Stockport NHS
NHS Foundation Trust

BOARD OF DIRECTORS

PUBLIC MEETING

26 MAY 2016

Your Health. Our Priority.

Board of Directors - PUBLIC MEETING - 26 May 2016 - agenda pack

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Stockport NHS
NHS Foundation Trust

May 2016

Dear Colleague

You are invited to a meeting of the Board of Directors which will be held on **Thursday 26 May 2016 at 1.15pm in Lecture Theatre A, Pinewood House, Stepping Hill Hospital.**

An agenda for the meeting is detailed below.

Yours sincerely

GILLIAN EASSON
CHAIRMAN

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AGENDA ITEM	TIME
1. Apologies for Absence.	1.15pm – 1.20pm
2. Opening Remarks by the Chairman.	"
3. Declaration of Amendments to the Register of Interests.	"
4. **OPENING MATTERS:**	
4.1 To approve the minutes of the previous meeting of the Board of Directors held on 28 April 2016 (attached).	1.20pm – 1.25pm
4.2 Patient Story.	1.25pm – 1.35pm
4.3 Report of the Chairman.	1.35pm - 1.45pm
5. **TRUST ASSURANCE / GOVERNANCE:**	
5.1 Integrated Performance Report (Report of Acting Chief Operating Officer attached).	1.45pm – 2.00pm
5.2 Corporate Objectives 2016/17 (Report of Deputy Chief Executive attached)	2.00pm – 2.10pm
5.3 PLACE Audit – Q4 2015/16 Progress Report (Report of Deputy Chief Executive attached)	2.10pm – 2.20pm
5.4 Board Assurance Framework (Report of Chief Executive attached).	2.20pm – 2.35pm
5.5 Strategic Risk Register (Report of Director of Nursing and Midwifery attached).	2.35pm – 2.45pm

AGENDA ITEM	TIME
5.6 Maintaining Safe Staffing Levels (Report of Director of Nursing & Midwifery attached)	2.45pm – 2.55pm
5.7 Key Issues Reports from Assurance Committees: 5.7.1 Workforce & OD Committee (attached and Angela Smith to report) 5.7.2 Audit Committee (attached and John Sandford to report) 5.7.3 Finance & Investment Committee (attached and Malcolm Sugden to report)	2.55pm – 3.10pm
5.8 Non-Executive Director – Declarations of Independence (Report of Company Secretary attached).	3.10pm – 3.15pm
5.9 Code of Governance Compliance Report (Report of Company Secretary attached).	3.15pm- 3.20pm
5.10 Annual Governance Statement 2015/16 (Report of Chief Executive attached).	3.20pm – 3.25pm
5.11 Governance Declaration – General Condition 6 (Report of Company Secretary attached).	3.25pm – 3.30pm
6 **STRATEGY AND DEVELOPMENT:**	
6.1 Report of Chief Executive (attached).	3.30pm – 3.40pm
6.2 Financial Strategy (Report of Director of Finance attached).	3.40pm – 3.45pm
6.3 Talent Management Strategy (Report of Director of Workforce & OD attached).	3.45pm – 3.50pm
7 **CLOSING MATTERS:**	
7.1 Any Other Urgent Business.	“
7.2 Date of next meeting: • Thursday 30 June 2016, 1.15pm, in Lecture Theatre A, Pinewood House, Stepping Hill Hospital.	“

STOCKPORT NHS FOUNDATION TRUST

Minutes of a meeting of the Board of Directors held in public
on Thursday 28 April 2016
1.15pm in Lecture Theatre B, Pinewood House, Stepping Hill Hospital

Present:

Mrs G Easson	Chairman
Mrs C Anderson	Non-Executive Director
Mrs A Barnes	Chief Executive
Dr M Cheshire	Non-Executive Director
Mrs J Morris	Director of Nursing & Midwifery
Mr P Orwin	Interim Chief Operating Officer
Mr F Patel	Director of Finance
Mr J Sandford	Non-Executive Director
Mr J Schultz	Non-Executive Director
Mrs J Shaw	Director of Workforce & Organisational Development
Ms A Smith	Non-Executive Director
Mr J Sumner	Deputy Chief Executive
Mr M Sugden	Non-Executive Director
Dr C Wasson	Medical Director

In attendance:

Mr P Buckingham	Company Secretary
Mrs S Curtis	Membership Services Manager

122/16 Apologies for Absence

There were no apologies for absence.

123/16 Declaration of Amendments to the Register of Interests

Mr J Schultz noted the addition of the following interests:

- Trustee, Halle Concerts Society Endowment Fund
- Consultant, Association of Local Authority Chief Executives and Senior Managers.

The Board noted that there was an item later on the agenda to complete an annual review of the Register of Interests.

124/16 Minutes of the previous meeting

The minutes of the previous meetings held on 31 March 2016 and 6 April 2016 were approved as a true and accurate record of proceedings. The action tracking log was reviewed and annotated accordingly.

125/16 Patient Story

Mrs J Morris presented this report and reminded the Board that the purpose of patient stories was to bring the patient's voice to the Board, providing a real and personal example of the issues within the Trust's quality and safety agendas. The Board noted the story of a stroke patient who had been treated on ward B2 and whose positive patient experience had been contributed to by a variety of staff, including porters, domestics, nurses and counsellors. When asked if there had been anything that could have been improved upon, the patient had commented on nurses always being busy and had made reference to the number of bathrooms and toilets available on the ward. Mrs J Morris advised that as ward B2 was an old fashioned "Nightingale" ward, there was little that could be done in terms of increasing the numbers of toilets due to the footprint of the older estate.

In response to a question from Mr J Sandford, Mrs J Morris confirmed that ward B2 was not one of the wards due to be closed down following the opening of the new Surgical Centre and noted that despite the layout issues, the ward did function well. In response to a question from Mrs G Easson, Mrs J Morris advised that the story had been shared with staff in the relevant business group.

The Board of Directors:

- Received and noted the Patient Story report.

126/16 Report of the Chairman

Mrs G Easson welcomed members of the Board to the meeting and, in particular, welcomed Ms A Smith (Non-Executive Director), Mr P Orwin (Interim Chief Operating Officer) and Dr C Wasson (Medical Director) to their first Board meeting. Mrs G Easson made reference to the two-day Industrial Action held by Junior Doctors and the unprecedented number of patients attending the Trust's Emergency Department in March 2016. Mrs G Easson advised the Board that the Surgical Centre project was on track to be completed at the end of August 2016 with the first patients to be treated in October 2016.

The Board of Directors:

- Received and noted the verbal report.

127/16 Trust Performance Report – Month 12

Mr J Sumner presented the Trust's Performance Report which summarised the Trust's performance against Monitor's Risk Assessment Framework for the month of March 2016 including the key issues and risks for delivery. The report also provided a summary of the key issues within the Integrated Performance Report which was attached in full in Annex A.

The Board noted that there were two areas of non-compliance in month 12 which were the non-achievement of the Accident & Emergency (A&E) 4-hour target and the Referral to Treatment 92% Incomplete Pathway target. With regard to the A&E 4-hour performance, it was noted that the main factor impacting on patient flow continued to

be delayed transfers of care. In addition, Mr J Sumner advised that March had seen the highest ever average daily attends in the Emergency Department. The Board noted that the Systems Resilience Group (SRG) was being pressed to deliver actions against the Emergency Care Intensive Support Team (ECIST) eight high impact changes for patient discharge and transfer. Mr J Sumner advised that a process mapping event to aid prioritisation of the eight work streams was being held next month. In response to a question from Mr M Sugden who queried the timescale for the delivery of the actions, Mr J Sumner commented that it was disappointing that the process had taken so long and noted that the actions should help improve the position for next winter.

With regard to the non-achievement of the Referral to Treatment (RTT) target in March 2016, the Board noted that the combined impact of reduced elective operating capacity, Junior Doctors strike action and continued winter pressures had resulted in a higher volume of more complex surgical patients who had been waiting for more than 18 weeks for treatment. Mr J Sumner advised that one month's failure to meet the RTT target had resulted in a Quarter failure. Mr J Sumner briefed the Board on mitigating actions and advised that Business Groups were in the process of completing recovery plans which included capacity and demand modelling, backlog recovery and sustainable delivery.

In response to a question from Dr M Cheshire who made reference to the non-achievement of the Clinical Correspondence turnaround time in March 2016 and queried the actions in place to ensure compliance during forthcoming summer holiday season, Mr J Sumner advised that the position had since been recovered and noted that a Trust-wide, collaborative approach to resource allocation had been implemented to address the position and to improve future performance.

In response to a question from Mr M Sugden who made reference to the Gastroenterology Outpatient Waiting List, Mr J Sumner advised that the figures on Chart 9 of the Integrated Performance Report had not incorporated the 40% of patients who had been identified for discharge back to their GP. Mrs G Easson made reference to the worrying deterioration of the RTT performance and sought assurance with regard to recovery plans going forward, particularly in the light of the recent two-day strike action by Junior Doctors which would have contributed adversely to the position. Mr J Sumner advised that it was the Trust's priority to treat those patients first who had waited the longest and noted that the Business Group recovery plans would provide further information with regard to the delivery of the target going forward.

In response to a question from Mrs G Easson, Mrs J Morris advised that to date there had been seven cases of Clostridium Difficile infections due to significant lapses in care and although a number of cases were still under review to establish if any of them had been caused by significant lapses in care, it was anticipated that the Trust would not exceed the trajectory of 17. In response to a further question from Mrs G Easson, Mr J Sumner confirmed that apart from the two areas of non-compliance around A&E and RTT, the Trust had met all other performance targets in the month.

In response to a question from Dr M Cheshire, Mr J Sumner briefed the Board of actions in place with regard to earlier discharges. In response to a question from Mr J Sandford, Mr F Patel briefed the Board on mitigating actions to help achieve the required reduction in agency costs as mandated by NHS Improvement. The Board of

Directors congratulated the Director of Finance and his team for achieving the Cost Improvement Programme for 2015/16.

The Board of Directors noted the High Profile Report and was advised of the retirement of Coroner J Pollard. The Board of Directors wished to thank Mr J Pollard, who had been a Coroner at Stockport for many years, and wished him well in his retirement. Mrs A Barnes advised that the current Deputy Coroner would take over as Coroner in the interim.

In response to a question from Mrs G Easson with regard to Datix 138712 (Breach of Confidentiality), Mrs J Morris briefed the Board of the mitigating actions and noted that the incident had been reported to the Information Commissioners Office.

The Board of Directors:

- Received and noted the contents of the Trust Performance Report
- Noted the current position for month 12 compliance standards
- Noted the future risks to compliance and mitigating actions
- Noted the key risk areas from the Integrated Performance Report
- Received and noted the High Profile Report.

128/16 Monitor Risk Assessment Framework – Quarter 4 2015/16 Compliance Return

Mr F Patel presented a report which set out the proposed declaration of performance against current and forward national targets and standards for the Quarter 4 submission to Monitor. He briefed the Board of Directors on the content of the report and noted that the Board was asked to declare on performance against the following categories:

- CQC concerns
- Access and outcomes metrics
- Third-party reports
- Quality governance indicators
- Financial risk and efficiency.

The Board of Directors:

- Confirmed the declaration of performance against current and forward national targets and standard as detailed in Appendix 1 of the report.
- Confirmed that there were no material causes for concern requiring reporting in any other “Indicator of Governance Concern” metric.
- Confirmed the declaration that Q1 A&E target would not be achieved and it was noted that further explanation would be included in Appendix 2 with regard to the forecast Referral to Treatment (RTT) position. All other indicators would be achieved.
- Would not confirm a Financial Sustainability Risk Rating of “3” over the next 12 months.
- Confirmed that the Trust’s capital expenditure for the remainder of the financial year would not materially differ from the amended forecast in the financial return.

- Approved the remaining declarations as detailed in Appendix 2, with the exception of narrative box 'C' which would be amended in the light of the RTT position.

129/16 Carter Review Summary

Mr J Sumner presented a report which summarised findings and recommendations from the Carter Review. He advised the Board that the Carter Review: "Operational productivity and performance in English NHS hospitals. Unwarranted variations" had reviewed productivity and efficiency in English non-specialist acute hospitals using a series of metrics and benchmarks to enable comparison. The review had found "significant unwarranted variation across all of the main resource areas" and consequently there were 15 recommendations for trusts to action.

Mr J Sumner briefed the Board on actions in place to address the recommendations in areas such as procurement, digital information and estates. He advised that in addition, the benchmarking information from the Carter Review had been used to set objectives for efficiency in clinical services. The Board noted that gaps in other areas would be assessed by the Strategic Planning Team and reported back to the Executive Team during May / June 2016. The Board was asked to note the summary of the Carter Report and the action to incorporate the recommendations into the Trust's Sustainability Plan. Mr J Sumner advised that further updates would be provided to the Strategic Development Committee.

The Board of Directors:

- Received and noted the Carter Review Summary report.

130/16 Strategic Risk Register

Mrs J Morris presented the Strategic Risk Register and advised the Board that there were two new strategic risks added this month (2936 and 2942) and four risks had been removed from the register (2809, 2808, 2899 and 2785). Mr J Schultz commented that it was encouraging to see that the Strategic Risk Register was a dynamic document with new risks added and old risks removed.

In response to a question from Mr M Sugden who queried the residual risk score of 10 of risk 1881 ('Delivery of the 4-hour A&E target'), Mr J Sumner noted that he would need to look at the action plan to establish whether the residual risk score was the intended position after the Stockport Together actions had been delivered. In response to a further comment from Mrs G Easson, Mr J Sumner agreed to amend the definition of the risk to reference the position for 2016/17 as the target had been failed for 2015/16.

In response to a question from Dr M Cheshire with regard to risk 2644 ('Upper GI Bleed Service Provision'), Mrs J Morris agreed to review the narrative of the risk with Dr C Wasson. In response to a question from Ms A Smith who queried risk 2942 ('Hospital CCTV'), Mr J Sumner advised that there were a number of CCTV systems in Maternity and the Emergency Department that were working and briefed the Board of plans in place to resolve the issue with regard to the failing analogue CCTV systems.

In response to a question from Mr J Sandford with regard to risk 2824 ('Safe Staffing Surgery and Critical Care Wards'), Mrs J Morris advised that the risk rating had increased to a 20 as a consequence of increased staffing issues and briefed the Board of mitigating actions.

In response to a question from Mrs G Easson with regard to risk 2936 ('Unsent referrals Advantis'), Mrs J Morris advised that the backlog of 500 unsent referrals had been resolved and noted that it was anticipated that the risk would be closed following the final validation meeting. Mr J Sumner advised that risk 2567 ('Loss of Aspen House Server Room') had been resolved and would be removed from the Strategic Risk Register.

The Board of Directors:

- Received the report and noted the content.

131/16 Principal Annual Objectives 2015/16

Mrs A Barnes presented a report which provided the Board of Directors with an update against the achievement of the principal annual objectives for the year 2015/16. The Board noted that this was an exception report and any required explanatory comments associated with an 'off track' status were featured at the end of the report. Mrs A Barnes provided an overview of the content of the report and briefed the Board of mitigating actions with regard to any 'off track' objectives.

Mr J Sandford commented that it was pleasing that Business Groups had been given greater accountability for the delivery of the objectives. In response to a question from Mr J Sandford, Mrs J Shaw advised that the Leadership Strategy had been approved by the Board of Directors in March 2016 and that the associated implementation plan as well as the Talent Management Strategy would be considered by the Workforce & Organisational Development Committee on 5 May 2016. The Board was advised that the 2016/17 Principal Annual Objectives would be presented to the Board of Directors at its meeting in May 2016.

The Board of Directors:

- Received the report and noted the content.

132/16 Maintaining Safe Staffing Levels

Mrs J Morris presented a report which provided an overview, by exception, of actual versus planned staffing levels for the month of March 2016. Specific reference was made to the increased demand for temporary staffing in March 2016 which had been linked to the requirement to staff additional capacity (Transfer Unit) and to provide staffing for additional in-patient beds.

Mrs J Morris also briefed the Board on international recruitment and noted the impact of recently introduced International English Language Test (IELTs) requirements for European Union staff which was likely to delay recruitment timeframes. The Board of Directors received assurance that safe staffing levels had been maintained during March 2016.

The Board of Directors:

- Received the report and noted the content.

133/16 Key Issues Reports

Finance & Investment Committee

Mr M Sugden briefed the Board on matters considered at a meeting of the Finance & Investment Committee held on 6 April 2016. He advised the Board that the Committee had considered a report detailing the Trust's financial position as at 29 February 2016 and had been assured that financial performance was on track to achieve the financial plan for the year. The Committee had requested that future reports be amended to incorporate key metrics for 2016/17 and to provide an extended view of the forecast cash position over a 14-month period. The Committee had been advised by the Director of Finance of plans to develop forecasting over a 24-month period for a range of financial metrics during 2016/17. Mr M Sugden noted that the key risk identified by the Committee had been the delivery of the 2016/17 Cost Improvement Programme which would be the subject of a detailed discussion at the next meeting of the Committee.

Strategic Development Committee

Mr J Schultz briefed the Board on matters considered at a meeting of the Strategic Development Committee held on 21 April 2016. He advised that the Committee had considered a report presented by the Deputy Chief Executive which provided an overview of progress with key programmes during Month 1 2016/17. It was noted that the programmes served to both achieve transformational change and, in the process, realise efficiencies as part of the Trust's Cost Improvement Programme. Mr J Schultz advised that the Committee was able to report partial assurance on Month 1 progress based on the data available at the time of the meeting. Finally, Mr J Schultz noted that on completion of the meeting, the Committee had considered reporting requirements and had agreed a revised approach with a greater emphasis on assurance reporting and a simplified form of presentation.

The Board of Directors:

- Received and noted the Key Issues Reports.

134/16 Annual Review of Register of Interests

Mr P Buckingham presented a report, the purpose of which was to present the Board of Directors' Register of Interests for annual review. He noted that during April 2016, copies of the Register had been circulated to all Board members for review, and update where appropriate, to ensure currency and accuracy of content. Mr P Buckingham advised that the current Register of Directors' Interests, which incorporated any amendments arising from the review in April 2016, was included for reference at Annex A to the report and requested Board members to review the Register and confirm that the current content was accurate and up to date.

Mrs C Anderson clarified her involvement with previously declared interests and added the following:

- Chair and Trustee Director – South Liverpool Education Trust
- Foundation Governor and Chair – Mount Carmel RC Primary School
- Chair of North West Region – Institute of Hospitality.

Mr J Schultz noted the addition of the following interests:

- Trustee, Halle Concerts Society Endowment Fund
- Consultant, Association of Local Authority Chief Executives and Senior Managers.

Ms A Smith clarified her position with previously declared interests and Mrs A Barnes advised of the deletion of an interest relating to her husband's hand crafted card business as this was no longer applicable.

The Board of Directors:

- Received and noted the report and, subject to the above amendments, confirmed that the content of the Register of Interests was accurate and up to date.

135/16 Report of the Chief Executive

Mrs A Barnes presented a report to update the Board of Directors on both national and local strategic and operational developments. The report covered the following subject areas:

- Urology Cancer Procurement
- Industrial Action
- Never Events Report
- Publications

With regard to the industrial action by Junior Doctors, Mrs A Barnes advised the Board that prior planning, particularly with regard to the staffing levels in the Emergency Department, had ensured that patient safety had been maintained. Reference was made to the cover provided by Senior Doctors in the Emergency Department during the strike and Mrs A Barnes advised that this had positively contributed to an improved patient flow and had therefore highlighted the importance of early senior decision-making. Mrs G Easson thanked the Chief Executive and her team for the arrangements during the two-day industrial action.

The Board of Directors:

- Received and noted the Report of the Chief Executive.

136/16 Date, time and venue of next meeting

There being no further business, Mrs G Easson closed the meeting and advised that the next meeting of the Board of Directors would be held on Thursday 26 May 2016 at 1.15pm in Lecture Theatre A, Pinewood House, Stepping Hill Hospital.

Signed: _____ Date: _____

BOARD OF DIRECTORS: ACTION TRACKING LOG

Ref.	Meeting	Minute Ref	Subject	Action	Responsible
15/15	24 Sep 15	228/15	Integrated Performance Report	*Never Events* – Following the completion of the external review undertaken by Professor B Toft, a report, including a presentation, would be provided to the Board of Directors at its meeting in November 2015. **Update on 26 Nov 15** – As the report had not yet been completed, it would be provided to the Board on 28 January 2016. **Update on 26 Jan 16** – The report was not yet ready and would either be presented to the February Board meeting or if still not ready, Dr J Catania would provide an update at that meeting. **Update on 25 Feb 2016** – The Board noted an update provided in the Chief Executive's Report which anticipated presentation of the final Never Events Report in March / April 2016. **Update on 31 Mar 2016** – Dr J Catania advised the Board that the Trust had received a draft report from Prof B Toft which would be checked for factual accuracy. The final report would be considered in detail by the Quality Assurance Committee in May 2016 and would be presented to the public Board meeting in May 2016 via the Committee's Key Issues Report. **Update on 28 April 2016** – As advised at the previous meeting, the final report from Prof B Toft would be considered by the Quality Assurance Committee on 24 May 2016 prior to consideration by the Board of Directors.	Dr J Catania Dr C Wasson
2/16	31 Mar 16	84/16	Trust Performance Report	Mrs G Easson made reference to chart 84 which showed the rate of misadventures against National Hospital Episodes Statistics (HES) peer group, an issue which had been raised by Mrs C Anderson at the last meeting. Mrs J Morris agreed to provide feedback on the progress made by the project group at the next meeting. **Update on 28 April 2016** – Mrs J Morris advised that further detail had been included on page 39 of the Integrated Performance Report and noted that the project group, led by Dr J Harrop, was taking this forward. **Action complete**.	J Morris

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Report to:	Board of Directors	**Date:**	26th May 2016
Subject:	Trust Performance Report – Month 1		
Report of:	Chief Operating Officer	**Prepared by:**	Joanne Pemrick, Head of Performance

REPORT FOR APPROVAL

Corporate objective ref: -----	**Summary of Report** This report summarises the Trust's performance against the key standards within the Monitor compliance framework and also provides a summary of the key issues within the Integrated Performance Report.
Board Assurance Framework ref: -----	
CQC Registration Standards ref: -----	
Equality Impact Assessment: ☐ Completed ☒ Not required	

Attachments:

Appendix 1
Monitor score card

This subject has previously been reported to:	☒ Board of Directors ☐ Council of Governors ☐ Audit Committee ☒ Executive Team ☒ Quality Assurance Committee ☐ FSI Committee ☐ Workforce & OD Committee ☐ BaSF Committee ☐ Charitable Funds Committee ☐ Nominations Committee ☐ Remuneration Committee ☐ Joint Negotiating Council ☒ Other

1. Introduction

This report provides a summary of performance against Monitors Compliance Framework for the month of April 2016, including the key issues and risks to delivery. It also provides, in section 4, a summary of the key risk areas from the Trust Integrated Performance Report which is attached in full in Annexe A.

2. Compliance against Regulatory Framework

The table below shows performance against the indicators in the Monitor regulatory framework. The forecast position for May is also indicated by a red (non-compliant) or green (compliant) box.

Standard	Weighting	Monitoring Period	Apr-15	May-15	Jun-15	Q1	Jul-15	Aug-15	Sep-15	Q2	Oct-15	Nov-15	Dec-15	Q3	Jan-16	Feb-16	Mar-16	Q4	Apr-16	May-16 (f/cast)
92%	1.0	Quarterly	92.9%	92.9%	93.1%	93.0%	93.4%	92.8%	92.8%	93.0%	92.4%	92.7%	92.1%	92.4%	92.1%	92.0%	91.2%	91.8%	90.7%	
95%	1.0	Quarterly	89.1%	97.0%	94.3%	93.5%	94.8%	92.5%	91.5%	93.0%	91.0%	78.0%	73.7%	80.6%	73.5%	72.8%	72.60%	73.0%	79.3%	
85%	1.0	Quarterly	95.9%	86.8%	72.4%	85.9%	84.7%	94.9%	87.0%	89.4%	78.5%	92.5%	92.6%	87.9%	87.2%	81.6%	90.0%	86.4%	89.50%	
90%			n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
94%	1.0	Quarterly	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100.0%	100.0%	100%	100%	100%	
98%			100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100.0%	100.0%	100%	100%	100%	
94%			n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
96%	1.0	Quarterly	97.3%	98.2%	96.8%	98.1%	98.7%	97.1%	97.5%	97.9%	98.6%	97.5%	96.1%	97.8%	98.6%	97.4%	98.6%	98.2%	97.3%	
93%	1.0	Quarterly	95.5%	98.3%	95.8%	96.6%	97.1%	96.0%	94.7%	95.9%	96.0%	97.3%	97.6%	97.0%	96.8%	98.1%	97.5%	97.5%	96.6%	
93%			96.7%	98.6%	94.7%	96.7%	96.3%	96.1%	95.9%	96.1%	94.2%	94.7%	98.7%	95.6%	96.4%	98.9%	99.1%	98.1%	98.8%	
de minimis applies	1.0	Quarterly	0	0	0	0	1	2	0	3	0	1	0	1	1	2	0	3	0	

3. Month 1 Performance against Regulatory Framework

There were two areas of non-compliance against the regulatory framework in month 1:

A&E 4hr target

April's improved position correlated with a reduction in attends, despite a continued increase in delayed transfers of care. The last two weeks saw performance reaching mid-high 80's.However, May has seen a sustained and unprecedented increase in attends (circa 295) with no improvement in the level of delayed transfers of care.

The Systems Resilience Group are being pressed to focus on the ECIST 8 high impact changes for patient discharge and transfer. A process mapping event to aid prioritization of the 8 work streams is being held this week.

The Urgent Care Review Group (UCRG) have been working towards implementing a series of key changes in the urgent care pathway aimed at improving performance which are clinically led and based on the evidence available from internal and external review. In summary these key changes are:

1) Identifying and avoiding 4hr breaches by proactive management and escalation once a patient's attendance reaches 2.5hrs

2) Protecting flow through the Medical Admissions Unit/Clinical Decisions Unit (MAU/CDU) by avoiding overnight patient stays

3) Utilising the protected clinical decision beds for patients requiring a 'watch/wait for results' approach to free the space they might otherwise occupy in ED

Given the wide reaching impact of these changes on various individuals, their roles, responsibilities and actions in times of escalation; a communication strategy will be formulated to ensure effective roll out.

Other work in support of the above and for future implementation

- Changes to the 10 Pledges to ensure ED referrals to surgical specialties meet agreed KPIs regarding time to be seen (to be measured and monitored by the UCRG weekly).
- Urgent review of estate to create additional capacity in ED to avoid overcrowding. This is particularly vital as average attends appear to be on the increase.

Referral To Treatment, 92% Incomplete Pathway Target

Non-compliance against the RTT Incomplete standard is expected to continue throughout Q1 of this year. The ability to begin recovering the position in April was impeded by the Junior Doctors strike action, which resulted in a loss of 96 elective cases.

Recovery plans are now in place, which predict a return to compliance by month 4 and therefore Q2 onwards. Achievement of the admitted trajectory is reliant on the ability to outsource cases to the required volumes and timescales with partner providers, and having full surgical capacity to maximise in-house activity. Progress against trajectory will be scrutinized weekly.

Business Groups have now completed capacity & demand modelling to identify current gaps and are proposing solutions for sustained delivery.

Future risks to compliance against Regulatory Framework

The risks to both the A&E and the RTT standard are expected to continue throughout Q1 of 2016/17.

4. Key Risks/hotspots from the Integrated Performance Report

4.1 Quality

- **Discharge Summary**

  The volume of patients and rotating workforce through acute assessment areas continues to be the main contributing factor to underperformance. Additionally, the Junior Dr strike also impacted in month. The following processes have recently been implemented:

  - An alert to clinicians of any HCR not completed within 24hrs.
  - HOT Consultant of the day in Child & Family now ensuring completion for all outstanding HCR's from previous day discharges.

- **Patient Experience**

  The Friends and Family response rate reduced in April, despite an increase in footfall through the ED department. Poor response rate for Paediatric ED continues, and an options appraisal has been developed for consideration to improve patient engagement in this area.

4.2 Performance

- **Outpatient Waiting Lists**

  Gastroenterology

  Funding for an Interim Locum has been approved to continue to provide sufficient medical cover until the 6th substantive consultant begins in post in July 2016

  Cardiology

  There have been unforeseen issues with Medical capacity which has resulted in adverse

performance. Interviews are scheduled to provide Maternity cover and CVs have been requested to backfill lost capacity

Respiratory

The Service has recently lost capacity due to the redistribution of duties within the Medical team and reprioritisation of clinical responsibilities. Additional capacity is currently being provided via Agency locum, this will be reviewed on an ongoing basis.

Ophthalmology

Confirmation is awaited that the paediatric element of the service will transfer to Central Manchester.

- **Cancelled operations on the day**
  There were a total of 26 cancellations on the day for non-clinical reasons, which is a much improved position from the previous 2 months. 9 patients were cancelled due to lack of theatre time and 7 due to surgeon sickness on the day.

- **Cancelled operations: 28 day rebook target**
  April again saw a number of breaches against the 28-day standard, resulting from a sustained high number of last minute cancellations. Unavailability of HDU beds on the day of admission remains an issue, accounting for 3 of the breaches in April.

- **Emergency Readmissions**
  Emergency readmissions forms one of the strategic staircase projects, and progress will be monitored at Senior Management Board.

4.3 Finance

- The Trust has a deficit of £2.4m at the end of April 2016 and this is in line with the financial plan. The Trust has a planned deficit of £16.9m for the financial year 2016/17 and this is after a cost improvement plan of £17.5m.

- Clinical income in April is behind plan by £418k and the most significant variance within this is the impact of the two day planned junior doctors strike, which is estimated to be £160k in elective activity.

- In April the Staircase schemes were expected to deliver £461k and only delivered £85k, a shortfall of £376k. The BAU schemes were not expected to deliver any savings until Month 3 but have delivered £223k in month. The total adverse variance to plan is £153k.

- Cash in the bank at the 30th April 2016 was £27.1m against an operational plan of £28.5m and therefore there is a negative variance of £1.4m in April. This can be explained by at VAT refund of £700k which was not received until the first week in May and a debtor of £600k from Tameside Foundation Trust which remains unpaid. The year- end cash forecast position remains at c.£10m.

4.4 Workforce

- **Essentials training**
  Compliance continues to be a challenge. The Head of OD and Learning has contacted those Business Groups who are under 90% to ascertain the plans they have in place to achieve 95% compliance.

- **Appraisals**
  The Trust's total appraisal compliance for April 2016 is 84.89%, an increase of 2.9% since March 2016 (81.99%). This figure takes account of the 15-month appraisal window

introduced by the new performance appraisal framework for non-medical staff.

- **Turnover**
  The Trust's permanent headcount turnover figure for the 12 months ending April 2016 is 11.09%. This is an increase of 0.01% compared to the March 2016 figure of 11.08%, showing some stability in the turnover activity

- **Induction**
  There has been a significant drop in completion of the Local Induction. The Head of OD and Learning will contact those Business Groups whose compliance falls below 95% to understand the reasons why and to offer support and guidance.

- **Efficiency**
  Bank & Agency costs
  The percentage of pay costs spent on bank and agency in April 2016 is 10% (a decrease of 1% from March's position) which equates to £1,714,000 a decrease of £305,826 from £2,019,826 in March 2016. The Medicine Business Group has the highest spend on bank/agency at £1,082,000 in April 2016 which equates to 62.4% of the overall spend.

  Agency shifts above cap
  April 2016 shows a decrease in the number of shifts which are taking place above the agency cap. Work has commenced in line with the IDP Agency Cap programme to address the level of cap breaches and work to model the impact is underway. The biggest area of cap breaches are within medical staff and the Medicine Business Group. The Deputy Director of Workforce is meeting with the Business Group Director to look to support a reduction in this position

5. Recommendations

The Board is asked to:

- Note the current position for month 1 compliance against standards.
- Note the future risks to compliance and corresponding actions to mitigate.
- Note the key risks areas from the Integrated Performance Report

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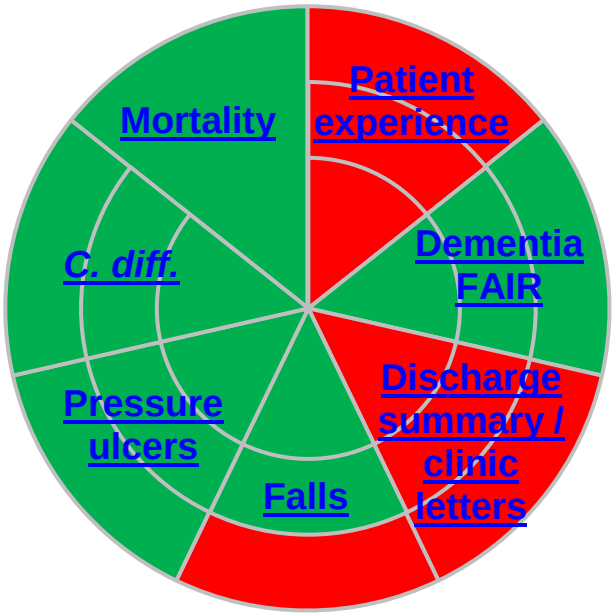
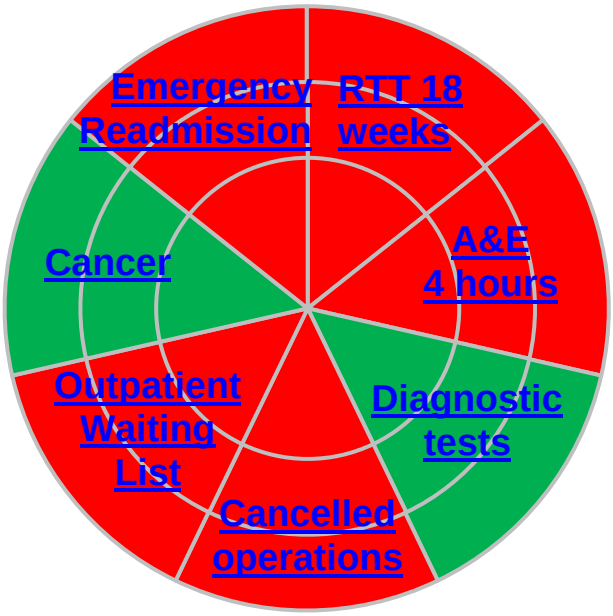
Integrated Performance Report
April 2016

Stockport NHS Foundation Trust

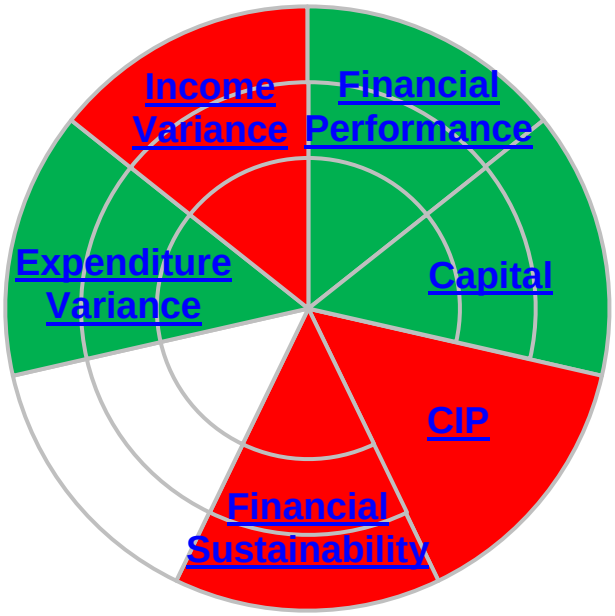
1.Quality



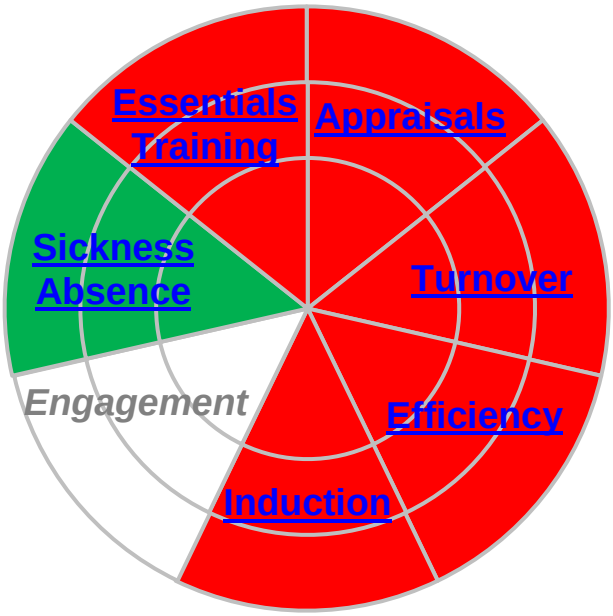
2.Performance



3.Finance



4.Workforce



Key to wheels:

Outer ring; Year-to-date performance. Middle ring, latest quarter. Inner ring, latest month.

Mortality is assessed on the latest 12 months, CIP (Cost Improvement Programme) on the year-to-date.

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Integrated Performance Report
Changes to this month's report – April 2016

- Indicators now categorised Quality, Performance, Finance, and Workforce. The main changes are:
- Mortality moved to 1st wheel with other quality indicators.
- Discharge summary and Clinical correspondence combined to one segment (in Quality wheel.)
- Emergency Readmissions added to Performance wheel as a new indicator.
- Elective income versus plan, Income variance, and Expenditure variance added to Finance wheel.
- Workforce wheel indicators are Appraisals (now including Medical Appraisals), Turnover, Efficiency (made up of Agency shifts above cap, Staff in post, Bank and agency pay costs, and Pay variance), Induction, Engagement (to be based on Pulse survey responses), Sickness absence, and Essentials Training.
- Hot Spots section, CQUIN summary and Nursing Dashboard are no longer shown within the Integrated Performance Report.
- The Monitor declaration for RTT has changed to red.

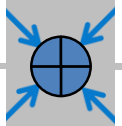
Key to indicators:

Monitor indicators (in Risk Assessment Framework): M
Monitor indicators for which we have made forward declaration: M

Corporate Strategic Risk Register rating (current or residual): 15
Risks rated on severity of consequence multiplied by likelihood, both based on a scale from 1 to 5. Ratings could range from 1 (low consequence and rare) to 25 (catastrophic and almost certain), but are only shown for significant risks which have an impact on the stated aims of the Trust, with an initial rating of 15+.

Data Quality: Kite Marking given to each indicator in this report 
This scoring allows the reader to understand the source of each indicator, the time frame represented, and the way it is calculated and if the data has been subject to validation. The diagram below explains how the marking works.

Filled Trust Data	**Blank** National Data	**Filled** Validated	**Blank** Unvalidated
Filled Automated	**Blank** Not Automated	**Filled** Current Month	**Blank** Not Current Month



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Patient Experience

Chart 1

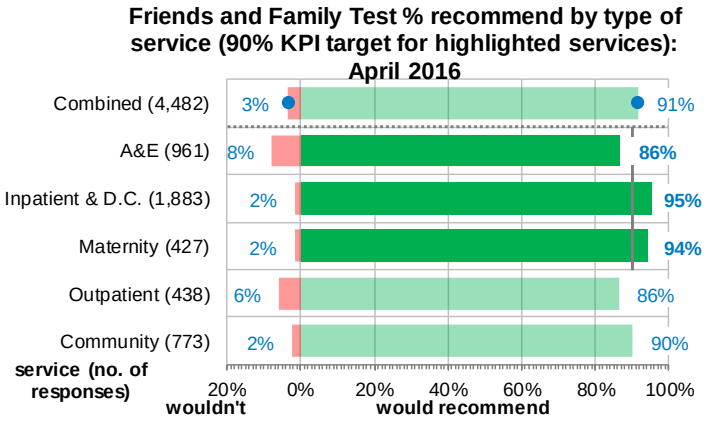
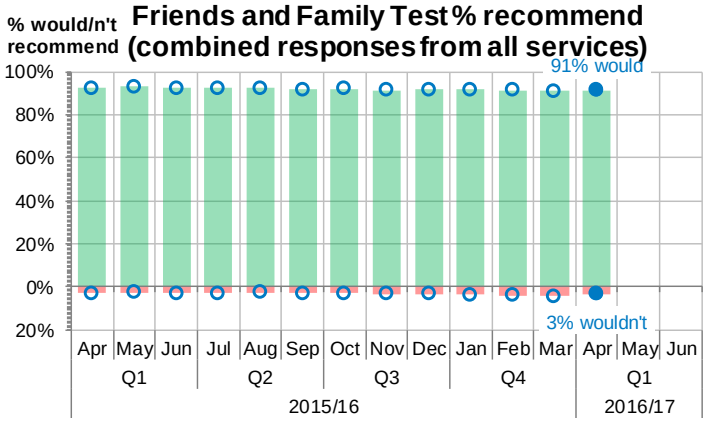


Chart 2



The Friends and Family response rate for ED reduced in April, despite an increase in footfall through the ED department. Poor response rate for Paediatric ED continues, and an options appraisals has been developed for consideration to improve patient engagement in this area.

Feedback Themes (acute):

ED (adult) – Positive comments received for April state staff were caring and through. Some patients acknowledged they had been provided with drinks and food and that some staff had a good attitude overall.

Negative comments continue to include long waiting times with patients commenting when sat in the waiting room they do not know what is happening next and some comments stated they did not hear their name called due to hearing difficulties. Comments report a lack of information and conflicting information with some staff poor attitude.

Inpatients (adults) Positive comments received included being treated with respect and dignity, good levels of care with staff being reassuring and welcoming.

Negative comments included wards noisy at night and some patient's perception of not enough staff to care for them.

Maternity – Overall positive comments received included patients felt reassured and stated they had a positive experience. Comments stated staff were approachable and breast feeding advice was good. Minimal negative comments were received stating some staff attitude was poor (delivery and ward).

Daycase - Negative comments continue to report long waiting times when admitted for procedures and poor communication and information, especially following surgery. Some comments stated some staff poor attitude and procedures administered by medical staff unduly painful (endoscopy – BG to be informed with report). Positive comments reported good care and patients felt they were looked after well. Some patient comments mentioned good care also in theatre. Top positive themes are staff attitude and care.

Chart 3

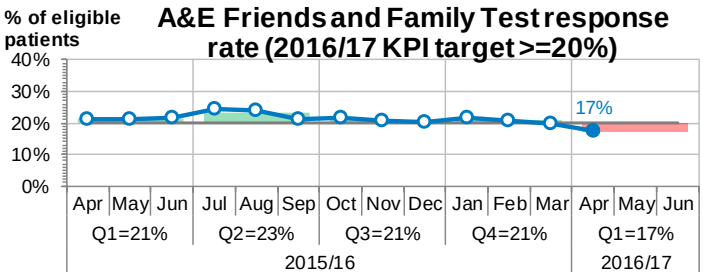
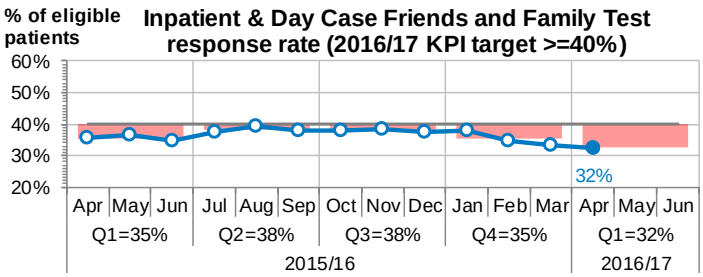


Chart 4



Out Patients - Positive comments received included staff were professional, courteous and reassuring with patients stating they were treated with respect. Negative comments report
being given the same appointment time as other patients resulting in delays, poor communication and some medical staff poor attitude at the consultation.

Paediatrics (inpatients) - Positive comments received stated staff put minds 'at rest' and were 'fantastic'. Other comments stated good care and staff were compassionate.

Neonatal Unit – comments continue to be positive and include staff being friendly and supportive.

Community Services - *Stockport*: Overall positive comments were received which continue to state good care received, good staff attitude and communication. Negative comments continue to state there was a long time to wait for appointments and when arriving at clinic.

IPad Inpatient Surveys

In April **285** inpatient iPad surveys were undertaken, which is an increase of **33** compared to March. All wards now have log in access to the surveys in order to assist in obtaining patient feedback via the iPads and this continues to be encouraged, but a heavy reliance on volunteers to undertake surveys continues.

All results can be seen via the trust Corporate Information System. Using a RAG rating system these results are presented in a format which enables an overall trust wide view of where performance is good and where targeted focus is required. Overall, the trust scored 85% positive responses in April which is the same as March.

Responses to the questions and business group actions regarding nutrition and hydration will continue to be monitored via the trust Nutrition and Hydration group and reported through the designated governance structures.

Return to FRONT page

Dementia 16

Chart 5

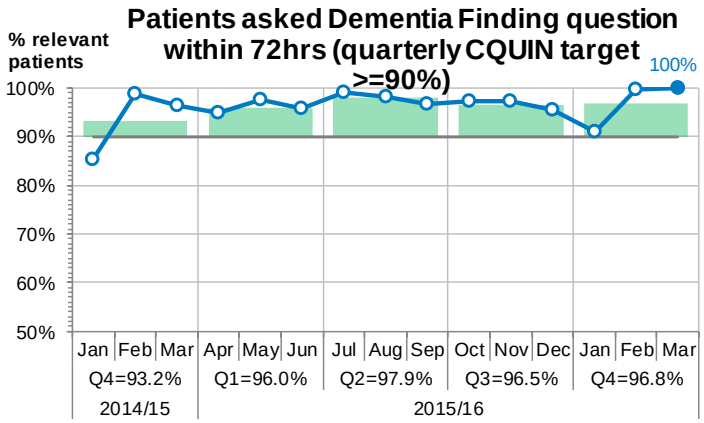


Chart 6

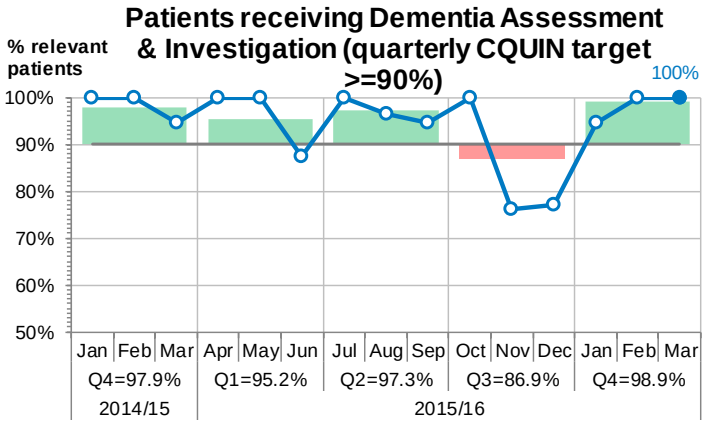
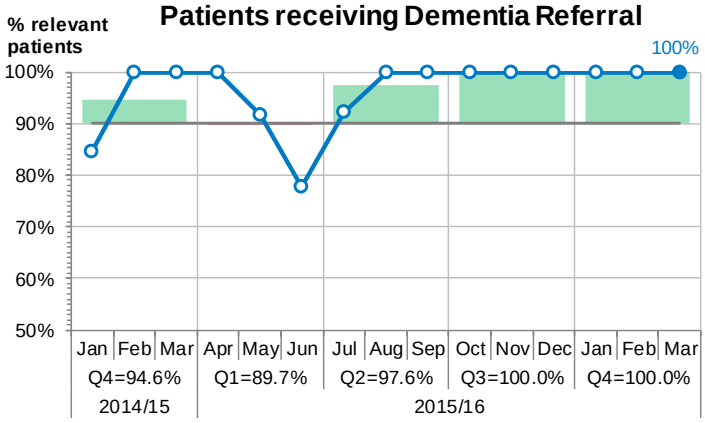


Chart 7



Charts 5 to 7 show performance against the dementia standards. Compliance with standard is expected to continue following implementation of an electronic recording.

Return to FRONT page

Discharge summary (published within 48 hours)

Chart 8

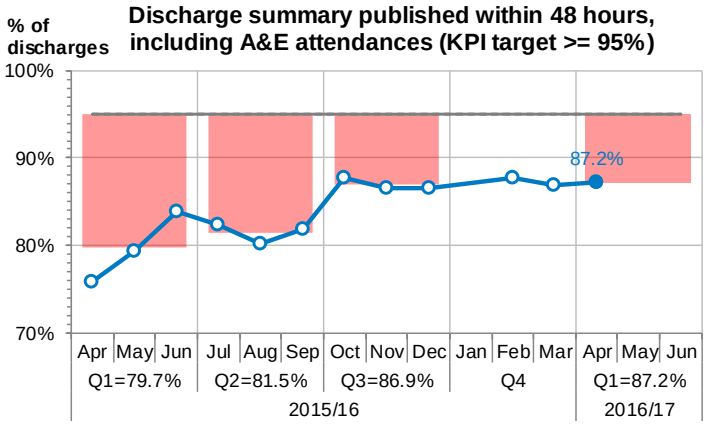


Chart 8 shows compliance with discharge summary completion within 48hrs.

The volume of patients and rotating workforce through acute assessment areas continues to be the main contributing factor to underperformance. Additionally, the Junior Dr strike also impacted in month. The following processes have recently been implemented:

- An alert to clinicians of any HCR not completed within 24hrs.
- HOT Consultant of the day in Child & Family now ensuring completion for all outstanding HCR's from previous day discharges.

Return to FRONT page

Clinical correspondence (typing backlog)

Chart 9

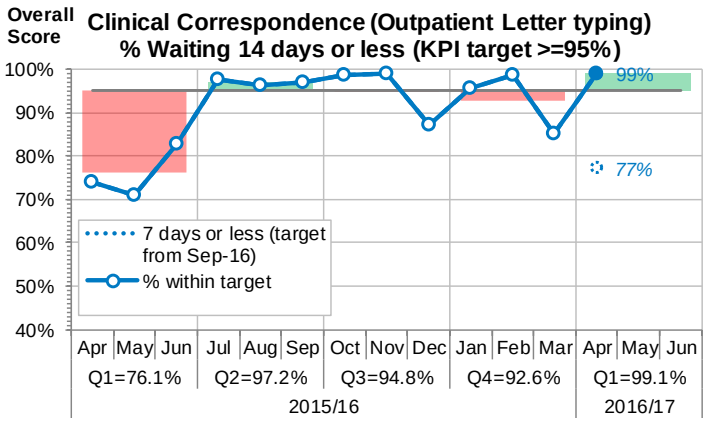


Chart 9 shows the performance against the clinical correspondence standard of 95% of Outpatient letters to be typed within 14 days.

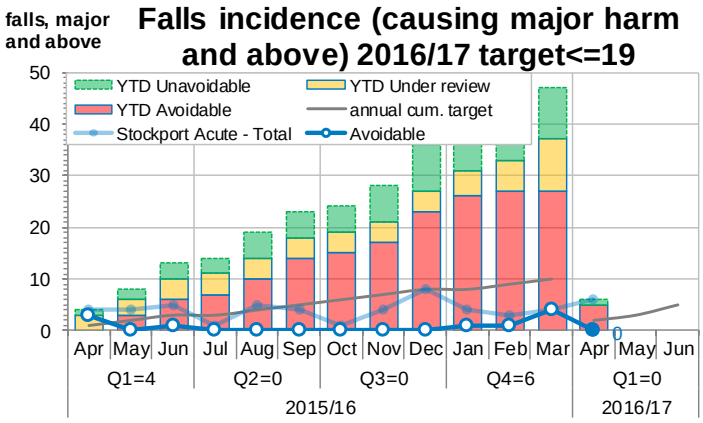
Compliance against standard was resumed in April

From September, the KPI will change to a 7 day turnround time. Achievement against the new target will be shadow reported to track progress. The graph indicates that current performance against the 7 day target is 77%.

Return to FRONT page

Falls

Chart 10



This year's target is 19 avoidable falls. In April there were 6 severe falls:

- 5 are under review
- 1 has been deemed as unavoidable

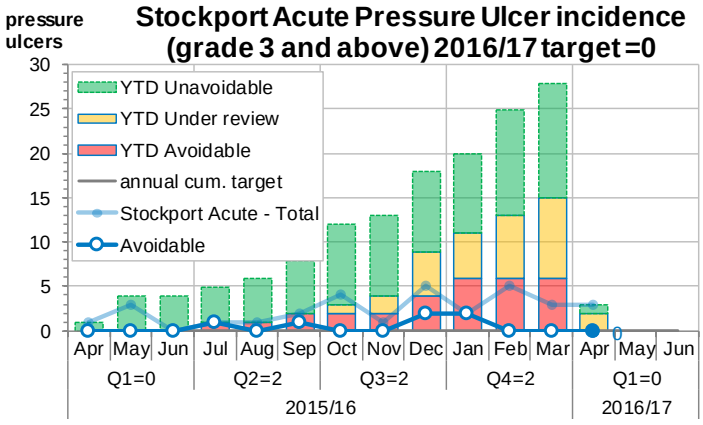
A new corporate risk assessment has been completed to reduce the number of serious falls.

A workshop is being held on the 9th June to review current state in relation to falls prevention bundle and to prioirtise actions for the forthcoming year.

Return to FRONT page

Pressure Ulcers 16

Chart 11

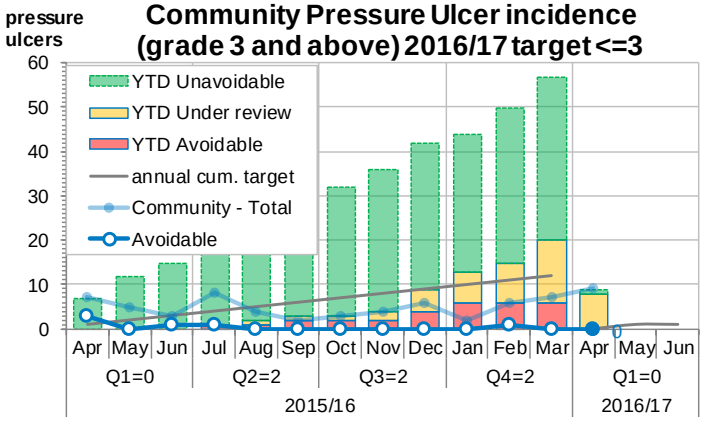


The stretch target for Stockport Acute services is zero tolerance of avoidable pressure ulcers grade 3 and 4 by the end of 2017.

In April there has been 3 avoidable pressure ulcers, 2 are under review and 1 has been deemed as unavoidable.

The stretch target for Stockport Community is 50% reduction in grade 3 and 4 avoidable pressure ulcers by end of 2017. The target is 3 avoidable pressure ulcers.

Chart 12



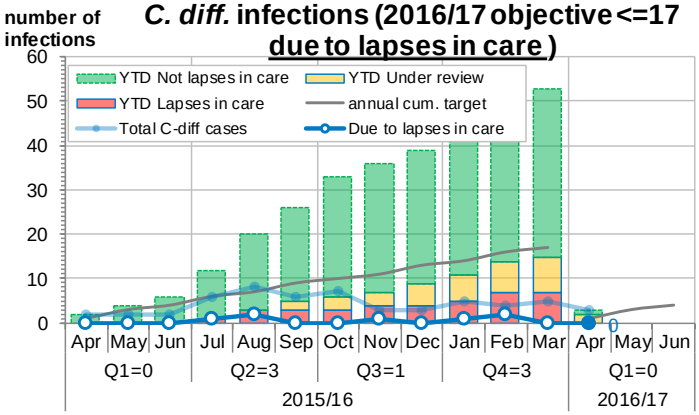
In April there have been 9 grade 3/4 pressure ulcers, 8 are under review and 1 has been deemed as unavoidable.

Work has started promoting the 'React to Red' campaign - Early detection of signs of pressure enable interventions for prevention to be commenced in a timely and responsive manner in order to reduce harm occurring. This concept along with a number of other pressure relieving strategies including the use of silicone dressings to minimise the risk of shear/friction is being promoted.

Return to FRONT page

Clostridium difficile (C. diff.) infections

Chart 13



During 2015/16 there were 53 cases of Clostridium difficile, of these, 7 cases were found to have significant lapses in care. Currently there are 12 cases still under review and as a result we are unable to determine whether the trajectory of 17 has been achieved.

For 2016/17 there has been 3 cases of Clostridium difficile in April, the total number YTD is 3. Of these 3 cases all are still under review therefore to date we have had no significant lapses in care counting towards the trajectory of 17.

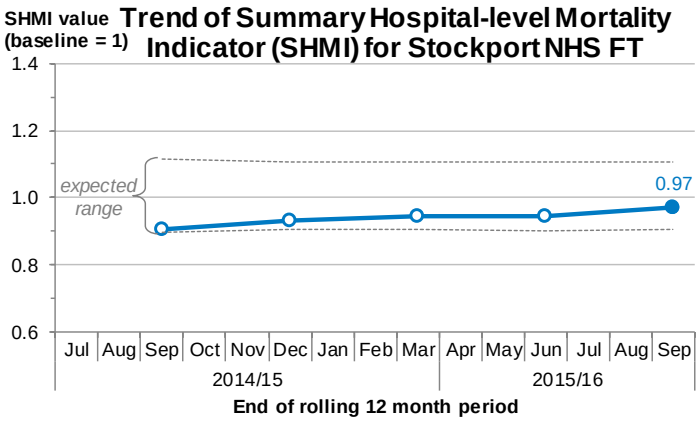
Return to FRONT page

Mortality

Summary Hospital-level Mortality Indicator (SHMI)

This is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. It covers all deaths reported of patients who were admitted to non-specialist acute trusts in England and either die while in hospital or within 30 days of discharge.
Data source: Health and Social Care Information Centre

Chart 14



Mortality analysis now includes 3 measures, SHMI, RAMI, and HSMR (not Dr Foster HSMR but a proxy provided by the CHKS software). Where possible data is shown to represent performance over time, against peers and with weekend/week comparisons.

Whilst overall mortality profile is good and reported as Green, investigation is needed into the varying mortality at the weekend compared to the week. This would be in tandem with the Trust 7 day services action plan

Chart 15

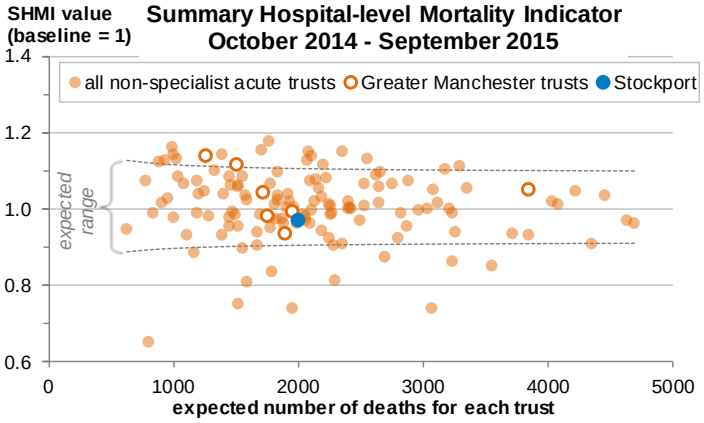
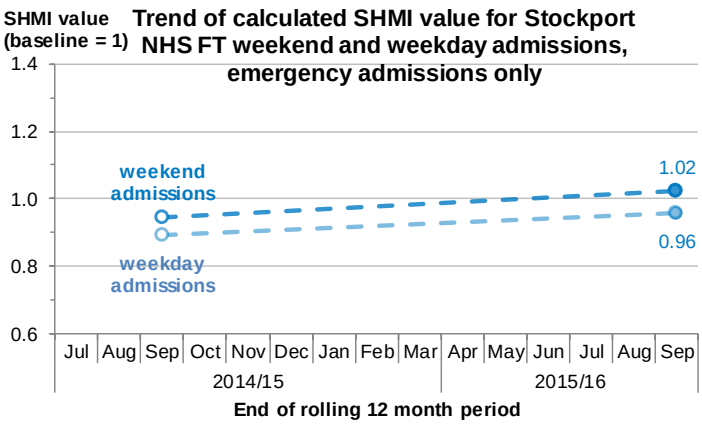


Chart 16



Return to FRONT page

Risk Adjusted Mortality Index (RAMI)

The main differences in calculation from SHMI are: RAMI only includes in-hospital deaths; it excludes patients admitted as emergencies with a zero length of stay discharged alive, and patients coded with receiving palliative care; the estimates of risk used to work out the number of expected deaths are calculated once per year ("rebasing"), data is shown here using latest 2014 benchmarks; RAMI includes data from the whole patient spell rather than just the first two admitting consultant episodes.

Data source: CHKS

Chart 17

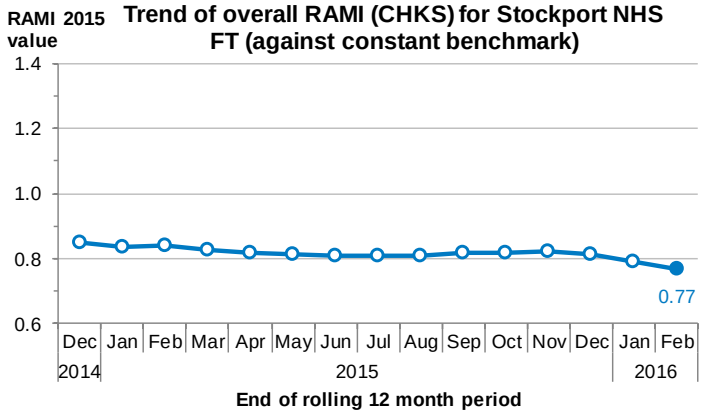


Chart 18

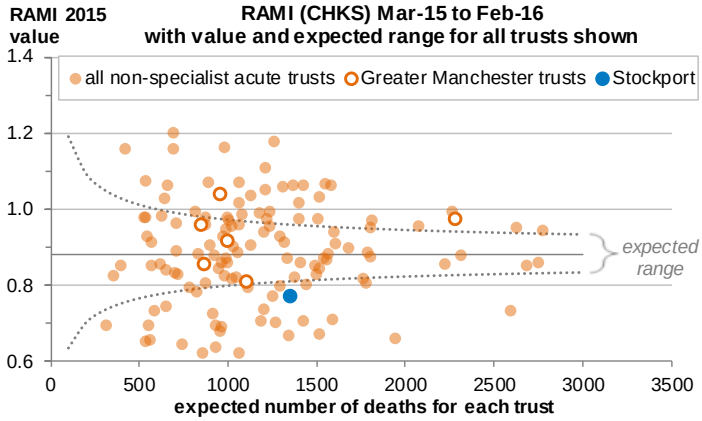
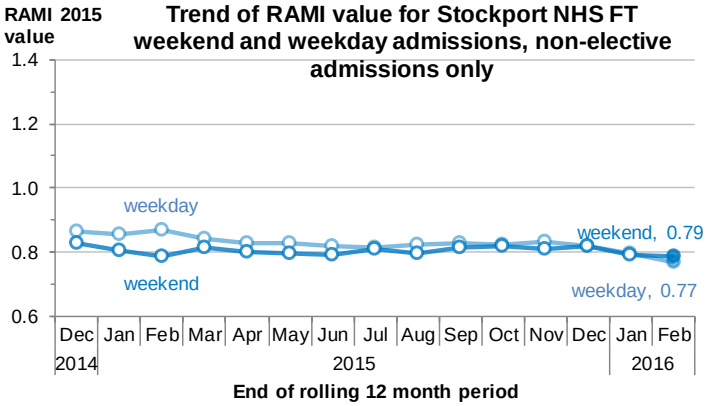


Chart 19



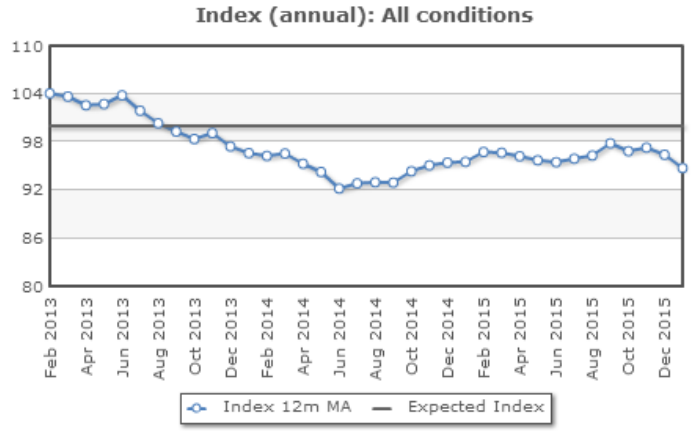
Return to FRONT page

Hospital Standardised Mortality Data (HMSR)

The main differences in calculation from SHMI are: HSMR only includes in-hospital deaths; the factors used in estimating the number of patients that would be expected to die includes whether patients are coded with receiving palliative care, and socio-economic deprivation; the estimates of risk used to work out the number of expected deaths are calculated once per year ("rebasing"), data is shown here using latest benchmarks.

Data source: CHKS (using Dr Foster Intelligence methodology)

Chart 20



Return to FRONT page

Referral to Treatment (RTT) waiting times

Chart 21

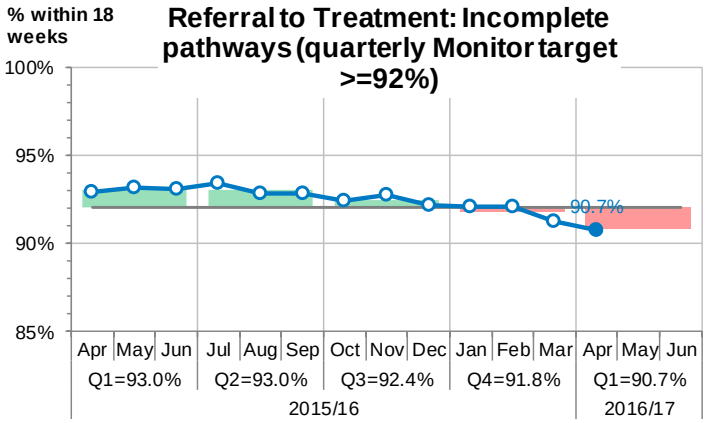


Chart 21 shows performance against the RTT Incomplete standard.

Non-compliance against the RTT Incomplete standard is expected to continue throughout Q1 of this year. The ability to begin recovering the position in April was impeded by the Junior Doctors strike action, which resulted in a loss of 96 elective cases.

Recovery plans are now in place, which predict a return to compliance by month 4 and therefore Q2 onwards. Achievement of the admitted trajectory is reliant on the ability to outsource cases to the required volumes and timescales with partner providers, and having full surgical capacity to maximise in-house activity. Progress against trajectory will be scrutinized weekly.

Chart 22

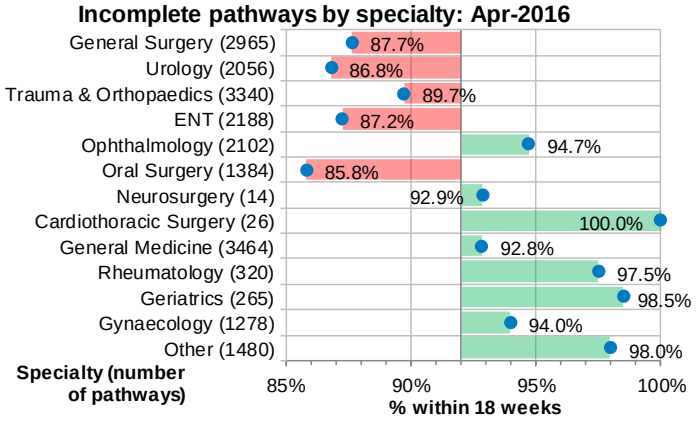


Chart 22 shows performance against the incomplete standard at specialty level.

Business Groups have now completed capacity & demand modelling to identify current gaps and are proposing solutions for sustained delivery.

Chart 23

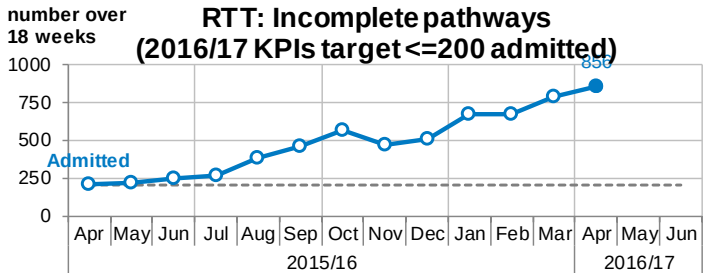
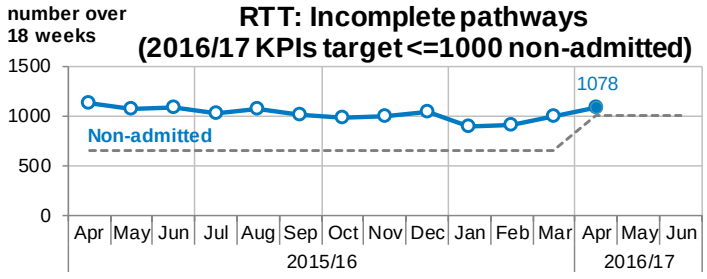


Chart 23 reflects the continued increase in the admitted waiting list, which stands at 856 at month end, against target level of 200.

Chart 24



Accident & Emergency total time in dept.

Return to FRONT page

Chart 25

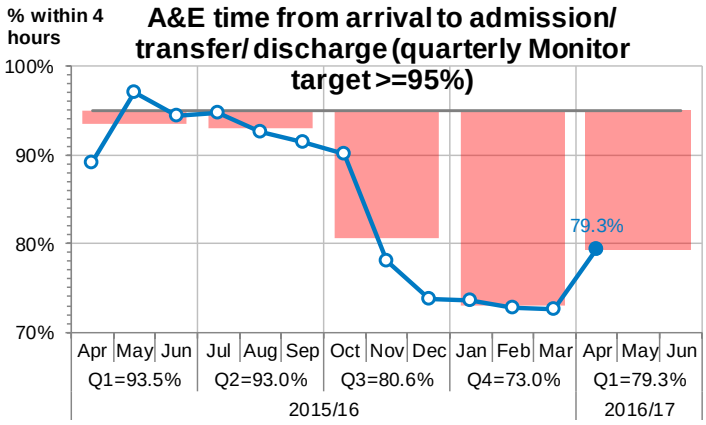
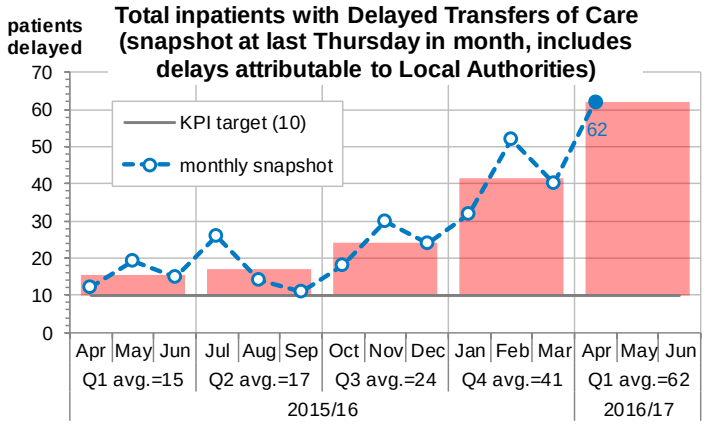


Chart 25 shows compliance against the 4hr A&E standard.

April's improved position correlated with a reduction in attends, despite a continued increase in delayed transfers of care. The last two weeks saw performance reaching mid-high 80's.

However, May has seen a sustained and unprecedented increase in attends (circa 295) with no improvement in the level of delayed transfers of care.

Chart 26



The Systems resilience Group are being pressed to focus on the ECIST 8 high impact changes for patient discharge and transfer. A process mapping event to aid prioritization of the 8 work streams is being held this week.

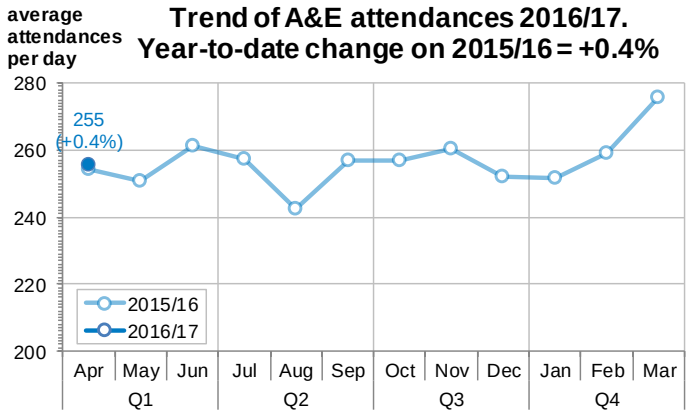
The Urgent Care Review Group (UCRG) have been working towards implementing a series of key changes in the urgent care pathway aimed at improving performance which are clinically led and based on the evidence available from internal and external review. In summary these key changes are:

1) Identifying and avoiding 4hr breaches by proactive management and escalation once a patient's attendance reaches 2.5hrs

2) Protecting flow through the Medical Admissions Unit/Clinical Decisions Unit (MAU/CDU) by avoiding overnight patient stays

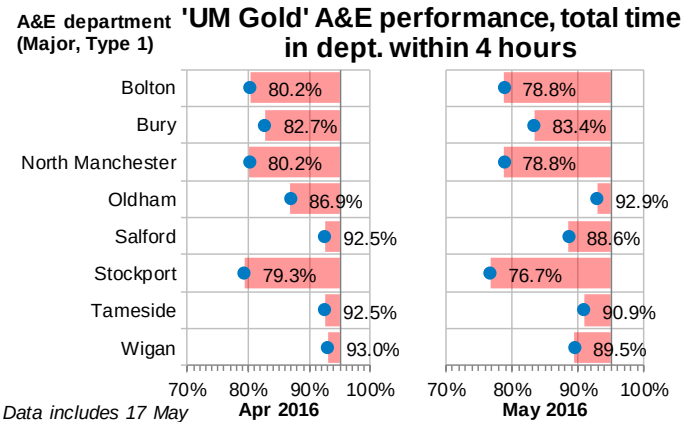
3) Utilising the protected clinical decision beds for patients requiring a 'watch/wait for results' approach to free the space they might otherwise occupy in ED

Chart 27



Given the wide reaching impact of these changes on

Chart 28



Data includes 17 May

Source: Greater Manchester Academic Health Science Network.

various individuals, their roles, responsibilities and actions in times of escalation; a communication strategy will formulated to ensure effective roll out.

Other work in support of the above and for future implementation

- Changes to the 10 Pledges to ensure ED referrals to surgical specialties meet agreed KPI's regarding time to be seen(to be measured and monitored by the UCRG weekly).
- Urgent review of estate to create additional capacity in ED to avoid overcrowding. This is particularly vital as average attends appear to be on the increase.

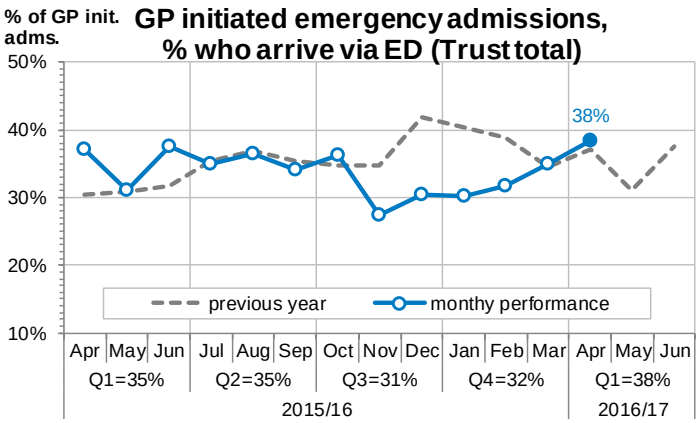
Chart 28 shows ED pressures continue throughout Greater Manchester.

Return to FRONT page

The next four pages show urgent care indicators (Chart 29 to Chart 41)

Urgent Care Key Performance Indicators

Chart 29



The following charts (29 to 34) are the high level KPIs to measure progress realized through the implementation of the Urgent care 90 day plan.

Chart 30

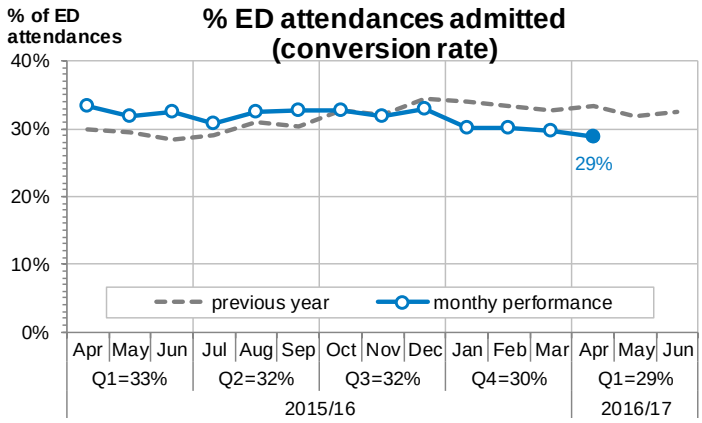


Chart 31

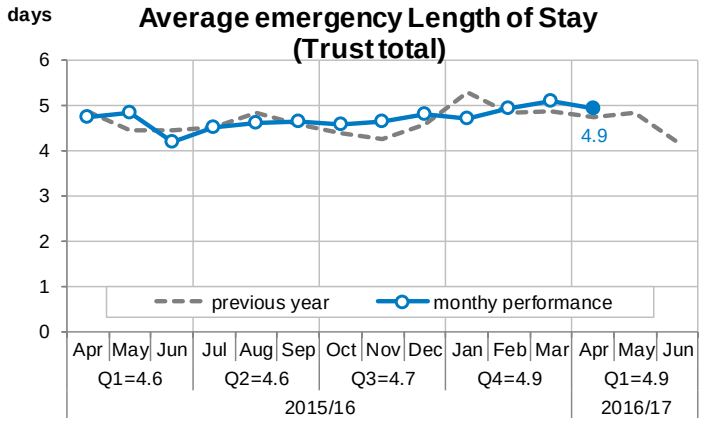


Chart 32

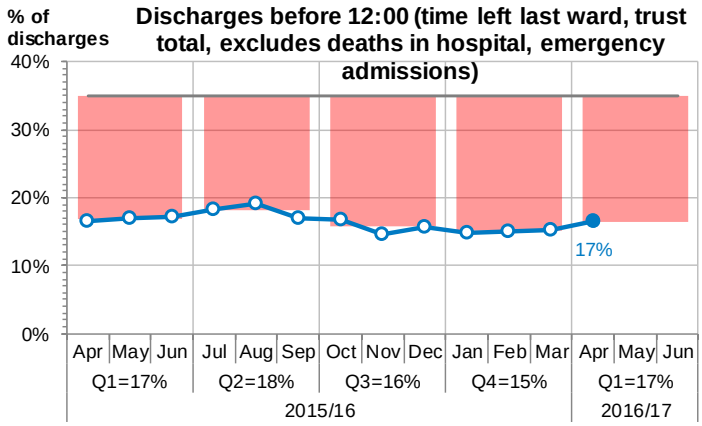


Chart 33

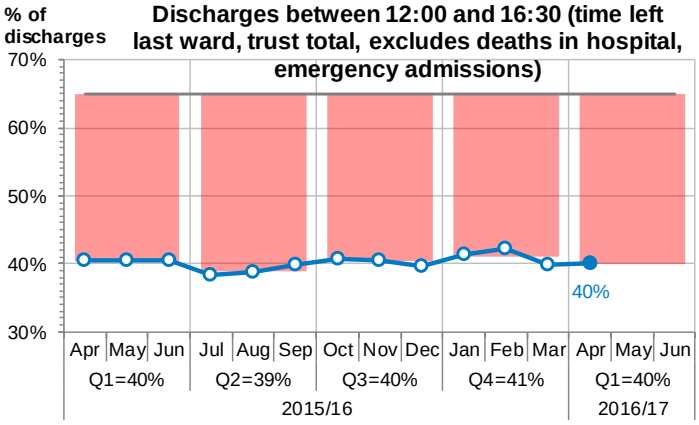
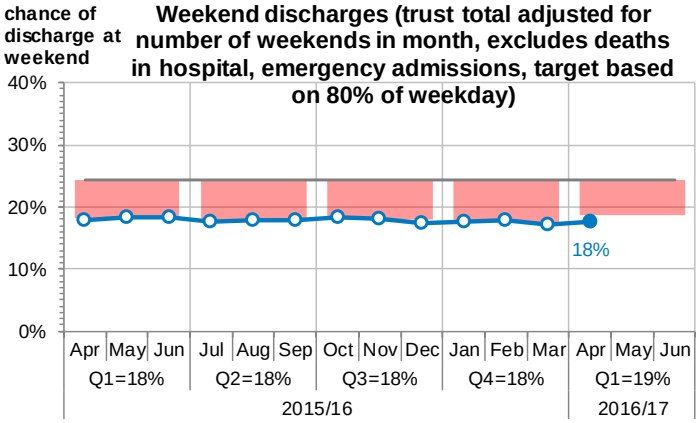


Chart 34



Return to FRONT page

Trust Urgent Care Key Performance Indicators

Chart 35

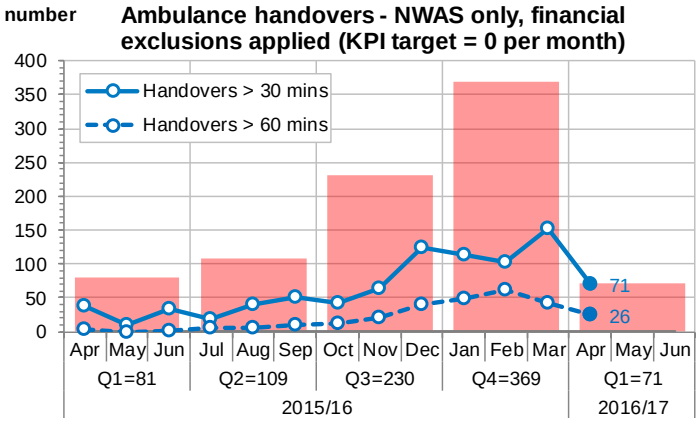


Chart 36

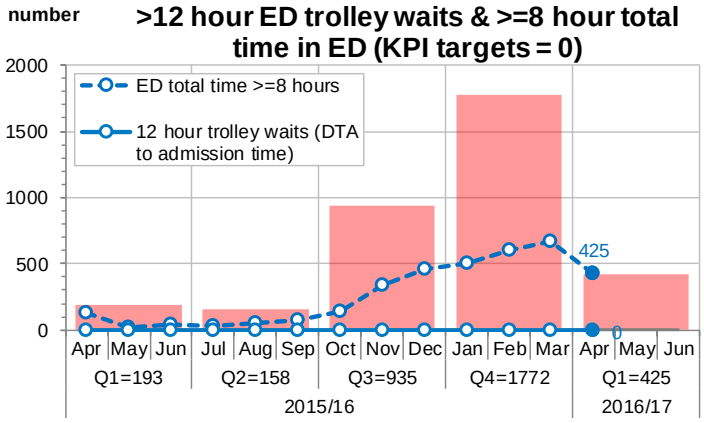


Chart 37

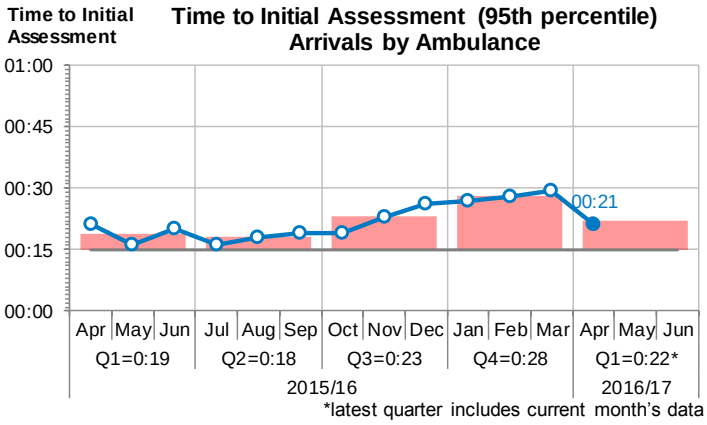


Chart 38

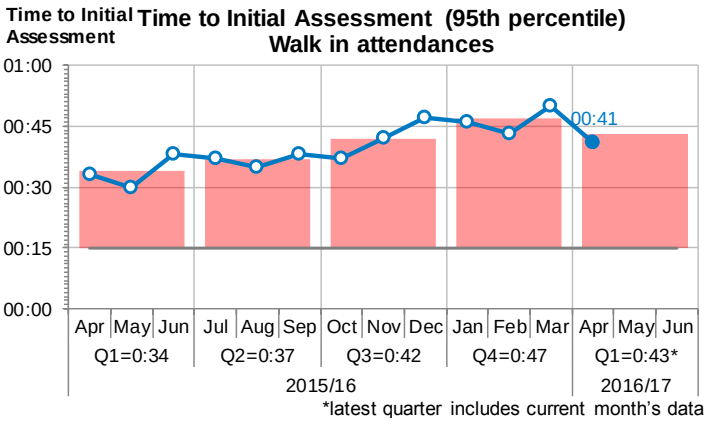


Chart 39

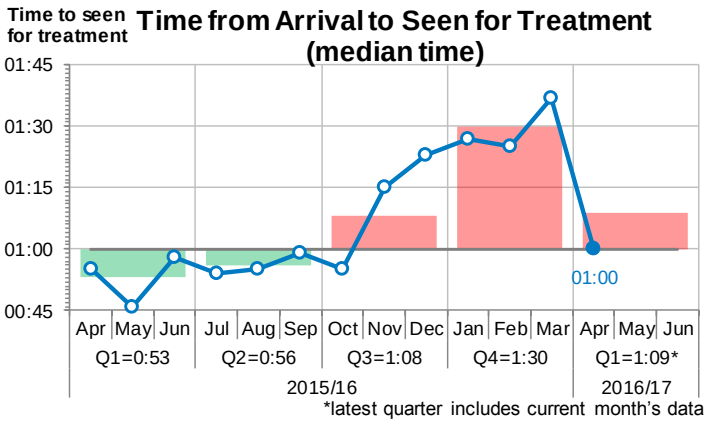


Chart 40

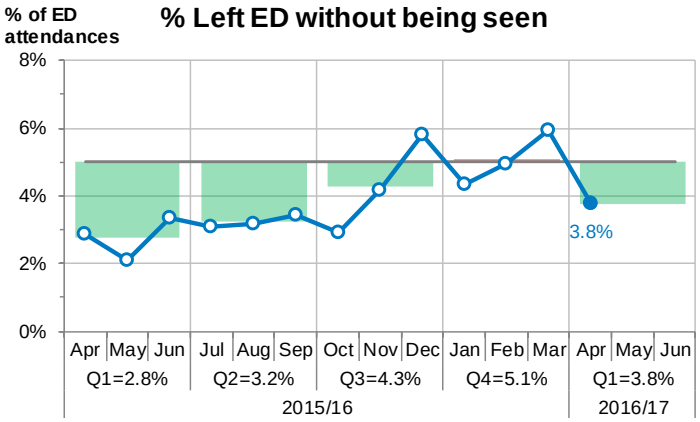
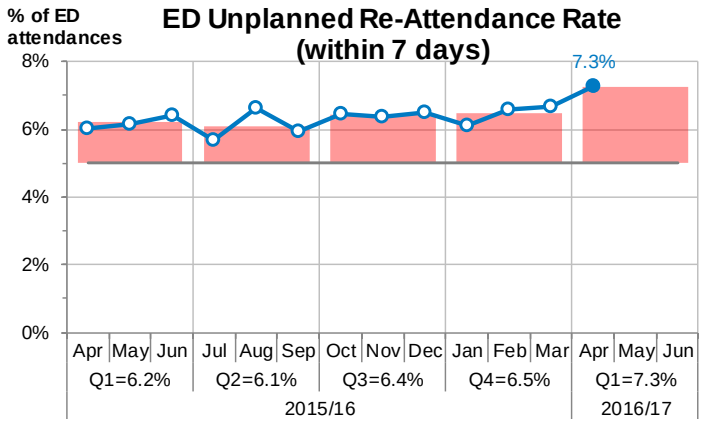


Chart 41



Return to FRONT page

Diagnostic tests (6 week wait) 16

Chart 42

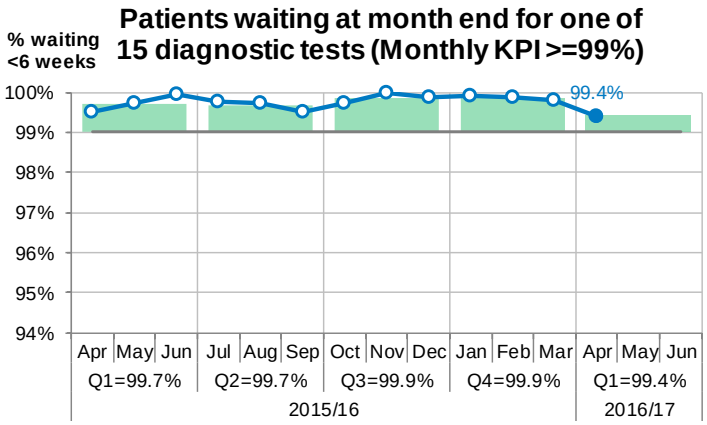


Chart 42 shows performance against the diagnostic standard. It is forecast that compliance with this standard will continue.

Return to FRONT page

Cancelled Operations 20

Chart 43

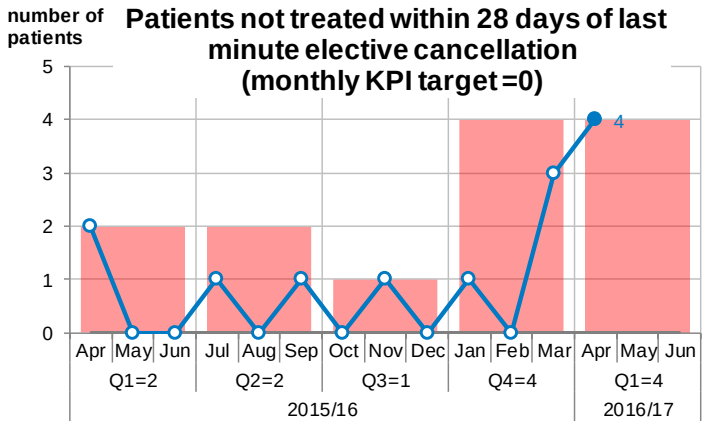


Chart 43 shows there were 4 breaches of standard in month.

April again saw a number of breaches against the 28 day standard, resulting from a sustained high number of last minute cancellations. Unavailability of HDU beds on the day of admission remains an issue, accounting for 3 of the breaches in April.

Chart 44

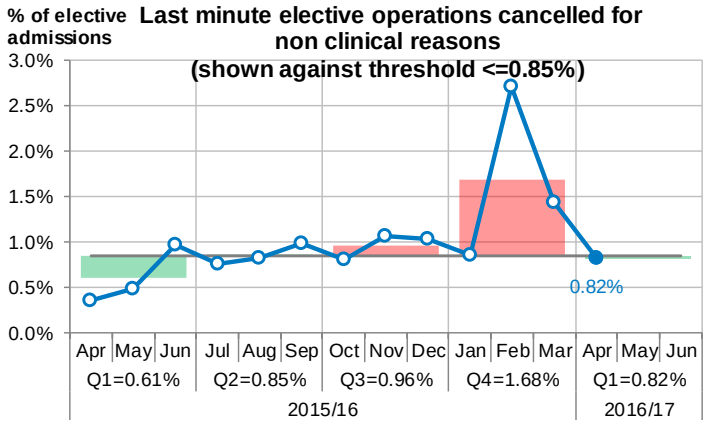


Chart 44 shows compliance against the standard for last minute cancelations in April.

There were a total of 26 cancellations on the day for non-clinical reasons, which is a much improved level compared to the previous 2 months.

The top reasons for cancellations were:

- 9 due to lack of theatre time
- 7 due to surgeon sickness

Return to FRONT page

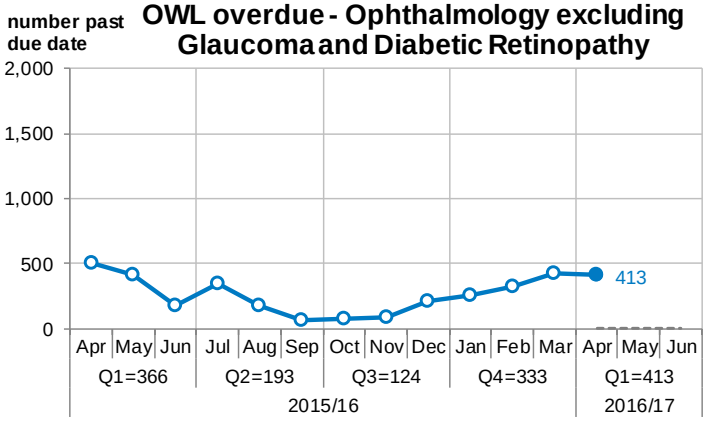
Outpatient Waiting List (OWL) 20

The Outpatient Waiting List (OWL) is where patients are placed when awaiting a future follow up appointment. When capacity and demand are mismatched, the numbers of patients who are overdue their follow up by a certain date will increase and delay these patients.

There are four specialties within the Trust where this is a current problem. This situation is being monitored by the Quality Assurance Committee (a sub-committee of the Board of Directors). This committee requested that the data should be shared with the Board through the Integrated Performance Report.

The Trust has been issued a First Exception Report based on performance against the original clearance trajectories and is now required to provide a refreshed plan for each of the four specialties in addition to completed Quality Impact Assessments to confirm patient care is not being compromised.

Chart 45 Ophthalmology OWLs past due date

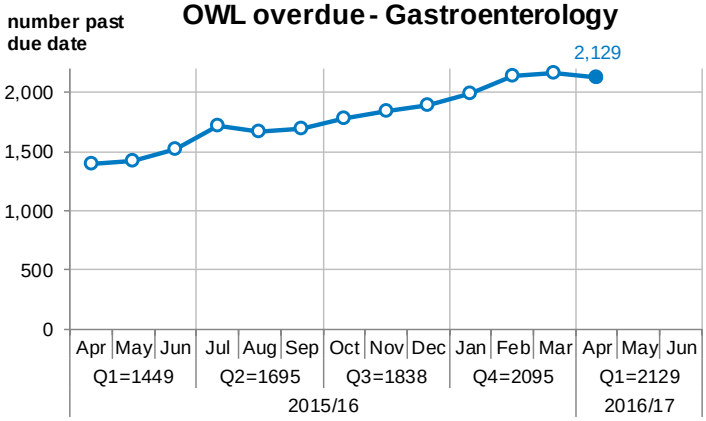


Ophthalmology

The clearance trajectory for Ophthalmology has been revised from April, with a plan to clear by November 2016. However, recovery is reliant on the locum Consultant retention whilst awaiting the established appointments to commence.

Confirmation is awaited that the paediatric element of the service will transfer to Central Manchester.

Chart 46 Gastroenterology OWLs past due date

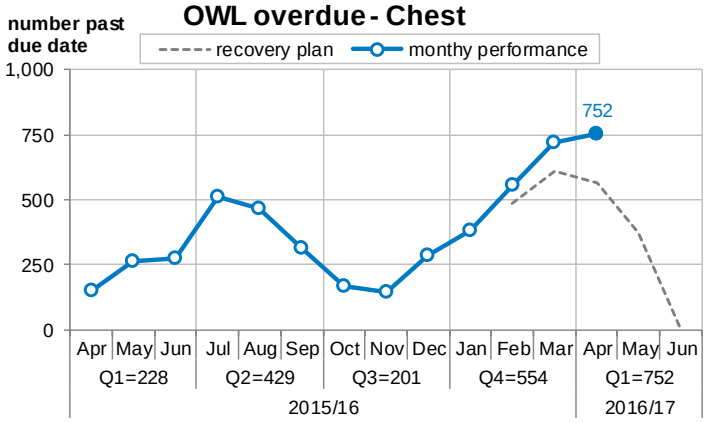


Gastroenterology

Chart 46 shows the number of Gastroenterology patients on the Outpatient waiting list beyond their due date.

Funding for an Interim Locum has been approved to continue to provide sufficient medical cover until the 6th substantive consultant begins in post in July 2016.

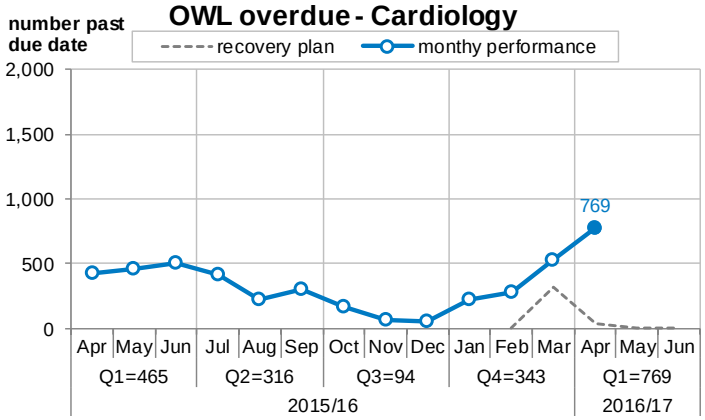
Chart 47 Respiratory Medicine OWLs past due date



Respiratory Medicine

The Service has recently lost capacity due to the redistribution of duties within the Medical team and reprioritisation of clinical responsibilities. Additional capacity is currently being provided via Agency locum, this will be reviewed on an ongoing basis.

Chart 48 Cardiology OWLs past due date



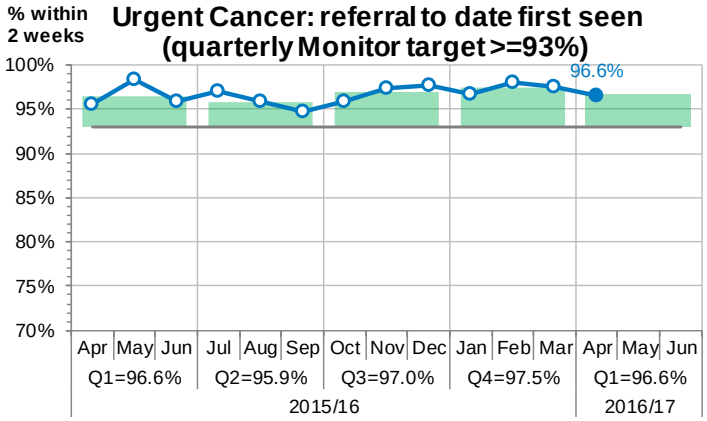
Cardiology

There have been unforeseen issues with Medical capacity which has resulted in adverse performance. Interviews are scheduled to provide Maternity cover and CVs have been requested to backfill lost capacity.

Return to FRONT page

Cancer waiting times M 16

Chart 49



Compliance with the urgent referral standard continues.

Chart 50

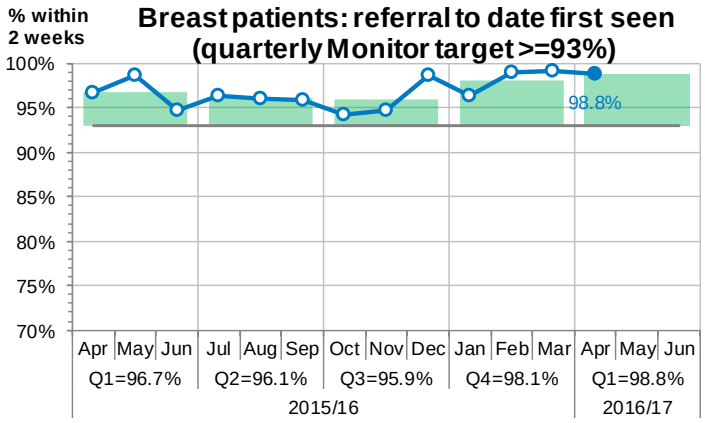


Chart 51

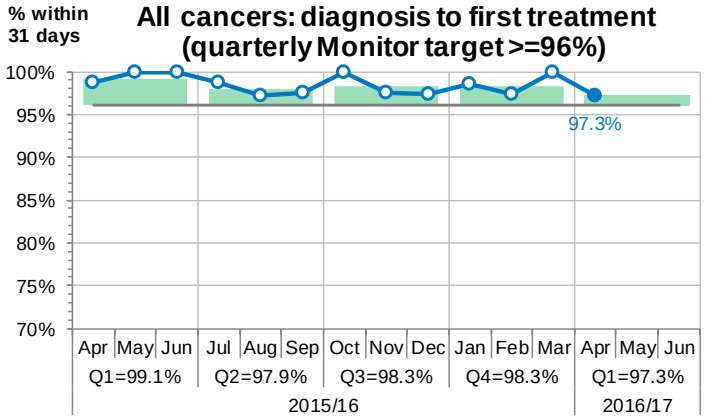


Chart 52

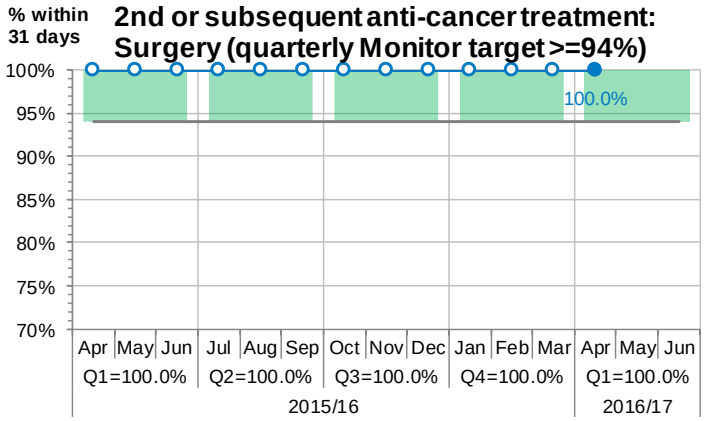


Chart 53

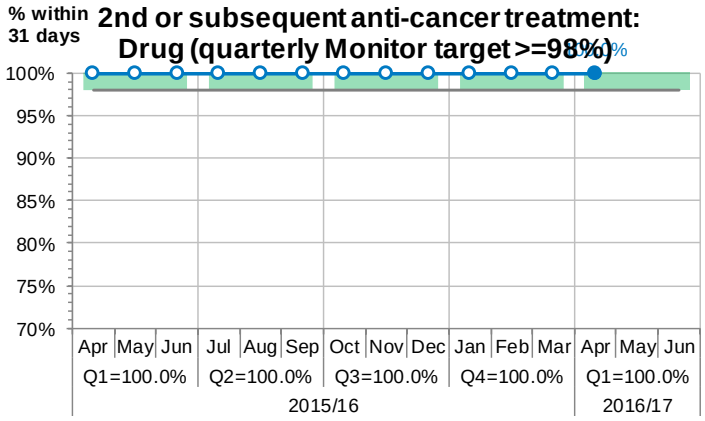


Chart 54

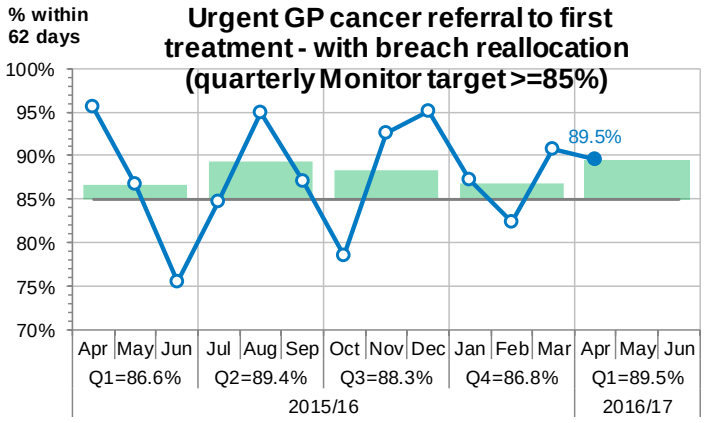


Chart 54 shows performance against the 62 day cancer standard.

Compliance for March and Q4 has now been confirmed following data upload.

Latest indications are that the standard will be achieved for April, provisional performance indicating performance of 89.5%

As reported last month, continued compliance with the standard remains challenged, in particular regarding HDU bed capacity. Additionally, there are a number of patients beyond day 62 of their pathway due to choosing to delay the diagnostic stage of their care.

Chart 55 GP referral to first treatment with breach reallocation, by tumour group.

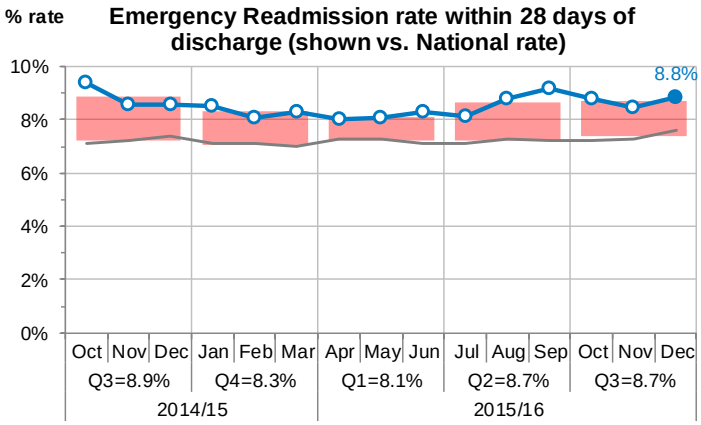
Chart 55 shows performance against the 62 day standard by tumour group.

Tumour Group (Apr-16 data)	Number of breaches / cases	Performance (85% target)	Monthly trend
Upper GI	2 / 4.5	56%	
Colorectal	1.5 / 7	79%	
Haematology	1 / 4.5	78%	
Head & Neck	1 / 3	67%	
Breast	0 / 16.5	100%	
Urology	0 / 13	100%	
Gynaecology	0 / 3.5	100%	
Lung	0 / 2	100%	

Return to FRONT page

Emergency Readmissions

Chart 56



Data source: CHKS / Health and Social Care Information Centre

Chart 56 shows the Emergency Readmission rate within 28 days of discharge.

Emergency readmissions forms one of the strategic staircase projects, and progress will be monitored at Senior Management Board.

Return to FRONT page

Financial Performance

Chart 57

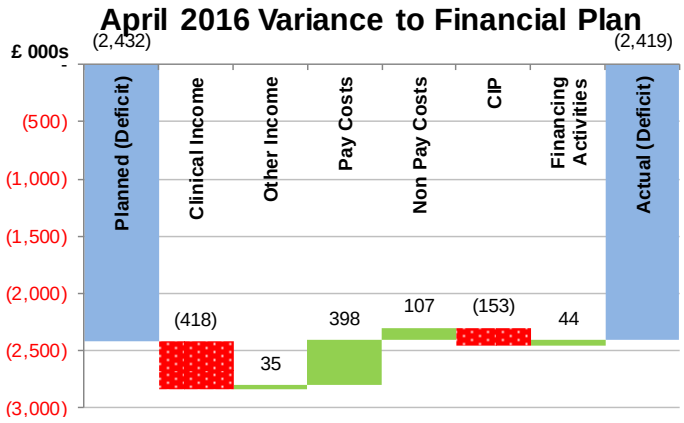


Chart 58 (same as Chart 57 for April)

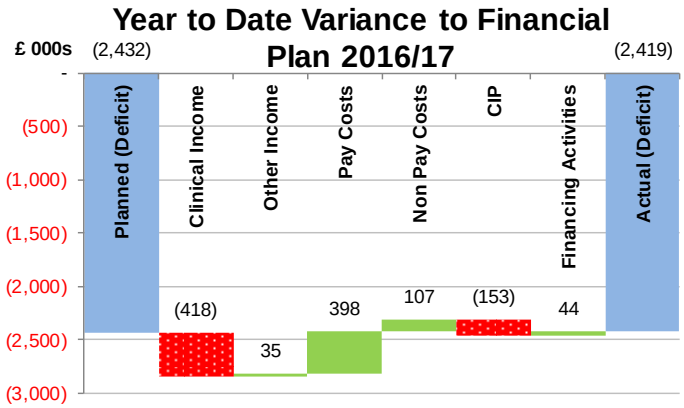
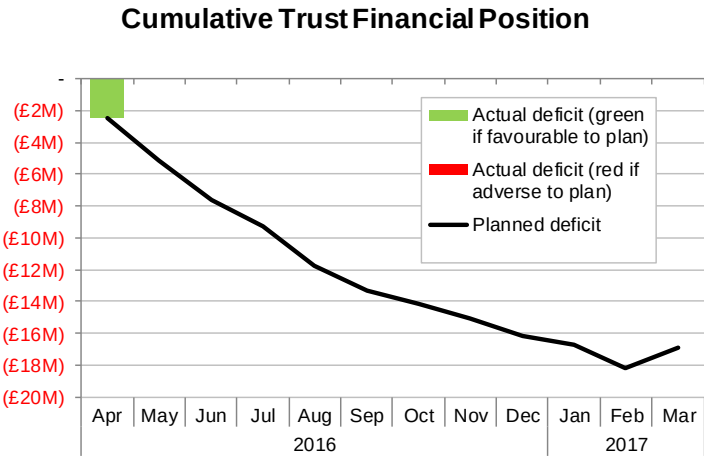


Chart 59



The Trust has a deficit of £2.4m at the end of April 2016 and this is in line with the financial plan. The Trust has a planned deficit of £16.9m for the financial year 2016/17 and this is after a cost improvement plan of £17.5m.

Clinical income in April is behind plan by £418k and the most significant variance within this is the impact of the two day planned junior doctors strike, which is estimated to be £160k in elective activity.

A block contract for non elective, out patients and accident & emergency attendances has been agreed with Stockport CCG for 2016/17. All elective activity is priced at national tariff. All other commissioners are on tariff for their contracts.

The actual priced activity position for April is not finalised until the end of the following month and therefore average prices are used. There is the possibility therefore that the income position reported may improve once the actual position is finalised as the new tariffs and contracting rules for 2016/17 are applied.

The impact of the strike on out patients is only therefore seen on income lost on patients from contracts other than Stockport CCG and the £15k below plan in April is likely to relate to this.

Expenditure budgets are £505k underspent before CIP variances and this is predominantly on pay costs. The business groups have continued to underspend by holding vacancies on a non-recurrent basis, as a continuaton of the non-recurrent CIP theme from 2015/16 and focus needs to be made by the business groups in removing these costs on a permanent basis.

Return to FRONT page

Capital Programme

Chart 60

Description	Plan 2016/17 Year £'000	Month 1 April 2016/17 Plan £'000	Actual £'000	Variance £'000
Surgical Centre - Building	3,740	880	634	246
Surgical Centre - Furniture & Fittings	600	0	0	0
Surgical Centre - Medical Equipment (partly donated)	660	0	0	0
Medical Ward Refurbishments	250	0	0	0
Electronic Patient Records - Purchased Software	598	0	0	0
Electronic Patient Records - Estates Enabling scheme b/f	55	0	0	0
Facilities Equipment b/f	60	0	0	0
Medical Equipment b/f	52	0	0	0
Aspen House Server Room b/f	0	0	0	0
	6,015	880	634	246
Medical Equipment	1,290	0	38	-38
Facilities Equipment	75	0	0	0
IT Hardware	503	106	2	104
IT Software	297	43	0	43
Estates -Backlog Maintenance	125	0	4	-4
Estates - Non Backlog Maintenance	710	0		0
	3,000	148	43	105
	9,015	1,028	677	351
Revenue to Capital	0	0	0	0
Capital to Revenue	0	0	0	0
TOTAL (excluding Finance leases)	**9,015**	**1,028**	**677**	**351**
New Finance Lease Contracts				
I M & T - Intersystems EPR Software	1,006	0	0	0
I M & T - EMIS Community EPR Software	0	0	0	0
	1,006	0	0	0
TOTAL including new Finance Lease Contracts	10,021	1,028	677	351

The Trust's capital programme for 2016/17 is £10.021m. At the end of April 2016 the plan was for £1,028k and actual expenditure was £677k which is £351k below profiled plan.

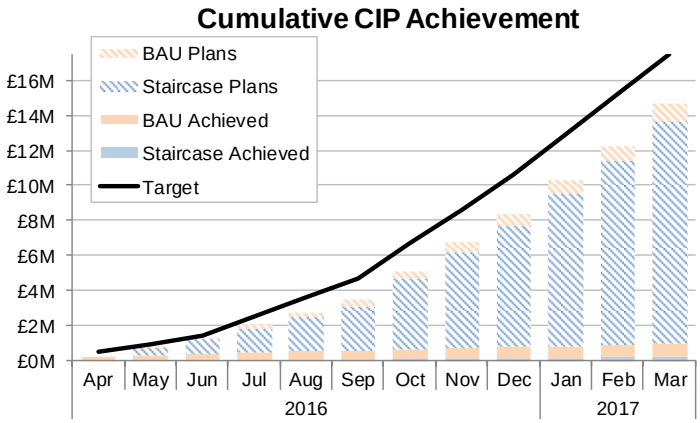
The D block build was reported as being 1.3 weeks behind at the end of April 2016 but an action plan has been agreed with the contractor to bring this back into line. Therefore the cost profile is expected to catch up over the next two months.

Both EPR projects are underway although the profiling of expenditure for this is considered under finance leases as shown in the bottom section of table.

Return to FRONT page

Cost Improvement Programme

Chart 61



The Cost Improvement Programme for 2016/17 is split into Staircase plans of £13m and Business as Usual (BAU) schemes of £4.5m. Each scheme has an individual profile which cumulatively is represented in Chart 61 and shows how the schemes are predominantly weighted to the second half of the year.

In April the Staircase schemes were expected to deliver £461k and only delivered £85k, a shortfall of £376k. The BAU schemes were not expected to deliver any savings until Month 3 but have deliverd £223k in month. The total adverse variance to plan is £153k.

The savings delivered by BAU schemes are predominantly non-recurrent pay savings and focus needs to remain on delivering recurrent pay savings.

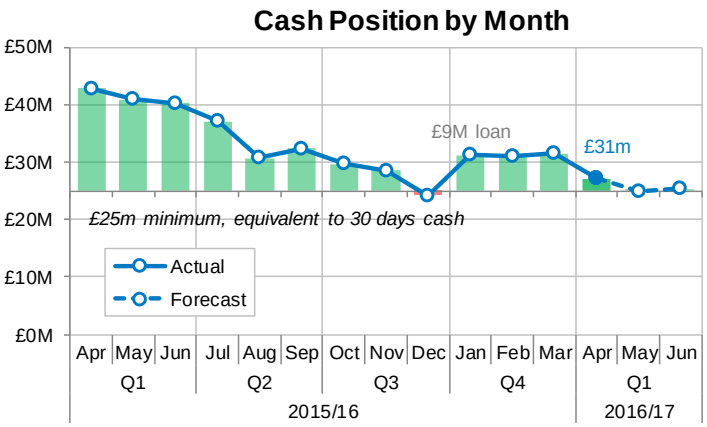
Return to FRONT page

Financial Sustainability Risk Rating

Chart 62

		Forecast rating	Initiate Override?	Excellent 4	3	2	Poor 1	Weight	Weighted score
Balance Sheet Sustainability	Capital service capacity (times)	1	Yes	2.50	1.75	1.25	< 1.25	25%	0
Liquidity	Liquidity (days)	4	No	0	-7	-14	< -14	25%	1
Underlying Performance	I&E margin (%)	1	Yes	1.00%	0.00%	-1.00%	<-1.0%	25%	0
Variance from Plan	Variance in I&E margin as a % of income (%)	3	No	0.00%	-1.00%	-2.00%	<-2.0%	25%	1
Financial Sustainability & Performance Risk Rating - Calculated									**3**
OVERRIDE INITIATED?			Yes						Yes
Financial Sustainability & Performance Risk Rating - Final Reportable									**2**

Chart 63



The Trust's overall Financial Sustainability Risk Rating (FSR) is 2, classified by Monitor as a material risk. This is in line with the operational plan for 2016/17.

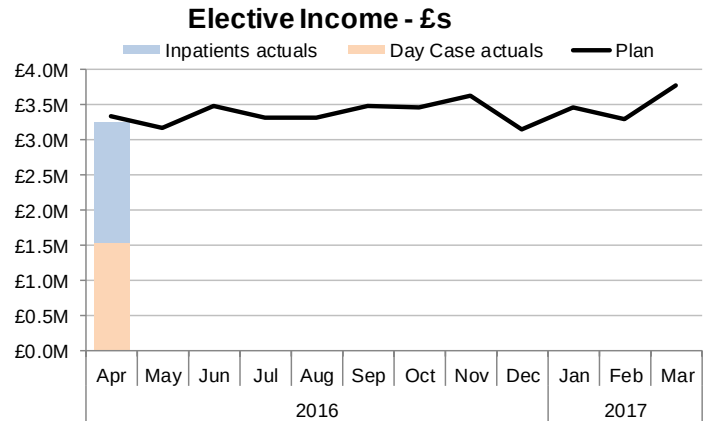
Cash in the bank at the 30th April 2016 was £27.1m against an operational plan of £28.5m and therefore there is a negative variance of £1.4m in April. This can be explained by at VAT refund of £700k which was not received until the first week in May and a debtor of £600k from Tameside Foundation Trust which remains unpaid.

The year- end cash forecast position remains at c.£10m.

Return to FRONT page

Elective Income vs. Plan

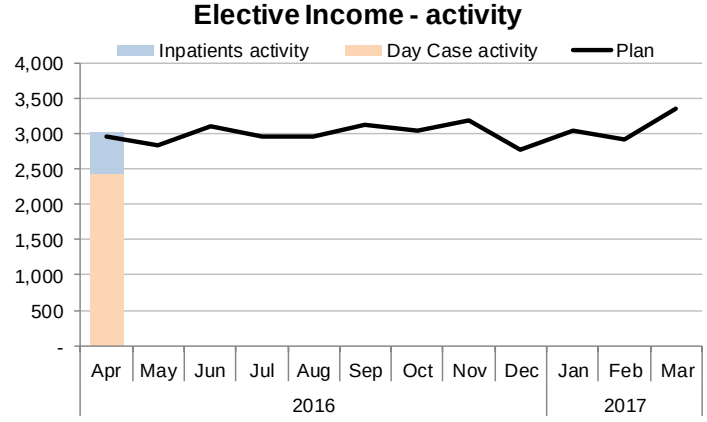
Chart 64



Elective income is behind plan by £147k in April 2016. However this is forecast activity based on average expected price and therefore this is a prudent position at this stage. The actual casemix of patients will be priced for the Month 2 finanical position.

The two day planned junior doctor strike is estimated to have lost £160k in elective income in April and therefore is the main reason for performance below plan in April.

Chart 65

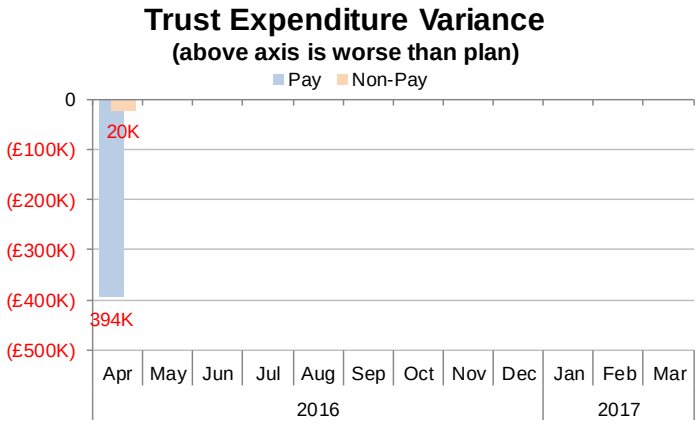


Depite the loss of 18 day cases and 67 in patients due to the two day junior doctors strike, the actual activity is in line with plan for April 2016.

Return to FRONT page

Expenditure Variance

Chart 66



The Trust is underspent on expenditure budgets in April 2016 by £414k; £394k on pay budgets and £20k on non pay budgets . This includes the shortfall of CIP of £90k in month.

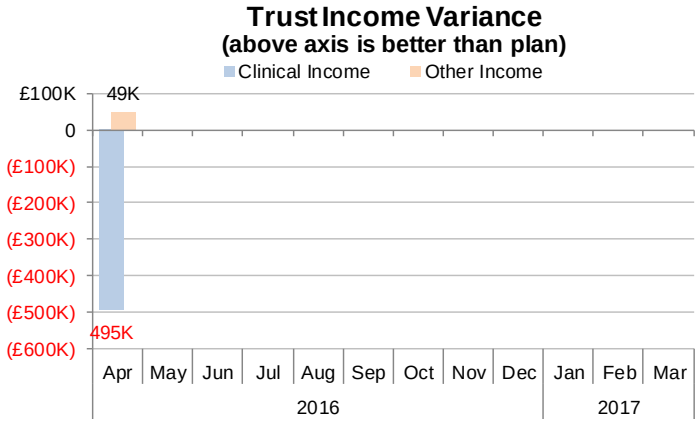
The Trust continues to have a level of vacancies which are contributing to non-recurrent cip and the focus remains on removing costs on a recurrent basis to deliver CIP savings.

There is a variation across business groups and there remains a high number of premium rate medical staff within the Medicine business group covering a number of different specialties. There is an action plan in place for each of these with focus on international recruitment.

Return to FRONT page

Income Variance

Chart 67



Income is below plan by £446k in April 2016; Clinical income is below plan by £495k and offset by other income above plan by £49k. This includes the shortfall on CIP of £63k in month.

Return to FRONT page

See also Financial Income and Expenditure table

Workforce Appraisals

Chart 68

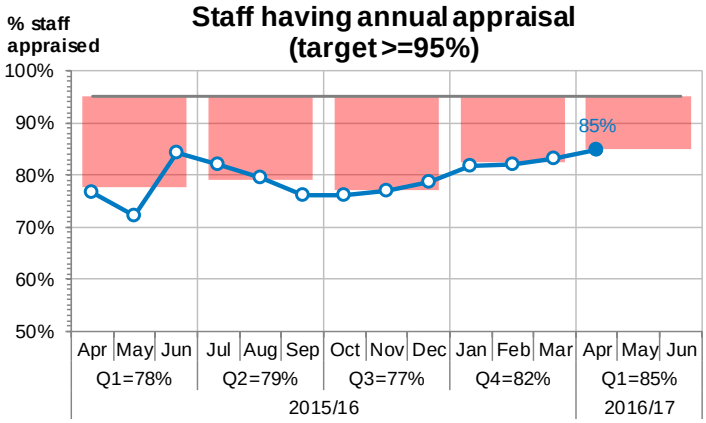
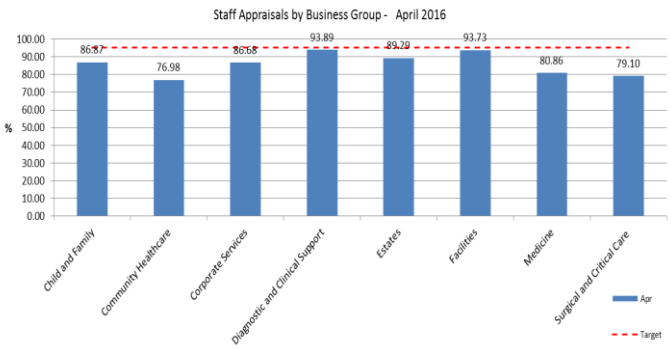


Chart 69



The Trust's total appraisal compliance for April 2016 is 84.89%, an increase of 2.9% since March 2016 (81.99%).

This figure takes account of the 15-month appraisal window introduced by the new performance appraisal framework for non-medical staff.

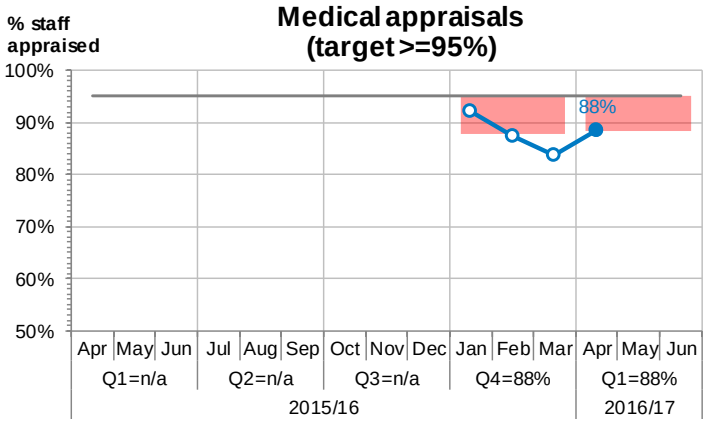
The following Business Groups have seen increases this month; Diagnostic & Clinical Support from 91.54% to 93.89%, and Facilities from 90.75% to 93.73%, Child & Family from 84.87% to 86.87%, Corporate Services from 81.12% to 86.68%, Estates from 87.72% to 89.29%, Medicine from 77.39% to 80.86%, and Surgical & Critical Care from 75.08% to 79.10%.

The following Business Group saw a drop in compliance from last month; Community Healthcare from 79.85% to 76.98%.

There has been a change to the way the appraisal percentage is calculated. Those members of staff who are on maternity leave, external secondments, or career breaks are no longer included in the figures.

Individuals who do not have an update to date appraisal will not be approved to attend external training. The Head of OD and Learning has met with individual Business Group Directors to offer support, advice and assistance; in addition to attending team meetings.

Chart 70



The medical appraisal rate for April 2016 is 88.41%, an increase of 11.19% from March 2016 (77.22%).

The compliance rates and the importance of the completion of Appraisals continue to be presented at the Trust's monthly Team Briefing sessions.

Return to FRONT page

Workforce Turnover

Chart 71

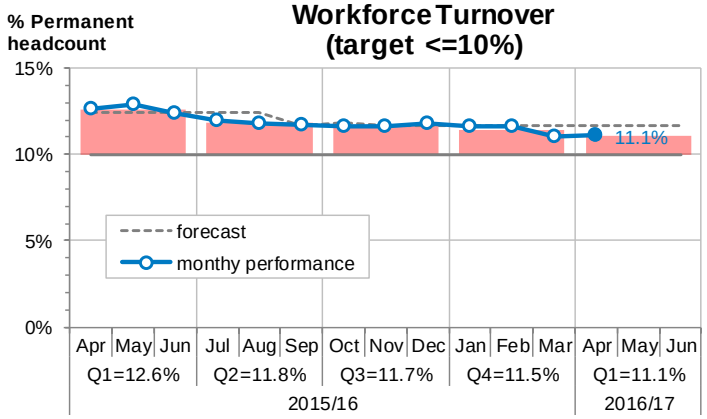
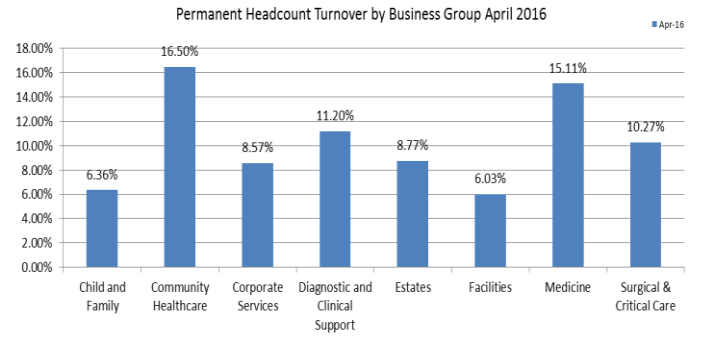


Chart 72



The Trust's permanent headcount turnover figure for the 12 months ending April 2016 is 11.09%. This is an increase of 0.01% compared to the March 2016 figure of 11.08%, showing some stability in the turnover activity. (This does not include the TUPE transfer staff which increase the April 2014 turnover figure to 25.24%). The turnover rate for comparison to April 2015 was 12.61%.

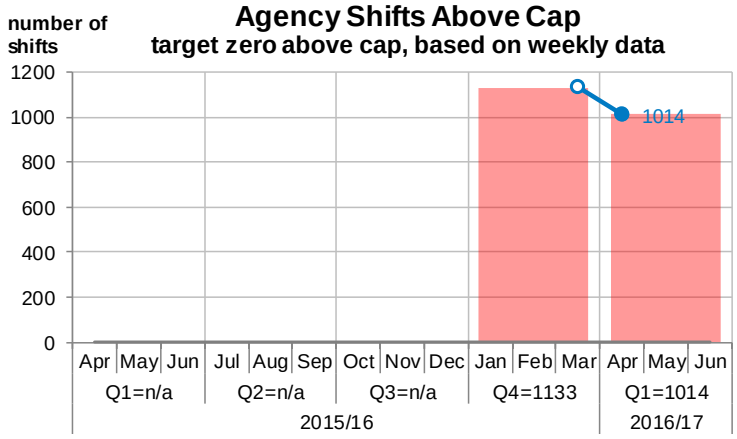
Facilities have the lowest turnover at 6.03%, followed by Child & Family at 6.36% in April 2016. Community Healthcare has the highest turnover rate at 16.50% and Medicine Business Group remains high at 15.11% in April 2016. .

Estates Business Group has seen the biggest decrease of 3.73% down to 8.77% in April 2016 from 12.50% in March 2016.

Return to FRONT page

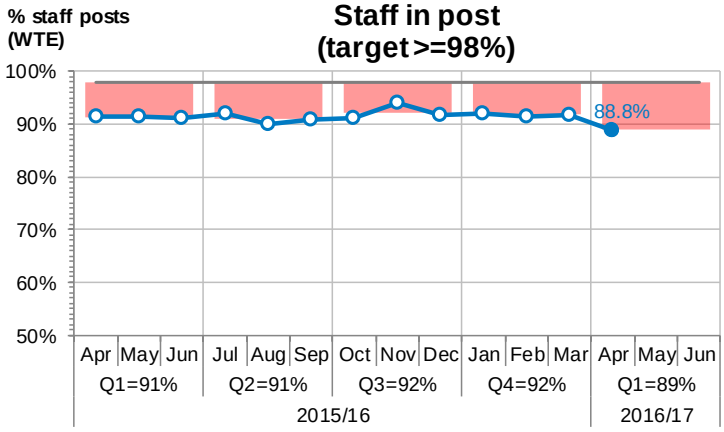
Workforce Efficiency

Chart 73



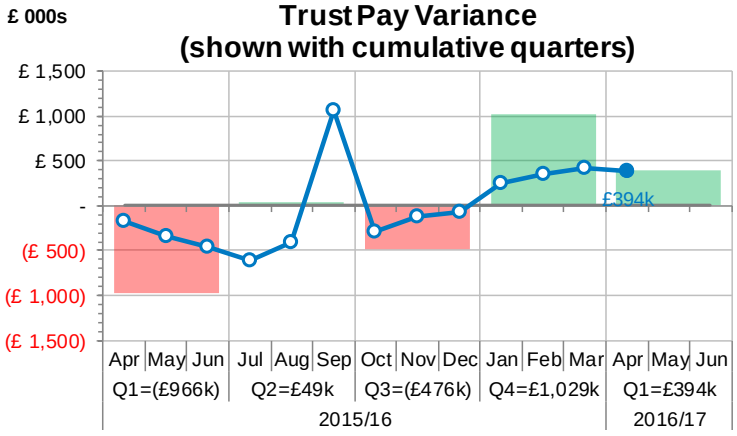
April 2016 shows a decrease in the number of shifts which are taking place above the agency cap. Work has commenced in line with the IDP Agency Cap programme to address the level of cap breaches and work to model the impact is underway. The biggest area of cap breaches are within medical staff and the Medicine Business Group. The Deputy Director of Workforce is meeting with the Business Group Director to look to support a reduction in this position.

Chart 74



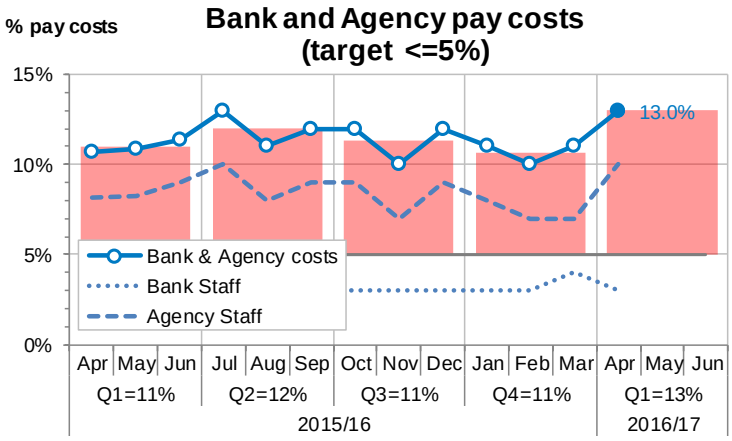
The Trust staff in post for April 2016 is 88.8% of the establishment, which is a decrease of 3.1% from 91.9% in March 2016.

Chart 75



The Trust pay variance, expenditure above the financial envelope of establishment, including vacancies in April 2016 showed a £394,198 underspend, a decrease of £32,564 from the £426,762 underspend reported in March 2015.

Chart 76



The percentage of pay costs spent on bank and agency in April 2016 is 10% (a decrease of 1% from March's position) which equates to £1,714,000 a decrease of £305,826 from £2,019,826 in March 2016.

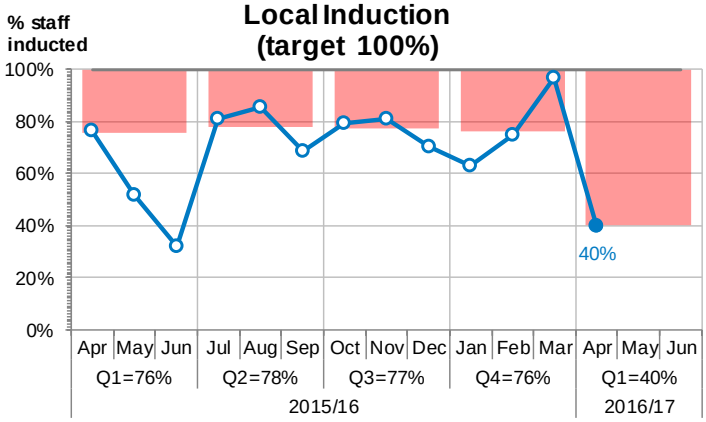
The Medicine Business Group has the highest spend on bank/agency at £1,082,000 in April 2016 which equates to 62.4% of the overall spend.

In April 2016 3% of total pay costs were attributed to bank staff, a 1% reduction from March 2016, and 7% of total pay costs were attributed to agency staff. The use of bank and agency staff is closely monitored at Business Group Finance and Performance meetings and the Establishment Control Panel.

Return to FRONT page

Workforce Induction

Chart 77



Corporate Welcome attendance remains consistently at 100%. There has been a significant drop in completion of the Local Induction. The Head of OD and Learning will contact those Business Groups whose compliance falls below 95% to understand the reasons why and to offer support and guidance.

Return to FRONT page

Staff Engagement

To be developed

Return to FRONT page

Sickness Absence

Chart 78

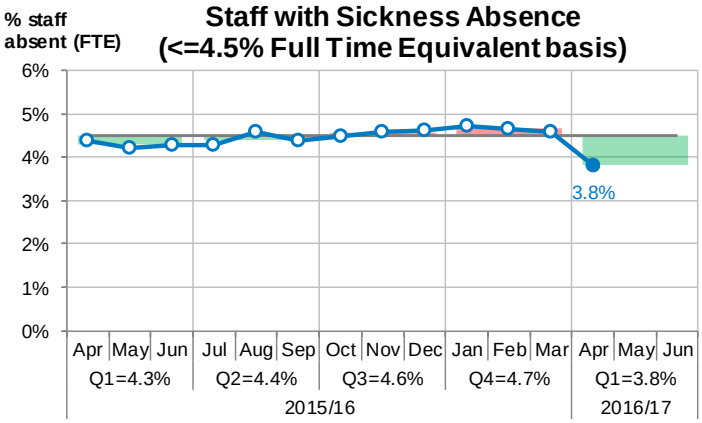
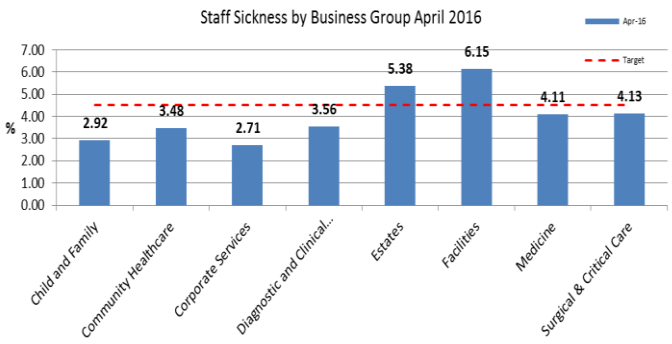


Chart 79



The in-month unadjusted sickness absence figure for April 2016 is 3.82%. This is a decrease of 0.75% compared to the March 2016 adjusted figure of 4.57%. The sickness rate for comparison in April 2015 was 4.40%.

The unadjusted cost of sickness absence in April 2016 is £388,831, a decrease of £173,391 from the adjusted figure of £562,222 in March 2016. This does not include the cost to cover the sickness absence.

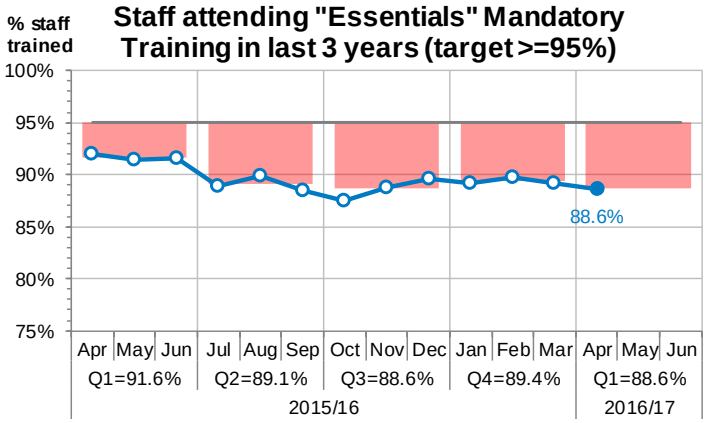
All Business Groups have reported a reduction in sickness absence in April 2016. Only Estates and Facilities are above the revised 4.5% target in April 2016. Estates have a recorded sickness rate of 5.38% and Facilities have a recorded sickness rate of 6.15% in April 2016. Estates Business Group has seen the biggest decrease from 8.25% in March 2016, followed by Child & Family with a decrease of 1.19% from 4.11% in March 2016.

The top 3 known reasons for sickness in April 2016 are back problems and other musculoskeletal problems including injury/fracture at 24.71% (a 3.41% increase from 21.30% in March 2016), stress at 23.82% (a 4.37% decrease from 28.19% in February 2016), and cough, cold, flu, chest, respiratory problems at 7.75% (a 1.16% decrease from 8.91% in March 2016).

Return to FRONT page

Essentials Training

Chart 80



In April 2016 there was a decrease of 0.6% in compliance from the March position, from 89.2% to 88.6%.

Only one of the Business Groups achieved compliance, Estates.

Diagnostics and Clinical Support achieved 93.57%, Child & Family 90.87% and Community 93.18%. The remaining Business Groups are under 90%. The Head of OD and Learning has contacted those Business Groups who are under 90% to ascertain the plans they have in place to achieve 95% compliance.

- External training will only be approved if a member of staff is fully compliant with their Essentials Training and has an up to date appraisal.

- Monthly emails reminders are sent to all staff that are non-compliant.

- Improved use of the Core Skills Framework e-learning packages. Supported by Health Education North West the Core Skills e-learning modules are easier to access and quicker to complete. The framework can be adapted for all Trust staff to use in place of the existing e-learning catalogue of topics and covers a wider range of topics.

Return to FRONT page

Integrated Performance Report
April 2016 Financial Table

Stockport NHS Foundation Trust

Income and Expenditure Statement

	Trust Annual Plan	Year-to-date		
		Plan	Actual	Variance
	£k	£k	£k	£k
INCOME				
Elective	41,668	3,384	3,238	(147)
Non Elective	74,730	6,236	6,092	(143)
Outpatient	34,366	2,800	2,785	(15)
A&E	12,038	981	992	12
Total Income at Full Tariff	**162,801**	**13,400**	**13,107**	**(293)**
Community Services	31,834	2,715	2,703	(12)
Non-tariff income	52,630	4,364	4,285	(79)
Clinical Income - NHS	**247,265**	**20,479**	**20,095**	**(384)**
Private Patients	698	58	22	(36)
Other	959	80	5	(75)
Non NHS Clinical Income	**1,656**	**138**	**27**	**(111)**
Research & Development	454	35	31	(4)
Education and Training	7,117	598	613	15
Stockport Pharmaceuticals/RQC	5,956	483	431	(52)
Other income	14,196	1,461	1,551	90
Other Income	**27,723**	**2,577**	**2,626**	**49**
TOTAL INCOME	**276,644**	**23,193**	**22,747**	**(446)**
EXPENDITURE				
Pay Costs	(207,545)	(17,806)	(17,412)	394
Drugs	(15,858)	(1,648)	(1,621)	26
Clinical Supplies & services	(19,067)	(1,700)	(1,710)	(10)
Other Non Pay Costs	(36,621)	(3,245)	(3,241)	4
TOTAL COSTS	**(279,091)**	**(24,398)**	**(23,984)**	**415**
EBITDA	**(2,447)**	**(1,205)**	**(1,236)**	**(31)**
Depreciation	(9,094)	(737)	(715)	21
Interest Receivable	63	5	7	2
Interest Payable	(936)	(79)	(76)	3
Other Non-Operating Expenses	(706)	(59)	(34)	25
Fixed Asset Impairment Reversal	-	-	-	-
Unwinding of Discount	(30)	-	-	-
Profit/(Loss) on disposal of fixed ass	-	-	(7)	(7)
Donations of cash for PPE	540	-	-	-
PDC Dividend	(4,291)	(357)	(357)	(0)
RETAINED SURPLUS / (DEFICIT) FOR PERIOD	**(16,900)**	**(2,432)**	**(2,419)**	**13**

Report to:	Trust Board	**Date:**	26 May 2016
Subject:	Corporate Objectives: 2016/17		
Report of:	Deputy Chief Executive	**Prepared by:**	Donna Lynch, Director of Strategy and Planning

REPORT FOR APPROVAL

Corporate objective ref:	Master
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.

To provide the Trust Board with corporate objectives for 2016/17 for discussion and approval.

These in-year objectives have been aligned to the strategic objectives (S01-S06) and referenced to the BAF which was agreed by the Trust Board in March 2016.

The attached summary is intended to identify operational and tactical key deliverables against each of the strategic objectives in 2016/17, which when delivered, will demonstrate progress towards the strategic objectives.

These deliverables have been in the main sourced from the Final Operational Plan 2016/17 submitted to NHS Improvement (Monitor) on 11 April 2016.

Appendix A provides the full list of the strategic objectives and corporate objectives for 2016/17.

Recommendations:

- Discuss and agree the proposed in-year deliverables against the strategic objectives.

Attachments: Appendix A

This subject has previously been reported to:	☐ Board of Directors ☐ Council of Governors ☐ Audit Committee ☒ Executive Team ☐ Quality Assurance Committee ☐ FSI Committee	☐ Workforce & OD Committee ☐ BaSF 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 discuss and agree the corporate objectives for 2016/17.

2. BACKGROUND

2.1 The key strategic objectives have been identified and aligned to the strategic risks as outline in the Board Assurance Framework (BAF) dated 31 March 2016 which was approved by the May Board.

2.2 The attached appendix builds on these strategic objectives and attempts to identify the in-year operational and tactical key deliverables that demonstrate progress towards the achievement of the Trusts Strategy. These deliverables have been extracted in the main from the *Final Operational Plan- 2016/17* submitted to NHS Improvement (Monitor) in April 2016.

3. CONSIDERATION AND APPROVAL – COPRORATE OBJECTIVES

3.1 Attached in Appendix A is a schedule which sets out the strategic objectives (S01-S06) allocated to executive directors.

3.2 Aligned to each of the strategic objectives are the suggested associated operational and tactical deliverables (corporate objectives) for 2016/17. The number in 2016/17 is intentionally fewer than 2015/16 so as to be broad enough so as to facilitate Business Group alignment of objectives and achieve a 'golden thread' approach from Board to ward / staff objectives.

3.3 In order to monitor progress against these corporate objectives they will be incorporated into the Trust Integrated Delivery Plan (IDP); where relevant business stream objectives will aligned to these corporate objectives to demonstrate a golden thread approach to objective setting for 2016/17.

4. LEGAL IMPLICATIONS

4.1 There are no legal implications arising out of the subject matter of this report.

5. RECOMMENDATIONS

5.1 The Trust Board is recommended to:

- Agree a final set of corporate objectives to be incorporated into the Integrated Delivery Plan (IDP) for 2016/17.

Stockport NHS
NHS Foundation Trust

Annexe A
17 May 2016 - Executive Team
Strategy, Vision, Strategic and Corporate Objectives 2016/17
1 April 2016 to 31 March 2017

In 2016 our strategy is to deliver the efficiency phase of our 5 year strategy whilst commencing work on next years transformation stage.

The strategic objectives S01- S07 are supported by key corporate objectives which demonstrate key deliverables in 2016/17 towards the strategy.

Key for progress: **On track** / **Off track**

Ref	In order to achieve our strategy our strategic objectives and corporate objectives for 2016/17 are;	BAF Source	Strategic / Tactical / Operational	Executive Director accountable	Measure of success monitored via:	Assurance obtained from subcommittee:	Milestone Deadline occurs in:	Progress Q1	Q2	Q3	Q4
S1	**To achieve best outcomes for patients through full and effective participation in local strategic change programmes including; Stockport Together, Healthier Together & Greater Manchester Devolution.**	**S02**	**S**	**Chief Executive**							
C1	During 2016/17 the Trust will be an active member of Greater Devolution Manchester programme, ensuring continued alignment with the Trust strategy and operational plans taking into account Trust sustainability, staff welfare and patient experience.	S02	T	Chief Executive		SDC	**Q4**				
C2	During 2016/17 we will work with partners in the Stockport Together programme to collectively establish the MCP; identifying and delivering the objectives of the Provider Board.	S02	T	Deputy Chief Executive	MCP provider	SDC	**Q4**				
C3	During 2016/17 the Trust will continue to progress the implementation of the Healthier Together Programme in line with the Greater Manchester defined timescales.	S02	T	Chief Executive / Deputy Chief Executive	Healthier Together Board	SDC	**Monthly**				
S2	**To secure full compliance with requirements of the NHS Provider Licence through fit for purpose governance arrangements. (non-financial)**	**S03**	**S**	**Chief Operating Officer**							
C4	During 2016/17 the Trust will implement seven day working across defined services in line with national and local guidance, in order to reduce weekend mortality rates.	S03	O	Director of Operations	Performance Report	QAC	**Q4**				
C5	By Q2 the Trust will comply with 18 week RTT standards in order to improve access to care.	S03	O	Chief Operating Officer	Performance Report	QAC	**Q2**				
C6	The Trust will comply with its trajectory for improvement against the 4hr A&E target.	S03	O	Chief Operating Officer	Performance Report	QAC	**Monthly**				
S3	**To achieve, and maintain, a minimum 'Good' rating under the Care Quality Commission inspection regime.**	**S04**	**S**	**Director of Nursing & Midwifery**							
C7	We will achieve the 2016/17 objectives of the Trust Quality Strategy delivery plan, which cover areas of patient safety, clinical effectiveness and patient experience.	S04	O	Director of Nursing & Midwifery / Medical Director		QAC	**Monthly**				
C8	Following the publication of the Trust CQC report the Trust will develop an action plan with key delivery dates.	S04	O	Director of Nursing & Midwifery		QAC	**Monthly**				
S4	**Whilst maintaining our standards of patient experience and clinical quality we will achieve financial sustainability in order to achieve the Trust strategy**	**S05**	**S**	**Director of Finance**							
C9	We will enhance our financial performance management framework in order to foster a culture to achieve financial balance.	S05	O	Director of Finance	Performance Report	F&I Committee	**Monthly**				
C10	In 2016/17 we will identify and deliver CIP savings for the Trust to reduce the deficit without adverse impact on patient experience and clinical quality.	S05	O	Director of FIP / Director of Finance	Action Plan	F&I Committee	**Q2**				
C11	During 2016/17 we will embrace the Financial Improvement Programme to ensure that the Trust optimises the benefits from participation in the programme.	S05	T	Chief Executive	Action Plan	F&I Committee	**Monthly**				
C12	By the end of 2016/17 we will consider develop and implement the recommendations outlined in the Carter report.	S01	O	Deputy Chief Executive	IDP	SDC	**Q1**				
S5	**To develop and maintain an engaged workforce with the right skills, motivation and leadership to deliver our strategy**	**S06**	**S**	**Director of Workforce & Organisational Development**							
C13	We will achieve annual KPI's for sickness absence, appraisals and mandatory / essentials training to enhance the performance management resilience of the workforce.	S06	O	Director of Workforce & Organisational Development	Report to WOD	Workforce & Organisational Development	**Quarterly**				
C14	During 2016/17 we will develop and implement an engagement plan to support improvements in staff engagement and a culture of involvement and ownership.	S06	O	Director of Workforce & Organisational Development	Report to WOD	Workforce & Organisational Development	**Quarterly**				
C15	In 2016/17 15% of staff in management and leadership roles will undertake a leadership / management development programme.	S06	O	Director of Workforce & Organisational Development	Report to WOD	Workforce & Organisational Development	**Quarterly**				

Annexe A
17 May 2016 - Executive Team
Strategy, Vision, Strategic and Corporate Objectives 2016/17
1 April 2016 to 31 March 2017

In 2016 our strategy is to deliver the efficiency phase of our 5 year strategy whilst commencing work on next years transformation stage.

The strategic objectives S01- S07 are supported by key corporate objectives which demonstrate key deliverables in 2016/17 towards the strategy.

Key for progress: **On track** / **Off track**

Ref	In order to achieve our strategy our strategic objectives and corporate objectives for 2016/17 are;	BAF Source	Strategic / Tactical / Operational	Executive Director accountable	Measure of success monitored via:	Assurance obtained from subcommittee:	Milestone Deadline occurs in:	Progress Q1	Q2	Q3	Q4
C16	We will reduce the average time to hire period from 14 weeks to 12 weeks to support the reduction in agency spend.	S06	O	Director of Workforce & Organisational Development	Report to WOD	Workforce & Organisational Development	**Q3**				
S6	**We will create an environment that maximises the use of resources to improve efficiency, patient experience and clinical quality.**	**S07**	**S**								
C17	We will implement the EPR system in line with the programme timescales to improve efficiency of systems and technology resulting in a positive impact on patient experience.	S07	O	Deputy Chief Executive		F&I Committee	**Quarterly**				
C18	We will review and relocate services to maximise the use of the estate and improve access to clinical services resulting in improved patient care.	S07	O	Deputy Chief Executive		F&I Committee	**Quarterly**				

Stockport NHS
NHS Foundation Trust

Report to:	Trust Executive Board	**Date:**	26th May 2016
Subject:	Patient Led Assessment of the Care Environment (PLACE) - Q4 Update		
Report of:	Deputy Chief Executive	**Prepared by:**	Director of Estates & Facilities

REPORT FOR APPROVAL

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

Summary of Report

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

The purpose of this report is to give a Quarter 4 2015/16 update to the Trust Board in respect of the actions and progress made against recommendations from the Trust's PLACE Assessment which took place during May 2015.

Recommendations

The Trust's Board of Directors are requested to receive and note the content of this report and comment accordingly.

Attachments:	Appendix A – PLACE Action Plan Tracker, March 2016 Appendix B – Mini PLACE Food Assessment, 14th January 2016

This subject has previously been reported to:	☒ Board of Directors	☐ Workforce & OD Committee
	☐ Council of Governors	☐ BaSF Committee
	☐ Audit Committee	☐ Charitable Funds Committee
	☐ Executive Team	☐ Nominations Committee
	☐ Quality Assurance Committee	☐ Remuneration Committee
		☐ Joint Negotiating Council
	☐ FSI Committee	☒ Other

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1. INTRODUCTION

1.1 The purpose of this report is to give a 2015/16 Quarter 4 update to the Trust Board in respect of the actions and progress made against recommendations from the Trust's PLACE Assessment which took place during May 2015.

2. BACKGROUND

2.1 During the week commencing 18th May 2015, PLACE inspections, led by 19 Patient Assessors, were conducted across four of our sites.

2.2 Assessments took place at each of SNHSFT's inpatient venues at the following locations; Stepping Hill Hospital; The Devonshire Centre for Neuro rehabilitation; Shire Hill Intermediate Care Unit; and The Meadows, Bluebell Ward.

3. FINDINGS

3.1 The Trust was rated higher than the National Average on Food and Hydration but lower for Cleanliness, Privacy, Dignity & Wellbeing, Condition, Appearance and Maintenance and Dementia.

3. ACTION PLANS

3.1 Detailed action plans have been developed and are formally reviewed monthly at the PLACE Group. In addition an Estates and Facilities Work Group, led by the Director of Estate and Facilities and meets fortnightly to discuss progress with both the PLACE and CQC action plans.

3.2 Works to rectify the issues identified by the PLACE Assessment were undertaken during Q2, Q3 and Q4 with significant improvements being made to all four areas inspected i.e. Steeping Hill Hospital, The Devonshire Centre, Shirehill and The Meadows.

3.3 During Q4 (January 2016) the CQC also undertook a full Inspection of the Trust. Advance notice was received and in support of the impending CQC Inspection, funds were identified within the Capital Budget (First Impressions Funding) to undertake additional improvement work alongside the PLACE Action Plan.

3.4 Please refer to Appendix A for the updated PLACE Action Tracker.

4. PROGRESS

4.1 <u>Estates</u>

4.1.1 Redecoration and painting has been completed to the following areas:

Wards E1, E2 and E3	OPD Suite 3	OPD A
Ward C2	DMOP lobby	Ground floor of maternity corridor
Wards D1 and D2	Maternity Ultrasound	Training office in theatre area
Oak House reception	B Bridge	Glass corridor to maternity wards
X-Ray A	C Bridge	Walls to new kitchen on link corridor
Radiology B	X-Ray B recovery	Treehouse rooms 2, 5, 6, 7, 8 and corridor
E1 gardens facia and soffit boards	Woodlands corridor	Restaurant corridor

4.1.1 Installation of new flooring and flooring repairs has been undertaken in the following areas:

Corridor from A1 to A14 and A15	Ramp near cash machine outside main restaurant	Ground floor maternity public toilets
Various corridors throughout the estate	Poplar Grove public toilets	B Bridge
Devonshire Centre	C Bridge	

4.1.2 Replacement entrance matting has also been installed throughout the site.

4.1.3 In addition new window replacements have been installed in Laurel, B Bridge, C Bridge and Lime Suite.

4.1.4 To improve traffic and patient/visitor flow the site wide signage, including external and internal wayfinding, has been improved.

4.2 <u>Cleanliness, Privacy and Dignity</u>

4.2.1 In terms of Cleanliness, Privacy and Dignity replacement shower curtains have been sourced, infection and prevention training to domestic staff has been undertaken and cleanliness monitoring (C4C) has continued to improve.

4.2.1 A review of cleaning hours was undertaken at The Devonshire Centre and cleaning tasks realigned. This resulted in much better cleanliness results.

4.2.2 Long standing staff vacancies within the domestic department have been filled which has helped our ability to provide a consistent cleaning service during periods of staff annual leave a short term absences.

4.2.3 Disposable curtains have also been installed to a number of very high risk areas to support the Trust Infection and Prevention Control.

4.2.4 The internal and external glazing to the link corridors has been cleaned as well as the cleaning of the large glass façade and glass lift shaft in the Treehouse Children's Centre.

4.3 Portering and Logistics

4.3.1 The portering rosters have been reviewed and we have now been able to allocate a fulltime resource to the corridors ensuring they remain clear from clutter, beds and mattresses.

4.3.2 The logistics team have ensured that all empty delivery cages are removed to the compound by the end of the shifts and our transport staff having been assisting the gardener with external litter picking and general tidying up of the car parks and external areas.

4.4 Food and Hydration

4.4.1 With regard to Food and Hydration, steps have been taken to improve legislative compliance including; Catering compliance checks and documentation, revisions to our Food Safety Policy, Level 2 Food Hygiene Training and allergens training provided to our staff. In addition meetings have been arranged with our nutrition and dietetics team to discuss menu revisions.

4.4.2 On 14th January 2016 the Trust's catering team supported by Patient Assessors carried out a mini PLACE food inspection on wards A10, A12 and A15. The food inspections were carried out three teams who followed the trolleys from the point of origin to the designated wards and then observed the health care assistants serve the patients meal. We identified a number of small issues with regard to the length of time the food trolleys were left before the staff began the service.

4.4.3 The majority of the food temperature checks were good and in the 70 degree celsius area with the Food Safety Regulations stating that hot food holding should be held at a temperature of 63 degrees celsuis or above.

4.4.4 The patients comments were excellent and are happy with the food provided. There are areas that need addressing on the wards with regard to serving the food as quickly as they can, whilst ensuring that the food is kept as hot as it can be.

4.4.5 The catering manager has liaised with the patient experience matron and made a number of recommendations to include; adhering to protected meal times and keeping food trolley doors closed during service. We have also provided food allergen posters to all wards.

4.4.6 In addition, the catering department have implemented a monthly Mini PLACE Food Assessment on two randomly selected wards. The results so far have been very good.

4.4.7 Please refer to Appendix B for a record of the Mini PLACE Food Assessments.

5. CURRENT POSITION - 2016 PLACE ASSESSMENT

5.1 The Trust was advised that the 2016 PLACE Assessments would be undertaken during the week of 18th April 2016. Initial feedback following the assessments has been very positive with improvements made in both the estates condition and cleanliness.

5.2 An update report will be provided for 2016/17 Q1 at the July Trust Executive Board meeting.

6. RECOMMENDATION

6.1 The Trust's Board of Directors are requested to receive and note the content of this report and comment accordingly.

PLACE Action Tracker 2015/16

Site	Domain	% Score	Area for Improvement	Action	Lead	Due Date	RAG
Stepping Hill Hospital	Cleanliness	94.03	Ward & Internal areas: A number of issues were identified on the day with dust, dirt and residues being found on a number of surfaces throughout the unit. (some issues identified in: Wards: C5, SSSU, E1, D5, C2, B3 OPD: Treehouse clinic, X-ray B, Bobby Moore, Eye Centre, ED.	Use external contractor to support in-house domestic service, ensuring cleanliness standards are achieved and maintained.	Head of Facilities	Complete	Green
Stepping Hill Hospital	Cleanliness	94.03	Ward & Internal areas: A number of issues were identified on the day with dust, dirt and residues being found on a number of surfaces throughout the unit. (some issues identified in: Wards: C5, SSSU, E1, D5, C2, B3 OPD: Treehouse clinic, X-ray B, Bobby Moore, Eye Centre, ED.	All areas cleaned and brought up to standard. On-going review of domestic rota to ensure appropriate allocation of resources.	Domestic Manager	Complete	Green
Stepping Hill Hospital	Cleanliness	94.03	Ward & Internal areas: A number of issues were identified on the day with dust, dirt and residues being found on a number of surfaces throughout the unit. (some issues identified in: Wards: C5, SSSU, E1, D5, C2, B3 OPD: Treehouse clinic, X-ray B, Bobby Moore, Eye Centre, ED.	Establish robust monitoring arrangements.	Domestic Manager	Complete	Green
Stepping Hill Hospital	Cleanliness	94.03	Ward & Internal areas: A number of issues were identified on the day with dust, dirt and residues being found on a number of surfaces throughout the unit. (some issues identified in: Wards: C5, SSSU, E1, D5, C2, B3 OPD: Treehouse clinic, X-ray B, Bobby Moore, Eye Centre, ED.	Review staff training needs.	Domestic Manager	Complete	Green
Stepping Hill Hospital	Cleanliness	94.03	Equipment cleanliness: Clean and ready for use equipment is not clearly identified as such in all areas. 7 out of 10 wards visited were not using the green tagging system and this has been fed back to Infection Prevention (SSOP / Neonatal / A10 / C2 / C5 / E1 / D4).	Roll out Clinell green tag system across all wards to identify clean and ready for use patient equipment.	Heads of Nursing	Complete	Green
Stepping Hill Hospital	Food & Hydration	92.90	Timings of service: Evening meal service commences before 5.30pm.	Based on patient feedback the timing of the evening meal service is deemed acceptable and to change may impact negatively on visiting hours. Monitoring of feedback will continue.	n/a	Complete	Green
Stepping Hill Hospital	Food & Hydration	92.90	Menu & choice: Breakfast options include 4 different items, including 3 different cereals & 1 hot/cooked option. Gold standard is 5 options with at least 2 hot options. Evening meal include a choice of 2 desserts, but no hot option. Patients not requiring a special diet can only choose from 3 hot options; with 4 or more being the gold standard.	Options reviewed and opportunities to improve actioned.	Catering Manager	Complete	Green
Stepping Hill Hospital	Food & Hydration	92.90	Menu & choice: Patients choose their meals two meals ahead (e.g. evening for lunch next day).	Options for meal ordering and reducing the order to service gap are already under review. No further action. On-going updates to PLACE Group.	Catering Manager	Complete	Green
Stepping Hill Hospital	Food & Hydration	92.90	There is no separate area away from the bedside to have meals. 4 out of 5 wards visited on the day did not have a separate area away from the bedside. Most ward design and build does not allow for this to happen.		n/a	Complete	Green
Stepping Hill Hospital	Food & Hydration	92.90	Clear information was not available on 2 wards advising patients how to obtain advice on food allergens.	Re-issue information to Treehouse & E2.	Catering Manager	Complete	Green
Stepping Hill Hospital	Food & Hydration	92.90	Hydration: All patients have a water jug at their bedside, and at the time of the assessment none were empty. On the day, 1 ward assessed had a water cooler in place. In all other areas water jugs were used and are checked regularly. Consider installation of a water chiller for those patients who are able to independently access water when they wish.	Hydration requirements are already under review. Updates to PLACE Group on progress.	Nutrition & Hydration Group	Complete	Green
Stepping Hill Hospital	Food & Hydration	92.90	Hospital Food Standards: (Unscored this year). The Trust does not have a Food & Drink Strategy (in accordance with the recommendations from the Hospital Food Standards Panel). Compliance with the 10 Key Characteristics of Good Nutritional Care (Nutrition Alliance). Compliance with the British Dietetic Association's Nutrition and Hydration Digest. The Hospital Food Standards work is being progressed via the Nutrition & Hydration Group and the Health & Wellbeing Group, both of which are attended by the Catering Manager.	Food standards are already under review. Updates to PLACE Group on progress. Food and Drinks Strategy compiled in Feb/March 2016 and approved by relevent group.	Nutrition & Hydration Group	Complete	Green
Stepping Hill Hospital	Privacy, Dignity & Wellbeing	83.53	Other: Family, relatives, guardians or carers are not able to access meals/snacks within the building at all times of the day and night.	Complete OJEU tender for the provision of retail services	Head of Facilities	Complete	Green
Stepping Hill Hospital	Privacy, Dignity & Wellbeing	83.53	External social spaces: Some outside garden areas are unkempt and do not encourage their use.	First impression funding identified. Develop schedule of works to be completed.	Estates Building Manager	Complete	Green
Stepping Hill Hospital	Privacy, Dignity & Wellbeing	83.53	Internal social spaces: Not all wards have access to a day room, social/communal area on the ward (SSOP, A10, C2, B3, D4).	Areas reviewed and social spaces created where possible.	Heads of Nursing	Complete	Green
Stepping Hill Hospital	Privacy, Dignity & Wellbeing	83.53	Ward privacy, dignity & wellbeing: Some bathrooms / showers are visible when the door is open due to privacy curtain missing (wards: C2 & B3).	Assess requirement and order replacement shower curtains.	Domestic Manager	Complete	Green
Stepping Hill Hospital	Privacy, Dignity & Wellbeing	83.53	Access: availability of a toilet big enough to allow space for a wheelchair and carer (including staff) to assist when the door is closed. Patient toilets for Lilac Suite are outside the Department, however, staff toilets are located inside. No provision of a wheelchair accessible toilet in SSOP.	Review options and feedback proposed action to PLACE Group.	Heads of Nursing/ Estates Building Manager	Dec-15	Amber
Stepping Hill Hospital	Privacy, Dignity & Wellbeing	83.53	Toilet signage: Not all toilets and bathrooms have appropriate signs, denoting male / female usage.	Review and procure appropriate signage for wards A10, E1, Treehouse clinic and X-ray B.	Estates Building Manager	Complete	Green
Stepping Hill Hospital	Privacy, Dignity & Wellbeing	83.53	Wards: Not all wards have access to a separate treatment room for minor procedures/wound dressing (wards: SSSU / E1 / D4). OPDs: Not all OPDs were designed to allow patients/families to leave consultation rooms without having to return through the general waiting area or had sufficient space at the reception desk so that conversations between staff and patients are not overheard. (OPDS: Magnolia, Lilac, Eye Centre). The existing design and build does not allow for this in all wards / OPDs. The investment to achieve this would be significant.		n/a	Complete	Green

Stepping Hill Hospital	Condition, Appearance & Maintenance	82.49	Internal decoration: Minor issues identified in most wards and OPDs, relating to chipped or marked paint work due to wear and tear. (Wards: D4, D5, E1, SSSU, C5, B3, C2, A10) (OPDS: X-ray B, Eye Centre, DMOP, Lilac, Treehouse clinic). Internal fixtures & fittings: Minor issues identified in 4 wards, ED and 5 OPDs to be addressed. (Wards: E1, C5, B3, C2) (OPDS: B.M.U, X-ray B, Eye Centre, OPDA, Treehouse clinic). Floors: Minor issues with flooring identified in X-ray B, OPDA and DMOP.	Review all areas where issues identified and produce an action plan to complete necessary work.	Heads of Nursing/ Estates Building Manager	Complete	Green
Stepping Hill Hospital	Condition, Appearance & Maintenance	82.49	Lighting: Issues were identified in Lilac around the use of natural light, and C5 and SSOP.	Review all areas where issues identified and produce an action plan to complete necessary work.	Heads of Nursing/ Estates Building Manager	Dec-15	Amber
Stepping Hill Hospital	Condition, Appearance & Maintenance	82.49	General storage: Items being stored inappropriately in some bathrooms and in corridors (Wards: C2, A10) (OPDs: X-ray B, Eye Centre, Lilac). Internal & External signage: Some signage is confusing and does not help you find your way around the building. Assessment of signage: No assessment has been undertaken to ascertain if signage (inside & outside) is appropriate for the patient population.	Advise Ward/ OPD Managers of issue to be resolved asking them to flag if they require any support by december 2015.	PLACE Lead (LC)	Complete	Green
Stepping Hill Hospital	Condition, Appearance & Maintenance	82.49	General storage: Items being stored inappropriately in some bathrooms and in corridors (Wards: C2, A10) (OPDs: X-ray B, Eye Centre, Lilac). Internal & External signage: Some signage is confusing and does not help you find your way around the building. Assessment of signage: No assessment has been undertaken to ascertain if signage (inside & outside) is appropriate for the patient population.	Options for way finding to be discussed with Director of Estates & Facilities and fed back to the PLACE Group.	Head of Facilities	Complete	Green
Stepping Hill Hospital	Condition, Appearance & Maintenance	82.49	Access: In some OPDs and wards it was noted that there were no handrails along the corridors or on the approach to toilets and bathrooms (wards: D4, D5, E1, SSSU, C5, B3, Neonatal, SSOP) (OPDs: Treehouse clinic, Lilac, Magnolia, Eye Centre).	Review clinical need/requirement for handrails in each area and advise Estates so that a proposal including costings may be developed.	Heads of Nursing	Ongoing	Amber
Stepping Hill Hospital	Condition, Appearance & Maintenance	82.49	Waste Management: Not all bins were labelled as clinical and / or domestic to clearly identify the waste stream for patients, staff & visitors (X-ray B).	Review waste arrangements in X-Ray B and advise Department on requirements.	PLACE Lead (LC)	Complete	Green
Stepping Hill Hospital	Condition, Appearance & Maintenance	82.49	Car parking: There is no availability to pay for parking via debit / credit card or with notes. No change is offered by the machines. Parking machines, where located outside are not covered in the majority of areas. Car Parking Strategy options paper submitted in July, including options for new Pay & Display machines and alternative methods of payment.	Purchase new pay and display machines with alternative payment options.	Head of Facilities	Complete	Green
Stepping Hill Hospital	Dementia	61.63	Ward / OPD / Communal Areas Flooring: Floor is not of a consistent colour (without speckles, stripes or swirls). Floor not a colour that contrasts with walls in bed areas. Toilets & Toilet signage: Signs for toilets cannot be seen from all areas. Not all toilet signage is consistent. Not all signs use large, easily readable text. Not all toilet signs use pictures and text. Toilet seats, flushes and rails are not in a colour that contrasts with the bathroom walls & floors. Toilet flushes, basins & taps are not all of a familiar design. Not all taps are marked clearly as hot / cold. Toilet doors are not painted in a different colour so as to distinguish them from others. General Signage: Not all signs use large, easily readable text. Not all signs are large enough or use contrasting colours to make them easy to see. Not all signs are hung at a height that makes viewing them easy. There is no clear signage prominently displayed showing the name of the ward & hospital. Other: There are no handrails along the corridors or on the approach to toilets and bathrooms. Seating provided in reception/waiting areas does not provide for the range of patient needs including chairs of different heights, chairs both with and without arms and bariatric chairs. Mirrors in ward bathrooms/ toilets cannot be removed or covered easily. Doors to staff only areas are not disguised (e.g. by painting the doors same as walls. The day and date is not displayed and clearly visible within the ward.	Submit PLACE Dementia assessment to the Dementia Strategy Group for comment and action.	PLACE Lead (LC)	Complete	Green
Stepping Hill Hospital	Dementia	61.63	Ward / OPD / Communal Areas Flooring: Floor is not of a consistent colour (without speckles, stripes or swirls). Floor not a colour that contrasts with walls in bed areas. Toilets & Toilet signage: Signs for toilets cannot be seen from all areas. Not all toilet signage is consistent. Not all signs use large, easily readable text. Not all toilet signs use pictures and text. Toilet seats, flushes and rails are not in a colour that contrasts with the bathroom walls & floors. Toilet flushes, basins & taps are not all of a familiar design. Not all taps are marked clearly as hot / cold. Toilet doors are not painted in a different colour so as to distinguish them from others. General Signage: Not all signs use large, easily readable text. Not all signs are large enough or use contrasting colours to make them easy to see. Not all signs are hung at a height that makes viewing them easy. There is no clear signage prominently displayed showing the name of the ward & hospital. Other: There are no handrails along the corridors or on the approach to toilets and bathrooms. Seating provided in reception/waiting areas does not provide for the range of patient needs including chairs of different heights, chairs both with and without arms and bariatric chairs. Mirrors in ward bathrooms/ toilets cannot be removed or covered easily. Doors to staff only areas are not disguised (e.g. by painting the doors same as walls. The day and date is not displayed and clearly visible within the ward.	Invite Matron for Dementia to become a member of the PLACE Group.	PLACE Lead (LC)	Complete	Green
Devonshire	Cleanliness	82.08	Ward & Internal areas: A number of issues were identified on the day with dust, dirt and residues being found on a number of surfaces throughout the unit.	Deep clean undertaken within 4 days of PLACE inspection to bring Unit up to the required standard.	Head of Facilities	Complete	Green
Devonshire	Cleanliness	82.08	Ward & Internal areas: A number of issues were identified on the day with dust, dirt and residues being found on a number of surfaces throughout the unit.	All areas cleaned and brought up to standard. On-going review of domestic rota to ensure appropriate allocation of resources.	Domestic Manager	Complete	Green
Devonshire	Cleanliness	82.08	Ward & Internal areas: A number of issues were identified on the day with dust, dirt and residues being found on a number of surfaces throughout the unit.	Establish robust monitoring arrangements.	Domestic Manager	Complete	Green
Devonshire	Cleanliness	82.08	Ward & Internal areas: A number of issues were identified on the day with dust, dirt and residues being found on a number of surfaces throughout the unit.	Review staff training needs.	Domestic Manager	Complete	Green
Devonshire	Cleanliness	82.08	Hand hygiene: Not all bedsides had anti-bacterial hand gel available. Equipment Cleanliness: clean 'ready for use' patient equipment is not clearly identified as such.	Review requirement, order supplies and ensure available at all times.	Head of Nursing/ Lead Nurse	Complete	Green
Devonshire	Cleanliness	82.08	Hand hygiene: Not all bedsides had anti-bacterial hand gel available. Equipment Cleanliness: clean 'ready for use' patient equipment is not clearly identified as such.	Roll out Clinell green tag system to identify clean and ready for use patient equipment.	Head of Nursing/ Lead Nurse	Complete	Green

Devonshire	Food & Hydration	91.15	Timings of service: Evening meal service commences before 5.30pm.	Based on patient feedback the timing of the evening meal service is deemed acceptable. Monitoring of feedback will continue.	n/a	Complete	Green
Devonshire	Food & Hydration	91.15	Menu & choice: Breakfast options include 4 different items, including 3 different cereals & 1 hot/cooked option. Evening meal includes 3 hot options and a choice of 2 desserts (1 hot & 1 cold).	Options reviewed and opportunities to improve actioned.	Catering Manager	Complete	Green
Devonshire	Food & Hydration	91.15	Menu & choice: Patients choose their meals two meals ahead (e.g. evening for lunch next day).	Options for meal ordering and reducing the order to service gap are already under review. No further action. On-going updates to PLACE Group.	Catering Manager	Complete	Green
Devonshire	Food & Hydration	91.15	Protected meal times: On the day of the assessment protected meal time was not observed for all patients.	Remind staff that unless there are specific agreed reasons, protected meal times are to be observed for all patients.	Head of Nursing/ Lead Nurse	Complete	Green
Devonshire	Food & Hydration	91.15	Hospital Food Standards: (Unscored this year). The Trust does not have a Food & Drink Strategy (in accordance with the recommendations from the Hospital Food Standards Panel). Compliance with the 10 Key Characteristics of Good Nutritional Care (Nutrition Alliance). Compliance with the British Dietetic Association's Nutrition and Hydration Digest.	Food standards are already under review. Updates to PLACE Group on progress. Food and Drinks Strategy compiled in Feb/March 2016 and approved by relevent group.	Nutrition & Hydration Group	Complete	Green
Devonshire	Food & Hydration	91.15	Malnutrition Universal Screening Tool (MUST): No audit has taken place in the past 6mths prior to the PLACE assessment.	Add Devonshire to 2015/16 clinical audit cycle for MUST.	Head of Nursing/ Fiona Brennan	Complete	Green
Devonshire	Privacy, Dignity & Wellbeing	83.33	Recreation areas & social spaces (external & ward-based): There is no designated room(s) / area(s) for exclusive use for family/visiting. Family, relatives, guardians or carers are not able to access meals/snacks within the building at all times of the day and night. Quiet room available. Staff are able to segregate the dining room. Garden space available with seating. Families have access to a drinks machine they do not have access to food however toast or biscuits can be offered if necessary.		n/a	Complete	Green
Devonshire	Privacy, Dignity & Wellbeing	83.33	Access: there is no hearing loop or other portable assistive system at the reception desk.	Review options and feedback to PLACE Group on action taken.	Head of Nursing	Complete	Green
Devonshire	Privacy, Dignity & Wellbeing	83.33	Ward privacy, dignity & wellbeing: Some bathrooms / showers are visible when the door is open due to privacy curtain missing.	Assess requirement and order replacement shower curtains.	Domestic Manager	Complete	Green
Devonshire	Privacy, Dignity & Wellbeing	83.33	Ward TV & radio access: Not all patients have access to headsets / earphones.	Review requirement, order supplies and ensure available at all times.	Lead Nurse	Complete	Green
Devonshire	Condition, Appearance & Maintenance	74.24	WARD AREA: Internal decoration: walls chipped and paintwork chipped in some areas. Internal fixtures & fittings: mirror in one bedroom to be replaced, one tap lost hold/cold indicator, sealant around sink needs replacing. broken towel rail in one bed room. Floors: some starting lifting across whole unit floors in bathroom + main ward badly stained due to bins.	Review all areas where issues identified and produce an action plan to complete necessary work.	Heads of Nursing/ Estates Building Manager	Complete	Green
Devonshire	Condition, Appearance & Maintenance	74.24	General storage: Items being stored inappropriately in some bathrooms and in corridors.	Advise Ward / OPD Managers of issue to be resolved, asking them to flag if they require any support by December 2015.	PLACE Lead (LC)	Complete	Green
Devonshire	Condition, Appearance & Maintenance	74.24	External signage: signs help you find your way around the building grounds, and clearly identify all important/ regularly used parts e.g. main entrances, main department. Internal signage: some signs are confusing and handwritten.	Heads of Nursing/ Lead Nurse to review internal signage requirements and advise Estates Building Manager.	Head of Nursing/ Lead Nurse	Complete	Green
Devonshire	Condition, Appearance & Maintenance	74.24	Assessment of signage: No assessment has been undertaken to ascertain whether the signage (inside & outside) is appropriate for the patient population.	Options for way finding to be discussed with Director of Estates & Facilities and fed back to the PLACE Group.	Head of Facilities	Complete	Green
Devonshire	Condition, Appearance & Maintenance	74.24	Car parking: Car parking spaces are not clearly marked. This will be resolved early 2016 as part of the redevelopment of the adjacent building site.		n/a	Complete	Green
Devonshire	Condition, Appearance & Maintenance	74.24	Access: There is no travel plan in place for the Devonshire.	Review requirement for travel plan and propose action.	Head of Facilities	Ongoing	Amber
Devonshire	Condition, Appearance & Maintenance	74.24	Access: There are no handrails along the corridors or on the approach to toilets and bathrooms.	Review clinical need/requirement for handrails in each area and advise Estates so that a proposal including costings may be developed.	Heads of Nursing	Jan-16	Amber
Devonshire	Condition, Appearance & Maintenance	74.24	Access: Seating provided in reception/waiting areas does not provide for the range of patient needs including chairs of different heights, chairs both with and without arms and bariatric chairs.	Review options and feedback to PLACE Group on proposed action.	Head of Nursing/ Lead Nurse	Ongoing	Amber

Devonshire	Dementia	51.77	Ward / OPD / Communal Areas Flooring: Floor is not of a consistent colour (without speckles, stripes or swirls). Floor not a colour that contrasts with walls in bed areas. Toilets & Toilet signage: Signs for toilets cannot be seen from all areas. Not all toilet signage is consistent. Not all signs use large, easily readable text. Not all toilet signs use pictures and text. Toilet seats, flushes and rails are not in a colour that contrasts with the bathroom walls & floors. Toilet flushes, basins & taps are not all of a familiar design. Not all taps are marked clearly as hot / cold. Toilet doors are not painted in a different colour so as to distinguish them from others. General Signage: Not all signs use large, easily readable text. Not all signs are large enough or use contrasting colours to make them easy to see. Not all signs are hung at a height that makes viewing them easy. There is no clear signage prominently displayed showing the name of the ward & hospital. Other: There are no handrails along the corridors or on the approach to toilets and bathrooms. Seating provided in reception/waiting areas does not provide for the range of patient needs including chairs of different heights, chairs both with and without arms and bariatric chairs. Mirrors in ward bathrooms/ toilets cannot be removed or covered easily. Doors to staff only areas are not disguised (e.g. by painting the doors same as walls. The day and date is not displayed and clearly visible within the ward.	Submit PLACE Dementia assessment to the Dementia Strategy Group for comment and action.	PLACE Lead (LC)	Complete	Green
Devonshire	Dementia	51.77	Ward / OPD / Communal Areas Flooring: Floor is not of a consistent colour (without speckles, stripes or swirls). Floor not a colour that contrasts with walls in bed areas. Toilets & Toilet signage: Signs for toilets cannot be seen from all areas. Not all toilet signage is consistent. Not all signs use large, easily readable text. Not all toilet signs use pictures and text. Toilet seats, flushes and rails are not in a colour that contrasts with the bathroom walls & floors. Toilet flushes, basins & taps are not all of a familiar design. Not all taps are marked clearly as hot / cold. Toilet doors are not painted in a different colour so as to distinguish them from others. General Signage: Not all signs use large, easily readable text. Not all signs are large enough or use contrasting colours to make them easy to see. Not all signs are hung at a height that makes viewing them easy. There is no clear signage prominently displayed showing the name of the ward & hospital. Other: There are no handrails along the corridors or on the approach to toilets and bathrooms. Seating provided in reception/waiting areas does not provide for the range of patient needs including chairs of different heights, chairs both with and without arms and bariatric chairs. Mirrors in ward bathrooms/ toilets cannot be removed or covered easily. Doors to staff only areas are not disguised (e.g. by painting the doors same as walls. The day and date is not displayed and clearly visible within the ward.	Invite Matron for Dementia to become a member of the PLACE Group.	PLACE Lead (LC)	Complete	Green
Shirehill	Cleanliness	99.53	Ward & Internal areas: A minor issue was identified with the cleanliness of ventilation / air conditioning grills.	Request NHS Property Services include cleaning of grills on domestic/ maintenance schedule.	PLACE Lead (LC)	Complete	Green
Shirehill	Cleanliness	99.53	Ward & Internal areas: A minor issue was identified with the cleanliness of ventilation / air conditioning grills.	SNHSFT Domestic Manager to monitor domestic services at Shirehill.	Domestic Manager	Complete	Green
Shirehill	Food & Hydration	87.44	Menu & choice: Lunch and Evening Meal consists of only 2 courses, and not 3 courses and only 1 appetiser as opposed to 2 (e.g. soup, fruit juice). Patients cannot always choose a salad at lunch time (with protein accompaniment). Evening meal does not offer a choice of 1 hot and 1 cold dessert options. Evening meal does not offer the choice of a soup & sandwich in addition to the hot options. Evening meal does not offer the choice of at least 2 sandwiches (one suitable for vegetarians) and 2 types of bread.	Review current arrangements under SLA with TGH and agree action to be taken. Update PLACE Group.	Tameside Catering Manager / Head of Nursing	Dec-15	Amber
Shirehill	Food & Hydration	87.44	24-hour service: Only snacks are available 24 hours a day.	Review current arrangements under SLA with TGH and agree action to be taken.	Catering Manager	Dec-15	Amber
Shirehill	Food & Hydration	87.44	Menu & choice: Patients choose their meals two meals ahead (e.g. evening for lunch next day). This has not been raised as an issue by patients in feedback. Patients are able to review their choice of menu as copies of their chosen meals/menu are kept on a weekly basis.		n/a	Complete	Green
Shirehill	Food & Hydration	87.44	Hydration: All patients have a water jug at their bedside, and at the time of the assessment none were empty. Drinks are offered regularly throughout the day and ad hoc at the request of patients. Jugs of juice are also available on request. Water jugs are checked regularly and changed twice daily. Consider installation of a water chiller for those patients who are able to independently access water when they wish.	Hydration requirements are already under review. Updates to PLACE Group on progress.	Nutrition & Hydration Group	Complete	Green
Shirehill	Privacy, Dignity & Wellbeing	79.03	Other: Facilities for family, relatives, guardians or carers to stay overnight are limited to at the bedside only. Family, relatives, guardians or carers are not able to access meals/snacks within the building at all times of the day and night. Patient family, relatives, guardians or carers can be accommodated to stay over if necessary and a small dining room area made available when needed. A reclining chair is available for rest purposes. Although there is no facility to access meals/snacks/drinks for visitors, In the event that family, relatives, guardians or carers require food or drink, dependent on reason/length of visit, drink and small snack can be given.		n/a	Complete	Green
Shirehill	Privacy, Dignity & Wellbeing	79.03	Internet access: Patients do not have access to the internet.	Head of Nursing/ Lead Nurse to review and discuss requirement with NHS Property Services.	Head of Nursing/ Lead Nurse	Dec-15	Amber
Shirehill	Privacy, Dignity & Wellbeing	79.03	Ward privacy, dignity & wellbeing: Some bathrooms / showers are visible when the door is open due to privacy curtain missing.	Assess requirement and order replacement shower curtains.	Domestic Manager	Complete	Green
Shirehill	Privacy, Dignity & Wellbeing	79.03	Ward TV & radio access: Not all patients have access their own TV and radio. TVs are not available in every room, but patients can bring in their own providing this is a small portable TV for safety reasons. We have a number of donated TV's for patients who are bed bound, or do not wish/unable to attend the communal room or without relatives to bring own property in.		n/a	Complete	Green
Shirehill	Condition, Appearance & Maintenance	87.14	Internal fixtures & fittings: One blind broken in the quiet room. Floors: On Charlesworth ward the appearance of the floor in bathrooms / toilets made it look dirty due to its condition.	Issues reported to NHS Property Services for action.	PLACE Lead (LC)	Complete	Green
Shirehill	Condition, Appearance & Maintenance	87.14	General storage: Items being stored inappropriately in some bathrooms and in corridors.	Advise Ward / OPD Managers of issue to be resolved, asking them to flag if they require any support by December 2015.	PLACE Lead (LC)	Complete	Green

Shirehill	Condition, Appearance & Maintenance	87.14	Internal signage: Some signage is confusing and does not help you find your way around the building. The main entrance is through a disused reception area which has redundant signage.	Request redundant signage is removed by NHS Property Services.	Head of Nursing	Sep-15	Amber
Shirehill	Condition, Appearance & Maintenance	87.14	Access: There is no travel plan in place for Shirehill.	Review requirement for travel plan and propose action	Head of Facilities	Ongoing	Amber
Shirehill	Condition, Appearance & Maintenance	87.14	Access: There are no handrails along the corridors or on the approach to toilets and bathrooms.	Review clinical need/requirement for handrails in each area and advise Estates so that a proposal including costings may be developed.	Head of Nursing	Jan-16	Amber
Shirehill	Condition, Appearance & Maintenance	87.14	General Storage: Ludworth end bathroom was used for storing commodes and 'clean & ready for use equipment'. Some of the items were being charged at the end of the corridors.	Review requirement for bathroom and convert to store room if necessary.	Head of Nursing	Sep-15	Amber
Shirehill	Condition, Appearance & Maintenance	87.14	Waste Management: Not all bins were labelled as clinical and / or domestic to clearly identify the waste stream for patients, staff & visitors.	Provide labels for clear identification.	Trust Waste Lead	Complete	Green
Shirehill	Dementia	66.96	Ward / OPD / Communal Areas Flooring: Floor is not of a consistent colour (without speckles, stripes or swirls). Floor not a colour that contrasts with walls in bed areas. Toilets & Toilet signage: Signs for toilets cannot be seen from all areas. Not all toilet signage is consistent. Not all signs use large, easily readable text. Not all toilet signs use pictures and text. Toilet seats, flushes and rails are not in a colour that contrasts with the bathroom walls & floors. Toilet flushes, basins & taps are not all of a familiar design. Not all taps are marked clearly as hot / cold. Toilet doors are not painted in a different colour so as to distinguish them from others. General Signage: Not all signs use large, easily readable text. Not all signs are large enough or use contrasting colours to make them easy to see. Not all signs are hung at a height that makes viewing them easy. There is no clear signage prominently displayed showing the name of the ward & hospital. Other: There are no handrails along the corridors or on the approach to toilets and bathrooms. Seating provided in reception/waiting areas does not provide for the range of patient needs including chairs of different heights, chairs both with and without arms and bariatric chairs. Mirrors in ward bathrooms/ toilets cannot be removed or covered easily. Doors to staff only areas are not disguised (e.g. by painting the doors same as walls. The day and date is not displayed and clearly visible within the ward.	Submit PLACE Dementia assessment to the Dementia Strategy Group for comment and action.	PLACE Lead (LC)	Complete	Green
Shirehill	Dementia	66.96	Ward / OPD / Communal Areas Flooring: Floor is not of a consistent colour (without speckles, stripes or swirls). Floor not a colour that contrasts with walls in bed areas. Toilets & Toilet signage: Signs for toilets cannot be seen from all areas. Not all toilet signage is consistent. Not all signs use large, easily readable text. Not all toilet signs use pictures and text. Toilet seats, flushes and rails are not in a colour that contrasts with the bathroom walls & floors. Toilet flushes, basins & taps are not all of a familiar design. Not all taps are marked clearly as hot / cold. Toilet doors are not painted in a different colour so as to distinguish them from others. General Signage: Not all signs use large, easily readable text. Not all signs are large enough or use contrasting colours to make them easy to see. Not all signs are hung at a height that makes viewing them easy. There is no clear signage prominently displayed showing the name of the ward & hospital. Other: There are no handrails along the corridors or on the approach to toilets and bathrooms. Seating provided in reception/waiting areas does not provide for the range of patient needs including chairs of different heights, chairs both with and without arms and bariatric chairs. Mirrors in ward bathrooms/ toilets cannot be removed or covered easily. Doors to staff only areas are not disguised (e.g. by painting the doors same as walls. The day and date is not displayed and clearly visible within the ward.	Invite Matron for Dementia to become a member of the PLACE Group.	PLACE Lead (LC)	Complete	Green
Meadows	Cleanliness	98.67	Equipment Cleanliness: clean 'ready for use' patient equipment is not clearly identified as such.	Roll out Clinell green tag system to identify clean and ready for use patient equipment.	Head of Nursing/ Lead Nurse	Complete	Green
Meadows	Food & Hydration	83.68	Food Temperature: Of the 10 items tested, 2 were rated as poor in terms of temperature (mincemeat & chips).	Report to TGH Catering Department.	PLACE Lead (LC)	Complete	Green
Meadows	Food & Hydration	83.68	Menu & choice: Breakfast choice consists of 3 different options (incl. cereals) and only 2 preserves. Up to 5 options, including 4 or more preserves is the gold standard. Lunch and Evening meal consists of only 2 courses, and not 3 courses and only 1 appetiser as opposed to 2 (e.g. soup, fruit juice). Patients cannot always choose a soup & sandwich option in addition to options at Lunch and Evening meal. A range of only 3 (and not 5) condiments/sauces are available at lunch & evening meal. Patients requiring special diets cannot choose from at least 2 hot options. Patients not requiring a special diet can only choose from 2 hot options; with 4 or more being the gold standard.	Review current arrangements under SLA with TGH and agree action to be taken.	Meadows Hotel Services Manager/ Head of Nursing	Dec-15	Amber
Meadows	Food & Hydration	83.68	Timings of service: Evening meal service commences before 5.30pm. The current time the evening meal is delivered suits patients. Supper is also provided, and staff support a twilight shift rota to support this.		n/a	Complete	Green
Meadows	Food & Hydration	83.68	24-hour service: Only snacks are available 24 hours a day.	Review current arrangements under SLA and agree action to be taken.	Meadows Hotel Services Manager/ Head of Nursing	Dec-15	Amber
Meadows	Food & Hydration	83.68	Menu & choice: Patients choose their meals more than 24 hours ahead. Families are encouraged to support the filling in of patient menus. Due to the type of patients who use this facility, i.e. palliative care, staff are often left to complete / support completion of menus on behalf of patients. Current arrangements deemed acceptable.		n/a	Complete	Green
Meadows	Food & Hydration	83.68	Hydration: All patients have a water jug at their bedside, and at the time of the assessment none were empty. Water jugs are checked regularly and changed twice daily. Consider installation of a water chiller for those patients who are able to independently access water when they wish.	Hydration requirements are already under review. Updates to PLACE Group on progress.	Nutrition & Hydration Group	Complete	Green

Meadows	Food & Hydration	83.68	Hospital Food Standards: (Unscored this year). The Trust does not have a Food & Drink Strategy (in accordance with the recommendations from the Hospital Food Standards Panel). Compliance with the 10 Key Characteristics of Good Nutritional Care (Nutrition Alliance). Compliance with the British Dietetic Association's Nutrition and Hydration Digest.	Food standards are already under review. Updates to PLACE Group on progress. Food and Drinks Strategy compiled in Feb/March 2016 and approved by relevent group.	Nutrition & Hydration Group	Complete	Green
Meadows	Food & Hydration	83.68	Malnutrition Universal Screening Tool (MUST): No audit has taken place in the past 6mths prior to the PLACE assessment.	Add Meadows to 2015/16 clinical audit cycle for MUST.	Head of Nursing/ Fiona Brennan	Nov-15	Amber
Meadows	Privacy, Dignity & Wellbeing	90.74	Other: Facilities for family, relatives, guardians or carers to stay overnight are limited to at the bedside only. There are 4 beds available for relatives who want to stay. This is deemed acceptable.		n/a	Complete	Green
Meadows	Privacy, Dignity & Wellbeing	90.74	Internet access: Patients do not have access to the internet.	Head of Nursing/ Lead Nurse to review and discuss requirement with MITIE.	Head of Nursing/ Lead Nurse	Dec-15	Amber
Meadows	Privacy, Dignity & Wellbeing	90.74	Access: there is no hearing loop or other portable assistive system at the reception desk.	Review options and feedback to PLACE Group on action taken.	Head of Nursing	Dec-15	Amber
Meadows	Privacy, Dignity & Wellbeing	90.74	Ward privacy, dignity & wellbeing: Some bathrooms / showers are visible when the door is open due to privacy curtain missing.	Assess requirement and order replacement shower curtains.	Meadows Domestic Manager	Complete	Green
Meadows	Condition, Appearance & Maintenance	88.19	Internal Decoration: some corner of wall paper beginning to curl around grab rails.	Report issues to MITIE and request action to address.	PLACE Lead (LC)	Complete	Green
Meadows	Condition, Appearance & Maintenance	88.19	General storage: Items being stored inappropriately in some bathrooms and in corridors.	Advise Ward Manager of issue to be resolved, asking them to flag if they require any support by December 2015.	PLACE Lead (LC)	Complete	Green
Meadows	Condition, Appearance & Maintenance	88.19	External signage: signs help you find your way around the building grounds, and clearly identify all important/ regularly used parts e.g. main entrances, main departments. There is a sign at the entrance to the car park, but not at the entrance to the building itself. Internal signage: Toilets aren't clearly signed.	Report findings to MITIE and request action to address.	Head of Nursing	Dec-15	Amber
Meadows	Condition, Appearance & Maintenance	88.19	Access: There is no travel plan in place for the Meadows.	Review requirement for travel plan and propose action.	Head of Facilities	Ongoing	Amber
Meadows	Condition, Appearance & Maintenance	88.19	Access: Seating provided in reception/waiting areas does not provide for the range of patient needs including chairs of different heights, chairs both with and without arms and bariatric chairs.	Review options with MITIE and feedback to PLACE Group on proposed action.	Head of Nursing/ Lead Nurse	Nov-15	Amber
Meadows	Dementia	72.20	Ward / OPD / Communal Areas Flooring: Floor is not of a consistent colour (without speckles, stripes or swirls). Floor not a colour that contrasts with walls in bed areas. Toilets & Toilet signage: Signs for toilets cannot be seen from all areas. Not all toilet signage is consistent. Not all signs use large, easily readable text. Not all toilet signs use pictures and text. Toilet seats, flushes and rails are not in a colour that contrasts with the bathroom walls & floors. Toilet flushes, basins & taps are not all of a familiar design. Not all taps are marked clearly as hot / cold. Toilet doors are not painted in a different colour so as to distinguish them from others. General Signage: Not all signs use large, easily readable text. Not all signs are large enough or use contrasting colours to make them easy to see. Not all signs are hung at a height that makes viewing them easy. There is no clear signage prominently displayed showing the name of the ward & hospital. Other: There are no handrails along the corridors or on the approach to toilets and bathrooms. Seating provided in reception/waiting areas does not provide for the range of patient needs including chairs of different heights, chairs both with and without arms and bariatric chairs. Mirrors in ward bathrooms/ toilets cannot be removed or covered easily. Doors to staff only areas are not disguised (e.g. by painting the doors same as walls. The day and date is not displayed and clearly visible within the ward.	Submit PLACE Dementia assessment to the Dementia Strategy Group for comment and action.	PLACE Lead (LC)	Complete	Green
Meadows	Dementia	72.20	Ward / OPD / Communal Areas Flooring: Floor is not of a consistent colour (without speckles, stripes or swirls). Floor not a colour that contrasts with walls in bed areas. Toilets & Toilet signage: Signs for toilets cannot be seen from all areas. Not all toilet signage is consistent. Not all signs use large, easily readable text. Not all toilet signs use pictures and text. Toilet seats, flushes and rails are not in a colour that contrasts with the bathroom walls & floors. Toilet flushes, basins & taps are not all of a familiar design. Not all taps are marked clearly as hot / cold. Toilet doors are not painted in a different colour so as to distinguish them from others. General Signage: Not all signs use large, easily readable text. Not all signs are large enough or use contrasting colours to make them easy to see. Not all signs are hung at a height that makes viewing them easy. There is no clear signage prominently displayed showing the name of the ward & hospital. Other: There are no handrails along the corridors or on the approach to toilets and bathrooms. Seating provided in reception/waiting areas does not provide for the range of patient needs including chairs of different heights, chairs both with and without arms and bariatric chairs. Mirrors in ward bathrooms/ toilets cannot be removed or covered easily. Doors to staff only areas are not disguised (e.g. by painting the doors same as walls. The day and date is not displayed and clearly visible within the ward.	Invite Matron for Dementia to become a member of the PLACE Group.	PLACE Lead (LC)	Complete	Green

Stockport NHS
NHS Foundation Trust

Mini PLACE – Food Inspection

Ward / Area inspected: **A10** **Date: 14th January 2015**

Inspection Team: **Charles Gordon – Interim Catering Manager**

Michelle Mullender – Front of House Manager

	Function Score %	National Average %
Food Testing	**83.33%**	**88.49%**

Summary:

Food Tested	Did the food taste nice?	Texture Score?	Temperature?
Soup	Poor	Acceptable	Good 68c
Potato	Acceptable	Good	Good 56c
Turkey Casserole	Good	Good	Good 56c
Sweetcorn	Good	Good	Good 56c
Rice Pudding	Good	Acceptable	Good 64.4c

NB: The food tested was put into a room with a window open whilst the inspection team went to observe the patients so the temperatures scored above are not a true reflection of the temperatures served to patients.

Observation: Salt and pepper being put onto individual trays prior to serving whilst doors left open, then separately prior to serving napkins being put onto trays before the meals are served. Meals not in order of beds would be easier if in numerical order.

Staff complained about not having gloves to protect from the heat of the trays, these are to be purchased by the ward manager.

No red trays in use as described in the patient hand book, this has been taken out of operation and a red rimmed plate is used to identify vulnerable patient.

The team felt the tomato soup was lacking in flavour.

If 'No' answered to any of the questions, please state reasons why:

Q3 Is fresh fruit freely available? No, however it is available upon request but ward staff were not aware of this.

Q5. Where meals consist of more than one course, is each course served separately? No all courses are served at the same time**.**

Q10. There is no separate area away from the bedside where patients can take their meals? No all meals are served at the bed side.

Patients Comments/ feedback:

The Inspection team spoke to three patients who were really happy with the food.

Distribution List:	Ward Manager	
	Carol Sparkes:	Asst. Director of Nursing
	Sharan Arkwright:	Matron for Quality Improvement
	Margaret Gilligan:	Matron for Patient Experience
	Sharon Potts:	Infection Prevention
	David Williams:	Building Manager - Estates
	Lorna Hough:	Domestic Services Manager
For information:	Carol Prowse:	Deputy Chairman / Non Executive Director
	John Killeen	Director of Estates and Facilities

Stockport NHS
NHS Foundation Trust

Mini PLACE – Food Inspection

Ward / Area inspected: **A15** **Date: 14th January 2015**

Inspection Team: **David Williams – Estates Manager**

Julie Dyer – Car Park Administrator

	Function Score %	National Average %
Food Testing	**86.66%**	**88.49%**

Summary:

Food Tested	Did the food taste nice?	Texture Score?	Temperature?
Soup	Good	Good	Good 74c
Potato	Acceptable	Acceptable	Good 63c
Turkey Casserole	Good	Good	Good 63c
Sweetcorn	Good	Good	Good 65.2c
Rice Pudding	Acceptable	Acceptable	Good 67c

If 'No' answered to any of the questions, please state reasons why:

Q3 Is fresh fruit freely available? No, however it is available upon request but ward staff were not aware of this.

Q5. Where meals consist of more than one course, is each course served separately? No all courses are served at the same time.

Q10. There is no separate area away from the bedside where patients can take their meals? No all meals are served at the bed side.

Patients Comments/ feedback:

The following comments were made from three patients:

Patient 1

Soups, rice pudding, fruit juices, cheese and biscuits all excellent, sandwiches nice but ice cream is too sweet, however not impressed with the main meals although the menu offered good choice.

The food has deteriorated since 2014 (the patient accepted that this could be down to his condition and how he was feeling)

Patient 2

Very happy with the food.

Patient 3

Chilli a bit spicy and the food was cold on arrival.

Distribution List:	Ward Manager	
	Carol Sparkes:	Asst. Director of Nursing
	Sharan Arkwright:	Matron for Quality Improvement
	Margaret Gilligan:	Matron for Patient Experience
	Sharon Potts:	Infection Prevention
	David Williams:	Building Manager - Estates
	Lorna Hough:	Domestic Services Manager
For information:	Carol Prowse:	Deputy Chairman / Non Executive Director
	John Killeen	Director of Estates and Facilities

Stockport NHS
NHS Foundation Trust

Mini PLACE – Food Inspection

Ward / Area inspected: **A12** **Date: 14th January 2015**

Inspection Team: **Joanne Morris – Logistics Manager**

Ged Carpenter – Catering Manager

	Function Score %	National Average %
Food Testing	**100%**	**88.49%**

Summary:

Food Tested	Did the food taste nice?	Texture Score?	Temperature?
Soup	Good	Good	Good 76c
Chilli	Good	Good	Good 70c
Rice	Good	Good	Good 70c
Baked Beans	Good	Good	Good 70c
Yogurt	Good	Good	Good Chilled

NB: The food tested was very tasty and of a good temperature.

Observation: There was a 5 minute delay before anyone started to serve the meals as the staff were still preparing the patients when the food trolley arrived on the ward. Initially there were only 2 staff serving the meals, this increased as more staff became available. All patients were given napkins and wipes for their hands and salt and pepper with their meals. There was a patient who required assistance with feeding and this was done professionally by a member of the nursing team.

All staff were observed eating and looked like they were enjoying their meals.

Tea and coffee was being served alongside the meals.

There were a number of meals that had not been given out and this was due to either patients being discharged or nil by mouth.

If 'No' answered to any of the questions, please state reasons why:

Q3 Is fresh fruit freely available? **No, however it is available upon request but ward staff were not aware of this.**

Q5. Where meals consist of more than one course, is each course served separately? **No all courses are served at the same time.**

Q10. There is no separate area away from the bedside where patients can take their meals? **No all meals are served at the bed side.**

Patients Comments/ feedback:

Patients Comments/ feedback:

The following comments were made from three patients:

Patient 1

Good meals, plenty of choice, always received the meals he has asked for however would like larger portions.

Patient 2

Cannot fault the food especially the sausages.

Patient 3

Very happy with the food, good choice.

Distribution List:	Ward Manager	
	Carol Sparkes:	Asst. Director of Nursing
	Sharan Arkwright:	Matron for Quality Improvement
	Margaret Gilligan:	Matron for Patient Experience
	Sharon Potts:	Infection Prevention
	David Williams:	Building Manager - Estates
	Lorna Hough:	Domestic Services Manager
For information:	Carol Prowse:	Deputy Chairman / Non Executive Director
	John Killeen	Director of Estates and Facilities

Stockport NHS
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	26 May 2016
Subject:	Board Assurance Framework		
Report of:	Chief Executive	**Prepared by:**	P Buckingham

REPORT FOR APPROVAL

Corporate objective ref:	N/A
Board Assurance Framework ref:	BAF Risk 2
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 the revised Board Assurance Framework 2016/17 to the Board of Directors for consideration and approval.

Attachments: Annex A – Board Assurance Framework

This subject has previously been reported to:

- ☐ Board of Directors
- ☐ Council of Governors
- ☐ Audit Committee
- ☐ Executive Team
- ☐ Quality Assurance Committee
- ☐ FSI Committee
- ☐ Workforce & OD Committee
- ☐ BaSF 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 the revised Board Assurance Framework 2016/17 to the Board of Directors for consideration and approval.

2. BACKGROUND

2.1 Assurance Frameworks vary across organisations and, in some instances, can be lengthy documents that are not always well understood. This can prevent the Framework's effective use for managing the business and its strategic priorities. To be of real value to an organisation, the Board Assurance Framework must be clear, concise and tailored to the organisation's needs.

2.2 The format for the Trust's current Board Assurance Framework was designed in partnership with Mersey Internal Audit Agency (MIAA) with scope of content and presentation informed by best practice identified by MIAA. The form of the Board Assurance Framework was reviewed by Internal Audit in March 2016 and the review concluded that *"The organisation's Assurance Framework is structured to meet the NHS requirements, is visibly used by the Board and clearly reflects the risks discussed by the Board".*

2.3 At the Board of Directors meeting on 31 March 2016, the Board adopted a revised approach to the Board Assurance Framework to ensure that strategic objectives, and the principal risks to achievement of these objectives, were subject to periodic review in order to maintain currency of the Framework content. To this end, the Board of Directors formally closed the previous Board Assurance Framework and approved a revised set of strategic objectives and principal risks which would form the basis of the Board Assurance Framework 2016/17.

3. CURRENT SITUATION

3.1 The current Board Assurance Framework 2016/17, which is included for reference at Annex A of the report, has been reviewed by the relevant risk owners and updated accordingly. There have been no significant upward movements in the residual risk rating for the various elements.

3.2 The Board Assurance Framework was a subject considered during a Board Development Session on 29 April 2016 and Board members ill recall the need to ensure that the risks documented in the Framework continue to accurately reflect the principle risks to achievement of strategic objectives. In addition, Board members should satisfy themselves that the content of the Framework is appropriately informing the content of Board agendas.

4. LEGAL IMPLICATIONS

4.1 There are no legal implications arising out of the subject matter of this report.

5. RECOMMENDATIONS

5.1 The Board of Directors is recommended to:

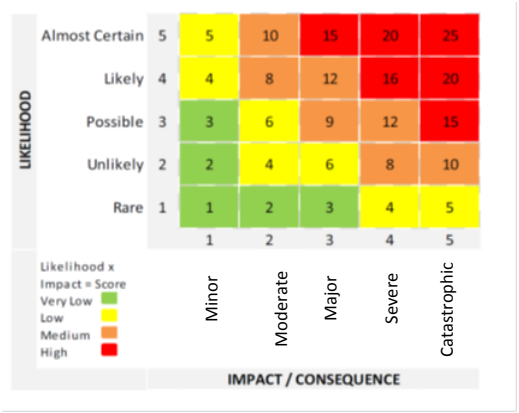
- Consider and approve the content of the Board Assurance Framework at Annex A.

SO1	**To achieve full implementation and delivery of the Trust's Five Year Strategy 2015-20.**	
Risk 1	**Emphasis on day to day operational delivery, in response to environmental pressures, results in lack of focus on strategic change programmes with consequent impairment or failure to deliver the Trust's Five Year Strategy.**	**Risk Owner: Chief Executive**

Board Risk Rating

	L	C	Level
Initial	*2*	*4*	*8*
Current	2	4	8

Opened Date	01/04/2016
Review Date	
Review Date	
Review Date	



RISK CONTENT

The Board needs to spend time on ensuring delivery of the Five Year Strategic Staircase as described in the approved Strategy, ensuring congruence with other significant strategic partnerships programmes of Healthier Together, Stockport Together and GM Devolution.

BOARD RISK APPETITE

The Trust is not risk averse in this area and accepts that there may be exposure to reputation and staff engagement risks in pursuing service transformation. The communication and engagement of staff and key stakeholders is recognised as essential. However, the Trust remains risk averse to any negative quality, safety or patient experience issues and understands the balance required for financial efficiency. Reduction of 50% of strategic Board discussions would require immediate review.

CONTROLS

- **Dedicated Board Strategy sessions.**
- **Communications Plan for Strategy developed, implemented & monitored via Planning and Performance Group.**
- **Resources identified to ensure detailed work up of the Strategic Staircase and Innovation Programmes projects.**
- **Assurance reports to the Finance & Investment Committee on financial delivery of the strategic projects.**
- **Assurance reports to the SDC Committee on operational delivery of the strategic projects.**

BOARD ASSURANCE

- **Regular CEO reports on progress with strategic programmes.**
- **Quarterly review of progress against key organisational objectives.**
- **Strategy 2016/17 presentation to senior managers and clinical managers 16 March 2016.**
- **Start the Year: 3 & 5 May 2016 and rollout for all staff planned.**
- **Increased capacity and focus at senior level on strategy delivery implemented from April 2016.**
- **Increased capacity and focus through the Financial Improvement Programme to ensure financial improvement, efficiency and effectiveness of operational performance is managed robustly and does not impinge on strategic delivery focus**

GAPS IN CONTROLS

- **Outcome of Monitor assessment of 2016/17 Operational Plan submitted on 18 April 2016.**

GAPS IN ASSURANCE

- **Risk that concurrent strategic programmes will impair senior management capacity.**

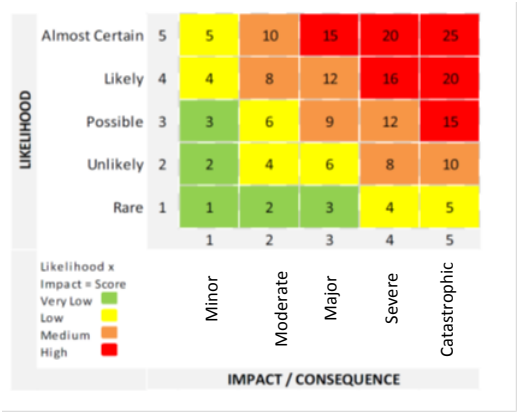
ACTION PLAN	*Assigned to*	*Action Detail*	*Progress to Date*	*Due Date*
	Chief Executive	**Board to be given dedicated time for strategic discussion**	**Board to hold monthly strategy sessions**	**Ongoing**
	Deputy Chief Executive	**Monitor engagement with staff and facilitate workshop with Child and Family Business Group**	**Performance & Planning Committee monitoring communication plan delivery. Further workshop held and future workshops scheduled.**	**Ongoing**

SO2	**To achieve best outcomes for patients through full and effective participation in local strategic change programmes including; Stockport Together, Healthier Together & Greater Manchester Devolution.**	
Risk 2	**Failure to plan, resource and engage effectively with strategic change programme impairs level of control and influence with a consequent detrimental impact on patient services.**	**Risk Owner: Chief Executive**

Board Risk Rating

	L	C	Level
Initial	*2*	*4*	*8*
Current	2	4	8

Opened Date	01/04/2016
Review Date	
Review Date	
Review Date	



RISK CONTENT

The Board needs to spend time on ensuring delivery of the Five Year Strategic Staircase as described in the approved Strategy, ensuring congruence with other significant strategic partnerships programmes of Healthier Together, Stockport Together and GM Devolution.

BOARD RISK APPETITE

The Trust is not risk averse in this area and accepts that there may be exposure to reputation and staff engagement risks in pursuing service transformation. The communication and engagement of staff and key stakeholders is recognised as essential. However, the Trust remains risk averse to any negative quality, safety or patient experience issues and understands the balance required for financial efficiency. Reduction of 50% of strategic Board discussions would require immediate review.

CONTROLS

- **Dedicated Board Strategy sessions.**
- **Chief Executive and other Executives (especially Finance and HR) participation in Greater Manchester Devolution developments.**
- **Chief Executive and Executive Director participation in the Stockport Together programme.**
- **Deputy Chief Executive participation as member of the MCP Shadow Provider Board.**
- **CEO, Deputy Chief Executive and Clinical Lead attendance at South East Sector Healthier Together Planning Committee.**
- **Director of Partnership designated as Programme Director for SE Sector Healthier Together implementation with consultancy resource support.**
- **Locality plan for Stockport consistent with Trust Strategic Plan and planning assumptions.**

BOARD ASSURANCE

- **Positive outcome of the Healthier Together Judicial Review.**
- **Regular CEO reports on progress with strategic programmes.**
- **Stockport Together adoption of the Trust's patient segmentation approach.**
- **Increased capacity and focus at senior level on Stockport Together programme implemented from April 2016.**
- **Board approval of GM Devolution governance arrangements.**
- **Appointment of interim Director of Provider MCP (all providers)**
- **Chief Executive, Deputy Chief Executive and Director of Finance are members of key Stockport Together governance meetings**

GAPS IN CONTROLS	GAPS IN ASSURANCE
• Resource pressure associated with strategic change programmes. • Risk on full allocation of resource to fund the change programme as Vanguard monies are now through the GM Health and Social Care Transformation Programme Fund • Clarity on future organisational form of MCP provider – alternative models being considered.	• Risk that concurrent strategic programmes will impair senior management capacity.

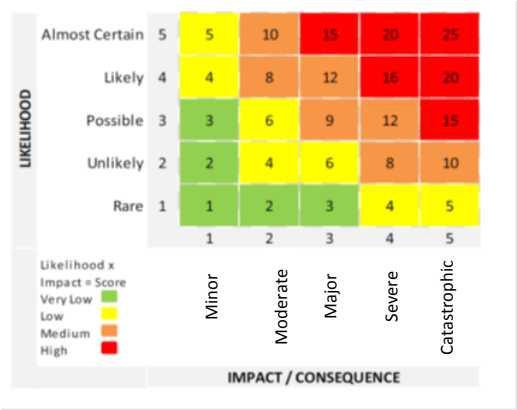
	Assigned to	*Action Detail*	*Progress to Date*	*Due Date*
ACTION PLAN	**Chief Executive**	**Board to be given dedicated time for strategic discussion**	**Board to hold monthly strategy sessions**	**Ongoing**
	Chief Executive/Deputy Chief Executive	**Working with Stockport partners to bid for transformation fund monies to support the Vanguard work**	**Outline bid made and further information on ROI and other issues being submitted to GM**	**June/July**
	Director of Finance / Director of Workforce & OD	**Information requirements from Trust as result of the Provider efficiency programmes Directors of Finance are undertaking at the request of the Provider Federation Board**	**Information provided as required**	**Ongoing**
	Deputy Chief Executive	**Member of newly established Executive Committee for Stockport Together to ensure delivery of programme and member of shadow Provider Board to ensure Trust as key stakeholder in future organisational form, contract arrangements and delivery.**	**Revised governance arrangements developed and agreed by Senior Leaders Group**	**Ongoing**

SO3	**To secure full compliance with requirements of the NHS Provider Licence through fit for purpose governance arrangements.**	
Risk3	**Failure to achieve sustainable delivery of the 4-hour A&E target impairs quality of patient care and results in further regulatory intervention.**	**Risk Owner: Chief Operating Officer**

Board Risk Rating

Initial	***4***	***4***	***16***
Current	***4***	***4***	***16***
	L	**x C =**	**Level**

Opened Date	01/04/2016
Review Date	
Review Date	
Review Date	



RISK CONTENT

Meeting national standards is key to maintaining the provider license. Failure to meet standards may adversely affect patient experience and have a negative impact on the Trust's reputation. There may also be contractual penalties imposed by commissioners.

BOARD RISK APPETITE

The Board is prepared to take informed risks to resolve performance issues such as a period of planned underperformance against standard in order to resolve patient wait times more quickly.

CONTROLS

- **Executive accountability and capacity enhanced with appointment of Interim Chief Operating Officer**
- **Business group quality governance meetings and IPRs**
- **Monthly Performance & Planning meeting**
- **Standard specific groups, i.e. cancer board, 18 week meeting etc**
- **Performance Management Framework to proactively monitor all standards and provide holding to account mechanism for delivery.**

BOARD ASSURANCE

- **Key Issues Reports from Quality Assurance Committee**
- **Integrated Performance Report (IPR) to Board**
- **Escalation process to Board through IPR report**
- **External reports on areas of underperformance, e.g. Cancer or ED through ECIST or other bodies**

GAPS IN CONTROLS

- **Emergency Department standard is still reliant on reduced demand which has not yet manifested despite actions taken by commissioners. There is also a reliance on social and community care to egress patients from hospital.**

GAPS IN ASSURANCE

- **Matching capacity and demand within clinical services to best mitigate failure**
- **Effectiveness of MCP in supporting long term sustainability against the 4 hour target.**

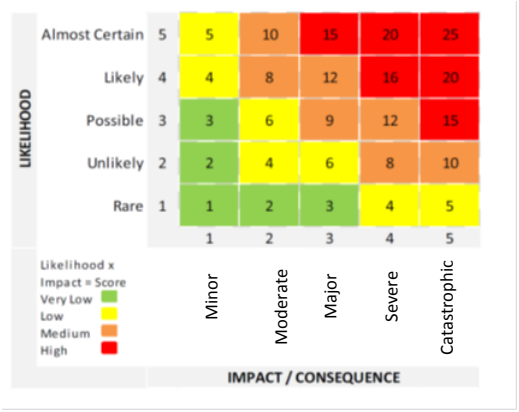
ACTION PLAN	Assigned to	Action Detail	Progress to Date	Due Date
	Chief Operating Officer, Chief Executive & Director of Finance	**Continue to work with the Health and Social Care Economy leaders on the gaps in Urgent Care Provision across the health economy to enable achievement of the ED target**	**Systems Resilience Group now in place and meeting monthly**	**Ongoing**
	Interim Chief Operating Officer	**Introduction of effective assurance reporting of outcomes from the monthly Performance & Planning meeting to the Quality Assurance Committee.**		

SO4	**To achieve, and maintain, a minimum 'Good' rating under the Care Quality Commission inspection regime.**	
Risk 4	**Inability to maintain and improve compliance with Care Quality Commission standards impairs patient experience, damages Trust reputation and results in regulatory intervention.**	**Risk Owner: Director of Nursing & Midwifery**

Board Risk Rating

	L	C	Level
Initial	*4*	*4*	*16*
Current	*3*	*4*	*12*

Opened Date	01/04/2016
Review Date	
Review Date	
Review Date	



RISK CONTENT

If CQC outcomes are not met, then patient and family experience will be jeopardised. Closely linked to culture and values and issues arising from Francis, Keogh and Berwick reports. If CQC inspection results in a 'Requires Improvement' or 'Inadequate' rating, the reputation of the Trust will be damaged.

BOARD RISK APPETITE

Risk averse with regard to all aspects of CQC compliance. Three or more wards or departments in a business group, which continue in 'turnaround' following CQC mock inspections and Nursing Dashboard escalation for longer than three months would trigger an immediate review and further action.

CONTROLS

- **Quality Improvement Matron in post – lead for implementing CQC compliance policy (mock CQC inspections to check compliance, action planning and re-inspections)**
- **CQC assurance manager in post – lead for evidence and learning from other organisations' CQC inspections**
- **Monitoring of performance with commissioners**
- **Programme of activity forward to Board assurance through visibility and structured clinical activity for senior nursing staff**
- **Nursing & Midwifery Dashboard and escalation process for agreed triggers, including action plans for 'turnaround' wards**
- **CQC mock inspections and action plans included on business group quality governance committees and process redefined to include automatic escalation to Quality Governance Committee for areas identified as 'requires improvement' or 'inadequate'**
- **CQC mock inspection action plans monitoring outside business group – included in revised Strategic Heads of Nursing meeting structure for scrutiny.**

BOARD ASSURANCE

- **Key Issues Reports from Quality Assurance Committee**
- **Patient stories / complaints / incidents / patient experience quarterly report / High Profile Report – shared widely throughout organisation**
- **Quality elements of Integrated Performance Report**
- **Annual Quality Report**
- **Infection prevention and control reports**
- **Mock CQC inspection results to ADs and Heads of Nursing / Midwifery**
- **Independent internal reviews of ongoing compliance**
- **CQC inspection results and any resultant action plans**
- **Twice yearly nursing and midwifery staffing reviews**
- **Outcomes of patient surveys**

GAPS IN CONTROLS	GAPS IN ASSURANCE
• Ongoing recruitment issues for some areas of nursing and medical workforce may jeopardise compliance with CQC standards	• Outcomes of CQC inspection completed in January 2016.

ACTION PLAN	*Assigned to*	*Action Detail*	*Progress to Date*	*Due Date*
	Director of Nursing & Midwifery	**Lead the action planning required following the CQC inspection**	**Draft report not received as at 20 May 2016**	

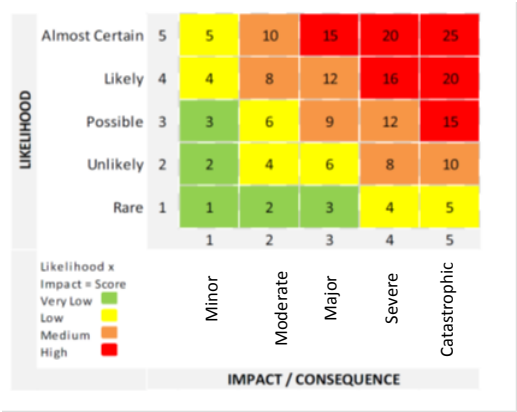
SO5	**To achieve the level of financial sustainability necessary to ensure provision of good quality services and facilitate delivery of the Trust's Five Year Strategy**	
Risk 5	**Failure to deliver annual cost improvement programmes and realise planned benefits from strategic transformation projects impairs the Trust's financial position, with a consequent impact on patient services, and increases the likelihood of regulatory intervention.**	**Risk Owner: Director of Finance & Deputy Chief Executive**

Board Risk Rating

Initial	***4***	***5***	***20***
Current	***4***	***4***	***16***

L x C = Level

Opened Date	01/04/2016
Review Date	
Review Date	
Review Date	



RISK CONTENT

Failure to pay staff and suppliers to continue to provide safe and effective services.

Triggering the need for distress financing which would increase the risk of regulatory intervention.

Not being able to provide the range of services and failing respective access and contract targets / clauses leading to financial penalties.

Not being able to support Strategic Development initiatives including the need to modernise the estate and replace aging medical equipment.

BOARD RISK APPETITE

Necessity to take risks to deliver the strategic and innovation programmes to achieve financial resilience with a willingness to review core services with a view to third party delivery and/or outsourcing of corporate departments.

CONTROLS

- **Detailed financial planning process including activity, workforce and capital planning**
- **Operational Plan 2016/17**
- **Implementation of a CIP Governance Framework with Executive-level monitoring**
- **Performance Management Framework and Performance Review Meetings**
- **Establishment Control Panel**
- **Detailed financial report to F&I Committee**

BOARD ASSURANCE

- **Finance and CIP Performance reports**
- **Budget and Plan approval**
- **CQUIN update**
- **Finance & Investment Committee review of progress reported to Board**
- **Strategic Development Committee reporting to Board**

GAPS IN CONTROLS	GAPS IN ASSURANCE
• Wider clinical ownership and accountability for programme delivery • CQUIN objectives need to be devolved to those charged with delivery • CCG agreement on re-investment of contract penalties	• Well defined and realistic efficiency programme for 2016/17 • Appropriate targeting and deployment of additional resources to deliver savings and improvements – capacity and capability • Potential conflict between Trust plans and those of wider health economy • Programme management experience amongst senior managers across the Trust

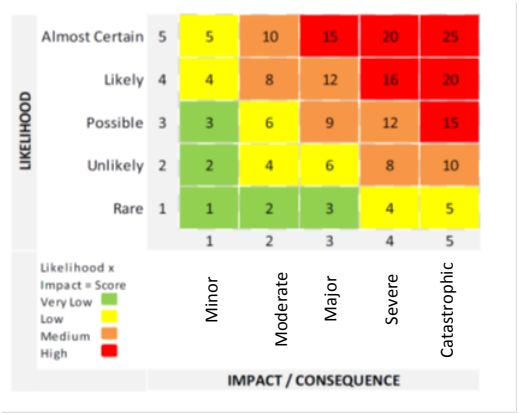
ACTION PLAN	*Assigned to*	*Action Detail*	*Progress to Date*	*Due Date*
	Interim Chief Operating Officer	**Hold Business Group Directors to account for delivery of their financial and activity plans**		
	Director of Finance	**Develop and deliver a clinical and non-clinical engagement programme to ensure that staff across the Trust understand the financial challenges facing the organisation.**		
	Director of Finance	**Progress application for a further loan as normal course of business with the ITFF.**		
	Director of Finance / Deputy Chief Executive	**Work with the Financial Improvement Programme to identify and deliver cost savings over and above those identified in the financial plan.**		
	Director of Workforce & OD	**Preparation of a workforce plan which incorporates current and future vacancies in order to establish workforce requirements over the next 24 months.**		

SO6	**To develop, and maintain, a flexible, motivated and proficient workforce**	
Risk 6	**Failure to prepare and deliver effective workforce plans supported by continuous professional development impairs the availability of workforce resources with a consequent impact on the delivery of patient services.**	**Risk Owner: Director of Workforce & Organisational Development**

Board Risk Rating

	L	C	Level
Initial	*3*	*4*	*12*
Current	*3*	*4*	*12*

Opened Date	01/04/2016
Review Date	
Review Date	
Review Date	



RISK CONTENT

An engaged workforce is critical during a period of transformation and associated uncertainty. Different staffing models will be needed resulting in different ways of working with an increased requirement for new roles, skill mix and role development. Key supply risks exist in relation to a number of roles including medical and nursing posts and other specialist roles.

BOARD RISK APPETITE

Risk averse given the necessity to engage successfully with the workforce to achieve change.

Triggers for consideration:

1. **>50% of the KPIs in the Integrated Performance Report are outside of a 15% threshold**
2. **The Trust's staff engagement score in the annual staff survey falls below 3.0**

CONTROLS

- **Policies and procedures**
- **Appraisal Framework**
- **Mandatory training**
- **Establishment Control Panel**
- **Quarterly Pulse Surveys, including Staff Friends & Family Test**
- **Operational Plan 2016/17**
- **Leadership plan**
- **Staff focus groups**
- **Business group performance meetings.**

BOARD ASSURANCE

- **Workforce & OD Committee**
- **Business Group assurance reporting**
- **Assurance reporting on attendance, sickness, absence, mandatory training, turnover and medical appraisal & temporary staffing spend**
- **Annual Staff Survey results and Friends & Family results (3 x per year)**
- **Freedom to Speak Up Guardian commenced in post in February 2016**
- **Health & Wellbeing Strategy**
- **Recruitment & Retention Strategy approved by Board of Directors**
- **OD Strategy approved by Board of Directors**
- **Leadership Strategy approved by Board of Directors**
- **Talent management strategy**

GAPS IN CONTROLS	GAPS IN ASSURANCE
• Succession Plan • Staff Engagement Plan • Workforce Plan	• Engagement Strategy • Assurance on being "well led"

	Assigned to	*Action Detail*	*Progress to Date*	*Due Date*
ACTION PLAN	**Head of Organisational Development and Learning**	**To ensure staff survey results are widely shared and robust action plans are developed in response to the annual staff survey and quarterly pulse surveys. Further information to be sought through focus group engagement.**	**Results shared. Business group action plans in development. Focus groups underway.**	**Ongoing**
	Director of Workforce and Organisational Development	**Workforce KPIs reviewed for 2016/17 and approved by Workforce Organisational Development Committee**	**Business group performance monitored in Performance meetings.**	**Complete Ongoing**
	Deputy Director of Workforce	**Workforce planning cycle to be aligned to business planning and workforce numbers monitored monthly**	**Workforce planning update shared with Workforce and Organisational Development Committee. Business group planning template approved**	

SO7	**To implement and embed an Electronic Patient Record (EPR) system.**	
Risk 7	**Failure to ensure efficient management of the EPR project results in data loss from current systems and the inability to realise the benefits expected to accrue from implementation of a comprehensive electronic system.**	**Risk Owner: Deputy Chief Executive**

Board Risk Rating

Initial	***3***	***4***	***12***
Current	***3***	***4***	***12***

L x C = Level

Opened Date	01/04/2016
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Review Date	
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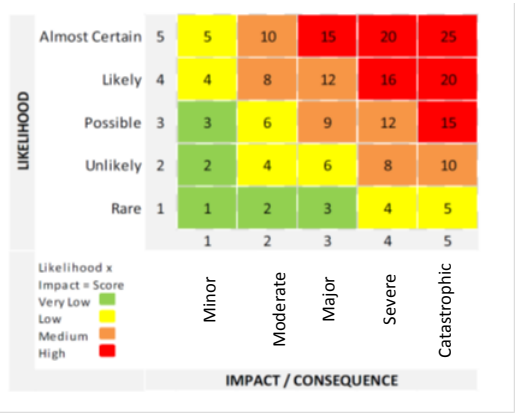

RISK CONTENT

Redesign of clinical and operational workforce will need to be enabled by IT both within the Trust and across GM to ensure a sustainable future.

Technology is key to delivering clinical services in terms of quality, safety and outcomes. The Board needs to be sighted on key projects.

BOARD RISK APPETITE

The Board is prepared to take decisions on investment at scale in IT provided that there is strong assurance that there is the ability to recover costs through efficiencies.

CONTROLS

- **Health Informatics Programme**
- **Programme and project governance through Health Informatics Strategy Board**
- **Policies and procedures**
- **Audit programme**
- **IGT**

BOARD ASSURANCE

- **External and internal audit reporting of design and operation of plans**
- **Approval of strategies and plans through Finance & Investment Committee**
- **Data integrity assurance – through data quality strategy**
- **IGT assurance – through HIS Board**
- **Project and programme assurance – through HIS Board & Capital Programme Development Group**
- **EPR Governance Assurance Report – Audit Committee 17 May 2016**

GAPS IN CONTROLS

- **Gaps in IT systems**

GAPS IN ASSURANCE

- **Benefits realisation on large scale IT projects – further work required**

ACTION PLAN	Assigned to	Action Detail	Progress to Date	Due Date
	Deputy Chief Executive	**Ensure Electronic Patient Record programme has suitable governance process in place**	**Programme Board in place with terms of reference and executive leadership**	

Report to:	Board of Directors	**Date:**	26th May 2016
Subject:	Strategic Risk Register		
Report of:	Director of Nursing & Midwifery	**Prepared by:**	Head of Risk & Customer Services

REPORT FOR APPROVAL

Corporate objective ref:	**Summary of Report** • The strategic risk register reports on distribution of risk across the Trust and presents in greater detail those risks which have an impact upon the stated aims of the Trust • As part of the new reporting structure all business groups will report their own risk register to the Risk Management Committee twice yearly for peer review and support. • 4 strategic risks have been mitigated and managed to below a risk score of 15 this month • Currently there are 9 severe strategic risks scoring 20. The Board is asked to note: ○ The content of the report ○ The new format of the report
Board Assurance Framework ref:	
CQC Registration Standards ref:	
Equality Impact Assessment: Not required	

Attachments: Corporate Risk Register

This subject has previously been reported to:	☒ Board of Directors ☐ Council of Governors ☐ Audit Committee ☐ Executive Team ☐ Quality Assurance Committee ☐ FSI Committee ☐ Workforce & OD Committee ☐ BaSF Committee ☐ Charitable Funds Committee ☐ Nominations Committee ☐ Remuneration Committee ☐ Joint Negotiating Council ☒ Other

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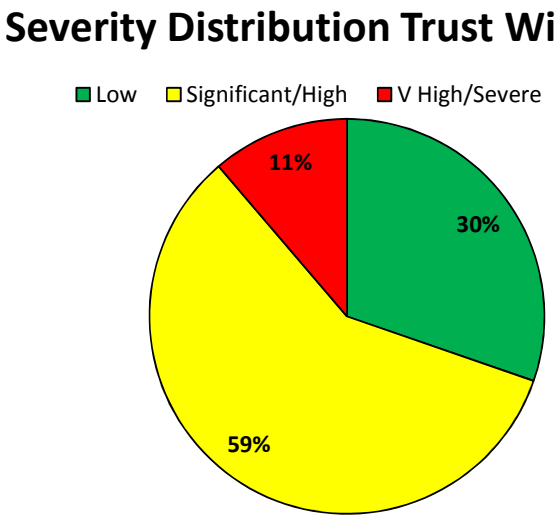
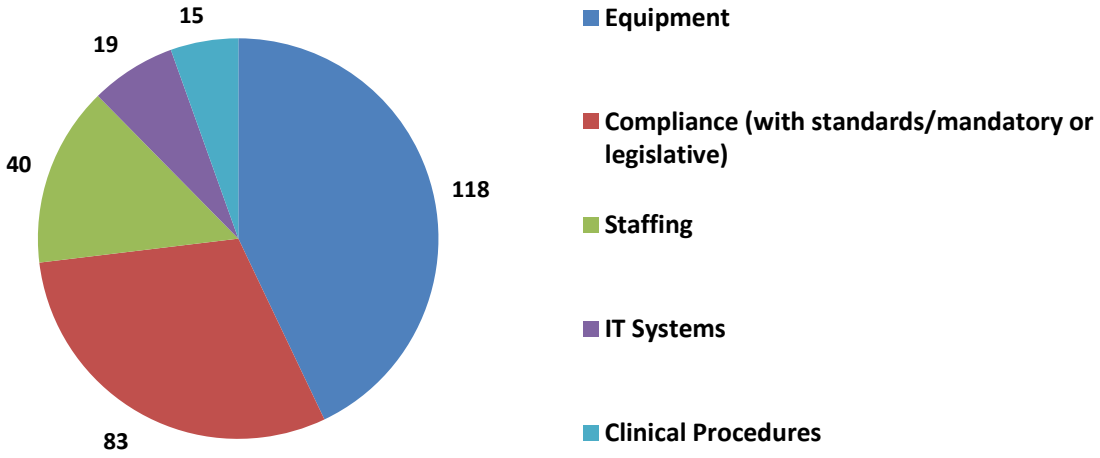
Trust wide Risk and Severity Distribution

1.1 There are currently 373 live risks recorded on the Trust Risk Register system compared to 401 the previous month. Trust wide distribution of risk is shown below.

	Low				Significant			High			Very High		Severe	Unacceptable
	1	2	3	4	5	6	8	9	10	12	15	16	20	25
April	0	16	33	64	4	33	45	35	5	108	12	30	15	1
May	0	16	32	65	4	30	45	34	5	100	9	20	13	0



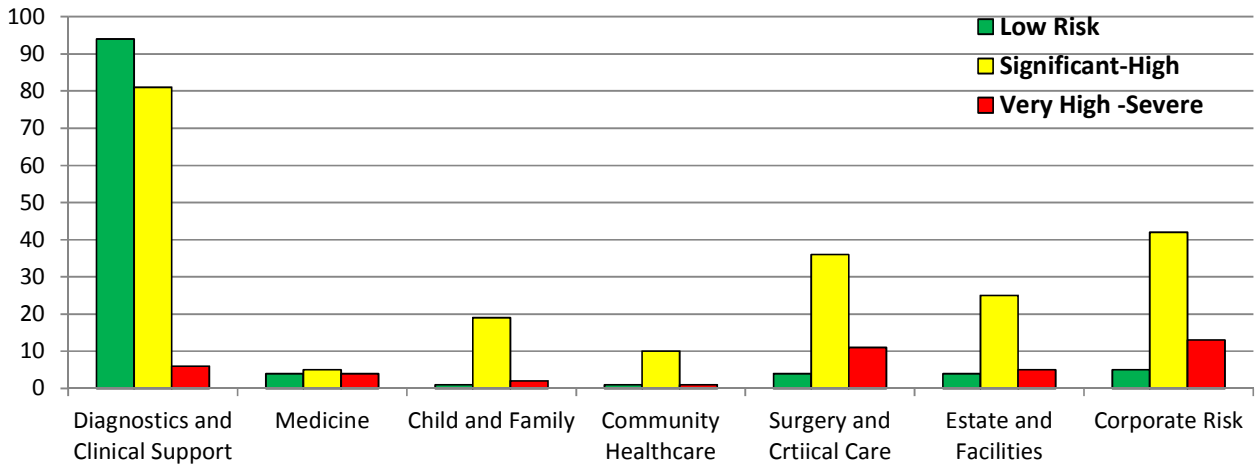
1.2 Top Five Sources of Risk across the Trust



2.1 Strategic risk *distribution across business groups*

Very High		Severe	Unacceptable
15	16	20	25
Medicine			
0	0	2	0
Child and Family			
0	1	0	0
Community Healthcare			
0	0	0	0
Surgery and Critical Care			
0	1	1	0
Estate and Facilities			
2	0	1	0
Corporate Risk (Nursing, Finance, I.T. Executive Team, HR.)			
0	5	4	0
Diagnostics and Clinical Support			
0	2	1	0

2.2 Severity Distribution in Business Groups



3.1 Closed risks and mitigated risks

The corporate risks below have been reviewed and either closed or de-escalated

- *2936- Unsent referrals Advantis*
- *2777- Maternity Safeguarding Practice*
- *2860- Safeguarding/Fire Prevention training access for all volunteers working at SFT*
- *2567- Loss of Aspen House Server*

3.2 New Strategic Risk

There are no new strategic risks added this month

3.3 Changes in risk rating

All strategic risks are reviewed monthly. Currently there are 20 strategic risk, 9 of these are considered severe. In April, no risks have had their current risk rating amended based upon the actions carried out and assurances received.

Key for Committees:
QAC – Quality Assurance Committee
WOD – Workforce & Organisational Development Committee
FS&I – Finance, Strategy & Investment Committee

Strategic Risk Register

Business Group	ID	Source	Risk Owner	Risk Type	Risk	Existing Controls	Initial Rating	Current Consequence	Current Likelihood	Current Rating	Mitigating actions to be completed	Date for action plan completion	Target Risk Score	Key Indicators	Progress Arrow Key: Red = increase in current rating Green = reduction in current rating Yellow = no change	Exec Owner/ Committee (See Key above)
Child and Family	2060	Staffing	Claire Woodford	Strategic	**Out of hours consultant provision – Pediatrics** *Inadequate senior cover in three acute areas simultaneously for seriously unwell children or neonate*	This risk is constant but low(all year 24/7) that 2 emergencies will occur at once out of hours, when there are only one senior decision maker/experienced paediatrician (could be ST3) on the premises and a Consultant non-resident on call to readily attend	16	4	4	16	Formally review new arrangements - consider invited review from RCPCH	30/06/2016	**12**	Provision of senior cover in three acute areas simultaneously for seriously unwell children or neonate.	⟷	CW/WOD
Corporate Nursing	2742	Analysis & Improvement	Cathie Marsland	Strategic	**Poor level of investigation into serious incident** *A number of investigations which have not been felt to be robust, and some investigations where poor engagement by clinicians both nursing and medical has led to considerable delays and inadequately completed investigations* .	Standard Operating procedure which clearly details the requirements for a robust investigation Guidelines for all staff conducting investigations Training offered via training brochure on how to undertake an investigation Number of governance and senior management staff have undertaken the NPSA root cause analysis training.	16	4	4	16	Risk team to be given further training in investigating incident to ensure they are able to challenge poor practice Monitor quality of patient safety reports on a random basis by CM	30/06/2016	**8**	Reduced amount of reinvestigation and reduced criticism from external regulator	⟷	JM/QAC
Corporate Nursing	2806	Compliance	Cathy Gibson	Strategic	**Non Compliance with the Trust Alert & Hazards SOP** *Lack of staff awareness of the Trust Risk Management Alerts and their requirements*	Trust process in place to circulate alerts through Risk & Safety Team	16	4	4	16	Further spot checks to be completed and results to Risk Committee	30/06/2016	**8**	Staff compliance with Alert and Hazard notices SOP	⟷	JM/QAC

Business Group	ID	Source	Risk Owner	Risk Type	Risk	Existing Controls	Initial Rating	Current Consequence	Current Likelihood	Current Rating	Mitigating actions to be completed	Date for action plan completion	Target Risk Score	Key Indicators	Progress Arrow Key: Red = increase in current rating Green = reduction in current rating Yellow = no change	Exec Owner/ Committee (See Key above)
Corporate Nursing	2888	Falls	Cathy Gibson	Strategic	**Failure to Achieve Trust Falls Targets for 2015 & 2016** *Failure to meet Trust Falls Targets (data as of end of November 2015 – 24 major and above gone or going through investigation to determine if avoidable – lapses in care identified*	Hospital falls group meets 6 weekly to review corporate falls data report. Severe and catastrophic falls reported to Trust Incident Review Meeting, reported to Commissioners and full root cause investigation undertaken by business groups. Policies and procedures in place regarding falls prevention and management. Initiatives to assist in the management and prevention of falls - low profiling beds, alarms, slipper project etc. Risk & safety Team review falls incidents, and escalate as and when required for investigation. Wards notify risk and safety team/business group of falls which result in fracture or serious injury. Specialised falls prevention and management training mandatory every 3 years for nursing and therapy staff.	16	4	4	16	Meeting with Ward Sisters regarding alarm upgrade and complete program Review of Corporate data reports presented to group. Falls Policies to be reviewed with Falls Quality Standards. Medication Review to be reviewed and implemented. Lying and Standing BP Assessment to be clarified and implemented. Continue slipper project with Age UK, undertake trial of slipper socks.	29/06/2016	**12**	To have less than 10 avoidable falls in a year	⟷	JM/QAC
Corporate Nursing	2194	Infection Prevention and Control	Nesta Featherstone	Strategic	**Reduction in number of single rooms for isolation of patients** *With the rising trend and increased outbreaks during 2014-15 from Carbapenemase producing Entrobacteriaceae cases, the requirement and recommendations for single room isolation facilities continues to be a challenge across the Trust. No Robust Alert system in place across the Trust to highlight previous patients with Health care associate infections.*	SOP for isolation of patients	16	4	4	16	Bed managers following training will take over side room database. opening of D block	31/10/2016	**8**	A robust system is in place to ensure patients are appropriately managed in single rooms	⟷	JM/QAC

Business Group	ID	Source	Risk Owner	Risk Type	Risk	Existing Controls	Initial Rating	Current Consequence	Current Likelihood	Current Rating	Mitigating actions to be completed	Date for action plan completion	Target Risk Score	Key Indicators	Progress Arrow Key: Red = increase in current rating Green = reduction in current rating Yellow = no change	Exec Owner/ Committee (See Key above)
Diagnostic & Clinical Support	2718	Medication	Paul Buckley	Strategic	**Medication Errors Occurring as a Result of Having Different Systems for Prescribing** *Prescribing on different systems inevitably leads to confusion and errors occurring. There have already been incidents on Datix where patients had the potential to be harmed. At the present time prescribing may take place on Advantis ED, on a paper prescription chart or on EPMA.*	A notice has been put on the front page of the ePMA screen and on the intranet alerting staff to the risks of having different systems for prescribing and that all drugs prescribed must be transferred to ePMA as soon as possible after admission. A warning on this risk added to the nurses' essential training.	16	4	4	16	Review any incidents and report back to risk management committee. Implementation of new EPR system.	01/09/2016	**12**	Implementation of new EPR system.	⟷	JS/QAC
Diagnostic & Clinical Support	2130	Clinical procedures	Sara Wilson	Strategic	**Insufficient capacity in Endoscopy to meet the current demand** *The Trust is at risk of not achieving its target*	Flexible use of existing staff to cover as many unused lists as possible. A plan to review the utilisation of the unit and the changes needed to meet demand. Mediscan have been commissioned to conduct 10 additional weekend lists per month. There is close monitoring of the breaching of targets and the Senior Team are alerted to any immediately. Introduced new role of Inpatient co-ordinator to manage all inpatient referrals to prioritise referrals and maximise use of capacity. Endoscopy Cancellation escalation procedure developed.	20	4	5	20	Continue to support estates/procurement in establishing plans for unit expansion Improve sessional productivity, adding 1 unit to each list by developing case pre-assessment and additional nurses allocated to procedure rooms	30/06/2016	**12**	Endoscopy target to be achieved	⟷	JS/QAC
Diagnostic & Clinical Support	2877	Compliance	Grace Davie	Strategic	**Continued operation and sustainability of existing AOS.** *AOS is currently operating as a single-handed nurse-led model and 3.5 PAs of oncologist time which is provided by 4 visiting oncologists from The Christie Hospital and is non-compliant with the requirement.*	Service pager held by non-clinical staff in times of absence as a message relaying service only to the visiting oncologists. Staff training in acute areas on management of neutropenic sepsis and MSCC. Options paper prepared for Trust consideration to increase staffing. 24 hour advice line available at The Christie	16	4	4	16	Await outcome of options paper	07/06/2016	**12**	To be compliant with requirement	⟷	JS/QAC

105 of 212

Business Group	ID	Source	Risk Owner	Risk Type	Risk	Existing Controls	Initial Rating	Current Consequence	Current Likelihood	Current Rating	Mitigating actions to be completed	Date for action plan completion	Target Risk Score	Key Indicators	Progress Arrow Key: Red = increase in current rating Green = reduction in current rating Yellow = no change	Exec Owner/ Committee (See Key above)
Estates and Facilities	2942	Equipment	Russell James	Strategic	**Hospital CCTV.** *A significant proportion of the hospitals Closed Circuit Television surveillance equipment is an old analogue system that was originally installed up to 20 years ago. This equipment is starting to fail and large parts of the systems covering the Maternity Building and the Emergency Department have already broken down. There are no maintenance contracts in place.*	CCTV analogue, Door access to wards Door access to main door (Through the night) Security Awareness Training Conflict Resolution Training,	20	5	4	20	Submit to Directorate Management. Obtain quotations for CCTV. Further management action to be determined once the cost of possible options are known.	30/06/2016	**10**	Maintenance contract in place for any of the CCTV installations	⟷	JS/QAC
Estates and Facilities	2730	Compliance	Russell James	Strategic	**Pharmaceutical waste** *A recent waste audit has shown that pharmaceutical waste e.g. used medicine bottles and blister packs which may be hazardous are being disposed of at ward/ department level into the domestic waste stream.*	Training on waste streaming at ward/ department level, staff were trained to put medicines (pharmaceutically active) into yellow lidded sharps containers. Since this training took place, suppliers of waste disposal containers have introduced dedicated blue lidded containers for this type of pharmaceutical waste, allowing improved segregation.	15	3	5	15	Monitor compliance on a routine basis both through a responsible person (waste manager) and frontline staff involved in waste disposal. When appropriate arrangements are in place, train all staff involved in waste disposal on new processes	30/07/2016	**6**	No breach of waste disposal legislation	⟷	JS/QAC

Business Group	ID	Source	Risk Owner	Risk Type	Risk	Existing Controls	Initial Rating	Current Consequence	Current Likelihood	Current Rating	Mitigating actions to be completed	Date for action plan completion	Target Risk Score	Key Indicators	Progress Arrow Key: Red = increase in current rating Green = reduction in current rating Yellow = no change	Exec Owner/ Committee (See Key above)
Estates and Facilities	2748	Environment	Russell James	Strategic	**Corridor obstruction** *Obstruction of corridors 9the Hospital Street) compromising means of escape by : obstructing freedom of movement into and through corridor fire compartments, obstructing access by the emergency services in getting to any fire and preventing automatic fire doors from closing*	Additional Storage space including the bed store. Two dedicated corridor agency porters. Corridor Review Group has been established - however due to capacity pressures representation from all business groups have proved difficult. The action tracker outlining the work of the group so far is attached for.	15	5	3	15	Engage with ward and departmental managers/clinical leads through a user group Consider any infection prevention issues that might arise from mattrasses /beds/medical equipment review and report any possible options for the implementation of a trustwide asset management system to the risk management committee Implement agreed corridor actions and ensure where apprpropraite that operational procedures are developed and embedded	30/07/2016	**10**	Fire service compliance	⟷	JS/QAC
Finance	2896	Financial	Kay Wiss	Strategic	**Delivery of 2016/17 CIP** *The Annual Plan of the Trust for 2016/17 needs to deliver a break-even position and in order to achieve this significant transformational savings needs to be realised.*	As part of the Board Assurance Framework Structure performance (including finance and standards) are reported through the committees. This has been enhanced by a second tier of performance and CIP escalation meetings.	20	5	4	20	A weekly Senior Management Group has been established and will receive updates from the Programme Manager to help resolve issues Design and introduction of innovation projects to deliver transformational change	30/04/2017	**15**	CIP delivery	⟷	FP/FS&I

Business Group	ID	Source	Risk Owner	Risk Type	Risk	Existing Controls	Initial Rating	Current Consequence	Current Likelihood	Current Rating	Mitigating actions to be completed	Date for action plan completion	Target Risk Score	Key Indicators	Progress Arrow Key: Red = increase in current rating Green = reduction in current rating Yellow = no change	Exec Owner/ Committee (See Key above)
Human Resources	2879	Finance	Tracey Bradshaw	Strategic	**Use of Temporary Staffing** *Risk to patient care through ongoing or increasing use of temporary staffing*	Twice yearly train the trainer updates at the CPF workshops Bi monthly report to the medical devices committee regarding compliance New RNs being taught at clinical induction from September 2015	20	4	5	20	Development of action plan in response to 1. Completion of Agency Diagnostic Tool. Deliver identified actions and report progress at WODC. Evaluation and Learning of action taken	30/06/2016	**12**	Reduction in cost and use of Temporary Staffing	⟷	JSh/WOD
Medicine	2470	Other	Stuart Rogers	Strategic	**Gastroenterology service provision** *Insufficient capacity to adequately deliver all service areas within Gastroenterology* Failure to meet NICE guidance	OWL Backlog patients are being clinically validated by one of the substantive team to ensure the safety of patients with extended waits. Reliance on Locum medical staff is reducing as substantive recruitment continues, this is improving the quality and continuity of clinical care, as well as pathway management. The 6th Substantive Consultant post is back out to advert to allow the implementation of the COW model.	20	4	5	20	Management Validate 1800 patients Begin CNS Validation	31/07/2016	**8**	Nice guidance compliance	⟷	CW/QAC
Medicine	2721	National Recommendation	Rebecca Barker	Strategic	**Trauma Unit External Peer Review Serious Concerns** *Following the Trauma Unit Peer review , serious concerns were expressed in terms of three aspects of the Emergency Department and Trust delivering Trauma Care*	Currently there is an ED Consultant on call for trauma 24/7. The ED Consultant is on site between 09.00 and 22.00, they are then on call and respond within 30 minutes. Currently every patient has a named Nurse could take this role. Current baseline is that less than 16% are seen by a consultant within 30 minutes, according to data.	20	4	5	20	Review the process of recording of the CT reporting within 1 hour to assure demonstrates performance indicator is reached for appropriate patients Develop a Yearly Trauma Audit plan and findings to be fed into Quality Board meetings Develop a plan to enable a robust Trauma coordinator service 7 days a week that can demonstrate the use of Rehabilitation prescriptions	30/06/2016	**8**	Trauma unit peer review compliance	⟷	CW/QAC

Business Group	ID	Source	Risk Owner	Risk Type	Risk	Existing Controls	Initial Rating	Current Consequence	Current Likelihood	Current Rating	Mitigating actions to be completed	Date for action plan completion	Target Risk Score	Key Indicators	Progress Arrow Key: Red = increase in current rating Green = reduction in current rating Yellow = no change	Exec Owner/ Committee (See Key above)
Surgery and Critical Care	2824	Staffing	Pauline Enstone	Strategic	**Safe Staffing Surgery and Critical Care Wards** *There is currently a lack of Trust registered nurses and nursing assistants on wards to ensure consistent, safe staffing levels. This is contributed to by vacancies, long term sick and maternity leave*	Matron shift by shift safety huddle reviews to equalising staffing daily. 1135 senior nurse reviews out of hours. Utilisation of Trust safe staffing escalation policy utilising, when authorised Pulse/Thornbury. Surgery now recruiting in November internationally. Revised rosters now in place from 21st September to maximise roster benefits. Adherence to roster policy. Robust absence management. Proposed recruitment UK day Nov 2015. Offer all students that work in the Trust positions. Embraced apprentice scheme. Embraced CSWd trainee scheme. Requesting funding for a pool of band 2 staff to relieve pressure on wards and backfill long term sick and maternity leave. DoN has supported and approved NHSP NTL and NTM rates to encourage senior nurses to undertake in charge shifts to stabilise the wards where gaps in off duties require senior support. Non front line nurse provided refresher training to support wards in escalation.	16	4	5	20	Follow up leads from Manchester university student nurse event attended sept 2015	28/06/2016	12	Maintain safe staffing level	⟷	JSh/WOD

Business Group	ID	Source	Risk Owner	Risk Type	Risk	Existing Controls	Initial Rating	Current Consequence	Current Likelihood	Current Rating	Mitigating actions to be completed	Date for action plan completion	Target Risk Score	Key Indicators	Progress Arrow Key: Red = increase in current rating Green = reduction in current rating Yellow = no change	Exec Owner/ Committee (See Key above)
Surgery and Critical Care	2826	Finance	Karen Hatchell	Strategic	**Non-delivery of S&CC CIP/Income targets 2015-2016** *The Trust is unable to deliver the £11.8 million Monitor CIP savings required in 2015/16*	Monthly reporting finance and performance. Weekly local meeting with Accountants for income & activity and finance & CIP. Monitor and tracking of project KPI's. Monthly information produced by BG Accountant. All vacant posts to be scrutinised by BG Director prior to approval to recruit. Restructures across departments and specialties Headcount reduction/MARs. Income generation opportunities	20	4	5	20	Reduce Outsourcing. Review of capacity to maximise income potential from targeted specialties eg., weekend, evening, Trust Health. Reduce Locum/Agency and WLI spend. SLR/PLiCs review. Improving staff productivity schemes. Departmental efficiency schemes. On-going work with the Procurement team to review prosthetic usage, to realise extra savings and longer term savings on tenders. Work closely with Corporate Teams to ensure target delivery of project work-streams relevant to Business Group e.g., outpatients, drugs, HR. 15/16 Headcount reduction	20/06/2016	**12**	Achieve Business Group CIP Target for 2015/2016.	⟷	FP/FS&I

Business Group	ID	Source	Risk Owner	Risk Type	Risk	Existing Controls	Initial Rating	Current Consequence	Current Likelihood	Current Rating	Mitigating actions to be completed	Date for action plan completion	Target Risk Score	Key Indicators	Progress Arrow Key: Red = increase in current rating Green = reduction in current rating Yellow = no change	Exec Owner/ Committee (See Key above)
Trust Executive Team	2889	Compliance	Collin Wasson	Strategic	**7 day working** *The Keogh Review has recommended 10 standards to support the NHS in improving clinical outcomes and patient experience at weekends. 4 of these standards have been prioritised and there is a risk that at present the trust cannot achieve them in the given timeframes:*	Extending palliative care team support for community and hospital over Saturday and Sunday, 8am to 430pm. Rota changes of consultants in Medicine Business Group to provide Consultant Physical presence on AMU from 8am to 5pm on Saturday and Sunday; to provide Consultant delivered ward rounds on B2/E1 (stroke unit) on Saturday and Sunday; to provide in reach Consultant Cardiology input to AMU and CCU on Saturday and Sunday Radiology staff on site 24/7 to provide plain film x rays, mobile x rays, theatre imaging and CT scans. There is now continuous CT provision on site providing swifter patient access to CT scanning for trauma and stroke patients out of hours.	20	4	5	20	All actions to be taken through Stockport Together Transformational Project	30/06/2016	**12**	Achievement of standards in 7/7 working	⟷	CW/QAC
Trust Executive team	2644	Compliance	Colin Wasson	Strategic	**Upper GI Bleed Service Provision (Non Compliance with NCEPOD Gastrointestinal Haemorrhage (Time to Get Control) published in 2015 and NICE Guidance 141)** *NICE Clinical Guidance 141 has 9 quality standards at present the Trust is fully compliant with 2 standards, partially compliant with 3 standards and non-compliant with 4 (claim of breach of duty).*	*There is guidance for the management of those patients who are haemodynamically unstable to receive endoscopy this plan is different for in hours and out of hours (Standard 2). Endoscopy within 24 hours can be offered to patients with the exception of those being admitted on Saturdays and on Sundays preceding bank holidays In hours, the appropriate endoscopic treatment for non variceal bleeding can be offered. Aspirin and antibiotic therapy advice is a given as per guidance*	20	4	4	16	Identify a Clinical Lead for GI Bleeding Separate rota for endoscopy staff and organisation of Endoscopy list to prioritise blood Development of a separate "bleeder rota" to provide 24/7 provision of endoscopic diagnostic and treatment service	30/06/2016	**8**	Full compliance with the NICE/NCEPOD guidance	⟷	CW/QAC

Business Group	ID	Source	Risk Owner	Risk Type	Risk	Existing Controls	Initial Rating	Current Consequence	Current Likelihood	Current Rating	Mitigating actions to be completed	Date for action plan completion	Target Risk Score	Key Indicators	Progress Arrow Key: Red = increase in current rating Green = reduction in current rating Yellow = no change	Exec Owner/ Committee (See Key above)
Trust Executive team	1881	Compliance	Cathie Marsland	Strategic	**Deliver 4 hour Performance Target within ED** *Failure to achieve this target would represent a significant corporate risk to the Foundation Trust both financially and reputation.*	Existing internal escalation processes Daily monitoring of staffing rotas in ED and on-call The trust Unscheduled Care Plan- monthly meetings Whole health economy collaboration to deliver this target	20	5	4	20	Ownership of longer term issues DTOCs - Ownership of longer term issues. DTOCs - Formalised outputs with clear escalation where required. Clear escalation where required. DTOCs - 11:30 Meeting Structure/ Agenda. CAIR - Leadership/ Presence? CAIR - Daily processes. CAIR - Clarity of Roles and Responsibilities. Clarity of Roles and Responsibilities. Junior Doctors Batching of jobs e.g. TTO's Acutes entering EDD into Advantis. Surgery escalation - SOP (Co-ordination/ Leadership) Surgery escalation - SOP (Roles and responsibilities). RAT Model - 1hr from arrival to consultant (95th Centile). Triage Plus Model - 15 min to Triage (95th Centile)	30/06/2016	**10**	Achieving 95% in the 4 hour Performance Target within ED	⟷	JS/QAC

6. RISK ASSESSMENT SCORING/RATING MATRIX

LIKELIHOOD OF HAZARD

LEVEL	DESCRIPTER	DESCRIPTION
5	Almost certain	Likely to occur on many occasions, a persistent issue - 1 in 10
4	Likely	Will probably occur but is not a persistent issue - 1 in 100
3	Possible	May occur/recur occasionally - 1 in 1000
2	Unlikely	Do not expect it to happen but it is possible - 1 in 10,000
1	Rare	Can't believe that this will ever happen - 1 in 100,000

QUALITATIVE MEASURES OF CONSEQUENCE OF RISK

Level	Descriptor	Injury/Harm	Service Continuity	Quality	Costs	Litigation	Reputation/Publicity
1	Low	Minor cuts/ bruises	Minor loss of non-critical service	Minor non-compliance of standards	<£2K	Minor out-of-court settlement	Within unit Local press <1 day coverage
2	Minor	First aid treatment <3 days absence <2 days extended hospital stay	Service loss in a number of non-critical areas <2hours or 1 area or <6 hours	Single failure to meet internal standards of follow protocol	£2K-£20K	Civil action - Improvement notice	Within unit Local press <1 day coverage
3	Moderate	Medical treatment required >3 days absence >2 days extended hospital stay	Loss of services in any critical area	Repeated failures to meet internal standards or follow protocols	£20K-£1M	Class action Criminal prosecution Prohibition notice served	Regulatory concern Local media <7 day of coverage
4	Major	Fatality Permanent disability Multiple injuries	Extended loss of essential service in more than one critical area	Failure to meet national standards	£1M-£5M	Criminal prosecution - no defence Executive officer fined	National media <3day coverage Department executive action
5	Catastrophic	Multiple fatalities	Loss of multiple essential services in critical areas	Failure to meet professional standards	>£5M	Imprisonment of Trust Executive	National media >3 day of coverage MP concern Questions in the House Full public enquiry

The risk factor = severity x likelihood

By using the equation, a risk factor can be determined ranging from 1 (low severity and unlikely to happen) to 25 (just waiting to happen with disastrous and widespread consequences). This risk factor can now form a quantitative basis upon which to determine the urgency of any actions.

	CONSEQUENCE				
LIKELIHOOD	**1** **Low**	**2** **Minor**	**3** **Moderate**	**4** **Major**	**5** **Catastrophic**
5 - Almost Certain	AMBER *(significant)*	AMBER *(high)*	RED *(very high)*	RED *(severe)*	RED *(unacceptable)*
4 - Likely	GREEN *(low)*	AMBER *(significant)*	AMBER *(high)*	RED *(very high)*	RED *(severe)*
3 - Possible	GREEN *(low)*	AMBER *(significant)*	AMBER *(high)*	AMBER *(high)*	RED *(very high)*
2 - Unlikely	GREEN *(low)*	GREEN *(low)*	AMBER *(significant)*	AMBER *(significant)*	AMBER *(high)*
1 - Rare	GREEN *(low)*	GREEN *(low)*	GREEN *(low)*	GREEN *(low)*	AMBER *(significant)*

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Stockport NHS
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	26th May 2016
Subject:	Safe Staffing report		
Report of:	Director of Nursing and Midwifery	**Prepared by:**	Deputy Director of Nursing and Midwifery

REPORT FOR APPROVAL

Corporate objective ref: -----	**Summary of Report** The report provides an overview, by exception, of actual versus planned staffing levels, for the month of April 2016. Key points of note as follows; • Fill rates for Registered Nurses (RN) and care staff remain above 90% • Staffing challenges remain across Trauma and Orthopaedics whilst staff undertaken induction and complete their supernumerary period • Movement of staff from B2 has been an issue and is being monitored The Board of Directors is asked to note the contents of this report with assurance given that Safe Staffing was maintained during April 2016.
Board Assurance Framework ref: -----	
CQC Registration Standards ref: -----	
Equality Impact Assessment: ☐ Completed ☐ Not required	

Attachments:	Annex A – Historical submission data Annex B – UNIFY submission April 2016

This subject has previously been reported to:	☐ Board of Directors ☐ Council of Governors ☐ Audit Committee ☐ Executive Team ☐ Quality Assurance Committee ☐ FSI Committee	☐ Workforce & OD Committee ☐ BaSF Committee ☐ Charitable Funds Committee ☐ Nominations Committee ☐ Remuneration Committee ☐ Joint Negotiating Council ☒ Other

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i INTRODUCTION

1.1 As part of the ongoing monitoring of staffing levels, this paper presents to the Board of Directors a staffing report of actual staff in place compared to staffing that was planned for the month of April 2016.

Work-streams to support safe staffing continue with a monthly Safe staffing group chaired by the Director of Nursing and Midwifery.

The Board of Directors is asked to note the contents of this report.

2. BACKGROUND

2.1 NHS England is not currently RAG (Red, Amber, Green) rating fill rates. A review of local organisations shows that fill rates of 90% and over are adopted with exception reports provided for those areas falling under this level.

April 2016	DAY	NIGHT
RN/RM Average Fill Rate	90.3%	95.7 % ↑
Care Staff Average Fill Rate	107.6% ↑	122.9% ↑

3. CURRENT SITUATION

3.1 Registered Nurse/Midwife

3.2 Overall Performance

Whilst April 2016 has continued to report further favorable staffing levels on day and night shifts overall, there has been continued pressure on wards D1, D2 and M4 within Surgery and Critical care business group and on wards A15, B2 and Bluebell with Medicine.

3.3 Temporary Staffing

Registered nursing agency reliance figures are 2 months in arrears and so are reported here for March 2016. Overall reliance on Registered Nursing agencies maintained at 4.7% in March compared to the decrease reported in January of 4.1%. This remains linked to the demand across Trauma and Orthopaedics whilst recruitment was underway.

3.3 Surgery

Surgery has continued to report sub-optimal staffing levels across D1, D2 and M4 although it is pleasing to now record that staff have been recruited and are working in their supernumerary period. Safe staffing has been maintained due to the daily actions put in place.

3.4 Medicine

Wards Bluebell and B2 continue to report reductions In March. B2 relates to some recruitment and movement of staff. This has been flagged as a concern and will be monitored going forward as B2 requires the increased staffing levels as part of the Hyper acute staffing model. A15 also reports reductions in staffing – this is a continued observation for A15 where retention appears to be an issue. The Head of Nursing has been

asked to undertake a review, working with HR and OD and an update will be provided in a subsequent report.

3.5 **Community**

The second meeting with the CCG took place in April 2016 to discuss the Staffing review paper presented in February. This has culminated in the agreement for increases in the Band 5 establishment.

3.6 **Recruitment**

EU recruitment continues as per agreed plan and discussions are underway to understand the impact of recently introduced International English Language Test (IELTs) requirements for EU staff, which is likely to delay recruitment timeframes. A Greater Manchester International Recruitment group has been established and the organisation is meeting in advance of this to share our learning and good practice to date.

Further local 'one stop' recruitment events are planned for June 2016

4. RISK & ASSURANCE

4.1 The Organisation can be assured that Safe Staffing levels were maintained during April 2016.

5. CONCLUSION

5.1 Safe staffing levels continue to be a significant focus and recently agreed further international recruitment will ensure recent improvements are maintained.

6. RECOMMENDATIONS

6.1 The Executive Team are asked to note the contents of this report

Appendix A – Previous months staffing fill rates

March 2016	DAY	NIGHT
RN/RM Average Fill Rate	90.3% ↑	95.3 %
Care Staff Average Fill Rate	101.5% ↑	116.2% ↓

Feb 2016	DAY	NIGHT
RN/RM Average Fill Rate	90.2% ↓	95.3 % ↓
Care Staff Average Fill Rate	101.1% ↓	118.9% ↓

Jan 2016	DAY	NIGHT
RN/RM Average Fill Rate	92.2% ↑	96.1 % ↑
Care Staff Average Fill Rate	105% ↑	120.1% ↑

Dec 2015	DAY	NIGHT
RN/RM Average Fill Rate	92.1% ↑	94.5 % ↓
Care Staff Average Fill Rate	101.4% ↑	113.5% ↓

Nov 2015	DAY	NIGHT
RN/RM Average Fill Rate	91.4% ↓	104.1 % ↑
Care Staff Average Fill Rate	95.8% ↓	117.1% ↑

Oct 2015	DAY	NIGHT
RN/RM Average Fill Rate	91.9% ↑	97.1% ↓
Care Staff Average Fill Rate	102.1% ↑	110.8% ↑

Sep 2015	DAY	NIGHT
RN/RM Average Fill Rate	90.7% ↑	97.3% ↑
Care Staff Average Fill Rate	99.7% ↑	109.8% ↑

Aug 2015	DAY	NIGHT
RN/RM Average Fill Rate	89.6% ↓	94.9% ↓
Care Staff Average Fill Rate	98.7% ↓	108.2% ↑

July 2015	DAY	NIGHT
RN/RM Average Fill Rate	90.9% ↑	97.2% ↑
Care Staff Average Fill Rate	101% ↑	106.4% ↓

June 2015	DAY	NIGHT
RN/RM Average Fill Rate	90.3% ↓	95.2% ↑
Care Staff Average Fill Rate	100.4% ↓	106.6% ↑

May 2015	DAY	NIGHT
RN/RM Average Fill Rate	91.4% ↓	95.1% ↓
Care Staff Average Fill Rate	101.5% ↑	105.7% ↓

April 2015	DAY	NIGHT
RN/RM Average Fill Rate	93% ↑	95.7% ↑
Care Staff Average Fill Rate	100.3% ↑	108.2% ↓

March 2015	DAY	NIGHT
RN/RM Average Fill Rate	92% ↑	93.3% ↑
Care Staff Average Fill Rate	97.9% ↓	106.9% ↓

February 2015	DAY	NIGHT
RN/RM Average Fill Rate	90% ↓	91.8% ↓
Care Staff Average Fill Rate	100.4% ↓	108.5% ↓

January 2015	DAY	NIGHT
RN/RM Average Fill Rate	91.7% (62.4%-104%) ↓	94.5% (58.9%-113.2%)↑
Care Staff Average Fill Rate	101% (71% -137.9%)↑	110.6% (51.6%-217%)↑

December 2014	DAY	NIGHT
RN/RM Average Fill Rate	92.2% (69.5%-112.4%) ↓	93.6% (59.7%-112.9%)↓
Care Staff Average Fill Rate	98.8% (62.8%-122.2%)↓	106.5% (71%*-125.8%)↑

November 2014	DAY	NIGHT
RN/RM Average Fill Rate	93% (72.7%-100%) ↑	95.7% (69.2%-107.9%)↑
Care Staff Average Fill Rate	102.4% (67.6%-132.4%)↑	106.1% (30%*-140.8%)↓

Fill rate indicator return
Staffing: Nursing, midwifery and care staff

Org: RWJ - Stockport NHS Foundation Trust

Period: April_2016-17

Please provide the URL to the page on your trust website where your staffing information is available

www.stockport.nhs.uk/112/safe-staffing

Hospital Site Details		Ward name	Main 2 Specialties on each ward		Day				Night				Day		Night		
					Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff						
Site code	Hospital Site name		Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Head of Nursing Comment
RWJ09	STEPPING HILL HOSPITAL - RWJ09	NNU - Neonatal Unit	420 - PAEDIATRICS		2250	2235	0	0	1575	1512	0	0	99.3%	n/a	96.0%	n/a	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	TH - Tree House	420 - PAEDIATRICS		3150	2977.5	450	450	2100	1880	0	0	94.5%	100.0%	89.5%	n/a	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	JW - Jasmine Ward	502 - GYNAECOLOGY		900	900	450	450	600	600	0	0	100.0%	100.0%	100.0%	n/a	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	BC - Birth Centre	501 - OBSTETRICS	560- MIDWIFE LED CARE	1800	1777.5	450	450	1200	1200	300	290	98.8%	100.0%	100.0%	96.7%	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	M1 - Delivery Suite	501 - OBSTETRICS		2700	2655	450	405	1800	1750	300	280	98.3%	90.0%	97.2%	93.3%	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	M2 - Maternity 2	501 - OBSTETRICS		1575	1567.5	900	877.5	600	600	300	300	99.5%	97.5%	100.0%	100.0%	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	ICU & HDU	192 - CRITICAL CARE MEDICINE		4500	4452	750	750	3960	4048	0	0	98.9%	100.0%	102.2%	#DIV/0!	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	SSSU - Short Stay Surgical Unit	101 - UROLOGY	100 - GENERAL SURGERY	1873	1612	575	548	620	610	310	394	86.1%	95.3%	98.4%	127.1%	New staff in place, new rigistered nurses awaiting NMCregistration. Safe staffing assured
RWJ09	STEPPING HILL HOSPITAL - RWJ09	B3	100 - GENERAL SURGERY	101 - UROLOGY	1350	1152	1125	1065	660	594	660	627	85.3%	94.7%	90.0%	95.0%	All vacancies recuited to with staff either awaiting start date or UK registration, RN suboptimal with minimum 2 RN's per shift. Daily Matron assurance provided
RWJ09	STEPPING HILL HOSPITAL - RWJ09	B6	100 - GENERAL SURGERY	101 - UROLOGY	1350	1035	1125	1516.5	660	649	660	816	76.7%	134.8%	98.3%	123.6%	Escalation beds open RN ratio appropriate
RWJ09	STEPPING HILL HOSPITAL - RWJ09	C3	100 - GENERAL SURGERY	101 - UROLOGY	1575	1560	1080	1061	840	799	660	650	99.0%	98.2%	95.1%	98.5%	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	C6	101 - UROLOGY	300 - GENERAL MEDICINE	1350	1260	1350	1610	660	660	660	962	93.3%	119.3%	100.0%	145.8%	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	D1	110 - TRAUMA & ORTHOPAEDICS		1575	1110	1350	1666.5	660	682	660	1122	70.5%	123.4%	103.3%	170.0%	New starters recruited awaiting registration and start date. Care staff increased to support sub optimal days RN safety assured
RWJ09	STEPPING HILL HOSPITAL - RWJ09	D2	110 - TRAUMA & ORTHOPAEDICS		1350	1077.5	1125	1066.5	660	648	660	648	79.8%	94.8%	98.2%	98.2%	Never less than 2 RN's on sub-optimal days, safety assured
RWJ09	STEPPING HILL HOSPITAL - RWJ09	D4	110 - TRAUMA & ORTHOPAEDICS		900	878.25	900	982.5	660	671	660	807	97.6%	109.2%	101.7%	122.3%	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	M4	110 - TRAUMA & ORTHOPAEDICS		2025	1360.75	2025	2649.5	990	968	990	1540	67.2%	130.8%	97.8%	155.6%	New starters recruited awaiting registration and start date. Care staff increased to support sub optimal days RN safety assured
RWJ09	STEPPING HILL HOSPITAL - RWJ09	AMU1	300 - GENERAL MEDICINE		2707.5	2220	1890	1897.5	1980	1621.75	1650	1793	82.0%	100.4%	81.9%	108.7%	Reduction in RN due to sickness, and vacancy.Ongoing recruitment to RN vacancies. Two new starters in May
RWJ09	STEPPING HILL HOSPITAL - RWJ09	AMU2	300 - GENERAL MEDICINE		1890	1560	1530	1746	1650	1500	1320	1368	82.5%	114.1%	90.9%	103.6%	RN vacancy being recruited to - ward monitored by Matron for safety
RWJ09	STEPPING HILL HOSPITAL - RWJ09	A10	430 - GERIATRIC MEDICINE		1726.6	1606.6	1620	1935	660	660	660	1804	93.0%	119.4%	100.0%	273.3%	Additional HCA's to support highly dependant patients
RWJ09	STEPPING HILL HOSPITAL - RWJ09	A11	300 - GENERAL MEDICINE		1860	1657.5	1395	1432.5	660	660	660	1092	89.1%	102.7%	100.0%	165.5%	Additional HCA hours to support slight reduction of RN which is being addressed
RWJ09	STEPPING HILL HOSPITAL - RWJ09	A12	300 - GENERAL MEDICINE		1681	1568.5	1410	1320	660	660	660	660	93.3%	93.6%	100.0%	100.0%	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	A14	300 - GENERAL MEDICINE		1614.5	1479.5	1170	1170	660	660	660	759	91.6%	100.0%	100.0%	115.0%	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	A15	300 - GENERAL MEDICINE		1707	1062	1170	1818.5	660	660	660	799	62.2%	155.4%	100.0%	121.1%	Vacancies have been recruited to and due to start in May Additional HCA's supporting patient care. Ward is safe and monitored by Matron
RWJ09	STEPPING HILL HOSPITAL - RWJ09	B2	430 - GERIATRIC MEDICINE		1620	1272	810	936	1320	852	660	708	78.5%	115.6%	64.5%	107.3%	Recruitment is ongoing. Unit is safe. Monitored by Matron
RWJ09	STEPPING HILL HOSPITAL - RWJ09	B4	320 - CARDIOLOGY		1050	1042.5	810	927.5	660	660	330	473	99.3%	114.5%	100.0%	143.3%	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	B5	300 - GENERAL MEDICINE		1050	1101	810	799.5	660	660	660	413.25	104.9%	98.7%	100.0%	62.6%	
RWJ88	THE MEADOWS - RWJ88	BW - Bluebell Ward	318- INTERMEDIATE CARE		1170	810	2370	2562	660	660	660	1210	69.2%	108.1%	100.0%	183.3%	RN vacancy which is being recruited to.Additional HCA hours are supporting the ward and patient care
RWJ09	STEPPING HILL HOSPITAL - RWJ09	C2	300 - GENERAL MEDICINE		1050	971.25	810	950	660	644.25	660	803	92.5%	117.3%	97.6%	121.7%	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	C4	320 - CARDIOLOGY		1035	1005	810	832.5	660	638	330	308	97.1%	102.8%	96.7%	93.3%	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	CCU	320 - CARDIOLOGY		810	810	450	435	660	660	330	330	100.0%	96.7%	100.0%	100.0%	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	CLDU	300 - GENERAL MEDICINE		480	480	480	480	300	300	300	300	100.0%	100.0%	100.0%	100.0%	
RWJ03	CHERRY TREE HOSPITAL - RWJ03	DCNR - Devonshire Centre	314 - REHABILITATION		1110	1008	1935	1830	660	660	660	660	90.8%	94.6%	100.0%	100.0%	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	E1	430 - GERIATRIC MEDICINE		1950	1755	2235	1897.5	990	891	1320	1320	90.0%	84.9%	90.0%	100.0%	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	E2	430 - GERIATRIC MEDICINE		2302.5	2280	1620	2000.5	990	973	990	1254	99.0%	123.5%	98.3%	126.7%	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	E3	430 - GERIATRIC MEDICINE		2302.5	2297.5	1620	1624.5	990	1001	990	1375	99.8%	100.3%	101.1%	138.9%	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	SSOP - Short Stay Older People	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	810	720	450	345	660	660	330	319	88.9%	76.7%	100.0%	96.7%	
		Total			60149.6	54316.35	39500	42487.5	35045	33552	21310	26184.25	90.3%	107.6%	95.7%	122.9%	

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Stockport NHS
NHS Foundation Trust

Board of Directors' Key Issues Report

Report Date: 26/05/16		**Report of:** Workforce & Organisational Development Committee
Date of last meeting: 05/05/16		**Membership Numbers:** Quorate Apologies from: Donald Menzies
1.	Key Issues Highlighted:	The Committee considered an agenda which included the following: • Staff Story, "Reciprocal Mentoring" • Draft Management and Leadership Development Plan • Pay Progression Policy • Junior Doctors' Contract Implementation • NHS Working Longer Group Age Awareness • Health & Wellbeing CQUIN • WRES Update • Gender Equal Pay Gap • Workforce & OD Quarter 4 Performance Report • Apprenticeship Scheme Update • Value Based Recruitment • Shift Pattern Changes Review • Consent agenda: - Corporate Risk Register - Talent Management Strategy - Medical Education Annual Report 2015/16 - Policies for Validation • Key Issues Reports from Reporting Groups With regard to matters to bring to the attention of the Board, the Committee received a presentation from Richard Lewis (IM&T Training Manager) and Vanessa Trimble (Head of OD & Learning) about the Trust's Reciprocal Mentoring Programme. Mr Lewis briefed the Committee with regard to the programme which was aimed at staff who were looking to progress in their careers. As a joint Chair of the Trust's Black or Minority Ethnic (BME) network, Mr Lewis also advised the Committee of associated issues in this area and challenges faced by BME staff. With regard to development of supporting strategies, the Committee considered a draft Management and Leadership Development Plan following the Board's approval of the Leadership Strategy at its meeting on 31 March 2016 and was invited to provide feedback on its content. The Committee considered, and subsequently ratified, a Pay Progression Policy subject to the approval by the Joint Consultation & Negotiation Committee (JCNC)

on 9 May 2016. The Committee noted the change to the normal approval process which had been necessitated by the timing of the meetings and which would ensure a timely implementation of the communications plan with staff in advance of the introduction of the policy from 1 October 2016.

The Committee also received a report which provided an outline of the final Junior Doctor Contract and provided assurance on plans for implementation of the new contract. The Committee noted that NHS Improvement had written to all trusts to ensure Junior Doctors and employers were clear and prepared for the forthcoming changes. The letter stated that Trust Boards needed to assure themselves that they had a process for implementing the new Junior Doctors Contract as per the timetable below:

Date	Action
End Apr 2016	Rotas (which need amending for August) mapped against new shift rules and amended where required
End May 2016	Work schedules for all F1 posts agreed and signed off
8 June 2016	Deadline for employers to offer jobs to doctors for August, with work schedules and details of pay and rotas
26 Jul 2016	Guardian of safe working hours should be appointed by this time
Aug 2016	Induction to be set up for August, including different HR aspects for doctors on different contracts
3 Aug 2016	New placements / contracts commence
Late Aug 2016	First payroll run under new system

The Committee was provided with assurance that actions were in place to ensure that the deadlines in the above timetable would be met. The Committee approved an Implementation Plan and Terms of Reference of a Task & Finish Group and it was proposed that a member of the Communications Team be co-opted to the Task & Finish Group to ensure that staff was kept appropriately informed of developments.

The Committee considered a report which informed of the current work undertaken to assess and improve the Trust's age awareness, using the NHS Working Longer Group Age Awareness Toolkit. Reference was made to the ways in which the Trust could support employees who wished to work longer. The Committee endorsed the associated action plan which would be delivered through the Equality and Diversity Steering Group. The Committee also received a report which updated on the Trust's Health & Wellbeing CQUIN and it was noted that progress monitoring would be undertaken by the Health & Wellbeing Steering Group.

The Committee received a report which provided an update with regard to the Workforce Race Equality Standard (WRES) and subsequently approved the submission of refreshed WRES data in July 2016. It was noted that an updated action plan would be presented to the Committee at its meeting in August 2016. The Committee also considered a report on Mandatory Gender Pay Gap Reporting following a Government consultation on draft regulations requiring companies with 250+ employees to carry out equal pay reviews and publish details of their gender pay gaps. The report highlighted the Trust's initial findings and supporting narrative

		in preparation for its publication in April 2017 and it was noted that since 2013, the gender pay gap had all but disappeared in a number of areas. The Committee reviewed a Quarterly Performance Report which detailed performance against key workforce metrics during Quarter 4 2015/16. The Committee noted deterioration from the position at Quarter 3 with metrics related to sickness absence (increase of 0.14%) and essentials training (decrease of 1%). Reference was made to an improved position with regard to metrics related to turnover, bank & agency spend, appraisals and essentials training. The Committee received a verbal update on the planned changes to the National Apprenticeship Scheme from April 2017 and noted that a further written report would be provided to the Committee at its next meeting. The Committee also considered a Managers Guide to Value Based Recruitment which had been launched for all recruitment on 1 May 2016. The Committee considered a report which provided an update following the successful implementation of revised shift patterns and establishments across in-patient Nursing & Midwifery areas and noted the positive feedback received from staff. The Committee received Key Issues Reports from the various Groups which report to the Committee. Finally, the Committee noted the following items which had been included on a Consent Agenda and validated the necessary policy and procedure documents: • Corporate Risk Register • Parental Leave Policy • Annual Leave Policy • Alcohol and Substance Misuse at Work Policy • Special Leave Policy • Professional Registration SOP • Talent Management Strategy • Medical Education Annual Report 2015/16		
2.	Risks Identified	Junior Doctors' Contract Implementation		
3.	Actions to be considered at the *(insert appropriate place for actions to be considered)*	Nil		
4.	Report Compiled by	Angela Smith, Chair	Minutes available from:	Company Secretary

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Stockport NHS
NHS Foundation Trust

Board of Directors' Key Issues Report

Report Date: 26/05/16		**Report Of:** Audit Committee
Date of last meeting: 17/05/16		**Membership Numbers:** Quorate
1.	Key Issues Highlighted:	The Committee considered an agenda which included the following: ▪ Internal Audit Progress Report ▪ Internal Audit Review - Catering Review ▪ Director of Audit Opinion 2015/16 ▪ Electronic Patient Record (EPR) Programme Governance ▪ Draft Financial Statements 2015/16 ▪ Draft External Audit Report ISA 260 ▪ Management Response to ISA 260 ▪ Draft Annual Quality Report 2015/16 ▪ External Audit Report on the Annual Quality Report ▪ Compliance with FT Code of Governance ▪ Draft Annual Governance Statement 2015/16 ▪ Draft Annual Report 2015/16 With regard to matters to bring to the attention of the Board, the primary focus of the meeting was on consideration of a range of statutory reports relating to 2015/16. The Committee reviewed the draft Financial Statements 2015/16 together with the draft ISA 260 report from External Audit and the Management Response to the ISA 260. The Committee held a comprehensive discussion with management and auditors in relation to the Trust's Going Concern declaration and agreed that it was appropriate for the 2015/16 accounts to have been prepared on a Going Concern basis. The Committee also confirmed that the Going Concern principle would remain appropriate for the next 12 months. However, the Board should note the importance of the Trust's cash position in maintaining this principle and the imperative of ensuring effective cash flow and cash management throughout 2015/16. The Committee noted a positive outcome from the audit work with a small number of checks still to be completed at the date of the meeting. On the basis of the Committee's review of both the financial statements and the draft ISA 260 report, the Committee recommended the Financial Statements 2015/16 to the Board of Directors for approval. The Committee noted the significant efforts made by both the Trust's Finance team and the External Audit team to ensure successful completion of the audit process within extremely challenging timescales. The Committee reviewed a draft Annual Quality Report 2015/16 together with a report detailing outcomes of a Quality Report Assurance Review completed by External Audit. The Committee noted much improved presentation of the document

		and also noted that content and consistency work completed by External Audit provided assurance that the Quality Report satisfied the relevant regulatory requirements. However, Board members should note that work on mandated indicator testing identified issues relating to data validity for the 18 week incomplete Referral to Treatment Time indicator which will result in a qualified opinion being issued for this indicator. The Committee is aware that work to strengthen data in this area was undertaken during 2015/16 and has requested an assurance report on further actions for consideration at its next meeting on 12 July 2016. The Committee considered reports relating to; Compliance with the FT Code of Governance, draft Annual Governance Statement 2015/16 and draft Annual Report 2015/16. No adverse comments / findings were reported by External Audit in relation to these reports although the Committee noted that the draft Annual Governance Statement would need to be amended to reflect the audit findings on the Quality Report. The Committee's consideration of Code of Governance compliance was supported by the outcomes of an Internal Audit review of the compliance process which resulted in an assessment of High Assurance. Consequently, the Committee endorsed the Trust's compliance declarations in relation to the Code of Governance and recommended the draft Annual Governance Statement 2015/16 and draft Annual Report 2015/16 to the Board of Directors for approval. Helen Bennett, Assistant Director EPR Programme Delivery and James Catania, Chief Clinical Information Officer, attended the meeting and presented a comprehensive report which detailed governance arrangements for the EPR Programme. The Committee was assured that a robust governance structure has been established for this key Trust programme. Finally, the Committee considered a progress report from Internal Audit which detailed outcomes as follows for audit work completed since the last meeting in March 2016: ▪ Combined Financial Systems Review - Significant Assurance ▪ E-rostering Review - Significant Assurance ▪ FT Code of Governance Review - High Assurance ▪ Information Governance Toolkit - Significant Assurance ▪ Scanning Review - Limited Assurance ▪ Assurance Framework Opinion - Confirmed Compliance ▪ Catering Follow-Up Review - Satisfactory Review Completed The Committee reviewed the Director of Audit's Opinion for 2015/16 and noted a positive outcome with an overall opinion of Significant Assurance. Board members should note that the Opinion outcome contributes to the assurances available to the Accountable Officer and the Board which underpin the Board's own assessment of the effectiveness of the Trust's system of internal control.		
2.	Risks Identified	Quality and accuracy of data relating to 18-week Referral to Treatment Time		
3.	Actions to be considered at the Audit Committee	Assurance report detailing actions to mitigate and address the above risk to be considered at the next Audit Committee meeting on 12 July 2016.		
4.	Report Compiled by	John Sandford, Chair	Minutes available from:	Company Secretary

Stockport NHS
NHS Foundation Trust

Board of Directors' Key Issues Report

Report Date: 26/05/16		**Report of:** Finance & Investment Committee
Date of last meeting: 18/05/16		**Membership Numbers:** Quorate
1.	Key Issues Highlighted:	The Committee considered an agenda which included the following: ▪ 2015/16 Financial Outturn Position ▪ Month 1 Finance Report 2016/17 ▪ Capital Report ▪ CIP Executive Group - Key Issues Report ▪ Finance Strategy ▪ Greater Manchester Providers - Gain Share Principles ▪ Site Utilisation Report ▪ Surgical Centre Progress Report ▪ Pathology Service Report ▪ Tender Log - April 2016 With regard to matters to bring to the attention of the Board, the Director of Finance briefed the Committee on the financial outturn for 2015/16 and noted an outturn deficit of £12.9m against a planned deficit of £13.1m. This outturn followed delivery of a cost improvement programme of £11.8m. However, as Board members will be aware, a large proportion of the 2015/16 savings were delivered on a non-recurrent basis which has added to the financial challenge for 2016/17. Progress with the delivery of recurrent savings will be a key area of focus for the Committee throughout 2016/17. The need for this focus was emphasised during consideration of the Month 1 Finance Report. While the deficit at 30 April 2016 was in line with plan at £2.4m, the Committee noted an overall shortfall against the CIP programme of circa £153k, with a shortfall of £376k against sustainability projects offset by £223k over-delivery in business as usual savings. In addition, circa 60% of the savings in Month 1 were delivered on a non-recurrent basis. This is clearly an area where management action is necessary to achieve the profiled level of savings in future months. The Committee received and noted a Key Issues Report from the CIP Executive Group, which is the forum for Executive-level monitoring of both CIP delivery and progress with the Integrated Delivery Plan. The Committee was briefed on a revised approach to conducting performance review meetings with Business Groups and noted that these meetings will be held with individual Business Groups on a monthly basis as part of measures to enhance organisation grip. This revised approach will be implemented during May 2016. The Committee also reviewed a draft Financial Strategy and proposed a number of amendments aimed at providing additional clarity on the Trust's plans. Subject to these amendments, the

		Committee recommended the draft strategy to the Board of Directors for approval and this will be the subject of a separate agenda item at the meeting on 26 May 2016. The Committee considered a report which detailed outturn against the Capital programme 2015/16 and noted delivery of 100.84% against plan for the year which is comfortably within Monitor's tolerance level of 15%. The Director of Estates & Facilities also presented a report which provided assurance on progress with the new Surgical Centre Project and the Committee was assured that there are no significant concerns associated with the build programme. The Deputy Chief Executive presented a report which provided the Committee with an update on site utilisation developments. The Committee noted plans to review configuration of the new Surgical Centre as a result of continued pressures on the Emergency Department and Acute Medicine. Developments relating to Ward Demolition (post-occupation of the Surgical Centre), Commercial Opportunities and Car Parking were also noted. The Deputy Chief Executive also presented a report which provided a summary of matters relating to the Pathology Service and opportunities to generate efficiencies through implementation of recommendations made by the Carter Review. The Committee endorsed the recommendations made in the report and noted the planned introduction of a national Pathology Quality Assurance Dashboard in July 2016 which will be hosted by NHS Improvement. Finally, the Committee was briefed by the Deputy Chief Executive on the outcomes of a meeting of Strategic Development Committee members held on 16 May 2016. He explained that the purpose of this meeting had been to identify means of improving the quality and content of reports to this particular Committee, with a view to ensuring distinct separation between the functions of the Committee and those of the Finance & Investment Committee. The Deputy Chief Executive advised that this had been a productive meeting, in terms of agreeing measures to enhance report content. However, those present had concluded that the functions of the two Committees relating to assurance on the Integrated Delivery Plan were intrinsically linked and that a more efficient and effective approach would be to merge the two Committees. Members of the Finance & Investment Committee unanimously endorsed this approach and recommended that merger of the two Committees be formally approved by the Board of Directors. Terms of Reference for a merged Committee will be presented to the Board of Directors for approval on 30 June 2016.		
2.	Risks Identified	Delivery of 2016/17 cost improvement programme		
3.	Actions to be considered at the *(insert appropriate place for actions to be considered)*	Nil		
4.	Report Compiled by	Malcolm Sugden, Chair	Minutes available from:	Company Secretary

Stockport NHS
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	26 May 2016
Subject:	Independence of Non-Executive Directors		
Report of:	Company Secretary	**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 the report is to facilitate a decision by the Board of Directors relating to the independence of Non-Executive Directors.
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 Assurance Committee ☐ F&I Committee	☐ Workforce & OD 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 the report is to facilitate a decision by the Board of Directors relating to the independence of Non-Executive Directors.

2. BACKGROUND

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

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

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

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

3. CURRENT SITUATION

3.1 Declarations of Independence, based on the criteria detailed at s2.2 of the report have been completed by the Chairman and each Non-Executive Director. Copies of the completed declaration forms are held by the Company Secretary. All Non-Executive Directors certified a 'clean' declaration with the exception of Mrs G Easson and Mrs C Prowse, both of whom declared that they had served on the Board for more than six years.

3.2 In the case of Mrs G Easson, Board members should note that the total time served on the Board includes time as a Non-Executive Director prior to her appointment as Chairman on 1 November 2012. In the case of Mrs C Prowse, her final one-year appointment as a Non-Executive Director expired on 31 March 2016. In both cases, tenure of appointment will

have been considered, and found not to be a barrier to appointment, by the Council of Governors.

3.3 In reaching a conclusion on Non-Executive Director independence, the Board should take into account the outcomes of the declaration process together with the content of the Register of Interests and observations on the independent nature of colleagues' performance. The conclusion of the Board of Directors will support an appropriate statement in the Annual Report 2015/16.

4. LEGAL IMPLICATIONS

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

5. RECOMMENDATIONS

5.1 The Board of Directors is recommended to:

- Confirm that it considers the Chairman and Non-Executive Directors to be independent.

Stockport NHS
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	26 May 2016
Subject:	Compliance with NHS Foundation Trust Code of Governance		
Report of:	Company Secretary	**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 Board of Directors for compliance statements relating to the NHS Foundation Trust Code of Governance. NHS Foundation Trusts are required to provide a specific set of disclosures to meet the requirements of the NHS Foundation Trust Code of Governance which should be submitted as part of the Annual Report (as referenced in the NHS Foundation Trust Annual Reporting Manual).
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 Assurance Committee ☐ F&I Committee	☐ Workforce & OD 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 Board of Directors for compliance statements relating to the NHS Foundation Trust Code of Governance.

2. BACKGROUND

2.1 The NHS Foundation Trust Code of Governance (the Code of Governance) was first published in 2006 and was most recently updated in July 2014. The purpose of the Code of Governance is to assist NHS Foundation Trust Boards in improving their governance practices by bringing together the best practice of public and private sector corporate governance. The Code is issued as best practice advice but imposes some disclosure requirements.

2.2 NHS Foundation Trusts are required to provide a specific set of disclosures to meet the requirements of the NHS Foundation Trust Code of Governance which should be submitted as part of the Annual Report (as referenced in the NHS Foundation Trust Annual Reporting Manual).

3. CURRENT SITUATION

3.1 During 2015/16 the Audit Committee implemented a schedule of six-monthly reviews of the Trust's compliance position against Code of Governance requirements. The reviews were completed on 8 September 2015 and 1 March 2016 and no issues were identified as a result of these reviews. A review of the draft Compliance Statements was completed by the Audit Committee on 17 May 2016 to confirm that there had been no material changes in compliance status in the intervening period. Board members should note that Audit Committee consideration was supported by the outcomes of an Internal Audit review of the Trust's processes relating to Code of Governance compliance which resulted in an assessment of High Assurance.

3.2 Schedule A to the Code of Governance details disclosure requirements and is divided into six categories as follows:

i) Statutory requirements of the Code of Governance. This supersedes the "comply or explain" requirements of the Code. There is no need to report on these provisions in the Code disclosure.

ii) Provisions which require a supporting explanation even in the case that the NHS Foundation Trust is compliant with the provision. Where the information is already contained within the Annual Report, a reference to its location is sufficient to avoid unnecessary duplication.

iii) Provisions which require supporting information to be made publicly available even in the case that the NHS Foundation Trust is compliant with the provision. This requirement can be met by making supporting information available on request and on the NHS Foundation Trust's website.

iv) Provisions which require supporting information to be made available to Governors, even where the NHS Foundation Trust is compliant with the provision.

v) Provisions which require supporting information to be made available to members of the Trust, even where the NHS Foundation Trust is compliant with the provision.

vi) Other provisions where there are no special requirements as per i) to v) above. For these provisions the basic comply or explain requirement stands. The disclosure should therefore contain an explanation in each case where the Trust has departed from the Code explaining the reasons for the departure and how the alternative arrangements continue to reflect the main principles of the Code.

3.3 A disclosure is only required for departures from the Code. Trusts are welcome, but not required, to provide a simple of statement of compliance with each individual provision. However, this is useful in ensuring that the disclosure is comprehensive and helps to ensure that each provision has been considered in turn. For purposes of completeness, the Trust has commented on each requirement as detailed at Appendix 1 to this report.

3.4 Having reviewed the content of Appendix 1 at its meeting on 17 May 2016, the Audit Committee recommended the Code of Governance disclosures as presented to the Board of Directors for approval.

4. LEGAL IMPLICATIONS

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

5. RECOMMENDATIONS

5.1 The Board of Directors is recommended to:

- Approve the Code of Governance disclosures as presented at Appendix 1.

NHS Foundation Trust Code of Governance

The NHS Foundation Trust Code of Governance (the Code of Governance) was first published in 2006 and was most recently updated in July 2014. The purpose of the Code of Governance is to assist NHS Foundation Trust Boards in improving their governance practices by bringing together the best practice of public and private sector corporate governance. The Code is issued as best practice advice but imposes some disclosure requirements. Stockport NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

NHS Foundation Trusts are required to provide a specific set of disclosures to meet the requirements of the NHS Foundation Trust Code of Governance which should be submitted as part of the Annual Report (as referenced in the NHS Foundation Trust Annual Reporting Manual). Schedule A to the Code of Governance specifies everything that is required within these disclosures. Schedule A is divided into six categories and the disclosures being made by the Trust for each of these categories are detailed below:

Below are the statutory requirements that we have highlighted in the Code. This supersedes the "comply or explain" requirements of the Code. **However, there is no need to report on these provisions in the Code disclosure**. For the purpose of completeness, the Trust will comment upon each requirement.

Reference	Statutory requirement:
A.2.2	The roles of chairperson and chief executive must not be undertaken by the same individual. ***The Trust complies with this requirement.***
A.5.10	The council of governors has a statutory duty to hold the non-executive directors Individually and collectively to account for the performance of the board of directors. ***The Board of Directors and the Council of Governors comply with this requirement.***
A.5.11	The 2006 Act, as amended, gives the council of governors a statutory requirement to receive the following documents. These documents should be provided in the annual report as per the *NHS Foundation Trust Annual Reporting Manual*: (a) The annual accounts; (b) Any report of the auditor on them; and (c) The annual report. ***The Trust complies with this requirement.***

A.5.12	The directors must provide governors with an agenda prior to any meeting of the board, and a copy of the approved minutes as soon as is practicable afterwards. There is no legal basis on which the minutes of private sessions of board meetings should be exempted from being shared with the governors. In practice, it may be necessary to redact some information, for example, for data protection or commercial reasons. Governors should respect the confidentiality of these documents. ***The Trust complies with this requirement.***
A.5.13	The council of governors may require one or more of the directors to attend a meeting to obtain information about performance of the trust's functions or the directors' performance of their duties, and to help the council of governors to decide whether to propose a vote on the trust's or directors' performance. ***The Trust is aware of this requirement. This situation did not arise during 2015/16.***
A.5.14	Governors have the right to refer a question to the independent panel for advising governors. More than 50% of governors who vote must approve this referral. The council should ensure dialogue with the board of directors takes place before considering such a referral, as it may be possible to resolve questions in this way. ***The Trust is aware of this requirement. This situation did not arise during 2015/16.***
A.5.15	Governors should use their new rights and voting powers from the 2012 Act to represent the interests of members and the public on major decisions taken by the board of directors. These are outlined in full at A.5.15. ***The Trust complies with this requirement.***
B.2.11	It is a requirement of the 2006 Act that the chairperson, the other non-executive directors and – except in the case of the appointment of a chief executive – the chief executive, are responsible for deciding the appointment of executive directors. The nominations committee with responsibility for executive director nominations should identify suitable candidates to fill executive director vacancies as they arise and make recommendations to the chairperson, the other non-executives directors and, except in the case of the appointment of a chief executive, the chief executive. ***The Trust complies with this requirement.***
B.2.12	It is for the non-executive directors to appoint and remove the chief executive. The appointment of a chief executive requires the approval of the council of governors. ***The Trust complies with this requirement.***
B.2.13	The governors are responsible at a general meeting for the appointment, re-appointment and removal of the chairperson and the other non-executive directors. ***The Trust complies with this requirement.***

B.4.3	The board has a duty to take steps to ensure that governors are equipped with the skills and knowledge they need to discharge their duties appropriately. ***The Trust complies with this requirement.***
B.5.8	The board of directors must have regard for the views of the council of governors on the NHS foundation trust's forward plan. ***The Trust complies with this requirement.***
B.7.3	Approval by the council of governors of the appointment of a chief executive should be a subject of the first general meeting after the appointment by a committee of the chairperson and non-executive directors. All other executive directors should be appointed by a committee of the chief executive, the chairperson and non-executive directors. ***The Trust complies with this requirement.***
B.7.4	Non-executive directors, including the chairperson should be appointed by the council of governors for the specified terms subject to re-appointment thereafter at intervals of no more than three years and subject to the 2006 Act provisions relating to removal of a director. ***The Trust complies with this requirement.***
B.7.5	Elected governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. ***The Trust complies with this requirement.***
D.2.4	The council of governors is responsible for setting the remuneration of non-executive directors and the chairperson. ***The Trust complies with this requirement.***
E.1.7	The board of directors must make board meetings and the annual meeting open to the public. The trust's constitution may provide for members of the public to be excluded from a meeting for special reasons. ***The Trust complies with this requirement.***
E.1.8	The trust must hold annual members' meetings. At least one of the directors must present the trust's annual report and accounts, and any report of the auditor on the accounts, to members at this meeting. ***The Trust complies with this requirement.***

The provisions listed below require a supporting explanation, even in the case that the NHS foundation trust is compliant with the provision. **Where the information is already contained within the annual report, a reference to its location is sufficient to avoid unnecessary duplication**.

Reference	Statutory requirement:

A.1.1	The schedule of matters reserved for the Board of Directors should include a clear statement detailing the roles and responsibilities of the Council of Governors. This statement should also describe how any disagreements between the Council of Governors and the Board of Directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the Board of Directors and the Council of Governors operate, including a summary of the types of decisions to be taken by each of the Boards and which are delegated to the executive management of the Board of Directors. ***See Annual Report page 30 and page 40.***
A.1.2	The annual report should identify the chairperson, the deputy chairperson (where there is one), the chief executive, the senior independent director (see A.4.1) and the chairperson and members of the nominations, audit and remuneration committees. It should also set out the number of meetings of the board and those committees and individual attendance by directors. ***See Annual Report pages 31, 35, 39 and 54.***
A.5.3	The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor. ***See Annual Report page 42.***
FT ARM	The annual report should include a statement about the number of meetings of the council of governors and individual attendance by governors and directors. ***See Annual Report page 42.***
B.1.1	The board of directors should identify in the annual report each non-executive director it considers to be independent, with reasons where necessary. ***See Annual Report page 30.***
B.1.4	The board of directors should include in its annual report a description of each director's skills, expertise and experience. Alongside this, in the annual report, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS foundation trust. ***See Annual Report page 34.***
FT ARM	The annual report should include a brief description of the length of appointments of the non-executive directors and how they may be terminated. ***See Annual Report pages 31 and 39.***

B.2.10	A separate section of the annual report should describe the work of the nominations committee(s), including the process it has used in relation to board appointments. ***See Annual Report page 39.***
FT ARM	The disclosure in the annual report on the work of the nominations committee should include an explanation if neither an external search consultancy nor open advertising has been used in the appointment of a chair or non-executive director. ***See Annual Report page 39.***
B.3.1	A chairperson's other significant commitments should be disclosed to the council of governors before appointment and included in the annual report. Changes to such commitments should be reported to the council of governors as they arise, and included in the next annual report. ***See Annual Report page 31.***
B.5.6	Governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied. ***See Annual Report page 46.***
FT ARM	If, during the financial year, the Governors have exercised their power under paragraph 10C of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report. ***See Annual Report page 40.***
B.6.1	The board of directors should state in the annual report how performance evaluation of the board, its committees, and its directors, including the chairperson, has been conducted. ***See Annual Report page 35.***
B.6.2	Where there has been external evaluation of the board and/or governance of the trust, the external facilitator should be identified in the annual report and a statement made as to whether they have any other connection to the trust. ***No external evaluation was undertaken during 2015/16.***
C.1.1	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report). ***See Annual Report pages 38 and 88.***

C.2.1	The annual report should contain a statement that the board has conducted a review of the effectiveness of its system of internal controls. ***See Annual Governance Statement on page 88.***
C.2.2	A trust should disclose in the annual report: a) If it has an internal audit function, how the function is structured and what role it performs; or b) If it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes. ***See Annual Report page 37.***
C.3.5	If the council of governors does not accept the audit committee's recommendation on the appointment, reappointment or removal of an external auditor, the board of directors should include in the annual report a statement from the audit committee explaining the recommendation and should set out reasons why the council of governors has taken a different position. ***This situation did not arise during 2015/16.***
C.3.9	A separate section of the annual report should describe the work of the audit committee in discharging its responsibilities. The report should include: • the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed; • an explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and • if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded. ***See Annual Report page 35.***
D.1.3	Where an NHS foundation trust releases an executive director, for example to serve as a non-executive director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings. ***This situation did not arise during 2015/16.***
E.1.5	The board of directors should state in the annual report the steps they have taken to ensure that the members of the board, and in particular the non- executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, for example through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations. ***See Annual Report page 35.***

E.1.6	The board of directors should monitor how representative the NHS foundation trust's membership is and the level and effectiveness of member engagement and report on this in the annual report. ***See Annual Report page 46.***
FT ARM	The annual report should include: • A brief description of the eligibility requirements for joining different membership constituencies, including the boundaries for public membership; • Information on the number of members and the number of members in each constituency; and • A summary of the membership strategy, an assessment of the membership and a description of any steps taken during the year to ensure a representative membership including progress towards any recruitment targets for members. ***See Annual Report page 44.***
FT ARM	The annual report should disclose details of company directorships or other material interests in companies held by governors and/or directors where those companies or related parties are likely to do business with the NHS foundation trust. As each NHS foundation trust must have registers of governors' and directors' interests which are available to the public, an alternative disclosure is for the annual report to simply state how members of the public can gain access to the registers instead of listing all the interests in the annual report. ***See Annual Report pages 35 and 43.***

'FT ARM' indicates that the disclosure is required by the NHS Foundation Trust Annual Reporting Manual rather than the Code of Governance.

The provisions listed below require supporting information to be made publicly available even in the case that the NHS foundation trust is compliant with the provision. This requirement can be met by making supporting information available on request and on the NHS foundation trust's website.

The information detailed below is available on request from the Company Secretary and will also be placed on the Trust's website.

Reference	Statutory requirement:
A.1.3	The board of directors should make available a statement of the objectives of the NHS foundation trust showing how it intends to balance the interests of patients, the local community and other stakeholders, and use this as the basis for its decision-making and forward planning.
B.1.4	A description of each director's expertise and experience, with a clear statement about the board of director's balance, completeness and appropriateness.

B.2.10	The main role and responsibilities of the nominations committee should be set out in publicly available, written terms of reference.
B.3.2	The terms and conditions of appointment of non-executive directors.
C.3.2	The main role and responsibilities of the audit committee should be set out in publicly available, written terms of reference.
D.2.1	The remuneration committee should make available its terms of reference, explaining its role and the authority delegated to it by the board of directors. Where remuneration consultants are appointed, a statement should be made available as to whether they have any other connection with the NHS foundation trust.
E.1.1	The board of directors should make available a public document that sets out its policy on the involvement of members, patients and the local community at large, including a description of the kind of issues it will consult on.
E.1.4	Contact procedures for members who wish to communicate with governors and/or directors should be made clearly available to members on the NHS foundation trust's website.

The provisions listed below require supporting information to be made available to governors, even in the case that the NHS foundation trust is compliant with the provision. This information should be set out in papers accompanying a resolution to re-appoint a non-executive director

Reference	Statutory requirement:
B.7.1	In the case of re-appointment of non-executive directors, the chairperson should confirm to the governors that following formal performance evaluation, the performance of the individual proposed for re-appointment continues to be effective and to demonstrate commitment to the role.

There were no instances of Non-Executive Directors seeking re-appointment during 2015/16. Relevant information was provided to the Council of Governors by the Senior Independent Director in relation to re-appointment of the Chairman with effect from 1 November 2015.

The provisions listed below require supporting information to be made available to members, even in the case that the NHS foundation trust is compliant with the provision. This information should be set out in papers accompanying a resolution to elect or re-elect a governor.

Reference	Statutory requirement:
B.7.2	The names of governors submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to take an informed decision on their election. This should include prior performance information.

This information is included within the election material circulated to members by

Electoral Reform Services who manage governor elections on behalf of the Trust.

For all provisions listed below there are no special requirements as per1-5 above. For these provisions, the basic "comply or explain" requirement stands. The disclosure should therefore contain **an explanation in each case where the trust has departed from the Code, explaining the reasons for the departure and how the alternative arrangements continue to reflect the main principles of the Code.**

A disclosure is only required for **departures** from the Code for the provisions listed in this section. NHS foundation trusts are welcome but not required to provide a simple statement of compliance with each individual provision. This may be useful in ensuring the disclosure is comprehensive and may help to ensure that each provision has been considered in turn.

In providing an explanation for any variation from the *NHS Foundation Trust Code of Governance,* the NHS foundation trust should aim to illustrate how its actual practices are consistent with the principle to which the particular provision relates. It should set out the background, provide a clear rationale, and describe any mitigating actions it is taking to address any risks and maintain conformity with the relevant principle. Where deviation from a particular provision is intended to be limited in time, the explanation should indicate when the NHS foundation trust expects to conform to the provision.

The table below provides a summary of the provisions – the full provisions as listed in the document should be used for reference. In this summary '"the board" refers to the board of directors, "the council" to the council of governors, and "trust" refers to the NHS foundation trust.

Provision	Summary:
A.1.4	The board should ensure that adequate systems and processes are maintained to measure and monitor the NHS foundation trust's effectiveness, efficiency and economy as well as the quality of its health care delivery ***The Trust is declaring compliance.***
A.1.5	The board should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and delivery of performance ***The Trust is declaring compliance.***
A.1.6	The board should report on its approach to clinical governance. ***The Trust is declaring compliance.***
A.1.7	The chief executive as the accounting officer should follow the procedure set out by Monitor for advising the board and the council and for recording and submitting objections to decisions. ***The Trust is declaring compliance.***

A.1.8	The board should establish the constitution and standards of conduct for the NHS foundation trust and its staff in accordance with NHS values and accepted standards of behaviour in public life. ***The Trust is declaring compliance.***
A.1.9	The board should operate a code of conduct that builds on the values of the NHS foundation trust and reflect high standards of probity and responsibility. ***The Trust is declaring compliance.***
A.1.10	The NHS foundation trust should arrange appropriate insurance to cover the risk of legal action against its directors. ***The Trust is declaring compliance.***
A.3.1	The chairperson should, on appointment by the council, meet the independence criteria set out in B.1.1. A chief executive should not go on to be the chairperson of the same NHS foundation trust. ***The Trust is declaring compliance.***
A.4.1	In consultation with the council, the board should appoint one of the independent non-executive directors to be the senior independent director. ***The Trust is declaring compliance.***
A.4.2	The chairperson should hold meetings with the non-executive directors without the executives present. ***The Trust is declaring compliance.***

Provision	Summary:
A.4.3	Where directors have concerns that cannot be resolved about the running of the NHS foundation trust or a proposed action, they should ensure that their concerns are recorded in the board minutes. ***The Trust is declaring compliance.***
A.5.1	The council of governors should meet sufficiently regularly to discharge its duties. ***The Trust is declaring compliance.***
A.5.2	The council of governors should not be so large as to be unwieldy. ***The Trust is declaring compliance.***
A.5.4	The roles and responsibilities of the council of governors should be set out in a written document. ***The Trust is declaring compliance.***

A.5.5	The chairperson is responsible for leadership of both the board and the council but the governors also have a responsibility to make the arrangements work and should take the lead in inviting the chief executive to their meetings and inviting attendance by other executives and non-executives, as appropriate. ***The Trust is declaring compliance.***
A.5.6	The council should establish a policy for engagement with the board of directors for those circumstances when they have concerns. ***The Trust is declaring compliance.***
A.5.7	The council should ensure its interaction and relationship with the board of directors is appropriate and effective. ***The Trust is declaring compliance.***
A.5.8	The council should only exercise its power to remove the chairperson or any non-executive directors after exhausting all means of engagement with the board. ***The Trust is declaring compliance.***
A.5.9	The council should receive and consider other appropriate information required to enable it to discharge its duties. ***The Trust is declaring compliance.***
B.1.2	At least half the board, excluding the chairperson, should comprise non-executive directors determined by the board to be independent. ***The Trust is declaring compliance.***
B.1.3	No individual should hold, at the same time, positions of director and governor of any NHS foundation trust. ***The Trust is declaring compliance.***

Provision	Summary:
B.2.1	The nominations committee or committees, with external advice as appropriate, are responsible for the identification and nomination of executive and non- executive directors. ***The Trust is declaring compliance.***
B.2.2	Directors on the board of directors and governors on the council should meet the "fit and proper" persons test described in the provider licence. ***The Trust is declaring compliance.***
B.2.3	The nominations committee(s) should regularly review the structure, size and composition of the board and make recommendations for changes where appropriate. ***The Trust is declaring compliance.***
B.2.4	The chairperson or an independent non-executive director should chair the Nominations committee(s). ***The Trust is declaring compliance.***

B.2.5	The governors should agree with the nominations committee a clear process for the nomination of a new chairperson and non-executive directors. ***The Trust is declaring compliance.***
B.2.6	Where an NHS foundation trust has two nominations committees, the nominations committee responsible for the appointment of non-executive directors should consist of a majority of governors. ***The Trust is declaring compliance.***
B.2.7	When considering the appointment of non-executive directors, the council should take into account the views of the board and the nominations committee on the qualifications, skills and experience required for each position. ***The Trust is declaring compliance.***
B.2.8	The annual report should describe the process followed by the council in relation to appointments of the chairperson and non-executive directors. ***The Trust is declaring compliance.***
B.2.9	An independent external adviser should not be a member of or have a vote on the nominations committee(s). ***The Trust is declaring compliance.***
B.3.3	The board should not agree to a full-time executive director taking on more than one non-executive directorship of an NHS foundation trust or another organisation of comparable size and complexity. ***The Trust is declaring compliance.***
B.5.1	The board and the council of governors should be provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make. ***The Trust is declaring compliance.***

Provision	Summary:
B.5.2	The board and in particular non-executive directors, may reasonably wish to challenge assurances received from the executive management. They need not seek to appoint a relevant adviser for each and every subject area that comes before the board, although they should, wherever possible, ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis. ***The Trust is declaring compliance.***
B.5.3	The board should ensure that directors, especially non-executive directors, have access to independent professional advice, at the NHS foundation trust's expense, where they judge it necessary to discharge their responsibilities as directors. ***The Trust is declaring compliance.***

B.5.4	Committees should be provided with sufficient resources to undertake their duties. ***The Trust is declaring compliance.***
B.6.3	The senior independent director should lead the performance evaluation of the chairperson. ***The Trust is declaring compliance.***
B.6.4	The chairperson, with assistance of the board secretary, if applicable, should use the performance evaluations as the basis for determining individual and collective professional development programmes for non-executive directors relevant to their duties as board members. ***The Trust is declaring compliance.***
B.6.5	Led by the chairperson, the council should periodically assess their collective performance and they should regularly communicate to members and the public details on how they have discharged their responsibilities. ***The Trust is declaring compliance.***
B.6.6	There should be a clear policy and a fair process, agreed and adopted by the council, for the removal from the council of any governor who consistently and unjustifiably fails to attend the meetings of the council or has an actual or potential conflict of interest which prevents the proper exercise of their duties. ***The Trust is declaring compliance.***
B.8.1	The remuneration committee should not agree to an executive member of the board leaving the employment of an NHS foundation trust, except in accordance with the terms of their contract of employment, including but not limited to service of their full notice period and/or material reductions in their time commitment to the role, without the board first having completed and approved a full risk assessment. ***The Trust is declaring compliance.***
C.1.2	The directors should report that the NHS foundation trust is a going concern with supporting assumptions or qualifications as necessary. ***The Trust is declaring compliance.***

Reference	Statutory requirement:
C.1.3	At least annually and in a timely manner, the board should set out clearly its financial, quality and operating objectives for the NHS foundation trust and disclose sufficient information, both quantitative and qualitative, of the NHS foundation trust's business and operation, including clinical outcome data, to allow members and governors to evaluate its performance. ***The Trust is declaring compliance.***

C.1.4	a) The board of directors must notify Monitor and the council of governors without delay and should consider whether it is in the public's interest to bring to the public attention, any major new developments in the NHS foundation trust's sphere of activity which are not public knowledge, which it is able to disclose and which may lead by virtue of their effect on its assets and liabilities, or financial position or on the general course of its business, to a substantial change to the financial wellbeing, health care delivery performance or reputation and standing of the NHS foundation trust. b) The board of directors must notify Monitor and the council of governors without delay and should consider whether it is in the public interest to bring to public attention all relevant information which is not public knowledge concerning a material change in: i. The NHS foundation trust's financial condition; ii. The performance of its business; and/or iii. The NHS foundation trust's expectations as to its performance which, if made public, would be likely to lead to a substantial change to the financial wellbeing, health care delivery performance or reputation and standing of the NHS foundation trust. ***The Trust is declaring compliance.***
C.3.1	The board should establish an audit committee composed of at least three members who are all independent non-executive directors. ***The Trust is declaring compliance.***
C.3.3	The council should take the lead in agreeing with the audit committee the criteria for appointing, re-appointing and removing external auditors. ***The Trust is declaring compliance.***
C.3.6	The NHS foundation trust should appoint an external auditor for a period of time which allows the auditor to develop a strong understanding of the finances, operations and forward plans of the NHS foundation trust. ***The Trust is declaring compliance.***
C.3.7	When the council ends an external auditor's appointment in disputed circumstances, the chairperson should write to Monitor informing it of the reasons behind the decision. ***The Trust is declaring compliance.***
C.3.8	The audit committee should review arrangements that allow staff of the NHS foundation trust and other individuals where relevant, to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. ***The Trust is declaring compliance.***

D.1.1	Any performance-related elements of the remuneration of executive directors should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels. ***The Trust did not have a performance-related element of remuneration for Executive Directors during 2015/16.***
D.1.2	Levels of remuneration for the chairperson and other non-executive directors should reflect the time commitment and responsibilities of their roles. ***The Trust is declaring compliance.***
D.1.4	The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointments would give rise to in the event of early termination. ***The Trust is declaring compliance.***
D.2.2	The remuneration committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments. ***The Trust is declaring compliance.***
D.2.3	The council should consult external professional advisers to market-test the remuneration levels of the chairperson and other non-executives at least once every three years and when they intend to make a material change to the remuneration of a non-executive. ***The Trust is declaring compliance.***
E.1.2	The board should clarify in writing how the public interests of patients and the local community will be represented, including its approach for addressing the overlap and interface between governors and any local consultative forums. ***The Trust is declaring compliance.***
E.1.3	The chairperson should ensure that the views of governors and members are communicated to the board as a whole. ***The Trust is declaring compliance.***
E.2.1	The board should be clear as to the specific third party bodies in relation to which the NHS foundation trust has a duty to co-operate. ***The Trust is declaring compliance.***
E.2.2	The board should ensure that effective mechanisms are in place to co-operate with relevant third party bodies and that collaborative and productive relationships are maintained with relevant stakeholders at appropriate levels of seniority in each. ***The Trust is declaring compliance.***

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Stockport NHS
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	26 May 2016
Subject:	Annual Governance Statement 2015/16		
Report of:	Chief Executive	**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 present the draft Annual Governance Statement 2015/16 to the Board of Directors for approval.
Board Assurance Framework ref:	N/A	
CQC Registration Standards ref:	N/A	
Equality Impact Assessment:	☐ Completed X Not required	

Attachments: Annex A – Draft Annual Governance Statement 2015/16

This subject has previously been reported to:	☐ Board of Directors ☐ Council of Governors ☐ Audit Committee ☐ Executive Team ☐ Quality Assurance Committee ☐ F&I Committee	☐ Workforce & OD 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 the draft Annual Governance Statement 2015/16 to the Board of Directors for approval.

2. BACKGROUND

2.1 The NHS Foundation Trust Annual Reporting Manual (ARM) 2015/16 requires that all entities covered by the requirements of the manual prepare an Annual Governance Statement. The ARM includes a model Annual Governance Statement which may be adapted and expanded to reflect the particular circumstances of individual NHS Foundation Trusts. The completed Annual Governance Statement is to be incorporated in the Annual Report & Accounts.

3. CURRENT SITUATION

3.1 A draft Annual Governance Statement, based on the guidance provided in the ARM has been prepared by the Company Secretary, and is attached for reference at Annex A to this report. The draft document has previously been circulated to Executive Team members for review and comment and the version included with this report incorporates feedback received from Executive Team members.

3.2 A copy of the draft Annual Governance Statement was forwarded to External Audit for review on 6 May 2016 and the document was subsequently subject to formal consideration by the Audit Committee on 17 May 2016. The Committee recommended the Annual Governance Statement to the Board of Directors for approval subject to an amendment of the Annual Quality Report section to incorporate outcomes of the external review of mandated indicators completed by Deloitte LLP.

3.3 Board members should note that, following approval, a signed copy of the Annual Governance Statement will be submitted to Monitor and the approved version will also be incorporated in the Trust's Annual Report & Accounts 2015/16.

4. LEGAL IMPLICATIONS

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

5. RECOMMENDATIONS

5.1 The Board of Directors is recommended to:

- Approve the draft Annual Governance Statement 2015/16 at Annex A of the report.

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Annual Governance Statement 2015/16

Scope of Responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Foundation Trust Accounting Officer Memorandum*.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Stockport NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Stockport NHS Foundation Trust for the year ended 31 March 2016 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

Leadership and management of the risk management process is provided through:-

- The Quality Assurance Committee as the Board of Directors committee with responsibility for overseeing all aspects of risk management
- The Audit Committee whose role is to receive and review assurance on the systems in place to manage risk
- The Chief Executive and the designated Executive Directors with responsibility for specific aspects of risk management
- The Risk Management Committee, a sub-committee of the Quality Assurance Committee, which has responsibility for organisation-wide co-ordination and prioritisation of risk management issues.
- An assessment of the level of risk management training that is required for staff and its delivery
- Review of the Risk Management Training Needs Audit matrix by the Risk Management Committee, which strengthens assurance that risk management training is effective, inclusive of a monitoring and review process
- Ensuring that employees with specific responsibilities for co-ordinating and advising on aspects of risk management have adequate training and development to fulfil their role
- The Trust's Risk Management Strategy, which clearly defines managers' levels of authority to manage and mitigate risks, according to risk scored ratings.

The risk and control framework

The Trust has a Board-approved Risk Management Strategy which sets out our approach to the management of risk and the system which assists in the identification, assessment, control and

monitoring of risk. Risk management is recognised as a fundamental part of the Trust's culture and is firmly embedded in our philosophy, practices and business plans.

Our risk assessment process, incident reporting and investigation and matters arising from complaints and claims are the principal sources of risk identification. The Trust has an open and accountable reporting culture and staff are encouraged to identify and report incidents by means of an online incident reporting tool. The Trust's Incident Reporting and Management Policy aims to ensure that when a serious event or incident occurs, there are systematic measures in place for safeguarding patients, property, resources and reputation. The policy ensures that a thorough investigation is undertaken and that any lessons learned are disseminated throughout the Trust and, if applicable, to other agencies to reduce the likelihood of a reoccurrence.

We use a '5x5 matrix' to assess and rate risks on both the likelihood and consequence to generate a risk score of between 1 and 25. The risk score then determines an appropriate level of escalation, management and scrutiny. The Risk Assessment process applies to all types of risk; clinical, financial, and operational, and risk registers are maintained by each of our Business Groups with registers subject to regular review at Business Group Quality Board meetings. Any risks with a residual risk score of 15 or above are placed on the Corporate Risk Register which is monitored on a monthly basis by the Risk Management Committee, Board-level Committees and the Board of Directors.

The Board Assurance Framework details risks associated with delivery of the Trust's principal objectives. Following work with Mersey Internal Audit Agency to review the format and presentation of the Board Assurance Framework, a revised, more concise, version was adopted by the Board of Directors in July 2014. Control measures and sources of assurance are clearly detailed in the Board Assurance Framework, together with details of any gaps in either control or assurance, and each entry has an associated action plan. The Board Assurance Framework is reviewed by the Board of Directors on at least a quarterly basis and the Board considers developments in the external environment in relation to inform Board Assurance Framework content. An Internal Audit assessment completed in March 2016 confirmed that "*The organisation's Assurance Framework is structured to meet the NHS requirements, is visibly used by the Board and clearly reflects the risks discussed by the Board"*.

Management capability, in terms of leadership, the availability of knowledgeable and skilled staff and adequate financial and physical resources, to ensure that processes and internal controls work effectively is routinely monitored by the Executive Team. The Board monitors and reviews the system of internal control and, where necessary, will identify improvements to accountability arrangements, processes or capability in order to deliver better outcomes. In 2015/16 this included further development of the Board's Committee arrangements to build on work previously undertaken to address recommendations made during an independent Governance Review conducted by Deloitte LLP.
A fundamental review of Board Committee arrangements resulted in the establishment of four Assurance Committees, each of which is chaired by a Non-Executive Director and report directly to the Board. These Committees are:

- Finance & Investment Committee
- Quality Assurance Committee

- Strategic Development Committee, and
- Workforce & Organisational Development Committee

Reports from the Assurance Committees which detail key issues considered by the Committees and associated risks are presented by the Committee chairs at each Board of Directors meeting.

Key Organisational Risk in 2015/16 and 2016/17
The risks to the principal objectives of the Trust, as identified in the Board Assurance Framework for 2015/16, were:

- Failure to meet all access and other targets resulting in adverse impact on patient experience, reputation, provider licence and contractual payments
- Inability to deliver financial recovery through cost improvement and innovation leading to reduced working capital and therefore an impact on safe and effective services and the ability to fund the strategic investment programme
- Not having the right number of staff who have the right skills and are engaged, developed and motivated to deliver services now and into the future and is affordable
- Failure to deliver the approved strategic plan resulting in a lack of focus on developing the right service changes resulting in a detriment to influence, decision-making, engagement and appropriate utilisation of resources
- Failure to continue to establish, engage and update effectively with, appropriate governance arrangements resulting in loss of influence and effectiveness
- Inability to deliver CQC compliance resulting in poor patient experience, loss of reputation and regulatory intervention
- Failure to maintain and enhance the quality and safety of the patient experience resulting in poor outcomes, loss of reputation, loss of market share and regulatory and commissioner concerns
- Poor planning and execution of infrastructure plans to deliver IT and Estates and Facilities strategies.

The principal risks to compliance with condition FT4 of the Trust's provider licence ('the FT governance condition') are as follows:

- 4-hour emergency department waiting time (target breached in all four Quarters during 2015/16)

The Trust remained in breach of its provider licence throughout 2015/16 as a result of failure to achieve the 4-hour Emergency Department target and Board members have continued to meet with Monitor representatives at regular intervals to discuss the effectiveness of measures being taken to address weaknesses in performance. Clearly, the Trust's performance against the 4-hour emergency department standard has continued to be a key area of scrutiny due to non-achievement of the target in any Quarter during 2015/16. Delivery of this standard remains a risk in 2016/17. The Trust implemented initiatives to manage patient flows, which included the provision of additional bed capacity over and above winter plan levels and the outsourcing of activity to create capacity. However, difficulties were experienced in managing the effective discharge of patients with social care needs, particularly at weekends, which had a significant impact on capacity. It has become evident that delivery of the standard on a sustainable basis is reliant on a local health economy approach to ensure that processes are efficient and effective at

each point in the patient journey. Monitor recognises the necessity of such an approach and has been supportive in facilitating a series of meetings attended by representatives from NHS England, Stockport CCG, Stockport Metropolitan Borough Council and the Trust during 2015/16 to drive the development of a local health economy resilience plan. This work, and development of a sustainable, resilient solution through the Stockport Together programme, will continue in 2016/17.

On 31 March 2016, the Board of Directors formally closed the Board Assurance Framework for 2015/16 and approved the opening of a refreshed Framework based on a revised set of strategic objectives and the principal risks to these objectives. The principal risks identified for 2016/17 are:

- Emphasis on day to day operational delivery, in response to environmental pressures, results in lack of focus on strategic change programmes with consequent impairment or failure to deliver the Trust's Five Year Strategy
- Failure to plan, resource and engage effectively with strategic change programme impairs level of control and influence with a consequent detrimental impact on patient services
- Failure to achieve sustainable delivery of the 4-hour A&E target impairs quality of patient care and results in further regulatory intervention
- Inability to maintain and improve compliance with Care Quality Commission standards impairs patient experience, damages Trust reputation and results in regulatory intervention
- Failure to deliver annual cost improvement programmes and realise planned benefits from strategic transformation projects impairs the Trust's financial position, with a consequent impact on patient services, and increases the likelihood of regulatory intervention
- Failure to prepare and deliver effective workforce plans supported by continuous professional development impairs the availability of workforce resources with a consequent impact on the delivery of patient services
- Failure to ensure efficient management of the Electronic Patient Record (EPR) project results in data loss from current systems and the inability to realise the benefits expected to accrue from implementation of a comprehensive electronic system.

The governance framework described above will ensure that risks are identified and, where necessary, escalated for action from Business Groups to Executive Team, Committees and the Board of Directors. Risks or developments that may have a consequent impact on quality of care will be identified through completion of quality impact assessments for business cases and cost improvement schemes. The outcomes of quality impact assessments are subject to validation by the Medical Director and Director of Nursing & Midwifery.

Quality Governance Framework

Stockport NHS Foundation Trust has effective arrangements for monitoring and continually improving the quality of care provided to its patients. The Board of Directors monitors performance against a suite of indicators relating to clinical, access and partnership and efficiency metrics through consideration of an Integrated Performance Report at each Board meeting. This report incorporates specific quality metrics relating to the five domains of the NHS Operating Framework:

- Mortality & preventable deaths
- Quality of life in long term conditions
- Helping patients recover
- Positive experience of care
- Avoidable harm & complications

The Trust is fully compliant with the registration requirements of the Care Quality Commission. Assurance on continued compliance is gained through a system of 'mock' CQC inspections framed around a comprehensive audit programme. The format of the inspections is based on the five domains of safe, well-led, caring, effective and responsive to patients' needs. Action plans are developed to address any identified weaknesses which are followed up during repeat inspections, the frequency of which is determined by the relevant level of compliance. Outcomes of the inspections are monitored by the Quality Governance Committee which is a sub-committee of the Quality Assurance Committee.

The Trust was subject to a Care Quality Commission inspection in January 2016 and this was the first inspection carried out at the Trust under the Chief Inspector of Hospitals inspection regime. At the time of writing, the outcomes of the inspection had yet to be received by the Trust. The foundation trust is fully compliant with the registration requirements of the Care Quality Commission.

The Trust identified three Never Events during 2015/16 which were categorised as follows, in accordance with the NHS England Never Events List 2015/16:

- Wrong Site Surgery - Two incidents
- Retained Foreign Object Post-Procedure - One incident

All three incidents were subject to thorough investigation in accordance with the Trust's Incident Reporting & Management Policy and immediate actions were taken to prevent reoccurrence. In addition, the Trust commissioned a comprehensive independent review of Never Events that had occurred in the Trust since December 2012 to determine any systemic weaknesses and to identify learning to mitigate the risk of such incidents. The final report was received on 18 April 2016 and is scheduled for consideration by the Board of Directors on 26 May 2016. The Trust plans to publish the final report to assist wider NHS learning in this area. An action plan will be developed to address recommendations arising from this review. However, the review stated that *"The pattern of Serious Untoward Incidents experienced by the trust is not unusual. Furthermore, following a review of all appropriate documentation, no evidence has been found to suggest that the Trust has an unrecognised systematic patient safety problem. On the contrary, the evidence indicates that the vast majority of the activities undertaken by the Trust, with respect to patient safety meet the highest standards".*

Information Risks

Specific risks relating to information governance and data quality are co- ordinated by the Information Governance Committee (IGC) and overseen by the Health Informatics Steering Board (HISB). As well as adopting proactive measures to prevent loss of data and improvements in data quality and security, the IGC adheres to specific procedures for detecting, reporting and dealing with any issues of data loss. Other steps taken to safeguard against risks to information

include:

- IT security controls for the encryption of all laptops and mobile devices including restriction on the use of removable media.
- On-going review of Information flows of person identifiable data internally and externally within the Trust and ensuring appropriate measures to maintain secure transfer of data.
- Review and continued focus on security policies and guidance issued around handling and sharing of personal data in compliance with the Data Protection Act.
- Board-level Senior Information Risk Owner (SIRO) with lead responsibility for ensuring that information risk is properly identified, managed and that appropriate assurance mechanisms exist. This role is undertaken by the Deputy Chief Executive.
- All staff are required to complete an Information Governance training session as part of the mandatory training programme.

The overall Information Governance Toolkit self-assessment score for version 13 (2015/16) achieved 71% with all 45 of the requirements met at Level 2 standard or above. Action plans are in place to further improve performance during 2016/17. An Internal Audit review of IG Toolkit evidence resulted in an assessment of Significant Assurance.

The Trust reported four serious IG incidents (level 2) to the Information Commissioner's Office (ICO) during 2015/16 which related to data loss or confidentiality breaches. Each incident was subject to a full investigation, with appropriate action taken to mitigate risk of reoccurrence, and no regulatory action was taken by the ICO as a result of these incidents. A summary of the incidents is included below:

Date of Incident	Nature of Incident
April 2015	Information relating to one individual was disclosed in error. Data subject kept informed.
June 2015	Loss of paperwork relating to 28 individuals. All data subjects kept informed.
August 2015	Information relating to one individual was disclosed in error. Data subject kept informed.
September 2015	Information / correspondence relating to one individual disclosed in error on multiple occasions. Data subject kept informed.

Other risk areas

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The foundation trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Review of economy, efficiency and effectiveness of the use of resources

The Board draws on a range of assurance sources and material in its on-going review of economy, efficiency and effectiveness of the use of resources. The annual internal audit programme, together with the reports from individual audits, provides assurance to the Audit Committee on the operational arrangements to secure economy, efficiency and effectiveness in the use of resources.

Assurance on the effectiveness of use of resources is also provided through scrutiny of performance against objectives and targets which is achieved through a number of channels, including:

- Approval of annual budgets by the Board of Directors
- Monthly reporting to the Board on key performance indicators covering access, finance, quality and workforce targets
- Scrutiny of performance against the financial plan by the Finance & Investment Committee
- Monitoring of delivery of strategic change projects by the Strategic Development Committee
- Board of Directors consideration of key issues reports from its Assurance Committees
- Executive team meetings with Business Groups.

In February 2016 the Trust expressed an interest in participating in a national Financial Improvement Programme (FIP) which is being coordinated by NHS Improvement. The Trust was subsequently selected as a first-wave participant in the programme which is planned to commence in April / May 2016. The Board anticipates that outcomes from the FIP will further contribute to economy, efficiency and the effective use of resources.

Monitor Review of Trust Position

On the 24 April 2013 the Trust signed Enforcement Undertakings with Monitor (a copy of which is on Monitor's website) in relation to the Trust's breaches of the A&E 4 hour target and highlighted potential weaknesses in Governance processes. Monitor's concerns were such that this was superseded on 4 August 2014 by imposition of an additional licence condition under section 111 of the Health and Social Care Act 2012 (a copy of which is available on Monitor's website). In July 2015 the additional licence condition relating to Governance was formally removed by Monitor in recognition of the actions taken by the Trust in response to recommendations made following an independent Governance Review completed by Deloitte LLP during 2014/15.

However, sustainable delivery of the A&E 4-hour waiting time standard has continued to be a major challenge despite the considerable efforts made by the Trust to achieve this target. This will continue to be a feature of the Trust's progress review meetings with Monitor and our aim in

2016/17 is to take the necessary actions to provide Monitor with assurance that the Trust is returning to full and sustainable compliance with the terms of its licence.

Annual Quality Report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS Foundation Trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the *NHS Foundation Trust Annual Reporting Manual*.

The steps that the Board has taken to assure itself that the Quality Report presents a balanced view, and that there are appropriate controls in place to ensure the accuracy of data, include:

- Seeking feedback on presentation and content of the Quality Report from commissioners, governors and other key stakeholders
- The data used for reporting quality metrics is regularly reviewed and triangulated against other performance measures, using a variety of different methods, including internal audit review. The Trust also engages with national coding audits and uses external benchmarking provided through CHKS to compare its performance with similar organisations.
- The development of underpinning policies and procedures to embed and sustain quality improvement, thereby enhancing longer-term achievement of quality objectives.

However, the external testing of mandated indicators, completed by Deloitte LLP to support a limited assurance opinion on the Quality Report, identified weaknesses in data management process and practice relating to the 18-week incomplete Referral to Treatment indicator. The weaknesses resulted in a qualified opinion for this specific indicator. Actions to address the identified weaknesses were implemented during 2015/16 and, while some progress has been made, further action to fully resolve these issues has been initiated and assurance on the effectiveness of this action will be monitored by the Audit Committee.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and the other committees that form part of the Trust's assurance structure and a plan to address weaknesses and ensure continuous improvement of the system is in place.

In describing the process that has been applied in maintaining and reviewing the effectiveness of the system of internal control I have detailed below some examples of the work undertaken during 2015/16.

My review has been informed by:

- The Board Assurance Framework which provides the Trust with evidence of the effectiveness of the system of internal controls that manage the principal risks to the organisation's strategic objectives. The Assurance Framework is subject to regular review by the Board of Directors.
- Internal Audit review of the Board Assurance Framework and the effectiveness of the overall system of internal control as part of the Internal Audit plan which is agreed by the Audit Committee
- The Director of Audit Opinion which gave an overall significant assurance opinion on the system of internal control for 2015/16
- The Trust continues to be registered with the Care Quality Commission without conditions
- The process for the follow-up of audit recommendations which is monitored by the Audit Committee
- Committees within the Board's committee structure having a clear timetable of meetings and a clear reporting structure which enables matters to be reported and/or escalated in a timely manner

The Trust has a comprehensive risk-based internal audit programme in place and the programme was delivered in full during 2015/16. Outcomes of the internal audit programme are reported to the Audit Committee and appropriately led action plans are in place to address any audits which result in a limited assurance assessment.

Conclusion

During 2015/16, with the exception of the Never Events detailed above, no significant control issues have been identified by the Trust's systems of internal control. My review confirms that Stockport NHS Foundation Trust has generally sound systems of internal control that support the achievement of its policies, aims and objectives.

Ann Barnes
Chief Executive

Date: 26 May 2016

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Stockport NHS
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	26 May 2016
Subject:	Year-End Governance Declaration		
Report of:	Company Secretary	**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 allow the Board of Directors to determine a positive declaration against General Condition 6 of the NHS Provider Licence or identify why such a declaration cannot be made.
Board Assurance Framework ref:	N/A	
CQC Registration Standards ref:	N/A	
Equality Impact Assessment:	☐ Completed X Not required	

Attachments:	Appendix 1 - Condition G6 – Systems for compliance with licence conditions

This subject has previously been reported to:	☐ Board of Directors ☐ Council of Governors ☐ Audit Committee ☐ Executive Team ☐ Quality Assurance Committee ☐ F&I Committee	☐ Workforce & OD 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 allow the Board of Directors to determine a positive declaration against General Condition 6 of the NHS Provider Licence or identify why such a declaration cannot be made.

2. BACKGROUND

2.1 The requirements of General Condition 6 are reproduced at Appendix 1 of the report. In essence, the requirement is for *"licensees to establish and implement systems and processes to identify risks and guard against their occurrence. It also requires them to regularly review the effectiveness of these systems and processes".* (Monitor: The new NHS Provider Licence, 14 Feb 2013).

2.2 The required declarations are:

> Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have regard to the NHS Constitution.
>
> AND
>
> The board declares that the Licensee continues to meet the criteria for holding a licence.

3. CURRENT SITUATION

3.1 The form of the declaration is included for reference at Appendix 2 of the report and the nature of the declaration is both retrospective, in terms of arrangements in the Financial Year just ended, and prospective, in terms of continuation in meeting the relevant criteria.

3.2 The systems and processes for identifying and controlling risks are set out in the Annual Governance Statement 2015/16. In reaching a decision on the declaration, the Board of Directors will need to consider the arrangements described in the Annual Governance Statement and the effectiveness of the Risk Management Policy, Risk Registers and the Board Assurance Framework as key components of the risk management system. The Board should note the risk-based Internal Audit programme which was in place throughout 2015/16, the positive outcome of the Internal Audit assessment of the Board Assurance Framework and the outcome of the Head of Audit Opinion which resulted in an assessment of Significant Assurance.

3.3 With regard to part 2 of the declaration, the Board should consider whether there have been, or there are planned to be, any changes to internal control arrangements that have the potential to impair the Trust's continuation of meeting the criteria for holding a licence. In particular, the Board should consider whether the application of s111 and s105 licence conditions, and the continuing nature of these conditions, should be referenced in the

Trust's declaration. The declaration against General Condition 6 is required to be submitted to Monitor by noon on 27 May 2016.

4. LEGAL IMPLICATIONS

4.1 Completion of the relevant declarations is a requirement of the NHS Provider Licence.

5. RECOMMENDATIONS

5.1 The Board of Directors is recommended to:

- Consider the content of the report and agree an appropriate declaration against General Condition 6.

Appendix 1

Condition G6 – Systems for compliance with licence conditions and related obligations

1. The Licensee shall take all reasonable precautions against the risk of failure to comply with:

    a) The Conditions of this Licence,
    b) Any requirements imposed on it under the NHS Acts, and
    c) The requirements to have regard to the NHS Constitution in providing health care services for the purpose of the NHS.

2. Without prejudice to the generality of paragraph 1, the steps that the Licensee must take pursuant to that paragraph shall include:

    a) The establishment and implementation of processes and systems to identify risks and guard against their occurrence; and
    b) Regular review of whether those processes and systems have been implemented and of their effectiveness.

3. Not later than two months from the end of each Financial Year, the Licensee shall prepare and submit to Monitor a certificate to the effect that, following a review for the purpose of paragraph 2(b) the Directors of the Licensee are or are not satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with this Condition.

4. The Licensee shall publish each certificate submitted for the purpose of this Condition within one month of its submission to Monitor in such manner as is likely to bring it to the attention of such persons who reasonably can be expected to have an interest in it.

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Worksheet "Certification G6"

Declarations required by General condition 6 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with license conditions

1 Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.

AND

2 The board declares that the Licensee continues to meet the criteria for holding a licence.

Signed on behalf of the board of directors, and having regard to the views of the governors

Signature	Signature
Name	**Name**
Capacity [job title here]	**Capacity** [job title here]
Date	**Date**

Further explanatory information should be provided below where the Board has been unable to confirm declarations 1 or 2 above.

A

B

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Stockport NHS
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	26 May 2016
Subject:	Report of the Chief Executive		
Report of:	Chief Executive	**Prepared by:**	P Buckingham

REPORT FOR NOTING

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 advise the Board of Directors of national and local strategic and operational developments which include:

- Junior Doctors Industrial Action
- Stockport Together
- Healthier Together
- Surgical Centre
- Publications

Attachments: Annex A – Healthier Together Memorandum of Understanding

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

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1. INTRODUCTION

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

2. JUNIOR DOCTORS INDUSTRIAL ACTION

2.1 The British Medical Association, NHS Employers and the Secretary of State for Health reached an agreement on the new junior doctors' contract on 18 May 2016, thereby resolving the current dispute; subject to securing the support of BMA junior doctor members in a referendum.

2.2 Work commenced immediately after the agreement to finalise the communications with BMA members on all the details of the agreement and their new contract. Some elements of the new contract, if approved in the referendum, will be implemented in August this year and all junior doctors will move on to the agreed new terms between October 2016 and August 2017. No further industrial action will be called while the referendum is underway.

2.3 The Trust has charged a Task and Finish Group with the responsibility of implementing the new contract. The Group reports to the Workforce and OD Committee and is chaired by the Deputy Medical Director.

3. STOCKPORT TOGETHER

3.1 The group of providers involved in the Stockport Together programme, in the form of a Shadow Provider Board, have recruited an interim Provider Board Director to support develop the implementation plan for the new models of care and work on the form of the new organisation. Keith Spencer, who has been appointed on an initial 6-month contract, has set out a proposed schedule of work to both providers and commissioners in order to meet the timescales required within the programme. Keith will be attending the upcoming Trust Board strategy session to focus on the MCP development in Stockport.

4. HEALTHIER TOGETHER

4.1 Since judgement was made in January 2016, upholding the *Healthier Together* decision at judicial review, the Greater Manchester Team has now strengthened its central arrangements for oversight and assurance of the implementation process. Correspondingly, each of the four Sectors in Manchester has progressed with establishment of its own programme management arrangements.

4.2 In the South East Sector of Manchester, the mandate provided by the *Healthier Together* decision relates directly to providers and commissioners in Stockport and Tameside, and they are required to develop plans to implement the agreed service models and achieve the *Healthier Together* best practice standards, within a "single service" grouping – that is, through combined teams of consultant (and other) staff, working cross-site where necessary. Eastern Cheshire CCG and Trust have opted to participate in the South East Sector programme in respect of General Surgery only, and North Derbyshire CCG are also

key partners, in view of the significant flow of their residents into Greater Manchester (and some to Macclesfield) from the area north of Buxton.

4.3 A revised programme structure has now been put into place. This includes a Programme Board on which all relevant Chief Executives are represented, a senior officer Programme Management Group, and a Clinical Leadership Group, comprising the Programme's Clinical Director, Specialty Leads and Medical Directors. Clinical Workstream groups, covering the scope *of Healthier Together* have been designated – in General Surgery, Diagnostics, Acute Medicine, A&E, Critical Care and Anaesthetics. There are also groups established to work through, for instance, the Manpower/HR implications, Finance and Contracting, and Communications. The Senior Responsible Officers for the Programme are Ranjit Gill, Chief Executive of Stockport CCG (Commissioner), and Ann Barnes, Chief Executive of Stockport FT (Provider). The Interim Programme Director is Ann Schenk, identified from the workforce at Stockport FT.

4.4 The most significant changes within the *Healthier Together* model relate to General Surgery. It is intended that Stepping Hill Hospital (the hub) will become one of four centres in Manchester for the management of high risk/complex emergency and elective general surgical cases. Suspected emergency surgical cases picked up by Ambulances in the Sector will be taken to the nearest of these four sites. Stepping Hill will, therefore, receive directly (via ambulance) known or suspected high risk general surgical emergencies. It will also receive transfers of such cases identified at its partner sites.

4.5 In terms of high risk elective abdominal and colorectal surgery, the model also anticipates that these would be concentrated in the hub. Local sites will be expected to maintain services for lower risk cases, within a model providing daily hot clinics, day case/low risk admission and local outpatient and diagnostic capability. Appropriate capacity and skills will be maintained in all parts of the network through operating in a "single service" model. Within the Greater Manchester *Healthier Together* model, Tameside DGH and Stepping Hill Hospital will have a full A&E service.

4.6 The programme is concentrating essential and complex first task of reaching agreement on the clinical model for General surgical patient pathways, and the distribution of casemix between the hub (Stockport) and local (Tameside and Macclesfield) sites. The Greater Manchester Clinical Advisory Group has now provided a Clarification Paper which sets out in more detail the definitions of "high" or "low" risk conditions, and of the services needed to support them. Based on the General Surgical agreement, it will be possible to progress to understanding in detail the impact on co-dependent services, the manpower planning, activity or financial projections, capacity planning etc. which will underpin the implementation plan.

4.7 A process has now been agreed to assess and audit the current workload at South East Sector sites. It is anticipated that this will allow the design of the" local" elements of the service, in particular, and will identify the volume and types of cases which it would be appropriate to retain in the non-hub sites. The preliminary draft timeline for the South East Sector Programme envisages initial implementation from April 2017. This is likely to be changed as more detail becomes available, but it serves to highlight the pressing need for some very concentrated work in the coming months in order to confirm the model,

produce a detailed analysis, statement of case and costings, and implementation plan, by July this year. The governing bodies of each partner in the Sector will be asked to endorse the case.

4.8 In the meantime, the Memorandum of Understanding, included at Annex A, is being presented to each governing body for adoption as a means of encapsulating and consolidating the intention of the South East Sector partners to find joint solutions to the design and implementation of the *Healthier Together* changes. It is worth remembering that, at its heart, this work is intended to establish new ways of working which will underpin a more widespread and consistent delivery of best practice standards, and through that means, better outcomes for surgical patients. The evidence described by *Healthier Together* estimates that greater centralisation and specialisation for high risk cases in GM would save about 300 lives per annum. Although a number of sites, have clinical outcomes in surgery that measure very favourably with national comparisons, there are no sites in *Healthier Together* that currently achieve the full range of standards, particularly in respect of senior medical presence.

5. SURGICAL CENTRE

5.1 The Executive Team considered proposals in May from the Interim Chief Operating Officer to change the use of the Ground Floor of the new D Block Development. This change of use is to create space for the Acute Medical Unit and Medical Assessment function. This decision was taken in order to bring these functions together as they are currently separated and then co-locate this function next to the Emergency Department in order to improve the flow of patients through Urgent Care. This is also aligned to the Healthier Together Programme as there will be an increasing number of Emergency Department and Acute Medicine patients when this new way of working is introduced.

5.2 This change of use is purely a change in the specialties which will be using the beds rather than a structural building change and therefore does not change the building costs or the demolition of older estate outlined in the business case. This change, along with an update on the site strategy was presented to the Finance & Investment Committee on 18 May 2016.

6. PUBLICATIONS

6.1 Could I draw the attention of the Board of Directors to the following items from issues 79 - 80 of the NHS England 'Informed' publication.

- **Three million patients benefit from new innovations in pioneering NHS programme**

  The NHS Innovation Accelerator (NIA) is a fellowship programme which is being delivered collaboratively by NHS England, UCLPartners, The Health Foundation and with the academic health science networks (AHSNs). It was launched last year to help introduce new innovations into the NHS and its success after just nine months was highlighted this month at the UK e-Health Week conference. Three million patients have begun to access new digital apps, safety devices, online networks, and a host of other new technologies and services during the first nine months of this pioneering NHS

programme.

68 NHS organisations are using one or more of 17 new innovations which aim to improve care by, for example, reducing clinical incidents, helping people self-care and linking up patients with others or with research schemes.

- **Nearly two million patients to receive person-centred support to manage their own care**

  People with long-term conditions will be supported to better manage their own health and care needs, thanks to the rollout of an evidence-based tool over the next five years. NHS England has agreed a deal which will grant nearly two million people access to more person-centred care as part of its Self Care programme.

  Local NHS organisations and their partners are being invited to apply for access to patient activation licences, which will help them assess and build their patients' knowledge, skills and confidence, empowering people to make decisions about their own health and care. The Patient Activation Measure (PAM) is a tool which captures how engaged and confident people feel in taking care of their health and wellbeing.

- **NHS Confederation's Annual Conference and Exhibition: 15-17 June 2016, Manchester Central**

  This year's conference is structured around five conference themes with a mix of plenary sessions, panel discussions, debates, seminars and workshops. It will focus on the huge effort that is underway in the NHS and wider health and care system, to transform care for patients. It will also build on the momentum for change – helping to strengthen emerging solutions, new ways of working and shared plans for achieving more integrated, effective and sustainable care. The event will showcase the transformation already taking place as well as celebrate and show our pride in the amazing work that goes on every day in our NHS. In his keynote speech on 15 June 2016, Chief Executive of NHS England, Simon Stevens, will summarise how NHS England will support the transformation of health and care. Come and talk to NHS England on stand 30 which will be Five Year Forward View themed. Join the conversation @NHSC_conference, #confed2016.

- **Nominations for the Kate Granger Compassionate Care Awards are open**

  Nominations are now open for the Kate Granger Compassionate Care Awards, which are being led by NHS England for the first time this year. The awards are named after Dr Kate Granger, who has worked tirelessly to raise awareness around compassion in the NHS through her #hellomynameis social media campaign. The awards will again take centre stage at this year's Health and Care Innovation Expo. The judges are looking for individuals, teams and organisations who have made a difference and demonstrated outstanding care for their patients. Anyone can nominate, using the online nomination form on the NHS England website. Nominations close on 30 June 2016.

- **NHS England's Informed bulletin will now be published once a month**

  The Informed bulletin will now be published monthly instead of weekly. This is to make sure that we are providing you with the most relevant and up to date news on our

priority areas of work. The bulletin will be published on the last Wednesday of each month.

- **A different ending: addressing inequalities in end of life care**

  The Care Quality Commission has published a report examining people's experiences of end of life care across England. The report highlights many examples of good practice, but shows that the quality of care for some people at the end of their life is still not good enough. It finds that where commissioners and services are taking an equality-led approach, responding to individuals' needs, people receive better care. The report also contains recommendations for commissioners, a good practice case studies document, and detailed findings of the ten specific groups that the review studied.

7. RECOMMENDATIONS

7.1 The Board of Directors is recommended to:

- Receive and note the content of the report.

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Title	**South East Sector Single Service Memorandum of Understanding, Confidentiality Agreement and Non-Disclosure Agreement**
Author	Jen Parsons
Target Audience	South East Sector Programme Board
Version	V0.5
Created – date	06/01/2016
Date of Issue	
Document Status	DRAFT
File name and path	S:\Transformation\SERVTRAN\South East Sector\Governance

Document History:

Date	Version	Author	Details
14/12/2015	V0.1 – 0.2	Jen Parsons	First Draft including comments on principles from SES Programme Board
09/02/2016	V0.3	Jen Parsons	Incorporates a guidance note for Boards, redrafted Confidentiality Agreement and Non-Disclosure Agreement from Hempsons
23/03/2016 – 29/04/2016	V0.5	Jen Parsons	Incorporation of amendments from SES Programme Board and removal of guidance note
Approved by:			**SES Programme Board**

Governance route:

Group	Date	Version	Purpose
South East Sector Programme Board	20/04/2016	V0.5	Approved for sign-off at member organisation boards.

Purpose

The purpose of this document is to provide guidance to Boards with regards to signing off the enclosed Memorandum of Understanding, Confidentiality Agreement and Non-Disclosure Agreement – to support collaborative working the South East Sector.

Memorandum of Understanding

South East Sector Collaboration

East Cheshire NHS Trust

Stockport NHS Foundation Trust

Tameside Hospital NHS Foundation Trust

NHS Eastern Cheshire Clinical Commissioning Group

NHS North Derbyshire Clinical Commissioning Group

NHS Stockport Clinical Commissioning Group

NHS Tameside & Glossop Clinical Commissioning Group

'The Parties'

May 2016

IMPORTANT

This Memorandum of Understanding (MoU) and all discussions between the Parties and their representatives regarding the subject matter of this document are subject to contract and nothing in this document shall constitute a legally binding obligation on any Party to it.

1 Introduction

1.1 The Parties are providers and commissioners of a wide range of healthcare services for the populations of East Cheshire, Stockport, Tameside and Glossop and North Derbyshire (the South East Sector) and have agreed to collaborate with each other to implement Healthier Together in the South East of Greater Manchester following the decision of the 12 Greater Manchester CCGs on the 15th July 2015. This Memorandum of Understanding does not seek to limit the scope solely to the Healthier Together implementation and leaves open the potential for the Parties to explore future collaborations on the delivery of other services beyond Healthier Together.

1.1 The purpose of this Memorandum of Understanding is to:

- Set out the principles on which the Parties will work together and the basis of this understanding
- Set out the Healthier Together South East Single Service Mandate as the first 'collaboration' under this Memorandum of Understanding
- Set out any agreements that are required alongside this Memorandum of Understanding.

2 Basis of understanding

2.1 The Parties have agreed to the following principles in relation to the proposed collaboration:

- To act in the best interests of service users and an engaged public
- To demonstrably improve the quality and clinical outcomes of the clinical services which the Parties provide to their patients
- To work as a partnership of equals
- To adopt an open and constructive relationship with each other in relation to the collaboration
- At all times to act in good faith towards one another
- To be cognisant of the sustainability of the system
- To manage all information supplied by other parties in a confidential manner (as per the Confidentiality Agreement).

3 South East Sector Single Service Mandate

3.1 NHS Stockport CCG, NHS Tameside & Glossop CCG and NHS North Derbyshire will formally amend their commissioning intentions in line with the Healthier Together decision. NHS Eastern Cheshire CCG have agreed to collaborate with the South East Single Service to fully understand the impact of the proposed changes; with an initial focus on General Surgery.

3.2 The scope and focus of the Healthier Together hospital programme is:

- Urgent, Emergency & Acute Medicine;
- General Surgery.

3.3 In addition, it is recognised that there are key services that are interdependent with the above services which will be included *to the extent of their dependency*, within the final Model of Care (Hospital Services):

- Anaesthetic Services;
- Critical Care;
- Clinical Support Services (e.g. Diagnostics).

3.4 Furthermore, programme documentation will also describe the enabling changes in local "Out of Hospital" services that will need to take place before changes to hospital services are made. *(Scope and focus of HT hospital programme taken from Terms of Reference for Greater Manchester Healthier Together Joint Committee V1.4).*

4 Data Sharing and Confidentiality

4.1 The Parties acknowledge and agree that each may be required to disclose to others, information which is regarded as confidential or commercially sensitive. The Parties undertake for themselves and their respective Boards and employees:

(a) The disclosing Party shall confirm whether information is to be regarded as confidential prior to its disclosure;
(b) All Parties shall use no lesser security measures and degree of care in relation to any confidential information received from the other Party than it applies to its own confidential information;
(c) The Parties shall not disclose any confidential information of the other Parties to any third party without the prior written consent of the other Parties; and
(d) On the termination of this Agreement, each Party shall return any documents or other material in its possession that contains confidential information of the other Parties.

4.2 Clause 4.1 shall not apply to any information which is already in the public domain (other than by a breach of this Agreement), or where disclosure is required by law or in relation to any information which is lawfully requested by government, Monitor or NHS England.

4.3 The Parties agree that information will need to be shared with external suppliers to enable the business case to be completed for the sector. For the avoidance of doubt:

(a) The Trusts and CCGs that are subject to this MOU agree to provide in a timely manner and without restriction all information requested and required by the contractor to carry out the work including but not limited to relevant detailed financial, activity, workforce and estates related information pertaining to the proposed changes;
(b) All Parties agree that publically available information may be shared fully with all other Parties that are subject to this agreement;
(c) Non-publically available information provided to the contractor as part of this project including (but not limited to) relevant financial, activity, workforce and estates related information will be held securely by the contractor and not shared with the other providers, CCGs connected to this project without the express permission of the relevant originating organisation; and
(d) No information will be shared with parties outside of the project.

4.4 Express permission will be sought from the three provider Trusts to share the following information:

(a) All in and out of scope activity information at each hospital site;
(b) Whole-time equivalent workforce information for the in-scope sites and services;
(c) Estates information in relation to in and out of scope services; and
Financial information, including Service Line Reporting information, should be provided to the advisors for each Trust as a whole (i.e. for both in and out of scope sites and services) but will be shared between the three providers for in scope activity only.

5 Review

5.1 The Memorandum of Understanding shall be reviewed by the Parties three years after the seven signatories have applied their signatures to this document. However any Party may withdraw from the Memorandum of Understanding at any time without penalty by informing the other Parties of their intention to do so in writing.

SIGNED ON BEHALF OF THE BOARD:

1) East Cheshire NHS Trust of Victoria Road, Macclesfield, Cheshire, SK10 3BL

Chief Executive Date

2) Stockport NHS Foundation Trust of Stepping Hill Hospital, Poplar Grove, Stockport, SK2 7JE

Chief Executive Date

3) Tameside Hospital NHS Foundation Trust of Fountain Street, Ashton-under-Lyne, OL6 9RW

Chief Executive Date

4) NHS Eastern Cheshire Clinical Commissioning Group of New Alderley House, Macclesfield, Cheshire SK10 3BL

Chair Date

5) NHS North Derbyshire Clinical Commissioning Group of Nightingale Close, Off Newbold Road, Chesterfield, S41 7PF

Chair Date

6) NHS Stockport Clinical Commissioning Group of Regent House, Heaton Lane, Stockport, Cheshire SK4 1BS

Chair Date

7) NHS Tameside & Glossop Clinical Commissioning Group of New Century House, Progress Way, Windmill Lane, Denton, Manchester, M34 2GP

Chair Date

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Stockport NHS
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	26 May 2016
Subject:	Financial Strategy		
Report of:	Director of Finance	**Prepared by:**	Director of Finance

REPORT FOR APPROVAL

Corporate objective ref: -----	**Summary of Report** The Financial Strategy is an enabler to meet the Trust Strategy published in 2015-16.
Board Assurance Framework ref: -----	The Financial Strategy documents the challenges facing the Trust in the next five years and the Trust response to bring ensuring the trust is cash resilient in the short-term moving towards a sustainable position in the medium to long term.
CQC Registration Standards ref: -----	**Purpose of the Paper** The purpose of this paper is to discuss and agree the Financial Strategy as an accompanying document to the Trust's overall Strategy.
Equality Impact Assessment: ☐ Completed ☐ Not required	

Attachments:

This subject has previously been reported to:	☐ Board of Directors ☐ Council of Governors ☐ Audit Committee ☐ Executive Team ☐ Quality Assurance Committee ☐ FI Committee	☐ Workforce & OD Committee ☐ Strategic Devt Committee ☐ Charitable Funds Committee ☐ Nominations Committee ☐ Remuneration Committee ☐ Joint Negotiating Council ☐ Other

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STOCKPORT NHS FOUNDATION TRUST

FINANCE STRATEGY

1. Alignment to the Trust Strategy

In 2014, Stockport NHS Foundation Trust celebrated ten years as a Foundation Trust. The past decade has brought significant changes to the running of the NHS, the health needs of the population and a challenging economic climate. Despite these challenges the Trust has continued to focus on providing high quality, sustainable services and this is reflected in our ongoing strategic priorities; Quality, Partnership, Integration and Efficiency.

The NHS regulator Monitor requested that for the period 1 April 2015 to 31 March 2016, NHS Trusts develop an annual operational plan. As part of this development and through working with key stakeholders the Board of Directors took the decision to 'refresh' and update our overall Trust Strategy. This decision was made in order to take into account the significant changes in our internal and external environment.

In order to refresh the Trust Strategy and develop this year's annual operational plan we completed a number of tasks. An overview of these is listed below;

- Within our Trust a group of medical, nursing, pharmacists, allied health professionals and managers looked at our performance over several years. This included clinical, operational and financial performance data and information. Financial sustainability going forward is something that all NHS Trusts have to consider. It was acknowledged that the current model of providing 'everything to everyone', as is traditional in a district general hospital, is unsustainable.
- We reviewed our capability to deliver and excel at certain services, along with an analysis of the health market surrounding us which includes private health providers.
- We spent a lot of time getting to know who our patients are, why they come to our Trust and how they access our services. This included the health profiles of our population using public health information.
- We also looked at what services we have within the hospital and our community services and how much specific services are used.

This then gave us a view of what the hospital and our community services should be providing in the future to meet the needs of our population. Our refreshed Trust Strategy was approved by the Board of Directors on 24 April 2015.

The Trust Strategy going forward will be focused on care for older people and care for people with cancer. This does not mean stopping the provision of services currently provided by Stockport NHS Foundation Trust, but that we need to review how we provide certain services by exploring new models of care as described in the Dalton Review and the Five Year Forward View.

The roll out of the Trust Strategy will also include focus on the Innovation Programme. This will focus on cross-cutting problems that we aim to address in order to improve the patient experience, efficiency and improve performance. This will be a continuous cycle of design thinking improvements within the Trust.

A more focused strategic position for the Trust will ensure a sustainable longer term future within the context of a new Greater Manchester health and social care system.

The Finance Strategy document is a key underpinning/ supporting strategy which will enable us achieve our overall Trust Strategy.

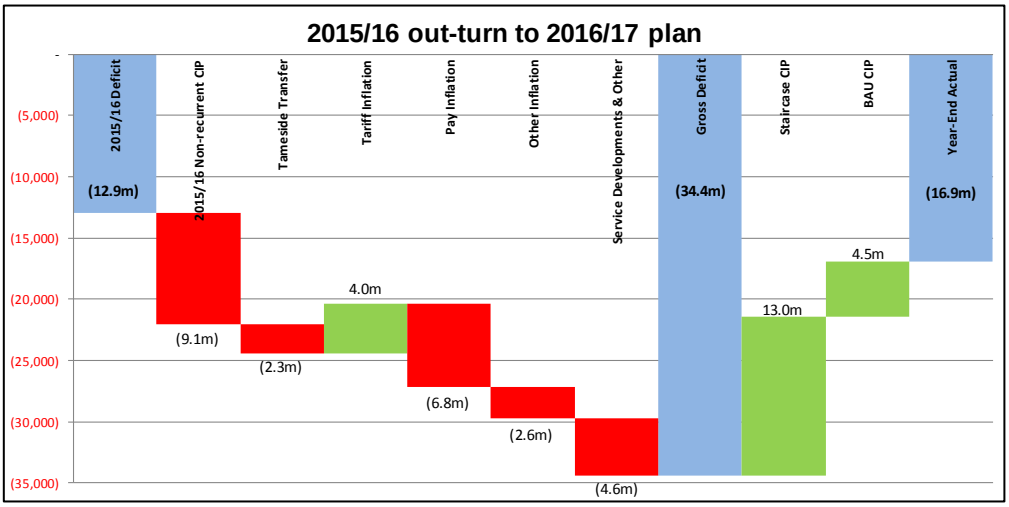
2. Executive Summary

The Board of Directors of Stockport NHS Foundation Trust is committed to managing its financial resources efficiently and effectively, to ensure continued provision of high quality services for the people of Stockport and neighbouring areas. The Trust is embarking on the delivery of a five year strategy focussing on care for older people and patients with cancer to deliver high quality resilient and sustainable services.

3. Where are we now

Between 2010-11 and 2014-15, the Trust had delivered strong financial surpluses, however in 2015-16, the Trust was only able to deliver £11.8m of cost improvement programme (CIP) savings (£2.7m recurrent) and therefore the financial year resulted in a deficit of £12.9m.

The financial deficit in 2015-16 was a result of a culmination of the Trust not able to achieve recurrent and sustainable change in previous financial years and therefore leading to a £34.4m recurrent shortfall in financial planning for 2016-17. The movement between the two financial years is illustrated in the chart below.



To help reduce the underlying recurrent financial position, the Trust is embarking upon a five year sustainability program, of which £13m will be realised in 2016-17. A further £4.5m target has been distributed to Business Groups and Corporate Services for Business As Usual savings to make the overall saving of £17.5m.

The Trust has continued to invest in the estate, medical equipment replacement and the implementation of an acute and community electronic patient record (EPR) system. The Trust capital expenditure was £16.8m in 2015-16 and we are planning a further £10.0m in 2016-17. The Trust has previously utilised internally generated resources for capital expenditure, however, with reduced levels of recurrent CIP leading to the Trust delivering deficits, the reduced cash balances has therefore meant that the Trust has had to resort to borrowing from the Independent Trust Financing Facility (ITFF). The overall level of borrowing is currently £25.7m with a further £3m due in July 2016.

In 2016-17, the Trust's operating income is planned to be £276.3m, of which £248.4m (90%) relates to clinical income. The Trust's private patient clinical income is only £0.3m (0.1% of clinical income) and the main commissioner of healthcare services is Stockport CCG with a contract value of £167.3m accounting for 61% of the overall Trust income plan and 67% of the Trusts clinical income.

4. Factors affecting the Trust Financial Strategy

There are a number of contributing factors affecting the Trusts financial plans over the next five years:

a) The Stockport Locality is financially challenged with the Trust planning a significant deficit, Stockport Clinical Commissioning Group (CCG) not able to meet NHS England business rules around required levels of surplus and Stockport Metropolitan Borough Council (MBC) having an underlying savings requirement. The underlying financial challenge facing the locality is in excess of £134m over the next 5 years;

b) The Trust is facing an ambitious CIP challenge in 2016-17 and with the planned £16.9m deficit, the Trust cash balance is reducing from £31.4m to £10m by the end of the financial year. Reduced levels of internally generated resources and therefore cash will have a direct impact upon the Trust's ability to invest in new developments and meet the loan repayments;

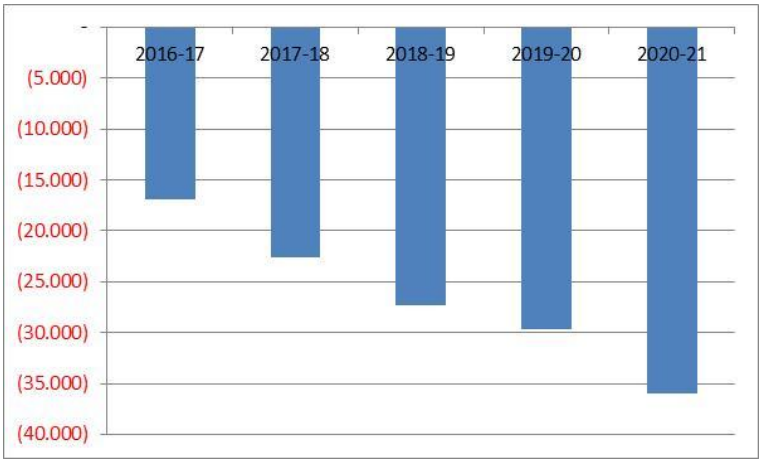
c) The 5 year Economic Assumptions published by NHS Improvement in 2016-17, shows that the NHS Providers will have to continue to make a minimum of 2% recurrent savings per year for the upcoming five years. Due to the underlying financial deficit, Stockport FT will need to make considerably higher levels of efficiency in the short-term to recover the deficit position and remain in a positive cash balance;

d) The Trust continues to face increasing demand for urgent care services from older people and patients with chronic diseases. Although quality and safety is maintained, the demand

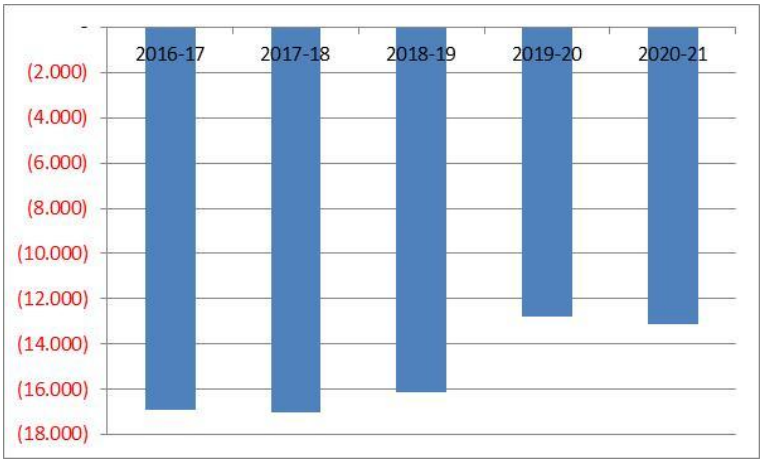
is affecting the Trust's ability to meet national Emergency Department Standards and is now also affecting the Trust's inpatient elective capacity and therefore adding pressure to the RTT waiting list numbers; and

e) The Trust has been chosen as the fourth specialist site for the south east sector and therefore will treat patients for complex surgery from other localities such as Tameside, East Cheshire and West Derbyshire. The patient pathway changes will require significant capital investment on the Stockport Site.

Assuming the Trust delivers the 2016-17 planned CIP of £17.5m CIP recurrently, the Trust will continue to have significant deficits leading to a £36m deficit in 20/21. By doing nothing, the Trust could run out of cash to continue services in early 2017-18. The chart below shows the underlying financial deficit over the next five years.



If the Trust was to deliver the 2% efficiency requirement only (approximately £5m) as per the national five year economic assumptions, the Trust can maintain the level of deficit in the short-term but again cash will be diminished in 2017-18.

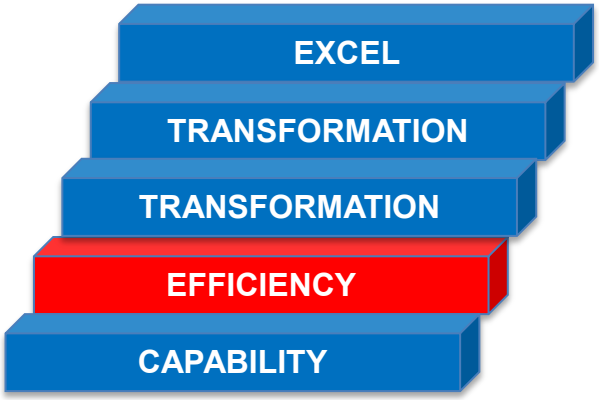


5. Where we want to be and how we will achieve it

In order for the Trust to be cash resilient in the short-term, and sustainable in the medium to long-term, we will need to deploy two workstreams utilising the recent investment in capacity and capability investment. It is imperative that the Trust delivers £20m financial improvement in each of the next two financial years (2017-18 & 2018-19) to remain in a positive cash position before it is able to return to the national level of CIP requirement.

Short-term Workstream

The Trust is starting year two of the five year strategy and is focussed upon efficiency in 2016-17.



We will need to deploy financial improvement actions in 2016-17 in the form of:

- Operational Grip – To ensure a forensic review of the income and expenditure incurred by the Trust to assess the whether more economic and efficient options are available without impacting upon the quality of care to patients. The Trust will review utilisation of theatres, wards and outpatients to ensure that the current capacity is fully utilised and therefore reduce the need for additional capacity through either waiting lists or outsourcing;

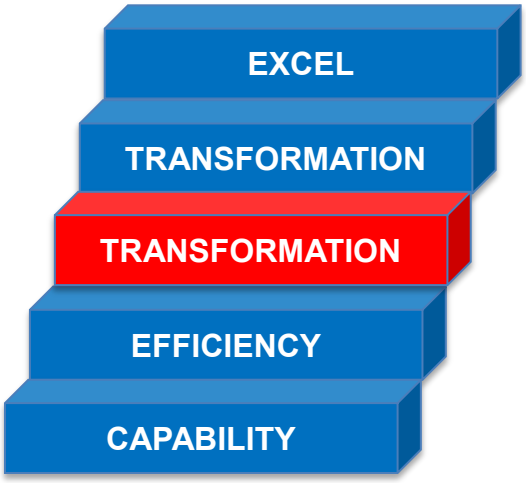
- Income Opportunities – To ensure the Trust is maximising all opportunities in relation to income through either better utilisation or more accurate counting / coding. The Trust will review private patient / commercial opportunities due to the financial restraints of local NHS CCGs;

- Financial Grip – To ensure the ordering process is effective by reviewing the procurement policy and the Standing Financial Instructions (SFIs) and review the number of staff that are able to authorise expenditure including their financial limits.

- Cash Grip – The Trust will establish a Cash Committee to strengthen the trust's liquidity performance through reviewing stock levels, assessment of the payment policy to large / multi-national companies and ensure Trust debtors have swift payment mechanism.

The Trust will receive management support from NHS Improvement in 2016-17 to assist in the implementation of the short-term workstream.

Medium - Long Term Work Stream



As illustrated in the staircase above, the next two financial years of the Trust will be focussed on the transformation of services, however to implement the changes at pace the following projects have or will be initiated in 2016-17:

- Stockport Together - The Trust is working closely with Stockport CCG and Stockport MBC to re-design Health and Social Services for over 65s across Stockport through the development of eight neighbourhoods and aligned to Primary Care. This Vanguard proposition could see a significant reduction in admissions to Acute Hospital Beds on the Stepping Hill site. This development in turn will reduce the significant locum and agency costs faced by the Trust in meeting acute bed coverage, furthermore, it will allow the Trust to realise site rationalisation savings in both reduced running costs but also dispose of land and building to property developers;

- Commercial Opportunities - The current 67% of clinical income being recovered from one single financially challenged CCG is not sustainable in the short-term and therefore the Trust needs to employ commercial marketing expertise to increase demand from neighbouring Commissioners or bring in additional private patient income;

- Investment Partners - Due to limited capital resources being made available in the short-term, the Trust will have to utilise disposal proceeds in the longer term but will have to attract partners to invest in the Stepping Hill site resulting the Trust having to pay operating leasing fees on a revenue basis. This could be exercised through a Managed Equipment Supplier and / or and investment company looking for revenue returns; and

- Workforce Planning - As with many NHS Acute Providers across the country, the Trust is facing significant shortfalls in the ability to recruit substantial medical and nursing staff. The Trust has initiated an international recruitment campaign with high levels of success in

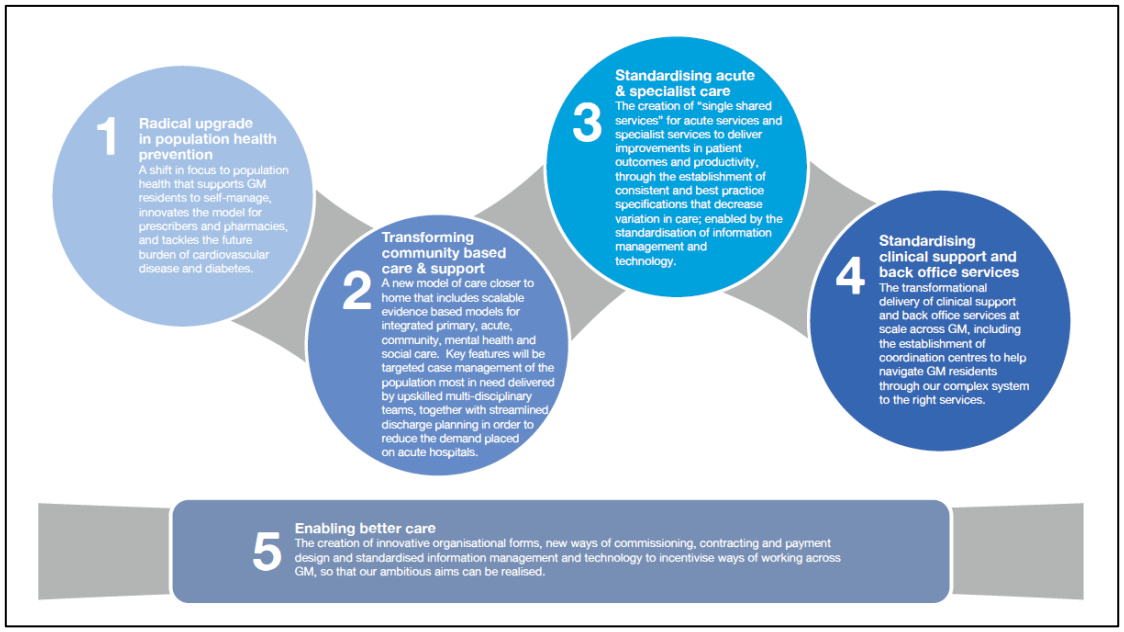
nursing however medical recruitment is still challenged. With the Trust being appointed the Specialist Hospital in the South East Sector, the Trust will now use this opportunity to attract medical staff from other Trusts and further afield.

Greater Manchester Health and Social Partnership

In February 2015 the 37 NHS organisations and local authorities in Greater Manchester signed a landmark devolution agreement with the Government to take charge of health and social care spending and decisions in our city region.

The overall size of the resource devolved to the Greater Manchester Health and Social Partnership (GMHCS) is £6bn however the aggregated level of financial challenge is £2bn by 2020-21. This value includes the financial challenge faced by Stockport NHSFT. The vision is 'to deliver the fastest and greatest improvement in the health and wellbeing' of the 2.8 million population of GM, creating a strong, safe and sustainable health and care system that is fit for the future.

GMHSC is planning developing services Greater Manchester through five themes illustrated below.



Stockport Foundation Trust will be collaborating closer with Health and Social Partners to accelerate the Trust's Strategy of delivering services for older people and people with cancer.

6. Financial Summary

In summary, the financial outlook for the next five years along with the respective Financial Sustainability rating is summarised in the table below

	2016-17	2017-18	2018-19	2019-20	2020-21
Underlying Deficit	(34.4)	(22.6)	(7.0)	11.3	11.8
CIP	17.5	20.0	20.0	5.5	5.5
Surplus / Deficit	(16.9)	(2.6)	13.0	16.8	17.3
Year-End Cash position	10.0	0.1	7.0	17.0	27.6
FSR	2.0	2.0	3.0	4.0	4.0

7. Key Policies

In order to deliver the Financial Strategy, a number of key policies will need to be developed including the transition from a strategic document into an operational plan for the next two financial years.

Feroz Patel
Director of Finance

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Report to:	Board of Directors	**Date:**	26 May 2016
Subject:	Talent Management Strategy		
Report of:	Head of OD and Learning	**Prepared by:**	Head of OD and Learning

REPORT FOR NOTING

Corporate objective ref:	-----	**Summary of Report** Further to presentation and approval at the May 2016 Workforce and OD Committee, the Board are requested to note the final version of the Trust's Talent Management Strategy.
Board Assurance Framework ref:	-----	
CQC Registration Standards ref:	-----	
Equality Impact Assessment:	☐ Completed	

Attachments:

This subject has previously been reported to:	☐ Board of Directors	X Workforce & OD Committee
	☐ Council of Governors	☐ BaSF Committee
	☐ Audit Committee	☐ Charitable Funds Committee
	☐ Executive Team	☐ Nominations Committee
	☐ Quality Assurance Committee	☐ Remuneration Committee
	☐ FSI Committee	☐ Joint Negotiating Council
		☐ Other

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Stockport NHS
NHS Foundation Trust

Talent Management Strategy 2016 – 2020

1. Introduction

Our vision is to be nationally recognised for our specialism in the care of older people and as an organisation that provides excellent cancer care.

We have exciting and ambitious plans for our Trust and our staff are a crucial part of our plans. We are at the centre of some exciting changes within the health and social care system of both Stockport and Greater Manchester. The next five years will see our organisation significantly transform. We are facing both urgent and important issues. There is an urgent need for more efficiency savings and increased pressure on services from an aging population with multiple needs. These are both risks and opportunities.

In order for us to achieve our ambitions and to gain competitive advantage there is a need to develop a strategic approach to talent management that suits the needs of our patients and gets the best from our people. This will provide a focus for investment in the people who make things happen, our staff. Additionally it will also add tangible benefits by contributing to building a high performing workplace, supporting and promoting a learning organisation and adding value to our employer of choice agenda.

There is a compelling case for managing talent and maximising the potential of our workforce in a structured way. Evidence has shown that effective talent management can lead to more engaged and motivated staff, which in turn will lead to improved patient outcomes and the achievement of our goals and targets, all of which research has proven, saves lives.

We also recognise that it is not enough to just attract individuals with high potential; we also need to develop, manage and retain all of our high performing staff as part of a planned strategy for talent, ensuring that it is closely aligned to our Trust strategy and operational priorities.

We define talent as anyone who can increase the capability and effectiveness of our organisation. All of our staff have an important part to play in improving our patient experience and our relentless drive for high quality care. Talent management embraces our approach to attracting, developing and retaining good people, developing highly effective leaders and ensuring we have plans for succession. We want to make sure that each person has the chance to reach their full potential. The achievement of full potential means the each member of our workforce will be inspired to make the most of the development opportunities that we create, be able to apply this experience to every day practice, and align this to the roles they are best suited for.

Support for talent management will flow from the top of our Trust and engage all of our people managers and leaders to ensure they are committed to our Trust's approach. Using a joined-up approach we will ensure our talent management activities will be developed in line with our Trust strategies, objectives and policies and practices. Talent management is a dynamic process that will be continually reviewed to ensure that our requirements as a Trust are still being met in light of our changing needs and the current economic climate. This makes the effective and strategic management of talent more, not less, important.

2. Why Talent Management is Important to Us

We passionately believe that our people are our greatest asset and are fundamental to the future success of our Trust. We know there is a clear link between better talent and better organisational performance and clinical outcomes. In the current economic climate and with the challenges of future public sector cost improvement plans, the optimal use of the talents of all of our staff is a rapidly increasing source of a value-added activity.

We also acknowledge that talent management has changed over the past decade. The working environment today is more dynamic and uncertain and the movement of staff within the regional health and social care community is anticipated to be much more fluid, with a greater emphasis on strategic alliances, partnership working and integration.

3. Components of a Highly Effective Talent Management Strategy

To ensure our plans for managing our talent meet our requirements we need to have:

- A clear understanding of our Trust's current and future priorities
- Identification of key gaps between the talent we have and the talent we need to drive achievement of our goals and objectives
- A sound talent management plan integrated with our business plans that is designed to identify and close talent gaps
- The focused development of all talent to enhance individual and team performance
- A robust values-based resourcing process that recruits for attitude as well as skill
- A dynamic performance and development review experience
- Regular succession planning assessment, with focused action plans
- A retention strategy that starts with an effective on-boarding approach through to developed and engaged staff with rewarding careers within our Trust and the health economy generally

4. Our Approach to Talent Management

At Stockport NHS Foundation Trust we have adopted an inclusive attitude to talent management and have created an "everyone matters" approach to talent development. Talent management encompasses everyone in our business. We firmly believe that the future success of our Trust is based on having the right talent, in the right place at the right time and we are reliant on every individual consistently contributing their talents to achieve our ambitions.

It is also important to acknowledge, that critical to our success, is the development of our senior leaders who will lead the way in the achievement of our ambitions and therefore specific development interventions are needed to support them (as outlined in our Leadership Strategy).
We also recognise that whilst the processes of an effective talent management system are facilitated by the Workforce & OD directorate, they need to be owned and embraced by the whole organisation.

Our approach and plans for managing and developing the talents of all our staff is one of the five key goals in our Trust's Organisational Development Strategy and will further support the goals of developing a performance management culture and enhancing our leadership capability:

"Goal 4 – Improving Talent Management and Succession Planning
To improve our approach to attracting, training, developing, promoting and retaining staff at all levels across the Trust; alongside identifying, releasing, and guiding untapped potential in people."

Inclusion, diversity and an inclusive approach to talent management are fundamentally linked. In order for our Trust to support an inclusive approach, it will require us to recognise the diversity of the talent within the organisation, the aspiration to be open to new ideas and a positive attitude towards everyone contributing to the organisation's objectives and innovation agenda, each using their unique contributions.
Consideration will need to be given as to how we link our management of talent to our workforce plan and how this can bridge the gap between the current skills level and that required in the future.

Of vital importance is that our talent is aligned to our organisational values. We want people who reflect and role model our values in everything that they do, every day.

Based on our current position, and in view of the challenges ahead, we will focus our attention on five priorities for talent management that will support our continued growth and success as an organisation. The five priorities are:

1. Attracting the best talent- how we attract the very best people who will contribute to our success and continue to enhance our reputation.
2. Recruiting the best talent - how we use robust assessment and recruitment processes to ensure we employ the right people, with the right values, attitude and skills into the right roles.

3. Developing the talent of all of our staff- how we design and deliver innovative, needs–based and value-added learning and development solutions.
4. Developing all of our leaders – how we enhance the capacity and capability of leaders at all levels of our Trust and develop our future leaders.
5. Succession planning – how we identify and develop the roles and people most critical to the future success of our Trust.

5. Attracting the Best Talent

These are exciting times for our Trust; we are an ambitious organisation that is passionate about achieving our vision– for our patients, our staff, our commissioners and partners and our community. There is an expectation of success and we need dynamic individuals with a high performance mentality and the ability to deliver high quality services. This involves the continued development of a culture that supports and promotes our aspirations and ambitions. We want people outside of the Trust and outside of the health economy to see Stockport NHS Foundation Trust as a great place to work.
We will continue to develop and enhance our employer brand and attract the best people through the marketing and promotion of our successes and achievements.

6. Recruiting the Best Talent

Our patients deserve the very best people providing the highest quality care and that is why our recruitment process needs to be robust, seamless, efficient and effective. It also makes good business sense as research suggests that the cost of recruiting the wrong person is the equivalent to three times their salary. This is of particular relevance to the recruitment of senior manager posts whose capacity to influence and shape our services and add value to our business is significant. Additionally, there is a need to identify resourcing gaps and possible future challenges in hard to recruit to posts.

The Talent Management Strategy will support the key objectives of the Recruitment and Retention Strategy to ensure we have the right staff and skills mix to be able to respond speedily and effectively to necessary changes. This will be key to support our strategic direction and innovation agenda.

7. Developing the Talent of All

We acknowledge that we will only be a successful organisation if our leaders are positively committed to, and engaged in, the development of individuals, their teams and themselves. Developing a talented, highly skilled workforce is central to our ambitions. Key to achieving this is embedding our Performance Appraisal process where all our people will have clear objectives and a focused Personal Development Plan.

We have re-designed and re-launched our Performance Appraisal process to facilitate a greater emphasis on a values-based performance review. We continue to support a high quality review experience with our “how to” guidelines, Appraisal Briefing workshops and one to one coaching.

Our Education Centre and library facilities offer a great learning environment and our extensive learning and development programme will be continually improved to facilitate the development needs of all of our staff so that they are able to reach their full potential. In addition, training resources will be targeted more efficiently to ensure that staff have the required skills and competences to deliver operational priorities and are supported to meet future requirements.

8. Developing all of our Leaders

We recognise that effective leadership is one of the critical success factors in achieving our ambitions. We know that our leaders will shape and influence our culture, and this will drive our performance. The expectations we have of our leaders is changing, both in what we need to achieve and how we go about our business. To support this, we need to develop the leaders of tomorrow and create the conditions where outstanding leadership can flourish. It will be our most enduring legacy. The planned development of our leaders either through internal development interventions or with our partners the NW Leadership Academy is key to our success.

The ethos of our leadership programmes is one of a developmental approach to enable the individual, with the full support their line manager, to take responsibility for enhancing their performance as a leader. The aim of our leadership programmes is to be both supportive and challenging and will enable individuals to think about their role as a leader and the impact this has on their team, their service and our patients.

9. Succession Planning

Effective succession planning is a key factor in ensuring our long-term growth as a Trust. The aim of succession management in its basic form is to minimise the disruption, ensure business continuity and possible risks to organisational objectives caused by personal changes and periods of time a post may be left vacant during the post filling process.

It is proposed that as a Trust, in the first phase, we focus on three priority areas for succession planning; our Executive Team, their direct reports and specific critical roles within our organisation. To achieve this we will develop a succession plan for the top leadership levels, identifying options for replacement of roles on an emergency, three to twelve months, one to two years and two years plus basis.

We will identify critical roles which are either strategically or operationally critical to achieving our business objectives and have traditionally proved difficult to fill. For these roles we will put in place a programme of supported development based on the capabilities identified within each role. The programme of development will be aligned to leadership competences and the individual's personal development plan.

10. Next Steps

1. Gain agreement and sign up to the principles and approach of the Talent Management Strategy
2. Align the Talent Management Strategy with the Trust Strategy, operational and workforce plans and appraisal process
3. Develop a talent and succession planning framework
4. Implement, measure progress and adapt accordingly

11. Conclusion

On the understanding that talented people can drive productivity, improve performance and can be a competitive differentiator, then the business case for taking a strategic approach to talent management is a persuasive one. As a Trust, we need to retain and develop talented leaders and to ensure than an inclusive approach to talent delivers maximum performance. Talented people, effectively developed and deployed will facilitate a high performance workplace, enhancing staff recognition and engagement, encouraging a learning organisation and making Stockport a great place to work, grow and develop.

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