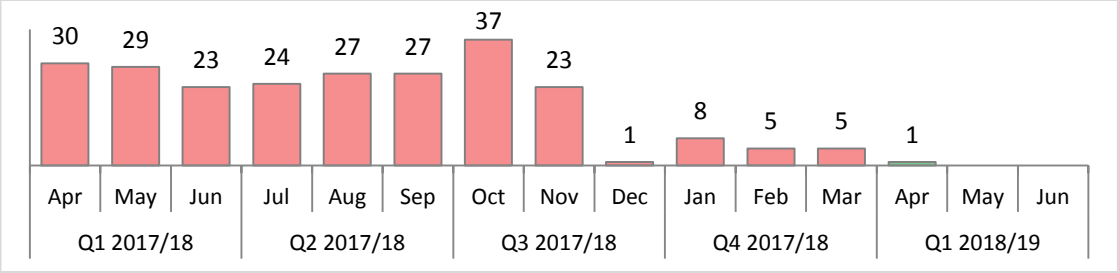
Indicator Detail

Apr-18	Falls: Total Incidence of Inpatient Falls
120	Total number of Inpatient falls
Target	Our Quality Improvement Aim is to reduce all in-patient falls by 10% compared to the total falls recorded in 2017/2018. In April 2018, 122 patients falls have occurred.
<=115 *	



Actions
As part of our Quality Improvement Plan, we have agreed a number of patient safety collaboratives. During Q1 208/19 we aim to introduce our patient mobility safety collaborative, which will support us in our drive to reduce the number of in-patient falls.

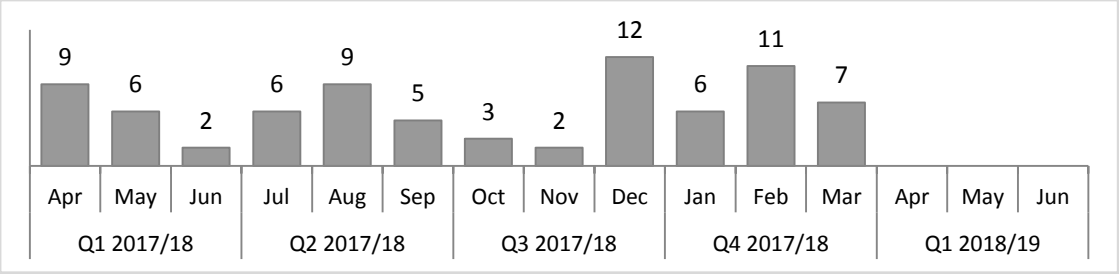
Apr-18	Falls: Causing Moderate Harm and Above
1	Total number of falls causing moderate harm and above.
Target	Our Quality Improvement aim is to reduce in-patient falls with harm by 25% compared to the total falls recorded in 2017/2018. The total number of falls with harm for April was 1. This resulted in a fractured pubic rami. This has been reported through the Strategic Executive Incident System. The total number of falls with harm for 2017/18 was 239.
<=15 *	



Actions
As part of our Quality Improvement Plan, we have agreed a number of patient safety collaboratives. During Q1 208/19 we aim to introduce our patient mobility safety collaborative, which will support us in our drive to reduce the number of in-patient falls. The fall in April 2018 is currently under investigation by the business group.

Indicator Detail

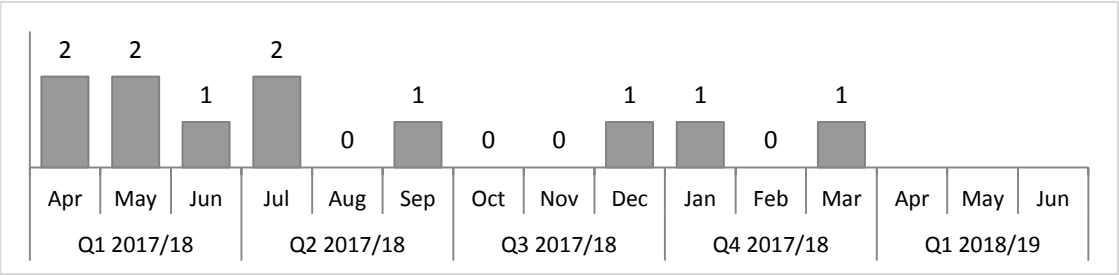
Mar-18	Pressure Ulcers: Hospital, Stage 2
7	Total number of stage 2 pressure ulcers in a hospital setting.
Target	Through our Quality Improvement Plan, it is our aim to reduce hospital acquired stage 2 pressure ulcers by 50% by end March 2019. The figure represented here relates to March 2018 as stage 2 pressure ulcers that relate to April 2018 are not yet validated.



Actions

In line with our Quality Improvement Plan, we launched our Pressure Ulcer Safety Collaborative in March 2018. The collaborative provides a Trust wide approach to reducing hospital acquired pressure ulcers through a series of work-streams, these include:
The introduction of a specific assessment tool
The development of a link nurse steering group
The role out of React to Red training package
The use of safety crosses across all wards

Mar-18	Pressure Ulcers: Hospital, Stage 3
1	Total number of stage 3 pressure ulcers in a hospital setting.
Target	Through our Quality Improvement Plan, it is our aim to reduce hospital acquired stage 3 pressure ulcers by 50% by end March 2019. The figure represented here relates to March 2018 as stage 3 pressure ulcers that relate to April 2018 are not yet validated.



Actions

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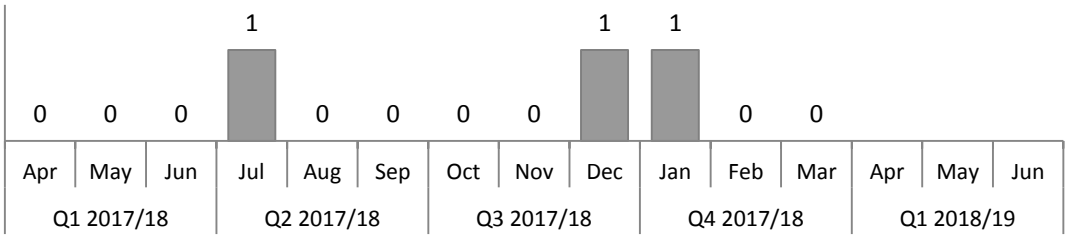
The introduction of a specific assessment tool
The development of a link nurse steering group
The role out of React to Red training package
The use of safety crosses across all wards

It is possible due to an increase in vigilance and visibility of concern, an increase in incident reporting may be seen, as staff education and awareness is raised.

Indicator Detail

Mar-18	Pressure Ulcers: Hospital, Stage 4
0	Total number of stage 4 pressure ulcers in a hospital setting.
Target	Through our Quality Improvement Plan, it is our aim to reduce hospital acquired stage 4 pressure ulcers by 50% by end March 2019. The figure represented here relates to March 2018 as stage 4 pressure ulcers that relate to April 2018 are not yet validated.



Actions

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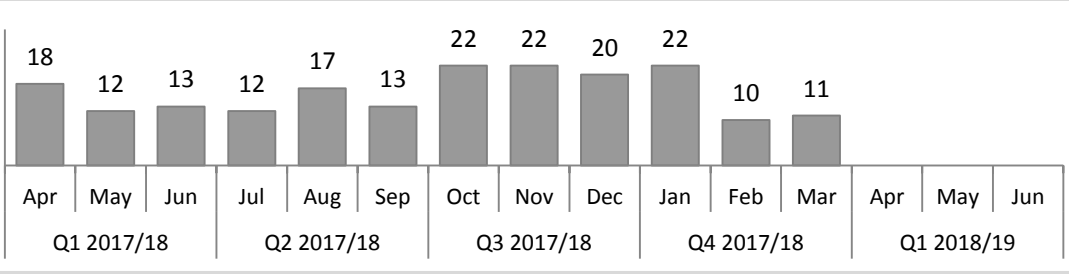
The introduction of a specific assessment tool
The development of a link nurse steering group
The role out of React to Red training package
The use of safety crosses across all wards

It is possible due to an increase in vigilance and visibility of concern, an increase in incident reporting may be seen, as staff education and awareness is raised.

Mar-18	Pressure Ulcers: Community, Stage 2
11.00	Total number of stage 2 pressure ulcers in a community setting.
Target	Through our Quality Improvement Plan, it is our aim to reduce community acquired stage 2 pressure ulcers by 50% by end March 2019. The figure represented here relates to March 2018 as stage 2 pressure ulcers that relate to April 2018 are not yet validated.

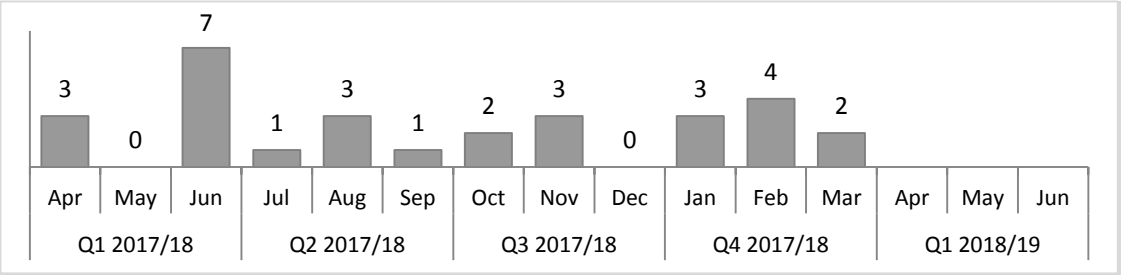


Actions

In line with our Quality Improvement Plan, we launched our Pressure Ulcer Safety Collaborative in March 2018. The collaborative provides a Trust wide approach to reducing community acquired pressure ulcers through a series of work-streams, these include:
The introduction of a specific assessment tool
The development of a link nurse steering group
The role out of React to Red training package

Indicator Detail

Mar-18	Pressure Ulcers: Community, Stage 3
2	Total number of stage 3 pressure ulcers in a community setting.
Target	Through our Quality Improvement Plan, it is our aim to reduce community acquired stage 3 pressure ulcers by 50% by end March 2019. The figure represented here relates to March 2018 as stage 3 pressure ulcers that relate to April 2018 are not yet validated.



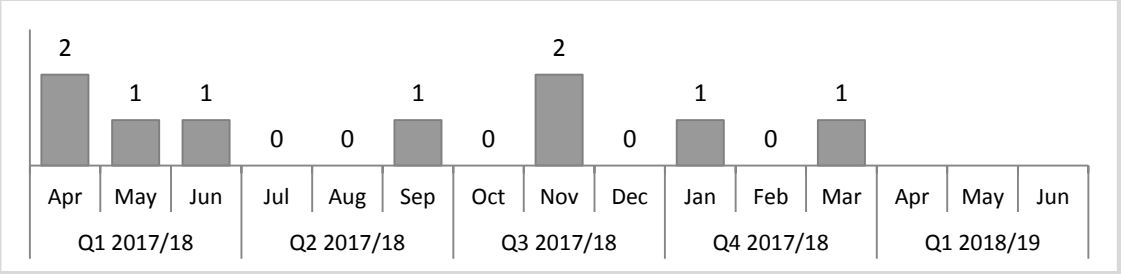
Actions

In line with our Quality Improvement Plan, we launched our Pressure Ulcer Safety Collaborative in March 2018. The collaborative provides a Trust wide approach to reducing community acquired pressure ulcers through a series of work-streams, these include:

The introduction of specific assessment tool
The development of a steering group link nurse group
The role out of React to Red training package

It is possible due to an increase in vigilance and visibility of concern, an increase in incident reporting may be seen, as staff education and awareness is raised.

Mar-18	Pressure Ulcers: Community, Stage 4
1	Total number of stage 4 pressure ulcers in a community setting.
Target	Through our Quality Improvement Plan, it is our aim to reduce community acquired stage 4 pressure ulcers by 50% by end March 2019. The figure represented here relates to March 2018 as stage 4 pressure ulcers that relate to April 2018 are not yet validated.



Actions

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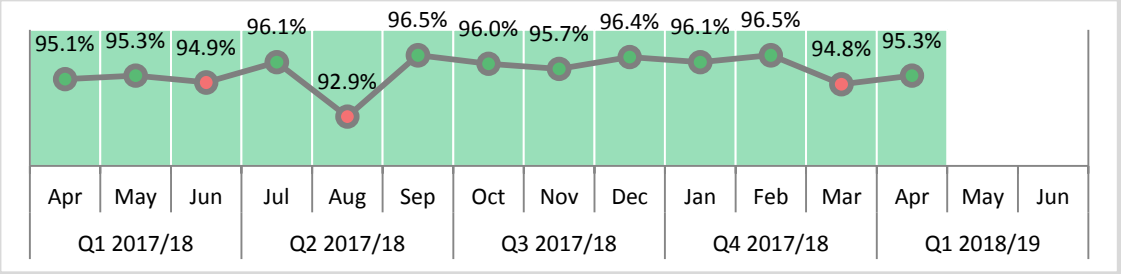
The introduction of specific assessment tool
The development of a steering group link nurse group
The role out of React to Red training package

It is possible due to an increase in vigilance and visibility of concern, an increase in incident reporting may be seen, as staff education and awareness is raised.

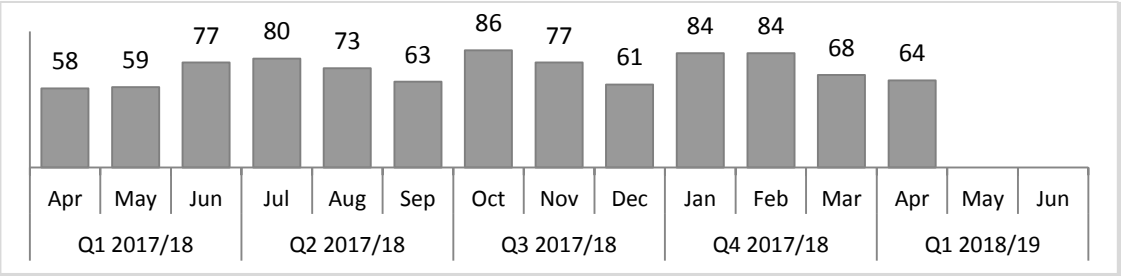
Indicator Detail

Apr-18	Safety Thermometer: Hospital
95.3%	The percentage of patients receiving harm-free care, calculated using a point prevelance sample based on falls, pressure ulcers, UTIs and VTE assessments.
Target	The Trust aim is that >95% of patients receive harm free care as monitored by the Safety Thermometer. In April 2018, 95.3% of our patients received harm free care as measured by the Safety Thermometer.
>= 95%	



Actions
The Safety Thermometer data includes catheter associated urinary tract infections, new and old pressure ulcers, falls, and VTE. Information is collected during the morning on a weekly basis and is collected by nursing staff on duty on the ward assisted by the corporate nursing team. There has been an increased awareness of both the collection and validation of the safety thermometer data across the organisation. All wards present their data weekly with specialist nurse involvement, to ensure there is a robust approach to the process and that the data is accurate.

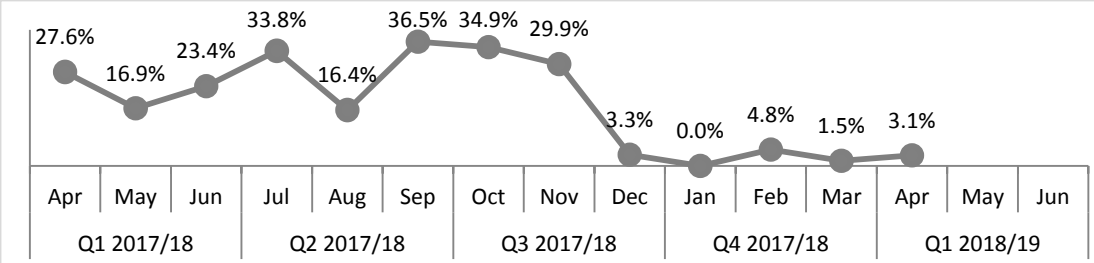
Apr-18	Medication Errors: Overall
64	Total number of Medication Errors.
Target	In April 2018, there have been 64 medication incidents reported. In 2017/18 the total number of medication incidents was 870, with an average therefore of 72 a month



Actions
All medication incidents are reviewed weekly by a trust executive at the Patient Safety Summit. A theme has been identified following the reviews that relates to the duplication of medications using both a paper and electronic prescription. An alerting system has been developed which includes the introduction of an orange arm band, to alert staff to the use of a paper kardex being in progress. Learning from medication incidents is included in the weekly Patient Safety Summit Update and shared widely across the organisation.

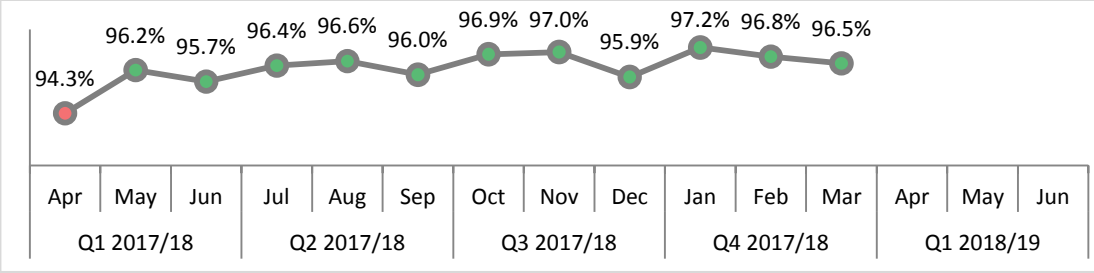
Indicator Detail

Apr-18	Medication Errors: Moderate Harm and Above
3.1%	The percentage of medication errors causing moderate harm and above.
Target	In April 2018/19, 2 medication errors were reported as incidents where moderate harm had occurred. In 2017/18 a total of 166 medication incidents were recorded as causing moderate harm or above.



Actions
The two incidents reported in April 2018/19 are currently under investigation by the Business Groups. In December 2017/18 the number of medication incidents causing moderate harm or above dropped significantly. This coincided with the new datix system being introduced and the introduction of the weekly Patient Safety Summit . A trajectory for medication incidents causing moderate harm or above is to be agreed by the end of Quarter 1 2018/19.

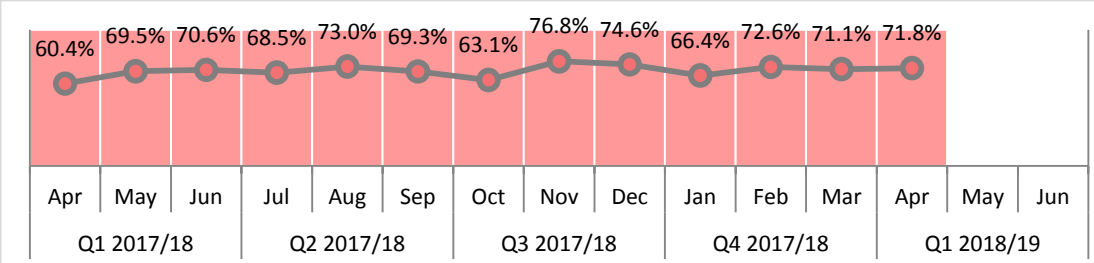
Mar-18	VTE Risk Assessment
96.5%	The percentage of eligible admitted patients who have been given a VTE risk assessment.
Target	Our aim is to have >95% compliance with VTE Risk Assessment. This month we are slightly above target at 96.5%
>= 95%	



Actions
The VTE specialist nurses make contact with all senior nursing staff to raise the raise the awareness of the need for risk assessment completion and this is escalated in a report to the Thrombosis Committee. Going forward the VTE specialist nurses will be included in the weekly validation meeting to support the safety thermometer programme.

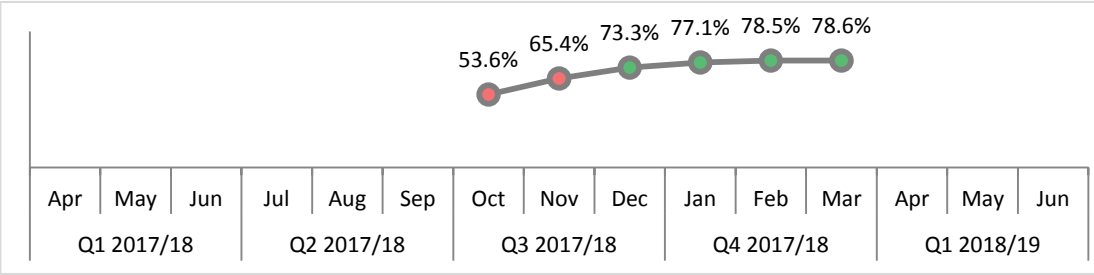
Indicator Detail

Apr-18	Clinical Correspondence
71.8%	The percentage of clinical correspondence typed within 7 days.
Target	Whilst 7 day performance remains below target, the wait for letters to be typed has reduced significantly in month in all but one area, which is Paediatrics.
>= 95%	



Actions
The Paediatric service has approval to outsource typing in the short –term, whilst recruitment to vacant posts is underway. The clinical team is also exploring the possibility of adopting the 'Dragon' voice recognition system. Continuing actions include: Recruitment to the significant number of vacant posts. Commencement of the second phase of the Admin & Clerical review, meaning further specialties will join the Correspondence Hub team. Ongoing feedback with clinicians regarding the use of standard SAIL (Sheffield Assessment Instrument for Letters) criteria and clarity of dictation.

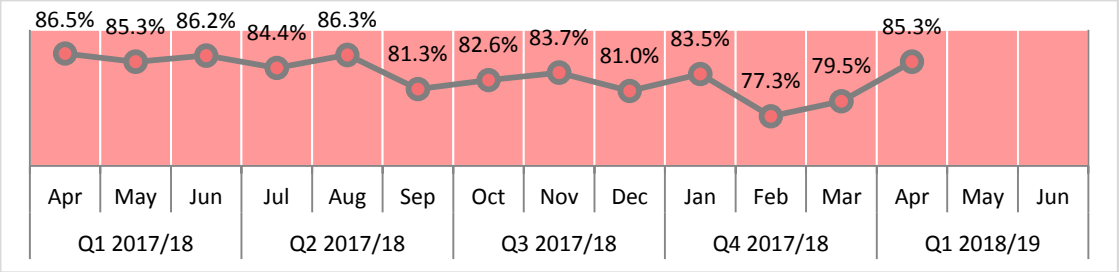
Apr-18	Flu Vacination Uptake
78.6%	The percentage of staff receiving the flu vaccination.
Target	This was the final position as of March 2018.
>= 70%	



Actions
The flu campaign will restart in September 2018.

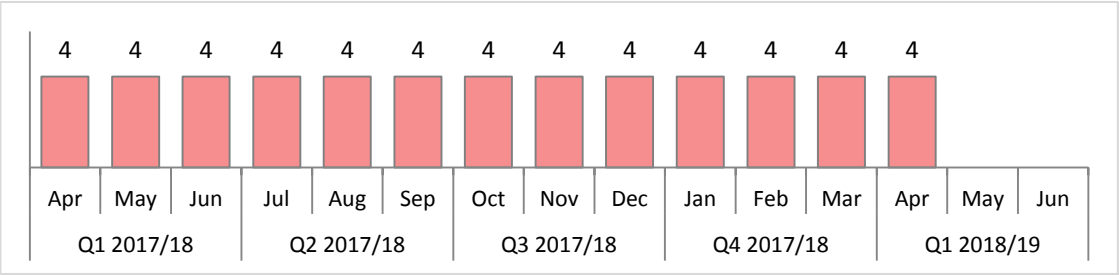
Indicator Detail

Mar-18	Discharge Summaries
85.3%	The percentage of discharge summaries published within 48hrs of patient discharge.
Target	Performance is on an upward trend, with a significant improvement seen in April. This is as a result of the daily reminder process embedding in across the Trust.
>= 95%	



Actions
AMU have implemented a daily process of lead Clinician assigning specific patient HCRs to the junior doctors during the whiteboard rounds. A system message 'reminder' has also been implemented to highlight when documents have been re-opened for editing and not signed off. Continuing actions include: - a process for operations cancelled on the day - resolving remaining IT issues that have been identified

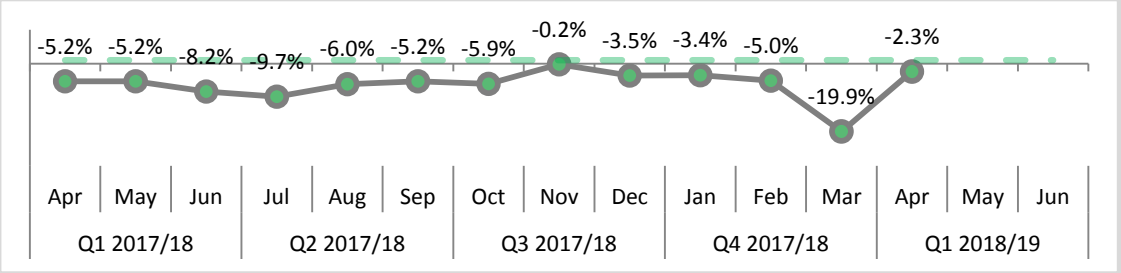
Apr-18	Financial Efficiency: I&E Margin
4	A calculated score based on the Income & Expenditure surplus or deficit against total revenue.
Target	The Trust's planned £34m loss scores a 4 (worst) under the NHSI Use of Resources (UoR) metric in the Single Oversight Framework.
<= 2	



Actions
To improve to a 3 the planned deficit would need to improve by £31.5m to a deficit of £2.5m (within 1% of planned operating income). The Trust is currently developing a Medium Term Financial Strategy (MTFS) to demonstrate the delivery of available opportunities to improve this rating.

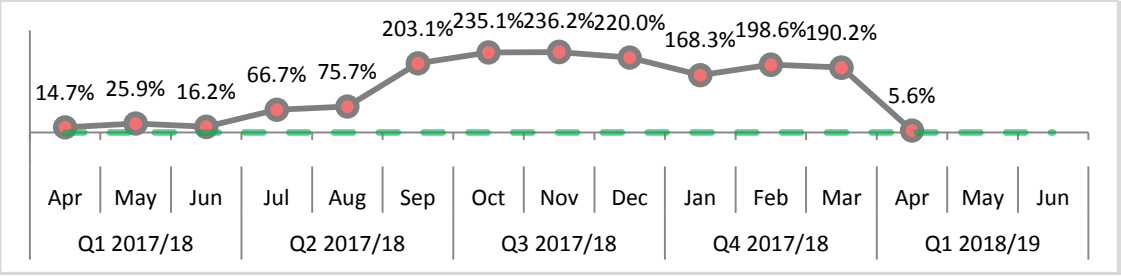
Indicator Detail

Apr-18	Financial Controls: I&E Position
-2.3%	The percentage variance between planned financial position and the actual financial position.
Target	In the first month of the new financial year the Trust has lost £4.0m. The planned deficit was £4.1m so this is £0.1m favourable to plan. The loss is £0.3m worse than April last year, and the average loss is £133,000 per day.
<= 1%	



Actions
As the Trust is favourable to plan this scores a 1 (best) under the NHSI Use of Resources (UoR) metric in the Single Oversight Framework. The Trust Finance & Performance Committee has been given significant assurance at this stage in the financial year that the forecast plan will be delivered. However there are a number of risks which will need to be actively managed to maintain that level of assurance.

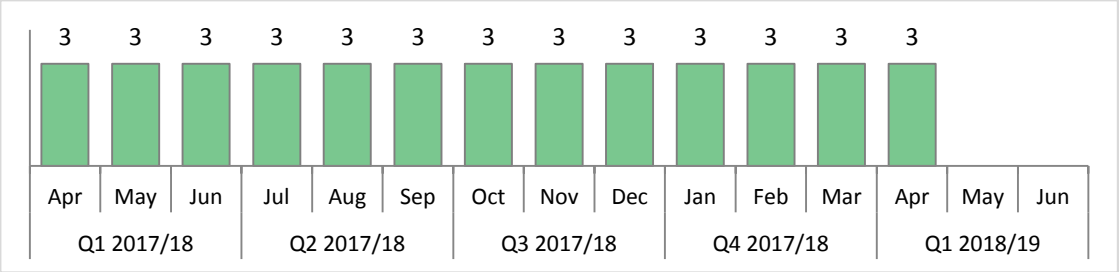
Apr-18	Cash
5.6%	The percentage variance between planned borrowing-to-date and the actual borrowing-to-date.
Target	Cash in the bank on 30th April 2018 was £13.4m, which is £2.9m less than last month and £0.7m better than planned.
+/- 1%	



Actions
Cash is carefully managed and the requirement for a working capital support facility loan is now likely to be in July 2018. The planned level of borrowing July 2018 to March 2019 is £24.7m. The Trust is continuing to model a 13 week cash-flow through the Trust's Cash Action Group and is submitting the information to NHSI's Cash and Capital Team to ensure swift agreement of the revenue financing.

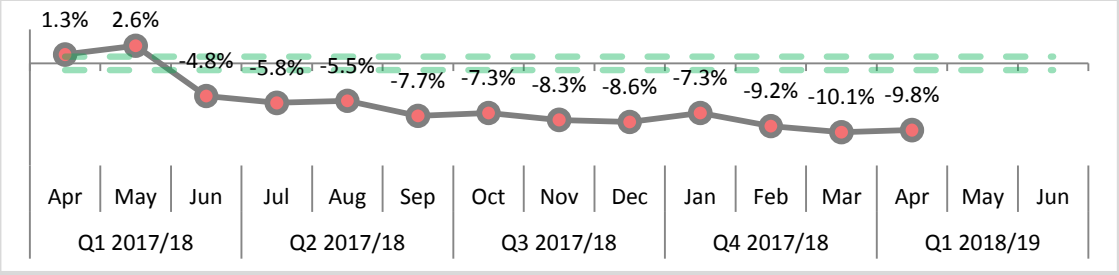
Indicator Detail

Apr-18	Financial Use of Resources
3	A calculated score based on capital service capacity, liquidity, income & expenditure margin, distance from financial plan, and agency spend.
Target	The Trust's draft Use of Resources (UOR) score under the Single Oversight Framework is a 3, classified by NHSI as triggering significant concerns. The Trust only reports key data to NHSI for April's financial position so there is no formal calculation to verify this score until M02 (May) reporting.
<= 3	



Actions
For the three metrics on financial sustainability and financial efficiency the Trust scores a 4 (worst). This is not expected to change. The Trust has breached the agency ceiling in month so this score has moved from 1 (best) to 2. If the planned deficit is not delivered, then the overall Trust score will deteriorate to a 4 and fall into the special measures segment. At this point NHS Improvement (NHSI) could chose to invoke regulatory action against the Trust. This is a forward risk for the organisation.

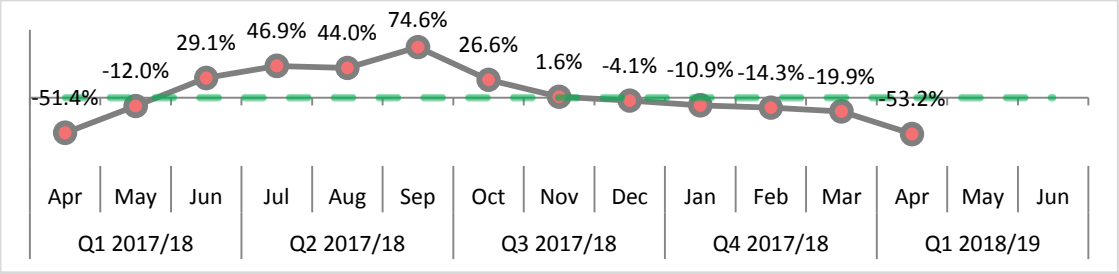
Apr-18	Elective Income vs. Plan
-9.8%	The percentage variance between planned elective income and the actual elective income.
Target	Elective income is £0.3m adverse to plan in April 2018. This is as a result of the full elective inpatient operating programme not recommencing until 9th April 2018, particularly affecting orthopaedics which is 144 cases behind plan. The operating restrictions of the past few months has resulted in a backlog of major cases in April, resulting in more single case lists in orthopaedics and urology in particular.
+/- 1%	



Actions
The shortfall in activity this month presents the Surgical business group with a significant challenge to recover the lost activity from April alongside delivering the activity plan for the remainder of the financial year. The number of lists undertaken and average cases per list must be closely monitored to ensure the agreed level of income is delivered in year, with particular focus on urology and orthopaedics. Sickness/absence, annual leave patterns, winter cancellations and recruitment issues all pose a risk to delivery of the overall plan. Focus on theatre list utilisation, beds and maximising of day case opportunities continue in order to absorb the required activity levels.

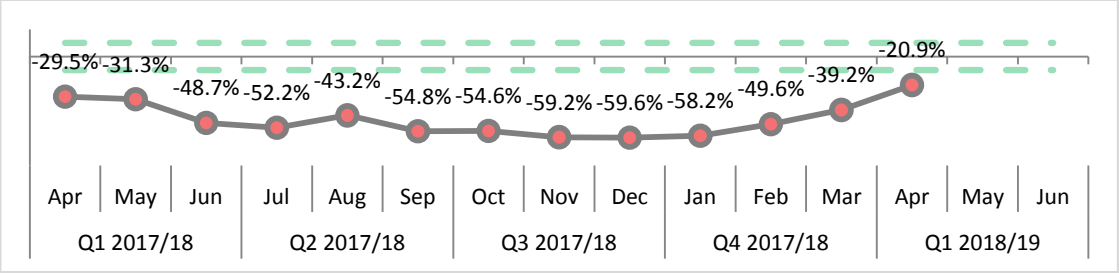
Indicator Detail

Apr-18	CIP Cumulative Achievement
-53.2%	The percentage variance between planned CIP achievement and the actual CIP achievement.
Target	The Cost Improvement Programme (CIP) is £0.3m adverse to the profiled plan in month; £0.5m (3.3%) was expected by this stage in the year when £0.2m (1.6%) has been transacted.
+/- 1%	



Actions
Recurrent CIP delivery is the most significant risk to the Trust's financial position for 2018/19 and beyond, as it is a key driver for the deterioration in the Trust's underlying financial position and planned £34m deficit in 2018/19. Even with potential mitigation the Trust can only provide limited assurance at this stage on the delivery of the 2018/19 Cost Improvement Programme. Whilst there is robust support for each of the programmes and a large amount of work is being undertaken, there is currently a lack of evidence for this without the production of supporting documentation. This was raised at the Financial Improvement Group (FIG) in April and the SROs for each theme were tasked with driving this forward.

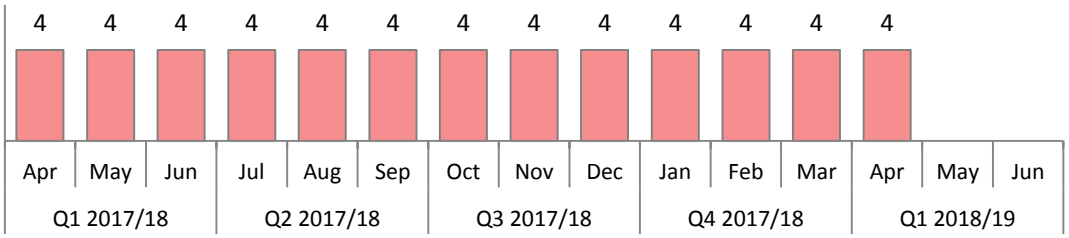
Apr-18	Capital Expenditure
-20.9%	The percentage variance between planned capital expenditure and the actual capital expenditure. Capital expenditure includes such things as buildings and equipment.
Target	Capital costs of £0.2m have been incurred in April against a plan of £0.3m and so is £0.1m behind plan.
+/- 10%	



Actions
The externally funded Healthier Together schemes are fundamental to the delivery of the capital programme but is reliant on external parties and their approval processes via the Greater Manchester Devolution Team (GM Devo). This has taken much longer than envisaged and the projects still do not have an expected start date. All other schemes are progressing in line with the agreed plan.

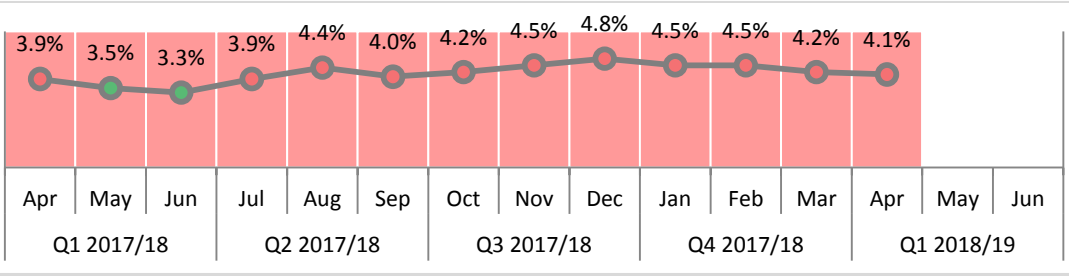
Indicator Detail

Apr-18	Financial Sustainability
4	A calculated score based on the Capital Service Capacity (the degree to which the Trust's generated income covers its financial obligations) and Liquidity in days (the number of days of operating costs held in cash or cash-equivalent).
Target	For the two metrics on financial sustainability the Trust scores a 4 (worst). This is not expected to change in the short-term.
<= 2	



Actions

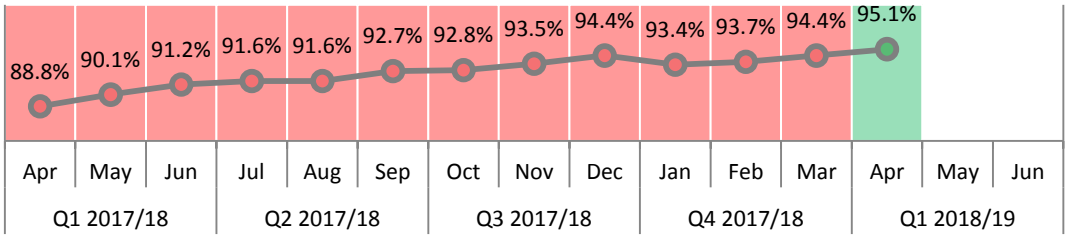
Apr-18	Sickness Absence Rate
4.1%	The percentage of staff on sickness absence, based on whole time equivalent.
Target	The in-month unadjusted sickness absence figure for April 2018 is 4.07% (a 0.35% reduction from March 2018 4.42%). All Business Groups, with the exception of Corporate Services and Surgery, GI & CS are above the 3.5% target in April 2018. Estates & Facilities and Medicine & CS have seen an increase since March 2018.
<= 3.5%	



Actions
Ongoing dedicated HR support is provided to assist managers with the management of attendance. Continued regular audits to ensure policy and procedural compliance.

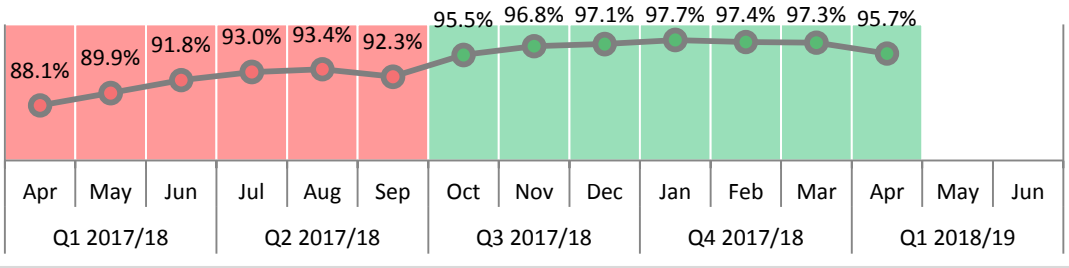
Indicator Detail

Apr-18	Appraisal Rate: Non-medical
95.1%	The percentage of non-medical staff that have been appraised within the last 15 months.
Target	The Trust has achieved the compliance standard for month 1 2018/19. This has been due to the considerable efforts and commitments of the business groups working in collaboration with OD and learning.
>= 95%	



Actions
OD and learning will continue to actively support the areas that are below 95% and address any key issues

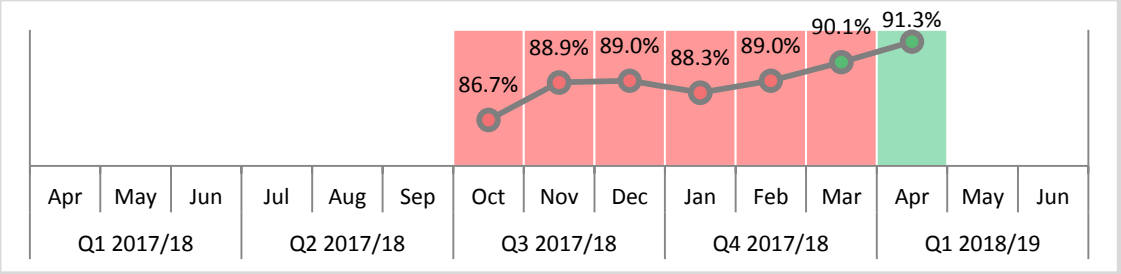
Apr-18	Appraisal Rate: Medical
95.7%	The percentage of medical staff that have been appraised within the last 15 months.
Target	309 of the 323 required medical appraisals have been completed (95.7%).
>= 95%	



Actions
Compliance against this standard is monitored via Business Group performance meetings.

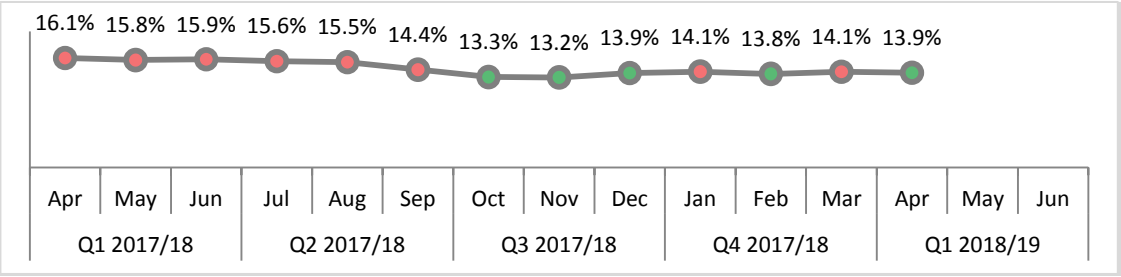
Indicator Detail

Apr-18	Statutory & Mandatory Training
91.3%	The percentage of statutory & mandatory training modules showing as compliant.
Target	Statutory and Mandatory training has achieved the compliance standard in month 1, 2018/19. This is due the commitment of staff to complete the core skills and learning and development offering diverse ways of completing the training.
>= 90%	



Actions
The e-learning system is being reviewed by the system provider to streamline access to improve user experience. Workbooks are being produced for all topics to support teams with limited access to IT.

Apr-18	Workforce Turnover
13.9%	The percentage of employees leaving the Trust and being replaced by new employees.
Target	The rolling 12-month unadjusted April turnover rate is 13.91% (April 2017 2.96%). Reasons for leaving: Relocation 20%, Retirement 18.60%, Work Life Balance 16.59%. Integrated Care has the highest turnover rate at 17.02% (adjusted figure is 15.43%). The Registered Nursing & Midwifery turnover has decreased by 0.09% from March.
<= 13.94%	

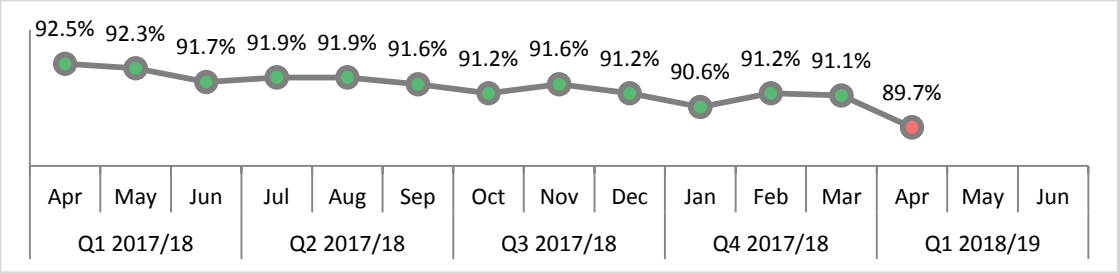


Actions
Action to deliver the recruitment and retention programme is ongoing.

Indicator Detail

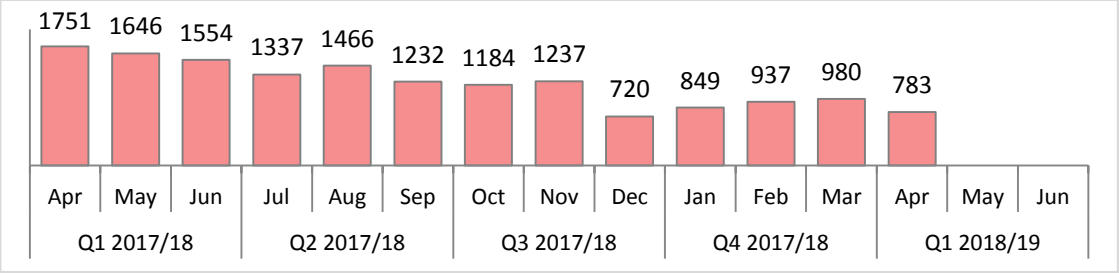
Apr-18	Staff in Post
89.7%	The percentage of whole time equivalent staff in post compared with the current establishment.
Target	The staff in post figure (89.70%) is a decrease of 1.39% from March 2018. IC has the highest vacancy rate at 18% (212.09 FTE vacancies) attributed to the realigning of budgets within Stockport Neighbourhood Care. (recruitment to posts is underway).
>= 90%	

Actions
Action to deliver the recruitment and retention programme is ongoing.



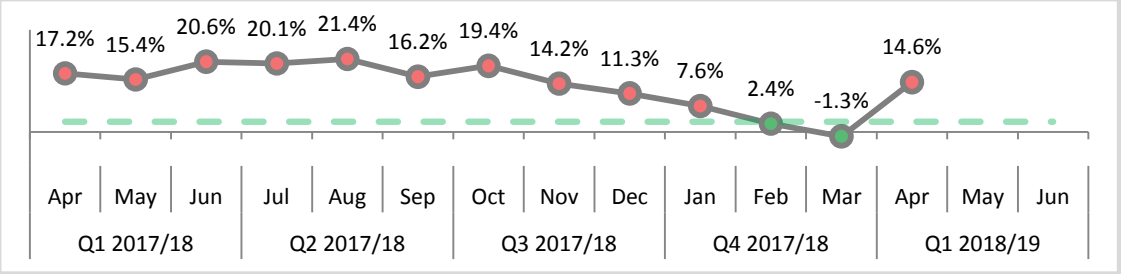
Apr-18	Agency Shifts Above Cap
783	Number of agency shifts above above the provider spend cap.
Target	There were a total of 783 agency shifts paid above the price cap in April. The Medicine & CS Business Group spend has increased by £52K to £848K in April 2018 (continuing with the highest spend on bank & agency equating to 4.58% of the paybill), attributable to clinical vacancies.
<= 0	

Actions
Continue to promote the Trust bank. Requirement for Agency usage and rate to be risk assessed against clinical need and appropriately escalated for approval.



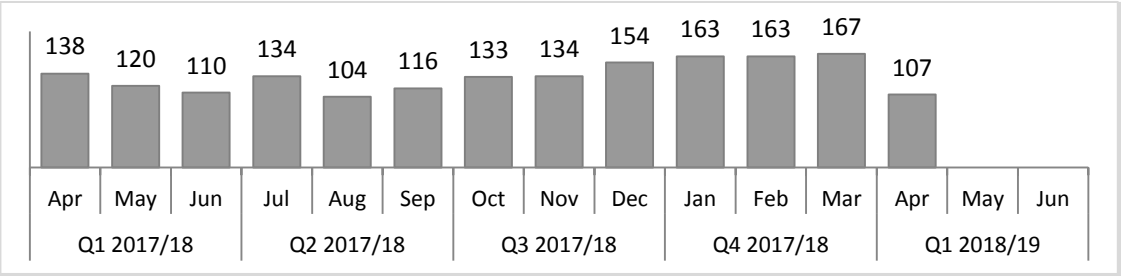
Indicator Detail

Apr-18	Agency Spend: Distance from Cap
14.6%	The percentage variance between Trusts expenditure on agency and external locums across all staff groups and the cap set by NHSi.
Target	The total pay spend in April 2018 was £16.422M, excluding bank and agency spend. This is an increase of £2.315M compared to March 2018.
<= 3%	Total spend, including bank and agency, equates to £18.510M, which is £0.115M under the total pay budget for the month.



Actions
Continue to promote the Trust bank. Requirement for Agency usage and rate to be risk assessed against clinical need and appropriately escalated for approval.

Apr-18	Mortality: Deaths in ED or as Inpatient
107	Total number of patient deaths while patient was in the emergency department or as an inpatient.
Target	Higher number of deaths over the winder months typical of a national picture of high acuity of illness, particularly in the frail elderly population. This may alter mortality data - but is likely to do so across all peer hospitals.

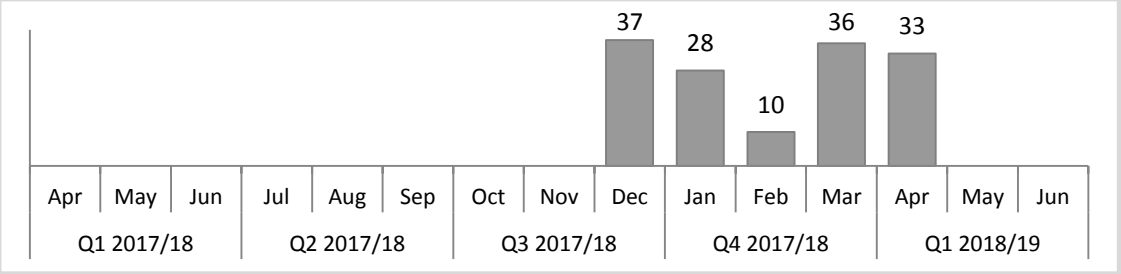


Actions
Monitor mortality ratio's relative to peer hospitals.

Indicator Detail

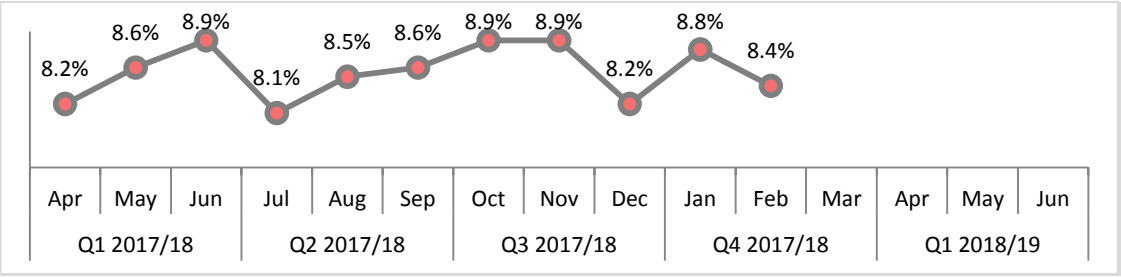
Apr-18	Mortality: Case Note Reviews
33	The total number of case note reviews undertaken of each death in ED or as inpatient
Target	Good progress in the numbers of 'learning from deaths reviews' undertaken. This month exceeded our 30% target.

Actions
Focus upon effective cascading of the learning from these reviews.



Apr-18	Emergency Readmission Rate
8.4%	The percentage of emergency re-admissions within 28 days following an inpatient discharge.
Target	Static picture, which should be improved by the investment in crisis response and Stockport Neighborhood integration.
<= 7.9%	

Actions



Safer Staffing Report

Apr-18	Day				Night				Day		Night		Care Hours Per Patient Per Day (CHPPD)				Safety Thermometer			
	Registered midwives/nurses		Non-registered		Registered midwives/nurses		Non-registered													
Ward Name	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Registered fill rate	Non-registered fill rate	Registered fill rate	Non-registered fill rate	Cumulative number of patients at 23:59 each day	Registered midwives/ nurses	Non-registered	Overall	Pressure Ulcers	Falls with Harm	Catheters & UTIs	VTEs
AMU	3,960	3,654	3,240	3,013	3,600	3,061	2,970	3,262	92.3%	93.0%	85.0%	109.8%	1542	4.4	4.1	8.4	0	0	0	0
Clinical Decisions Unit	360	360	360	360	330	330	330	330	100.0%	100.0%	100.0%	100.0%	146	4.7	4.7	9.5	0	0	0	0
Short Stay Olders People's Unit	1,125	1,035	765	750	660	660	660	649	92.0%	98.0%	100.0%	98.3%	439	3.9	3.2	7.0	2	2	0	2
A3	1,377	1,295	945	923	990	869	660	660	94.0%	97.6%	87.8%	100.0%	700	3.1	2.3	5.4	0	0	0	0
A10	2,700	2,082	1,980	2,052	1,980	1,970	1,320	1,320	77.1%	103.6%	99.5%	100.0%	715	5.7	4.7	10.4	0	0	0	0
A11	1,530	1,358	1,575	1,575	660	660	660	638	88.7%	100.0%	100.0%	96.7%	855	2.4	2.6	4.9	1	0	0	0
A12	1,845	1,718	1,395	1,448	660	660	660	768	93.1%	103.8%	100.0%	116.4%	772	3.1	2.9	5.9	0	0	0	0
A15	1,170	765	585	891	660	660	660	660	65.4%	152.3%	100.0%	100.0%	482	3.0	3.2	6.2	0	0	0	1
B4	513	383	513	494	418	418	418	539	74.7%	96.2%	100.0%	128.9%	313	2.6	3.3	5.9	0	0	0	0
B6	1,170	1,068	1,035	1,109	660	693	660	884	91.3%	107.1%	105.0%	133.9%	655	2.7	3.0	5.7	0	0	0	0
Bluebell Ward	1,170	1,170	2,010	2,460	660	660	660	885	100.0%	122.4%	100.0%	134.1%	579	3.2	5.8	8.9	1	0	0	0
C4	1,170	1,035	585	827	660	660	660	748	88.5%	141.4%	100.0%	113.3%	460	3.7	3.4	7.1	0	0	0	2
Coronary Care Unit	810	810	450	351	660	660	330	319	100.0%	78.0%	100.0%	96.7%	173	8.5	3.9	12.4	0	0	0	0
Devonshire Centre for Neuro-Rehabilitation	1,035	1,035	1,935	1,871	660	660	660	671	100.0%	96.7%	100.0%	101.7%	552	3.1	4.6	7.7	0	0	0	0
E1	1,881	1,506	2,235	2,190	990	770	1,320	1,320	80.1%	98.0%	77.8%	100.0%	917	2.5	3.8	6.3	0	0	0	0
E2	2,205	2,183	1,530	1,963	990	990	990	1,320	99.0%	128.3%	100.0%	133.3%	990	3.2	3.3	6.5	0	0	0	0
E3	2,205	2,198	1,530	1,788	990	979	990	1,375	99.7%	116.9%	98.9%	138.9%	1036	3.1	3.1	6.1	0	0	0	1

Safer Staffing Report

Apr-18	Day				Night				Day		Night		Care Hours Per Patient Per Day (CHPPD)				Safety Thermometer			
	Registered midwives/nurses		Non-registered		Registered midwives/nurses		Non-registered													
Ward Name	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Registered fill rate	Non-registered fill rate	Registered fill rate	Non-registered fill rate	Cumulative number of patients at 23:59 each day	Registered midwives/ nurses	Non-registered	Overall	Pressure Ulcers	Falls with Harm	Catheters & UTIs	VTEs
A1	1,395	1,313	1,170	1,118	990	990	990	968	94.1%	95.5%	100.0%	97.8%	750	3.1	2.8	5.9	0	0	0	2
B3	810	798	945	941	660	649	473	726	98.5%	99.6%	98.3%	153.5%	420	3.4	4.0	7.4	0	0	0	0
C6	810	804	945	855	660	660	660	660	99.3%	90.5%	100.0%	100.0%	459	3.2	3.3	6.5	0	0	0	0
D1	1,530	1,118	1,305	1,419	660	660	990	990	73.0%	108.7%	100.0%	100.0%	659	2.7	3.7	6.4	0	0	0	0
D2	1,092	942	945	915	660	638	561	570	86.3%	96.8%	96.7%	101.6%	399	4.0	3.7	7.7	0	0	0	0
D6	1,170	1,088	1,170	1,095	660	660	660	693	92.9%	93.6%	100.0%	105.0%	657	2.7	2.7	5.4	0	0	0	0
M4	1,508	1,299	1,620	1,594	660	594	990	979	86.2%	98.4%	90.0%	98.9%	738	2.6	3.5	6.1	0	0	0	0
SAU	1,755	1,701	945	837	990	902	660	627	96.9%	88.6%	91.1%	95.0%	413	6.3	3.5	9.8	0	0	0	0
Short Stay Surgical Unit	1,775	1,694	744	625	847	858	561	561	95.4%	83.9%	101.3%	100.0%	624	4.1	1.9	6.0	0	0	0	0
ICU & HDU	4,320	4,068	750	702	3,990	3,816	0	0	94.2%	93.6%	95.6%	na	317	24.9	2.2	27.1	0	0	0	0
Birth Centre	900	848	450	450	600	520	300	300	94.2%	100.0%	86.7%	100.0%	51	26.8	14.7	41.5	0	0	0	0
Delivery Suite	2,700	2,693	450	398	1,800	1,790	300	260	99.7%	88.3%	99.4%	86.7%	215	20.8	3.1	23.9	0	0	0	0
Maternity 2	1,575	1,575	900	878	600	600	300	280	100.0%	97.5%	100.0%	93.3%	467	4.7	2.5	7.1	0	0	0	0
Jasmine Ward	900	900	450	450	600	600	0	0	100.0%	100.0%	100.0%	na	204	7.4	2.2	9.6	0	0	0	0
Neonatal Unit	2,250	1,883	0	0	1,575	1,281	0	0	83.7%	na	81.3%	na	269	11.8	0.0	11.8	0	0	0	0
Tree House	3,150	2,925	450	450	2,100	1,803	0	0	92.9%	100.0%	85.9%	na	451	10.5	1.0	11.5	0	0	0	0
	53,865	49,298	35,907	36,787	34,280	32,381	22,053	23,962	91.5%	102.5%	94.5%	108.7%	18419	4.4	3.3	7.7	0	0	0	0

Safer Staffing Report

Apr-18	Registered midwives/nurses		Non-registered		Registered midwives/nurses		Non-registered		Registered fill rate	Non-registered fill rate	Registered fill rate	Non-registered fill rate	Cumulative number of patients at 23:59 each day	Registered midwives/ nurses	Non-registered	Overall	Pressure Ulcers	Falls with Harm	Catheters & UTIs	VTEs
Ward Name	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual												
Bramhall																	1	0	0	0
Brinnington																	0	0	0	0
Victoria																	0	0	0	0
Cheadle Hulme																	0	0	0	0
Stepping Hill																	0	0	0	0
Gatley																	0	0	0	0
Heald Green																	0	0	0	0
Heatons Central																	0	0	0	0
Marple																	1	0	0	0
South Reddish																	0	0	0	0
Werneth																	1	0	0	0
ENS																	0	1	0	0
Comm Rehab																	0	0	0	0
Active Recovery																	0	0	0	0
																	3	1	0	0

Safer Staffing Report

BOARD PAPERS – Quality, Safety & Experience Section : April 2018			
DESCRIPTION	**AGGREGATE POSITION**	**TREND**	**PERFORMANCE AGAINST PREVIOUS MONTH**
Registered Nurses monthly expected hours by shift versus actual monthly hours per shift. Day time shifts only.	91.5% of expected Registered Nurse hours were achieved for day shifts. Any Registered Nurse numbers that fall below 85% are required to have a business group review & an update of actions provided to the Chief Nurse & Director of Quality & Deputy Chief Nurse.	April 2018 91.5% March 2018 90.8% Feb 2018 91.1%	The lowest RN staffing levels during the day were on Ward B4: 65.4%. The ward was closely supported by Matron to assure safety. Non registered staffing levels were increased to support safe care. Vacancies have been recruited to. Never less than 2 RNs on duty at all times.
Registered Nurses monthly expected hours by shift versus actual monthly hours per shift. Night time shifts only.	94.5% of expected Registered Nurse hours were achieved for night shifts.	April 2018 94.5% March 2018 93.8% Feb 2018 94.3%	The lowest RN staffing levels during the night were on Ward E1 77.8% due to vacancies and moving RN staff to support other wards. Associate Nurse Director and Matron closely monitor.

Non-registered staff monthly expected hours by shift versus actual monthly hours per shift. Day time shifts only.	102.5% of expected Non-registered hours were achieved for day shifts.	April 2018 102.5% March 2018 98.4% Feb 2018 99.9%	The lowest staffing levels during the day were on the coronary care unit: 78.0%. Vacancies have been recruited to. Support has been provided by Matron as well as aligning staffing levels for safety with the co- located ward A3.
Non-registered staff monthly expected hours by shift versus actual monthly hours per shift. Night time shifts only.	108.7% of expected Non-registered hours were achieved for night shifts. For areas with over 100% staffing levels for non-registered staff this is reviewed & is predominately due to wards requiring 1:2:1 specials for patients following a risk assessment or to support Registered Nurses staffing numbers when there are unfilled Registered Nurse shifts.	April 2018 108.7% March 2018 106.9% Feb 2018 108.5%	The lowest staffing levels during the night were on the delivery suite with 86.7% due to a vacancy, which has been recruited to and short term sickness. Matron assures safety .

NHS
Stockport
NHS Foundation Trust

Report to:	Council of Governors	**Date:**	23 May 2018
Subject:	Final Operational and Winter Plan Submission		
Report of:	Director of Support Services	**Prepared by:**	Associate Director Strategy & Planning

REPORT FOR INFORMATION & DISCUSSION

Corporate objective ref:	All
Board Assurance Framework ref:	-----
CQC Registration Standards ref:	-----
Equality Impact Assessment:	☐ Completed ☒ Not required

Summary of Report

This purpose of the report is to present the Trust's Operational Plan 2018/19 and Winter Plan to the Council of Governors for information and discussion.

Governors were provided with the opportunity to comment on the draft Operational Plan at the Council of Governors meeting held on 21 March 2018.

The final Operational Plan and Winter Plan narrative was considered and approved by the Board of Directors on 26 April 2018 and was subsequently submitted to NHS Improvement by the deadline of 30 April 2018

Attachments:

Annex A - Final Operational Plan
Annex B - Winter Plan
Annex C - Attachment to Winter Plan

This subject has previously been reported to:

☒ Board of Directors	☐ PP Committee
☐ Council of Governors	☐ SD Committee
☐ Audit Committee	☐ Charitable Funds Committee
☒ Executive Team	☐ Nominations Committee
☐ Quality Committee	☐ Remuneration Committee
☒ F&P Committee	☐ Joint Negotiating Council
	☒ Other

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1. INTRODUCTION

1.1 This purpose of the report is to present the Trust's Operational Plan 2018/19 and Winter Plan to the Council of Governors for information and discussion.

2. CURRENT SITUATION

2.1 Governors were provided with the opportunity to comment on the draft Operational Plan at the Council of Governors meeting held on 21 March 2018.

2.2 The final Operational Plan and Winter Plan narrative was considered and approved by the Board of Directors on 26 April 2018 and was subsequently submitted to NHS Improvement by the deadline of 30 April 2018

3. ASSURANCE ON DELIVERY

3.1 In reviewing the Operational Plan for approval on 26 April 2018, the Board of Directors took into account the following management and governance arrangements in place to ensure delivery of the component parts of the Operational Plan.

3.2 Operational Performance

3.2.1 Operational performance is a golden thread running through the Business Group governance structures, from individual specialty teams to Directorates and then Business Group Quality Boards. The Executive Management Group has oversight of the key indicators and receives a bi-weekly Flash Report that highlights key risks and emergent trends in performance.

3.2.2 Performance against Elective standards is monitored on a weekly basis by the Performance Team, with actions being taken to deliver month on month compliance with key elective indicators. The Head of Performance chairs a weekly meeting with Business Management teams to ensure any risks to in-month performance are managed and mitigated and to ensure a Trust-wide view of performance is maintained.

3.2.3 Performance against Urgent Care standards is monitored through the Urgent Care Cabinet as is the delivery of the Urgent Care Recovery plan. The Cabinet is made up of stakeholders from across the Stockport System, each with responsibility for the performance of their own elements of the Urgent Care System. A collaborative approach is taken between partner organisations to ensure all participants are clearly sighted on what they are accountable for. The Urgent Care Cabinet reports to the monthly Urgent Care Delivery Board, chaired by the Chief Executive of the Foundation Trust, with the senior leads of the Stockport Together partner organisations and other stakeholders forming the wider membership.

3.3 Winter Preparedness

3.3.1 Our initial winter plan has been developed based on adopting best practice and key principles to ensure the safest and highest quality of care to our patients and to have the largest operational benefit at a time when our teams are at their most stretched.

3.3.2 At present, this is primarily the Trust plan's and does not yet describe the detailed actions from other partners in the system, notably the CCG, SMBC and GP federation, Viaduct. A more robust 'system wide' winter plan will be developed at an operational level through the weekly Urgent Care Cabinet with approval and assurance provided by the Urgent Care Delivery Board chaired by the Trust CEO.

3.3.3 At an internal operational level the monitoring of winter plan and subsequent performance will be monitored at the Proposed Operational Management Group chaired by the COO. At an assurance level, the performance will be monitored at the Finance and Performance Committee.

3.3.4 At this stage of the financial year, the Trust is presenting a moderate level of assurance in delivery of the winter plan until the system wide response is better understood and business groups have made a full assessment of funded resources in 2018/19 budgets in order to enact the actions described in full.

3.4 **Quality Improvement Plan**

3.4.1 The Quality Improvement Plan brings together all the actions that the Trust believes to be the most important. The plan, developed with staff, patients, governors and stakeholders, intends to be the main driver in delivering the improvements necessary to achieve the strategic objective of delivering outstanding clinical quality and patient experience. The Medical Director and Chief Nurse & Director of Quality Governance have developed the new Quality Governance Framework which is operational from April 2018.

3.4.2 The benefits of our Quality Improvement Plan, to be measured at Trust Board, are to ensure:

- Achievement of the Trust strategic objectives
- Delivery of sustainable, safe, effective, and high quality services for patients
- Lessons are learned and shared across the trust thus reducing the risk of incidents and improving responsiveness, quality of care and experience for patients
- Robust systems and processes in place thus reducing clinical and reputational risk
- Compliance with CQC regulations
- Compliance with NHSI Provider Licence
- Well trained and valued staff
- Sustainable trust-wide process and governance arrangements in place to move programme work into business as usual at local level when appropriate
- Senior oversight and scrutiny on progress and any slippage allows executives to prioritise work

3.5 **Workforce Planning**

3.5.1 The on-going modelling of the overall workforce implications of the transformational change and cost improvement programmes is emerging, as the schemes develop; the workforce plans and implications will be updated accordingly in response to local and regional changes.

3.5.2 The Population Centric workforce planning model is used to assist with the determination of the Trust's workforce requirements. Plans are in place to continue with this approach

across the transformational change programmes.

3.5.3 The Workforce Efficiency Group (WEG) is used as the primary forum to measure and monitor the effectiveness, efficiency and efficacy of the Trust's workforce, including temporary staffing utilisation, to further improve the organisational view of the workforce themes and challenges. The People and Performance Committee (PPC) oversees the workforce plan, which is an iterative document, and is reviewed at regular intervals and in response to changes driven by strategic activity and developments. The workforce plan and workforce risks are regularly considered by PPC, within the Trust governance and assurance structure.

3.6 **Contract position**

3.6.1 Following successful negotiation with Commissioners, the Trust has been able to improve the draft financial plan by £2m and therefore the planned deficit is now £34m from £36m. The two main proposed changes are:

- An improved offer from Eastern Cheshire CCG that will see the commissioner fund the total cost of the service for the first half of the financial year with an improved excess bed day rate for the latter half. The CCG has agreed to enact the recommendation from the Stroke LoS audit and implement and Early Supported Discharge Service. The financial impact has improved from £1.5m to £0.6m and therefore £0.9m is an improvement to the deficit;
- Stockport CCG has agreed to contract and remunerate the Trust at the 2017/18 outturn levels of activity and whilst the Trust captured the capacity and cost in the draft operational plan, the contract offer is an improvement in the overall position by £0.9m; and
- A confirmation of the contract with Specialist Commissioners has also improved the position by a further £0.1m

3.6.2 At an operational level, the monitoring of contract performance will be monitored at the through the Executive Management Group. At an assurance level, the performance will be monitored at the Finance and Performance Committee through detailed activity reports.

3.7 **Cost Improvement Programme**

3.7.1 The CEO and DoF met with Business Group Directors on 11th April 2018 to review the overall resource, governance and structure that Directors will employ to deliver their respective CIP programme. Each SRO has a governance structure in place and will be supported by Workforce, Informatics, Finance and Transformation resource to ensure the projects deliver at pace in 2018/19.

3.7.2 Against the £15m CIP target for 2018/19, the Trust has identified £8.7m of opportunities that are being developed into projects and milestones. At an operational level, the development and delivery of the CIP will be monitored at the fortnightly Financial Recovery Meetings with the CEO and DoF and monthly at the Financial Improvement Group. At an assurance level, the development will be monitored at the Finance and Performance Committee through detailed presentations by Senior Responsible Officers.

3.7.3 At this stage of the financial year, the Trust is presenting a low to moderate level of assurance in the delivery of the £15m CIP.

3.8 **Performance Management Framework**

3.8.1 In order to ensure accountability for the delivery of targets and plans described above and in the operational plan narrative, the Executive Team will utilise the performance Management Framework. Bi-monthly performance review meetings are held with each business group triumvirate to ensure delivery is on plan and where this is not the case, agree and monitor targeted recovery plans.

3.9 **Stockport Neighbourhood Care**

3.9.1 Progress updates on the status and delivery of projects associated to SNC are received on a monthly basis. These are also reported to the Alliance Provider Board and will come to the Executive Management Group.

3.10 **Local & Regional Strategic Developments**

3.10.1 The Trust continues to be actively involved in the Greater Manchester Health & Social Care developments specifically relating to Theme 3 and Theme 4. Meetings are attended by the CEO, Deputy CEO and Associate Director Strategy & Planning as deemed appropriate.

3.10.2 The Trust is also involved in work more recently commissioned by Cheshire and Merseyside STP to review the clinical and financial sustainability of hospital services at East Cheshire Trust, taking into account clinical dependencies and the impact these options have on the proactive community care for the local population.

3.10.3 Updates on progress on strategic developments will be reported through to the Executive Management Group with assurance provided to the Finance and Performance Committee.

5. RECOMMENDATIONS

5.1 The Council of Governors is recommended to:

- Receive the Operational Plan 2018/19 and Winter Plan, at Annex A and B respectively, for information and discussion.
- Note the assurance provided to the Board on the management and governance arrangements for delivery of all respective parts of the operational plan.

Stockport NHS Foundation Trust – Final Operational Plan 2018/19

1. SUMMARY

In terms of refreshing our two-year plan submitted to NHSI in December 2016, this document provides an overview and explanation of the changes to the plan for 2018/19. The document includes:

- A refresh of activity assumptions taking account of service changes, commissioning intentions and an internal capacity and demand assessment at specialty level
- The anticipated impact of Stockport Together implementation
- Actions undertaken to improve our urgent care performance, capacity and resilience and an outline of our winter plans for 2018/19
- A summary of our Service review programme utilising quality, operational and financial benchmarks to drive efficiency and improvement aligned to our CIP programme
- Our revised quality improvement plans and approach in response to the CQC visits in June 2017
- Progress in respect of our workforce planning and steps being taken to reduce our agency expenditure
- An overview of our financial performance in 2017/18 and the specific factors affecting performance
- A change in our financial planning assumptions from those submitted in our original two-year plan including outline CIP planning for 2018/19
- An update on our involvement in Sustainability and Transformation Plans (STPs) at a local and regional level

It is important to note that this plan assumes not accepting our revised financial control total offer from NHSI in February 2018. The Trust would have to deliver a CIP of £40m (c15%) to be able to agree to the financial control total of £2.0m surplus including the enhanced provider sustainability fund of £10.7m. No further formal discussion has occurred with the Greater Manchester Health & Social Care Partnership and therefore the draft financial plan assumes non-acceptance of the control total.

The Trust has key challenges to overcome in terms of addressing some of its performance issues and financial sustainability which have deteriorated in 2017/18. The Trust has been subject to Enhanced Oversight measures since October 2017 for both the financial performance and the operational performance for Urgent Care. We are planning for a deficit budget of £34m with a CIP target of £15m – this is an improvement on the deficit position of £2m since the submission of our draft plan. We maintain that our system wide approach to transforming the way we deliver services in Stockport supports the system wide challenge of financial balance, however the anticipated deflections in activity in 2017/18 have not been realised as planned which has affected our ability to deliver against some of our challenges, most notably urgent care.

Key risks to delivery of the refreshed plan for 2018/19 are:

- Our capacity and capability to improve our CQC inspection rating from good and onto outstanding
- The inability to reduce reliance on temporary staffing in order to improve quality and safety
- The inability to recruit and retain the right staff in the right number to provide suitable capacity to meet demands – particularly in respect to delivering against national 7 day standards
- The inability to improve the ED 4hr standard due to flow issues across the H&SC system
- Level of emergency demand and cost of delivering additional short notice capacity

- The inability to reduce the level of stranded (7+ los) patients or the super-stranded (21+ day los) patients affecting flow and subsequent contract penalties levied
- Stockport Together business cases do not deliver as planned and deflections do not occur
- Availability of working capital facilities and sensitivities on cash action grips being reversed
- The failure to deliver recurrent CIP and efficiency gains identified through the model hospital and internal service reviews
- The stretch upon management capacity due to the high volume of transformational changes underway

2. ACTIVITY & OPERATIONAL PLANNING

As part of the 2017-19 planning process, the Trust agreed a two year contract with Stockport CCG that incorporated the impact of new models of care as part of the Stockport Together Programme. The major benefit was assumed to deliver in 2018/19. However, due to delays in the implementation across all partners in the economy, the Trust has not experienced nor is planning to experience significant reductions in activity in 2018/19.

2.1 Baseline Scenario

Fig 1 shows the proposed activity levels by point of delivery for 2018/19. The numbers are calculated based on activity profiled over the last 12 months, taking into account; known services changes or developments, commissioning intentions of the CCG and the products of our internal capacity and demand programme at a specialty level. The table also shows the variance of our baseline position for 2018/19 to the existing two year contract plan as part of our operational plan submission last year.

Fig. 1 – 2018/19 proposed activity plan by Point of Delivery (POD)

Point of Delivery	Existing Contract Plan 2018/19	Revised Baseline Activity 2018/19	Variance	Percentage Variance
Outpatient	319,723	313,850	-5,873	-1.8%
Elective	37,433	37,610	177	0.5%
Non-Elective	43,631	43,006	-625	-1.4%
ED Attendances	96101	97,620	1,519	1.6%

2.2 Activity Impacts

The main changes indicated above are as a result of the forecast position for 2017/18 that has been reviewed by business groups. In terms of outpatients, the main areas of change are as follows:

- General Surgery Upper GI has reduced by 1,733 attendances in line with projected outturn.
- ENT has reduced by 2,111 attendances in line with projected outturn
- Orthodontics reduction of 1,050 attendances in line with forecast outturn.
- Anti-Coagulation is showing a reduction of 4,402 attendances which is in line with the forecast outturn. The change is due to a change in the pathway requiring fewer attendances and an increase in tariff from July 2017
- Other changes above are in line with forecast outturn and are in line with business group reviews

2.2.1 Healthier Together

The transfer of any activity from Tameside is not expected to take effect until 2019/20 and is therefore not included in the activity plans presented above. Timelines continue to be subject to review dependant on the

availability of capital to make necessary changes to the estate to accommodate the service transfer. The modelled activity impact is presented below:

- Phase 1 is approx. 7 elective spells per month – to be profiled from proposed start date
- Annual activity impact for Phase 2 is 2388 spells, (205 elective and 2183 non elective)

2.2.2 Cardiology – Diagnostic Angiography transfer

Stockport CCG has decommissioned diagnostic angiography which will take effect from 1 April 2018 – this activity will transfer to the Wythenshawe site of Manchester University NHS FT. The activity impact (circa 700 cases) has been included in the baseline activity plan. The full financial impact is subject to final review following agreement of detailed costs but is expected to result in a financial pressure of £400k.

2.2.3 GM theme 3 & 4

It is not expected that any activity changes will impact in 2018/19 relating to GM H&SC themes 3 and 4. A stocktake of the GM programme took place in December 2017 which has resulted in revised timescales for the various specialty reviews. A detailed modelling exercise is currently being planned by GM partners to better inform overall impact across the sector at an individual site level.

2.2.4 Stockport Together

The Summary Economic case commits the health economy to saving £20.1m in 2018/19 based on cost reduction (£26.1m based on national tariff). The savings requirement for the providers in Stockport is £14.1m (£6.5m avoided growth) and £6m (£3m avoided growth) for non-Stockport Providers. The savings are underpinned by an agreed risk and gain share of equal thirds between Stockport NHSFT, Stockport CCG and Stockport MBC and investment of £19.3m.

The Stockport Together Integrated Service Solution (ISS) is expected to be fully deployed by the beginning of March 2018 based on current plans and assumptions. There will be an optimisation period between full deployment and benefits becoming available and therefore for planning purposes, the Health and Social care economy is assuming no material benefit in 2018/19 and, consequently, will enact the risk share. We will need to agree the 'benefits triggers' that will enable cost reduction. The key risk to full deployment of the model relate to implementation of 7-day working by community and social care staff and outcome of the associated consultation related to this. There are critical key contractual and operational delivery actions for both the Alliance and CCG.

Six priority projects have been identified as part of the Outpatient programme to deliver the necessary reductions in activity. These are:

- Active support for patients to enable them to take more control of their condition including decision making and self-care and provision of advice
- Support for GPs in clinical decision making
- Appropriate clinical triage of referrals and diagnostics
- Alternative mechanisms to traditional appointments & support to enable discharge from outpatient clinic
- Coordinated support for complex patients; and
- Identifying outpatient activity that can be stopped

The four providers of Health and Social Care services in Stockport have an alliance provider agreement in place with an Executive Director from each organisation creating an Alliance Provider Board. This Board is the main driver for the implementation of the new models of care and delivery of the benefits.

Acknowledging that implementation is behind original plan a Maturity Assessment exercise has been undertaken against all the programmes that are part of the ISS. This has established a criterion led checklist to assess implementation, reviewed economic case cost/benefit vs. status position, made an assessment of estimated slippage to plan and considered draft mitigations to manage benefit realisation. The draft outputs of this show the following results in terms of the categorisation of 'stages':

Stage	Definition	No of programmes
Stage 1	Scoping / Identification of opportunity (e.g. right care)	6
Stage 2	Pathway / process design - not costed likely implementation 19/20	2
Stage 3	Costed standards / specification ready for implementation - funding source to be agreed	1
Stage 4	Costed & funded route to implementation agreed	3
Stage 5	Implementation underway	23
Stage 6	Formal evaluation processes in place	0

A series of recommendations to ensure priority areas of focus and that programmes off-track are recovered, is due to be discussed at Alliance Programme Board in early March 2018.

2.3 Summary of bed reconfiguration plans

The proposed opportunity for bed reductions as a requirement of the 2018/19 Cost Improvement Programme and the expected benefits of Stockport Together is identified as a 74 acute bed reduction, split across Trauma and Orthopaedics and General Medicine. From length of stay analysis compared with best practice, the opportunities are identified as follows:

- Trauma & Orthopaedics – 16 bed reduction
- General Medicine – 24 bed reduction
- DMOP - 34 bed reduction

The detailed plan will incorporate the key milestones for deployment of initiatives central to the ISS to allow a greater level of granularity in the tracking of expected benefits. The routes for escalation are essential should the expected activity changes not materialise as a responsive system is needed to ensure all potential risks are understood and mitigated where possible.

A paper was considered by the Executive Management Group in March that outlines the ward closures taking effect from June 2018. While the full financial impact is yet to be calculated, a high level assessment of this is estimated to be approx. £3.4m saving – this excludes the potential savings on Medical costs, as the Medical model is still being finalised, and the fuller understanding of the potential impact on clinical vacancies across the Trust. All escalation beds have been closed as of the middle of April 2018.

2.4 Service review programme

As part of the Financial Recovery plan for 2017/18, and a key element in planning the CIP for 2018/19, a programme of Service Reviews is being led by a team made up of representatives from Finance, HR, Performance, Transformation and Operations.

The Service Review process brings together performance and quality data, financial benchmarking and best practice identified from Getting it Right First Time (GIRFT) and the model hospital. This is considered alongside

intelligence within the system provided by Clinical and operational teams to identify key actions required to ensure the future financial sustainability of services.
The outputs of each of the Service Reviews are grouped into the themes that run through the agenda of each meeting, namely; Market movement, Efficiency & Quality, Procurement & Finance and Workforce.

The Service review programme to date has progressed to the output stage for General Surgery, DMOP and Cardiology with opportunities for efficiency and cost reduction used in the development of the CIP programme. The other three specialties identified as priorities for phase 1 are Trauma & Orthopaedics, Rheumatology and Obstetrics. The timeline for these to reach the stage described above is by end of April 2018 – this will identify improvement schemes and potential savings opportunities for critical review and inclusion within our CIP where appropriate. Following this, a second tranche of priority service areas have been identified to go through the review process.

2.5 Performance against operational standards

Performance against the Emergency 4 hour standard has continued to be a point of focus. The Trust has not met the performance target or associated trajectory throughout 2017/18. The RTT standard has been maintained since November 2016 with one exception in September 2017. Performance in specialties highlighted last year has recovered, but others have presented an issue in 2017/18 - Rheumatology & Ophthalmology – if these continue at current levels of activity growth they could present an issue to trust level compliance in 2018/19. Both specialties are part of the first wave service review programme to identify corrective actions and solutions. How quickly we can implement these will affect our ability to sustain Trust level RTT compliance.

Performance against the cancer target has historically been an area of strong performance (compliant since Q1 2015/16) but the target was failed in Q1 2017/18 but recovered in Q2. There are GM wide challenges affecting local performance e.g. waits for specialist diagnostics (PET scans) that may impact on our ability to deliver compliance in 2018/19. The Trust, in line with the national picture has experienced continuing growth of 2 week wait referrals, increasing general demand on diagnostics of 10% year-on-year, struggled with workforce shortages and other issues which have made delivery of the national cancer waiting times an increasing challenge. There has been a GM wide review compiling best practice on 62 day management and performance.

Performance against these targets will be tracked and monitored against the revised trajectories submitted to NHSI in April.

2.6 System wide resilience capacity and planning

Significant work has continued with our H&SC partners to resolve our urgent care issues and delivery of our ED performance. In order to enable delivery of the whole health economy savings required for 2018/19 the key components of the Stockport Together ISS will need to reach full deployment during Quarter 4 2017/18. Plans are currently based on the assumption that full deployment of the ISS will be in place by March 2018.

Local focused actions being undertaken specifically at the Trust include:

- An Emergency Department specific action plan
- Stranded patient reviews focusing senior attention on those patients staying the longest in the hospital
- “CEEPFIT” meetings 3 times per week with the Clinical teams from across Medicine and Surgery to focus on early discharge and expediting patient flow across the system.
- Continued refinement of the OPEL escalation process and ensuring the Stockport System response is fit for purpose, has clear roles and responsibilities and is providing the required resilience

- A review of the Emergency Department Medical rota to provide two consultants every evening (from 1pm – 9pm) in order to meet the demands of the twice daily surges.
- Implementation of a Frailty Unit to increase capacity at the front end to ensure flow across the hospital
- The focus on the reduction of DTOCs and MOATs through further development of Discharge to Assess pathways with close working between system partners.

As per the planning guidance our detailed Winter Plan is now described within a separate document submitted alongside this final operational plan.

At present, this is primarily the Trust plan's and does not yet describe the detailed actions from other partners in the system, notably the CCG, SMBC and GP federation, Viaduct. It is identified that a more robust 'system wide' winter plan should be developed by the system operational group and approved by the Urgent Care Delivery Board. The Stockport System is also currently being supported by the North East Commissioning Support Unit to help coordinate a system wide improvement plan and it would be prudent to seek their advice to strengthen our system winter plan developments.

3. QUALITY PLANNING

3.1 Approach to quality improvement

This is led by our executive leads for quality improvement, the Medical Director and Chief Nurse & Director of Quality Governance, with a strong focus on the well-led elements of the CQC framework. The Trust recognises that following our CQC review and report in June 2017, this resulted in significant effort to deliver predominantly transactional actions that resolved specific issues identified in the CQC report.

Our focus and goal for the next 12-24 months is to develop and implement a more transformational programme of change that will result in a 'good' CQC outcome and more resilient assurance of high quality care. Development of a new Quality Strategy will be implemented via a Quality & Safety Improvement Programme which underpins the Trust Consolidated Action Plan and is intended as the driver programme for the Quality and Safety Improvements that are required.

The primary objectives for this programme are as follows:

- Reduce variation and patient harm by setting explicit standards and establishing clear accountability.
- Establish a process of oversight of clinical care that assures consistent delivery of clinical standards of care.
- Ensure a competent workforce who have been appraised and undertaken core learning
- Deliver consistent recording of adverse incidents, with effective feedback and learning from clinical incidents, complaints and litigation.
- Ensure all CQC Must Do actions and concerns are fully addressed

This will deliver the following benefits:

- Safe, effective, high quality services for patients
- Lessons are learned and shared across the Trust, thus reducing the risk of future incidents and improving responsiveness , quality of care and experience for patients
- The Trust has robust systems and processes in place thus reducing clinical and reputational risk

- The Trust is compliant with CQC regulations
- Well trained and valued staff
- There is a sustainable Trust-wide process and governance arrangements are in place to move programme work into business as usual at local level when appropriate
- Senior oversight on progress and any slippage allows executives to prioritise work

3.2 Key actions to improve Quality & Safety

3.2.1 Review function of the Quality Governance Committee

This has become overburdened within its current remit and there is a clear need to distribute work through a different framework. This will ensure that we can evidence sufficient assurance on quality governance within the organisation and comprehensive and valid assurance to the Board of Directors. This work was completed in Q4 2017/18 and will become operational in April 2018/19.

3.2.2 Ward Accountability & Oversight

A programme to ensure clear ward ownership at all staffing levels; matron, ward manager, consultant, and clinical director has been made transparent and communicated widely. This will ensure that everyone understands their role in achieving high standards of patient care on wards and being held accountable. Evaluation and success will be measured through a ward accreditation scheme and mock CQC inspections.

3.2.3 Clinical Leadership Structure

In line with revised business group structures, appointment of a new tier of medical leaders took place in Q3 of 2017/18. A new hospital associate medical director role has been created to support the medical director with key Trust wide programmes of improvement. The new structure divides services into more manageable directorates, enabling key standards in these areas to be more easily monitored and maintained. A leadership development programme to support the new structure will be embedded in 2018/19.

3.2.4 Objectives for clinical leaders

To support the new clinical leadership structures, explicit objectives for directorates have been set and communicated to teams. It is the job of the business group triumvirates (Business Group Director, Associate Medical Director & Associate Nurse Director) to monitor and manage these. Delivery of these objectives will be monitored through the business group performance meetings.

3.2.5 Seven day services

Progress in relation to the four key national standards will continue to be managed through a dedicated multidisciplinary group led by the Medical Director. An initial assessment of current adherence against standards and what resources may be required to meet each priority area by 2020 has been carried out. Current estimates for implementation of the 7 day working standards are £4.5 million recurrent. This conservative figure assumes that much of the resource will be delivered by 'efficient' reallocation of existing services. The multidisciplinary group will continue to identify a phased approach to these changes in the six acute admitting specialties. The estimated costs of 7 day services are been reflected within our plan submission.

In terms of trajectory, we continue to make improvements within existing budgets, and are developing plans for continued improvement. Full delivery of the standards will be dependent upon the funding available to support the augmentation of existing staffing resource. Further assessment of the risks, benefits and the financial impact will enable the Board to make decisions on the following:

- Where meeting standard is the right decision
- Where diluting the standard may be the right decision
- What can be done as an alternative

3.2.6 Mortality Reviews

In response to national guidance on learning from deaths report (published March 2017) a group led by the Medical Director has conducted a review of existing systems and processes. Reported mortality figures and associated reviews are now reported to the Board in line with expectations of the national report. By Q4 2017/18 a revised process and reporting system for mortality reviews will be in place. In 2018/19 this will be refined in order to meet the suggested KPIs that should be reported. This in turn will enable an increased oversight and accountability within business groups to manage mortality and morbidity process at directorate level.

3.2.7 Infection Prevention Control

Our service is currently in a vulnerable state due to unsuccessful recruitment to vacant consultant microbiology posts. This has presented significant challenges in optimally supporting the infection prevention team in delivering their agenda. Work is on-going to achieve a more resilient position through the appointment or substantive staff, however alternative arrangements are being considered; either a different staffing model making use of additional antimicrobial pharmacist posts or seeking support from other units.

The Infection Prevention and Control Committee has been replaced by a bi-monthly Infection Prevention and Control Group that now directly reports to a sub-committee of the Board from April 2018 in line with the new Quality Governance Framework.

Monthly infection prevention operational groups have been set up and commence in May 2018. This will be a meeting with business groups focusing on operational issues and will feed into the Infection Prevention and Control Group.

ACE (Accreditation for Continued Excellence) is being launched in April 2018, where wards will be working towards a set of 11 nationally and locally agreed quality standards including Infection prevention. Each ward will be assessed against the Infection prevention standards by the infection prevention nursing team and a level of accreditation awarded

The Trusts gram negative resistance rates are reviewed on a 6 monthly basis in line with the Trusts antibiotic guidelines to ensure they remain fit for purpose.

Fig. 2 - Quality and Safety Improvement Programme

Programme	Description
Quality Governance (Exec Lead Chief Nurse)	Review of: • Ward/Department to Board quality governance arrangements – MIAA Audit Recommendations • Risk Management Framework - Incident Reporting, Serious Incident Management • Duty of Candour – Re: ward staff understanding, compliance and corporate governance Develop plan to implement a new quality governance framework
CQC plan (Exec Lead Chief Nurse)	Plan to address gaps where fundamental standards were not being met: • Regulation 10 – Dignity and Respect • Regulation 12 - Safe Care and Treatment • Regulation 17 – Good Governance • Regulation 18 – Staffing

	Plan to include **Must and Should**, referencing GM Quality Framework, and include, but not exhaustively: • *Mortality and Morbidity* • *Incident Reporting* • *MCA / DoLS* • *Nurse Staffing* • *Medical Staffing* • *Access and Flow* • *Cleanliness and Infection Control* • *Health Records* • *Audit findings and action planning* • *Environment* • *Learning from incidents*
Deteriorating Patient (Exec Lead Medical Director)	Review EWS Policy Review themes from incidents Develop Care of Acutely Ill Patient Group Training and competency review of staff regarding EWS systems Communications material regarding EWS
Safeguarding (Exec Lead Chief Nurse)	• Improve risk assessment for adults and children (IHA) • MCA/ DOLS Training ○ Review of policies
Medicines Management (Exec Lead Medical Director)	• Medicines reconciliation and CD audits • Medicines safety and security • Medicines administration audits and action plans
Training & Competencies (Exec Lead Director of Workforce & OD)	• Maintain focus on achieving Trust target • Focus on areas noted in CQC reports
Appraisal & Supervision (Exec Lead Director of Workforce & OD)	• Achieving target rates for appraisal
Electronic Patient Record (Exec Lead Director of Support Services)	• Progression of the implementation plan
Quality Improvement Priorities (Exec Lead Chief Nurse)	Workshops were delivered with key stakeholders in January 2018 to agree Quality Improvement Priorities for 18/19 Quality Account. Following the workshops, we engaged with front-line staff and have agreed **nine quality indicators**, underpinned by our strengthened Quality Governance Framework: **Safety:** • 50% reduction in avoidable stage 2, 3 and 4 pressure ulcers (in both acute and community) by March 2019 • 10% reduction in in-patient falls, with 25% reduction in falls with moderate and above harm by March 2019 • Achieve 100% compliance with the Malnutrition Universal Screening Tool (MUST) by March 2019 **Effectiveness:**

	• Undertake a review of discharge planning process and establish a baseline and target for improvement by March 2019.
	• Following a successful pilot we will launch our ACE Ward Accreditation programme. We will undertake 6 ward accreditations per quarter with quarterly reports provided. By March 2019 we will have scoped and piloted the ACE programme for community, maternity and paediatrics.
	• Deteriorating Patient and NEWS introduction (metrics to be determined through AQuA program) for improvement by March 2019
	
	Experience:
	• Undertake a strategic staffing review with a report to board in October 2018
	  o Deliver 4 work streams identified through our staff retention programme
	  o Triangulate staffing levels with harm
	
	• Achieve an improvement in the top 5 worst performing questions from the inpatient survey by 5% measured in the 2018 in-patient survey
	
	• Introduce a suite of Always Events in Q1 (metrics to be determined by 30 June 2018) with 100% achievement by March 2019

Safe Staffing (non-medical) (Exec Lead Director of Workforce & OD)	• Reduction of reliance on temporary staffing through a series of schemes: • NHSI Retention Programme • Recruitment programme • Improved efficiencies in rostering • Development of a suite of measures with NHS Professionals
Reducing variation in practice in clinical areas (Exec Lead Medical Director)	• GIRFT • Pathways, clinical guidelines, care bundles, SOPs, NATSIPPs, LOCSIPP's • Standardised operating procedures and escalation processes for each ward – including staff numbers, skills and competencies • 7 Day Services programme
High Quality Safe Care Support Programme (Exec Lead Director of Workforce & OD)	A programme of work including: • Clinical leadership development / coaching for medical leaders including a Medical Engagement Survey using (MES) • Quality improvement capacity and capability, working towards a quality improvement culture • Enhanced Board and oversight scrutiny • Nursing and AHP leadership • Implementation of Schwarz Rounds • Healthcare Leadership Model 360 for senior leaders

3.4 Quality Impact Assessment Process

Project documentation was produced for all Cost Improvement Programme (CIP) schemes which were each QIA reviewed and approved by the Medical Director or Chief Nurse & Director of Quality Governance.
The project documentation template has been reviewed to ensure a full QIA is completed for all CIP schemes (see

This documentation/process is currently being reviewed and expanded to include all quality improvement projects, business cases and other projects within the Trust.

3.5 Triangulation of Quality indicators

During the three CQC inspections undertaken in 2016-17, concerns were identified relating to quality and safety governance. In addition the NHSI report relating to Board oversight and governance highlighted significant weaknesses.

Presentation and interpretation of the Trust's position in relation to delivering mandatory requirements and the Trust objectives is compromised and a review of effectiveness of the current Governance Framework and reporting to support improvement and assurance has been undertaken. This includes the Integrated Performance Report (IPR) together with the information reviewed at subcommittee and Business Group level, ensuring there is consistency with:

- Single Operating Framework (targets etc)
- Trust operating plan and objectives
- Quality Account/CQUIN
- Carter Operational Productivity
- CQC KLOE/Insight report/indicators

An initial assessment and process to develop the IPR has been outlined to the Board – work will be undertaken in conjunction with a structured plan to develop a range of governance and assurance arrangements:

- Review of the governance structure – Board and Subcommittees
- Review of Operational meetings to support delivery (ref MIAA report Committee Effectiveness Review); currently in draft.
- Operating Plan process and reviews including Board Assurance Framework (BAF)
- Business Group accountability, Business Group Board functions and performance reviews
- Well Led Self-Assessment priorities
- CQC Inspection (KLOE including use of resources and improving from Requires Improvement to Good and onto Outstanding)

The priority is to establish the Quality and Safety section first linked to the review of the Quality and Safety Governance framework and structure outlined in this section with a plan established to have a revised IPR in place to use the from April 2018.

4. WORKFORCE PLANNING

4.1 Workforce Planning

Having the right numbers and types of staff is crucial to the efficient and effective operation of the Trust. The time taken to train staff, the challenging changing landscape and the scale of the exercise, mean that workforce planning for the Trust is a complex issue and process.

The Population Centric workforce planning model is used to assist with the determination of the Trust's workforce requirements. Plans are in place to continue with this approach across the transformational change programmes which includes the modelling of the impact of 'new' roles, such as Advanced Pharmacists. The on-going modelling of the overall workforce implications of the transformational change and cost improvement

programmes is emerging as the schemes develop. Workforce plans and implications will be updated accordingly in response to local and regional changes.

4.2 Governance

The primary function of the Workforce Efficiency Group (WEG) is to measure and monitor the effectiveness, efficiency and efficacy of the Trust's workforce, including temporary staffing utilisation, to further improve the organisational view of the workforce themes and challenges. The People and Performance Committee (PPC) oversees the workforce plan, which is an iterative document, and is reviewed at regular intervals and in response to changes driven by strategic activity and developments. The workforce plan and workforce risks are regularly considered by PPC, within the Trust governance and assurance structure.

4.3. Workforce Supply

In response to recruitment and retention challenges, a number of initiatives are in place:

- Development of a Nursing & Midwifery Strategy which addresses the challenge of nurse recruitment.
- A cohort of adaptation nurses commenced in January 2017, with 24 throughout the year. However, we have encountered an unanticipated challenge with regard to the IELT pass rates. An evaluation of this approach will determine any future cohorts.
- Commencement of training of 16 Nursing Associates in January 2017, with a cohort of a further 20 in September 2017.
- Recruitment and Retention strategy and associated framework of benefits in support of attracting and retaining staff has been developed, this will be further underpinned via participation in the NHSI retention programme; which is a three year workforce retention programme with the objective of stabilising and subsequently reducing leaver rates across the sector. The Trust has been selected for the opportunity to participate in cohort 2 of the retention support programme.
- Continuation of recruitment to advance practitioners positions in existing service areas and new models of service delivery, for example the community neighbourhood teams; and paediatric nursing to enable the opening of Paediatric HDU beds next year as part of GMHSC Theme 3.
- Several new advanced roles have been developed and recruited to including, Plain films MSK reporters, CT Head reporters, Sonographers (Ultrasound), Fluoroscopy reporters. The Trust has also developed a new area of advanced practice and is training a Plain Film Chest reporter. There is an expectation that the number of Advanced Pharmacists will increase further next year; this development and implementation of new roles will be reviewed on an on-going basis.
- The Trust is continuing to develop other new roles including the Physicians Associate, with recruitment to an initial intake of 5 anticipated to conclude in Q1 2018/19.
- Development of extended roles in collaboration with our social care partner working within the integrated children's service and neighbourhood teams within Stockport Neighbourhood Care; and
- Detailed Apprentice Plan produced in January 2017, working in partnership with Greater Manchester Public Sector Steering Group to improve apprenticeships starts. Public sector target is 119 we currently have 54 apprenticeships underway with plans to increase monthly. Launch of new Leadership and Management Apprenticeship level 3/5 commenced in November 2017.

4.3.1 Workforce Supply (for Medical)

In response to recruitment and retention challenges, a number of initiatives are in place:

- International medical recruitment in urgent care and critical care
- Targeted domestic medical recruitment campaign

- Re-introduction of recruitment and retention initiatives for key medical roles
- Development of a medical internal bank with a view to collaboration with local Trusts.

4.4 Management of Temporary Staffing Spend

There is significant focus on recruiting hard to fill vacancies that are being covered by premium cost agency locums. The Trust continues to have success both domestically and internationally. There are significant controls in place to manage the agency spend which are currently being reviewed and improved, this is at corporate level by the Establishment Control Panel, at Business Group level to ensure operational challenge and by the Temporary Staffing team to ensure approvals are in place and that we challenge agency rates to achieve best value for money.

The Trust has reinvigorated the weekly performance management discussions that focus on agency usage to ensure that all relevant staff understands the importance of substantive appointments and agency reduction. In support of this there is an increase in recruitment activity for our medical staff bank and collaboration with other organisations within GM to implement a shared bank service. This has resulted in savings in 2017/18 and a reduced forecast for 2018/19 in accordance with the revised agency ceiling.

4.5 Effective use of Technology

E-rostering is used within the Trust to manage clinical rotas. The system highlights the effectiveness of rota practices so that unnecessary premium staffing costs can be avoided. Improvements in our approach to e-rostering have continued. The roll out of e-rostering to other areas including ED and theatres has been completed and the next phase of roll out to other non-clinical areas, such as corporate services is underway. Future system developments include the utilisation of the SafeCare module, in support of better matching staffing levels with patient needs.

E-JobPlan is currently utilised for Consultants and SAS doctors within the Trust. The system enables Job plan data collection, analysis and reporting; standardised job plans, efficient, transparent and clear processes of job planning, centralised record of medical job plans. It provides a structured and shortened process for carrying out successful job planning.

4.6 Workforce Development

In order to ensure the workforce have the right skills and competencies to support the Trust's strategy and to meet the requirements of Stockport Neighbourhood Care, a learning and development plan and a clinical skills plan have been created in conjunction with senior clinical staff and have been approved by PPC. Both plans identify the priorities over the next two years to support workforce transformation, including the need for greater partnership working and skills development across health and social care.

5. FINANCIAL PLANNING

5.1 Financial Performance 2017/18

In October 2016, the Board of Directors considered the Sustainability and Transformation Fund (STF) offer from NHSI and endorsed the view that to deliver a £4.4m deficit and £1m deficit in 2017/18 and 2018/19 respectively in exchange for £7.6m STF would be extremely challenging. The Trust would have had to deliver a CIP of £31m (c10%) in 2017/18 and therefore the Directors felt that on the balance of risk on delivery, the challenge was considered to be too great.

The Trust opted to seek efficiencies on a more sustainable basis over a longer period with a recurrent CIP target of £15m (c5%) per annum for two year plan. The planned deficit for 2017/18 was £27.4m, subsequently adjusted to £26.2m to take account of:

- The 2016/17 balance sheet adjustment of £390K relating to 2016/17 STF; and
- The Tranche 1 of winter monies in recognition of winter costs already being planned of £783k

The Trust was forecasting a significant shortfall on the delivery of the 2017/18 financial plan predominantly related to:

- Budgetary overspend in the Medicine Business Group related to higher than planned agency and staffing costs and as a result of CQC recommendations;
- Underperformance in elective activity predominantly related to changes in the patient pathway, restrictions on activity due to IR35 and a shortfall in theatre staff to meet the requirements; and
- Shortfall on the delivery of the in-year CIP target of £15m predominantly in bed and outpatient reconfigurations

The Trust was placed under Enhanced Oversight in October 2017 for both financial performance and the operational performance of Urgent Care. Since meeting with NHSI on a monthly basis to recover the financial performance, the Trust has implemented a number of recovery actions to provide a higher assurance that the revised plan will be delivered. The financial metrics between plan and forecasted is presented in Fig 3 below.

The Executive Team will continue to develop and pursue further actions; however these will be non-recurrent in nature and coupled with the low level of recurrent delivery of CIP in 2017/18, the financial outlook for 2018/19 remains extremely challenging.

Fig. 3 – Financial performance 2017/18

2017/18	Plan £m	Forecast out-turn £m	Variance £m
Income	273.0	286.7	13.7
Expenditure	(285.1)	(300.5)	(15.4)
EBITDA	(12.1)	(13.7)	(1.7)
Non-Operating Expenditure	(15.3)	(8.3)	7.1
Surplus / (Deficit)	(27.4)	(22.0)	5.4
Year-end cash balance	5.3	15.5	10.2
Recurrent CIP	15.0	6.1	(8.9)
Capital Expenditure	13.6	8.4	(5.2)
Finance Use of Resources Metric	3	3	-

5.2 Financial Planning 2018/19

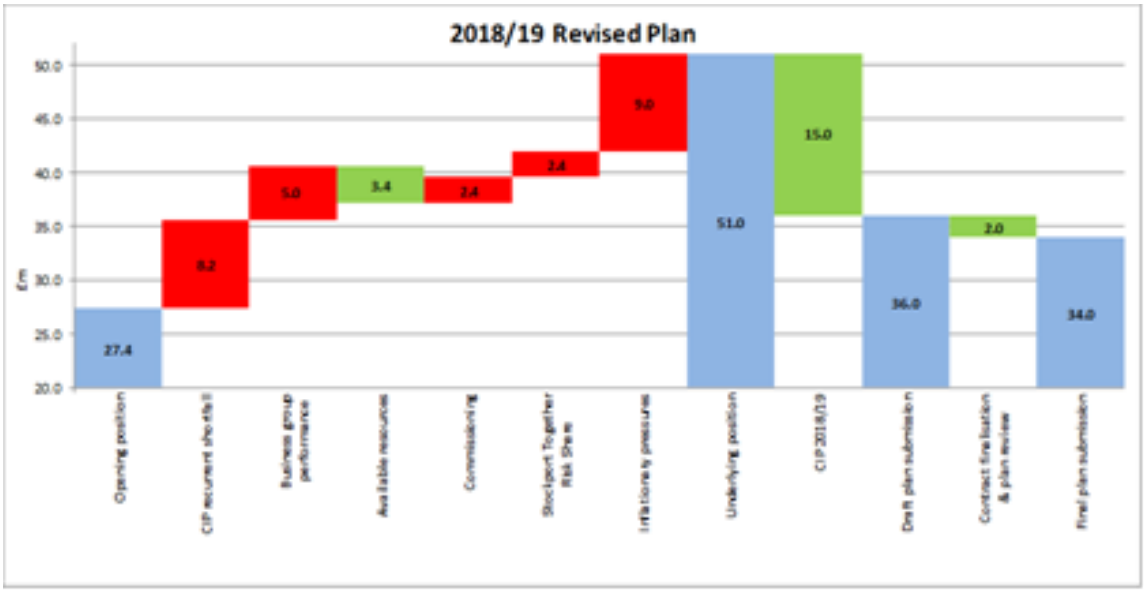
The Trust operates a two year model within its finance ledger and all financial reporting is driven from this one source to maintain financial integrity. The budget model has therefore been used extensively to model planning assumptions on areas such as pay inflation, which represents 70% of the Trust costs, and this has been done on a post by post basis. Therefore, the Trust has a high degree of confidence in its workforce planning numbers and

pay costs contained within the plan. The plan takes account of where CIP has been delivered on a non-recurrent basis. The Trust continues with the implementation of acute and community EPR systems.

One of the key challenges facing the Trust continues to be the recruitment of key medical and nursing posts. Despite international recruitment programmes there are still some vacancies which are being covered at agency rates and planning assumptions include continued costs at agency rates not within the agency cap.

The second year of the two-year Operational Plan forecasted a deficit of £24.4m. This allowed for £12m of inflationary pressures in 2018/19, but assumed full recurrent delivery of £15m CIP in both 2017/18 and 2018/19. As described in section 5.1 above, the Trust faced significant challenges delivering in year targets which in effect have increased the recurrent shortfall for 2018/19. This final Financial Plan forecasts a deficit of £34m with the main movements illustrated in fig 4 below.

Fig. 4 - Headline financial planning 2018/19



In our draft financial plan submission, we presented the following changes to the original 2 year assumptions:

- the original plan assumed that the £15m CIP in 2017/18 would be recurrent, however only £6.3m was recurrent creating an £8.7m recurrent shortfall
- the net effect of the budgetary overspends and the review of planning assumptions including the positive impact of the CQUIN agreement in negative movement of £1.6m
- the commissioning intention in relation to the decommissioning of Cardiac Angiography, the movement of price of Stroke Rehabilitation and the reduced contract value of district and school nursing amounts to £2.4m; and
- with the delay in the implementation of the new models of care, the health and social care economy has instigated the risk and gain share which means the Trust will have to fund a third of the agreed investment valued at £2.4m

Following a successful negotiation of the NHS Commissioning, the Trust has been able to improve the financial plan by £2m and therefore the planned deficit is now £34m from £36m. The two main proposed changes are:

- An improved offer from Eastern Cheshire CCG that see the commissioner fund the total cost of the service for the first half of the financial year with an improved excess bed day rate for the latter half. The CCG have agreed to enact the recommendation from the Stroke LoS audit and implement and Early Supported Discharge Service. The financial impact has improved from £1.5m to £0.6m and therefore £0.9m is an improvement to the deficit;
- Stockport CCG have agreed to contract and remunerate the Trust at the 2017/18 outturn levels of activity and whilst the Trust captured the capacity and cost in the draft operational plan, the contract offer is an improvement in the overall position by £0.9m;
- A confirmation of the contract with Specialist Commissioners has also improved the position by a further £0.1m

These changes have been reflected into our final plan submission.

The Trust has experienced an extremely difficult winter period only being able to deliver ED performance at approx. circa 70% and has increased medical bed capacity to cope with demand. At the time of this draft plan, there are 70 beds operational in excess of recurrent capacity.

The Trust's underlying deficit in the draft refreshed financial plan for 2018/19 is £51m. The Board of Directors reviewed and agreed that a suitably challenging CIP for the Trust should be circa 5% and therefore is planning £15m as per our original two year plan.

The Trust received the revised financial control total offer from NHSI in February 2018. However, based on the draft financial plan, the Trust would have to deliver a CIP of £40m (c15%) to be able to agree to the Financial Control Total of £2.0m surplus including the enhanced provider sustainability fund of £10.7m. No further formal discussion has occurred with the Greater Manchester Health & Social Care Partnership and therefore the draft financial plan assumes non-acceptance of the control total.

5.2.1 Efficiency savings for 2018/19

As described above, the Trust had targeted recurrent delivery of £15m per year for the two year operational plan. The Trust has delivered £12m in 2017/18 of which only £6.3m is recurrent. This performance has resulted in an in-year shortfall of £3m and a recurrent shortfall of £8.7m. A significant amount of in-year delivery was due to one-off non-recurrent cost improvements compared to the much needed transformational service improvement efficiency as described in the model hospital.

Against the £15m CIP target for 2018/19, the Trust has identified £8.7m of opportunities that are being developed into projects and milestones. These are primarily driven via service reviews led by the Deputy Chief Operating Officer summarised in Section 2.4 above. The service review process commenced in December 2017. Using all available benchmarking information such as the Model Hospital, CHKS and Lord Carter's provider operational productivity programme, the Trust is focussing on the stated opportunities to deliver real sustainable transformation change in the bed base, in theatres and outpatients.

Each SRO has a governance structure in place and will be supported by Workforce, Informatics, Finance and Transformation resource to ensure the projects deliver at pace in 2018/19. At an operational level, the development and delivery of the CIP will be monitored at the fortnightly Financial Recovery Meetings with the CEO and DoF and monthly at the Financial Improvement Group.

Fig. 5 – Cost Improvement planning 2018/19

Service Description/ Category	Beds £m	Theatres & Endoscopy £m	Outpatients £m	Clinical Support Services £m	Workforce £m	Procurement & Medicines Management £m	Corporate & Environment £m	Other £m	Proposed CIP Total £m
T&O	0.8	1.1			0.2				2.1
General Surgery		0.5			0.2				0.6
DMOP	1.0		0.1		0.6				1.6
Obstetrics				0.6					0.6
Cardiology	0.3		0.1		0.3				0.7
Other specialties	2.0	0.8	0.8	1.4	1.8				7.8
Medicines Management						0.4			0.4
Procurement						0.6			0.6
Estates & Facilities/Corporate							0.6		0.6
TOTAL	4.0	2.4	1.0	2.0	3.0	1.0	0.6	1.0	15.0

5.2.2 Contracting impact

The approach with the CCG is that the 2018/19 activity and financial plan will be consistent with the 2017/18 contract plan adjusted for known changes and developments. Discussions for refreshing the 2018/19 contract have begun and the main aspects of negotiation are:

- Underlying growth assumptions across all PODs
- The recurrent impact of changes to the pathway experienced in 2017/18
- Transacting the Stockport Together Investment Agreement and either the benefit assumptions or the gain / risk share; and
- Stockport CCG not imposing contract penalties and supporting the Trust across the GM footprint

The Trust as the designated specialist hospital for the South East part of Greater Manchester will ultimately increase its emergency surgery (Healthier Together Programme) however plans for 2018/19 have not been adjusted in activity terms as timescales mean this will not happen as originally planned are not confirmed. The Healthier Together Business Case has been approved by commissioners and planning towards implementation continues subject to capital investment and the associated lead time. There are no other significant planned changes to income for the Trust.

The Trust has planned for CQUIN at 90% delivery. The Trust has not planned for financial penalties and therefore there is a risk to the financial plan, for which a contingency continues to be held for non-Stockport CCGs.

5.2.3 Capacity

The Trust opened additional theatre capacity in 2016 which will give capacity to undertake the Healthier Together expansion but also allow resilience within the Trust which could reduce the need to undertake premium rate weekend lists and outsource to the private sector. Improved utilisation of theatre and out-patient resources continue to be key themes in the Trust's improvement programme for 2018/19

The Trust has discussed with the CCG that growth and demand need to be managed on a specialty by specialty basis in order to ensure that the Trust does not increase capacity at a premium cost which will further increase the Trust's deficit.

5.2.4 Single Oversight Framework (SOF)

Fig. 7 shows the single oversight framework ratings which highlights that the Trust is in a deteriorating position over the next two financial years. **The Trust is aware that due to not accepting the control total in 2017/18 and 2018/19, it will be limited to Segment 2, 3 or 4 under the SOF.**

Fig. 6 - Single Oversight Framework ratings

Metric	Plan 2017/18	Forecast Out-turn 2017/18	Plan 2018/19
Capital service	4	4	4
Liquidity	4	4	4
I&E margin	4	4	4
I&E Variance from plan		1	
Agency	1	2	1
Use of Resources Rating before overrides	3	3	3
4 Rating Trigger for Use of Resources Rating	TRIGGER	TRIGGER	TRIGGER
Use of Resources Rating after 4 overrides	3	3	3

5.2.5 Capital planning

As internal capital is more limited than in previous years, the programme is focused on utilising the best use of our estate and prioritising the highest areas of IM&T and medical equipment replacement. Restrictions on funding mean we are not in a position to purchase all of the medical equipment due for replacement or carry out all developments that would make best use of our estate – most notably demolition and the re-provision of old buildings.

A scheme to consolidate critical decontamination services is included in our planning, subject to approval of a final business case expected in Q1 2018/19. Work to begin planning the re-provision of our Laboratory Services linked to the direction of travel of the GM programme will also commence.

Due to the limited availability of funds, we have adopted a tightly managed risk based approach to replacement of key equipment, restricting our ability to fund more aspirational developments or much needed upgrades to parts of our estate. We anticipate completing a full 6 facet survey in the early part of 2018/19 which will enable us to inform our longer term plans for the site aligned to clinical priorities and a refresh of the Estates strategy following completion of work on the Trust strategy.

Fig. 7 Internal Capital Plan

Capital Plan	
Description	**2018/19 £'000**
Property & Estates Schemes	
Healthier Together Scheme	5,274
Urgent Treatment Centre	1,000
Minor Projects	380
Backlog Maintenance/Site Infrastructure	761
Non backlog Maintenance	944
	8,359
Equipment Schemes	
Plant and Equipment Other	570
Medical Equipment	2,337
	2,907
I M & T Projects	
EPR Acute and Community Finance Lease	1,147
Other IM &T	2,432
	3,579
Capital Programme 1819	**14,845**
Funded By:	
Depreciation 2018/2019	9,708
Less:	
Capital Loan Repayments	-1,551
	8,157
Vanguard - Community Funding	300
PDC carry forward GP streaming	1,000
Asset Disposals	190
Cash reserve (Healthier Together Funding approval)	5,198
Total Funding	**14,845**

The Trust has made a planning assumption of £5.274m for capital costs associated with expansion linked to Healthier Together; however this is subject to funding agreement and will not be spent until confirmation of funding is received. We have to date progressed the planning of these major schemes at risk as part of our internal capital programme.

Primary Care Streaming

The Trust was awarded £1m in Dec 2017 to implement enhanced streaming and an Urgent Treatment Centre as part of our emergency department. A plan has been developed to remodel the front end of our Emergency Department to develop an Urgent Treatment Centre – this is planned to be completed by November 2018 in readiness for the winter period.

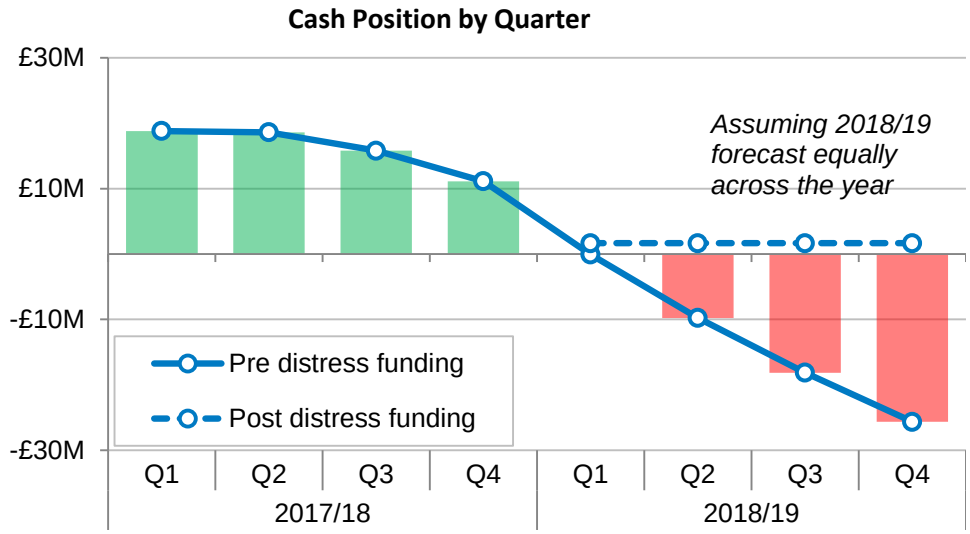
5.2.6 Cash Position

The key issue for the Trust with the refreshed level of deficit is the deterioration of liquidity from what has been a strong cash position since foundation status was achieved over 10 years ago. Working capital funding is required from the ITFF early in 2018/19 and our current planning assumption is that this will be in place in the final quarter of 2017/18. This is illustrated in fig 8 below.

Within the Trust's cash position are capital receipts that must be protected to deliver Healthier Together, Urgent Care and other capital commitments that have not yet had final approval for inclusion within the Plan submission.

Upon completion of the financial submission templates the cash position will be updated to reflect March 2018 outturn, working capital movements and final assessments of interest payable and PDC forecast for 2018/2019.

Fig. 8 - Cash position



6. LINK TO SUSTAINABILITY & TRANSFORMATION PLANS

The Trust continues to work in alignment and partnership with the Greater Manchester STP as well as the Stockport Locality Plan.

6.1 Locality Plans

In 2017/18, through agreement with our partners, a formal Alliance agreement was put in place and an Alliance Provider Board was established. This agreement enables us to provide an MCP service within a vehicle we have called Stockport Neighbourhood Care – this is our model of integration designed to provide services as a national vanguard.

The fundamental centre of the MCP is that it is based on the GP registered population and is primary care led. Providers and commissioners in Stockport have agreed that an Accountable Care Trust is the preferred organisational form through which services are provided in the future. In 2018/19 we will develop the architecture and necessary governance requirements to move forward with this transaction in collaboration with partners.

Aligned to this we have reconfigured our business groups in preparation to become an Accountable Care Trust that incorporates two major service components; one being specialist hospital services and the other integrated health and social care services.

One of the four business groups is Integrated Care which has brought together Community services and Emergency and Acute medicine – this is part of the structure of Stockport Neighbourhood care.

Our focus in 2018/19 will be implementation of the operational service models as part of the Stockport Together business cases approved by the Board in June 2017. Much of the groundwork and implementation will be complete by the end of 2017/18 and the emphasis will be to deliver the benefits articulated by the whole system working of the Stockport Together programme.

6.2 Locality financial planning

The Trust has worked closely with Stockport CCG and Stockport MBC in the development of the Stockport Together Programme that utilises £19m of Greater Manchester Health and Social Partnership Transformation Fund to deliver cost savings across the locality by 2020/21. The locality has a unified approach to activity planning and contract setting, the status and implications of which have already been described in previous sections.

In summary, upon full implementation in 2020/21, the combined business cases within the Stockport Together programme will deliver savings of £46.3m in activity priced at the national tariff (comprised of £43m from business case savings and an additional £3.3m CCG investment into Primary Care). This will result in a net system benefit of £26.67m after allowing for a recurrent investment in services of £19.7m (comprised of £16.4m Stockport Together investment and the £3.3m CCG investment into Primary Care referred to above.

6.3 Greater Manchester Plans

We continue to play a significant role in development of the GM Plan and partnership working. It is important that our locality plans reflect GM developments in Themes 1 and 2 which focus on communities, health and well-being and social care. However, development of future acute service provision under the scope of 3 and 4 will fundamentally impact the Trust and services delivered from the Stepping Hill site over the next 2-3 years.

Preparation for the implementation of Healthier Together (now under formal T3 governance) is anticipated to progress in early 2018/19 subject to access to national capital funding and agreement of revenue costs at a sector level with Tameside. Locally we continue to manage implementation through the south east sector programme board and an internal steering group. The transfer of high acuity surgical activity from Tameside is now likely to be in 2019/20.

Within Theme 3, the only formal decision (other than Healthier Together) to be made about changes to acute service provision is that specialist Urology Cancer will be delivered from the Wythenshawe and Christie sites. This will impact Trust activity but timescales and plans to how this will be enacted are not yet confirmed. The Trust has taken on the role as Provider Transformation Lead for Benign Urology. There is recognition that potential workforce implications resulting from a urology cancer surgery reconfiguration need to be clearly identified and worked through to ensure that benign urology services will not be destabilised as a result.

Other clinical programmes expected to change the delivery of service from the Stepping Hill site in the next two years are detailed below:

- Neuro-rehab - there is consensus to move to a single provider model with Salford the most likely lead provider. Our service provided at the Devonshire is anticipated to move to the management of Salford however this is subject to approval and confirmation through formal governance processes
- Breast Surgery - the clinical model is not yet developed but we will need to continue to align to a screening site (currently East Cheshire) and there is potential that surgical services could move to a larger hub
- MSK & Orthopaedics – the likely direction of travel is to consolidate high volume arthroscopy work on a number of hub sites with highly specialist work such as reconstruction, in designated centres. Given the quality of our current service we would aspire to be one of the hub sites.

Other significant programmes in earlier stages of development are; Paediatrics, Obstetrics, Cardiology, Respiratory and Critical Care & Anaesthetics

The GM Pathology programme has identified the need for greater consolidation via a number of major hub laboratories within GM. The Trust has endorsed a desire to be an early adopter of any consolidation which will help to mitigate risks we have about the resilience of our IT and estate infrastructure. Investment of capital at a local level will required to provide an acute pathology service at Stepping Hill and forms part of our longer term capital planning.

The primary focus of work in Radiology is to procure a new PACs system across GM which is seen as enabling greater transformation in terms of how clinical services can be delivered. The full business case is anticipated in Q1 2018/19. Whilst the Trust continues to be involved and will take advantage of any benefits of shared services at a GM level we are also exploring opportunities for consolidation at a local level, which is our preference, through our shared service programme with Stockport Council.

Stockport NHS Foundation Trust - Winter Plan 2018/19

1. INTRODUCTION

This document describes the Trust plan for winter preparedness 2018/19 which is supplemented by a more detailed action plan that will be enacted for the winter period. This is based on best practice guidance, '***Focus on improving patient flow'*** published by NHS Improvement and taking learning from actions we enacted for winter in 2017/18.

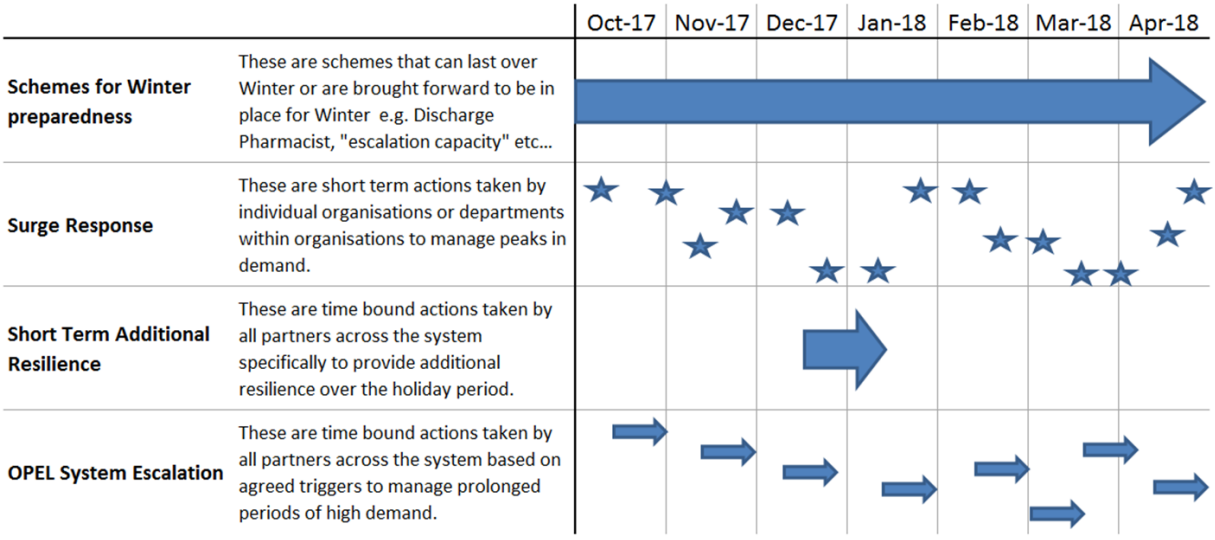
The impact on our elective programme has been accounted for within our 12 month activity profile included in the detailed technical annexes that accompany our plan submission.

At present, this is he Trust plan and does not yet describe the detailed actions from other partners in the system, notably the CCG, SMBC and GP federation, Viaduct. A more robust 'system wide' winter plan is being developed by the system operational group, to be approved by the Urgent Care Delivery Board. The Stockport System is also currently being supported by the North East Commissioning Support Unit to help coordinate a system wide improvement plan and it would be prudent to seek their advice to strengthen our system winter plan developments. A final system winter plan will be approved by the Stockport Urgent Care Delivery Board in May.

The plan has been developed using the following principals:

- To provide the safest and highest quality of care to our patients when they can be at their most vulnerable
- To have the largest operational benefit at a time when our operational teams are at their most stretched over an extended period
- For all activities to be cost neutral within existing financial envelope where possible
- All initiatives to be measurable through a weekly dashboard and their effectiveness evaluated regularly by the System Urgent Care Cabinet

There are four key elements to planning for Winter Preparedness, depicted and described below.



2. ADOPTION OF BEST PRACTICE

Stockport System Improvement plans for Urgent Care are based on the ***Good practice guide: Focus on improving patient flow*** published by NHS Improvement. This is a guide co-written with the Royal Colleges and Society for Acute Medicine, provided national priorities for Acute hospitals and is based on **10 areas of focus**:

1) Ambulance Handovers
2) Primary Care Streaming
3) Emergency Departments
4) Mental Health
5) Clinical Decision Units
6) Ambulatory Emergency Care
7) Acute Medical Units and other assessment services
8) Frailty
9) Specialties (medicine, surgery and paediatrics)
10) Admission, transfer and discharge.

In addition to the guidance provided by the ***Good practice guide: Focus on improving patient flow*** the Urgent Care plan and those for Winter preparedness are also based on our own analysis of the key factors affecting urgent care flow. They predominantly are:

1) Acute Medical Unit Occupancy is one of the key drivers to performance. **The lower the occupancy, the better the performance.**
2) Running a number of focused initiatives in the past 12 months (The "100% Challenge", Home for Christmas, Home for Easter) has highlighted the importance of a **decongested Emergency Department** and with flow, the system can perform to a high standard. Fast flow through to specialty assessment areas is essential.
3) The majority (81%) of our **discharges happen after midday** with 40% after 16:30. Bringing these earlier in the day will reduce our length of stay by 0.5 days.
4) **Influenza and Respiratory conditions peak over winter months** and can, if not treated by the appropriate specialists can result in extended periods of time in hospital.
5) To maintain flow across the system, our **Neighbourhood Response** is as essential as in-hospital capacity and planning.

While this best practice guidance is predominantly acute Trust focused, development of the system level plan will include pre and post hospital interventions.

2.2 Lessons Learnt

Development of our plan has also reflected on the previous winter and taking stock of learning areas, specifically:

- Operational management
    - Effective use of resource and time of managers. Sometimes widespread involvement diluted the effectiveness of operational management and focusing on existing

working relationships with clinical teams is a more productive and efficient use of resource

- Clinical leadership
    - The Triumvirate model is key to clinical engagement and identifying and resolving bottle necks as they occur. The maturity of the clinical leadership structure will be well established for winter 2018/19
- Site management and coordination
    - Effectiveness from the introduction of the team part way through the past winter was apparent. It is anticipated that the fully implemented model will provide a significant benefit and the required resilience and continuity to site management and improving patient flow

The Trust is also appointing a Delivery Director due to be recruited in April 2018. Agreement of this followed recommendations from NHSI and GM. The post will add resilience to winter providing focus and grip to the day to day operational flow in the hospital.

3. KEY AREAS OF FOCUS FOR OUR WINTER PLANNING

3.1 Acute Medical Unit Occupancy

Analysis has shown that Acute Medical Unit Occupancy is one of the key drivers to performance against the 4 hour standard. The Occupancy of the unit is measured as the percentage of patients in a bed at midnight; therefore the challenge is have as many empty beds at midnight as possible.

- We know approximately 80% of patients admitted through the Emergency Department will go to a Medical bed
- Our current Urgent Care pathway for Medical patients works on a linear flow dependent on clinical need
- We know approximately 28% of attendances to the Emergency Department result in an admission to a bed

Since December 2017 we have had in place a “Frailty Unit” located close to our ED. This is be a 16 bedded unit with a Length of Stay of less than 72 hours staffed by a mix of Geriatricians, nursing and therapy staff, linking closely with Primary care and Neighbourhood services to support flow back to Neighbourhood or Active Recovery support to enable an interim period of home/bed based re-ablement.

The unit accepts direct referrals from GPs, patients from ED and potentially acts as a step up facility from Neighbourhood and Crisis Response. The unit encompasses a ***Home First*** ethos, thereby reducing the occupancy and freeing up the AMU for patients more likely to require admission.

3.2 Decongested Emergency Department

The Emergency Department currently sees circa. 95,000 patients per year and analysis has shown that at peak times, there can be as many as 75 patients in the department, meaning at times our nursing staff can have 5 patients to care for at the same time. To ensure it functions to its optimal

level, it is imperative that flow through the Emergency Department is maintained at all times. To do this, we will:

- Provide dedicated Consultant level cover from the Surgical specialties, based on SAU to allow patients to go directly from ED to the Surgical Assessment Unit.

- Provide an additional Junior On Call rota in ENT to provide direct support to the Emergency Department.

- Reduce elective activity to ensure dedicated Cardiology and Respiratory in-reach to the Acute Medical Unit to promote flow through to the Specialty Medicine wards.

- Provide additional Middle Grade doctor cover in Paediatrics to ensure a 7 day service and enhanced support to the Paediatric Emergency Department.

3.3 Earlier Discharge

To ensure we bring forward discharges earlier in the day and provide flow across the system, there are a number of schemes that will be in place, they include;

- Hot Clinics
    - This will allow earlier discharge for Respiratory patients requiring a medical opinion as they will be able to access a ring-fenced outpatient appointment at the earliest opportunity within a clinically determined time frame

- Virtual Ward
    - This will allow patients to be discharged earlier from the AMU as they will be admitted to the Virtual Ward with a scheduled consultant telephone follow-up. This model will reduce patient's length of stay and allow for earlier discharge

- Daily Consultant Ward Rounds on all Acute Wards in the morning
    - An extensive review of rotas and job plans has been undertaken to ensure that all wards across the hospital will have a discharge focused consultant-led ward round on a daily basis.

3.4 Neighbourhood Response

The further maturity of our Neighbourhood services is essential to maintaining flow:

- Full implementation of our Integrated Neighbourhood Teams
- Enhanced Case Management
    - To identify and intensively manage the top 15% of patients at greatest risk of future admission. This approach will provide proactive, personalised and co-ordinated care to optimise the health, social and mental wellbeing of individuals.
- 7 day working
    - Access to Neighbourhood and Intermediate Tier services over seven days

- Acute Home Visiting Service
- Falls service
    - The Steady in Stockport falls and fracture prevention and bone health improvement pathway offers a pro-active short-term intervention to preserve the independence of people who might otherwise face unnecessarily negative impact on their quality of life related to a fall or fracture, unnecessary emergence attendance and hospital stays or inappropriate admission to hospital or residential care.

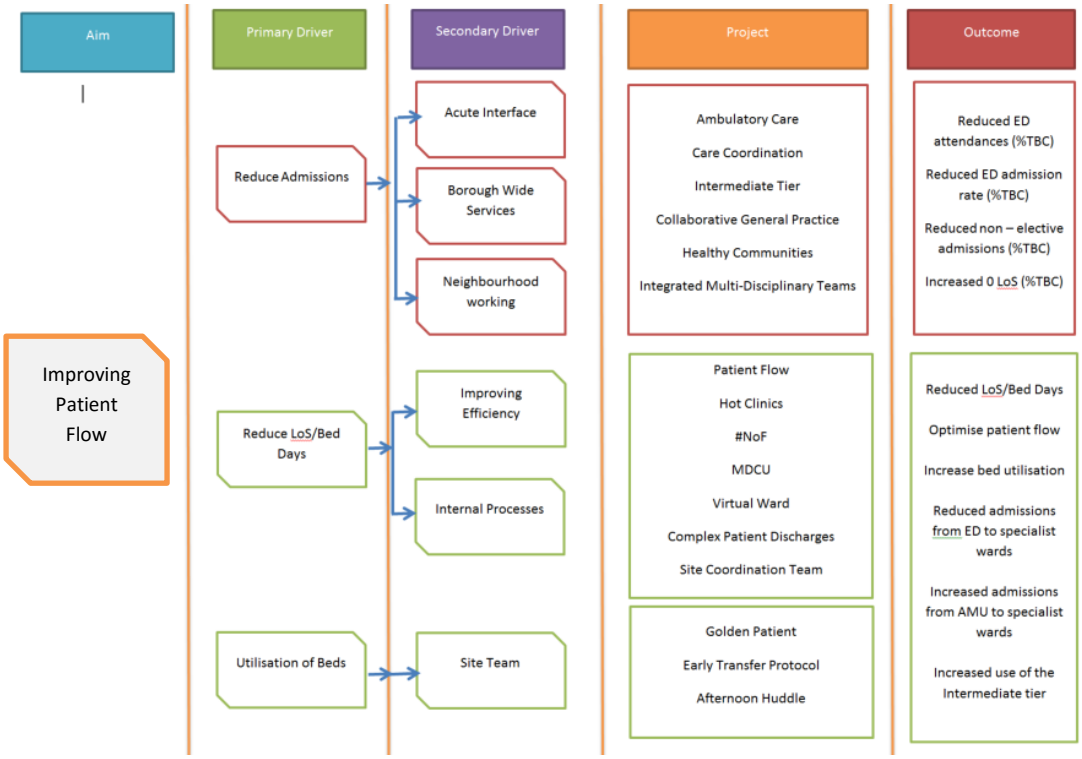
3.5 Managing Flu and Respiratory patients

The Winter season has historically seen a surge in patients suffering from Influenza and acute respiratory conditions. In the frail and elderly such conditions can be debilitating and result in a prolonged period of time in hospital. To ensure we have sufficient capacity to manage this anticipated surge, the following will be enacted:

- Administration of Quadrivalent flu vaccine in line with Public Health England recommendations – this offers superior effectiveness compared to the trivalent vaccine is likely to offer clinical benefit with improved protection to the health care worker themselves in terms of reduced absence and illness and also indirectly to their vulnerable patients as well.
- Increasing uptake of the Flu jab amongst staff via promotion campaigns
- Additional capacity to accommodate increased demand in respiratory patients

4. DEVELOPMENTS PRE-WINTER 2018/19

There are a number of improvement programmes, linked to our improving patient flow cost efficiency work stream that we expect to have in place prior to winter. The driver diagram below outlines the changes needed to successfully enhance our ability to manage winter demand.



A summary of other actions and programmes of work we expect to have implemented prior to winter are described in further detail in Annex A.

5. SPECIFIC ACTIONS FOR WINTER 2018/19

Also described in Annex A are the specific actions the Trust will enact for our winter plan at a business group and specialty specific level (where appropriate). These support the adoption of best practice and key areas of focus outlined in this plan.

WINTER PLANNING - PRE WINTER ACTIONS

	Workstream	Owner	Action	Progress
Pre-Winter Plan	**Urgent Care Access**	J.Harrop	**Ambulances -** To work collaboratively with our NWAS partners and sharing the problem and solutions for releasing crews earlier and managing the mostly predictable flows in demand **Triage -** Reduction in average wait time for triage by end of Q1 to national expectations of 15mns for both walk in and ambulance triage Implement 'Advancing ACU' work stream to ensure capacity always available for ED patients Zero tolerance to minors breaches and significant reduction in non-admitted breaches	Reviewing GMCA 3 target actions against Ambulances Maintaining 30 minutes handover time in the next 4-6 weeks Senior lead on programme of triage for junior staff Ops attendance at AMU ward rounds 12:30, consistent EDDs and golden patient Identification.
	Opel Framework	S.Goff	To continue to embed a whole system escalation framework, to ensure all partners within the system are contributing to the management of escalation	L.Yates leading on a project to 'spread the Opel word'
	Primary Care Streaming	J.Harrop	To continue to stream primary care though AI, to continue to capture data on a daily basis and to strive to reach the trajectory target of 18% of total ED attends To continue to focus on the build of an Urgent Treatment Centre, the build to be complete by Oct 2018 To provide the correct clinical streaming role for Urgent treatment Centre to ensure effective streaming and deflection	Capturing daily data analysis to capture ED attends in AI hours, AI patients diposed by stream and AI possibles Fortnightly Enhanced Streaming and Footprint Reconfiguration meetings being held to establish the build, equipment and workforce
	Elective Programme	K Hatchell	To review of theatre activity to be increased over 10 month period to support the January and February decrease	
		Business Group Triumvirates	To review and begin the implemntaiton of annualised hours for clincial staff to allow for more flexible use of resources	
	Frailty Unit	S.Plummer	To continue to accept direct referrals from GPs, patients from ED and potentially act as a step up facility from Neighbourhood and Crisis Response. This enables freeing up of AMU for patients that are more likely to require admission.	Implemented 6th Dec 2017 Review meetings being held by task and finish Groups- next meeting 6th June 2018 Co-ordinator role has been implemented to identify and pull appropriate patients from ED Reduction in LOS from 8.4 days to 4.6 days
	Diagnostic Capacity	C.Woodford	Increase our CT scanner capacity by procuring/leasing a 3rd CT Scanner for the SHH site Increasing radiologist and reporting radiographer workforce by converting WLI and outsourcing payments to Consultant and Radiographer substantive contracts	2 Business Cases are being produced to increase resilience and capacity in our Radiology department.

WINTER PLANNING - WINTER ACTIONS

	Workstream	Owner	Action
Winter Plan	**Primary Care Stream - UTC**	J.Harrop	Urgent Treatment Centre development and model to be implemented Correct Workforce model to be implemented Aim to deliver 35 patients 7 days a week
	Surgery Business Group	K.Hatchell	To Increase in bed capacity of 16 beds across Wards C6, D6 & A1 Orthopaedic elective activity to cease from 19th Dec 18 to 1st Mar 2019 Ward D1 to support capacity for Trauma orthopaedic, ENT and general surgery for the above period SSSU to convert 8 beds to increase SAU capacity to support patient flow through ED Staffing for ward areas to be reviewed and recruitment commenced where appropriate to support the additional capacity in ward areas Potential 3 session days by local agreement to release staff during winter 'downtime period'. This means Medicine would need a plan to cover the outliers.
	Women, Children and Diagnostics Business Group	C.Woodford	Paediatricians job plans to be flexed across summer and winter to provide extended hours/twilight/weekend cover in the winter months for our Assessment and ward areas. Paediatric middle grade cover to increase for winter twilight and weekends using our substantive staff grades and planned/budgeted additional locum cover. Paediatric nursing teams to work on annualised hours to ensure that winter months have a higher staffing ratio than in the other months – this has been in place for 5+ years and has proved to be successful in ensuring we use no bank or agency shifts at times of escalation and surge. Jasmine ward – during the winter months the gynaecology ward takes a higher percentage of gynaecology and breast day case lists to release beds on the day case ward for other surgical specialties. Consideration is being given to scheduling all female urology lists for Jasmine ward to support this service. Gynaecology – the service to run 24 hour assessment unit taking direct GP referrals and patients from ED on pathways to reduce any extended waits in the emergency department
	Medicine and Clinical Support Business Group	N.Armitage	Additional escalation beds in winter Additional consultant cover for weekends through winter period Additional pharmacy support over the weekends and for acute areas Additional resource to support the Christmas/NY period
	Integated Care Business Group	M.Malkin	> 56 hours of Medical SHO time (to clerk patients in ED) > 13 PA's Acute Consultant time to provide additional weekday and weekend cover > 14 PA's ED Consultant time to increase twilight cover to 2am > 56 hours ST4+ Middle Grade to act as 'waiting room doctor' > 84 hours of ANP time for streaming and deflection in ED > Housekeeper to allow for re-stock and care of dept > Additional Portering > Additional Domestic cover > Pharmacy support weekend To increase Therapy Support by the following: > Additional weekend therapy staff > Additional therapies to cover FRESH 4.00 pm – 8.00pm > Recruitment of bank staff to cover escalation areas To increase ITT Support by the following: > Hospital to home- additional > Discharge co-ordinator social worker > Weekend opening Transfer Unit > Transfer team – 1 porter and 1 HCA
	Flu	H.Thomson	To improve the uptake of Flu Vaccinations for frontline staff
	Christmas Plan	All	To ensure the key issues identified as barriers last winter are planned effectively as a system
	Staffing	Business Group Triumverates C.Wasson/A.Lynch	Address Staffing vacancies across Medical and Nursing staff

NHS
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Report to:	Council of Governors	**Date:**	23 May 2018
Subject:	Proud2Care: Our Quality Improvement Plan		
Report of:	Chief Nurse and Medical Director	**Prepared by:**	Chief Nurse

REPORT FOR INFORMATION & DISCUSSION

Corporate objective ref:	S02
Board Assurance Framework ref:	S02
CQC Registration Standards ref:	Regulation 10, 12, 17 18,
Equality Impact Assessment:	☐ Completed ☒ Not required

Summary of Report

This is the final draft of a Quality Improvement Plan which is in place to monitor the several plans that exist as vehicles to achieve improvements in the quality and safety of care received in sustainable ways.

We have made many changes since the CQC report was published in October 2017. The delivery of this plan, underpinned by good governance and staff development, will ensure that the changes made already are sustainable, and that those outstanding can be delivered in agreed timeframes. We all want our patients to receive consistent, high-quality care and we most certainly want Stockport NHS Foundation Trust to become the employer of choice.

The final draft of the Quality Improvement Plan is scheduled for approval by the Board of Directors on 24 May 2018. This overarching plan is designed to start to signal a common purpose and priority for the organisation that is owned by frontline staff, and recognised externally as our blueprint for success.

Attachments: Annex A – Quality Improvement Plan

This subject has previously been reported to:

☒ Board of Directors	☐ People Performance Committee
☐ Council of Governors	☐ Charitable Funds Committee
☐ Audit Committee	☐ Nominations Committee
☒ Executive Team	☐ Remuneration Committee
☒ Quality Committee	☐ Joint Negotiating Council
☐ Finance & Performance Committee	☒ Other

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1.	**INTRODUCTION**
1.1	The Trust is on a journey to becoming a recognised outstanding organisation, and we aim to demonstrate that the care and treatment delivered by all of our staff is of the best quality possible. We want to make sure that the high quality and safe care we aim to provide is recognised externally by our partners and colleagues because it has become *business as usual.* This plan describes the blueprint for our journey, it makes our objectives clear and sets timescales and performance indicators along the way.
1.2	We have made many changes since the CQC reports were published in October 2017 and the NHSI undertakings against our licence in September 2017. The delivery of this plan, underpinned by good governance and staff development, will ensure that the changes already made are sustainable, and that those outstanding can be delivered in agreed timeframes. We all want our patients to receive consistent, high-quality care and we most certainly want Stockport NHS Foundation Trust to become the employer of choice.
1.3	A core facet of the plan is the engagement of frontline staff in the improvement journey. This will ensure the impact of the improvement required is understood.
1.4	Further, it will allow us to take advantage of the expertise and knowledge of our staff, as well as key partnerships, to ensure the plan is delivered.
1.5	It will also start to signal a common purpose and priority for the organisation that is owned by frontline staff.
2.	**BACKGROUND**
2.1	The CQC report was published following their unannounced inspections of Urgent and Emergency Services and Medical Care at Stepping Hill Hospital in March and June 2017. The report was published on 3rd October 2017 and followed a letter from the CQC received in June 2017 relating to immediate findings from the June unannounced visit.
2.2	NHS Improvement wrote to the Trust in September 2017 setting out areas of concern in relation to our Provider Licence.
2.3	This plan addresses areas of concerns relating to patient safety that have been noted externally by the Care Quality Commission (CQC) and NHS Improvement, and that have also been recognised by us.
3.	**CURRENT SITUATION**
3.1	Since the inspections in March and June 2017, the Trust has made some significant and important changes, including strengthening the joint working of our doctors and nurses in the emergency department and medical care.
3.2	We have also developed a clear medical leadership structure under the Medical Director. We have improved how we care for our most vulnerable patients, including those who have lack capacity to make decisions.

3.3	We now have active, early risk assessments in our ED, a Mental Health Liaison Team working closely together and stronger cross-organisational working practices with colleagues from partners.
3.4	The Trust Board have made it clear that secrecy, not speaking up and not working together for the good of all our patients has no place in our Trust.
3.5	The Trust Board consider that we have the skills, dedication and ambition to address all the issues raised by the CQC and ensure we give the best possible care we can to every patient. The successful implementation of this Quality Improvement Plan will ensure that improvements are made and sustained for all Trust's services.
3.6	We have developed Seven Themes, underpinned by our strengthened Quality Governance Framework: • Quality Faculty • Reducing Unwarranted Variation in Clinical Practice • Safety Collaborative • Safe Staffing • Quality Improvement Initiatives • Urgent Care Delivery • High Quality Safe Care Plan
4.	**RISK & ASSURANCE**
4.1	Whilst the issues were identified within the Urgent and Emergency Services and Medical Care, we acknowledge that these findings are potentially translatable across the whole organisation. The identified aims align to the Trust Quality Account Priorities for 2018/2019 and to the Operational Plan 2018/2020.
4.2	The plan to demonstrate the requirements of 'Good' and beyond is very detailed within our High Quality Safe Care Plan.
4.3	We will approach our Quality Improvement Plan through: • Robust leadership to drive recovery • Focused Board oversight and scrutiny • Executive Accountability for delivery of improvement plans • Building strong leadership at all levels within the Trust • Extensive staff engagement and clinical leadership to drive innovation • A rigorous QI approach throughout the organisation • Supported Programme and Project management • A single reporting structure for Board, Commissioners and Regulators • Support and work with our partners • Support and involvement from patients, service users and the public • Relationships with the Acute and Mental Health Alliances • External support from experts to address capability
4.4	We will be evidence-based and will systematically monitor and test progress as well as look to outstanding organisations elsewhere to see how they do things and learn for our own development.

5.	**RECOMMENDATIONS**
5.1	The Council of Governors is recommended to: • Receive the draft Quality Improvement Plan at Annex A for information and discussion. • Consider ways in which Governors can contribute to delivery of the Quality Improvement Plan.

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Stockport NHS
NHS Foundation Trust

PROUD2CARE

Our Quality Improvement Plan 2018-2020: *FINAL DRAFT*

Contents

Foreword

I am delighted to be introducing the Quality Improvement Plan for Stockport NHS Foundation Trust. The trust was rated as 'Requires Improvement' in March 2016 and October 2017 by the Care Quality Commission. In the months since we have seen a tremendous commitment from our staff who, no matter where they work in the organisation, have come to work every day to contribute to, or deliver, high quality care in order to secure the best outcomes and experience for our patients.

Improving quality is essential to us all. Patients want to feel safe and secure when they receive care and treatment in our Trust. Our patients' families and carers want to know that we are taking the best possible care keeping them safe. We know that staff want to provide the highest quality care and treatment possible, and as a Trust we want to be recognised locally as a great place to work and as a health-care organisation that we can all be proud of.

We need to recognise this commitment and set a clear direction and approach to continuously improving quality recognising that everyone has a role to play and can contribute.

We are going to do this through being innovative and in developing a culture which supports continuous learning, improvement and develops compassionate leadership which inspires individuals, teams and services to be the best we can be.

Our goal is to be recognised as an outstanding organisation, and we aim to demonstrate that the care and treatment delivered by all of our staff is of the best quality possible. We want to make sure that the high quality and safe care we aim to provide is recognised externally by our partners and colleagues because it has become *business as usual.* This plan describes the blueprint for our journey, it makes our objectives clear and sets timescales and performance indicators along the way.

Our staff and key stakeholders have helped shape this plan, which is designed to be the golden thread in the direction of travel for quality improvement for the next two years

Best wishes

Helen Thomson

1. Introduction to our Quality Improvement Plan

We want our Quality Improvement Plan to take us from 'Requires Improvement' by being bold in taking us further on a trajectory to 'Good' and 'Outstanding'. Of course we must address areas of concerns relating to patient safety that have been noted externally by the Care Quality Commission (CQC) and NHS Improvement, and those that we have recognised ourselves. We all want our patients to receive consistent, high-quality care and our ambition is that the pride taken in delivering care to our patients helps us to become the employer of choice in the region.

The CQC rated the trust as 'requires improvement' overall, but also as 'inadequate' for *safe* in Medicine and in Urgent and Emergency Services, and as 'inadequate' in *well led* for Urgent and Emergency Services. Our status with NHS Improvement is that of a Trust challenged for quality, performance and finance in September 2017.

The dedication and efforts of all our staff has led to many improvements since the CQC reports were published in March and October 2017.

Quality Improvements include:

- Consistent approaches to reporting incidents, with a significant and sustained increase of 20% in reporting – leading to a greater opportunity to share immediate lessons learned and embed safer practice
- 60% improvement in the reporting of 'no and low harm' incidents – demonstrating an evolving safety culture and a passion to get things right
- Reduction in the number of complaints received and in those returned where the complainant did not feel the complaint was resolved
- Reduction in pressure ulcers, especially across surgery and critical care, although we did not achieve our stretch trajectory
- Introduction of our ward accreditation scheme – Accreditation for Continuous Excellence (ACE), resulting in immediate improvements in MUST scoring compliance
- Achievement of our 'no lapses in care' target for C-difficile cases that are healthcare acquired
- Every ward has a nurse on every shift who has up to date Basic Life Support training, meaning we are assured that our wards and departments have the right staff with the right skills on duty to respond if a patient were to suddenly deteriorate.
- In our Emergency Department we have improved patient experience by ensuring that privacy and dignity for patients who attend in an emergency is maintained.
- Introduction of a new Quality Governance Framework where assurance is monitored from 'ward to board'.

The delivery of our Quality Improvement Plan, underpinned by good governance and staff development, will ensure that the changes made already are sustainable, and that those outstanding can be delivered in agreed timeframes.

The Board of Directors are committed to provide full support, leadership and apply focus and rigour to ensure the delivery of the plan. The Board of Directors intend to ensure continuous focus on creating the conditions that allow staff to do their job well by removing blocks to success and making sure we are managing any risks to delivery.

Partner agencies have kindly offered their support to the Trust and this is warmly welcomed. We know that the Clinical Commissioning Group, Greater Manchester Health and Social Care Partnership, Local Authority, Health-Watch, NHS Improvement, NHS England and

others will play a key role in scrutinising assurance processes to ensure they are sufficiently robust.

A core facet of the Quality Improvement Plan is the engagement of frontline staff in the improvement journey, with everyone being able to influence and contribute and feel empowered to change and improve. We know that when our clinical, non-clinical support staff and managers work together then our patients get the best care possible.

We intend to continue to listen to our staff; making the most of their enthusiasm, expertise and knowledge and signalling a common purpose and priority for the organisation that is owned by everyone whether front-line staff providing direct patient care, human resource teams, staff working in information management and technology, estates and facilities, or finance and quality governance.

Delivery at pace

The Board of Directors is committed to ensuring that the Quality Improvement Plan is delivered at pace. Working with all staff in the Trust and with the support of partner organisations and agencies, the Board is confident that the plan will deliver an improved outcome at the next CQC inspection. Furthermore, by developing and embedding a culture of continuous improvement and supporting frontline staff to improve services through innovation, we have set our ambition to be rated "Good" by 2019 and "Outstanding" by 2020.

Our plan will help us to:

- improve quality and safety
- reduce variation and patient harm
- ensure every member of our staff has access to and has undertaken core learning and appraisal
- ensure all CQC Must Do actions and concerns are fully addressed and become the way we provide care for every patient every day
- act smart in the way we use our resources and prioritise safety and quality improvement to gain maximum impact
- work in conjunction with partner organisations to improve quality and safety for our most vulnerable patients

Purpose of the Quality Improvement Plan:

Patients will benefit from our Quality Improvement Plan

Successful delivery of our plan will mean that p*atients will have increased confidence in local services, that they have a better experience with better outcomes.*

Staff will benefit from our Quality Improvement Plan

Successful delivery of our plan will mean that staff will have increased pride and job satisfaction and knowing they have made a difference. We will become an employer of choice.

The Trust itself will benefit from our Quality Improvement Plan

Regulators will see our compliance improve and future inspections will focus on the improvements we have made. Stakeholders will know they are working with an organisation which is committed and has a clear plan for improvement. All of our community will see:

- Achievement of the Trust strategic objectives
- Delivery of sustainable, safe, effective, and high quality services for patients
- Lessons are learned and shared across the trust thus reducing the risk of incidents and improving responsiveness, quality of care and experience for patients

- Robust systems and processes in place thus reducing clinical and reputational risk
- Compliance with CQC regulations
- Compliance with NHSI Provider Licence
- Well trained and valued staff
- Sustainable trust-wide process and governance arrangements in place to move programme work into business as usual at local level when appropriate
- Senior oversight and scrutiny on progress and any slippage allows executives to re-prioritise work

2. Trust Values and Behaviours

Quality and Safety

- We deliver safe, high quality and compassionate care
- We ensure a clean and safe environment for better care

Communication

- We treat our patients, their families and our staff with dignity and respect
- We communicate with everyone in a clear and open way

Service

- We provide effective, efficient and innovative care
- We work in partnership with others, to deliver improved care, in the right place at the right time

3. Trust Strategy

The new strategic view for the Trust is one of cohesion and cooperation. We have taken into account the overarching priorities of; quality improvement, financial resilience, partnership working, operational effectiveness and leadership development and the drivers of change impacting the Trust. The following strategic view has emerged as critical to focus on and vital to now plan for in detail;

- Resilience and improvement (getting the basics right) such as Quality & Safety, Finance and Operational performance;
- Stockport integrated service solution (Stockport Together);
- Healthier Together implementation;
- The Trust's role in the Greater Manchester Sustainability and Transformation Plan and emerging Integrated Care System; and
- Preparation for future organisational form and function.

4. Trust Profile

The Trust provides acute hospital and community care for children and adults predominantly across Stockport and the High Peak area of Derbyshire. We employ over 5,200 staff working across hospital and community premises. Our major hospital is Stepping Hill Hospital situated on the A6, south of Stockport town centre. We also provide services from the Meadows, Swanbourne Gardens, the Devonshire Centre and in peoples' homes and the community within Stockport.

Services are delivered through our Business Groups which are led by a 'triumvirate' comprised of a Business Group Director, an Associate Medical Director (AMD) and an Associate Director of Nursing (ADN). Our Business Groups during 2017/18 were:

- Women's and Children's and Diagnostics
- Integrated Care
- Medicine and Clinical Support Services
- Surgery, Gastro-enterology and Critical Care

Our Business Groups are supported by corporate services which include:

- Finance
- Workforce and Organisational Development
- Learning and Education
- Corporate Quality and Governance (Corporate Nursing)
- Estates and Facilities
- Information Management and Technology and Communications

Some of our recent successes include:

- Opening of a new £20m Surgical & Medical Centre in October 2016, on time and within budget
- Reconfiguration of the Emergency Department to provide an additional seven cubicles and improve flow through to the hospital
- Introduction of primary care streaming from A&E facilitating G.P. treatment of patients who do not require specialist care
- Introduction of an Ambulatory Care Unit to treat patients direct from the Emergency Department together and patients directly referred by GPs
- Implementation of a multi-agency Crisis Response Team to respond to patients at risk of hospital admission within 2 hours
- Commencement of the hospital Electronic Patient Record (EPR) project and implementation of a Community EPR
- Hyper Acute Stroke Service officially rated 'best in the country'
- Stockport ranked in the top seven in the country for cancer care
- The national Bowel Cancer Audit shows high survival rates for patients who undergo surgery and treatment at Stepping Hill Hospital
- Data from the National Joint Registry shows Stepping Hill Hospital to be one of the best places in the country for knee and hip replacement surgery

5. How did we develop our Quality Improvement Plan?

Our Quality Improvement Plan has developed with the support/contribution/inputs from our key partners and stakeholders and not in isolation. It builds on the foundations and achievements from previous strategies; and was developed in collaboration with members of staff and local stakeholders. Staff from all areas of the organisation, along with Governors, the Clinical Commissioning Group (CCG) and HealthWatch were invited to provide their thoughts on key areas the organisation should focus its quality improvement efforts.

We have listened to feedback from the rich sources of information provided by our patients, their families and carers.

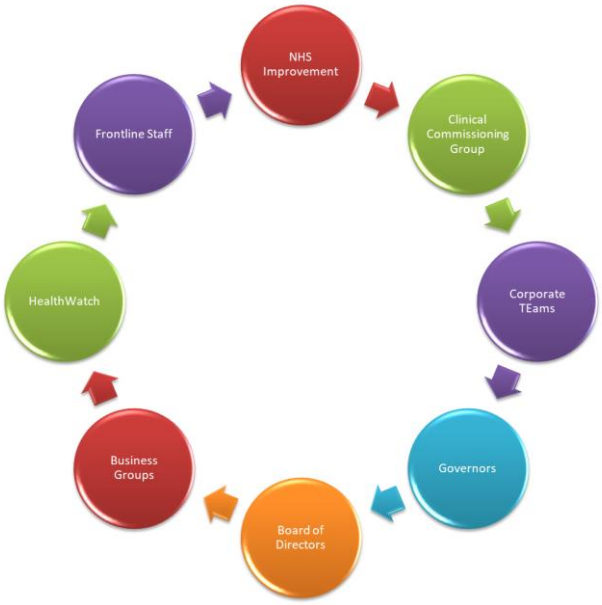
- In-patient surveys
- Staff surveys

- Complaints themes and trends
- Incident reports

The improvement work-streams in place to support urgent care delivery have been refreshed and aligned with GM Urgent Care Strategy. This has been an iterative process with support and engagement from Local Authority, Stockport Neighbourhood Care, CCG's, and NHSI improvement teams working alongside the Trust. All information and plans have been collated and merged to provide a clear map for our journey, based on the delivery of success of **seven themes.**

Stakeholder engagement

Through a series of engagement events, planned walkabouts, workshops and meetings, we listened to our stakeholders to ensure their views helped shape our Quality Improvement Plan.



6. CQC Report Findings 2017

The report was published following CQC unannounced inspections of Urgent and Emergency Services and Medical Care at Stepping Hill Hospital on March and June 2017. The report was published on 3rd October 2017 and followed a letter from the CQC received in June 2017 relating to immediate findings from the June unannounced visit.

The following ratings have been applied for Stepping Hill Hospital:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate	Requires improvement	Requires improvement	Requires improvement	Inadequate	Inadequate
Medical care	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Good	Good	Good	Good	Good	Good
Critical care	Good	Good	Good	Requires improvement	Good	Good
Maternity and gynaecology	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Services for children and young people	Requires improvement	Good	☆ Outstanding	Good	Good	Good
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	N/A	Good	Good	Good	Good
Overall	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

The following ratings have been applied for Stockport NHS Foundation Trust:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Concerns and key areas for improvement

A number of persistent concerns have been identified, recognised both by us as a Trust, and also by external agencies, which this plan intends to address:

Board governance and oversight
The need for a strategic plan reflecting Stockport Together and acute hospital services across Greater Manchester
Valuing the fundamentals of care such as Medicines management, Care of vulnerable patients, management of deteriorating patients and diabetes care
Safe staffing, access to mandatory training and Staff morale
The pressure or demand in emergency services and persistent problems with patient flow
Gaps in governance and risk management
Education and training opportunities for junior doctors
Recognising the importance of privacy, dignity and patient experience

Trust Board Response

The CQC reports made difficult reading for all of us working at the Trust. The Board of Directors have accepted the findings, acknowledging that the Trust had clearly fallen short in some key areas.

Since the inspections in March and June 2017, the Trust has made some significant and important infrastructure changes, including strengthening the joint working of our doctors and nurses in the emergency department and medical care. We have also developed a clear medical leadership structure under the Medical Director. We have developed and introduced our Quality Governance Framework, and our Risk Management Strategy is soon to be launched.

The Board of Directors have made it clear that a culture of being open and honest, speaking up and working together for the good of patients and staff is vital to the success of the Trust.

We have a strong belief in our staff – we know that we have the skills, dedication and ambition to address issues raised by the CQC and ensure we give the best possible care we can to every patient.

We believe that by ensuring there is clarity of our aim and ambition through a Quality Improvement Plan which is deliverable, then our staff will make sure it is delivered. We want to celebrate success whilst we deliver the aim and ambition, at the same time as developing a culture of continuous improvement.

7. Developing a Culture of Continuous Improvement

Patients are at the heart of everything we do at Stockport NHS Foundation Trust and we are committed to improving quality and achieving excellence in all that we do. Our aim is to be one of the most successful NHS trusts. We are committed to developing a culture of continuous learning and supporting continuous Quality Improvement (QI), as advocated within NHS Improvement's 'Developing People, Improving Care' document (2016).

For QI to be successfully embedded by all staff at all levels, a culture of improvement that spans the organisation is required. Importantly too, is the knowledge that a clear QI approach/methodology which is simple, effective and can be used by everyone.

The Trust has adopted the Advancing Quality Alliance QI methodology as our chosen QI approach. It is simple for all staff to use and is a widely understood methodology that has been successfully used in many healthcare settings. Furthermore it builds on the existing knowledge and skills of many of our staff, and harnessing that enthusiasm and knowledge from frontline staff will enable us to make progress faster.

Strong Leadership

Strong leadership is key to the development of an improvement culture, and organisations that have successfully implemented QI strategies have demonstrated improvements in standards and outcomes across all aspects of care. QI is distinctly different to quality strategies and audit and has been shown to bring about more sustained improvement as it enables those with the experiences to explore and co-create the process, resulting in it being more likely that the whole organisation will 'own' the approach.

Being bold – getting on at pace

The Quality Improvement Plan brings together all the actions that the Trust believes to be the most important. We want to be bold, though, and to deliver our aim and ambition at pace. Gaining traction quickly will deliver the improvements necessary to achieve the short-term goal of an overall Trust CQC rating of at least 'Good' by January 2019 and the longer-term ambition of an overall Trust CQC rating of 'Outstanding' by 2020.

We have already started with our weekly Quality Summit, where all staff are invited and the enthusiasm/attendance is growing exponentially.

We have already started our Quality Improvement Initiatives, with nine projects started in April 2018, all set to deliver demonstrable differences in areas where we knew we wanted to make changes. The nine projects align to the Trust Quality Account Priorities for 2018/2019 and to the Operational Plan 2018/2020.

The development of a virtual 'Quality Faculty' will support the delivery of the agreed Quality Improvement Strategy using QI training to build capability and capacity amongst the workforce. The vision of the 'Quality Faculty' is to oversee a 'hub' of QI Facilitators whose role will be to train, mentor and support staff working through QI projects.

We have already commenced work on a number of safety collaboratives providing a focused review of critical areas of patient care. The Pressure Ulcer Collaborative commencing ahead of time in March 2018.

We will approach our Quality Improvement Plan through:

- Board of Directors leadership, oversight and governance making quality are core aspect of our strategy and everything we do
- Executive Accountability for delivery of improvement plans
- Building strong leadership at all levels within the Trust
- Extensive staff engagement and clinical leadership to drive innovation
- A rigorous QI ethos and approach throughout the organisation
- Delivery supported through programme and project management
- Involving our patients, service users, membership/Governors and the public
- External support from experts to address capability

We will be evidence-based and will systematically monitor and test progress as well as look to outstanding organisations elsewhere to see how they do things and learn for our own development.

8. The Seven Themes of our Quality Improvement Plan

Underpinned by Trust Strategy and Quality, Finance and Operational Governance Frameworks

8.1 High Quality Safe Care Plan

The Trust has delivered to address gaps where fundamental standards relating to CQC regulations were not being fully met during the inspections of March and October 2017:

Regulation 10 – Dignity and Respect
Regulation 12 - Safe Care and Treatment
Regulation 17 – Good Governance
Regulation 18 – Staffing

The plan included our response to **Must and Should Do** actions, and was developed into 16 themes.

We knew when we had succeeded by measuring what matters, and by monitoring those measures:		
What matters	By when	Monitoring arrangements
Safe Staffing	Monthly monitoring	Quality Committee
Identifying the deteriorating patient	Monthly monitoring	Quality Committee
Medicines Management	Monthly monitoring	Quality Committee
Training and Development	Monthly monitoring	Quality Committee
Records Management	Monthly monitoring	Quality Committee
Cleanliness and Infection Prevention and Control	Monthly monitoring	Quality Committee
Privacy and Dignity	Monthly monitoring	Quality Committee
Mental Capacity Act	Monthly monitoring	Quality Committee
Incident and Risk Management	Monthly monitoring	Quality Committee
Mortality and Morbidity	Monthly monitoring	Quality Committee
Learning Organisation	Monthly monitoring	Quality Committee
Environment	Monthly monitoring	Quality Committee
Care of the Patient with Diabetes	Monthly monitoring	Quality Committee
Access and Flow	Monthly monitoring	Quality Committee
Emergency Department and Medicine Specific findings	Monthly monitoring	Quality Committee

8.2 Reducing Unwarranted Variation in Clinical Practice

We aim to improve patient care and increase efficiency by **reducing variation** in practice across the Trust.

We will know when we have succeeded by measuring what matters, and by monitoring those measures:		
Topic	By when	Monitoring arrangements
Using local and national benchmarking data to demonstrate consistently high quality clinical care with no unwarranted variation and performance in the top quartiles	March 2019	Bi-monthly performance meetings
Ensuring clinical service needs where required are delivered equitably across 7 days	March 2019	Bi-monthly performance meetings
Introduction of the Accreditation for Continued Excellence (ACE) programme	Launch in April 2018 for inpatient adult wards only. All wards to have undertaken assessment in the first 18months.	Monitored roll-out plan - Results & Action Plans to address short falls monitored by Business Group Quality Boards - Results reported to Quality Committee - Gold accreditation awarded by Quality Governance Group - Work will also be undertaken to develop ACE standards for specialist areas including Paediatrics, Maternity, Community, Theatre, ICU & OPD
Implementing advances in Information Technology, centred on a single electronic patient record across health and social care, which will support our journey of continuous improvement	Date to be confirmed	Electronic Patient Record Programme Board
Delivering the efficiencies identified through the model hospital and reduce unwarranted variation across a range of productivity and clinical effectiveness measures, including: GIRFT programme, NATSIPPs, LOCSIPP's	March 2019	Bi-monthly performance meetings Operational Management Group

8.3 Urgent Care Delivery

Our system is under pressure and we want to improve the urgent and emergency care system so patients get the right care in the right place, whenever they need it. We are working hard with our partners to embed good practice to enable appropriate patient flow, including admission avoidance, better and more timely hand-offs between the emergency department and clinicians and wards, streamlined continuing healthcare processes, better discharge processes and increased community capacity.

We will know when we have succeeded by measuring what matters, and by monitoring those measures:		
Topic	By when	Monitoring arrangements
Urgent Care Access: All patients to be seen by the most appropriate clinician for their needs within 2 hours and if they do not require inpatient specialty care to be discharged within 2 days.	30 June 2018 (GM Improvement Trajectory)	Urgent Care Cabinet, Urgent Care Access Daily touch point meeting
Patient Flow: Reduce to 35% the proportion of General & Acute beds occupied by patients staying longer than 7 days (Stranded Patients).	30 June 2018 (GM Improvement Trajectory)	Urgent Care Cabinet, Patient Flow Steering Group.
Complex Patients: To ensure that medically optimised patients are discharged home or an alternative community facility within 48 hrs.	30 June 2018 (GM Improvement Trajectory)	Urgent Care Cabinet, Borough Wide Keeping In Touch meeting
Community Capacity: To re-commission 60 fit for purpose Intermediate Tier beds.	31 March 2019	Urgent Care Cabinet, Bed configuration core action group

8.4 Safety Collaboratives

We want to introduce five Safety Collaboratives through 2018/20, to focus on delivering definitive and measurable improvements in specific patient safety issues that have been identified through incident reports, complaints, serious incidents or nursing care indicator reports.

We will know when we have succeeded by measuring what matters, and by monitoring those measures:		
Topic	By when	Monitoring arrangements
Pressure Ulcers: 50% reduction in avoidable stage 2, 3 and 4 pressure ulcers (in both acute and community)	31 March 2019	Quality Safety and Improvement Group Quality Committee
Falls: 10% reduction in in-patient falls (tbc following end of year figures) to be monitored quarterly	31 March 2019	Quality Safety and Improvement Group Quality Committee
Nutrition and Hydration: Improved nutrition and hydration (based on NHSI collaborative outcomes tbc)	31 March 2019	Quality Safety and Improvement Group Quality Committee
Deteriorating Patient: Deteriorating Patient and NEWS introduction (metrics to be determined through AQuA program)	30 September 2018	Quality Safety and Improvement Group Quality Committee
Safe Discharge: Delivery of Safe Discharge (metrics to be determined through AQuA program)	31 March 2019	Quality Safety and Improvement Group Quality Committee

8.5 Quality Improvement Initiatives

Our information tells us that we must make improvements in the quality of care and treatment in some areas. We have agreed our quality improvement methodology. Our ambition is that, across a range of identified areas, improvements are clinically led and managerially supported so that they are embedded in practice and focussed on getting the best outcomes for our patient, by the right staff and the right time.

We will know when we have succeeded by measuring what matters, and by monitoring those measures:		
Topic	By when	Monitoring arrangements
Improvement Methodology Training: Deliver workshops with key clinical and management teams to agree success measures. Stakeholders to agree Quality Improvement Priorities for 18/19 Quality Account	March 2018 October 2018 January 2019	N/A
Palliative Care: Improve team caseload flow (by an agreed number of days) for the Specialist Palliative Care team to deliver responsive equitable services and to support other professionals in delivering ace standards of general palliative care by end of March 2019	31 March 2019	Quality Safety and Improvement Group Quality Committee
Fracture Neck of Femur Pathways: To reduce the length of stay for our fractured neck of femur patients to below the national average by the end of March 2019.	31 March 2019	Quality Safety and Improvement Group Quality Committee
Intravenous Therapy (IV) in the community: 100% of AMU patients identified as socially and medically fit for discharge on the Acute Medical Unit who require IV therapy will be referred to the community IV team by the end of September 2018	30 September 2018	Quality Safety and Improvement Group Quality Committee
Optimising our discharge planning process: To reduce the number of adverse events (reported discharge incidents) from Medical wards by an agreed % from the 2017/18 baseline, by the end of March 2019	31 March 2019	Quality Safety and Improvement Group Quality Committee
Effective Management: By the end of March 2019 length of stay on ward A11 will be reduced by 50% from the January 2018 - March 2018 baseline	31 March 2019	Quality Safety and Improvement Group Quality Committee

Reducing variable care reviews in respiratory and endocrine areas: By end of March 2019 to reduce patients not reviewed by a doctor to 0% on any day By the end of March 2019 to increase daily senior reviews by 100% from 2017/18 baseline.	31 March 2019	Quality Safety and Improvement Group Quality Committee
Learning from deaths: 30 deaths per month will be subject to learning from deaths reviews by end of March 2019. 100% of all outcome 1 + 2s identified in the LFD reviews will be escalated for either Mortality and Morbidity review or investigation in line with Trust policies and procedures	31 March 2019	Quality Safety and Improvement Group Quality Committee
Reviewing our use of EWS and how we monitor and escalate deteriorating patients: To reduce by 5% the number of Stockport Foundation Trust inpatient cardiac arrests from the 2017/18 baseline by the end of March 2019	31 March 2019	Quality Safety and Improvement Group Quality Committee
Quality Improvement Practitioner	1 programme each quarter	Quality Safety and Improvement Group Quality Committee
Medical Clinical Leadership Programme – report to be produced	31 October 2018	People and Performance Committee
Nursing and AHP Clinical Leadership Programme - report to be produced	31 October 2018	People and Performance Committee

8.6 Safe Staffing

We aim to ensure safe staffing and a reduction on reliance on temporary staffing through a series of schemes associated with recruitment and retention.

We will know when we have succeeded by measuring what matters, and by monitoring those measures:		
Topic	By when	Monitoring arrangements
Recruitment programme – reduce vacancy rate	31 March 2019	People and Performance Committee
Retention Programme – reduce turnover rate by 1.5%	31 March 2019	People and Performance Committee
Improved efficiencies in e-rostering against a range of measures	30 November 2018	People and Performance Committee
Development of a suite of measures with NHS Professionals	30 June 2018	People and Performance Committee

8.7 Quality Faculty

We recognise improvement is more likely to succeed and be sustained if it is designed and led by the staff doing the job. In order to enable staff to make change happen they will be supported by improvement experts with quality improvement methodologies employed. We want to develop a hub of quality improvement champions working across the Trust, supporting and enabling the delivery of high quality, compassionate and continually improving care for all of our patients, their families and carers. The Faculty will encourage the sharing of best practice, improvement methods and approaches as widely as possible through the systems we work in.

We will know when we have succeeded by measuring what matters, and by monitoring those measures:		
Topic – What matters	By when	Monitoring arrangements
Agree the Trust Quality Improvement Methodology	31 March 2018	N/A
Scope feasibility of development of faculty	30 September 2018	Quality Committee
Describing what 'good' looks like in a quality faculty	30 September 2018	Quality Committee

9. Governance and Assurance

We want to extend from our emphasis placed on monitoring the Quality Improvement Plan and evaluating the impact and outcomes of the quality improvements made. From both a patient and staff perspective we intend that reports and updates about the plan will describe and evidence how we are safer, and how the improvements made are maintained and is sustainable.

We will use triangulation methods that involve describing how the improvements have made a difference for stakeholders or third parties; these will complement the usual range of business intelligence through a rigorous reporting programme both internally and to key stakeholders is now in place.

The Trust has established a series of groups that meet weekly or monthly to provide oversight and seek assurance against operational delivery of improvement plans:

Patient Safety Summit (weekly, chaired by Chief Nurse)
Patient Quality Summit (weekly, chaired by Chief Nurse)
Urgent Care Delivery Group (weekly, chaired by Chief Operating Officer)
Quality Safety and Improvement Strategy Group (chaired by Deputy Chief Nurse)

Sitting alongside the internal governance arrangements is the NHS Improvement Board, that is responsible for ensuring that as a health system there is ownership of issues and action taken to deliver system-wide improvements. Whilst this group has no formal reporting line into the Trust it provides external assurance to the Chief Executive and Executive Management Team.

10. Reporting arrangements

The ability for our organisation to deliver on all aspects of this plan also depends on our ability to measure progress against clear timeframes.

We have developed a mechanism for reporting on each of the seven themes to the Board of Directors and also to our external partners that will demonstrate delivery of our Quality Improvement Plan. We will do this by developing our Organisational Development accountability and compassionate leadership programmes; by improving our communication and engagement with staff and stakeholders via our safety bulletins, excellence awards and the introduction of our own annual Patient Safety Conference.

It is important to measure performance for improvement purposes as it enables us to fully understand the processes we are looking to improve, but also allows us to provide evidence that ideas for improvement work in practice and as a result increases the appetite for improvement amongst our staff toward helping us to realise successes.

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NHS
Stockport
NHS Foundation Trust

Report to:	Council of Governors	**Date:**	23 May 2018
Subject:	Governor Committee – Terms of Reference		
Report of:	Director of Corporate Affairs	**Prepared by:**	P Buckingham

REPORT FOR APPROVAL

Corporate objective ref:	N/A
Board Assurance Framework ref:	N/A
CQC Registration Standards ref:	N/A
Equality Impact Assessment:	☐ Completed X Not required

Summary of Report

Identify key facts, risks and implications associated with the report content.

The purpose of this report is to present revised Terms of Reference for the Governor Committees to the Council of Governors for approval.

Attachments:	Annex A – Terms of Reference Governance & Membership Committee Annex B – Terms of Reference Patient Experience Committee Annex C – Terms of Reference Quality Standards Committee

This subject has previously been reported to:	☐ Board of Directors ☐ Council of Governors ☐ Audit Committee ☐ Executive Team ☐ Quality Committee ☐ F&P Committee	☐ PP Committee ☐ SD Committee ☐ Charitable Funds Committee ☐ Nominations Committee ☐ Remuneration Committee ☐ Joint Negotiating Council ☐ Other

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1. INTRODUCTION

1.1 The purpose of this report is to present revised Terms of Reference for the Governor Committees to the Council of Governors for approval.

2. BACKGROUND

2.1 The Council of Governors approved Terms of Reference for revised Committee arrangements at its meeting held on 6 December 2017. It was agreed that the Terms of Reference would be subject to subsequent review by members of the new Committees during their initial meetings in January 2018.

3. CURRENT SITUATION

3.1 Initial meetings of the new Committees were held as follows:

- Governor & Membership Committee - 8 January 2018
- Patient Experience Committee - 11 January 2018
- Quality Standards Committee - 29 January 2018

A review of the Terms of Reference was completed by Committee members during each of the above meetings.

3.2 A number of minor amendments were proposed to the Terms of Reference for the Quality Standards Committee together with a common amendment relating to the number of Committee members. Proposed amendments are identified by use of bold italic and strikethrough in the documents included at Annex A - C of the report.

3.3 At the conclusion of the Council of Governors meeting held on 21 March 2018, Mr L Jenkins, raised a question s regarding Governor attendance at Committee meetings and the ability of non-members to participate in Committee debates. Due to time constraints, it was agreed that the matter would be considered at the next Council of Governors meeting.

3.4 Mr L Jenkins subsequently submitted the following for consideration by the Council of Governors on 23 May 2018:

In Autumn 2017 the long standing Governor Committee structure was reorganized. For many years there were three Committees:- Governance; Patient Safety and Quality Standards; Membership Development. The new Committee Structure became Governance and Membership; Quality Standards; Patient Experience.

Governors were asked to indicate by 1st choice and 2nd choice the Committees on which they wished to serve. All 1st choices were accommodated and Governance and Membership emerged with 7 members; Quality Standards with 6 members and Patient Experience with 6 members.

Terms of Reference were considered and endorsed by Council on 6 December 2017 and each contains at section 3.4 :-

"All Governors will be welcome to attend and observe meetings of the Committee. However participation in the debate and voting rights will be restricted to formal members of the Committee".

Subsequent meetings of the respective Committees has led to a view that observers should be able, as was the case under the old Committee structure, to contribute to proceedings and so Council is invited to amend the Terms of Reference of each Committee at section 3.4 to:-

"All Governors will be welcome to attend but speaking rights will be subject to the permission of the Chair and voting rights confined to formal members of the Committee".

4. RECOMMENDATIONS

4.1 The Council of Governors is recommended to:

- Approve the revised Terms of Reference for Governor Committees as detailed at Annex A-C of the report.
- Consider the proposal for further amendment submitted by Mr L Jenkins as detailed at s3.4 of the report.

Stockport NHS
NHS Foundation Trust

COUNCIL OF GOVERNORS
GOVERNANCE & MEMBERSHIP COMMITTEE

TERMS OF REFERENCE

1. CONSTITUTION

1.1 The Council of Governors hereby resolves to establish a Committee of the Council, to be known as the Governance & Membership Committee *(hereinafter referred to as 'the Committee')*. The Committee is a non-executive Committee of the Council of Governors and has no executive powers, other than those specifically delegated within these terms of reference.

2. REMIT AND FUNCTIONS OF THE COMMITTEE

2.1 The Committee is established to consider matters of both Governance and Membership related to the duties and responsibilities of the Council of Governors and to make recommendations, where appropriate, to the Council of Governors for approval.

2.2 The main functions of the Committee are to:

a. Governance

i. monitor compliance with the Council of Governor-related elements of the NHS Foundation Trust Code of Governance and other Governor-related guidance where the comply or explain principle applies.

ii. participate in periodic reviews of the Trust's constitution and make recommendations for amendments to the Council of Governors for approval.

iii. consider and inform arrangements for elections to the Council of Governors.

iv. work with the Audit Committee of the Board of Directors with regard to the appointment of the Trust's External Auditors by the Council of Governors.

v. provide a Governor view on general Annual Report content and work with the Company Secretary in preparing the Council of Governor-related content of the Trust's Annual Report and Accounts.

vi. monitor levels of Governor attendance at meetings of the Council of Governors and compliance with requirements of the Code of Conduct.

vii. consider the process for periodic review of the effectiveness of the collective performance of the Council of Governors and make recommendations as appropriate to the Council.

viii. consider the development needs of the Council of Governors and identify subject areas for the Council's development programme.

b. Membership

i. participate in periodic reviews of the Trust's Membership Strategy and recommend revised strategy documents to the Council of Governors for approval.

ii. monitor delivery of the Trust's Membership Strategy and formulate Annual Membership Plans to facilitate delivery. Annual Membership Plans will include:

- Review of progress with the Membership Strategy
- Annual recruitment targets
- Recruitment and engagement plans

iii. monitor delivery of the Annual Membership Plan through scrutiny of regular membership reports from the Communications Team.

iv. use membership report content to analyse the public membership profile and seek assurance that the membership remains representative of the local population.

v. contribute to the development of membership materials, including content of the Members' Newsletter.

vi. contribute to the preparation and delivery of an annual programme of members' events.

vii. support delivery of the Annual Membership Plan through; distribution of promotional materials, such as posters, newsletters and leaflets, raising awareness by attendance at public events and meetings and supporting member recruitment activities.

viii. identify opportunities for developing Governor and Member engagement and support activities in this area.

3. COMPOSITION AND CONDUCT OF THE COMMITTEE

3.1 ***Committee membership will be determined bi-annually by the Council of Governors and may include public, staff and appointed governors.*** ~~The Committee shall comprise of eight Governors and at least half of the membership shall be comprised of Public Governors.~~ The Chairman of the Committee will be elected by the Committee members on a bi-annual basis.

3.2 The Chair of the Council of Governors, the Senior Independent Director and the Chief Executive will be routinely invited to attend meetings in order to present and provide clarification on issues, and with the consent of the Chair will be permitted to participate in the debate. However, only members of the Committee are permitted to vote.

3.3 Membership of the Committee will be reviewed bi-annually at the first meeting of the Council of Governors after the Annual Members Meeting. Governors will be invited to express an interest in membership of the Committee prior to that meeting of the Council of Governors. Vacancies will be filled by open self nomination and election by the Council of Governors if necessary for the appropriate term.

3.4 All Governors will be welcome to attend and observe meetings of the Committee. However, participation in the debate and voting rights will be restricted to the formal members of the Committee.

3.5 There is an expectation that members will attend all Committee meetings during each financial year. Individual attendance levels will be monitored by the Chair of the Committee who will take appropriate measures to address any repeated instances of non-attendance.

3.6 ***Quorum.*** No business shall be transacted unless at least four of the members of the Committee are present.

3.7 ***Notice of meeting.*** Before each meeting, a notice of the meeting specifying the business proposed to be transacted shall be sent by post or electronic mail to the usual place of business or residence of each member, so as to be available at least three clear working days before the meeting.

3.8 ***Frequency of meetings.*** The Committee will normally meet on a quarterly basis. The Chair may, however, call a meeting at any time provided that notice of the meeting is given as specified in s. 3.6 above.

3.9 ***Minutes.*** The minutes of meetings shall be formally recorded by a member of the Corporate Governance team. Draft minutes will be checked by the Chair, will be circulated to Committee members as soon as practicable and will be submitted for

agreement at the next ensuing meeting, whereupon they will be signed by the person presiding at it.

3.10 ***Administration***. The Committee shall be supported administratively by the Company Secretary, whose duties shall include: advising the Committee on pertinent areas, agreement of the agenda with the Chair and collation of papers and producing the minutes of the meeting.

4. RELATIONSHIP WITH THE COUNCIL OF GOVERNORS

4.1 The Committee will provide a summary report of business conducted to the Council of Governors together with any relevant recommendations. The Council of Governors will use that report as the basis for their decisions, but would remain accountable for taking the decision. Minutes of the meetings of the Council of Governors will record such decisions.

Stockport NHS
NHS Foundation Trust

COUNCIL OF GOVERNORS
PATIENT EXPERIENCE COMMITTEE

TERMS OF REFERENCE

1. CONSTITUTION

1.1 The Council of Governors hereby resolves to establish a Committee of the Council, to be known as the Patient Experience Committee *(hereinafter referred to as 'the Committee')*. The Committee is a non-executive Committee of the Council of Governors and has no executive powers, other than those specifically delegated within these terms of reference.

2. REMIT AND FUNCTIONS OF THE COMMITTEE

2.1 The Committee is established to consider matters of Patient Experience related to the duties and responsibilities of the Council of Governors and to make recommendations, where appropriate, to the Council of Governors for approval.

2.2 The main functions of the Committee are to:

i. provide a Governor perspective on the content and delivery of the Trust's patient experience initiatives.

ii. consider reports on matters relating to complaints, claims and compliments.

iii. Consider outcomes of patient satisfaction surveys, both national and local, to gain an understanding of levels of patient care.

iv. Gain an understanding on behalf of the Council of Governors of the effectiveness of arrangements in place to comply with Safeguarding requirements

v. Provide a Governor view on outcomes of Patient-Led Assessment of the Care Environment (PLACE) inspections.

vi. Provide a governor view on the effectiveness of the Trust's communications with service users.

vii. develop a Governor perspective on matters of patient experience.

viii. Consider and propose ways in which governors and/or the wider membership could contribute to patient experience activities.

3. COMPOSITION AND CONDUCT OF THE COMMITTEE

3.1 ~~The Committee shall comprise of eight Governors.~~ ***Committee membership will be determined bi-annually by the Council of Governors and may include public, staff and appointed governors.*** The Chairman of the Committee will be elected by the Committee members on a bi-annual basis. In the event that the Chairman is unable to attend a meeting, the remaining members will elect a Chairman for the meeting from amongst those present.

3.2 The Deputy Director of Nursing and Matron for Patient Experience will be routinely invited to attend meetings in order to present and provide clarification on issues, and with the consent of the Chair will be permitted to participate in the debate. However, only members of the Committee are permitted to vote.

3.3 Membership of the Committee will be reviewed bi-annually at the first meeting of the Council of Governors after the Annual Members Meeting. Governors will be invited to express an interest in membership of the Committee prior to that meeting of the Council of Governors. Vacancies will be filled by open self nomination and election by the Council of Governors if necessary for the appropriate term.

3.4 All Governors will be welcome to attend and observe meetings of the Committee. However, participation in the debate and voting rights will be restricted to the formal members of the Committee.

3.5 There is an expectation that members will attend all Committee meetings during each financial year. Individual attendance levels will be monitored by the Chair of the Committee who will take appropriate measures to address any repeated instances of non-attendance.

3.6 ***Quorum***. No business shall be transacted unless at least three members of the Committee are present.

3.7 ***Notice of meeting***. Before each meeting, a notice of the meeting specifying the business proposed to be transacted shall be sent by post or electronic mail to the usual place of business or residence of each member, so as to be available at least three clear working days before the meeting.

3.8 ***Frequency of meetings***. The Committee will normally meet on a quarterly basis. The Chair may, however, call a meeting at any time provided that notice of the meeting is given as specified in s. 3.7 above.

3.9 ***Minutes***. The minutes of meetings shall be formally recorded by a member of the Corporate Governance team. Draft minutes will be checked by the Chair, will be circulated to Committee members as soon as practicable and will be submitted for agreement at the next ensuing meeting, whereupon they will be signed by the person presiding at it.

3.10 ***Administration***. The Committee shall be supported administratively by a member of the Corporate Governance team whose duties shall include: advising the Committee on pertinent areas, agreement of the agenda with the Chair and collation of papers and producing the minutes of the meeting.

4. RELATIONSHIP WITH THE COUNCIL OF GOVERNORS

4.1 The Committee will provide a summary report of business conducted to the Council of Governors together with any relevant recommendations. The Council of Governors will use that report as the basis for their decisions, but would remain accountable for taking the decision. Minutes of the meetings of the Council of Governors will record such decisions.

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Stockport NHS
NHS Foundation Trust

COUNCIL OF GOVERNORS
QUALITY STANDARDS COMMITTEE

TERMS OF REFERENCE

1. CONSTITUTION

1.1 The Council of Governors hereby resolves to establish a Committee of the Council, to be known as the Quality Standards Committee *(hereinafter referred to as 'the Committee')*. The Committee is a non-executive Committee of the Council of Governors and has no executive powers, other than those specifically delegated within these terms of reference.

2. REMIT AND FUNCTIONS OF THE COMMITTEE

2.1 The Committee is established to consider matters of Quality Standards related to the duties and responsibilities of the Council of Governors and to make recommendations, where appropriate, to the Council of Governors for approval.

2.2 The main functions of the Committee are to:

i. provide a Governor perspective on content and delivery of the Trust's Quality Improvement Plan.

ii. receive feedback from the Board's Quality Committee by means of a Key Issues Report and reports from Governor observers. The Chairman of the Quality Committee will be invited to attend meetings of this Committee.

iii. provide a Governor view on any proposed quality developments.

iv. provide a view on the content and presentation of the Trust's Annual Quality Report and collectively prepare the 'Statement from Governors' for inclusion in the report.

v. select an appropriate indicator for audit, as part of the audit of the Annual Quality Report, on behalf of the Council of Governors

vi. consider and propose ways in which the membership and public can be engaged in the Trust's Quality Improvement Plan.

vii. develop a Governor understanding on matters relating to quality assurance and clinical audit.

viii. Provide a view, on behalf of the Council of Governors, as to how Governors could contribute to assurance on compliance with quality standards e.g. through participation in mock inspections, patient safety walkabouts.

3. COMPOSITION AND CONDUCT OF THE COMMITTEE

3.1 ~~The Committee shall comprise of eight Governors.~~ ***Committee membership will be determined bi-annually by the Council of Governors and may include public, staff and appointed governors.*** The Chairman of the Committee will be elected by the Committee members on a bi-annual basis. In the event that the Chairman ***and the Deputy Chairman are*** ~~is~~ unable to attend a meeting, the remaining members will elect a Chairman for the meeting from amongst those present.

3.2 The Chairman of the Quality Committee, ***the Medical Director and the Director of Nursing & Quality*** will be routinely invited to attend meetings in order in order to present and provide clarification on issues, and with the consent of the Chair will be permitted to participate in the debate. However, only members of the Committee are permitted to vote.

3.3 Membership of the Committee will be reviewed bi-annually at the first meeting of the Council of Governors after the Annual Members Meeting. Governors will be invited to express an interest in membership of the Committee prior to that meeting of the Council of Governors. Vacancies will be filled by open self nomination and election by the Council of Governors if necessary for the appropriate term.

3.4 All Governors will be welcome to attend and observe meetings of the Committee. However, participation in the debate and voting rights will be restricted to the formal members of the Committee.

3.5 There is an expectation that members will attend all Committee meetings during each financial year. Individual attendance levels will be monitored by the Chair of the Committee who will take appropriate measures to address any repeated instances of non-attendance.

3.6 ***Quorum***. No business shall be transacted unless at least ***three*** ~~four~~ members of the Committee are present.

3.7 ***Notice of meeting***. Before each meeting, a notice of the meeting specifying the business proposed to be transacted shall be sent by post or electronic mail to the usual place of business or residence of each member, so as to be available at least three clear working days before the meeting.

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STOCKPORT NHSFT
Council of Governors

Report of: Les Jenkins **Date of Meeting: 23 May 2018**

Report of the Governance & Membership Committee

1. Present

Governors Present	Non-Executive Directors	Trust Representatives
Les Jenkins	Nil	Helen Thomson
Eve Brown		Paul Buckingham
Robert Cryer		Alicia Custis
Isabel Daniel		Helen O'Brien
Roy Greenwood		
Chris Hudsmith		
Tom McGee		

2. Meetings held on

Meetings were held on 8 January 2018 and 5 March 2018.

3. Agenda Items

1. Election of Committee Chair & Deputy Chair
2. Committee Terms of Reference
3. Committee Work Plan
4. Membership Report
5. Developing Council of Governor Practice
6. Chief Executive Updates
7. Membership Strategy & Plan
8. Stepping Up – Electronic Format
9. Annual Report & Accounts 2017/18
10. Constituency Boundaries – Outer Region
11. Council of Governors – Attendance

4. Issues to be brought to the attention of the Council of Governors

1. Election of Committee Chair & Deputy Chair

Mr L Jenkins and Mrs E Brown were elected as Chair and Deputy Chair respectively.

2. Committee Terms of Reference

Mr P Buckingham presented a report which detailed Terms of Reference approved by the Council of Governors on 6 December 2017 for review and familiarisation by Committee members. In reviewing s3.1 of the Terms of Reference, which related to the number of Committee members, the Committee agreed that an amendment should be proposed which removed the reference to a specific number of Governor members. It was also noted that such an amendment would need to be applied to the Terms of Reference of the other Governor Committees. The Committee consequently recommended an amendment to the Terms of Reference, as noted above, to the Council of Governors for approval.

3. Committee Work Plan

Following consideration of the content of a forward Work Plan at the Committee meeting on 8 January 2018, Mr P Buckingham circulated a draft Work Plan to Committee members for comment. The Committee also discussed the timing of future Committee meetings and it was agreed that the Committee would continue to meet on Mondays with meetings to commence at 2.00pm.

4. Membership Report

Mrs H O'Brien presented a report which detailed the current position on Trust membership. Those present noted an extremely positive position in terms of 'click through' rates for email engagement with the membership and the Committee was advised of the confirmation of the Health Talks programme.

5. Developing Council of Governor Practice

The Committee reflected upon the proposed approach developed by Mr C Hudsmith to improve effectiveness of Council of Governors meetings which had been trialled prior to the formal Council of Governors meeting on 6 December 2017. It was noted that the proposed approach, based on agreeing an approach to specific agenda items prior to the formal meeting, had been well received by both Governors and Non-Executive Directors. Those present had also found the pre-meeting helpful and felt that the approach would facilitate more effective Council meetings. The Committee acknowledged, however, the need to consider the loss of time that had previously been used for Governor development sessions.

6. Chief Executive Updates

The Committee received updates on the following subject areas:

- Emergency Department Performance
- CQC Inspections
- Strategic Programmes

7. Membership Strategy & Plan

Mrs H O'Brien presented a Membership Strategy & Plan for approval by the Committee. In considering the challenges detailed in s4 of the document, the Committee noted the decision to suspend the Open Day, originally scheduled to be held during the summer of 2018, and endorsed the rationale for this decision. The Committee was advised that the strategy in terms of overall membership numbers was to undertake sufficient recruitment to maintain current membership levels. Mrs H O'Brien also briefed the Committee on the content of the Membership Plan for 2018/19 and provided an overview of the planned activities. The Committee approved and Membership Strategy & Plan 2018/19.

8. Stepping Up – Electronic Format

Mrs H O'Brien briefed the Committee on the new style electronic format 'Stepping Up' which had been published on 20 February 2018. Those present made suggestions with regard to content for future issues.

9. Annual Report & Accounts 2017/18

Mr L Jenkins advised the Committee of discussions with Ms A Lynch which had resulted in the selection of 'Duty of Candour' as the local indicator for testing as part of the audit

on the Annual Quality Report. Mr P Buckingham presented a report which detailed the submission deadlines and associated planning timetable for production of the Annual Report & Accounts 2017/18. He noted in particular the Council of Governors section of the Annual Report and advised that content of the section was based on requirements set out in the Annual Report Manual. Mr P Buckingham noted, however, that additional narrative could be included and requested suggestions from the Committee for additional content relating to 2017/18. Committee members subsequently suggested that changes in the Council's Committee arrangements should be included, together with narrative describing the Council's 'new ways of working' approach. It was also suggested that Governors' participation in Patient Safety Walkrounds and mock CQC inspections should be included.

10. Constituency Boundaries – Outer Region

Mr P Buckingham presented a report seeking Committee consideration of the boundaries of the Council's Outer Region constituency. He noted that this issue had arisen at a meeting of the Nominations Committee and had been referred to the Governance & membership Committee for consideration and recommendation of outcomes to the Council of Governors. The Committee was advised that the issue related to whether the current boundaries unduly limited the catchment area for recruitment of Non-Executive Directors. Mr P Buckingham also noted that, while the constituency boundaries defined the geographical area for Non-Executive Director recruitment purposes, the primary purpose of constituency areas was to reflect patient flows and the principle of local accountability. In conclusion of a discussion regarding this matter, it was agreed that a recommendation would be made to the Council of Governors that constituency boundaries should remain unchanged.

11. Council of Governors – Attendance

The Committee considered details of Governor attendance at meetings of the Council of Governors during 2017/18 to date and noted the required attendance levels set out in Annex 5, Article 8 of the Trust's Constitution. Those present agreed that no actions were required at present.

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STOCKPORT NHSFT
Council of Governors

Report of: Julie Wragg **Date of Meeting: 23 May 2018**

Report of the Patient Experience Committee

1. Present

Governors Present	Non-Executive Directors	Trust Representatives
Linda Appleton	Nil	Paul Buckingham
Lance Dowson		Soile Curtis
Alan Gibson	**Governor Observers**	Joanne Morris
Tad Kondratowicz	Eve Brown	Emma Rogers
Julie Wragg	Les Jenkins	Carole Sparks

2. Meetings held on

A meeting was held on 11 January 2018.

3. Agenda Items

1. Election of Committee Chair & Deputy Chair
2. Committee Terms of Reference
3. Patient Experience Report
4. PLACE Assessments
5. Committee Work Plan

4. Issues to be brought to the attention of the Council of Governors

1. Election of Committee Chair & Deputy Chair

Mrs J Wragg and Mrs L Appleton were elected as Chair and Deputy Chair respectively.

2. Committee Terms of Reference

Mr P Buckingham presented a report which detailed the Committee's Terms of Reference approved by the Council of Governors on 6 December 2017 for review and familiarisation by committee members. He advised that following discussion at the Governance & Membership Committee meeting on 8 January 2018, it had been agreed that s3.1 of the Terms of Reference, which related to the number of Committee members, should be amended in all three Governor Committees' Terms of Reference. The rationale for the proposal was that current membership numbers would not facilitate a membership of eight Governors in any of the Committees. The Committee consequently endorsed the proposal to amend the Terms of Reference to remove the reference to a specific number of Governor members.

3. Patient Experience Report

Mrs E Rogers, Matron for Patient Experience, presented a Patient Experience Report for Quarter 2 2017/18. She briefed the Committee on the content of the report which provided assurance relating to patient experience and complaints and outlined changes to practice introduced as a result of feedback received. The Committee noted developments with regard to iPad surveys, Friends & Family Test and Complaints as well as service improvements with regard to patient experience.

4. PLACE Assessments

Ms J Morris, Facilities Support Services Manager, presented a Patient Led Assessment of the Care Environment (PLACE) Update Report. She briefed the Committee on the content of the report and provided an overview of actions and progress made against recommendations from the Trust's most recent PLACE assessment undertaken in April 2017 as well as planned improvements for 2018. Ms J Morris advised the Committee that the assessment had gone well and improvements had been noted in all three sites assessed. Governors were invited to participate in mini-PLACE inspections, details of which were circulated to Governors following the meeting. The Committee welcomed a suggestion to invite Mrs C Anderson, Non-Executive Director and Board level lead for PLACE, to a future Committee meeting to provide her perspective on the PLACE process.

5. Committee Work Plan

Committee members considered the content of a forward Work Plan and Mr P Buckingham agreed to circulate a draft Work Plan to Committee members for comment.