Stockport NHS
NHS Foundation Trust

BOARD OF DIRECTORS

PUBLIC MEETING

29 SEPTEMBER 2016

Your Health. Our Priority.

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Stockport NHS
NHS Foundation Trust

September 2016

Dear Colleague

You are invited to a meeting of the Board of Directors which will be held on **Thursday 29 September 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

****

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 25 August 2016 (attached).	1.20pm – 1.25pm
4.2 Patient Story.	1.25pm – 1.35pm
4.3 Report of the Chairman.	1.35pm – 1.40pm
5. **TRUST ASSURANCE / GOVERNANCE:**	
5.1 Performance Report (Report of Acting Chief Operating Officer attached).	1.40pm – 2.00pm
5.2 Financial Position Report (Presentation by the Director of Finance).	2.00pm – 2.20pm
5.3 CQC Action Plan (Report of Director of Nursing & Midwifery Attached).	2.20pm – 2.40pm
5.4 Safe Staffing Report (Report of Director of Nursing & Midwifery attached).	2.40pm – 2.50pm
5.5 Maintaining Safe Staffing Levels (Report of Director of Nursing & Midwifery attached).	2.50pm – 2.55pm
5.6 Seven Day Services – Progress Report (Report of Medical Director attached).	2.55pm – 3.10pm

AGENDA ITEM	TIME
5.7 Board Assurance Framework (Report of Chief Executive attached).	3.10pm – 3.20pm
5.8 Strategic Risk Register (Report of Director of Nursing and Midwifery attached).	3.20pm – 3.30pm
5.9 Key Issues Reports from Assurance Committees: 5.9.1 Audit Committee (attached and John Sandford to report) 5.9.2 Finance & Performance Committee (attached and Malcolm Sugden to report) 5.9.3 People Performance Committee (attached and Angela Smith to report) 5.9.4 Quality Assurance Committee (attached and Mike Cheshire to report)	3.30pm – 3.45pm
6 **STRATEGY AND DEVELOPMENT:**	
6.1 Report of Chief Executive	3.45pm – 3.55pm
7 **CLOSING MATTERS:**	
7.1 Any Other Urgent Business.	"
7.2 Date of next meeting: • Thursday 27 October 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 25 August 2016
1.15pm in Lecture Theatre A, Pinewood House, Stepping Hill Hospital

Present:

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

In attendance:

Mr P Buckingham	Company Secretary

244/16 Apologies for Absence

An apology for absence was received from Mr M Sugden.

245/16 Opening Remarks by the Chairman

Mrs G Easson welcomed members of the Board to the meeting and noted that this would be the final Board meeting for Mr J Schultz whose term of office as Non-Executive Director would be completed on 31 August 2016. She thanked Mr J Schultz for his positive contributions as a Board member during the previous three years and noted in particular his role as Chair of the Building a Sustainable Future Committee along with membership of other Board Committees. Mrs G Easson conveyed her best wishes to Mr J Schultz in the future. Board members present endorsed these sentiments.

246/16 Declaration of Amendments to the Register of Interests

The Chief Executive advised the Board of her nomination as a member of the University of Manchester General Assembly for a further three years and the Chairman advised of a similar nomination for a further four years.

247/16 Minutes of the previous meeting

The minutes of the previous meeting held on 4 August 2016 were approved as a true and accurate record of proceedings.

248/16 Patient Story

The Director of Nursing & Midwifery presented a report which reflected on feedback received from a patient who had spent eight weeks on the Treehouse Children's Unit following a back injury. She provided an overview of the patient feedback which she noted related to the patient's ability to consume meals due to his prone position as opposed to the quality of food provided. She advised the Board of work to ensure that all patients were able to take on necessary nutrition and hydration and noted that the feedback received from the patient had been shared with the ward and facilities teams. In response to a question from Dr M Cheshire regarding wider learning, the Director of Nursing & Midwifery noted her role as Chair of the Trust's Nutrition Group and advised that the Group considered how learning from such situations could be applied across the organisation.

The Board of Directors:

- Received and noted the Patient Story report.

249/16 Trust Performance Report – Month 4

The Acting Chief Operating Officer presented the Trust's Performance Report which summarised the Trust's performance against the Risk Assessment Framework standards for the month of July 2016. The report also provided a summary of the key risk areas within the Integrated Performance Report which was attached in full in Annex A. She briefed the Board on the content of the report and noted two areas of non-compliance in month 4 which were the non-achievement of the Accident & Emergency (A&E) 4-hour target and the Referral to Treatment (RTT) 92% Incomplete Pathway target. With regard to A&E performance, the Acting Chief Operating Officer noted levels of attendance during July 2016 which were circa 8% higher than forecast levels. She noted that, while a reduction in delayed transfer of care (DTOC) patients during July 2016 had prevented further impact on performance levels, DTOC levels had again increased during August 2016 with a consequent negative impact on performance. The Acting Chief Operating Officer of pressures being experienced at hospitals across the Greater Manchester area which would be the subject of a regional event on 26 August 2016.

In response to a question from Dr M Cheshire regarding discharge of patients, the Director of Nursing & Midwifery advised the Board of the SAFER initiative which was part of the Length of Stay programme. She noted that this included proactive monitoring of the discharge process, whiteboard rounds each morning and identification of opportunities for discharge earlier in the day. She advised that progress was slow but improving. In response to a question from Mr J Sandford regarding timescales for improvement, the Director of Nursing & Midwifery agreed to forward details of the improvement trajectory which formed part of the Length of Stay project plan. The Chief Executive commented on an increasing number of patients who were presenting with relatively minor conditions and advised that the Trust's

Communications Team was working with CCG colleagues on public messaging relating to access to services.

In response to a question from Mrs C Anderson, who queried measures to address increasing numbers of DTOC patients, the Acting Chief Operating Officer advised that introduction of crisis response teams and intermediate care initiatives were scheduled to be implemented in October 2016 but noted that the feasibility of advancing these initiatives was currently being assessed. She noted a reduction of circa 200 community beds during the last year which meant that solutions could not be bed-based. Dr M Cheshire noted the earlier response from the Director of Nursing & Midwifery and suggested that a slow improvement in discharge rates was not reflected in the charts 32-34 included in the IPR. The Director of Nursing & Midwifery acknowledged this point and advised that the charts did not reflect the week by week improvements realised during August 2016.

Mrs G Easson commented on the operational challenges facing the Trust, which emphasised the importance of effective winter planning, and queried when the winter plan would be available for consideration by the Board. The Acting Chief Operating Officer advised that the Trust's plan would reflect the initiatives scheduled to commence in October 2016 and re-design of the acute interface model. She agreed that progress with the winter plan would be reported to the Board on 29 September 2016. The Acting Chief Operating Officer then briefed the Board on RTT performance and noted the impact on performance of four specialties as detailed in the graph included at s3 of the report. She assured the Board that processes were in place to ensure that no patients were at risk as a result of the backlog. In response to a question from the Deputy Chief Executive, the Acting Chief Operating Officer acknowledged that the additional theatre capacity which would be provided on the opening of D Block would help to manage the backlog.

In response to questions from Mrs G Easson and Mrs C Anderson, the Acting Chief Operating Officer advised that specialty review of backlogs included clinical risk assessments in order to mitigate the risk of safety issues. She also noted that efforts to outsource activity had not been as successful as anticipated due to a combination of provider unwillingness to accept activity at tariff rates and patient choice. In response to a question from Ms A Smith regarding the Cardiology Outpatient Waiting List (OWL), the Acting Chief Operating Officer confirmed that a vacant consultant position would be filled in September 2016 and advised that this was expected to result in a speedy reduction in the OWL. In response to a question from Ms A Smith regarding pressure ulcer incidence detailed in Chart 11, the Director of Nursing & Midwifery provided an overview of the approach to incidence management and the monitoring role of the Quality Governance Committee.

The Director of Workforce & OD briefed the Board on the Workforce section of the report and noted a very positive compliance rate for appraisals of 92.2% in July 2016. She then noted the position relating to Bank & Agency costs in July 2016. In response to a question from Mr J Sandford, the Director of Finance advised that he was currently considering the subject of accruals accounting with the Director of Workforce & OD. In response to a question from the Financial Improvement Director, the Director of Workforce & OD agreed that in-month turnover data would be included in future reports. In response to questions from Mrs C Anderson, the Director of Workforce & OD confirmed that Bank & Agency costs remained within the Agency

Ceiling trajectory and confirmed that the Trust's 'hard to recruit to' positions reflected national experience. With regard to performance against the Agency Ceiling, the Director of Finance noted a potential risk to performance as a result of excessive agency use to manage winter pressures. The Director of Workforce & OD also noted a risk of increased agency use as a result of the transfer of stroke services from East Cheshire.

The Director of Finance briefed the Board on the Finance section of the report and noted a deficit position of £8.3m against a planned deficit of £8.9m as at 31 July 2016. He then provided an overview of performance against the Trust's cost improvement programme (CIP). In response to a question from Dr M Cheshire regarding recovery of CIP slippage, the Director of Finance advised that a significant risk to outturn had been considered at the Finance & Performance Committee meeting on 22 August 2016 and noted that the Committee had concluded that, at present, there was limited assurance on the financial position. The Director of Finance noted that this emphasised the need to pursue both delivery of the CIP programme and progress of the 'bold schemes'. In response to a question from Mr J Sandford regarding over-expenditure on clinical supplies detailed in the Income & Expenditure Statement, the Director of Finance advised that the increase in expenditure was related to cost of outsourced activity. He also noted that the future cash flow position was considered by the Finance & Performance Committee.

The Board of Directors:

- Received and noted the contents of the Trust Performance Report
- Noted the position for Month 4 compliance standards
- Noted the key risk areas from the Integrated Performance Report

250/16 Strategic Risk Register

Mrs J Morris presented the Strategic Risk Register and advised the Board that two new strategic risks had been added to the register (2990 and 2884), two strategic risks had been removed and that there were currently a total of 10 entries with a risk score of 20. She then provided an overview of the new entries related to Additional Beds within the Medicine Business Group (2884) and Registered Nurse staffing in the ED Department (2990). In response to a question from Dr M Cheshire regarding Risk ID 2884, the Director of Nursing & Midwifery advised that the issue of patients on beds in the ED corridor had been identified during the CQC inspection. In response to a question from Mrs C Anderson regarding Risk ID 2990, the Director of Nursing & Midwifery advised that the Trust sought to re-train existing nurses where possible but noted that the pressurised ED environment affected the number of nurses interested in this role.

Mrs G Easson then led the Board in conducting a page by page review of the Strategic Risk Register during which the following points were noted:

- Risk ID 2742 – Mr J Sandford queried whether the increase in risk score was correct. The Director of Nursing & Midwifery explained that the position had deteriorated hence the higher risk score.
- Risk ID 2969 – Mrs G Easson advised that Mrs C Anderson had been nominated as the Non-Executive Director member of the Hospital Falls Group

- Risk ID 2877 – In response to a question from Mr J Sandford regarding the likelihood of achieving a forecast completion date of 30 September 2016, the Director of Finance noted continuing negotiations with the Christie Hospital regarding the Acute Oncology Service and advised that 30 September 2016 had been set as the deadline for resolution of contractual issues.
- Risk ID 2721 – In response to a question from Dr M Cheshire, the Medical Director provided an overview of the Trust's response to the Trauma Unit External Peer Review
- Risk ID 2644 – In response to a question from Dr M Cheshire, the Medical Director provided an overview of challenges relating to Upper GI Bleed and noted that a report on this subject was scheduled to be considered by the Quality Governance Committee in September 2016.

The Board of Directors:

- Received the report and noted the content.

251/16 Maintaining Safe Staffing Levels

The Director of Nursing & Midwifery presented a report which provided an overview, by exception of actual versus planned staffing levels for the month of July 2016. She briefed the Board on the content of the report and noted sub-optimal staffing levels in certain areas of the Surgical & Critical Care Business Group with safe staffing levels being maintained as a result of daily actions taken by the Matrons. She also referred the Board to s3.9 of the report and provided an overview of recruitment plans. The Board of Directors received assurance that safe staffing levels had been maintained during June 2016.

The Board of Directors:

- Received and noted the positive assurance on staff staffing levels during July 2016.

252/16 Terms of Reference – People Performance Committee

The Company Secretary presented a report seeking approval of Terms of Reference for a People Performance Committee. He briefed the Board on the content of the report and noted that the Committee would replace the former Workforce & Organisational Development Committee. In response to a question from Mr J Sandford, the Company Secretary acknowledged that the Board had previously agreed that Committees would primarily operate on bi-monthly cycles. However, he advised that the monthly frequency set out in the Terms of Reference was considered necessary to reinforce the additional 'grip' activities applied during the Financial Improvement Programme.

In response to a further question from Mr J Sandford, the Chief Executive advised that, while she attended a range of Committee meetings, the People Performance Committee was the only Committee where she was formally identified as a member. She suggested that it was entirely appropriate for the Chief Executive to have an active involvement in Workforce-related matters. In response to a question from the Director of Finance regarding workforce planning functions, the Company Secretary

advised that additional clarity would be provided by an appropriate amendment to s2.2vii of the Terms of Reference.

The Board of Directors:

- Approved the Terms of Reference for the People Performance Committee subject to the amendment noted above.

253/16 Key Issues Reports

People Performance Committee

Ms A Smith briefed the Board on matters considered at a meeting of the People Performance Committee held on 18 August 2016. She provided an overview of what had been a busy agenda and noted that the monthly cycle for future meetings was likely to result in leaner agendas. Ms A Smith advised the Board that the Committee had noted positive assurance in relation to Nursing & Midwifery Revalidation and Medical Revalidation and noted that, with regard to the latter, the Trust's performance compared favourably with that of peer organisations. Ms A Smith also noted consideration of a report regarding the 2016 Staff Survey and advised the Board of national guidance which recommended that trusts undertake full surveys, rather than surveys based on a random sample, in order to achieve enhanced qualitative and quantitative data.

Ms A Smith concluded her report by advising the Board of improvements in sickness absence rates which had resulted in a Committee recommendation that the Trust's sickness absence target be amended to 3.5%. The Board of Directors approved this recommendation. Mrs G Easson noted reference in the Key issues Report to Committee consideration of a Medical Education Annual Report and commended what was a comprehensive report on Medical Education activities.

Finance & Performance Committee

In the absence of Mr M Sugden, the Director of Finance briefed the Board on matters considered at a meeting of the Finance & Performance Committee held on 22 August 2016. He referred the Board to Chart 59 in the IPR and provided an overview of the Committee's regular review of the Trust's cumulative financial position which included the monitoring of elements of the CIP programme which could be advanced for delivery earlier in the year. He also noted Committee consideration of a cash flow forecast through to July 2017.

In response to a question from the Chief Executive regarding levels of non-recurrent savings, the Director of Finance assured the Board that this subject was a feature of monthly performance meetings with Business Groups with an emphasis on achieving recurrent efficiencies through service re-design as opposed to delivery of non-recurrent savings. The Financial Improvement Director referred the Board to the section of the report regarding progress with the Financial Improvement Programme and advised Board members that the identified savings figure of £11.7m did not include benefits from any of the 'bold schemes'. Mrs G Easson thanked the Director of Finance for the report and the Board noted the limited assurance assessment on

overall FIP delivery. The Board of Directors also re-stated its commitment to delivery of the 'bold scheme' initiatives.

254/16 Chief Executive's Report

The Chief Executive presented a report which detailed matters relating to publication of the CQC Inspection Report and the 'D Block' Build Project. She briefed the Board on the content of the report and noted that the CQC Inspection Report had been published on 11 August 2016 and that the report was available on both the CQC and Trust websites. She advised that the overall outcome of 'Requires Improvement' was disappointing and noted that a number of areas of good practice had been identified during the inspection. She then referred the Board to s2.3 of the report and provided an overview of arrangements for the CQC Quality Summit which was scheduled to be held on 9 September 2016.

The Chief Executive informed the Board that the D Block Build Project had been handed over to the Trust on 5 August 2016 and noted that the facility was scheduled to become operational on 3 October 2016. She advised that the project had been delivered on time and on budget and noted that the facility would enhance patient experience and would make a huge difference in the working environment for staff. Mrs C Anderson commended the work of the Estates & Facilities team in project delivery and Mr J Sandford noted that an Internal Audit review of project management had resulted in an assessment of High Assurance. In response to a question from Mr J Sandford, the Chief Executive confirmed that plans were in place for fit-out and occupation of the new facility.

The Board of Directors:

- Received and noted the Chief Executive's report.

255/16 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 29 September 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
3/16	26 May 16	127/16	Trust Performance Report – Month 1	It was proposed to hold a deep dive session to share the Trust's Urgent Care Plan with the Board of Directors. Mr J Sumner proposed that this was combined with the strategic session that was being arranged for June 2016 to discuss the Trust's strategic direction. **Update on 30 June 2016** – The strategic session held on 16 June 2016 did not cover the Urgent Care Plan in depth. A date for a further strategic session to be confirmed. **Update on 4 Aug 2016** – A date for a further strategic session was to be confirmed.	J Sumner / S Toal J Sumner / S Toal
4/16	30 June 16	188/16	Trust Performance Report – Month 2	Mr J Sumner made reference to an Outpatient Waiting List national pilot and noted the innovative work that was being led by this Trust's staff. It was proposed that this be explored further either at the next Board meeting or the deep dive session. **Update on 4 Aug 2016** – This action was carried forward.	J Sumner
5/16	30 June 16	188/16	Trust Performance Report – Month 2	*Emergency Readmissions* - Ms A Smith requested that the Board be sighted of the different groups of patients re-admitted after 20+ days and it was proposed that this subject be covered at the forthcoming Board deep dive session. **Update on 4 Aug 2016** – This action was carried forward.	S Toal
7/16	30 June 16	190/16	External Review of Never Events	It was noted that in order to ensure appropriate closure of the process, a report would be considered by the Quality Assurance Committee in September followed by the Board of Directors in October 2016. **Update on 4 Aug 2016** – A report would be considered at the Board meeting in October 2016.	C Wasson

8/16	30 June 16	191/16	Strategic Risk Register	In response to a question from Mr J Sandford who queried risk 2889 (7 day working), Dr C Wasson provided an overview of actions in place and agreed to provide a comprehensive update to the Board at the September meeting. **Update on 4 Aug 2016** – A report would be considered at the Board meeting in September 2016.	C Wasson
10/16	4 Aug 16	206/16	PLACE – Quarter 1 Update	In response to a question from Mrs C Anderson who queried what actions were in place to address the issues around cleanliness, Mr J Sumner advised that these were included in the PLACE action plan which he agreed to distribute to the Board.	J Sumner
11/16	4 Aug 16	208/16	Strategic Risk Register	Ms A Smith made reference to the action plan completion column and queried the possibility of including a separate column with regard to progress against the actions. Mr P Buckingham agreed to review the presentation of the report with Mrs J Morris.	J Morris / P Buckingham
12/16	25 Aug 16	249/16	Trust Performance Report	Mrs G Easson commented on the operational challenges facing the Trust, which emphasised the importance of effective winter planning, and queried when the winter plan would be available for consideration by the Board. The Acting Chief Operating Officer agreed that progress with the winter plan would be reported to the Board on 29 September 2016.	S Toal

Report to:	Board of Directors	**Date:**	29 September 2016
Subject:	Trust Performance Report – Month 5		
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 ☐ F&P Committee ☐ PP Committee ☐ SD 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 August 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 Annex A.

2. Compliance against Regulatory Framework

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

	Standard	Weighting	Monitoring Period	Oct-15	Nov-15	Dec-15	Q3	Jan-16	Feb-16	Mar-16	Q4	Apr-16	May-16	Jun-16	Q1	Jul-16	Aug-16	Sep-16 (f/cast)
Maximum time of 18 weeks from point of referral to treatment in aggregate: Patients on an incomplete pathway	92%	1.0	Quarterly	92.4%	92.7%	92.1%	92.4%	92.1%	92.0%	91.2%	91.8%	90.7%	91.3%	91.5%	91.2%	91.4%	91.0%	
maximum waiting time of four hours from arrival to admission/ transfer/ discharge:	95%	1.0	Quarterly	91.0%	78.0%	73.7%	80.6%	73.5%	72.8%	72.60%	73.0%	79.3%	81.6%	85.2%	82.1%	81.5%	77.1%	
All cancers: 62-day wait for first treatment from: urgent GP referral for suspected cancer	85%	1.0	Quarterly	78.5%	92.5%	92.6%	87.9%	87.2%	81.6%	90.0%	86.4%	89.5%	85.7%	93.3%	90.1%	86.5%	85.0%	
All cancers: 62-day wait for first treatment from: NHS Cancer Screening Service referral	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	
All cancers: 31-day wait for second or subsequent treatment, comprising:surgery	94%	1.0	Quarterly	100%	100%	100%	100%	100.0%	100.0%	100%	100%	100%	100%	100%	100%	100.0%	100.0%	
All cancers: 31-day wait for second or subsequent treatment, comprising:anti-cancer drug treatments	98%			100%	100%	100%	100%	100.0%	100.0%	100%	100%	100%	n/a *	100%	100%	100.0%	100.0%	
All cancers: 31-day wait for second or subsequent treatment, comprising:radiotherapy	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	
All cancers: 31-day wait from diagnosis to first treatment	96%	1.0	Quarterly	98.6%	97.5%	96.1%	97.8%	98.6%	97.4%	98.6%	98.2%	97.3%	100%	96.7%	97.8%	98.0%	96.2%	
Two week wait from referral to date first seen, comprising:all urgent referrals (cancer suspected)	93%	1.0	Quarterly	96.0%	97.3%	97.6%	97.0%	96.8%	98.1%	97.5%	97.5%	96.6%	96.6%	98.1%	97%	96.2%	97.4%	
Two week wait from referral to date first seen, comprising:for symptomatic breast patients (cancer not initially suspected)	93%			94.2%	94.7%	98.7%	95.6%	96.4%	98.9%	99.1%	98.1%	98.8%	97.4%	98.7%	98.3%	97.9%	100.0%	
Meeting the C. difficile objective (< 17 in year due lapse in care)	de minimis applies	1.0	Quarterly	0	1	0	1	1	2	0	3	1	0	2	3	0	0	

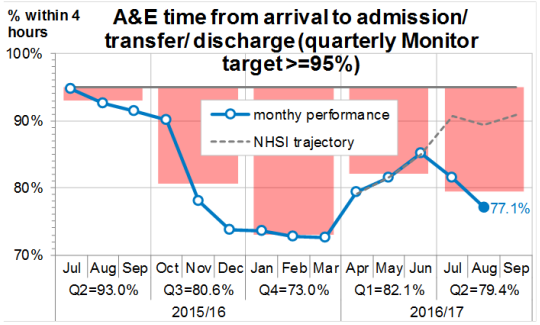
**= no patients treated in month.*

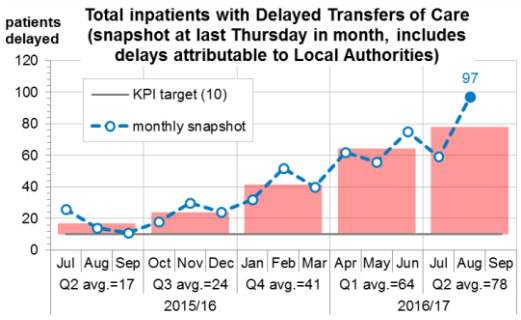
3. Month 5 Performance against Regulatory Framework

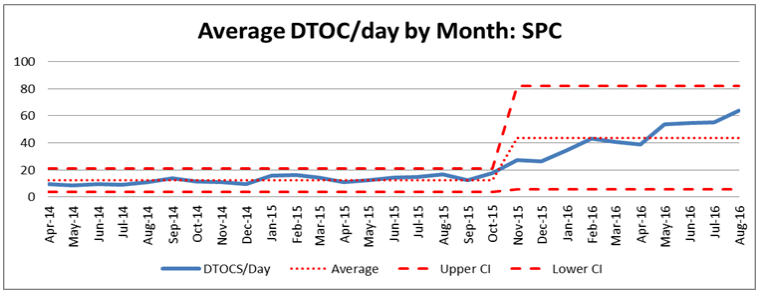
There were two areas of non-compliance against the regulatory framework in month 5:

A&E 4hr target

Performance in August was 77.1% and was below the NHSI trajectory. Attendances were 3.5% above expected with a further significant increase in delayed transfers of care.







Strategies to affect performance centre on three of the five NHSI/NHSE mandated themes for Urgent Care Improvement with specific sub projects designed to:

1) Appropriately stream patients in increasing number to ambulatory and primary care – planned to commence October 17th in initial scope format
2) Improved flow related to the implementation of the SAFER bundle
3) Mandated discharge to assess planned to commence October 16

The numerous work-streams within these themes are owned by the organisational strategy and implemented by the Urgent Care Review Group (UCRG)/Urgent Care Lead.

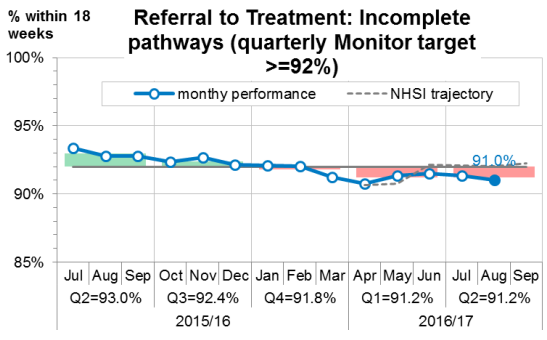
Long term models of care to address high volumes of attendances which could be managed elsewhere and patients whose continuing care need not be in the acute setting are in development with other providers through commissioners and Stockport Together for implementation in 2016.

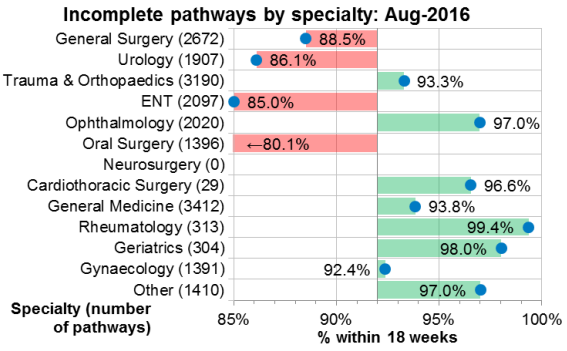
Short term internal measures to address performance include:

- Identifying and avoiding 4hr breaches by proactive management, escalation and leadership once a patient's attendance reaches 2.5hrs
- Protecting flow through the Medical Admissions Unit/Clinical Decisions Unit (MAU/CDU) by avoiding overnight patient stays
- 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 – analysis pending
- 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.

Referral To Treatment, 92% Incomplete Pathway Target

Performance in August was 91.0%, which remains behind NHSI trajectory.





Of the 4 under-performing specialties reported in July, there has been a significant improvement in General Surgery within month. The latest position for General Surgery is 88.3%, compared to July's performance of 85.8%.

Urology's performance has remained static, as predicted, despite an increase in referrals and a recurrent capacity gap.

Discussions are being progressed with NHS England as Commissioners regarding Oral Surgery. There was a significant increase in referrals last year, and despite activity being above contracted levels, the RTT backlog is unable to be sufficiently addressed.

ENT requires a further service review and options appraisal.

Future risks to compliance against Regulatory Framework
The risk to the A&E standard and RTT standard is expected to remain throughout Q2.

4. Key Risks/hotspots from the Integrated Performance Report

4.1 Quality

- **Discharge Summary**
  The percentage of discharge summaries published within 48 hours including A&E attendances has increased from 86.53% in July to 88.54% in August.

  The most significant factor in performance below trajectory is again due to volume of patients through acute assessment areas. The substantive Acute Junior Doctor Rota came into effect on the 8th August 2016 which allocates focused time to complete HCR's.

  Alerts are still distributed daily to Consultants/Junior doctors detailing any outstanding HCR's at 24 hrs. This should then enable the HCR to be completed within the 48 hr deadline.

- **Clinical Correspondence**
  The overall Trust performance for August was 89%. Ophthalmology was the only specialty to underperform, which was due to staffing pressures within the service.

- **Patient Experience**
  Overall in August, the trust scored 92% extremely likely or likely to recommend, total responses were 5437.

4.2 Performance

- **Cancelled ops – 28 day re-book**
  There was one breach of standard in month that related to a General Surgical patient that was cancelled twice due to no HDU bed. HDU bed capacity was prioritized for urgent cancer patients on both occasions.

- **Outpatient Waiting Lists:**

  Gastroenterology
  Vacancies at Consultant level remain, however a locum Consultant has now been secured which has significantly increased follow-up capacity in the short-term. It is forecast that the OWL should begin to decline as future demand is more proactively managed and fewer long term appointments are being given.

  Cardiology
  As described previously, the Cardiology OWL was expected to increase in the short term until vacancies had been recruited to. Unfortunately, further vacancies are expected as a locum has recently given notice. Assurance has been provided by the

directorate that high risk surveillance patients are monitored separately and given priority.

Respiratory
The Respiratory OWL remains slightly behind trajectory, and progress remains reliant on locum cover. Assurance has been provided by the directorate that high risk surveillance patients are monitored separately and given priority

Ophthalmology
The OWL is ahead of trajectory as at the end of August. The new Consultants commence September and October respectively. Assurance has been provided that there is minimal clinical risk in this backlog, as high risk surveillance patients are monitored separately and given priority. A vacancy remains at Specialty Doctor level which will impact on capacity.

- **Emergency Readmissions**
  The Gynaecology, Urology and General Surgery audits have now been completed and are in the analysis stage. Good progress has been made with the Medicine audit and it is anticipated the forms will be ready to forward for analysis this month.

  Plans then can progress as regarding feed back to the Business Groups to enable pathway improvements in specific HRG categories.

  As regards the work stream focusing on patient information and follow up telephone calls, significant progress has been made. Patients are now contacted at 48hrs and 14 days post discharge to check recovery and signpost them to more appropriate sources of support. This role is being incorporated into the patient flow team to enable full integration with the readmission avoidance plans.

4.3 Finance

- The Trust's overall Financial Sustainability Risk Rating (FSR) is 2, classified by Monitor as a material risk. The Trust's operational plan for 2016/17 predicted a score of 2 for August 2016 and our actual performance is in line with this.

  Cash in the bank at the 31st August 2016 was £30.9m. This is £2.2m ahead of plan due to low creditor payments during August and a receipt of £0.7m from charitable funds.

  NHSI released their new Single Oversight Framework on 13th September which will come into effect from 1st October 2016. It covers five themes linked to the CQC's key questions, aligned to the Carter review and the 'model' hospital, as well as NHS Improvement's 2020 Objectives:
    - Quality of care (safe, effective, caring, responsive)
    - Finance & use of resources
    - Operational performance
    - Strategic change
    - Leadership and improvement capability (well led).

4.4 Workforce

- **Essentials training**
  In August 2016 there was an increase of 1% in compliance from the July position, from 86.6% to 87.6%. 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.

- **Appraisals**
  Appraisals rates further improved in August to 93.59%, an increase of 1.36% from July 2016

- **Turnover**
  The Trust turnover in month has shown a relatively steady trend throughout the first quarter of 2016, with a small increase from 1.97% in July 2016 to 2.05% in August 2016. The turnover percentage does not include internal moves, such as promotion or transfers from within departments or other internal moves within the Trust.

- **Induction**
  Corporate Welcome attendance remains consistently at 100%. Local induction has decreased from 70.83% in July to 53.75% in August.

- **Efficiency**
  Bank & Agency costs
  The percentage of pay costs spent on bank and agency in August 2016 is 8.8% (the July 2016 position was 9%), which equates to £1,521,645, a decrease of £39,127 from £1,560,772 in July 2016.

  The Medicine Business Group has the highest spend on bank/agency at £1,021,072 in August 2016 which equates to 67.10% of the overall bank/agency spend, a decrease of 4.43% (£95,283) from the 71.53% July 2016 figure of £1,116,355.

  Agency shifts above cap
  August 2016 shows an increase in the number of shifts which are taking place above the agency cap of 171, from 1324 in July 2016 to 1495 in August 2016. Work continues in line with the IDP Agency Cap programme to address the level of cap breaches and to model the impact.

  Trust pay variance
  The Trust pay variance, expenditure above the financial envelope of establishment, including vacancies in August 2016 showed a £557,116 underspend, an increase of £403,372 from the £153,744 underspend reported in July 2016.

5. Recommendations

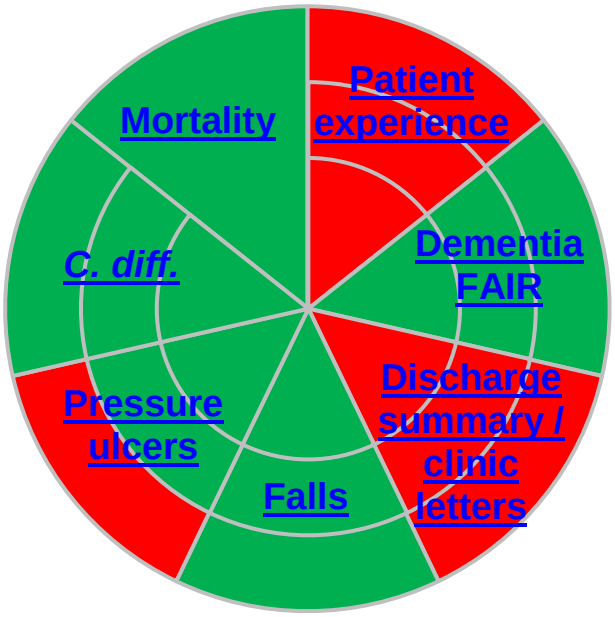
The Board is asked to:

- Note the current position for month 5 compliance against standards.
- Note the future risks to compliance and corresponding actions to mitigate.
- Note the key risks areas from the Integrated Performance Report

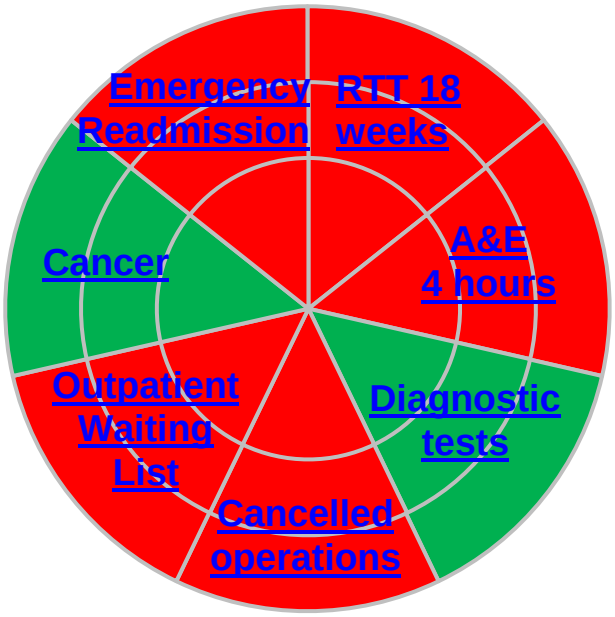
Integrated Performance Report
September 2016

Stockport NHS Foundation Trust

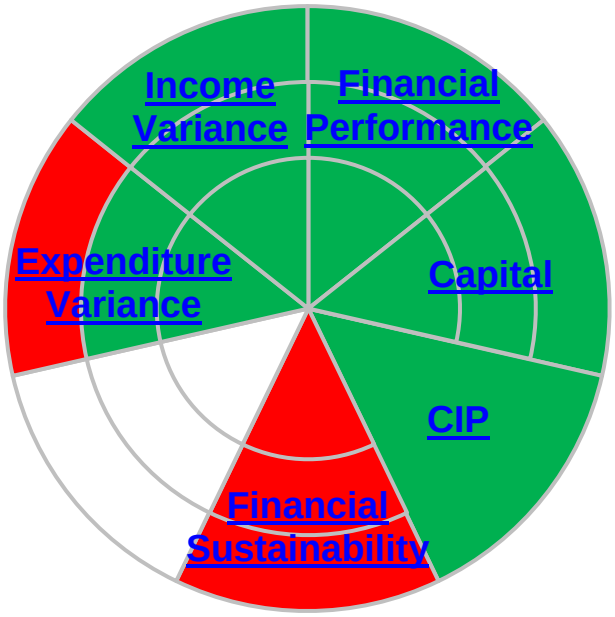
1.Quality



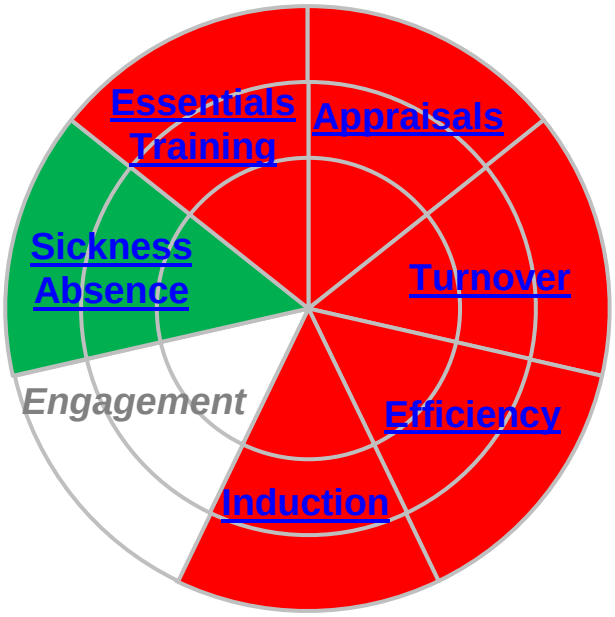
2.Performance



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 –September 2016

- Workforce turnover: in-month turnover rate is now reported alongside the 12 moth rolling turnover rate.

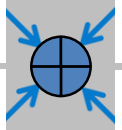
Key to indicators:

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

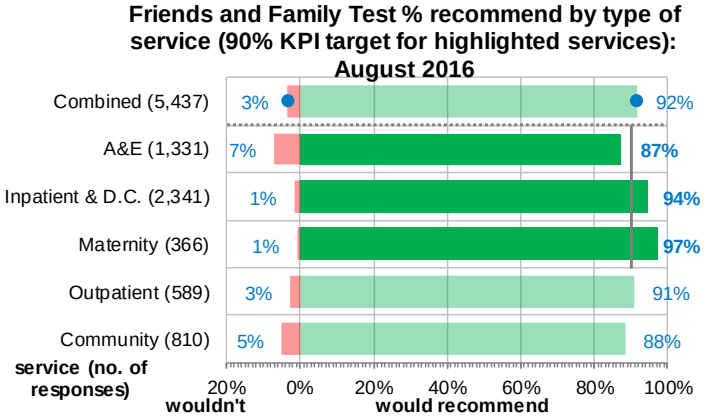
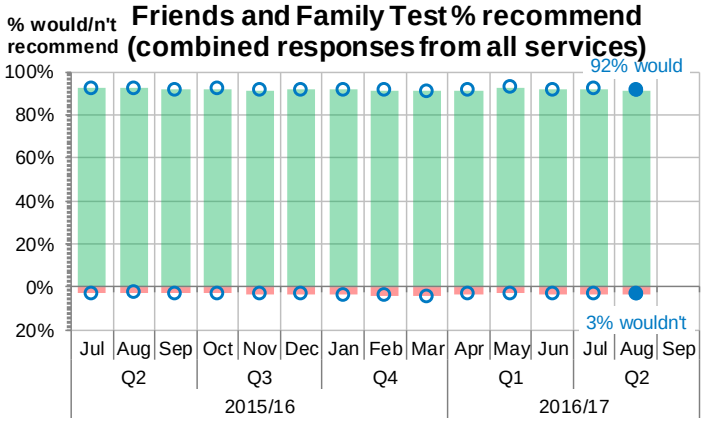


Chart 2



Overall in August, the trust scored 92% extremely likely or likely to recommend, total responses were 5437. Broken down:

AREA	Response rate August	Variance on previous month (RR)	% extremely likely / likely to recommend August	Variance on previous month (% Rec)
ED inc children's ED	24%	+3%	87%	same
Inpatients	44%	+6%	94%	-1%
Maternity	33%	-6%	99%	+3%
Outpatients	40%	+2%	91%	-3%
Daycase	39%	+3%	95%	same

Feedback Themes (acute):

ED (adult) Positive comments received for August state staff are friendly, caring and some have a good attitude (all disciplines) and provided a good service. Alternatively, excessive waiting times continues to receive negative feedback along with some staff poor attitude (Drs, nurses and reception). Some other negative comments included lack of information / communication regarding what was happening and the appearance of the department having a lack of organization.

ED (Paediatric)

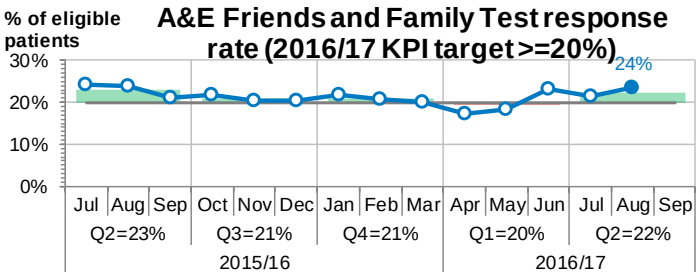
Overall positive comments were received in August from the children's ED. Feedback included staff were attentive, friendly, efficient giving prompt treatment. Positive comments were also received around a short waiting time to be seen. Responses predominately continue to be received via the iPads and encouraged by staff as much as possible within the department.

Inpatients (adults) Positive comments received included feeling well cared for, good staff attitudes and one comment stated the treatment took into consideration the patients dementia. Negative comments included excessive waiting times to be seen with no communication (C3 waiting area), poor communication and the appearance of not enough staff and staff being too busy.

Maternity – Overall positive comments were received including staff were friendly giving good care. Some comments stated care was excellent from triage through to discharge. Minimal negative comments were received, but of those received some patients stated some information was inconsistent and conflicting at times.

Paediatrics (inpatients) - Mainly positive feedback was received which stated staff were approachable and they introduced themselves at all times.

Chart 3

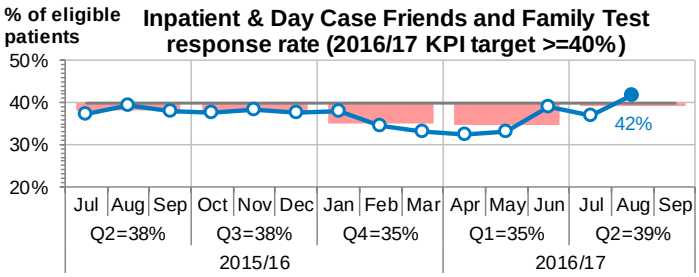


Daycase - Negative comments continue to report long waiting times when admitted for procedures, feeling 'rushed' at the visit, and the contact numbers to use if there was a problem did not work.

Positive comments reported all levels of staff encountered provided privacy and dignity and put patients at ease. Other positive comments included staff were informative, kind and knowledgeable

Out Patients - Positive comments received included staff were polite, friendly, informative and had a good attitude. Negative comments and the top theme for this area continues to be excessive waiting times with appointment times not being met and no communication with regards delays.

Chart 4



Community Services - Overall positive comments were received stating good advice was given, staff were caring and competent giving an excellent service. Negative comments received stated baby clinics were excessively busy leading to long waiting times and some comments continue to state poor waiting times for appointments.

IPad Inpatient Surveys

In August **204** inpatient iPad surveys were undertaken, which is a decrease of **40** compared to July. This was a challenge due to volunteers being on holiday in August which had an impact on the number of surveys being undertaken.

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Dementia 16

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

Chart 5

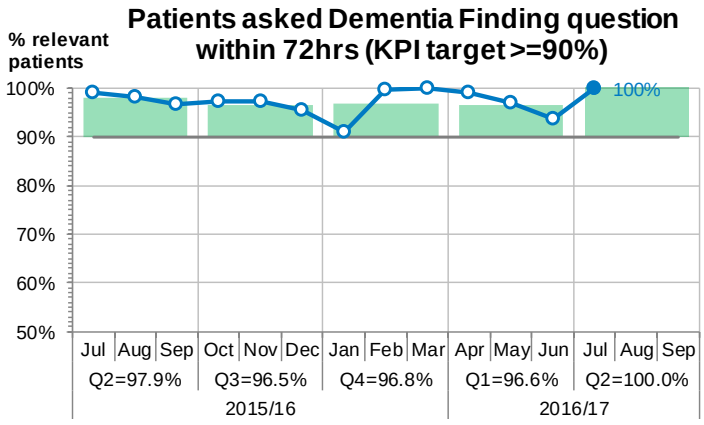


Chart 6

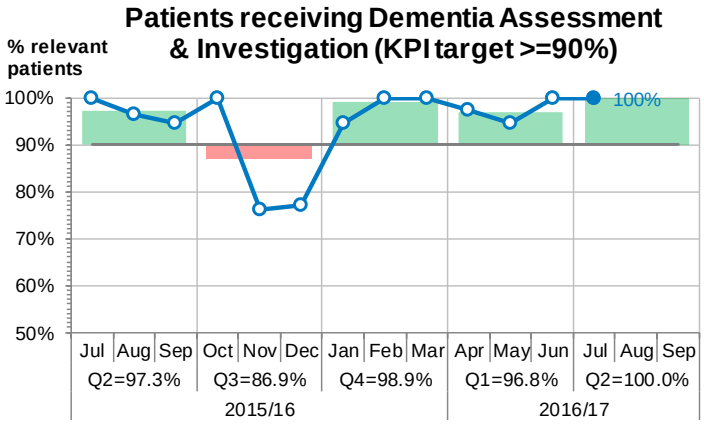
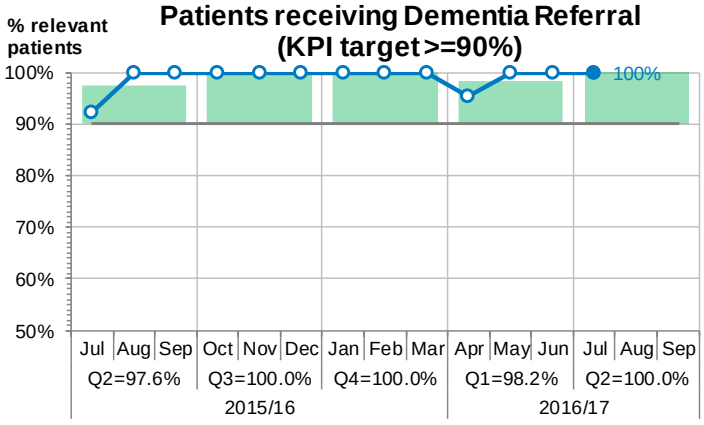


Chart 7



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Discharge summary (published within 48 hours)

Chart 8

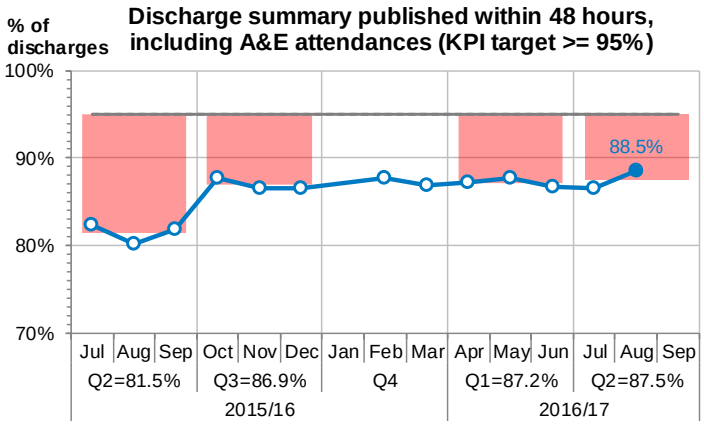

Chart 8 shows compliance with discharge summary completion within 48hrs.

The percentage of discharge summaries published within 48 hours including A&E attendances has increased from 86.53% in July to 88.54% in August.

The most significant factor in performance below trajectory is again due to volume of patients through acute assessment areas. The substantive Acute Junior Doctor Rota came into effect on the 8th August 2016 which allocates focused time to complete HCR's.

Alerts are still distributed daily to Consultants/Junior doctors detailing any outstanding HCR's at 24 hrs. This should then enable the HCR to be completed within the 48 hr deadline.

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Clinical correspondence (typing backlog)

Chart 9

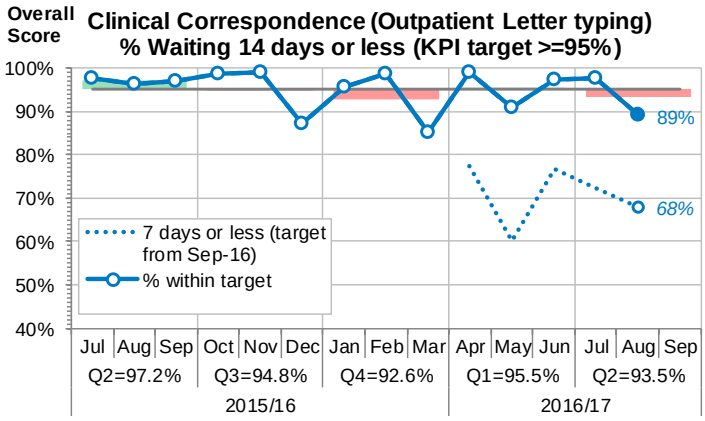

Chart 9 shows the performance against the clinical correspondence standard of 95% of Outpatient letters to be typed within 14 days.

The overall Trust performance for August was 89%. Ophthalmology was the only specialty to underperform, which was due to staffing pressures within the service.

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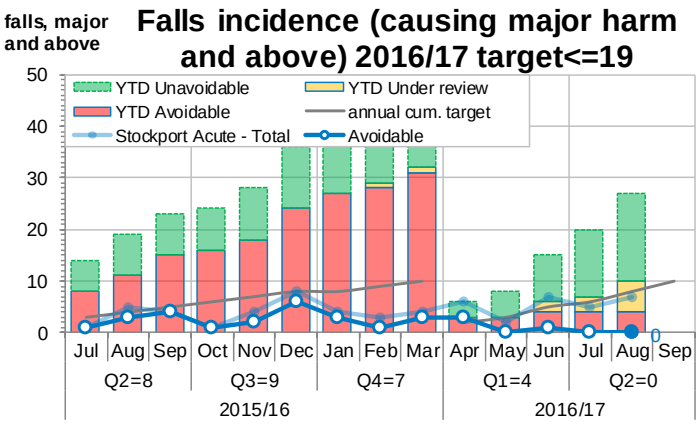
Falls

Chart 10



This year's target is 19 or below avoidable falls. In August there were 7 falls graded major and above:

- 3 are under review
- 4 have been deemed as unavoidable

Year to date:

- There have been **27** falls graded major and above April – end of August 2016
- **24** have occurred in Medicine, **3** in Surgery and **0** in C&F.
- There have been **4** avoidable falls, these occurred on E2, C2, A11 and B2.
- **17** falls out of the **27** were deemed unavoidable.
- **6** are still under investigation
- There is still one outstanding investigation yet to be completed for 2015/16 due to further work required after initial investigation
- To date the Trust is on target to meet its trajectory for 2016/17

A project overview document has been devised with milestones which will incorporate previous action plans. It has been agreed that this project plan will report into and be monitored by the the Optimising Capacity Steering Group every 2 weeks.

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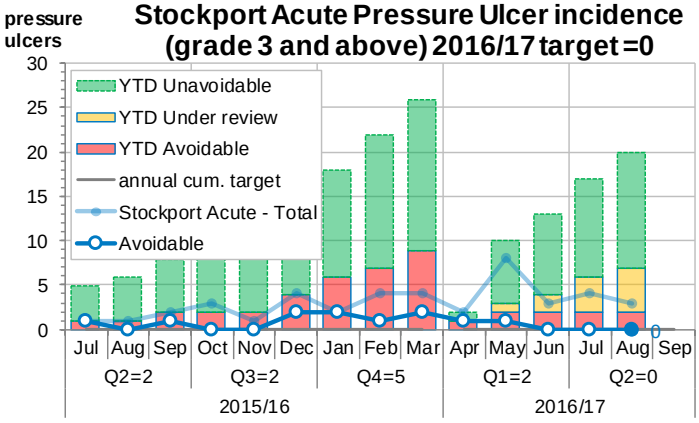
Pressure Ulcers 16

Chart 11

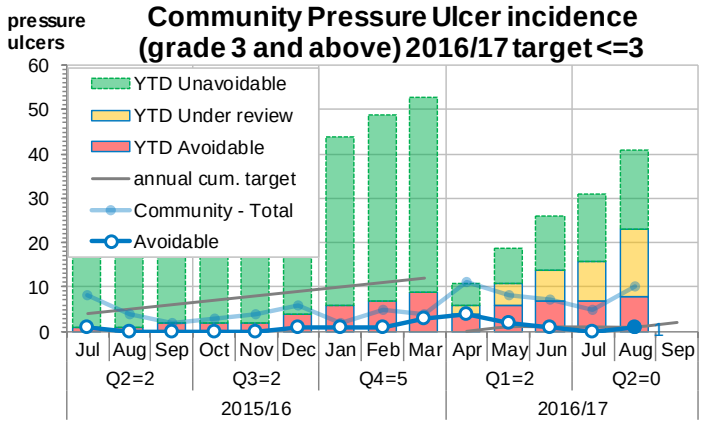


The stretch target for Stockport Acute services is zero tolerance of avoidable pressure ulcers grade 3 and 4 by the end of 2017.

In August there has been 3 x category 3 and above pressure ulcers, 1 are under review, and 2 have been deemed to be unavoidable.

In Q2 there have been no avoidable pressure ulcer's confirmed, however there were 2 avoidable pressure ulcers confirmed in Q1. There are 5 category 3+ pressure ulcers still under review, for

Chart 12



the acute hospital dating back to May this year.

The stretch target for Stockport Community is 50% reduction in grade 3 and 4 avoidable pressure ulcers by end of 2017. The target is 6 avoidable pressure ulcers for the year.

In August there have been 10 grade 3 or 4 pressure ulcers, 6 are under review and 3 have been deemed unavoidable, whilst 1 has been determined to be avoidable, bringing the total avoidable severe pressure ulcers this financial year to 8

The total numbers of new pressure ulcers that are being reported now appear to have stabilized, however the concern is the severity of the pressure ulcers that are developing, and the numbers being determined as avoidable.

The Pressure Ulcer Committee meets Bi monthly but attendance from key stakeholders remains poor, this is influencing the speed of which changes in practice can be established. Two key changes introduced this month are a revised sskin bundle documentation chart for critical care, which now includes a section for checks made to medical devices, and a revised PU screening tool /action plan for Maternity.

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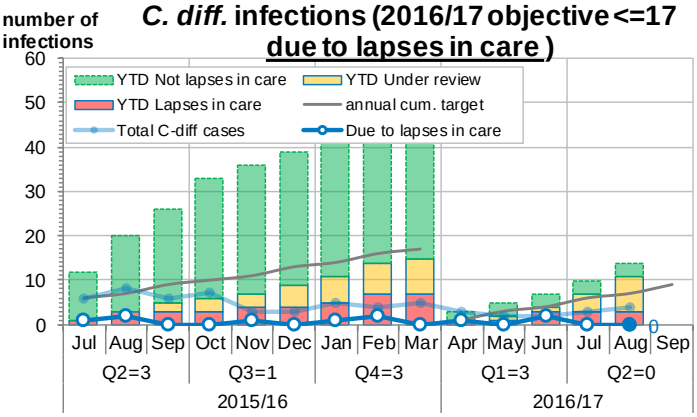
Clostridium difficile (C. diff.) infections

Chart 13



There has been 4 cases of Clostridium difficile in August, the total number YTD is 14. Of these 14 cases 6 have been reviewed with the other 8 cases still under review.

We have been advised by the CCG that three cases reviewed by them do not have significant lapses in care and do not reach the threshold for reporting; however 3 cases do have significant lapses in care and do reach the threshold for reporting. Therefore 3 cases would not count towards the trajectory of 17 significant lapses in care but 3 cases will.

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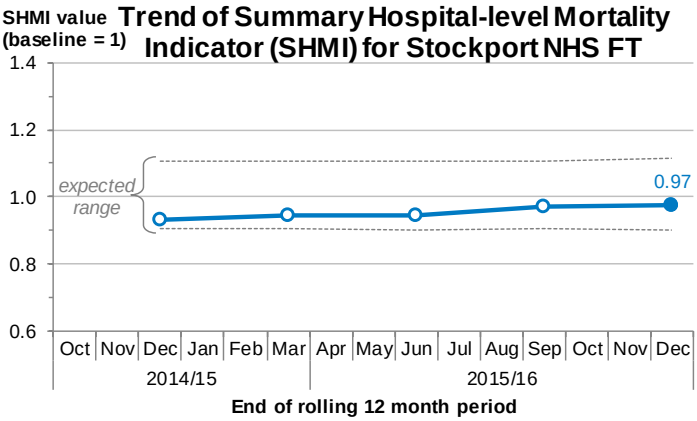
Mortality

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

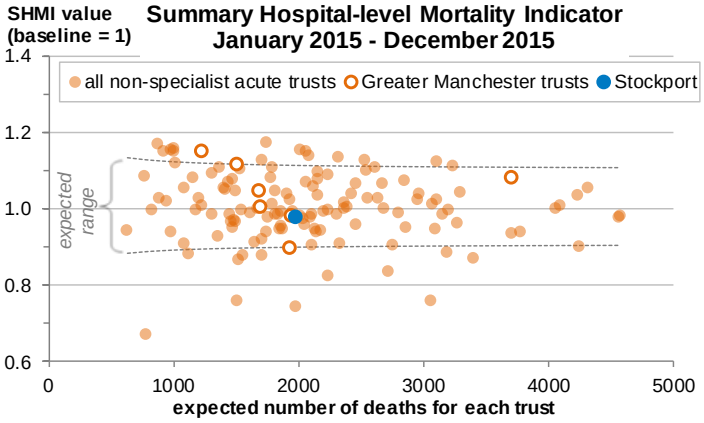
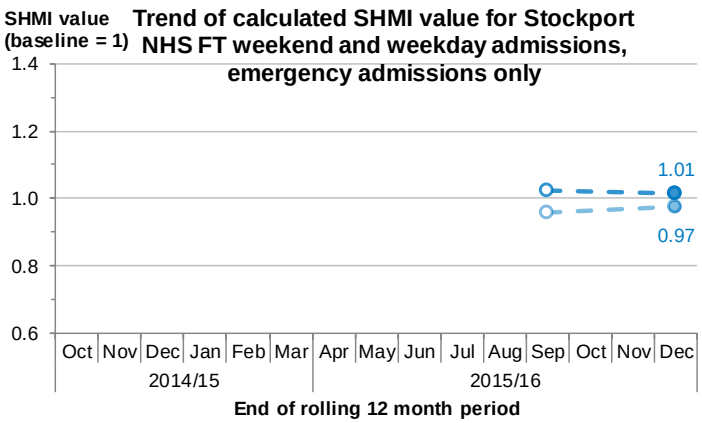


Chart 16



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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

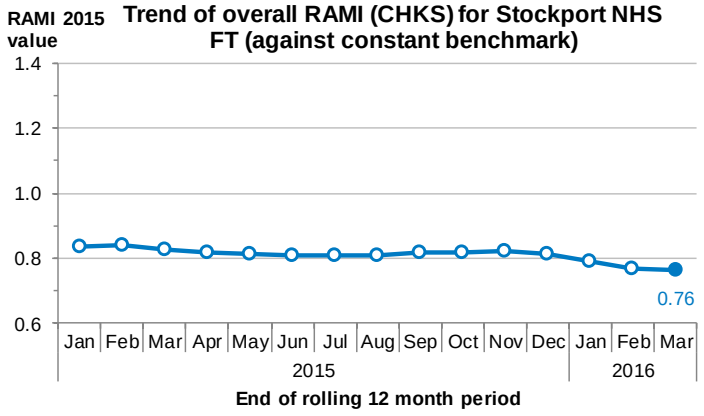


Chart 18

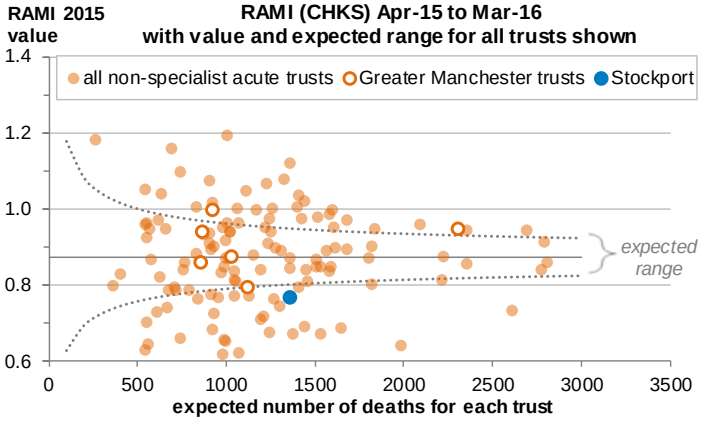
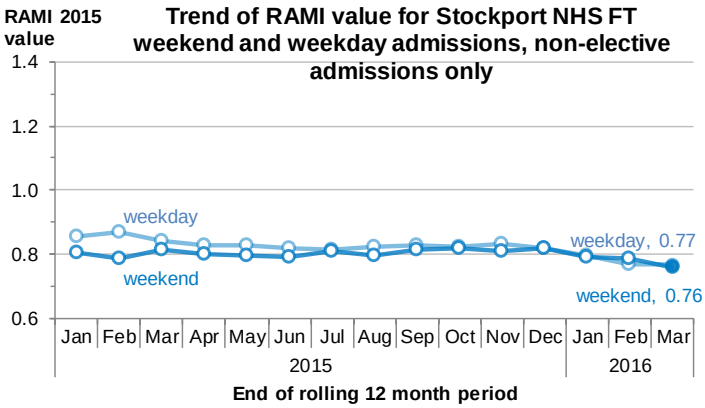


Chart 19



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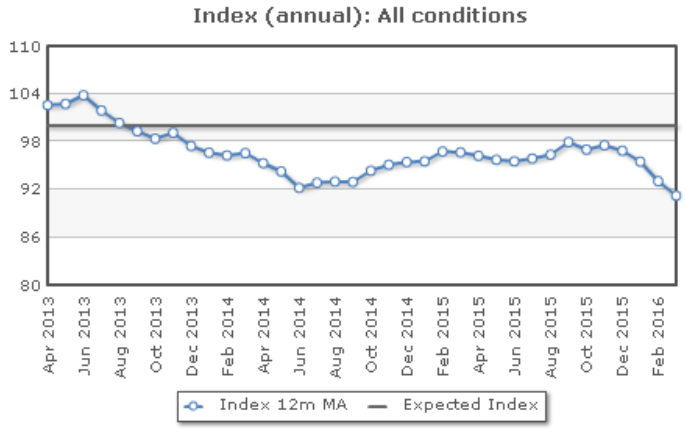
Hospital Standardised Mortality Data (HMSR)

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



Referral to Treatment (RTT) waiting times

Chart 21

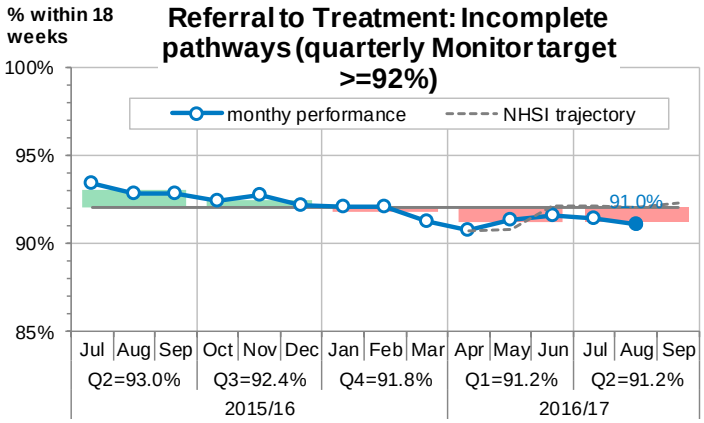


Chart 21 shows performance against the RTT Incomplete standard.

The Trust performance for August was 91.03%, which is behind NHSI trajectory.

Of the 4 under-performing specialties reported in July, there has been a significant improvement in General Surgery within month. The latest position for General Surgery is 88.3%, compared to Julys performance of 85.8%.

Urology's performance has remained static, as predicted, despite an increase in referrals and a recurrent capacity gap.

Discussions are being progressed with NHS England as Commissioners regarding Oral Surgery. There was a significant increase in referrals last year, and despite activity being above contracted levels this year, the RTT backlog is currently unable to be sufficiently addressed.

ENT requires a further service review and options appraisal.

Chart 22

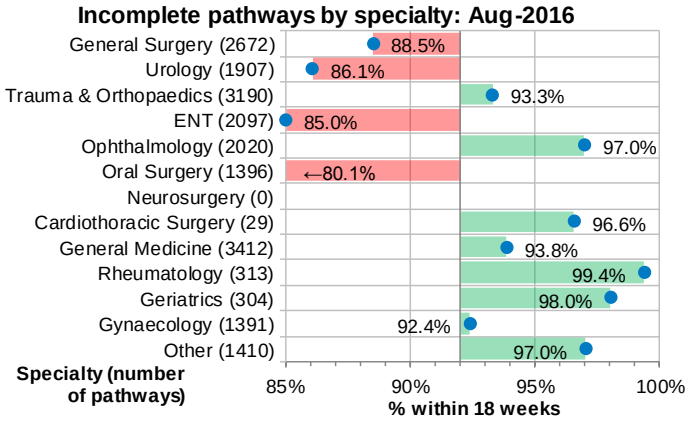


Chart 22 shows performance against the incomplete standard at specialty level.

Charts 23 and 24 show the number of patients waiting beyond 18 weeks split by admitted and non-admitted pathways.

Chart 23

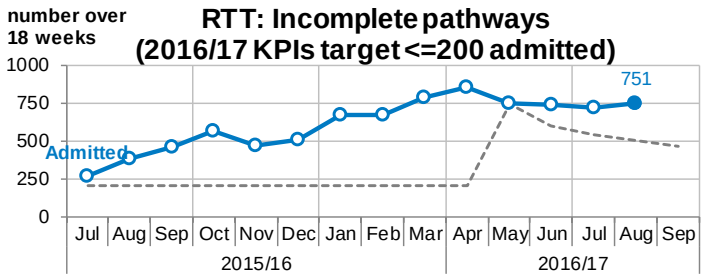
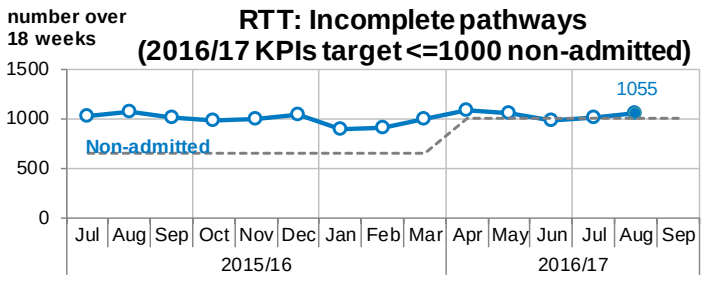


Chart 24



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Accident & Emergency total time in dept.

Chart 25

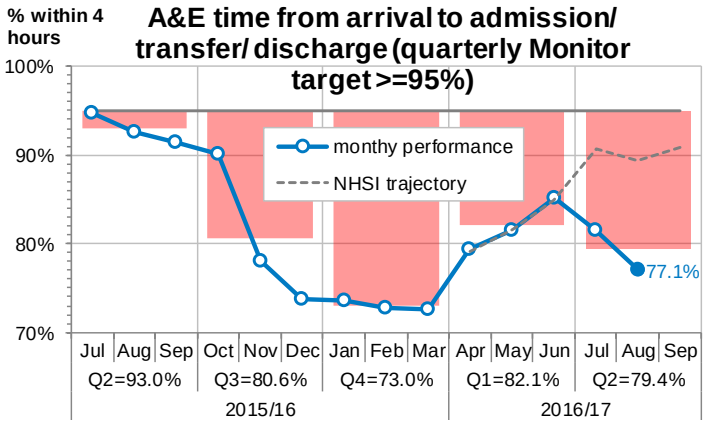


Chart 26

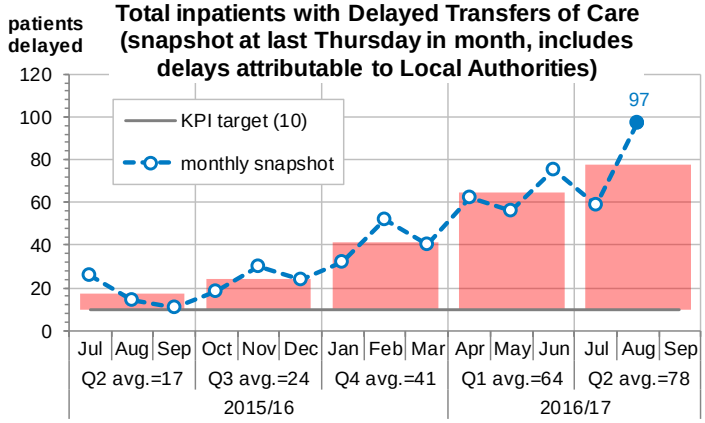


Chart 27

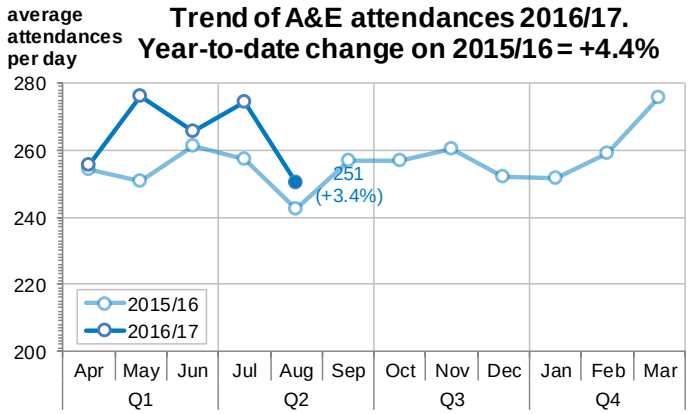


Chart 28

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

Performance in August was 77.1% which was behind NHSI trajectory. Attendances were 3.5% above expected with a further significant increase in delayed transfers of care as shown in Chart 26.

Strategies to affect performance centre on three of the five NHSI/NHSE mandated themes for urgent care improvment with specific sub projects designed to:

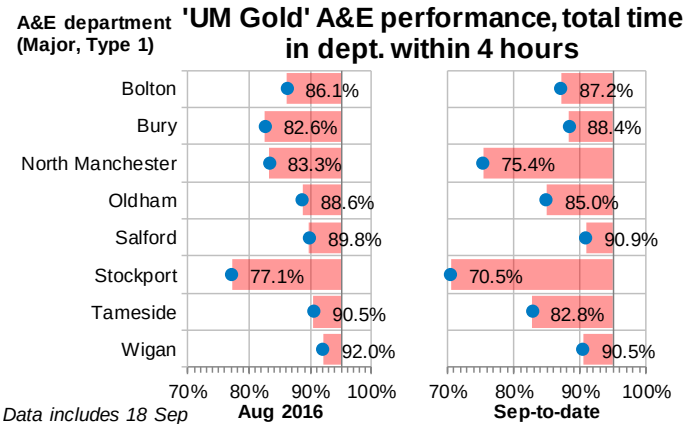
1) Appropriately stream patients in increasing number to ambulatory and primary care – planned to commence October 17th in initial scope format
2) Improved flow related to the implementation of the SAFER bundle
3) Mandated discharge to assess planned to commence October 16

The numerous workstreams within these themes are owned by the organizational strategy and implemented by the Urgent Care Review Group (UCRG)/Urgent Care Lead

Long term models of care to address high volumes of attendances which could be managed elsewhere and patients whose continuing care need not be in the acute setting are in development with other providers through commissioners and Stockport Together for implementation in 2016.

Short term internal measures to address performance include:

- Identifying and avoiding 4hr breaches by proactive management, escalation and leadership once a patient's attendance reaches 2.5hrs
- Protecting flow through the Medical Admissions Unit/Clinical Decisions Unit (MAU/CDU) by avoiding overnight patient



Data includes 18 Sep

Source: Greater Manchester Academic Health Science Network.

stays

- 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 – analysis pending
- 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.

Chart 28 shows ED pressures continue throughout Greater Manchester and a region wide series of confereces to address the required solutions has been convened by Greater Manchester Combine Authority with an initial event August 26th.

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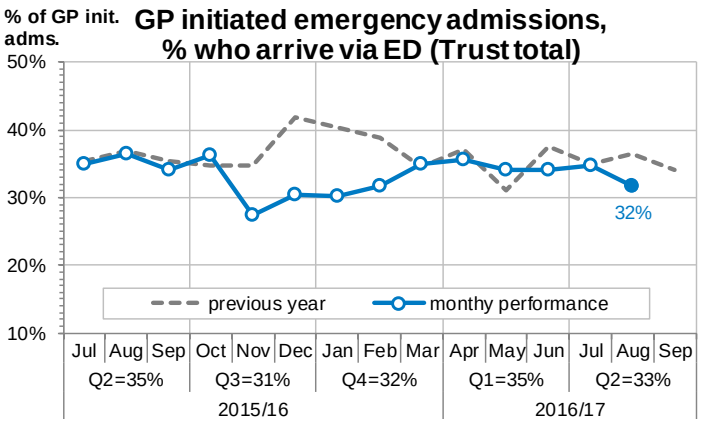
The next four pages show urgent care indicators (Chart 29 to Chart 41)

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

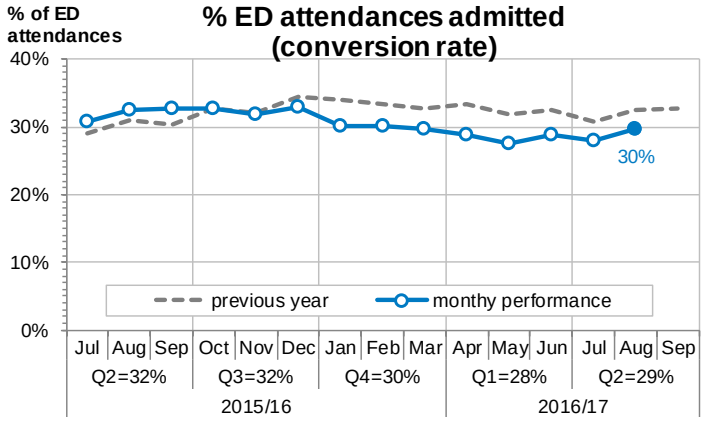


Chart 31

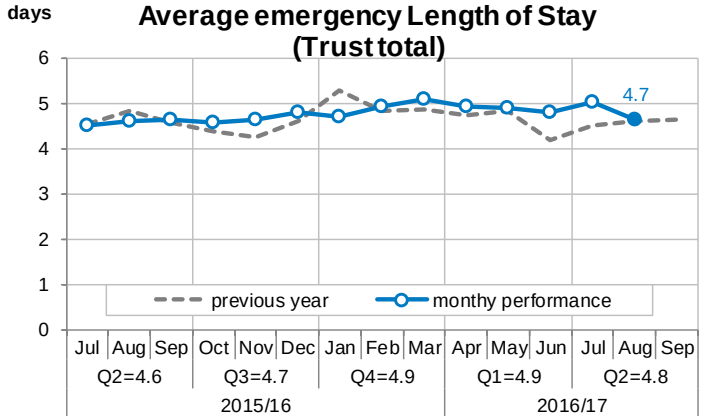


Chart 32

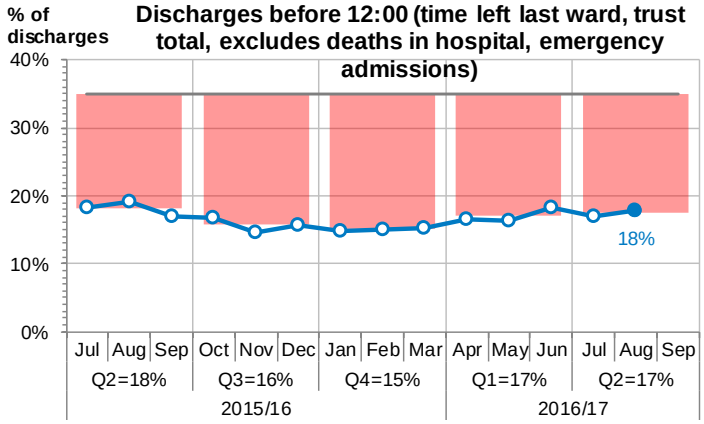


Chart 33

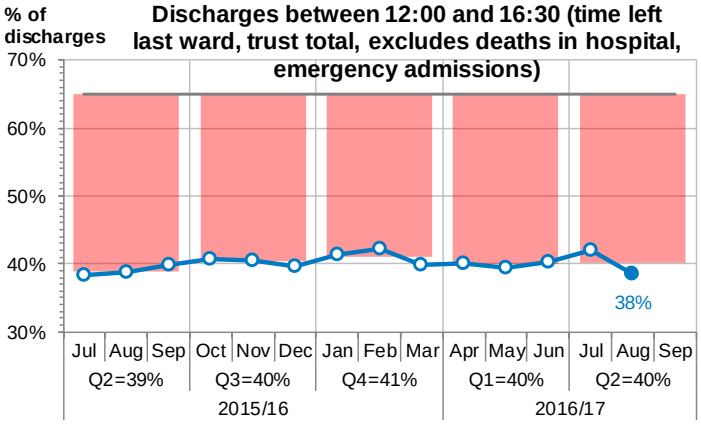
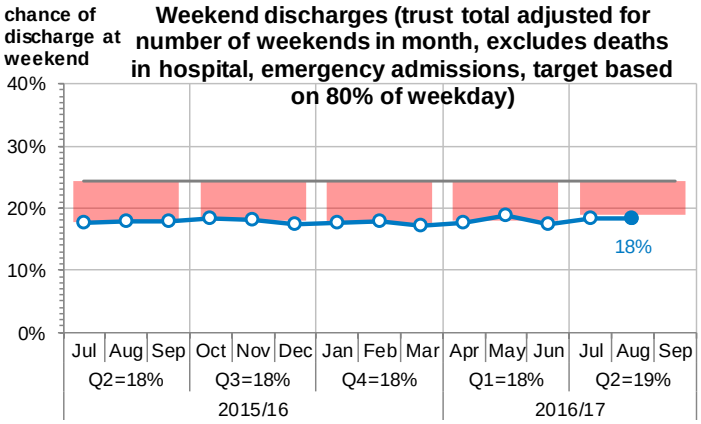


Chart 34



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Trust Urgent Care Key Performance Indicators

Chart 35

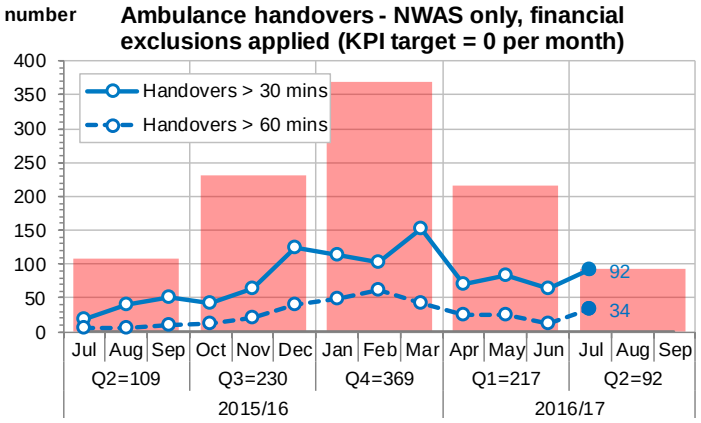


Chart 36

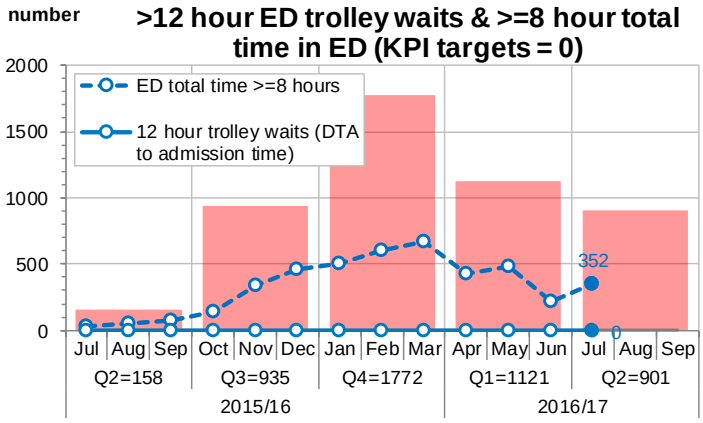


Chart 37

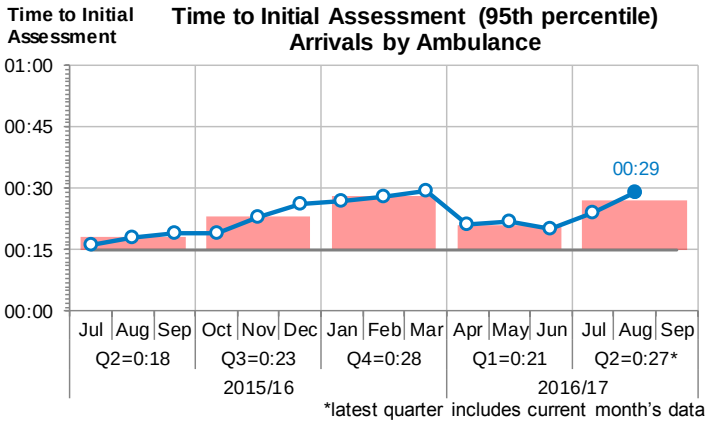


Chart 38

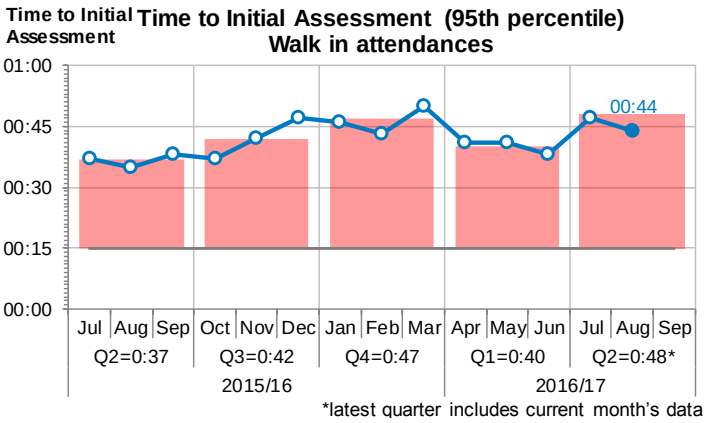


Chart 39

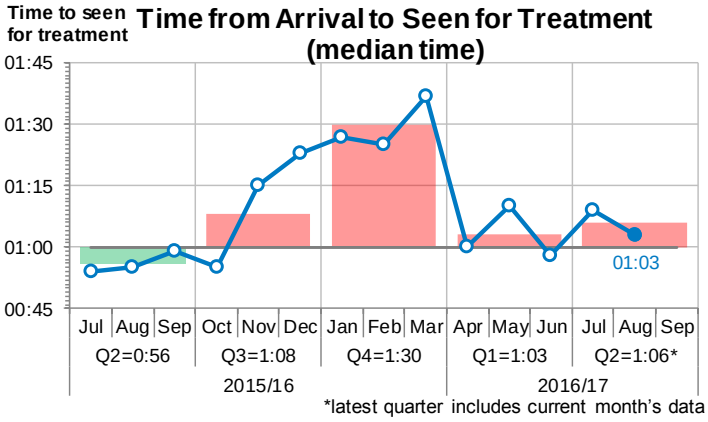


Chart 40

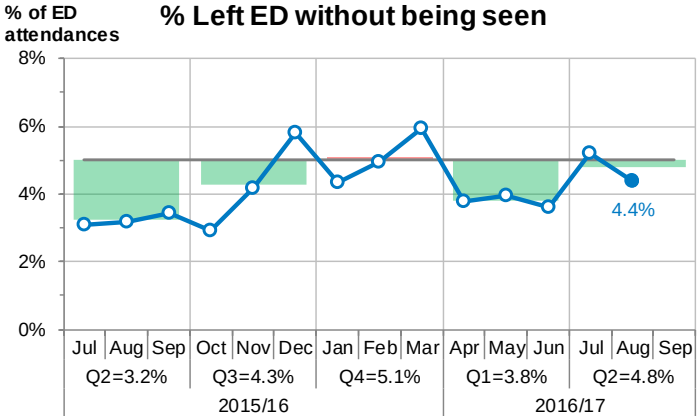
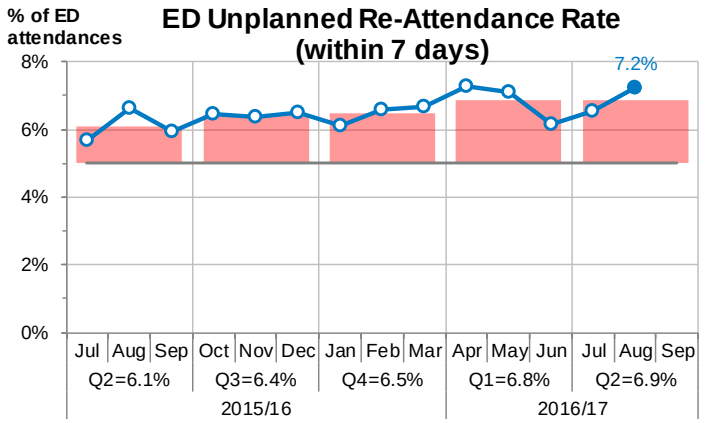


Chart 41



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Diagnostic tests (6 week wait) 16

Chart 42

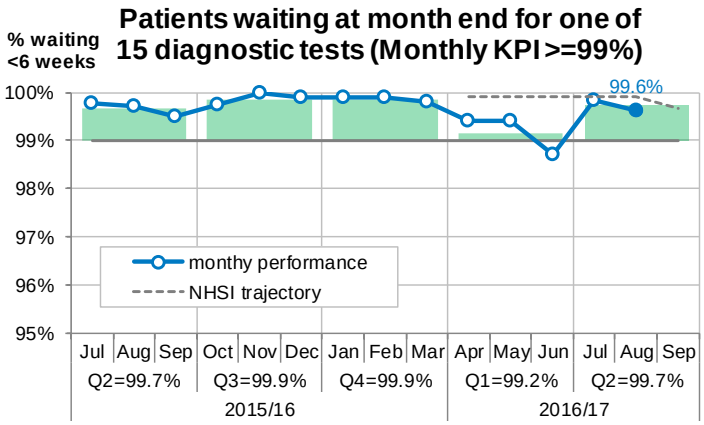

Chart 42 shows performance against the diagnostic standard.

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Cancelled Operations 20

Chart 43

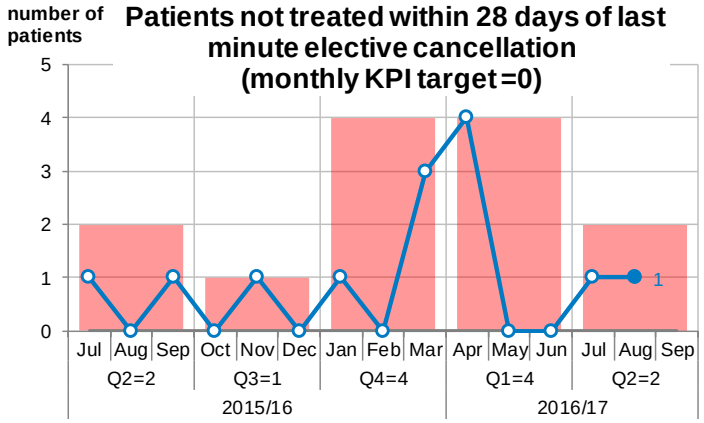

Chart 43 shows there was one breach of standard in month.

This related to a General Surgical patient that was cancelled twice due to no HDU bed. HDU bed capacity was prioritized for urgent cancer patients on both occasions.

Chart 44

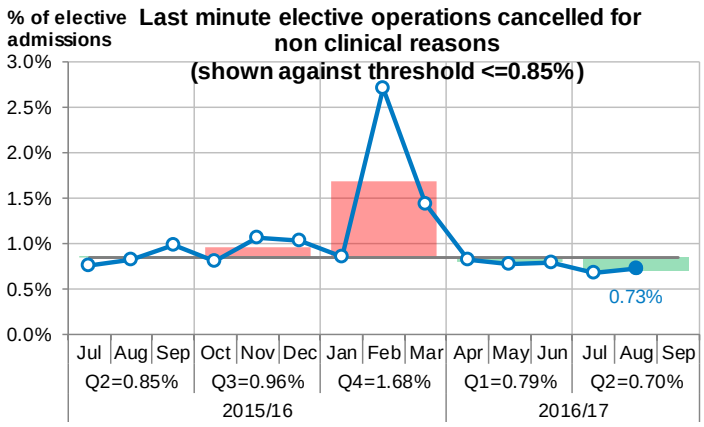

Chart 44 shows compliance against the standard for last minute cancellations in July.

There were a total of 22 cancellations on the day for non-clinical reasons.

The top reasons for cancellation were:

- 9 due to lack of theatre time
- 6 due to no HDU bed availability.

In August, a new Standard Operating Procedure was introduced to help minimise cancellations on the day.

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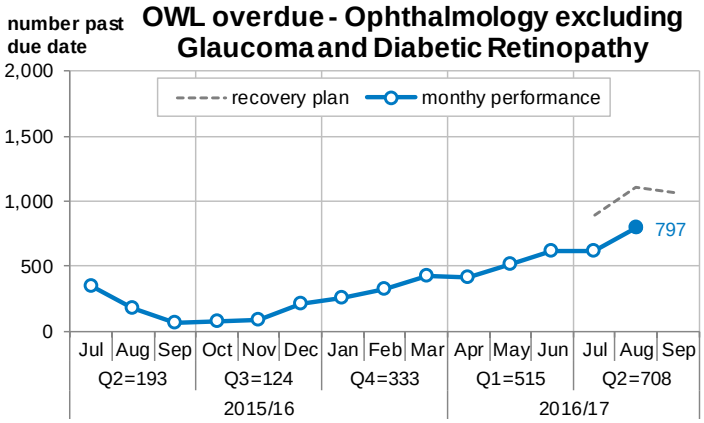
Outpatient Waiting List (OWL) 20

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.

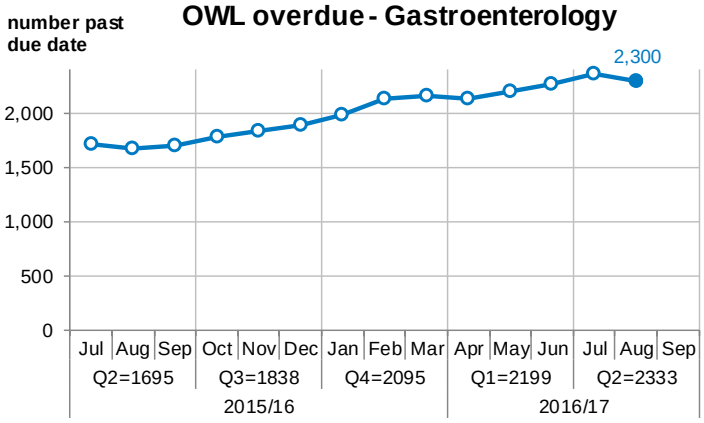
Chart 45 Ophthalmology OWLs past due date



Ophthalmology

The OWL is ahead of trajectory as at the end of August. The new Consultants commence September and October respectively. Assurance has been provided that there is minimal clinical risk in this backlog, as high risk surveillance patients are monitored separately and given priority. A vacancy remains at Specialty Doctor level which will impact on capacity.

Chart 46 Gastroenterology OWLs past due date

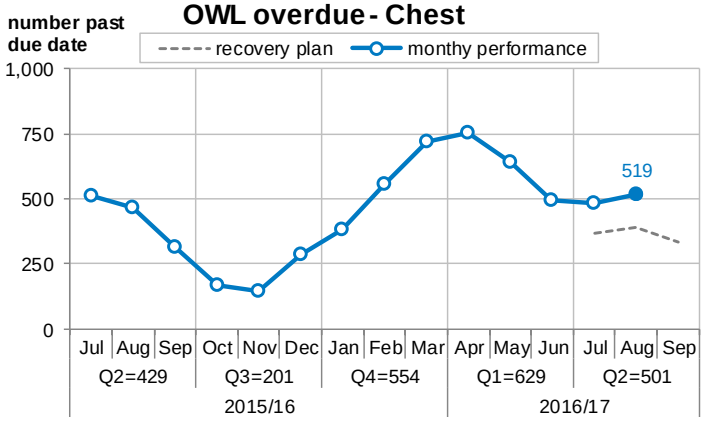


Gastroenterology

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

Vacancies at Consultant level remain, however a locum Consultant has now been secured which has significantly increased follow-up capacity in the short-term. It is forecast that the OWL should begin to decline as future demand is more proactively managed and fewer long term appointments are being given.

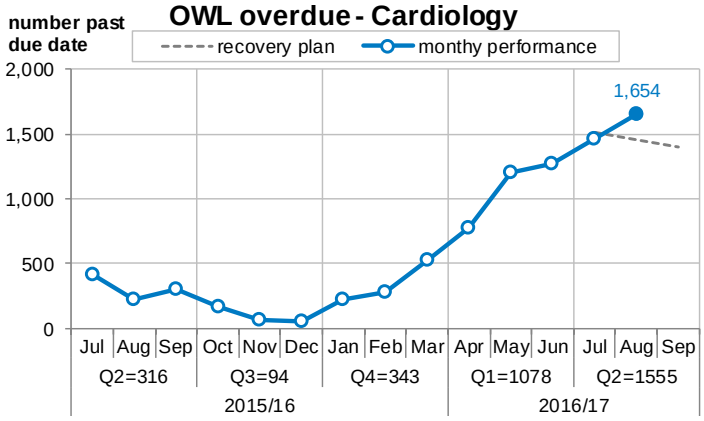
Chart 47 Respiratory Medicine OWLs past due date



Respiratory Medicine

The Respiratory OWL remains slightly behind trajectory, and progress remains reliant on locum cover. Assurance has been provided by the directorate that high risk surveillance patients are monitored separately and given priority.

Chart 48 Cardiology OWLs past due date



Cardiology

As described previously, the Cardiology OWL was expected to increase in the short term until vacancies had been recruited to. Unfortunately, further vacancies are expected as a locum has recently given notice. Assurance has been provided by the directorate that high risk surveillance patients are monitored separately and given priority.

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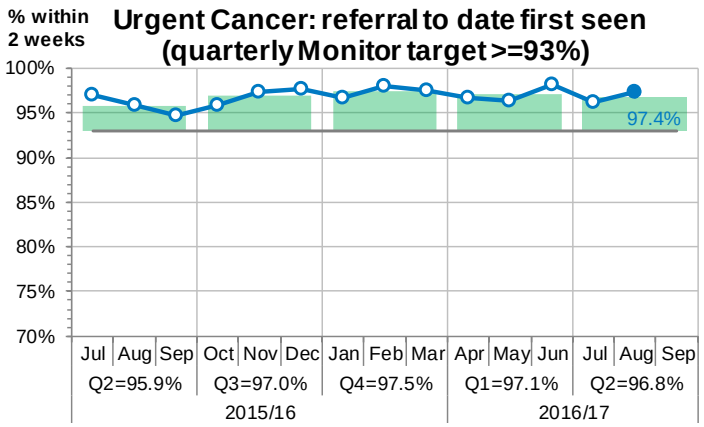
Cancer waiting times M 16

Chart 49



Compliance with the urgent referral standard continues.

Chart 50

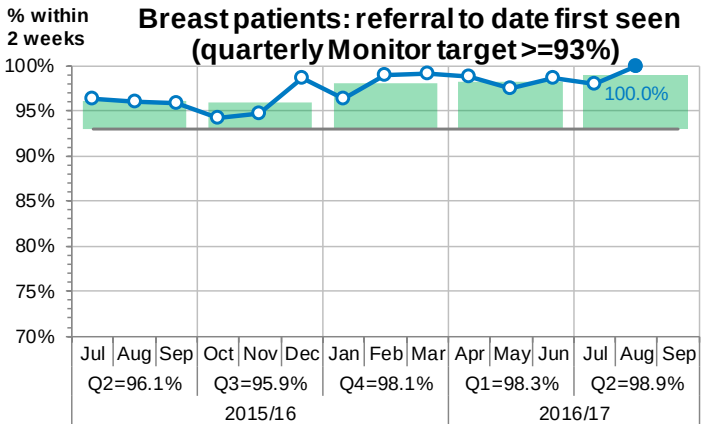


Chart 51

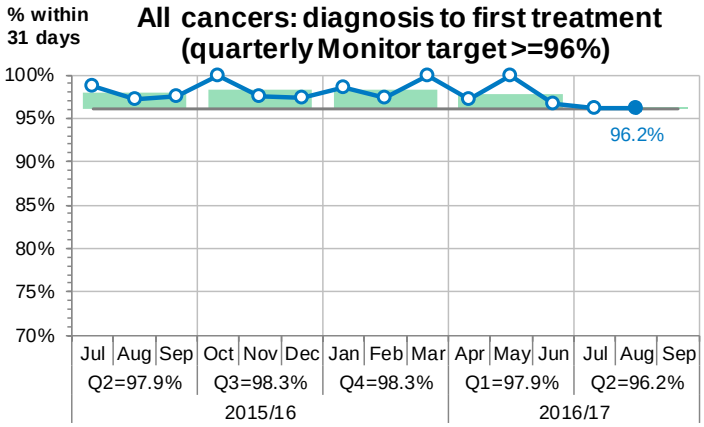


Chart 52

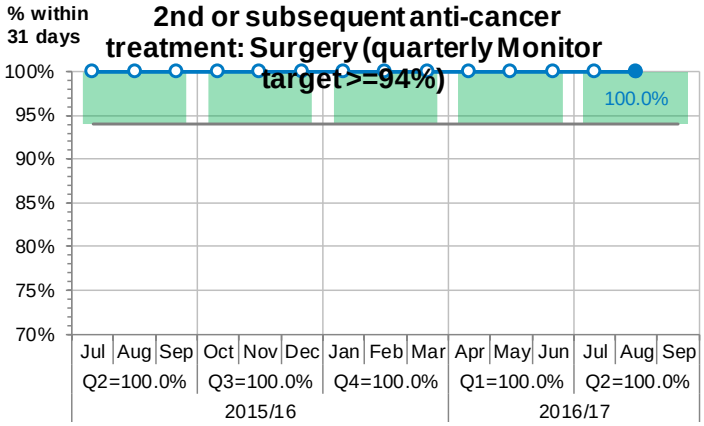


Chart 53

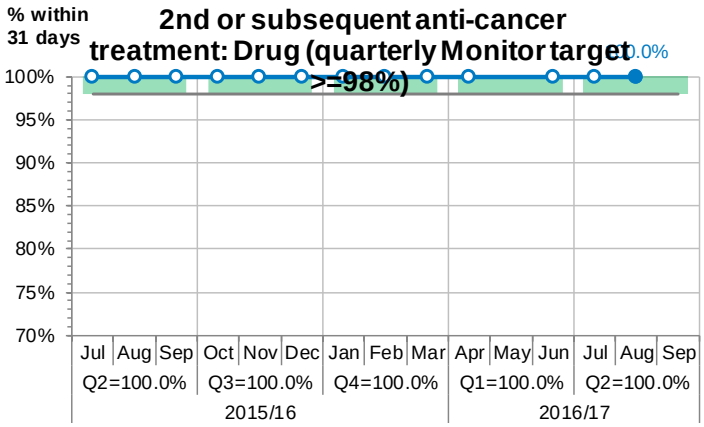


Chart 54

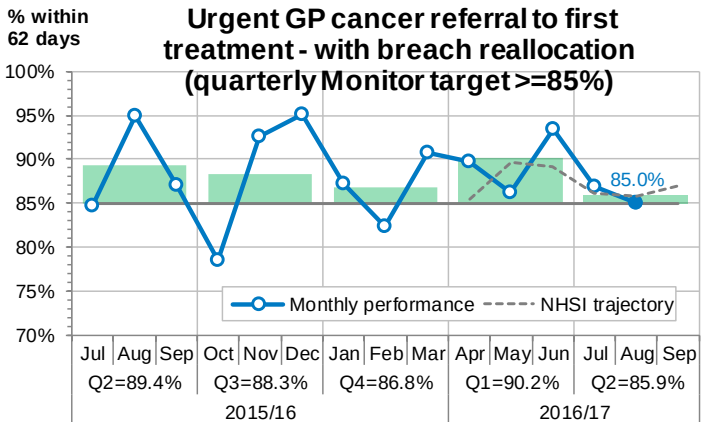


Chart 54 shows performance against the 62 day cancer standard.

Latest indications are that the standard will be achieved for the month of August.

There are still a small cohort of complex patients awaiting definitive treatment plans. Performance for the quarter therefore remains a challenge.

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

Tumour Group (Aug-16 data)	Number of breaches / cases	Performance (85% target)	Monthly trend
Urology	1.5 / 13	88%	
Upper GI	1.5 / 3.5	57%	
Haematology	1 / 2.5	60%	
Head & Neck	0.5 / 3	83%	
Breast	0 / 9	100%	
Colorectal	0 / 5.5	100%	
Lung	0 / 1	100%	
Gynaecology	0 / 0.5	100%	

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

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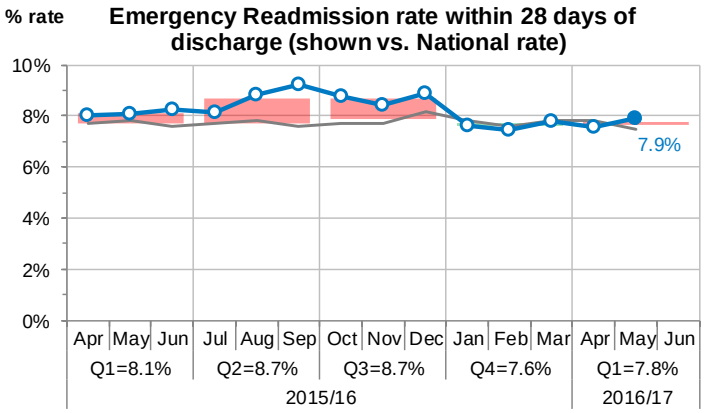
Emergency Readmissions

Chart 56



Data source: CHKS / Health and Social Care Information Centre

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

The Gynaecology, Urology and General Surgery audits have now been completed and are in the analysis stage. Good progress has been made with the Medicine audit and it is anticipated the forms will be ready to forward for analysis this month.

Plans then can progress as regarding feed back to the Business Groups to enable pathway improvements in specific HRG categories.

As regards the work stream focusing on patient information and follow up telephone calls, significant progress has been made. Patients are now contacted at 48hrs and 14 days post discharge to check recovery and signpost them to more appropriate sources of support. This role is being incorporated into the patient flow team to enable full integration with the readmission avoidance plans.

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Financial Performance

Chart 57

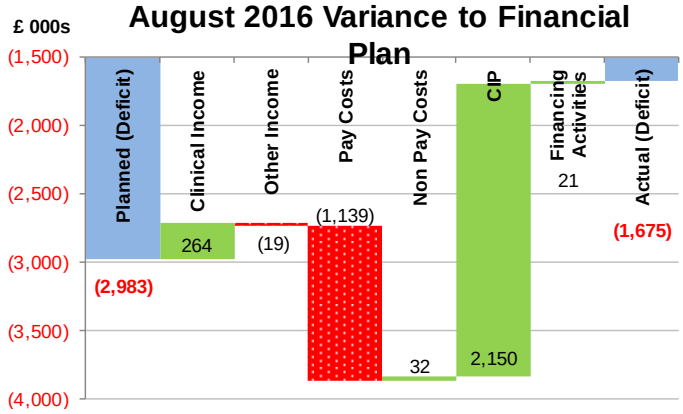


Chart 58

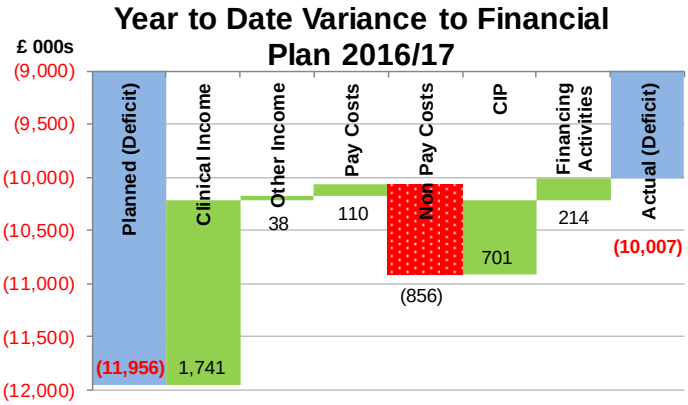
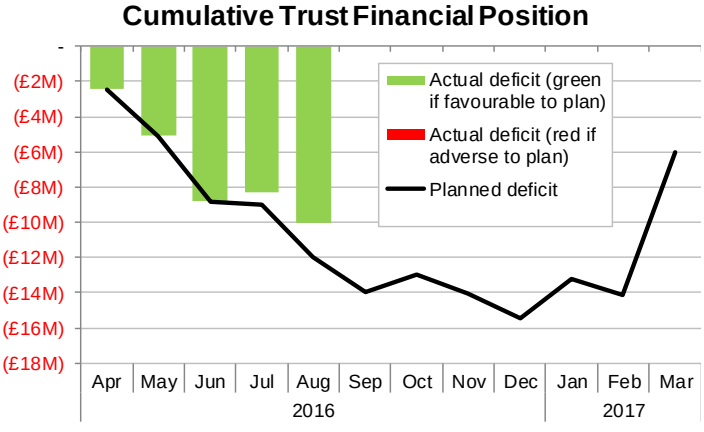


Chart 59



In the five months to August the Trust has made a £10.0m loss. The planned deficit was £11.9m, so this is £1.9m better than the profiled plan. Of this £1.1m is because NHS Improvement (NHSI) have asked for the Sustainability and Transformation Fund (STF) to be accounted for monthly, but the plan expected this income quarterly; we planned to have 3/12 at this point in the year but we have 5/12 which shows as a favourable variance to plan due to timing only and will catch up later in the year.

In total to August 2016 CIP is £0.7m ahead of the profiled plan as shown in Chart 60; £3.6m (14%) were expected by this stage in the year when £4.3m (17%) has been transacted. This is due to timing as there has been a drive to action savings earlier in the year, and reduced the favourable variance on pay costs reported last month.

During August £1.7m of vacancy factor CIP has been transacted relating to pay underspends in the five months to date. This shift of budget has created a pay over-spend and CIP favourable variance in month, shown in Chart 61, caused by the timing of these transactions as a catch up from previous months. This is reinforced by Chart 62 which shows the year-to-date pay and CIP favourable variances.

Excluding the STF above, income has improved again in August and is £0.3m ahead of plan in month, increasing the year-to-date variance to £0.9m favourable. Elective activity continues to perform above plan, but this is linked to out-sourced activity undertaken to reduce the referral to treatment backlog and represents a low or nil margin contribution to the Trust.

Plans to deliver savings on a recurrent basis are being actively progressed as part of the Financial Improvement Programme (FIP).

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Capital Programme

Chart 63

Description	Plan 2016/17 Year £'000	Year to Date August '16 Plan £'000	Actual £'000	Variance £'000
Surgical & Medical Centre - Building	3,740	2,770	2,847	(77)
Surgical& Medical Centre - Furniture & Fittings	600	175	3	172
Surgical& Medical Centre - Medical Equipment (partly donated)	660	-	802	(802)
Medical Ward Refurbishments	250	50	-	50
Emergency Department Expansion	-	-	-	-
Electronic Patient Records - Purchased Software	598	-	-	-
Electronic Patient Records - Estates Enabling scheme b/f	55	55	102	(47)
Facilities Equipment b/f	60	60	-	60
Medical Equipment b/f	52	52	-	52
Aspen House Server Room b/f	-	-	(4)	4
MRI Estates Enabling works b/f	-	-	5	(5)
	6,015	3,162	3,755	(593)
Medical Equipment	1,290	470	568	(98)
Facilities Equipment	75	-	(18)	18
IT Hardware	503	259	142	117
IT Software	297	118	63	56
Estates -Backlog Maintenance	125	50	(0)	50
Estates - Non Backlog Maintenance	710	225	(49)	274
	3,000	1,122	706	417
	9,015	4,284	4,461	(177)
Revenue to Capital	-	-	(18)	18
Capital to Revenue	-	-	-	-
TOTAL (excluding Finance leases)	**9,015**	**4,284**	**4,443**	**(159)**
New Finance Lease Contracts				
I M & T - Intersystems EPR Software	1,006	-	-	-
I M & T - EMIS Community EPR Software	-	-	-	-
	1,006	-	-	-
TOTAL including new Finance Lease Contracts	10,021	4,284	4,443	(159)

£4.4m capital costs have been incurred to date. This is against a plan of £4.3m so is £0.1m ahead of the profiled plan.

The Surgical and Medical Centre (D block) building is now substantially complete and was handed over to the Trust on 5th August as planned. The gain share agreement will split project savings 50:50 with the contractor, and this element along with the final contract value is due to be settled in October. The purchase of furniture and medical equipment is ahead of plan by £0.8m and currently being installed. This is in line with the overall budget for the project but it has been possible to accelerate the purchases to ensure everything is ready to open to patients on 3rd October 2016.

Building work has commenced on Phase 1 of the Emergency Department Expansion, with Phase 3 due for completion in December 2016. This is being carried out through the estates measured term contract for expediency.

IT and Estates projects have been intentionally held back as a cash preserving action to maintain the Trust's cash position and offset the accelerated Surgical and Medical Centre costs.

Both acute hospital and community EPR projects are underway but no payment have been made yet in year and this is considered under finance leases as shown in the bottom section of table.

Cost Improvement Programme

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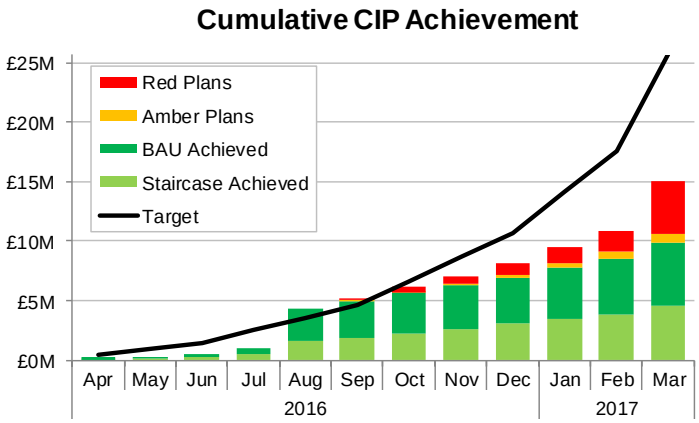
Chart 64



The total Cost Improvement Programme for 2016/17 needs to deliver £25.7m of savings to allow the Trust to deliver the planned £6.0m deficit. This target is weighted towards the end of the year, as shown as the black target line in Chart 65 gets steeper. The Trust needs to make a surplus of £4m in the next seven months to reduce the current five month loss from £10m to £6m and achieve the control total. This illustrates the scale of the task ahead.

To the end of August £4.3m of CIP has been actioned towards the year-to date target of £3.6m, so is £0.7m ahead of plan. This is due to timing as there has been a drive to action savings earlier in the year. £9.8m (38%) of the £25.7m annual saving has been achieved, of which £5.3m is recurrent.

A recurrent vacancy factor of £1.4m has been transacted in August. Non-recurrent vacancy factor generated from additional slippage on vacant posts of a further £1.1m to date is the key driver for the favourable variance on CIP in month. The green, amber and red schemes identified to date total £15.9m, which leaves £9.8m to be achieved primarily through bold actions by the end of the year (the gap between the top of the red bar and the black line in March).

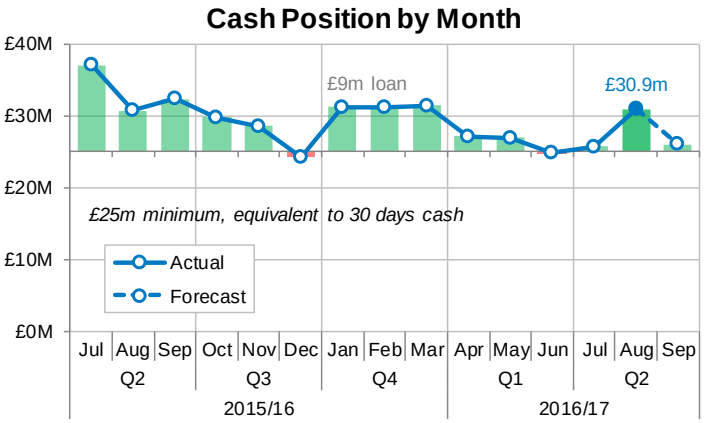
The Financial Improvement Group have been driving planned savings through the FIG A and FIG B meetings, and the Trust continues to work with its Financial Improvement Programme and further plans are being finalised and put through the assurance processes. Achievement of CIP is paramount in tackling the underlying deficit of the organisation, achieving the agreed NHSI control total and returning the trust to financial balance. Whilst Phase 2 of the Financial Improvement Programme (FIP) completes in September 2016 and KPMG's involvement with the Trust will reduce significantly, there will be a requirement for some continuity of the implementation of FIP to ensure the Trust manages the final delivery of CIP.

Financial Sustainability Risk Rating

Chart 66

		Actual	Rating	Initiate Override?	Excellent 4	3	2	Poor 1	Weight	Weighted score
Balance Sheet Sustainability	Capital service capacity (times)	(1.4)	1	Yes	2.50	1.75	1.25	< 1.25	25%	0
Liquidity	Liquidity (days)	-1.3	3	No	0	-7	-14	< -14	25%	1
Underlying Performance	I&E margin (%)	-9.9%	1	Yes	1.00%	0.00%	-1.00%	<-1.0%	25%	0
Variance from Plan	Variance in I&E margin as a % of income (%)	1.7%	4	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 67



The Trust's overall Financial Sustainability Risk Rating (FSR) is 2, classified by Monitor as a material risk. The Trust's operational plan for 2016/17 predicted a score of 2 for August 2016 and our actual performance is in line with this.

Cash in the bank at the 31st August 2016 was £30.9m. This is £2.2m ahead of plan due to low creditor payments during August and a receipt of £0.7m from charitable funds.

NHSI released their new Single Oversight Framework on 13th September which will come into effect from 1st October 2016. It covers five themes linked to the CQC's key questions, aligned to the Carter review and the 'model' hospital, as well as NHS Improvement's 2020 Objectives:

- Quality of care (safe, effective, caring, responsive)
- Finance & use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability (well led).

Scoring is between 1 (best) and 4 (worst), in reverse to the current ranking. Providers will be segmented into four, depending on the extent of support needs identified through the oversight process.

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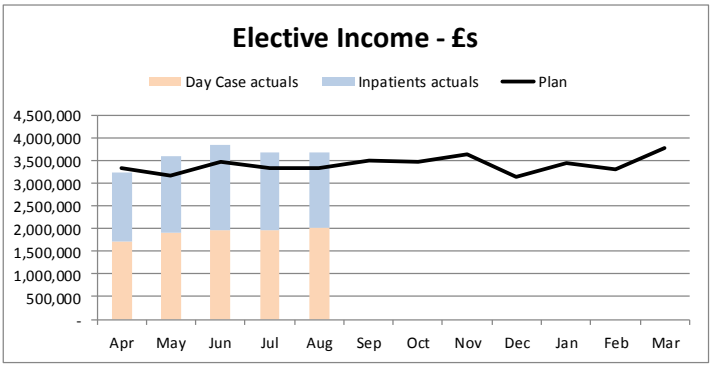
Elective Income vs. Plan

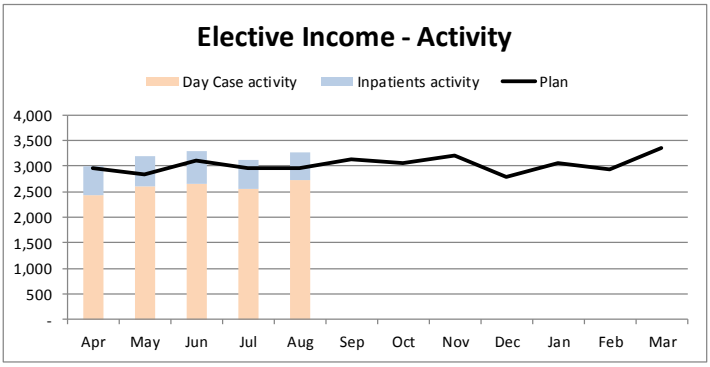
Chart 68



Elective income is above plan by £1.0m to the end of August 2016. This is a further improvement of £0.2m from last month, of which £0.1m relates to finalisation of July's case mix pricing of actual activity compared to forecast.

This over activity is linked to the RTT plan; however income at this level will not be sustainable for the rest of the year from Stockport CCG.

Chart 69



Elective in-patient activity is 149 cases (5%) above plan and 898 day cases (7%) above plan. This total of 1,047 cases above plan over five months has generated £1.0m income above plan, but has not all been delivered in house.

Endoscopy are 125 cases ahead of plan, but have spent £0.2m on in-sourcing in year. This activity is undertaken in our facilities with our equipment and consumables but with privately paid staff. Via Trust Health trauma and orthopaedics have in-sourced 161 cases, and ophthalmology 301. Out-sourcing to non-NHS providers of a further 141 cases. In addition, the Surgical & Critical Care business group has seen 751 patients as part of waiting list sessions above standard sessions.

This means that additional activity above regular in-house service has represented 1,479 cases and 9% of all elective activity in the first five months. The over-activity above plan is 1,047 cases in total, so all of the additional work has been delivered at a premium cost.

Additional in-house capacity will be realised with the opening of the new theatres as part of the Surgical & Medical Centre in October 2016, but requires detailed theatre scheduling work which is currently underway.

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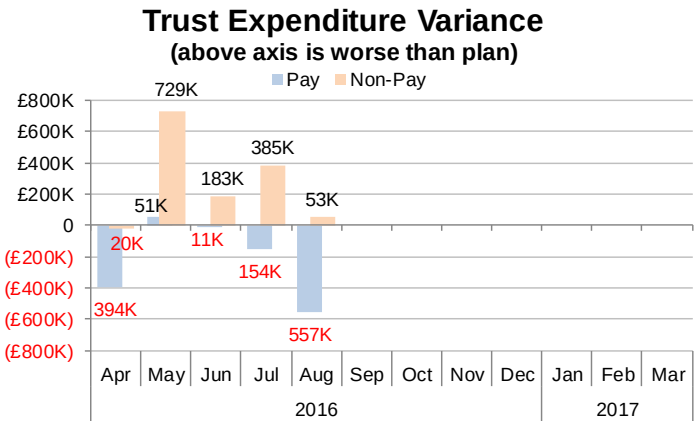
Expenditure Variance

Chart 70



The expenditure budgets overspend to date has reduced to £0.3m at the end of August, as the over achievement of CIP transacted in month has reduced the variance.

Pay costs in August were £17.3m, the same as last month. Agency expenditure was £0.9m in month, dipping below a million for the first time in the past 18 months. This is due to new starters recruited into vacancies and the work of the temporary staffing team as part of the Financial Improvement Programme to tackle agency usage. The Trust is currently in the process of a voluntary redundancy exercise which is focused on making long-term reductions in the total pay cost.

There is a variation across business groups but pay continues to overspend in Medicine and Surgery, where premium rate staff usage continues across a number of specialties. Particular pressure points for medical staffing are A&E and Acute Medicine, and in nursing for theatre staffing.

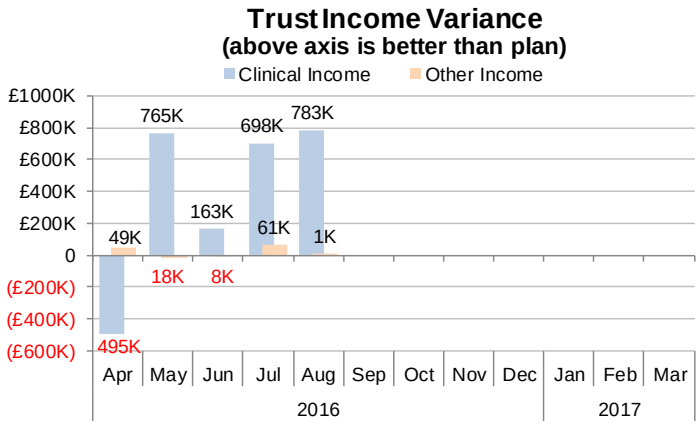
As referred to above under Elective Income, there have been significant amounts of in-sourcing and out-sourcing which have cost £0.9m to date; £0.4m orthopaedics, £0.2m ophthalmology, £0.2m endoscopy, £0.1m general surgery and urology.

Excluding external healthcare providers, the non-pay run-rate has reduced in August with total costs of £5.1m against an average to date of £5.5m per month. Drug costs of £1.7m were the highest to date, but this was mainly offset by additional income for specifically funded high-cost drugs.

The expenditure trend is moving in the right direction, but must reduce further to achieve the savings necessary to achieve the year end control total. The Trust needs to make a surplus of £4m in the next seven months to reduce the current five month loss from £10m to £6m to achieve the control total. This illustrates the scale of the task ahead.

Income Variance

Chart 71



In the five months to August the Trust is £2.0m ahead of plan on income. Of this £1.1m is because NHSI have asked for the Sustainability & Transformation Fund (STF) to be accounted for monthly, but we had only planned for it to come in quarterly; we planned to have 3/12 at this point in the year but we have 5/12 which shows as a favourable variance to plan due to timing only and will catch up during the financial year.

Receipt of the STF in Q1 was solely dependent on acceptance of the control total, but from July onwards payment is linked to separate financial and operational access standards. At the time of submitting the financial return to NHSI both RTT and A&E access targets have not been achieved in July and August, so we have lost 25% of these months' STF (£350k). This is recoverable if the cumulative position improves to within 1% of agreed trajectory by the end of Q2.

The remaining clinical income variance is primarily Elective, as discussed above.

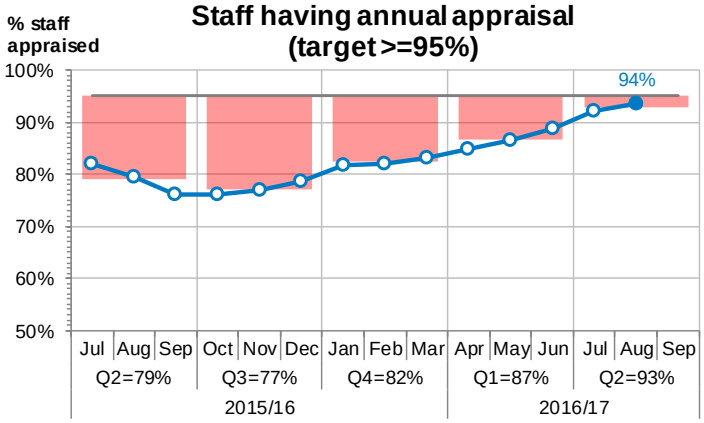
Stockport CCG Block Contract

- Non-elective activity for Stockport has highlighted the operational and financial pressure of delayed transfers of care. Activity numbers are down as patients are only counted on discharge, so patients still in beds with extended length of stay are skewing the reporting.
- Emergency Department activity is 4.2% above plan to date, so below the 5% threshold agreed with the CCG.
- Out-patient and non-tariff elements of the Stockport CCG block remain a marginal benefit to the Trust, which has not moved since last month. Activity is slightly behind plan but we are still receiving the standard level of income; this is expected to fluctuate during the year.
- The block position is being closely monitored and discussed with the CCG as part of the reconciliation of the overall financial position.

See also Financial Income and Expenditure table

Workforce Appraisals

Chart 72



The Trust's total appraisal compliance for August 2016 is 93.59%, an increase of 1.36% since July 2016 (92.23%).

The following Business Groups have seen increases this month; Corporate Services from 90.34% to 91.16%, Medicine from 90.73% to 92.74%, Surgical & Critical Care from 89.88% to 93.02%, Community Healthcare from 90.00% to 92.55%, Estates from 91.07% to 94.74% and Facilities from 94.65% to 97.85% (achieved trust target).

Diagnostic & Clinical Support decreased marginally from 98.66% to 98.63%, however they have still met the trust target. Child & Family decreased from 91.04% to 89.11%.

Individuals who do not have an update to date appraisal will not be approved to attend external training. In addition, an up to date appraisal is required for those staff who are eligible for a pay increment from the 1st October 2016.

Chart 73

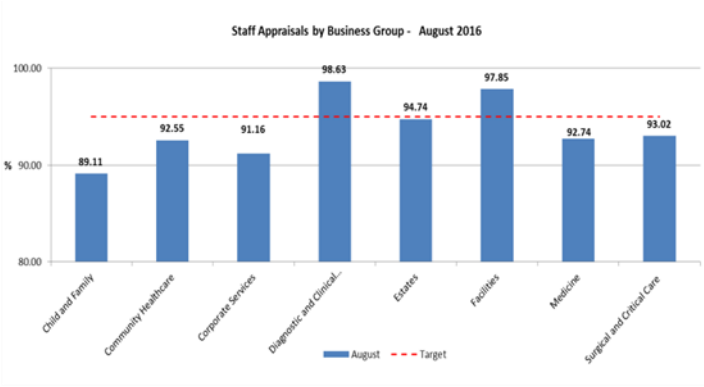
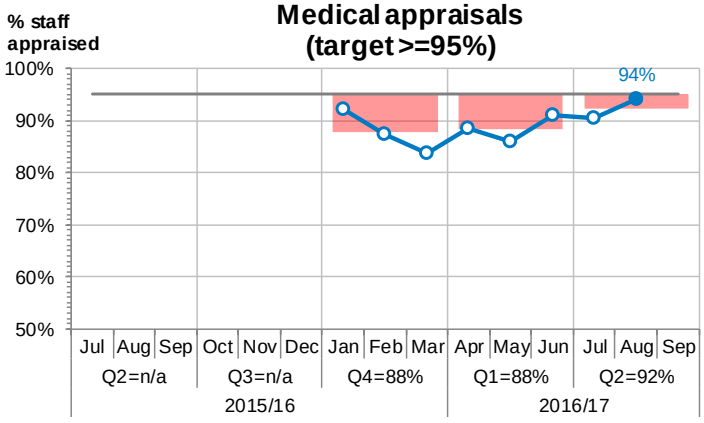


Chart 74



The medical appraisal rate for August 2016 is 94.14%, an increase of 3.6% from July 2016 (90.54%).

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

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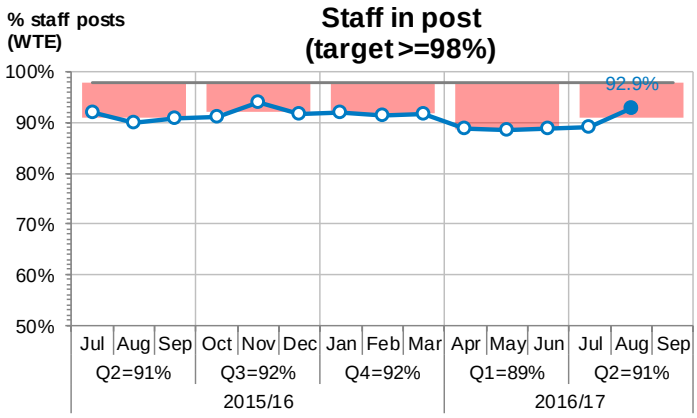
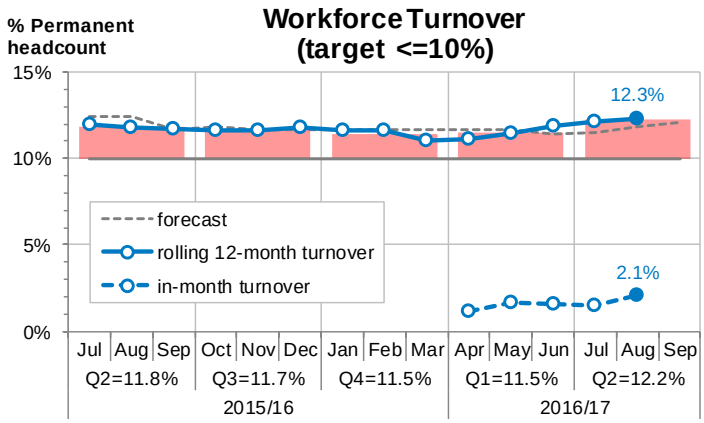
Workforce Turnover

Chart 75



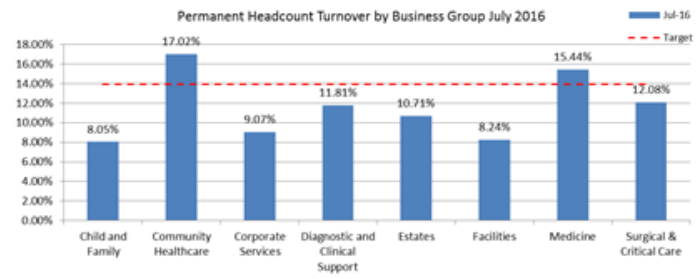
The Trust staff in post for August 2016 is 92.9% of the establishment, which is an increase of 3.17% from 89.03% in July 2016.

Chart 76



The Trust's permanent headcount turnover figure for the 12 months ending August 2016 is 12.33% against a national average rate of 13.93%. This is a slight increase of 0.20% compared to the July 2016 figure of 12.13%, showing some stability in the turnover activity. (This does not include the TFT TUPE transfer staff which increases the August 2016 permanent headcount turnover figure to 25.72%). The turnover rate for comparison to August 2015 was 11.82%.

Chart 77



The Trust turnover in month has shown a relatively steady trend throughout the first quarter of 2016, with a small increase from 1.97% in July 2016 to 2.05% in August 2016.

The turnover percentage does not include internal moves, such as promotion or transfers from within departments or other internal moves within the Trust.

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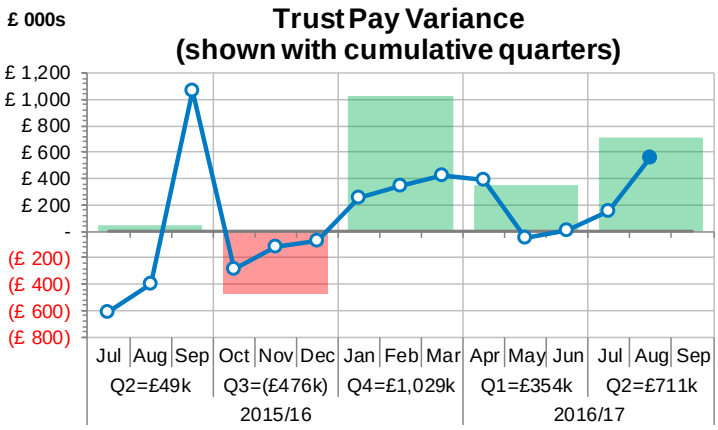
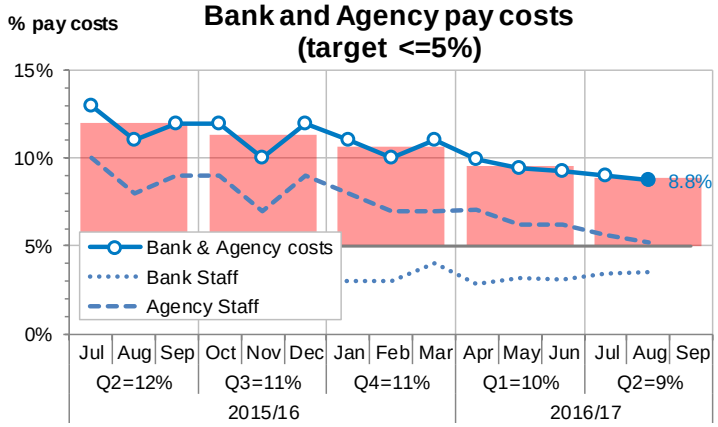
Workforce Efficiency

Chart 78



The Trust pay variance, expenditure above the financial envelope of establishment, including vacancies in August 2016 showed a £557,116 underspend, an increase of £403,372 from the £153,744 underspend reported in July 2016.

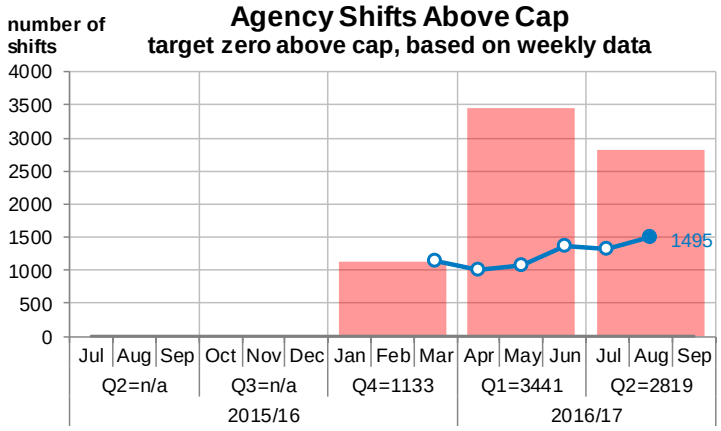
Chart 79



The percentage of pay costs spent on bank and agency in August 2016 is 8.8% (the July 2016 position was 9%), which equates to £1,521,645, a decrease of £39,127 from £1,560,772 in July 2016.

The Medicine Business Group has the highest spend on bank/agency at £1,021,072 in August 2016 which equates to 67.10% of the overall bank/agency spend, a decrease of 4.43% (£95,283) from the 71.53% July 2016 figure of £1,116,355.

Chart 80



In July 2016, 3.55% of total pay costs were attributed to bank staff and 5.25% of total pay costs were attributed to agency staff, which is a slightly higher % on bank and lower on agency than the July 2016 percentage figures of 3% bank and 6% agency. The use of bank and agency staff is closely monitored at Business Group Finance and Performance meetings and the Establishment Control Panel

August 2016 shows an increase in the number of shifts which are taking place above the agency cap of 171, from 1324 in July 2016 to 1495 in August 2016. Work continues in line with the IDP Agency Cap programme to address the level of cap breaches and to model the impact.

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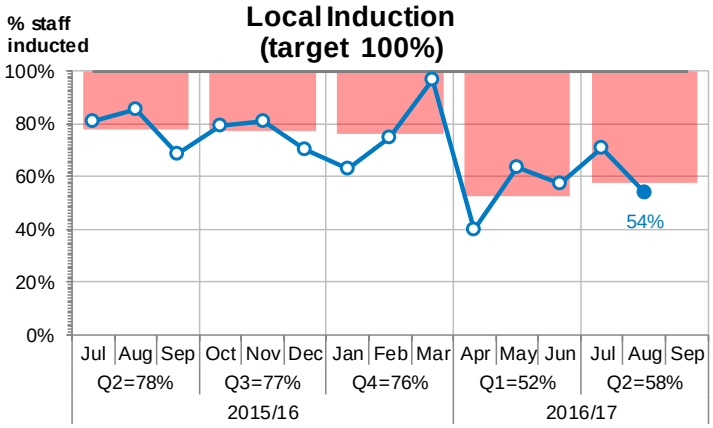
Workforce Induction

Chart 81



Corporate Welcome attendance remains consistently at 100%. Local induction has decreased from 70.83% in July to 53.75% in August.

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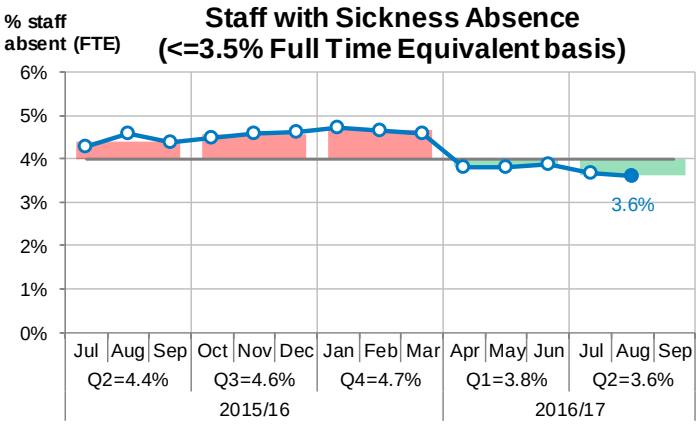
Staff Engagement

To be developed

Sickness Absence

Chart 82



The in-month unadjusted sickness absence figure for August 2016 is 3.60%. This is a decrease of 0.07% compared to the July 2016 adjusted figure of 3.67%. The sickness rate for comparison in August 2015 was 4.57%.

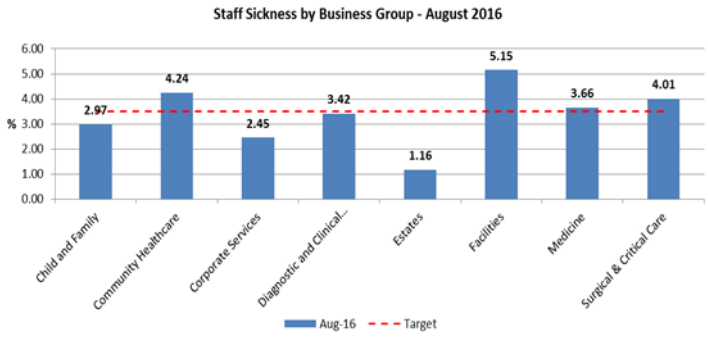
The reduction in absence has been predominantly from short term absences. In July short term absence was 1.09% reducing to 0.76% in August and long term absence increased from 2.58% in July to 2.87% in August 2016. The management and monitoring of sickness absence levels continues through the weekly tracker meetings.

The unadjusted cost of sickness absence in August 2016 is £357,894, a decrease of £13,369 from the adjusted figure of £371,263 in July 2016. This does not include the cost to cover the sickness absence.

Community Healthcare, Diagnostics &Clinical Services, and Surgical & Critical Care have reported an increase in sickness absence in August 2016. Community Healthcare (4.24%), Facilities (5.15%), Medicine (3.66%), and Surgical & Critical Care (4.01%) are above the target in August 2016.

The top 3 known reasons for sickness in August 2016 are back problems and other musculoskeletal problems including injury/fracture at 32.82% (a 7.27% increase from 25.55% in July 2016), stress at 29.61% (a 0.69% decrease from 30.30% in July 2016), and gastrointestinal problems at 6.81% (a 2.33% decrease from 9.14% in July 2016).

Chart 83



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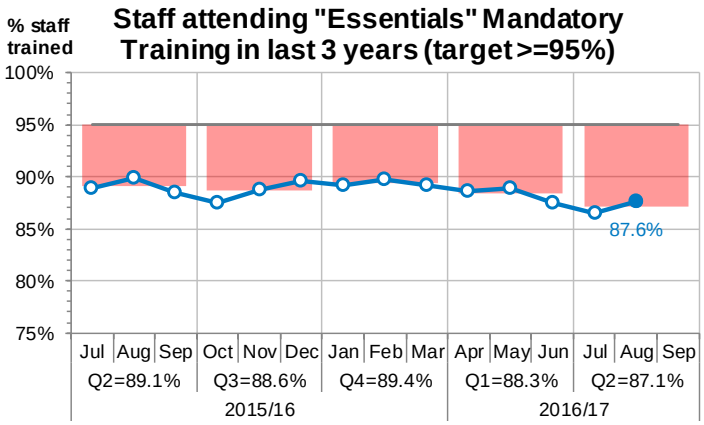
Essentials Training

Chart 84



In August 2016 there was an increase of 1% in compliance from the July position, from 86.6% to 87.6%.

Estates are the only Business Group to achieve compliance.

Diagnostics and Clinical Support achieved 93.41%, Child & Family 92.16% and Community 91.33%. The remaining Business Groups are under 90%.

- 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.
- Compliance with Essentials training is required for those staff who are eligible for a pay increment from the 1st October 2016.
- Monthly emails reminders are sent to all staff that are non-compliant.

The trust compliance rate for Prevent Level 2 is currently 78.29%, Prevent Level 3 is 70.55% and Information Governance is 87.25%

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Integrated Performance Report September 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	16,930	17,933	1,003
Non Elective	74,638	30,916	30,568	(349)
Outpatient	34,456	14,051	14,078	27
A&E	12,130	5,026	5,082	56
Total Income at Full Tariff	**162,892**	**66,923**	**67,661**	**738**
Community Services	31,369	13,209	13,161	(48)
Non-tariff income	61,837	24,084	25,514	1,430
Memo line: Sustainability & Transformation Fund (STF)	*8,400*	*2,100*	*3,150*	*1,050*
Clinical Income - NHS	**256,097**	**104,216**	**106,336**	**2,120**
Private Patients	698	291	84	(207)
Other	959	399	400	1
Non NHS Clinical Income	**1,656**	**690**	**484**	**(206)**
Research & Development	471	198	187	(11)
Education and Training	7,276	3,077	3,074	(3)
Stockport Pharmaceuticals/RQC	5,525	2,324	2,103	(221)
Other income	17,907	7,095	7,416	321
Other Income	**31,179**	**12,693**	**12,779**	**86**
TOTAL INCOME	**288,933**	**117,599**	**119,598**	**1,999**
EXPENDITURE				
Pay Costs	(206,174)	(89,025)	(87,960)	1,065
Drugs	(16,794)	(7,897)	(8,027)	(131)
Clinical Supplies & services	(18,947)	(8,582)	(9,284)	(702)
Other Non Pay Costs	(38,553)	(17,912)	(18,409)	(497)
TOTAL COSTS	**(280,468)**	**(123,415)**	**(123,680)**	**(265)**
EBITDA	**8,465**	**(5,816)**	**(4,082)**	**1,734**
Depreciation	(9,094)	(3,687)	(3,597)	90
Interest Receivable	63	26	37	11
Interest Payable	(936)	(397)	(378)	20
Other Non-Operating Expenses	(706)	(294)	(146)	148
Fixed Asset Impairment Reversal	-	-	-	-
Unwinding of Discount	(30)	-	-	-
Profit/(Loss) on disposal of fixed assets	-	-	(55)	(55)
Donations of cash for PPE	540	-	-	-
PDC Dividend	(4,291)	(1,788)	(1,788)	(0)
RETAINED SURPLUS / (DEFICIT) FOR PERIOD	**(5,988)**	**(11,956)**	**(10,007)**	**1,948**

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Stockport NHS
NHS Foundation Trust

Report to: Board of Directors	**Date:** 29th September 2016
Subject: CQC Action Plan	
Report of: Director of Nursing & Midwifery	**Prepared by:** Director of Nursing & Midwifery

REPORT FOR APPROVAL

Corporate objective ref: -----	**Summary of Report** The report of the CQC inspection of Stockport NHS Foundation Trust, undertaken in January 2016, was published on 11th August 2016. The overall rating of the Trust is 'Requires Improvement' and an action plan is required by the CQC by 1st October. This report details the action plan. The Board of Directors is asked to: • Approve the action plan and the way in which progress will be monitored
Board Assurance Framework ref: -----	
CQC Registration Standards ref: -----	
Equality Impact Assessment: ☐ Completed ☐ Not required	

Attachments:

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

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1. INTRODUCTION

1.1 The report of the CQC inspection of Stockport NHS Foundation Trust, undertaken in January 2016, was published on 11th August 2016. The overall rating of the Trust is 'Requires Improvement' and an action plan is required by the CQC by 1st October.

2. BACKGROUND

2.1 Following the CQC inspection in January this year, 'headline' feedback from the CQC was provided and some actions were taken immediately to address the concerns raised. The final report was published on 11th August, and a Quality Summit for key stakeholders was held on 9th September where the key findings were discussed.

2.2 The CQC require a comprehensive action plan to address the 'requirement notices' in the report and the range of other action areas across all the Trust services inspected.

3. CURRENT SITUATION

3.1 A comprehensive action plan has been developed which details all the required actions and this will be submitted to the CQC by 1st October. It will also then be available on the Trust website.

3.2 The action plan has been presented to the Quality Governance Committee and to the Quality Assurance Committee during September 2016.

4. RISK & ASSURANCE

4.1 The risk associated with not implementing the CQC action plan is that when the CQC revisits the Trust, there will have been little or no improvement and the Trust's CQC rating will remain the same or deteriorate.

4.2 Monitoring of the action plan will be through the Quality Governance Committee, with assurance provided to the Quality Assurance Committee on progress, which will in turn be reported to the Board of Directors.

5. CONCLUSION

5.1 A comprehensive action plan has been developed which details all the required actions and this will be submitted to the CQC by 1st October.

6. RECOMMENDATIONS

6.1 The Board of Directors is asked to:

- Approve the CQC action plan and the way in which progress will be monitored

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Stockport NHS
NHS Foundation Trust

Our Improvement Plan – responding to the Care Quality Commission Report

October 2016

Gillian Easson, Chairman

Ann Barnes, Chief Executive

Version as at October 2016 – Not yet approved with CQC
The plan is a live document, and will be adapted based on feedback

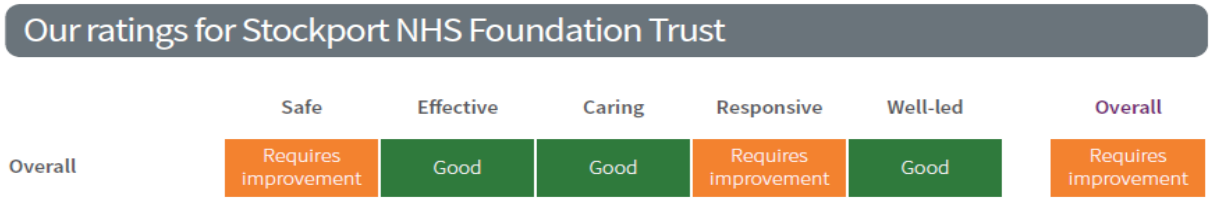
Introduction

Stockport NHS Foundation Trust underwent a comprehensive inspection by the Care Quality Commission (CQC) in January 2016.

The inspection was structured around the CQC's 5 key questions (are services safe, effective, caring, responsive, and well-led?) for each of the following eight core hospital services, plus community services:

- A+E
- Medical care, including frail elderly
- Surgical care, including theatres
- Critical care
- Maternity and family planning
- Children and young people
- End of Life Care
- Outpatients diagnostic and imaging

The Trust was rated overall as **'Requires Improvement'** by the CQC



This comprises of the following individual ratings:

Stepping Hill Hospital (eight service areas)**:** 5 Good, 3 Requires Improvement
Community Health Services for Adults: Requires Improvement
Community Health Services for Children, Young People and Families: Good
Community Health Inpatient Services: Good
End of Life care: Good

The final CQC reports were published on 11th August and the Quality Summit was held on 9th September 2016.
The reports are available from:

http://www.cqc.org.uk/sites/default/files/new_reports/AAAF0543.pdf

Governance Processes
Internal
• The Board of Directors approves CQC Action Plan and receives monthly assurance updates
• The Quality Assurance Committee provides non-executive director led scrutiny on progress
• The Quality Governance Committee directly monitors and provides assurance on delivery of the CQC Action Plan

External
• CQC reviews delivery of CQC Action Plan and re-inspects the Trust

The key themes identified in the report

3 priorities to address | work has already started

I. We need to **improve the safety of patients in our Emergency Department by reducing overcrowding and improving nursing and medical staffing.** We aim to reduce overcrowding by reducing Emergency Department attendances and admissions, and by enhancing capacity and flow through the hospital. These actions will not only improve patient safety, but also the care and experience of patients and families in the Emergency Department.

II. We need to **continue to improve our nursing and medical staffing** through effective recruitment and retention of staff, looking at new roles and continuing to reduce reliance on temporary staff. Whilst significant progress has been made, we recognise that there remains work to do in specific areas such as the Emergency Department, medical wards and Community Nursing.

III. We need to **improve and maintain compliance with mandatory training and appraisals for all staff.**

Version Control	
Version (s)	Approval
Drafts 1-2	Collation and consultative review as part of the process for development
Version 1	Approved by Trust Executive 28 September 2016
Action Plan Submitted to CQC	30 September 2016.

CQC Action Plan Status - Position at 30 September 2016

Service/Speciality	Regulation Requirement/Must do/Should do	Action No	Final Action Date	No. of Actions		Completed	On Track	Risks Overdue	Overdue / Concern
				Must	Should				
Stockport NHS Foundation Trust	Regulation Requirement	1-5	31/12/2016	22		9	1		
Stockport NHS Foundation Trust	Should do	6-18	31/12/2016		4	3			
Urgent and Emergency Care	Must do	19-32	31/12/2016	36		19	4		
Urgent and Emergency Care	Should do	33-47	31/12/2016		25	12	4		
Medicine	Must do	48-51	31/12/2016	10		1	4		
Medicine	Should do	52-54	31/10/2016		6				
Maternity and Gynaecology	Must do	55-61	01/12/2016	13		2			
Maternity and Gynaecology	Should do	62-66	01/12/2016		7	1			
Community End of Life Care	Must do	70-71	01/12/2016	5					
End of Life Care (Hospital)	Must do	72-76	30/04/2017	10					
Community Adults	Must do	77-80	31/12/2016	12		2			
Community Adults	Should do	81-89	31/12/2016		15	1			
Children and Young People	Must do	90-95	31/12/2016	31		9	4		
Diagnostics	Should do	96-101	31/03/2016		13	3	2		
Critical Care	Must do	102	31/12/2016	2		1			
Critical Care	Should do	103-106	31/12/2016		4	1	1		
Surgery	Should do	107-115	31/12/2016		18	6			

Key- Action Confidence Assessment

Blue = Completed Green = On Track Amber = Risk of Non Delivery Red = Overdue and cause for concern

CQC Action Plan Regulatory Requirements

	Regulated Activitiy	Regulation	Action area		Action required	Responsible person	Target date	Comments on progress	Completion Status
1	**Nursing Care Treatment of disease, disorder or injury**	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect. **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (part 3) Regulations 10 (1) (2) (a)** Service Users must be treated with dignity and respect	Ensure that all Service Users are treated with dignity and respect CQC observed multiple occasions where patients privacy and dignity was not maintained in the Emergency Department.	**1a**	ED expansion plans agreed at Board level July 2016. This will increase trolley spaces by 7 majors cubicles which should reduce the reliance of use of the corridor space.	Director of Medicine / Chief Operating Officer	31/12/2016		
				1b	Continued monitoring of Nursing Care Indicators.	ED Matron	01/09/2016	ED Care indicators show 100% compliance with regards to Dignity & Respect April to July 2016.	31/07/2016
				1c	Dignity and Respect, Equality and Diversity training to be monitored and staff identified routinely if out of date.	ED Matron, Business Manager, Clinical Director	31/10/2016		
				1d	Commence discussions with NWAS regarding handover process on arrival to the Emergency Department	ED Matron	31/10/16		
2	**Nursing Care Treatment of disease, disorder or injury**	Regulation 12 HSCA (RA) Regulations 2014 Safe Care and Treatment **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (part 3) Regulations 12 (1) (2) (a) (b) (c) (g) (h)** Care and treatment must be provided in a safe way for service users	Ensure that care and treatment is provided in a safe way for service users. CQC found: Risks to patients were not always recognised and assessed Control measures not always in place to mitigate these risks Medicines were not always managed safely or stored securely Patients were not always protected from risk of infections/isolated and clinical areas not always cleaned between patients uses in the emergency department	**2a**	Regarding pain scores - patients cannot now be fully triaged without having a pain score entered into AdvantisED. Pain has to be re-assessed at commencement of Medical assessment.	ED Nurse Consultant	15/09/2016	Changes to AdvantisED made.	25/08/2016
				2b	The ED Nursing care indicators (12 & 13) include "There is documented evidence in the notes of regular diet and fluids if not NBM". Ongoing adherence monitored by Head of Nursing and ED Matron.	ED Matron	30/09/2016		
				2c	To move the Anderson score assessment to be available for completion on arrival in ED.	ED Matron	30/09/2016		
				2d	Staff huddles regarding appropriate medication storage.	ED Matron	30/09/2016		
				2e	Reviewed the "Green Bag" scheme for patient's medication to ensure they are larger and more fit for purpose.	ED Pharmacy Lead	30/09/2016	To support this, work has been done to ensure all ambulance crews are aware of the system and other services within the hospital are clear on how they are to be used.	02/09/2016
				2f	Safe and Secure Handling of Medicines Audit (Duthie) planned for October 2016.	ED Pharmacy Lead / ED Matron	30/11/2016		
				2g	The drug fridge in the Resuscitation area of the ED is locked by staff in line with the policy and is subject to random spot checks by the ED Matron to ensure compliance.	ED Pharmacy Lead / ED Matron	31/08/2016		31/08/2016
				2h	Matron / Pharmacy to benchmark ED medicines management against Trust policies.	ED Pharmacy Lead / ED Matron	30/11/2016		
				2i	Ward reconfiguration of acute medicine will allow for GP referrals with possible infections to be isolated outwith ED in the acute medical unit. Therefore reducing the number of patients within ED who will require isolation.	Director of Business Group / Chief Operating Officer	31/10/2016		

	Regulated Activitiy	Regulation	Action area		Action required	Responsible person	Target date	Comments on progress	Completion Status
3	**Nursing Care**	Regulation 14 HSCA 2008 (Regulated Activities) Regulations Meeting nutritional needs **Health and Social Care ACT 2008 (Regulated Activities) Regulations 2014 (part 3)** **Regulations 14 (1)** The nutritional and hydration needs of service users must be met	Ensure that nutritional and hydration needs of service users are met. CQC found that patients were not always provided with adequate nutrition and hydration in the Emergency Department and that fluid balance recording was not always completed	**3a**	The ED Nursing care indicators (12 & 13) include "There is documented evidence in the notes of regular diet and fluids if not NBM". Ongoing adherence monitored by Head of Nursing and ED Matron. (currently at 100%)	ED Matron	31/08/2016		31/08/2016
4	**Nursing Care** **Treatment of disease, disorder or injury**	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (part 3)** **Regulations 17 (1) (2) (b) (c)** Systems or processes must be established and operated effectively to ensure compliance	Ensure that systems and processes are established and operated effectively to ensure compliance. CQC found that in the Emergency Department key risks had not been identified and assessed including the risk of patients being placed and accommodated in non clinical areas such as corridors. Records were not always up to date and lacked detail in some cases	**4a**	ED risk register to be robustly monitored and discussed in detail and actioned accordingly at every ED Quality Board meeting.	Consultant Governance Lead & Business Manager	30/09/2016	Risk register discussed at 07/09/2016 meeting and is a regular agenda item.	07/09/2016
				4b	Risk Assessment process formalised within the Business Group (process in place March 2016) including monthly informal review of pending risks and formal monthly review at Business Group Quality Governance Board, feeding into the Trust Quality Governance Committee.	Consultant Governance Lead, ED Matron, Business Manager, Governance & Quality Manager, Director	30/09/2016		01/09/2016
5	**Nursing Care**	Regulation 18HSCA (RA) Regulations 2014 Staffing **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (part 3)** **Regulations 18 (1) (2) (a)** Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed.	Ensure that there are sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed. CQC found that in the Emergency Department there was routine staffing deficits with 54 out of 121 shifts in a four month period being understaffed by at least one qualified nurse. The uptake for mandatory training for nursing staff and medical staff was significantly lower that the expected target in a number of subjects. The appraisal rated for staff were consistently and significantly below the trusts target	**5a**	International Recruitment continues with an additional 60 registered nurses commencing from November 2016. As at end of August 2016 the vacancy rate in ED	Head of Nursing	30/11/2016		
				5b	Additional registered nurses per shift to be agreed.	Head of Nursing	30/09/2016		12/09/2016
				5c	Ensure minimum safe staffing policy is adhered to.	Head of Nursing	30/09/2016		01/09/2016
				5d	The Trust is running next Health Care Assistant recruitment open day 24th September.	Head of Nursing	30/11/2016		
				5e	Actions in place to achieve and sustain compliance. Outstanding staff identified and dates planned for training completion.	ED Matron, Business Manager, Clinical Director	31/10/2016	As at 01/08/2016 Level 3 adult safeguarding training within ED is at 89.74%.	
				5f	All outstanding staff for mandatory training to be identified and dates planned for training completion scheduled.	ED Matron, Business Manager, Clinical Director	31/10/2016		

CQC Action Plan The Hospital

	Action area	Action required		Responsible person	Target date	Comments on progress	Completed Date
The Hospital Should:							
6	The hospital should ensure that all actions and and lessons learned from serious incidents are regularly reviewed and completed appropriately	Develop a robust mechanism within the Trust to ensure that there is a system in place to share learning from incidents. Including introduction of "7 minute briefing template".	**6a**	Head of Risk and Customer Services	31/12/2016		
		Redesign the monthly High Profile report to highllight more clearly lessons learnt	**6b**	Head of Risk and Customer Services / All Governance Leads	31/08/2016		30/07/2016
		Monthly review meetings with Clinical Commissioning Group which monitor robust action completion to include all business groups for constructive feedback on reports submitted	**6c**	Head of Risk and Customer Services / All Governance Leads	31/08/2016		30/07/2016
7	Consider monitoring all four harms outlined in the national safety thermometer for the Emergency Department	See Urgent and Emergency Services tab.					
8	Consider reviewing the number of defibrillators in the Emergency Department to assess whether additional equipment is required	See Urgent and Emergency Services tab.					
9	Consider that essential resuscitation equipment is regularly checked and that these checks are recorded in the emergency department.	See Urgent and Emergency Services tab.					
10	Consider that all appropriate risk assessments are completed for patients attending the emergency department.	See Urgent and Emergency Services tab.					
11	Consider that there are adequate numbers of suitably qualified nursing staff on duty at all times in the emergency department.	See Urgent and Emergency Services tab.					
12	Consider that all patients receive nutrition and hydration while in the emergency department.	See Urgent and Emergency Services tab.					
13	Consider that patients receive adequate pain relief within the emergency department if it is required.	See Urgent and Emergency Services tab.					

	Action area	Action required		Responsible person	Target date	Comments on progress	Completed Date
14	Consider that any actions which are recommended as a result of audits should be monitored and updated regularly.	Clinical Audit Steering Group to continue to review completion and monitoring of actions.	**14a**	Deputy Medical Director	30/08/2016		30/08/2016
15	Consider that deceased patients and their families are treated with compassion and dignity at all times in the emergency department.	See Urgent and Emergency Services tab.					
16	Consider that medical patients are not accommodated on the CDU or MAU unless there are exceptional circumstances.	See Urgent and Emergency Services tab.					
17	Consider that patients waiting for inpatient beds in the emergency department are kept informed of any delays in their allocation of a bed.	See Urgent and Emergency Services tab.					
18	Consider that there is clear nursing leadership within the emergency department and that the matron is able to undertake her management role effectively and unimpeded by the pressures of the department.	See Urgent and Emergency Services tab.					

CQC Action Plan - Urgent & Emergency Services

	Action area		Action required	Responsible person	Target date	Comments on progress	Date completed
The Hospital Must:							
19	Ensure that all medications in the emergency department are securely stored at all times.	**19a**	Introduction of 'Staff huddles' regarding appropriate medication storage.	ED Matron	30/08/2016		26/09/2016
		19b	Reviewed the "Green Bag" scheme for patient's medication to ensure they are larger and more fit for purpose.	ED Pharmacy Lead	30/09/2016	To support this, work has been done to ensure all ambulance crews are aware of the system and other services within the hospital are clear on how they are to be used.	02/09/2016
		19c	Regular and annual Safe and Secure Handling of Medicines Audit (Duthie) planned for October 2016.	ED Pharmacy Lead / ED Matron	30/11/2016		
		19d	The drug fridge in the Resus area of the ED is locked by staff in line with the policy and is subject to random spot checks by the ED Matron to ensure compliance.	ED Pharmacy Lead / ED Matron	01/09/2016		01/09/2016
		19e	Matron / Pharmacy to benchmark ED medicines management against Trust policies.	ED Pharmacy Lead / ED Matron	30/11/2016		
20	Ensure that patients received their medications in timely manner and ensure that any necessary checks are completed in line with local and national guidance and policy in the emergency department.	**20a**	Staff to be made aware of importance of giving timely medications via safety huddles.	ED Matron	01/09/2016		01/09/2016
		20b	Time critical medications to be included in outstanding actions if identified at triage.	ED Matron	30/09/2016		
		20c	Appropriate medication checks to be reviewed and changes made as required.	ED Pharmacy Lead / ED Matron	31/10/2016		
21	Ensure that patient records are accurate, up to date and reflect the care the patient receives in the emergency department.	**21a**	Staff reminded of the importance of timely documentation.	ED Matron	30/09/2016		31/05/2016
		21b	In recognition of the impact ED pressures are having, the Trust have implemented one or two additional registered nurse post per shift.	ED Matron / Head of Nursing.	30/09/2016		12/09/2016
22	Ensure that all staff are up to date with their mandatory training in the emergency department. Specifically in relation to life support and patient manual handling.	**22a**	Actions in place to achieve and sustain compliance. Outstanding staff identified and dates planned for training completion.	ED Matron, Business Manager, Clinical Director	31/10/2016	As at 01/08/2016 Level 3 adult safeguarding training within ED is at 89.74%.	
		22b	All outstanding staff for mandatory training to be identified and dates planned for training completion scheduled.	ED Matron, Business Manager, Clinical Director	31/10/2016		

	Action area		Action required	Responsible person	Target date	Comments on progress	Date completed
23	Ensure that patients are protected from infections by isolating patients with suspected infections and cleaning areas where patients receive care in line with their infection control policies and procedures in the Emergency Department.	**23a**	Ward reconfiguation of acute medicine will allow for GP referrals with possible infections to be isolated outwith ED in the acute medical unit. Therefore reducing the number of patients within ED who will require isolation.	Director of Business Group / Chief Operating Officer	31/10/2016		
		23b	To scope additional resources to support maintanence of the ED environment.	ED Matron	31/10/2016		
		23c	To review the role of Porters in ED to incorporate elements of environmental maintenance.	Business Manager	30/09/2016		
24	Ensure that patients risk is appropriately identified and all possible measures are taken to minimise risks to patients safety are in place. Specifically in relation to patients being accommodated in areas not designed for clinical care such as corridor areas.	**24a**	To move the Anderson score assessment to be available for completion on arrival in ED.	ED Matron	01/09/2016		01/09/2016
		24b	Poor compliance of fluid balance entry completion is being discussed for increased compliance at ED safety huddles and will be monitored for future improvement.	ED Matron	01/09/2016		01/09/2016
		24c	It has been recognised that AdvantisED system does not pull through fluids given once documented as administered. To be investigated and addressed by I.T. department.	ED Matron	31/12/2016		
		24d	Regarding pain scores - patients now cannot be fully triaged without having a pain score entered into AdvantisED. Pain has to be re-assessed at commencement of Medical assessment.	ED Nurse Consultant	15/09/2016		25/08/2016
25	Ensure that patients are treated with dignity and compassion and that their dignity and privacy is maintained at all times while they are in the emergency department.	**25a**	Dignity and Respect, Equality and Diversity training to be monitored and staff identified routinely if out of date.	ED Matron, Business Manager, Clinical Director	31/10/2016	Nursing Care Indicators have improved - ED Care indicators show 100% compliance with regards to Dignity & Respect April to July 2016.	
26	Ensure that patients can access emergency care and treatment in a timely way.	**26a**	To implement a formal clinical esclation model. To include escalation directly to consulant, specific amangement of elctive activity in times when thresholds related to capacity, demand and activity.	Chief Operating Officer	31/10/2016		
		26b	Increase nurse staffing establishment.	Head of Nursing	30/09/2016		12/09/2016
		26c	Review alternative workforce models.	Head of Nursing / ED Matron	30/09/2016		
		26d	Continue to progress workstreams which are planned to implement alternative models of emergency care access.	Chief Operating Officer / Director of Medicine	31/11/2016		

	Action area		Action required	Responsible person	Target date	Comments on progress	Date completed
27	Ensure that the trusts internal escalation policies are followed appropriately.	**27a**	Review of escalation triggers to ensure a consistent and proportionate response is always provided to times of surge both in and out of hours. This piece of work is being led by the Deputy Chief Operating Officer to ensure a "whole hospital" response.	Deputy Chief Operating Officer	31/10/2016		
		27b	A review of the roles and responsibilities of the Medical On-Call service to ensure we are supporting the key pressure points within the system and we have a fit-for-purpose On Call.	Associate Medical Director	31/10/2016		
		27c	A review of patient flow through the Acute Medical Unit to the specialty wards to ease times of surge - this is being led by the Clinical Director for Acute Medicine and will include criteria for outlying patients and suitability of transfer to specialty beds.	Clinical Director	31/10/2016		
28	Ensure that there is an adequate policy or procedure to guide the practice of 'boarding' to ensure patient safety.	**28a**	Procedure in place alongside risk assessment for management of capacity when additional beds required.	Head of Nursing	30/09/2016		31/05/2016
29	Ensure that all risks identified in relation to the emergency department are appropriately risk assessed and appropriate control measures are in place.	**29a**	ED risk register to be robustly monitored and discussed in detail and actioned accordingly at every ED Quality Board meeting.	Consultant Governance Lead & Business Manager	30/09/2016	Risk register discussed at 07/09/2016 meeting and is a regular agenda item.	07/09/2016
		29b	Risk Assessment process formalised within the Business Group.	Consultant Governance Lead, ED Matron, Business Manager, Governance & Quality Manager, Director	31/03/2016		31/03/2016
		29c	Monitoring of compliance via monthly informal review of pending risks and formal monthly review at Business Group Quality Governance Board, feeding into the Trust Quality Governance Committee.	Consultant Governance Lead, ED Matron, Business Manager, Governance & Quality Manager, Director	01/09/2016		01/09/2016
30	Ensure that there is an adequate provision of equipment used for resuscitation in all areas of the emergency department.	**30a**	Secure a loan of 2 defibrillators to give a complement of 4.	ED Matron / Business Manager	30/09/2016		16/09/2016
		30b	Submit request for 2 additional machines to replace those on loan.	ED Matron / Business Manager	31/10/2016		16/09/2016

	Action area		Action required	Responsible person	Target date	Comments on progress	Date completed
31	Ensure patients are offered food and drinks where clinically advised by staff members	**31a**	The ED Nursing care indicators (12 & 13) include "There is documented evidence in the notes of regular diet and fluids if not NBM". Ongoing adherence monitored by Head of Nursing and ED Matron. (currently at 100%)	ED Matron	31/08/2016		31/08/2016
32	Ensure that staff within the emergency department receive their annual appraisals	**32a**	New Incremental pay progession policy to include requirement for appraisal before increment to be launched	Executive Direcor of HR	01/05/2016		31/05/2016
		32b	All staff to made aware of new Incremental Pay progression	Executive Direcor of HR	01/05/2016		31/05/2016
The Hospital Should:							
33	Ensure that there is an adequate provision of equipment used for resuscitation in all areas of the emergency department.	**33a**	Secure a loan of 2 defribillators to give a complement of 4.	ED Matron / Business Manager	30/09/2016	Draft discussed at Business Group Quality Board 14/09/2016.	16/09/2016
		33b	Submit request for 2 additional machines to replace those on loan.	ED Matron / Business Manager	31/10/2016		16/09/2016
34	Ensure patients are offered food and drinks where clinically advised by staff members.	**34a**	The ED Nursing care indicators (12 & 13) include "There is documented evidence in the notes of regular diet and fluids if not NBM". Ongoing adherence monitored by Head of Nursing and ED Matron.(currently at 100%)	ED Matron	31/08/2016		31/08/2016
35	Ensure that staff within the emergency department receive their annual appraisals.	**35a**	New Incremental pay progession policy to include requirement for appraisal before	Executive Direcor of HR	01/05/2016		31/05/2016
		35b	All staff to made aware of new Incremental Pay progression	Executive Direcor of HR	01/05/2016		31/05/2016
36	Ensure that the care provided to patients presenting with sepsis is evidence based and in line with national and local guidance and ensure that this is reviewed and audited regularly.	**36a**	Sepsis audit within routine audit plans.	ED Audit Lead	31/10/2016		
		36b	Review of processes in view of Sepsis CQuIN and introduction of clinical leads to implement best practice.	Medical Director	31/12/2016		
		36c	Audit Lead to be supported to review all outstanding Audit action plans and amend accordingly.	Director of Business Group, Associated Medical Director, ED Clinical Director & Business Manager	31/10/2016		
37	Consider monitoring all four harms outlined in the national safety thermometer for the emergency department.	**37a**	Review the use of the safety thermometer and monitor those areas directly relevant to emergency care.	ED Matron	31/10/2016		
38	Consider reviewing the number of defibrillators within the emergency department to assess whether additional equipment is required.	**38a**	Hospital Survivial Group to review feasibility of standardisation of defibrilaltors across the Trust and present feasability study to Quality Governance Committee	Hospital Survival Group	30/11/2016		

	Action area		Action required	Responsible person	Target date	Comments on progress	Date completed
39	Consider that essential resuscitation equipment is regularly checked and that these checks are recorded in the emergency department.	**39a**	Daily checks in place. To be spot audited by Matron & Head of Nursing.	ED Matron / Head of Nursing.	31/10/2016		
40	Consider that all appropriate risk assessments are completed for patients attending the emergency department.	**40a**	Work ongoing to utilise AdvantisED to mandate risk assessment documentation e.g. a patient cannot be fully triaged without having a pain score entered into AdvantisED.	ED Matron	15/09/2016		25/08/2016
41	Consider that there are adequate numbers of suitably qualified nursing staff on duty at all times in the emergency department.	**41a**	International Recruitment continues with an additional 60 registered nurses commencing from November 2016. As at end of August 2016 the vacancy rate in ED is less than 4%.	Head of Nursing	30/11/2016		
		41b	Additional registered nurses per shift to be agreed.	Head of Nursing	30/09/2016		12/09/2016
		41c	Ensure minimum safe staffing policy is adhered to.	Head of Nursing	30/09/2016		01/09/2016
		41d	The Trust is running next Health Care Assistant recruitment open day 24th September.	Head of Nursing	30/11/2016		
42	Consider that all patients receive nutrition and hydration while in the emergency department.	**42a**	The ED Nursing care indicators (12 & 13) include "There is documented evidence in the notes of regular diet and fluids if not NBM". Ongoing adherence monitored by Head of Nursing and ED Matron. (currently at 100%)	ED Matron	31/08/2016		31/08/2016
43	Consider that patients receive adequate pain relief within the emergency department if it is required.	**43a**	Regarding pain scores - patients now cannot be fully triaged without having a pain score entered into AdvantisED. Pain has to be re-assessed at commencement of Medical assessment.	ED Nurse Consultant	15/09/2016	Changes to AdvantisED made.	25/08/2016
44	Consider that deceased patients and their families are treated with compassion and dignity at all times in the emergency department.	**44a**	Nursing Care Indicators have improved - ED Care indicators show 100% compliance with regards to Dignity & Respect April to July 2016.	ED Matron	01/09/2016		31/07/2016
		44b	Dignity and Respect, Equality and Diversity training continues on an upward trajectory to then achieve minimum 85% compliance.	ED Matron / Business Manager	31/10/2016		
		44c	The bereavement room facilities and environment will be reviewed and imporvements made as required	ED Matron	31/10/2016		

	Action area		Action required	Responsible person	Target date	Comments on progress	Date completed
45	Consider that medical patients are not accommodated on the CDU or MAU unless there are exceptional circumstances.	**45a**	Procedure in place alongside risk assessment for management of capacity when additional beds required.	Head of Nursing	30/09/2016	Processes put in place by Chief Operating Officer following risk assessment written by Head of Nursing, shared on 31/05/2016 to all Senior Managers on call, all Executives on Call and all Nursing Site Managers. Managers are now using these documents in times of extremis to prioritise the needs of our patients and the needs of our services accordingly.	31/05/2016
46	Consider that patients waiting for inpatient beds in the emergency department are kept informed of any delays in their allocation of a bed.	**46a**	Reviewing nurse staffing and flows in the ED to ensure that ambulatory patients waiting for an in-patient bed have a named nurse responsible for their care - this will allow the Bed Managers and Shift Co-ordinators to be aware of bed allocation to in turn inform a patient's named nurse.	ED Matron	31/10/2016		
		46b	Nursing staffing levels are being increased within the ED to ensure there is sufficient staff to maintain safety in times of surge and ensure communication to patients and their families is prioritised.	Head of Nursing	30/09/2016		see action 5
47	Consider that there is clear nursing leadership within the emergency department and that the matron is able to undertake her management role effectively and unimpeded by the pressures of the department.	**47a**	A review of senior nursing support within the department with a proposal to introduce a Consultant Advanced Practitioner role as additional clinical nurse leadership.	ED Matron / Head of Nursing.	31/10/2016	Within the Medicine business group all the matrons have time allocated daily (8-10am) to be visible in their clinical areas. Nursing leadership with the Business group is aware of the need to protect Matron management time.	
		47b	A review of the role of the Nurse Co-ordinator and Shop Floor Lead to ensure clarity of roles and responsibilites in addition to consistency of approach across all practitioners.	ED Matron / Head of Nursing.	30/10/2016		

CQC Action Plan - Medical Care (including Older People's Care)

	Action area		Action required	Responsible person	Target date	Comments on progress	Date completed
The Hospital Must:							
48	Ensure the agreed establishment of qualified nurses are employed and deployed in the medical division.	**48a**	International Recruitment continues with an additional 60 registered nurses commencing from November 2016. As at end of August 2016 the vacancy rate in ED is less than 4%.	Medicine Matrons / Head of Nursing	30/11/2016		
		48b	Active recruitment days throughout the year, liaising with universitities to attract new graduate nurses.	Medicine Matrons / Head of Nursing	30/11/2016		
		48c	Review of exit questionnaires to ascertain themes and trends with a view to improve recruitment and retention.	Medicine Matrons / Head of Nursing	30/11/2016		
		48d	Daily equalising of staff and skill mix to maximise safety across the Trust.	Medicine Matrons / Head of Nursing	30/11/2016		
		48e	Monthly review of Business Group wide nursing staff to redistribute staff if necessary.	Medicine Matrons / Head of Nursing	30/11/2016		
49	Ensure patients are not transferred from ward to ward for non clinical reasons and out of hours.	**49a**	Monitoring of inappropriate transfers by incident reporting system.	All Governance Leads	01/09/2016		01/09/2016
		49b	Adherence to policy report to be undertaken with findings presented to Risk Management Committee for development of action plan.	Risk and Customer Services Team Manager	31/12/2016		
		49c	Trust wide bed reconfiguration ongoing which will allocate appropriate bed numbers to specialties with a view for more appropriate patient allocation, improved length of stay and timely discharge.	Director of Business Group / Chief Operating Officer	31/10/2016		
50	Ensure that patients are discharged to their appropriate place of care when medically fit to do so.	**50a**	Through the Stockport Together Intermediate Tier programme a new model of care is being implemented with a focus on Discharge to Assess (Home First), increased Packages of Care in the community, the implementation of an Integrated Discharge team across Health and Social care and the introduction of a Crisis response team to in-reach into the Trust to expedite discharge.	Director of Business Group / Head of Capacity and Flow	30/11/2016		
51	Ensure that records trollies are kept locked when unattended to ensure they are not accessible to the general public.	**51a**	Business Group to review budgets to consider funding lockable notes trolleys for all appropriate areas.	Head of Nursing / Director of Business Group	31/10/2016		

	Action area		Action required	Responsible person	Target date	Comments on progress	Date completed
The Hospital Should:							
52	Ensure that records trollies are kept locked when unattended to ensure they are not accessible to the general public.	**52a**	Business Group to review budgets to consider funding lockable notes trolleys for all appropriate areas.	Head of Nursing / Director of Business Group	31/10/2016		
53	Ensure hand hygiene rules are met by staff.	**53a**	Regular hand hygiene audits ongoing.	Ward Sisters / Charge Nurses / Infection Prevention	01/09/2016		01/09/2016
		53b	Senior Staff completing ad hoc Infection Prevention walk rounds.	Business Managers / Clinical Directors / Matrons	01/09/2016		01/09/2016
		53c	Ad hoc checking by senior staff at least four times per month.	Business Managers / Clinical Directors / Matrons	01/09/2016		01/09/2016
54	Ensure patients receive care on a designated medical ward wherever possible.	**54a**	Daily review of outliers completed by Patient Flow Team with proactive attempts to get patients to their best location.	Head of Capacity & Flow	01/09/2016		01/09/2016
		54b	The Medicine ward reconfiguration is designed to ensure the Cardiology reconfiguration meets demand.	Director of Business Group	31/10/2016		

CQC Action Plan - Maternity & Gynaecology

	Action area		Action required	Responsible person	Target date	Comments on progress	
The Hospital Must:							
55	Trust must ensure all staff are up to date with Adult Basic Life Support training.	**55a**	Improve compliance rate for all staff to 100% in regards to Basic Life Support training by ensuring all ward managers are supported in monitoring timely compliance of their staff.	All Line Managers	31/10/2016	Up to date compliance as of August 16 is 75% from a baseline at inspection of <60%	
		55b	Central monitoring all episodes of withdrawal from training due to ward/department pressures	Governance Lead	31/10/2016		
56	Trust must ensure there is a system in place to learn and share learning from incidents, both locally and across the wider Trust	**56a**	Develop a robust mechanism within the business group to ensure that there is a system in place to share learning from incidents. Including introduction of "7 minute briefing template".	Governance Lead	30/09/2016		09/09/2016
		56b	Development of Key Issues report to be submitted monthly to the business group Governance Board and cascaded down to wards and departments	Governance Lead	31/10/2016		
		56c	Ensure Monthly Trust Governance report which highlights lessons learned is shared with all wards and departments within business group	Governance Lead	30/09/2016		19/09/2016
57	Trust must ensure all steps of the Safer Surgery checklist are completed for all surgical procedures in the obstetric theatre.	**57a**	Re-audit of Maternity WHO Checklist to be completed	Governance and Audit Leads	31/10/2016		
		57b	Develop Maternity team specific guidance following audit with cascade training to ensure adherence to WHO principles	Anaesthetic Consultant	30/11/2016	Discussed at labour ward forum August	
58	The Trust must ensure a system is in place to monitor patient outcomes against set local or national targets.	**58a**	Re introduce the use of RCOG Dashboard to be presented at Governance Quality Board with exception reporting at the Trust Performance/Finance meetings	Head Of Midwifery (HOM)/Clinical Director (CD)/Director	31/10/2016		

	Action area		Action required	Responsible person	Target date	Comments on progress	
59	The Trust must ensure that all midwives are up to date with Skills Drills training	**59a**	Improve compliance rate for all staff to 95% in regards to Skills Drills training by ensuring all ward managers are supported in timely compliance of their staff. Central monitoring of staff being withdrawn from training due to unit activity.	All Line Managers	31/10/2016	Up to date compliance as of August 16 - 80% from a baseline at inspection of 74%	
		59b	Central monitoring all episodes of withdrawal from training due to ward/department pressures	Governance Lead	31/10/2016		
60	The Trust must ensure midwives assisting the anaesthetist in the obstetric theatre are trained in line with national guidance.	**60a**	Develop bespoke training package for midwives to complete and demonstrate competence in line with National Guidance	Governance Leads C & F /Surgery	01/12/2016	Discussed at labour ward forum August	
61	The Trust must ensure that there is a system for continuous monitoring of the quality of the service provided and make necessary improvements.	**61a**	Continued monitoring of feedback from patients via friends and family surveys, I pad Surveys and Complaints.	HOM/CD/Director	09/09/2016		
		61b	Monthly Trust Governance Report to highlight themes and trends in incidents, claims and complaints, external concerns and be presented to Quality Governance Committee and Business Group Quality Boards	Head of Risk and Customer Services/Governance Lead/BG Director	31/10/2016		
The Hospital Should:							
62	To ensure that there is assurance that all emergency equipment is in full working order at all times	**62a**	Review process for equipment cleaning and checking and develop new checklist	Labour Ward Lead	01/10/2016		
		62b	Recruit to midwifery assistant staffing vacancies.	HOM	01/10/2016		
63	Ensure input from the pharmacy department for the management of medicines on the maternity services	**63a**	Liaise with lead pharmacist to review current support and medicine administration processes.	Director of Business Group	30/09/2016		
64	Ensure there is a system in place to monitor improvements identified during audits	**64a**	Submit data to SCN and display reports when published	HOM	01/11/2016		
		64b	Continue to submit data to the maternity data set and display published reports	HOM	01/11/2016		
65	Ensure sufficient specialist midwifery cover to support patients with additional mental and physical health need is provided	**65a**	CQC action plan for 2014 has clear trajectory for this and this is being met	HOM/Director	as per CQC action plan 2014		

	Action area		Action required	Responsible person	Target date	Comments on progress	
66	Ensure times against national 2 week cancer referral to treatment targets are improved	**66a**	Additional colposcopy and hysteroscopy clinics were established June 2016.	Director of Business Group / Business Manager	30/06/2016		30/06/2016

CQC Action Plan - Community End of Life Care

	Action area		Action required	Responsible person	Target date	Comments on progress	Date completed
The Trust Must							
67	Review the lack of medical cover for out of hours and annual leave for the specialist palliative care team	**67a**	Complete Risk Assessment for the lack of Consultant Palliative Medicine	Consultant in Palliative Medicine and Macmillan Palliative Care Lead Nurse	31/10/2016		
		67b	Pursue an outcome following the Business Case submission for additional Consultant / Medical cover for the Specialist Palliative Care Team - awaiting decision, track progress of decision making.	Acting Director Community Business Group	01/12/2016		
68	Focus should be made on increasing the number of community staff that have attended the mandatory training programme in end of life care	**68a**	Identify named staff (individuals and groups) from the Electronic Staff Record / Trust Training Matrix that require this training	Community EOL Facilitator	31/10/2016		
		68b	At the next Education Governance meeting discuss the inclusion of this training on the Trust Training Matrix to facilitate monitoring of compliance	Learning and Development Manager	31/10/2016		
		68c	Update District Nurse Pathway Leads and Band 7 District Nurses, Clinical Leads regarding nursing staff's compliance with training. Agree trajectory to achieve compliance with trust target by 31.03.17	Community EOL Facilitator	31/10/2016		
69	Fully implement and utilise the Individual plan of care (IPOC) document and standardise this procedure for the end of life patient	**69a**	Following the successful completion of the initial training programme and roll out of the IPOC, agree and implement an on-going programme to support the roll out of the individual plan of care for all community teams and new staff	Macmillan Palliative Care Lead Nurse	31/10/2016		
		69b	Support embedding of individual plan of care into practice through continued regular audit and presentation of results to the Quality Governance Committee to provide assurance of both roll out and effective implementation	End of Life Care Project Facilitators	01/10/2016		
		69c	Continue to keep record of community based training completed around the individual plan of care and last days of life care with annual summary data reported in April 2017	Community EOL Facilitator	30/04/2017		
70	Review the infection control risks to staff in respect of the procedure for the return and replacement of syringe drivers, with particular focus on the out of hours services	**70a**	Review process of decontamination and infection control process related to syringe drivers in Stockport District Nursing Service	District Nursing Pathway Leads	01/11/2016		
		70b	Present case to business group to rectify any gaps observed and update on actions already completed following the review	District Nursing Pathway Leads	01/12/2016		
		70c	Amend syringe driver policy to include process for decontamination of syringe drivers in the community setting	Macmillan Nurse	01/11/2016		

	Action area		Action required	Responsible person	Target date	Comments on progress	Date completed
71	Specialist team managers should be involved in engaging community staff in the trust and addressing the issues highlighted in the staff survey	**71a**	Specialist team managers to meet with Palliative Care Respite team to identify ways of improving engagement on a short term and medium to long term basis	Head of Neighbourhood Services	01/12/2016		
		71b	Ensure staff engagement a key focus as part of Stockport Together (Neighbourhood / Borough wide new models of care)	Head of Neighbourhood Services	31/10/2016		
		71c	Discuss potential support to improve staff engagement with the Head of Organisational Development	Head of Neighbourhood Services	31/10/2016		

CQC Action Plan - End of Life Care

	Action area		Action required	Responsible person	Target date	Comments on progress	Date completed
The Hospital Must;							
72	Ensure that when audit results are sent to Business Groups for actions that these are consistently followed up: Issues with the completion of the DNACPR forms had been highlighted in audits yet the completion of these continued to be variable in quality	**72a**	Continue to share End of Life care audit results with Trust Quality Governance Committee six monthly and for current performance to be discussed at October Quality Governance Committee	Medical Director	31/10/2016		
		72b	Clinical Audit team to ensure process in place to monitor that Business Groups complete relevant Action Plans, escalating concerns to Clinical Audit Committee	Deputy Medical Director	30/10/2016		
73	Ensure that the actions in the audit that identified a risk in terms of lapsed syringe driver training is followed up and ensure all syringe driver training is up to date	**73a**	Re-audit syringe driver training records as some concerns that the current database detailing competent staff is inaccurate. Results from this audit will provide a steer for future action plan around training requirements	Clinical Skills Development Manager	31/10/2016		
		73b	Develop individual Business Group Action Plans to address gaps in Training Compliance following the Audit results, and to include trajectory to achieve compliance by 30/12/16	Business Group Heads of Nursing and Midwifery	30/10/2016		
74	The service should consider formally auditing the rate of compliance with achieving patients' preferred place of care	**74a**	Discuss and clarify how data could be captured with Intercom and accessing data from current electronic systems (EPAC and EMIS)	Cons. in Palliative Care, Lead Palliative Nurse	31/12/2016		
		74b	Agree targeted training programme for Community Advanced Nurse Practitioners (ANPs) regarding recognition of; decline, advance communication skills and EPAC, to support the process of ACP and PPC with appropriate patients /families.	Head of Borough wide	30/10/2016		
75	The service should consider setting some clear target dates by when all End of life care patients (EOLC) should be supported by an individualised plan of care and all staff required to have completed the EOLC training have done so	**75a**	Agree timeframe for expectation of 100% EOLC patients receiving an Individualised plan of care.	Lead Palliative Nurse	01/11/2016		
		75b	Support embedding of individual plan of care into practice through continued regular audit and presentation of results to the Quality Governance Committee, against to provide assurance of both roll out and effective implementation	End of Life Care Project Facilitators	01/10/2016		
		75c	Continue to keep record of ward training completed around the individual plan of care and last days of life care with annual summary data reported in April 2017	EOL Facilitator	30/04/2017		

	Action area		Action required	Responsible person	Target date	Comments on progress	Date completed
76	Ensure all risks affecting the provision of palliative and EOLC are identified on one service-led risk register. Some risks identified by the service, for example the level of EOLC consultant care, were not included on the risk register. This meant that potential risks may not be managed as effectively as they would if they were regularly reviewed	**76a**	In conjunction with the Trust Medical Director and Trust Risk Lead scope and review a Trust Wide Palliative and EOLC Risk Register with a view to understanding the Governance arrangements to support this	Community Head of Governance	30/11/2016		

CQC Action Plan - Community Health Services for Adults

	Action area		Action required	Responsible person	Target date	Comments on progress	Date completed
The Trust Must;							
77	The Trust should ensure the privacy and dignity of service users by stopping the sharing of treatment rooms at Hazel Grove - Podiatry.	**77a**	Review room usage at Hazel Grove to scope the use of a second consulting / treatment room for Podiatry	Podiatry Team Lead	15/10/2016		
78	Ensure the reception area used for mother and baby clinic at Hazel Grove Health Centre is screened off to maintain service users privacy and dignity	**78a**	Administrator at the clinic to check whether the folding room divider is working and if not report it to NHS Estates	Administration Manager	12/09/2016		12/09/2016
		78b	Administrators to be instructed to close the screen when the baby clinics are held	Administration Manager	12/09/2016		12/09/2016
		78c	Case made to Children and Families Business Group for the purchase of additional screens	Service Manager, Children and Families Business Group	15/10/2016		
79	*Ensure that patient consent to treatment is indicated on Diabetic Clinic notes, even if this is just implied consent*	***79a***	*This was applicable to the Diabetes service which transferred to Tameside Hospital NHS Foundation Trust (THFT)*	*Not Applicable*	*Not Applicable*		
80	Ensure that sufficient numbers of suitably qualified, competent, skilled and experienced staff in District Nursing services are deployed to make sure that they can meet people's care and treatment needs and keep them safe at all times. Staffing levels and skill mix must be reviewed continuously and adapted to respond to the changing needs and circumstances of people using the service.	**80a**	Pursue an outcome from the Community Nurse staffing levels review	Acting Director Community Business Group	15/10/2016		
		80b	In conjunction with NHS Professionals recruit to bank posts both internally within the Trust and externally	Integrated Locality Lead	31/10/2016		
		80c	Introduce electronic rostering for District Nursing Off Duty planning to aid 'visibility' from any location	Head of Clinical Leadership and Governance	31/12/2016		
		80d	Integrated Locality Leads agree and monitor key performance indicators with respect to off duty planning and workload allocation, ensuring the District Nursing Escalation Policy is adhered to and the NHS Professional staff are booked appropriately	Head of Neighbourhood Services and Head of Borough Wide Services	15/10/2016		
		80e	Understand how Stockport Together and Vanguard might be utilised to promote a positive image of health and social care integration and community nursing to support further recruitment to district nursing	District Nurse Pathway Lead	15/10/2016		
		80f	Scope development opportunities for staff to take on different duties and review band 5 development post programme	District Nurse Pathway Lead	31/10/2016		
		80g	Repeat the District Nursing Acuity / Workload Audit at least annually	Head of Clinical Leadership and Governance	31/12/2016		
The Trust Should;							
81	The trust should consider re-commissioning a dedicated lone worker safety system or device to maximise the safety of those staff working alone in the community and out-of-hours	**81a**	To scope options and benchmark against other organisations, presenting an options appraisal to the Community business group for consideration	Governance Lead	30/10/2016		
		81b	Depending on outcome of above review, present business case to organisation for consideration	Acting Director Community Business Group	31/12/2016		
82	*Consider that Diabetes Clinic Care Plans are clear and written on the appropriate care plan documentation.*	**82a**	*This was applicable to the Diabetes service which transferred to Tameside Hospital NHS Foundation Trust (THFT).*	*Not Applicable*	*Not Applicable*		

	Action area		Action required	Responsible person	Target date	Comments on progress	Date completed
83	Consider keeping copies of care plans at District Nursing bases, as well as in the patient's home, to enable better support, clinical supervision and monitoring of compliance	**83a**	Review national practice to inform feasibility of care plans being kept at District Nursing bases once the District Nursing Pathway Leads have considered the implications of introducing this new way of working	Head of Neighbourhood Services	30/10/16		
84	Consider reviewing the clinical competencies passport scheme to enable competencies gained in other trusts or services to be transferable to Community Health Services and to minimise any delays where further competency training is identified	**84a**	District Nursing Managers to work with new staff at Service level Induction to build up a profile of skills and competencies, in line with the Clinical Competency Passport, to understand how new staff can best be deployed within their Team	District Nursing Practice Educator	30/10/2016		
85	The management board was unaware that the introduction of a clinical competencies passport was not working as intended.	**85a**	Discuss Competency Passport with band 6 staff and their teams to understand the issues before a re launch is planned	District Nursing Practice Educator	15/10/2016		
86	Consider providing more information leaflets for patients in different languages to reflect the local community and providing clinicians working in the community with means of identifying the language spoken by patients to enable future communication via an interpreter.	**86a**	Community Healthcare Safety, Quality and Standard Group to ensure there is a process to ensure that every validation new and revised Business Group / Service Leaflets includes the standard Trust 'Interpretation' information that makes it clear that leaflets can be interpreted.	Governance Lead	15/10/2016		
		86b	Make Language Identification Posters / Leaflets available in every service as part of the Language Line roll out.	Trust Equality and Diversity Lead	30/11/16		
87	Enable better analysis of sickness absence by correctly recording reasons for sickness absence and avoid recording "no reason given".	**87a**	Monitor the recording of sickness absence now that Line Managers have been instructed to obtain the reason for individual's sickness absence so that this can accurately recorded on SMART and on the Business Group's Sickness Absence Tracker.	Business Group HR Manager	30/08/16		30/08/2016
88	Look for ways to reduce the level of sickness absence due to stress-related reasons, especially amongst Band 5 staff in the Communities business group	**88a**	Introduce as standard practice exit interviews with District Nursing Service leavers to capture staff's experience of working in the service and the reason for leaving	Head of Neighbourhood Services	15/10/2016		
		88b	Increase level of informal visibility from Senior management team to enable; proactive communication exchange, supportive 1-1 dialogues to understand issues and how staff are feeling, with agreed feedback mechanisms and timeframes	Acting Director of Community Healthcare Business Group	15/10/2016		
		88c	To hold engagement sessions (immediate and additional at regular intervals over the year) with staff at Band 5 and below, supported by Organisational development, to 'listen' to concerns and agree actions	Head of Clinical Leadership and Governance	27/10/2016		
89	The Trust should ensure that staff in the Communities Business Group are receiving a 12-monthly appraisal	**89a**	Continue to ensure the Community Healthcare Business Group Recovery Plan is implemented to achieve 95% compliance as reported in the September Executive Review Report	Acting Director of Community Healthcare Business Group	15/10/2016		
		89b	Ensure Line Managers are monitoring monthly those staff whose appraisals are due in the forthcoming 3 months and that appraisal are booked in sufficient time to avoid staff becoming non-compliant..	Acting Director of Community Healthcare Business Group	15/10/2016		
		89c	Business Group to continue to monitor monthly at Operational meeting Services' compliance with appraisal and target support where services are at risk of falling below the 95% target	Acting Director of Community Healthcare Business Group	15/10/2016		

CQC Action Plan - Children & Young People

	Action area		Action required	Responsible person	Target date	Comments on progress	Date completed
The Hospital Must:							
90	The Trust must ensure there is a senior staff member on each shift on the Paediatric Unit.	**90a**	Monitor and ensure safe staffing levels in the Paediatric Wards and Neonatal Unit which meet national standards.	Ward Managers/ Matron for Paediatrics	31/10/2016		
		90b	Ensure robust system in place to identify senior lead/coordinator on every shift.	Ward Managers/ Matron for Paediatrics	31/10/2016		
		90c	Ensure robust rostering in place to ensure skill mix reflects service needs.	Ward Managers/ Matron for Paediatrics	31/10/2016		
		90d	Robust appraisal and monitoring of sickness and absence.	Ward Managers/ Matron for Paediatrics	31/10/2016		
		90e	Ensure strict adherence to Recruitment and Selection policies.	Ward Managers/ Matron for Paediatrics	31/10/2016		
		90f	Liaise with Finance to cost up extra band 6 to provide 24 hour cover.	Ward Managers/ Matron for Paediatrics	31/10/2016		
91	The Trust must ensure there is a staff member that is HDU trained on each shift.	**91a**	On call Paediatric Consultants and Registrars with APLS training to be resident.	Clinical Director Ward Manager Matron ANP	31/12/2016		
		91b	Ensure there is a robust system for ensuring that there is a nurse with HDU/PLS training on every shift.	Clinical Director Ward Manager Matron ANP	31/12/2016		
		91c	ANP/Consultant led teaching scenario's to be held on the Paediatric Ward.	Clinical Director Ward Manager Matron ANP	31/12/2016		
		91d	Nurses to attend PLS training every 4 years, and IV training /updates annually.	Clinical Director Ward Manager Matron ANP	31/12/2016		
		91e	100% staff have annual appraisal to identify learning and development.	Clinical Director Ward Manager Matron ANP	31/12/2016		
		91f	Increase the number of nurses attending HDU and APLS training.	Clinical Director Ward Manager Matron ANP	31/12/2016		
		91g	Work towards all experienced nurses having HDU competencies to work in HDU without close supervision.	Clinical Director Ward Manager Matron ANP	31/12/2016		
		91h	Nurses invited to attend Quarterly Critical Care Reviews with the medical staff.	Clinical Director Ward Manager Matron ANP	31/12/2016		
		91i	Monitoring of ongoing attendance at external training due to limited availability	Clinical Director Ward Manager Matron ANP	31/12/2016		

	Action area		Action required	Responsible person	Target date	Comments on progress	Date completed
92	The Trust must ensure the door exit systems on the Paediatric and Neonatal Unit are secure.	**92a**	Estates contacted to review the current system and recommend more secure system.	Estates Matron Ward manager	01/11/2016	A new door/entry has been approved for the NNU.	
		92b	Raise awareness of the potential risk and introduce a more robust way of monitoring who is exiting and entering the building.	Estates Matron Ward manager	01/11/2016		
		92c	Review current staffing and supervision of the entrance/exit.	Estates Matron Ward manager	01/11/2016		
		92d	Liaison with Voluntary services to look at possible cover for the units.	Estates Matron Ward manager	01/11/2016		
93	The Trust must ensure staff members medications are securely stored and do not include the Trust generic medication.	**93a**	Ensure that staff member's medications are securely stored away from the generic patient medication.	Ward Managers/ Matron for Paediatrics	30/07/2016		30/07/2016
		93b	Identify suitable storage on the ward for staff medication.	Ward Managers/ Matron for Paediatrics	30/07/2016		30/07/2016
		93c	Ensure all staff know where to store medication.	Ward Managers/ Matron for Paediatrics	30/07/2016		30/07/2016
		93d	Ensure the policy is complied with by carrying out spot checks.	Ward Managers/ Matron for Paediatrics	30/07/2016		30/07/2016
94	The Trust must ensure that fridge temperatures are regularly checked, documented and acted upon in accordance with the Trust's policy ad procedures.	**94a**	Ensure fridge temperatures are checked, documented daily.	Ward Managers/ Matron for Paediatrics	30/07/2016		30/07/2016
		94b	Staff to be familiar with Trust Policy and their duty around storage of medicine.	Ward Managers/ Matron for Paediatrics	30/07/2016		30/07/2016
		94c	Drug fridges to comply with standards for storing medications.	Ward Managers/ Matron for Paediatrics	30/07/2016		30/07/2016
		94d	Members of staff nominated to carry out daily checks.	Ward Managers/ Matron for Paediatrics	30/07/2016		30/07/2016
		94e	Spot checks to be carried out. Monitor compliance with Trust policy.	Ward Managers/ Matron for Paediatrics	30/07/2016		30/07/2016
95	The Trust must ensure all staff working with children and young people have level three safeguarding training. .	**95a**	Ensure all staff working with children and young people have achieved level 3 safeguarding training/updates. .	Ward Managers/ Matron for Paediatrics	30/09/2016	The percentage receiving level 3 training has increased to 90+%	
		95b	Liaise with safeguarding team to ensure teams are meeting their required level of training.	Ward Managers/ Matron for Paediatrics			
		95c	100% compliance with appraisals/identify training needs	Ward Managers/ Matron for Paediatrics			

CQC Action Plan - Diagnostics

	Action area		Action required	Responsible person	Target date	Comments on progress	Date completed
The Hospital Should:							
96	Ensure that number of overdue outpatient follow-up appointments, particularly in gastroenterology, are reduced	**96a**	1. 100 Day – Rapid access IBD pathway now in place to ensure referrals are streamlined into the correct clinics. Once fully operational this will reduce the number of FU appointments needed and create capacity to see more overdue patients.	Business Manager	01/07/2016	Daily monitoring of various cohorted lists to make sure appropriate next steps are logged and patients prioritised in order of need.	01/07/2016
		96b	All overdue FU appointments have been validated by the clinical nurse specialist (CNS) teams. Any urgent patients identified and all patients now have a cohort. We are now looking at pathways to bring the various cohorts into differing streams a. Some will come in for consultant FU b. Some will be given a telephone FU but have access to urgent advice a CNS clinics c. Some will be reviewed in a virtual clinic environment, with Consultant, CNS, pharmacy and Dietician present	(Business ManagerClinical Director)	31/03/2017		
		96c	Ongoing work with Stockport CCG to reduce OWL by collaborative working with the GPs and secondary care to ensure the care if offered at the right place at the right time by the right clinician. More meetings are being scheduled with the CCG and Consultant teams to take this work forward.	Clinical Director	31/12/2016		
		96d	Undertake review and explore possibility to secure resources for a 'Liver' CNS to undertake additional clinics following pathway work by the liver team.	Matron Medicine	31/12/2016		
		96e	Review capacity and approach clinicians to work additional sessions to reduce our outpatient waiting lists.	Business Manager	31/03/2017		
97	Ensure that floor area in outpatients B can be cleaned in line with HBN00-09 guidance for Infection Control in the Built Environment	**97a**	Remove all carpet within OPD B areas and replace with acceptable flooring	Clinical Service Lead for OPD, DCS (with IP and Estates)	31/12/2016		
		97b	review of state of flooring underneath carpeted areas- arranging meeting/discussion with IP and Estates	Clinical Service Lead for OPD, DCS (with IP and Estates)	31/10/2016		
		97c	Estates contacting flooring contractor to survey and provide quotes	Estates	30/11/2016		
98	Ensure the staff groups requiring level three children's safeguarding training in the Safeguarding Children Training and Competency Strategy is reviewed	**98a**	To identify the staff that require level 3 training in the area and ensure staff are then appropriately trained	Clinical Service Lead for OPD, DCS (with Safeguarding Children Lead)	31/10/2016		
99	Ensure the provision of sufficient car parking for patients at the Stepping Hill site is considered	**99a**	A new Car Parking strategy was launched August 2016. The strategy is designed to release more parking spaces for patients and visitors	Trust Resilience Manager, Estates	01/09/2016	Completed	31/08/2016
100	Ensure patient feedback about changes made to outpatient services as a result of complaints is considered	**100a**	To introduce Friends and Family - 'You said We did' posters in OPD areas.	Clinical Service Lead for OPD,	30/10/2016	Posters to be displayed in OPD areas	
		100b	To include a regualr agenda item on monhtly staff engagements across OPD areas	Clinical Service Lead for OPD,	01/09/2016	Included as regular agenda item on monthly 'staff engagement' across OPD areas.	01/09/2016
101	Ensure participation in the Imaging Services Accreditation Scheme (ISAS)	**101a**	Full scoping exercise needed prior to Business case - funding required to apply for scheme, additional funding required as F/T project manager at minimum Band 6 in addition to Clinician participation - minimum 1 PA per week needed to fullfil criteria.	*Clinical Service Lead for Radiology, DCS*	31/10/2016	Scoping exercise commenced	

CQC Action Plan - Critical Care

	Action area		Action required	Responsible person	Target date	Comments on progress	Date Completed
The Hospital Must:							
102	Ensure that the practice of pre-filling syringes with intravenous medicines and then storing them in the fridge is not continued. For any scenario where a clinical decision results in this practice being reconsidered, then a detailed risk assessment should be undertaken, which should include the involvement of the critical care pharmacist	**102a**	Inform all clinicians the practice must stop and spot check fridge for compliance.	Matron - Theatres	26/09/2016		26/09/2016
		102b	Actions monitored via Business Group Quality Governance Board	Business Group Quality Board	31/12/16		
The Hospital Should:							
103	Ensure that all staff receive training on the principles of Duty of Candour.	**103a**	Cascade training for staff via Matron/Governance Facilitator	Matron/Gov. Facilitator	31/12/2016		
104	Ensure that work continues to improve the access and flow in the department and improvements are made to the issue of delayed discharges	**104a**	Work-streams to improve the patient journey continue with rigorous monitoring in place and key performance indicators agreed	Acting Chied Operating Officer	30/11/2016		
105	Ensure that nutritional supplements are not stored in the visitors kitchen	**105a**	Cease storage of Nutritional Supplements in visitors kitchen	Matron	26/09/2016		26/09/2016
106	Consider how it is going to meet the requirements of the latest health building notes guidance in any future expansion of the critical care service.	**106a**	All points of the HBN to be reviewed and taken into account under any future expansion	Clinical Director - Anaesthetics / Director, S&CC	N/A		

CQC Action Plan - Surgery

	Action area		Action required	Responsible person	Target date	Comments on progress	Date Completed
The Hospital Should:							
107	Ensure the standardisation of defibrillators across the trust to comply with Resuscitation UK guidelines	**107a**	Hospital Survivial Group to review feasibility of standardisation of defibrilaltors across the Trust and present feasability study to Quality Governance Committee	Hospital Survival Group	30/11/2016		
108	Ensure the procedures for checking of resuscitation equipment and whether this is a daily of monthly check to ensure consistency between wards	**108a**	Checks to be made daily; spot checks for compliance. Actions will be monitored via Business Group Quality Governance Board	Matrons/Head of Nursing	26/09/2016		01/09/2016
109	Ensure that all resuscitation trolleys are sealed at all times when not in use. They should also ensure that when they are checked and re-sealed the relevant unique reference number recorded for safety and audit purposes.	**109a**	Additional medication removed from Recovery area arrest trolley. Emergency drug boxes stored (sealed) on shelf alongside arrest trolley (as agreed with pharmacy). overview to be monitored by theatres recovery coordinator.	Matron	30/09/2016		01/09/2016
		109b	Arrest trolley checks completed to be added to daily theatre checks;	Matron/Head of Nursing	30/09/2016		
		109c	The recovery defibrilator trolley did not have the ability to be sealed, this is currently being modified to comply with the yellow standard seal	Matron/Head of Nursing	30/09/2016		
110	Ensure that there is compliance with the medicines administration policy concerning the recording of wastage of controlled drugs that have not been used	**110a**	Medicines management presentation on this issue to be undertaken at Audit afternoon in Oct 16.	Matron/Head of Nursing	30/10/2016		
		110b	Re-iteration of correct procedure at senior staff meetings (band 6 and 7) throughout Sept and Oct.	Matron/Head of Nursing	30/10/2016		
		110c	Medicine management group to be commenced which will lead audit and implement actions in responce to audit results - to be led by A+R band 7.	Matron/Head of Nursing	30/11/2016		
		110d	Current snap shot audit undertaken shows compliance with practice but poor compliance with documentation of "wasting".	Matrons/Head of Nursing	01/09/2016		01/09/2016
		110e	Audits and actions will be directly reviewed by Theatre Matron.	Theatre Matron	30/11/2016		
		110f	Actions will be monitored via Business Group Quality Governance Board	S&CC Governance Board	31/12/2016		
111	Ensure that the policy regarding storage of IV medicines which are not in a recognised medicines cabinet, to ensure this complies with RPSGB	**111**	This is a Trust issue which has been discussed at Medicines Management Committee on a number of occasions. The Committee is happy to approve this deviation from the standard in the Safe and Secure handling of medicine recommendation because the drugs were being stored in a locked room AND there is CCTV in those rooms for additional security	Medicines Management Committee	30/09/2016	Discussed with Pharmacy regarding response	02/09/2016

	Action area		Action required	Responsible person	Target date	Comments on progress	Date Completed
112	Ensure the polices and procedures concerning PGD and ensure staff awareness in light of new electronic prescribing practice	**112**	Matron to contact all ward managers to ensure they create and hold an up to date PGD user list.	Matrons/Head of Nursing	31/10/2016		
113	Ensure their patient records are stored securely and cannot be accessed by non designated persons	**113a**	Business Group explore feasibility of purchasing lockable trolleys.	Governance Lead/HON	31/10/2016		
		113b	Communcation sent to all areas reminding all staff that records should be kept in staff areas only; if the staff area is unmanned the doors to these areas should be closed. Where this is not possible, notes trolley should be observed to prevent any unauthorised access or locked	Governance Lead/HON	31/10/2016		
114	Ensure steps to improve compliance with mandatory training and improve recording and accuracy of compliance are taken	**114a**	Work force report to be disseminated to Matron for Critical Care, Matron to have focussed management to reach and maintain target	Matron	30/11/2016		
115	Ensure compliance with staff annual appraisal targets are achieved	**115a**	New Incremental pay progession policy to include requirement for appraisal before increment to be launched	Executive Direcor of HR	01/05/2016		31/05/2016
		115b	All staff to made aware of new Incremental Pay progression	Executive Direcor of HR	01/05/2016		31/05/2016

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Stockport NHS
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	29th September 2016
Subject:	Safe Staffing		
Report of:	Director of N&M	**Prepared by:**	Deputy Director of N&M

REPORT FOR APPROVAL

Corporate objective ref: -----	**Summary of Report** Following the publication of the Francis report there was a requirement for a Nursing and Midwifery staffing review to be presented to the Board every 6 months. Recent amendments to the National Quality Board recommendations (June 2016) now require at least an annual strategic staffing review, with a comprehensive follow up review 6 months later. Review should also take place after any service change or where quality concerns are identified. This report represents the Strategic staffing review of Nurse and Midwifery staffing levels across the Organisation. The Organisation implemented improvements to both Nurse staffing levels and shift patterns in September 2015. Following this, two further audits of Nurse and Midwifery staffing levels have taken place for in-patient areas. The results provide assurance that safe staffing establishments are in place across in-patient areas with some areas requiring ongoing monitoring. Community Nursing establishments changes continue to be discussed with Commissioners with the aim of a further increase to Band 5 Community staff nurse levels. The Board of Directors is asked to note the contents of the report and to note the significant improvements in staffing levels and changes to shift patterns that have been introduced over the last 12 months.
Board Assurance Framework ref: -----	
CQC Registration Standards ref: -----	
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 ☐ 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 National Quality Board (NQB) recommendations require that all NHS organisations will take an annual strategic staffing review to their Board of Directors on the nurse and midwifery staffing levels within their organisation and confirm whether they are adequate to meet the acuity and dependency of their patient population. This is then followed by a further comprehensive review after 6 months. This report presents the Strategic staffing review for 2016.

2. BACKGROUND

2.1 There is a greater focus now on ensuring that organisations have the right size and shape of nursing and midwifery workforce to meet the needs and expectations of their patients. Evidence which wasn't always available can now directly attribute failings in care and increased mortality rates to poorly staffed wards. It is not however just about numbers of staff, delivery of safe dignified care is also underpinned by; strong, empowered leadership, resources directed at supporting the ward leaders and development and use of clinical and patient experience metrics.

The updated National Quality Board recommendations (June 2016) now suggest that establishment reviews are underpinned by the following 3 expectations;

- Expectation 1; Right staff – achieved through evidence based workforce planning, professional judgment and comparison of staffing with peers
- Expectation 2; Right skills – achieved through mandatory training, development and education, working as a multi professional team and through effective recruitment and retention
- Expectation 3; Right place and time – achieved through productive working time and eliminating waste, through efficient deployment and flexibility and minimizing agency

This report will subsequently provide assurance against these 3 expectations.

3. CURRENT SITUATION

3.1 Expectation 1: Right Staff

The NQB recommends that there is an annual strategic staffing review, with evidence that is developed using a triangulated approach (accredited tools, professional judgment and a comparison with peers). This should be followed with a comprehensive staffing report to the board after 6 months. The NQB recommends use of the Safer Nursing Care Tool (SNCT) (adult inpatient wards) and Birth-rate plus (Maternity) and Professional judgement. This organisation has used these tools for several years.

This report presents the Annual strategic staffing review but noting that national peer comparison remains under development whilst Care hours per patient day (CHPPD) is reviewed.

3.2 **Our approach to assuring safe staffing levels on our adult wards and within the Emergency Department (ED)**

i. The NQB recommends assessment incorporating evidence based tools and also; staff to patient ratios (CHPPD/NHPPD), Patient to staff ratios, skill mix, Whole time equivalents (WTE), Head count and fill rates. All these measurements are currently used by the organisation

ii. The Safer Nursing care Tool (SNCT) is deployed as the evidence based tool. It is recommended that changes to establishments are made based on a minimum of two sets of data across the calendar year. This organisation reviews 3 episodes of data collection. The current period runs from February 2016 to February 2017. Should a significant deficit be observed then action would be taken – such results are discussed further on in this report

iii. Determining skill mix was traditionally recommended as 65:35 RN:HCA. More recently, NICE guidance advocates implementation of acuity based tool recommendations in conjunction with RN to patient ratios

iv. The Emergency Department has now undertaken two acuity reviews using the Baseline emergency services tool (BEST) evidence base in 2015. The outputs of this have been reviewed. The Emergency Department has also now concluded the consultation to make changes to shift patterns to meet European Working Time Regulations and health & Safety Executive guidance. The changes have also transferred some temporary posts into substantive posts. Further discussion on ED staffing is contained in section 3.4

3.3 **Triangulation of Quality metrics and staffing outputs**

All wards are subject to a triangulation of data with each 6 monthly acuity review, including;

i. Red flag reporting – red flag events are used to report an issue which staff feel is due to reduced staffing levels and/or increased patient acuity and covers delays in administering pain relief to a reduction of staffing greater than 25%. During the period of this report (February to July 2016) a total of 110 incidents were reported (an increase from 61 for the previous 6 months). B5, AMU2 and A10 reported incidents on between 5 and 17 occasions, issues relating to staffing levels. All remaining areas reported isolated incidents. The increase is likely due to increased awareness of red flag events through leaflets distributed to clinical areas. No specific themes were reported.

ii. Safe staffing figures for the 6 month period since February 2016 show an overall fill rate of over 90.7% against both RN and HCA day and night shifts, against funded establishments which is in line with Greater Manchester performance

iii. Nurse sensitive indicators – nationally evidenced indicators which deteriorate in the absence of Registered nurse presence. These include falls, pressure ulcers and medication errors, measured per 1000 bed days. For this period, the top 5 locations are as follows;

Table 1; Harm data per 1000 bed days for period February 2016-July2016

	Pressure Ulcers	Falls	Medication Errors
Top 5 areas	MAU	D5	D5
	ICU	MAU	ICU
	AMU 1	A10	C2
	AMU 2	B5	AMU2
	M4	A11	B6

Of concern is the number of Falls reported for A10 and A11 as this coincides with concerns regarding staffing levels reported within section 3.4.

ICU has been subject to focussed action and harm rates are decreasing.

iv. Patient experience

The NICE in-patient guidance recommended that acuity results also be triangulated against 7 specific questions from the national in-patient survey. Table 2 provides the most recent results with previous year's results also shown. No specific concerns are drawn from this data

Table 2; National in-patient surgery Staffing related Questions

Survey Question	**Number of respondents**	**This trust score 2015**	**Compared With other Trusts**	**Change from 2014 this Trust** No statistical significant change	**2014 score this Trust**
Q23. Did you get enough help from staff to eat your meals?	151	7.5 / 10	About the same	No change	7.1
Q27. When you had important questions to ask a nurse, did you get answers that you could understand?	492	8.3 / 10	About the same	No change	8.3
Q30. In your opinion, were there enough nurses on duty to care for you in hospital?	563	7.7 / 10	About the same	No change	7.6
Q36. Did you find someone on the hospital staff to talk to about your	330	6.0 / 10	About the same	No change	5.6

worries and fears?					
Q37. Do you feel you got enough emotional support from hospital staff during your stay?	345	7.2 / 10	About the same	No change	7.2
Q41. Do you think the hospital staff did everything they could to help control your pain?	324	8.0 / 10	About the same	No change	8.0
Q42. After you used the call button, how long did it usually take before you got help?	271	6.7 / 10	About the same	No change	6.6

3.4 **Safer Nursing Care Tool (SNCT)Outputs July 2016**

Medicine

- **i.** Wards A10 and A11 continue to report staffing levels that do not meet the levels suggested by the SNCT. Ward A10 also features in the top 5 location for falls, however, there are other factors to be considered including the specialty of the ward (rehabilitation) and layout. Both wards continue to perform well against the Nursing and Midwifery dashboard. Local actions have been agreed to monitor these wards
- **ii.** Wards AMU 1 and 2 continue to show a difference between staffing requirements – this will be re viewed once AMU 1 and 2 merge in the opening of the new 'block' in October 2016
- **iii.** B2 and CCU continue to report staffing levels over suggested levels however, B2 is a stroke unit with nationally required staffing levels and Coronary care unit operates on 2 RNs per shift and so further reductions are not feasible. Changes are planned in line with the Cardiology review in October 2016
- **iv.** E3 continues to report a larger deficit between funded establishment levels and those recommended by the SNCT. This has maintained for the last two years. A review of Quality metrics provides assurance with respect to patient care. The business group has been asked to monitor staff attrition rates and sickness levels and for the leadership team to also be commended. E3 will need continued close monitoring and may require increased establishments in the future
- **v.** The Emergency department was highlighted in the CQC report due to Registered Nursing numbers per shift regularly falling to below established levels and compounded by ongoing increased demand in the department. To mitigate this, the establishment has temporarily been increased with support from temporary staffing (by way of fixed lines of work to ensure continuity). Additional workforce models are also under discussion to further strengthen both Nursing leadership in the department and provide additional resilience to workforce recruitment challenges

3.5 **Surgery and Critical care**

i. Surgery and Critical care report outputs in line with those received in 2014/15 and any other changes likely reflective of seasonal changes (trauma and orthopaedics)
ii. There are no areas of concern to report

3.6 **Our approach to achieving safe midwifery levels**

i. The workforce requirements for the maternity unit have been calculated using the national Birth-rate Plus tool and professional judgement
ii. Birth-rate Plus is based upon the principle of providing one to one care during labour and delivery to all women, with additional hours being identified for more complex deliveries
iii. The Birth-rate Plus overall recommended ratio is 1:29.5. Our funded Midwife to Birth ratio is agreed at 1:30, taking into account the role of the Assistant Practitioners in our workforce. For the period of reporting, the Midwife to Birth ratio was 1:29.99, **an improvement from the previously reported 1:29.40**
iv. NICE maternity guidance published in 2015 has been reviewed and our Maternity service is compliant against the various parameters set
v. In the same way as for adult in-patient wards, Maternity services are recommended to triangulate staffing data as follows;
    - Red flag staffing events – 23 flag events were reported by Delivery suite and Birth centre and related to staff not being able to take breaks. These will be reviewed by the Head of Midwifery
    - Safe staffing – fill rates for the period report achievement of above 95%

3.7 **Our approach to achieving safe community nursing levels**

i. The September 2015 and February 2016 Board staffing reports highlighted the review of Greater Manchester (GM) district nursing services that was commissioned by NHS England North on behalf of the twelve Clinical Commissioning Groups (CCGs) in partnership with eight community providers, including this organisation. The review was led by Keith Hurst, Independent Researcher, who has been instrumental in developing tools to measure staffing levels on acute wards. It looked at patient dependency/acuity, staff activity, workload, and quality and establishment data.
ii. This acuity reviews had been undertaken during May/June 2015, and again in autumn 2015, to ensure access to two sets of results (in the same way as for adult inpatient areas) to then inform subsequent proposals
iii. A review of Stockport community nursing also revealed that no uplift was built into the establishment and work has been continuing with the CCG to establish staffing to cover this increased level.

3.8 **Community Acuity Review Outputs**

In total, the reviews highlighted deficits across the Community Nursing budgets. However, ongoing changes in both skill mix and staffing models due to the Stockport Together Vanguard need to be acknowledged with the additional investment that this has secured. Nonetheless, discussions with the CCG agreed that the band 5

community staff nurse deficit needed funding in totality. This is in recognition that the community staff nurse and district nursing role will need an increase in numbers with changing care models. An overall increase of 12.83 B5 wte was requested. To date, this has been partially secured with 5.3 posts remaining to be funded. This is subject to ongoing discussions with preliminary expectations that posts can be secured from October 2016.

3.9 **Our approach to achieving safe and effective Paediatric and Neonatal staffing levels**

Neonatal Unit ward staffing

The DOH Neonatal (NN) Toolkit (2012) and BAPM (2011) staffing levels guidance suggests nursing requirements at the following ratios:-
NICU (neonatal) – 1:1
HDU – 2:1
SCBU (special care babies) – 4:1

Using our current average activity this would suggest a workforce between 30-34 WTE qualified nursing staff (this includes 25% uplift and a shift leader on every shift).

i. Current nurse staffing levels are showing a total of 28.94 WTE Qualified nursing workforce
ii. Each shift needs to have at least 2 nurses qualified in speciality (QIS) on every shift; this is usually at least one Band 6 or 7 and a Band 5 nurse who has completed a specialist training course. The Band 4 workforce is Assistant practitioners and can only work in the SCBU area under the supervision of a registered nurse.
iii. The CQC inspection highlighted the lack of 24/7 supernumerary shift coordinator on duty – this is BAPM guidance and the Business group is currently reviewing the provision of this cover in light of the report. This is in the CQC Action Plan.

3.10 **Paediatric Ward staffing establishment**

Guidance around staffing a paediatric ward is less robust with no statutory guidance to date. The Treehouse Children's unit consists of the following areas:-

- 8 Observation and Assessment beds (Open 10.00 – 22.00)
- 4 Day case surgical beds (Open daily around surgical activity)
- 10 Surgical in-patient beds (including 2 side rooms)
- 12 Medical in-patient beds
- 10 Medical in-patient side rooms
- 2 bedded High Dependency Unit

The RCN document "Defining staffing levels for children and young people's services" is often used as a benchmark and this was updated in 2013 but a survey of our peer Trusts showed that against most of the guidance there was no unit that was fully compliant. The headlines from this document are as follows and we are compliant against all:-

- Supernumerary shift supervisor on all shifts
- At least one RN on every shift be APLS trained

- Minimum staffing ratio of 70:30 Registered: Unregistered
- Minimum of 2 qualified RN (Child) in every setting where children are in patients or day cases
- Nurses working with children should be trained children's nurses.
- Support workers should have additional training in working with Children and Young People
- Additionally there should be at least 1 play specialist, but ideally one per day shift 7 days per week
- There is also the expectation within a DGH of a senior Children's nurse in a minimum of a band 8(a) position to advise the organisation and the nursing team in relation to nursing sick children

The CQC report highlighted two areas of concern for paediatric nurse staffing:-

1. The lack of 24 hour senior nursing staff as we currently cover the night shift with Band 6 staff
2. The need to ensure that we have APLS/HDU trained nurses on duty 24/7 in order to staff the HDU unit with appropriately skilled nurses

The senior nursing team have developed an action plan to address both of these areas of concern and will present this to the Director of Nursing in September.

3.11 **Expectation 2 – Right skills**

The NQB states that clinical leaders should be supported at a local level to deliver high quality, efficient services with a staffing resource that reflects a multi professional team approach. Specifically, the following is recommended;

- Establishments should take into account the need for staff to undertake training and fulfil all professional development requirements. Leaders should also have supervisory time allocated
- Organisations should commit to investing in new roles and skill mix
- That effective recruitment and retention strategies are in place

All in-patient wards and large departments (ED, ITU, and Theatres) have a minimum of 0.60 wte supervisory status for the Senior Sister/Charge Nurse.

3.12 **Expectation 3 – Right place and time**

The NQB recommends that in addition to the delivery of high quality care, Boards should ensure improvements in productivity. This will include effective management and rostering of staff, with clear escalation policies if concerns arise.

3.13 **Our approach to ensuring effective deployment of staff**

3.14 **Effective recruitment** – at present, the number of substantive vacancies has again reduced significantly with Medicine reporting circa 12WTE from a figure of 90WTE+ in September 2014 and Surgery reporting single figures (excluding theatres). Local recruitment remains a challenge, and commissioning increases in student nurse training places will not yield an outcome for 3 years. It is likely that further

international recruitment will be required in 2017/18 to maintain progress made to date.

3.15 **Rotational posts** – the organisation will run a rotational post for newly qualified registered Nurses (Medicine, Surgery and Community). This has already been recruited to and starts in September 2016 with 6 WTE confirmed

3.16 **Effective rostering** – the organisation utilises 'Health Roster' for nursing and midwifery staff. The diagnostic review referenced in the September 2015 report has been completed. The outputs support an effective rostering compliance, supported by a robust monthly key performance management framework. Additional amendments have been made and the rostering policy updated to reflect national best practice.

3.17 **Reducing the use of agency staff** – the organisation is working in partnership with four neighbouring acute providers. The % reliance on agency registered nursing staff continues to reduce, with July figures reported at 3.3% against a 2015/16 figure of 4.7%

3.18 **International recruitment** is expected to be required during 2017 to maintain the progress made and to off-set the annual deficit between current attrition rates (which are not an outlier) and the numbers of newly qualified staff available each year

3.19 **Care contact audits** (which record the % of value added and non-value added care delivery by banding and skill) have been repeated. Ensuring we have the right staff, with the right skills, in the right place is paramount if we are to support a high standard of care with quality and experience at the core. This is supported by Carter (2015) who emphasised within his report the importance of increasing productivity by reducing staffs non-productive time.

Therefore, to assist in the trust's safer staffing work, in February and March 2016 a group of wards participated in the second care contact audit over a 24 hour period. The aim of this audit was to identify what activities were undertaken by ward staff, what was indirect and direct nursing care, and what could be considered value and non-value adding time.

It is important to note due to the audit being undertaken over a 24 hour period only, this would provide a 'snapshot' of direct and indirect care delivered, and is not truly indicative of general ward activity as a whole.

Results showed that non-patient facing activities accounted for only an average of 7.8% of Registered Nursing time and 7.4% for HCAs – non-patient facing activities include; student support, breaks, stock ordering, searching for item, training and off ward with a patient. This supports a view that current processes maximise the skills and abilities of the Nursing workforce. Notwithstanding this, there were areas highlighted which are being reviewed as follows;

- On all wards meals / refreshments were given out by non-qualified staff only – it is imperative to ensure registered nursing staff still retain an oversight on patients intake and are an integral part of this fundamental activity of daily living
- For Registered Nursing staff, medications appeared to take up an increased amount of time. This requires review to ensure processes are both safe and lean, without interruptions

- Documentation results show that time spent completing documentation significantly increased overnight, potentially completing complex discharge referral information using readily available information. It is expected that the Electronic patient record (EPR) will support a decrease in time spent on documentation

The audit included 5 wards across medicine and surgery. This will be repeated on a larger scale following the planned reconfiguration of wards in October 2016.

3.20 **Care hours per patient day (CHPPD)**

There is currently national work underway to explore how Care Hours per patient day (CHPPD) can be deployed successfully to enable both comparisons between peers and to help inform daily deployment of staff linked to changes in acuity and occupancy. Currently, few organisations have the functionality to do this and where this is in place, additional software packages have been purchased. The Deputy Director of Nursing and Midwifery is visiting East Herfortshire in September 2016 to review one such system. CHPPD are being collected monthly but analysis of the information is currently limited.

4. RISK & ASSURANCE

4.1 This paper can assure the Board of Directors that there are safe staffing levels within the current funded establishments, however, challenges related to recruitment, retention and the covering of unforeseen absences requires at least daily reviews of staffing levels to ensure safe staffing levels are maintained.

5. CONCLUSION

5.1 The report presents a comprehensive overview of Nursing and Midwifery staffing levels across the organisation. Changes to both shift patterns and staffing establishments during 2015 and 2016 have been beneficial. The triangulation of Quality metrics provides assurance that staffing levels are currently safe supported by local leadership.

However, Nursing and Midwifery staffing levels are dynamic and need to be reviewed at least 6 monthly to respond to changes in acuity and dependency. A subsequent review will be presented in March 2017.

6. RECOMMENDATIONS

6.1 The Board of Directors is asked to;

- note the contents of this report

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Stockport NHS
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	29th September 2016
Subject:	Safe Staffing report		
Report of:	Director of Nursing and Midwifery	**Prepared by:**	Deputy Director of Nursing and Midwifery and Lead Corporate Nurse

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 August 2016. Key points of note as follows; • Average fill rates for Registered Nurses (RN) and Care staff remain above 90% • In Surgery and Critical Care Theatres presents the most significant staffing challenge with a 10.57% band 5 vacancy rate. Improvements are noted on the orthopaedic wards following redeployment of B3 staff • Neonates continues to receive support from Treehouse • Medicine continues to face staffing challenges in the Emergency Department with a 13% vacancy rate, and a 29% rate factoring in sickness and awaiting new starters – mitigating actions are in place The Board of Directors is asked to note the contents of this report with assurance given that Safe Staffing was maintained during August 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 August 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 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 August 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, and Green) rating fill rates. A review of local organizations shows that fill rates of 90% and over are adopted with exception reports provided for those areas falling under this level.

AUGUST 2016	DAY	NIGHT
RN/RM Average Fill Rate	91.9% ↑	95.3%↓
Care Staff Average Fill Rate	103.6%↓	117.2%↓

3. CURRENT SITUATION

3.1 Registered Nurse/Midwife

3.2 Overall performance

In August 2016 the wards continue to report safe staffing levels overall. Theatres continue to present significant recruitment challenges with difficulties encountered recruiting experienced staff. Additional actions are underway and these have recently been presented to the Workforce and Efficiency group. The Emergency Department is encountering significant Registered Nurse staffing challenges linked to both vacancies, sickness and maintained increased demand.

3.3 Temporary Staffing

Registered Nursing agency reliance figures are 2 months in arrears and therefore are reported here for July 2016. Overall reliance on Registered Nursing agencies is 3.3% for July 2016. Our compliance with the introduction of capped rates for agency nursing staff is now reported as 100% for all general areas from the 1st July 2016. Critical areas (ED, ITU, Theatres) remain above capped rates, in line with the picture nationally, however discussions continue as part of the Agency partnership programme with the aim to agree compliance with the February 2016 capped rates. Reliance on agency has predominantly been for Theatres although ED reliance is expected to rise due to vacancies

3.4 Surgery and Critical Care

The redeployment of B3 staff along with the seasonal bed closures have significantly improved the Registered Nurse staffing levels on M4 and D1 which are wards which have been highlighted on previous reports. Theatres continue to experience recruitment issues

3.5 **Medicine**

In month the care staff figures on 8 wards are showing increased levels which reflect the number of 1:1 specials that have been required to ensure safe staffing. An alternative model for the provision of 'specialling' is currently being scoped. B2 has now fully recruited to vacant Registered Nurse vacancies.

3.6 **Community**

Community currently has very limited vacancies and discussions continue with the CCG regarding sub optimal uplift/headroom provision. A risk register entry has been completed.

3.7 **Child and Family**

Neonatal reported high sickness levels which has contributed to their safe staffing figures. However Tree House has supported Neonatal as Tree House activity levels low in the month. 5 registered nurses have been recruited and will start September/October 2016

3.8 **Recruitment**

In month there has been a focus on preparing for the nurses arriving from India due to arrive Autumn 2016.Care support open days are planned for September 2016 and if successful this format will continue every 6 – 8 weeks. Also planned are student nurse open days to align with optimal university graduation schedules. A review of workforce requirements for 2017/18 is currently underway

3.9 **Care hours per patient day (CHPPD)**

August's report also includes information relating to care hours per patient day (CHPPD). This is the new staffing metric advised by the Carter review which aims to allow comparison between organisations to a greater extent than previously, whilst noting that location specific services (specialty centres for example) will influence the final measure.

The CHPPD calculates the total amount of Nursing (RN and Care staff) available during a month, and divides this by the number of patients present on the in-patient areas at midnight. This gives an overall average for the daily care hours available per patient (all nursing and midwifery staff). During the Carter pilot stages, 25 trusts were included and their results showed CHPPD range from 6.3 to 15.48 CHPPD and a median of 9.13.

For August 2016, our report shows an average CHPPD of 7.7. Further work is underway nationally to inform next steps in relation to the interpretation of CHPPD.

4. RISK & ASSURANCE

4.1 The Organisation can be assured that safe staffing levels were maintained during August 2016

5. CONCLUSION

5.1 Safe staffing levels have been maintained.

7. RECOMMENDATIONS

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

Appendix A – Previous months staffing fill rates

JULY 2016	DAY	NIGHT
RN/RM Average Fill Rate	90.5% ↓	96.6 % ↑
Care Staff Average Fill Rate	104.9% ↑	117.9% ↑

June 2016	DAY	NIGHT
RN/RM Average Fill Rate	91.1%↓	95.7 % ↑
Care Staff Average Fill Rate	103.6%↓	114.3%↓

May 2016	DAY	NIGHT
RN/RM Average Fill Rate	91.9% ↑	95.2% ↓
Care Staff Average Fill Rate	106.3% ↓	125.1% ↑

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

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%)↓

Appendix B – Unify entry

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

Org: RWJ - Stockport NHS Foundation Trust

Period: August_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			Main 2 Specialties on each ward		Day				Night				Day		Night		Care Hours Per Patient Per Day (CHPPD)				
					Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/nurses	Care Staff	Overall	Head of Nursing Comment
Site code	Hospital Site name	Ward 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									
RWJ09	STEPPING HILL HOSPITAL - RWJ09	Neonatal Unit	420 - PAEDIATRICS		2325	2040	0	0	1627.5	1323	0	0	87.7%	n/a	81.3%	n/a	378	8.9	0.0	8.9	Unit has 5 Registered Nurse vacancies - all recruited to and starting Sept/Oct - acuity and capacity balanced for staffing numbers.
RWJ09	STEPPING HILL HOSPITAL - RWJ09	Tree House	420 - PAEDIATRICS		2790	2490	465	465	1860	1772	0	0	89.2%	100.0%	95.3%	n/a	417	10.2	1.1	11.3	Summer capacity was low in August - safe staffing retained as one ward area closed due to low demand.
RWJ09	STEPPING HILL HOSPITAL - RWJ09	Jasmine Ward	502 - GYNAECOLOGY		930	930	465	465	620	620	0	0	100.0%	100.0%	100.0%	n/a	213	7.3	2.2	9.5	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	Birth Centre	560- MIDWIFE LED CARE	501 - OBSTETRICS	1860	1837.5	465	465	1240	1230	310	310	98.8%	100.0%	99.2%	100.0%	64	47.9	12.1	60.0	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	Delivery Suite	501 - OBSTETRICS		2790	2700	465	457.5	1860	1730	310	270	96.8%	98.4%	93.0%	87.1%	239	18.5	3.0	21.6	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	Maternity 2	501 - OBSTETRICS	560- MIDWIFE LED CARE	1627.5	1627.5	930	847.5	620	600	310	310	100.0%	91.1%	96.8%	100.0%	508	4.4	2.3	6.7	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	ICU & HDU	192 - CRITICAL CARE MEDICINE		4650	4496	775	775	4092	4235	0	0	96.7%	100.0%	103.5%	#DIV/0!	337	25.9	2.3	28.2	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	Short Stay Surgical Unit	101 - UROLOGY	100 - GENERAL SURGERY	2111.5	2027.5	802.5	778.5	891	881	682	647	96.0%	97.0%	98.9%	94.9%	618	4.7	2.3	7.0	Improvement from last month particularly around CSW cover
RWJ09	STEPPING HILL HOSPITAL - RWJ09	B6	100 - GENERAL SURGERY	101 - UROLOGY	1395	1333.5	1162.5	1357.5	682	682	682	924	95.6%	116.8%	100.0%	135.5%	671	3.0	3.4	6.4	Increased care staff to support dependent bariatric patient. Additonal beds were also open for a short period of time in month
RWJ09	STEPPING HILL HOSPITAL - RWJ09	C3	100 - GENERAL SURGERY	101 - UROLOGY	1627.5	1609.5	1116	1068	868	825	682	649	98.9%	95.7%	95.0%	95.2%	329	7.4	5.2	12.6	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	C6	101 - UROLOGY	100 - GENERAL SURGERY	1395	1245	1395	1383	682	682	682	682	89.2%	99.1%	100.0%	100.0%	651	3.0	3.2	6.1	Registered Nurse days shortfall continues to relate to vacancies , further recruits due to start September. Daily Matron assurance, minimum 2 Registered Nurses per shift
RWJ09	STEPPING HILL HOSPITAL - RWJ09	D1	110 - TRAUMA & ORTHOPAEDICS		1627.5	1500	1395	1347	682	682	682	814	92.2%	96.6%	100.0%	119.4%	701	3.1	3.1	6.2	Registered Nurse days shortfall continues to relate to vacancies , further recruits due to start September. Daily Matron assurance, minimum 2 Registered Nurses per shift . Additional CSW cover required to support dependent high risk patients
RWJ09	STEPPING HILL HOSPITAL - RWJ09	D2	110 - TRAUMA & ORTHOPAEDICS		1395	1149	1162.5	1138.5	682	682	682	682	82.4%	97.9%	100.0%	100.0%	495	3.7	3.7	7.4	Safety maintained, due to some capacity on the ward due to seasonal variation
RWJ09	STEPPING HILL HOSPITAL - RWJ09	D4	110 - TRAUMA & ORTHOPAEDICS		942	982.5	1009.5	979.5	682	678	495	489	104.3%	97.0%	99.4%	98.8%	440	3.8	3.3	7.1	Additonal Registered Nurse on days at the beginning of the month due to staff redeployment and the need to honour shifts
RWJ09	STEPPING HILL HOSPITAL - RWJ09	M4	110 - TRAUMA & ORTHOPAEDICS		1567.5	1334.5	1674	1670.5	682	671	1023	979	85.1%	99.8%	98.4%	95.7%	560	3.6	4.7	8.3	The staffing pressure was at the beginning of the month prior to bed closures.
RWJ09	STEPPING HILL HOSPITAL - RWJ09	AMU1	300 - GENERAL MEDICINE		2802	2592	1953	1885.5	2046	1760	1705	1815	92.5%	96.5%	86.0%	106.5%	994	4.4	3.7	8.1	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	AMU2	300 - GENERAL MEDICINE		1953	1695	1581	1707	1705	1661	1364	1375	86.8%	108.0%	97.4%	100.8%	679	4.9	4.5	9.5	Vacancies being recruited to . Safe staffing . Matron assurance ongoing .
RWJ09	STEPPING HILL HOSPITAL - RWJ09	A10	430 - GERIATRIC MEDICINE		1789	1473.75	1674	2457	682	649	682	1331	82.4%	146.8%	95.2%	195.2%	899	2.4	4.2	6.6	Recruitment ongoing .minimum 2 Registered Nurses on duty at all times . Safety assured by Matron. Care staff increased to support acuity and falls risk patients
RWJ09	STEPPING HILL HOSPITAL - RWJ09	A11	300 - GENERAL MEDICINE		1922	1824.5	1441.5	1494.5	682	682	682	1414	94.9%	103.7%	100.0%	207.3%	837	3.0	3.5	6.5	Night care staff to support dependency, 2 patients receiving 1-1 care and a bariatric patinet requiring additional staff to provide care.
RWJ09	STEPPING HILL HOSPITAL - RWJ09	A12	300 - GENERAL MEDICINE		1741	1425.5	1457	1442	682	682	682	682	81.9%	99.0%	100.0%	100.0%	819	2.6	2.6	5.2	New starters out of numbers awaiting Registered Nurse registration. Safety assured .
RWJ09	STEPPING HILL HOSPITAL - RWJ09	A14	300 - GENERAL MEDICINE		1672	1406.5	1209	1107	682	682	682	869	84.1%	91.6%	100.0%	127.4%	819	2.6	2.4	5.0	Vacancies being recruited to. Always minimum 2 Registered Nurses on duty . Matron assures safety .
RWJ09	STEPPING HILL HOSPITAL - RWJ09	A15	300 - GENERAL MEDICINE		1769	1439	1209	1533	682	715	682	682	81.3%	126.8%	104.8%	100.0%	752	2.9	2.9	5.8	Focus recruitment in progress . Care staff numbers increased to support dependency. Matron assurance for safety. Always 2 Registered Nurses minimum on duty
RWJ09	STEPPING HILL HOSPITAL - RWJ09	B2	430 - GERIATRIC MEDICINE		1674	1302	837	963	1364	968	682	693	77.8%	115.1%	71.0%	101.6%	460	4.9	3.6	8.5	4 nurses recruited awaiting start dates. Matron review for safety assurance . Always 2 Registered Nurses on duty minimum.
RWJ09	STEPPING HILL HOSPITAL - RWJ09	B4	320 - CARDIOLOGY		1085	1032.5	837	814.5	682	660	341	341	95.2%	97.3%	96.8%	100.0%	489	3.5	2.4	5.8	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	B5	300 - GENERAL MEDICINE		1085	973.5	837	782	682	654.25	682	662	89.7%	93.4%	95.9%	97.1%	428	3.8	3.4	7.2	Ward vacancies being recruited to. Always 2 Registered Nurses on duty . Safety assured by Matron
RWJ88	THE MEADOWS - RWJ88	Bluebell Ward	318- INTERMEDIATE CARE		1209	982	2449	2491	682	682	682	1001	81.2%	101.7%	100.0%	146.8%	769	2.2	4.5	6.7	Registered Nurse sickness . Always 2 Registered Nurses. Care staff increased to support dependency . Safety assured by Matron.
RWJ09	STEPPING HILL HOSPITAL - RWJ09	C2	300 - GENERAL MEDICINE		1085	1002.5	837	1057.5	682	682	682	1001	92.4%	126.3%	100.0%	146.8%	525	3.2	3.9	7.1	Increased care support workers due to patient acuity and a number of patients requiring 1-1 care
RWJ09	STEPPING HILL HOSPITAL - RWJ09	C4	320 - CARDIOLOGY		1069.5	975.75	837	844	682	670	341	533	91.2%	100.8%	98.2%	156.3%	472	3.5	2.9	6.4	Increased care support workers to support 1-1 for patient with safeguarding concerns
RWJ09	STEPPING HILL HOSPITAL - RWJ09	Coronary Care Unit	320 - CARDIOLOGY		837	837	465	495	682	706	341	341	100.0%	106.5%	103.5%	100.0%	174	8.9	4.8	13.7	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	Clinical Decisions Unit	300 - GENERAL MEDICINE		496	496	496	496	310	310	310	310	100.0%	100.0%	100.0%	100.0%	116	6.9	6.9	13.9	
RWJ03	CHERRY TREE HOSPITAL - RWJ03	Devonshire Centre for Neuro-Rehabilitation	314 - REHABILITATION		1147	1111	1999.5	1897.5	682	682	682	968	96.9%	94.9%	100.0%	141.9%	570	3.1	5.0	8.2	Increased care support workers at night to support patient on 1-1 care
RWJ09	STEPPING HILL HOSPITAL - RWJ09	E1	430 - GERIATRIC MEDICINE		2015	1675	2309.5	2169	1023	781	1364	1397	83.1%	93.9%	76.3%	102.4%	1005	2.4	3.5	6.0	Safe staffing , Head of Nursing review of Night Duty Registered Nurse levels. Safety assured .
RWJ09	STEPPING HILL HOSPITAL - RWJ09	E2	430 - GERIATRIC MEDICINE		2383.5	2383.5	1674	2077	1023	970	1023	1343	100.0%	124.1%	94.8%	131.3%	1050	3.2	3.3	6.5	Increase care support workers to support 1-1 patient care
RWJ09	STEPPING HILL HOSPITAL - RWJ09	E3	430 - GERIATRIC MEDICINE		2383.5	2376	1674	1666	1023	957	1023	1364	99.7%	99.5%	93.5%	133.3%	1070	3.1	2.8	5.9	Increased care support workers to support 1-1 care at night
RWJ09	STEPPING HILL HOSPITAL - RWJ09	Short Stay Olders People's Unit	430 - GERIATRIC MEDICINE		837	822	465	367.5	682	630.5	341	341	98.2%	79.0%	92.4%	100.0%	427	3.4	1.7	5.1	
		Total			59988	55127.5	39523.5	40943.5	35130.5	33476.75	21513	25219	91.9%	103.6%	95.3%	117.2%	19975	4.4	3.3	7.7	

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Stockport NHS
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	29 September 2016
Subject:	Update on 7 day working		
Report of:	Medical Director	**Prepared by:**	Medical Director

REPORT FOR APPROVAL

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

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

The purpose of this report is to update the trust board on progress towards the national standards relating to delivery of 7 day working.

Attachments:

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

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1. INTRODUCTION

1.1 The purpose of this report is to advise the Board of Directors about the current standards for seven day working, and progress within the trust in meeting these standards.

2. BACKGROUND

2.1 In December 2013, Sir Bruce Keogh set out expectations based upon 10 standards for trusts, to improve 7 day services. Of the original 10 standards, the focus has turned on four priority standards (highlighted in grey). It is these areas that are currently to be prioritised by the department of health.

2.2

	Standard
1	Patient experience
2	Time to first consultant review
3	MDT review for all acute admissions (the MDT will vary by speciality but as a minimum will include Nursing, Medicine, Pharmacy, Physiotherapy and for medical patients : OT)
4	Shift handovers
5	Diagnostic services
6	Interventions/key services (hospitals must have timely 24 hour access, 7 days a week to consultant directed interventions that meet the relevant speciality guidelines, either on site or through formally agreed networked arrangements with clear protocols)
7	Mental health services
8	On-going review
9	Transfer to community, primary and social care
10	Quality improvement

2.3 The rationale for the 7 day services initiative was a belief that mortality rates varied across the week. The department of '7 days services factsheet' (DOH 24th July 2015)summarised

- Patients are 16% more likely to die if they are admitted on a Sunday compared with a Wednesday.
- The risk of death for patients admitted on a Sunday compared with a Wednesday is 37% higher for acute and unspecified renal failure, 8% higher for urinary tract infections and 7% higher for a fractured neck of femur.
- Survival rates following a broken hip are much higher if patients are treated quickly, ideally within 2 days. Patients are 24% more likely to have to wait longer than 2 days for

a broken hip replacement on weekends.

- There is not always access to the right treatments or diagnostic tests at weekends, which can result in delays and worsen the outcomes and experience for patients.

2.4 There have been considerable questions raised in the medical literature about whether the evidence supporting the differing mortality rates between weekday and weekend admission stands up to scrutiny. The 'high intensity specialist acute led care' study (www.hislac.org/images/publications/HiSLAC-Lancet-paper-briefing-WEB.pdf), is an independent scientific investigation into the weekend effect, funded by the National Institute of Health Research. Phase 1 of this study concluded;

'the weekend effect (which has been studied in more than 100 publications covering different health systems and continents) is multifactorial. There is evidence that patients admitted at weekends are sicker (i.e. there are fewer low-risk admissions at weekends), and the weekend effect may therefore have a 'community dimension' - the causes may include community and social care as much as hospital care.' 'Policy makers should exercise caution before attributing the weekend effect mainly to differences in specialist staffing".

2.5 Stockport NHSFT, Risk adjusted Mortality Index (RAMI) data tracks weekday and weekend mortality rates and shows no significant difference between them.

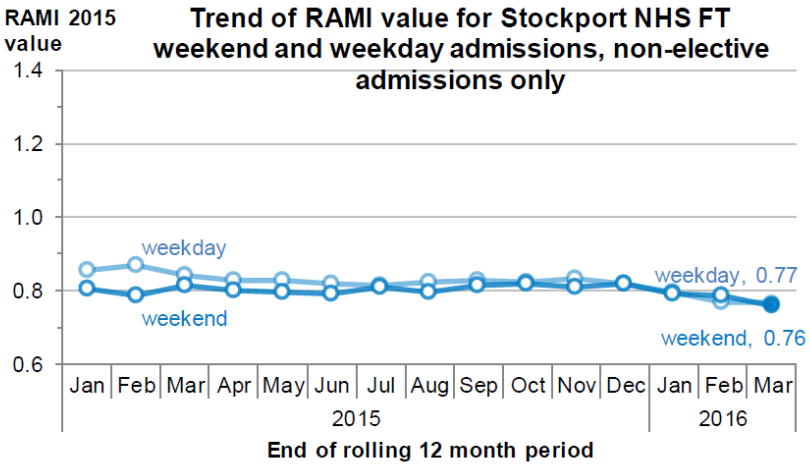

Fig1.

2.6 7 day working remains high on the national agenda, with no evidence of this focus being lost. National audit of 7 day working, using the '7 day self-assessment tool' (7daySAT) is currently underway, with all hospitals receiving acute admissions expected to submit data. Data will be collected every six months for the next 18 months to track progress against the four core standards. This data is likely to be publically shared and given a high profile.

While the relative merits of an evenly spreading all hospital activity over 7 days remains subject to debate, key aspects of the proposals are difficult to dispute;

- Delivery of consistent care to acutely unwell patients at all times.
- Ensuring that the deteriorating patient in hospital, is as effectively managed at all times.
- Ensuring the treatment and investigation of hospital in-patients continues to progress over the weekend.
- Ensuring patients who are fit to leave hospital do not wait over weekend for 'medical clearance' on the Monday before going home.

2.7 It is these aspects of 7 day working that are subject to the focus of the four 'prioritised standards'. It is our progress against these standards that are considered in the remainder of this paper.

3. **CURRENT SITUATION**

3.1 **Standard two : Timely consultant review:**

All emergency admissions (EA) have a thorough clinical assessment by a suitable consultant as soon as possible, but at the latest within 14 hours of arrival at hospital.

3.2 96% of admissions are under the care of 6 acute specialties (highlighted in grey).

Specialty	Number of emergency admissions per year	% of all emergency admissions
Accident & Emergency	934	2%
Breast Surgery	9	0%
Cardiology	278	1%
Critical Care	154	0%
ENT	349	1%
General Medicine and care of the elderly	23053	45%
General Surgery	4036	8%
Obstetrics, Gynaecology and midwife led care	9657	19%
Haematology	1	0%
Intermediate Care	9	0%
Oncology	0	0%
Ophthalmology	22	0%
Oral Surgery	1	0%
Paediatrics	7923	15%
Paediatric Surgery	1	0%
Paediatric T&O	3	0%
Pain	0	0%
Rehabilitation	46	0%
Respite Care	0	0%
Rheumatology	2	0%
Spinal Surgery	233	0%
Trauma & Orthopaedics	2172	4%
Urology	2661	5%
Grand Total	**51544**	100%

Figure 1.

Each of these 6 busiest specialties receive 7 – 63 admissions per day. For each of these specialties, delivery of a consultant review within 14 hours requires a twice daily consultant ward round. At present there is no comprehensive IT system for data capture the above process standards and hence the ability to assess the real time on-going compliance with the standard is

limited.

3.3 The 7days audit tool will provide a data snapshot by audit staff manually reviewing a sample of the case notes.

The current specialty position in Stepping Hill is summarised in figure two and detailed below.

Time to consultant review of emergency admissions – Stepping Hill		
Specialty	% share of emergency admissions	Current position
Acute medicine	45%	Standard met.
Acute stroke		Standard met.
Obstetrics and Gynaecology	19%	Standard partially met
Acute General Surgery	8%	Standard will be met 2017.
Paediatrics	15%	Standard partially met.
Urology	5%	Standard not met.
Trauma and orthopaedics	4%	Standard partially met.

Figure 2.

3.3.1 **Acute Medicine** (45% EA)

Weekday cover 14 hours per day onsite.

Weekend cover 12 hours per day onsite.

Standard met.

The redesign and co-location of the Acute Medical Unit (AMU) in "D" Block incorporating the GP Assessment Unit (GPAU) along with the redesign of the Acute Physician rota model, will enhance continuity of care and reduce delays and would facilitate further assurance with compliance with this standard.

3.3.2 **Acute Stroke:** (managed emergency sub-speciality within acute medicine).

The trust operates as a Primary Stroke Centre and has formal networked arrangements with clear protocols to provide 24/7 cover for acute stroke patients. We have stroke consultant presence on site for 11.5 hours per day during the week, 7.5 hours at weekends. Timely consultant reviews are supported with remote consultation with telemedicine ensuring timely assessment of patients. This use of technology to remote review patients, may be translatable to other specialties..

3.3.4 **Obstetrics and gynaecology:** (19% EA).

Consultants cover both obstetrics and gynaecology out of hours. There is a `consultant of the week` model so that all new admissions can be reviewed within the 14 hour standard. There is however considerable mal-distribution of on site consultant time between weekdays and weekends.

Stockport had 3474 deliveries in 2015/16. National standards dictate 60 hours per week of consultant cover on the delivery suite. We currently deliver 86 hours of consultant cover, managed between 0830 and 2100 Monday – Friday, and two consultant resident nights per week (no prospective cover). During the week, consultant review within 14 hours is consistently

delivered.

There are daily consultant ward rounds at weekends but the on site commitment is considerably less than is provided during the week, and a review within 14 hours is not consistently met.

3.3.5 **Acute General Surgery:** (currently 8% EA, likely to rise to 12% in 2017).

Currently run a 'hot consultant' model. Single consultant delivers 96 hours of continuous cover, including review of admissions and delivery of emergency surgery. Demands upon a single consultant see inconsistent delivery of the 14 hour standard.

Development of the Healthier Together initiative on the Stepping Hill site will see implementation of consultant delivered assessment on the acute surgical unit 14 hours per day, 7 days per week **(standard met).** A separate consultant will be available for emergency surgery. Implementation will begin from march 2017.

3.3.6 **Paediatrics** (15% EA)

From 1st October 2016 there will be a twilight consultant rota. This will deliver Monday – Friday on site cover to 10pm. This is not currently prospectively covered. Weekday review of admissions will be consistently deliverd.

At weekends there are only 6 hours per day of consultant on site presence. The 14 hour review standard is therefore not met.

3.3.6 **Urology.** (4% EA)

Currently runs a 'on call' system. 'On call' consultant can be off site during the week making routine review consultant of all admissions within 14 hours inconsistent **(standard not met)**.

Current plans being developed to move to a hot week model. This has considerable resource implications, but will deliver more consistent acute consultant time across 7 days. These plans will be presented to the executive team early next month.

3.3.7 **Trauma and orthopaedics** (5% EA)

Designated trauma consultant on site 7:30 – 6 pm 7 days per week (standard potentially met). In practice most consultant time is focused upon theatre cases. Routine review of every admission within 14 hours may be inconsistent.

4. **Standard 5: Improved access to diagnostics:**

4.1 ***Hospital inpatients have scheduled 7 day access to diagnostic services.***

Consultant-directed diagnostic tests and reporting available 7 days a week: within 1 hour for critical patients; within 12 hours for urgent patients; and, within 24 hours for non-urgent patients.

The key areas of intervention in our hospital are summarised in figure 3 and outlined in greater detail below

Summary of current diagnostic position at Stepping Hill		
Within 1 hour for critical patients	Within 12 hours for urgent patients	Within 24 hours for non urgent patients.

Figure 3

4.2 **Radiology**

Access to reported CT and ultrasound is available 7 days a week and within 1 hour for critical patients. Urgent in-patient surgical CT and ultrasound available within 12-24 hours 7 days a week. Urgent medical cases available with 12-24 during core hours and supported via on-call radiologist outside of core hours.

Non urgent CT are not typically delivered within 24 hours.

Access to plain film is available 24/7: this is reported later and is usually evaluated by the requesting clinician to inform immediate management.

We do not offer access to inpatient MR imaging outside of core hours Monday to Friday 9-

4.3 **Microbiology**

The microbiology laboratory is staffed 0800-2000 weekdays & 0900-1700 weekends, with an on-call service operating 24/7 outside these times. For urgent specimens requiring overnight processing e.g. CSF microscopy/ cell count results are available within 1 hour of specimen receipt. Rapid diagnostics are available for organisms with infection prevention and patient throughput ramification: C. difficile, Norovirus and Influenza. These results are available within 24 hours of receipt and if received within normal working hours within 4 hours. There is a 24/7 consultant led clinical on-call service for urgent clinical advice, provided within 1 hour.

4.4 **Lab medicine**

Blood sciences provide a full service 24/7 with capabilities to provide urgent results on demand. Consultant advice is available 24/7 provided within 1 hour.

5.0 **Standard 6: Consultant directed interventions:**

5.1 **Hospital inpatients must have timely 24 hour access, 7 days a week, to consultant-directed interventions.**

The current position for consultant directed interventions is summarised in figure 4, and outlined in greater detail below.

Summary of current delivery of consultant directed interventions over 7 days	
Non vascular interventional radiology	**In planning for 2017**
Emergency endoscopy	**In discussion, limited progress.**
General surgical intervention	**Compliant – 24/7 CEPOD**
Trauma surgical intervention	**Compliant – Daily trauma lists, 24/7 CEPOD**
Obstetric and gynaecology surgical intervention	**Compliant - 24/7 CEPOD theatre - 24/7 obstetric theatre**
Critical Care Review	**Compliant – consultant led 24/7**

Figure 4

5.2 **Non vascular Interventional Radiology (IR).**

Currently the interventional consultants can be contacted for urgent out of hours for non-vascular interventional cases such as nephrostomies and they perform this on a payment per case basis. There is no formal rota so this is not entirely robust but due to the occasional nature of this work has traditionally provided out of hours interventional cover when required. We are aiming to implement a formal out of hour's rota in line with healthier together requirements by Spring 2017. There are both pragmatic (spitting the rota) and resource (considerable cost) implications. This will be a minimum standard as a specialist hospital.

5.3 **Emergency endoscopy.**

NCEPOD report 'time to get control' stated 'Patients with any acute GI bleed should only be admitted to hospitals with 24/7 access to on-site endoscopy'. Emergency endoscopy is currently provided out of hours by the acute surgical team. They lack the competencies to endoscopically manage some causes of GI bleeding. Our role as a specialist surgical hospital will see us need to resolve this issue. The issue is common to many moderate sized hospitals.

5.4 **Surgical intervention.**

Currently the majority of surgical interventions are in Obstetrics, Gynaecology, Orthopaedics or General surgery. The current consultant provision is outlined above, but is facilitated in a 24/7 CEPOD theatre and 24/7 obstetric theatre, with 24/7 consultant anaesthetist cover.

5.5 **Critical Care Review**

Critical care consultants are on site 16.5 hours per day during the week, and 13.5 hours per day at the weekend. (compliant)

6.0 **Standard 8: On-going review**

6.1 **All patients on the AMU, SAU, ICU and other high dependency areas must be seen and reviewed by a consultant twice daily, including all acutely ill patients directly transferred, or others who deteriorate. To maximise continuity of care consultants should be working multiple day blocks.**

6.2 **Once transferred from the acute area of the hospital to a general ward patients should be reviewed during a consultant-delivered ward round at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the patient's care pathway.**

The current position with regards to on-going review in Stepping Hills high dependency areas is outlined in figure 5, and in more detail below.

Summary of high dependency areas delivery of 7 day standard	
Intensive Care Unit	**Compliant**
High Dependency Unit	**Compliant**
Coronary Care Unit	**Not compliant**
Surgical Assessment Unit	**Will be compliant 2017**
Medical Assessment Unit	**Compliant**
Hyper acute stroke unit.	**Compliant**
Paediatric HDU	**Partially compliant**
Neonatal Unit.	**Compliant**

Figure 5

6.2.1 **Intensive Care / High Dependency Unit:**

All patients are reviewed twice a day on the HDU / ICU **(compliant).** One review is in the form of a formal ward round. The second review is an informal appraisal that the actions from the ward round have been completed. Formalisation of the second patient review may be required to meet the audit standards.

6.2.2 **Coronary Care Unit:**

We have a relatively small cardiology service. The Coronary Care Unit provides a monitored bed, but only level 1 care (no invasive monitoring or organ supports). We have 4 hours of on site consultant time over the weekend. Patients are reviewed only once per day **(not compliant)**

6.2.3 **Surgical Assessment Unit:**

Currently provided by single 'hot surgical consultant'. Only one ward round per day, with acute review of deteriorating patients and admissions. From April 2017, Healthier Together standards will deliver 14 hours of SAU consultant time per day. All patients will be reviewed twice per day.

6.2.4 **Medical Assessment Unit:**

Even though there is scheduled twice daily ward rounds in AMU **(compliant)** the approach on the ground when consultant is on site onsite is more of a rolling consultant review of new admissions after the morning scheduled ward rounds of all patients in the acute medical unit (AMU). This is likely to require formalising to meet the audit standards.

6.2.5 **Hyper-acute stroke unit.**

There are twice daily ward rounds in Hyperacute stroke unit. (HASU). HASU cover is delivered as block rota to ensure continuity

6.2.6 **Paediatric HDU:** Weekday on site consultant until 10 pm will deliver consistent twice daily ward rounds. Weekend cover of only 6 hours will not. Paediatric HDU is only a level 1 unit, offering close monitoring but not organ support

6.2.7 **Neonatal Intensive Care Unit.**

Twice daily ward rounds in High Dependency areas do largely happen 7 days per week. They are not formally resourced, but are prioritised at the beginning and end of the paediatricians day.

6.3 **Consultant daily review in non acute areas.**

Delivery of 7 day consultant review of all in-patients in non acute areas.
Not delivered

Figure 6

This year, prioritisation has been given to addressing the 7 day standards relating to acute admitting areas. Daily review of patients in non acute areas occurs does not currently take place. The goal of these reviews is to ensure that;

- Ensuring the treatment and investigation of hospital in-patients continues to progress over the weekend.
- Ensuring patients who are fit to leave hospital do not wait over weekend for 'medical clearance' on the Monday before going home.

Daily review should reduce length of stay. It does require considerable resource. A daily 10 minute daily review of every non acute area in-patient would require a considerable expansion in consultant numbers. Reducing length of stay is unlikely to release sufficing funding to cover this cost.

Patients who are 'medically fit for discharge' do not need a daily review. Other patients who are in the rehabilitation phase of their illness could also be deemed not to require routine weekend review. Our next steps should be directed at quantifying how many patients would not fall into these categories, and to develop strategies in each admitting specialty for how this standard can be met.

7.0 Conclusions

Considerable progress has been made in our consistent care of acutely ill patients presenting to Stepping Hill across 7 days of the week. Over half of our acute admitting areas now meet the 7 day standards. Continued progress in other areas is required.

Emergency diagnostics are well delivered across 7 days, but routine radiological investigations are not. Recruitment in this area makes routine 7 day elective delivery challenging.

Plans for non vascular intervention are progressing. We need to renew focus on our development of a consistent emergency endoscopy service across 7 days.

Good progress is being made in the reliable, twice daily assessment of patients in our high dependency areas.

Routine daily consultant review of all in-patients remains a considerable challenge.

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Stockport NHS
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	29 September 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 current 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	☐ Workforce & OD Committee
☐ Council of Governors	☐ SD Committee
☐ Audit Committee	☐ Charitable Funds Committee
☐ Executive Team	☐ Nominations Committee
☐ Quality Assurance Committee	☐ Remuneration Committee
☐ F&P Committee	☐ Joint Negotiating Council
	☐ Other

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1. INTRODUCTION

1.1 The purpose of this report is to present the current 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.

3.2 Board members will be aware of the need to ensure that the risks documented in the Framework continue to accurately reflect the principal 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.

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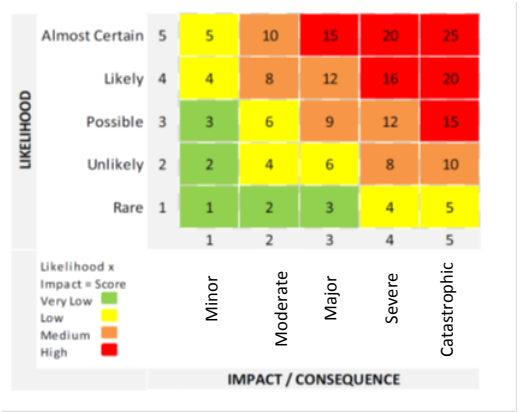
SO1	**To achieve full implementation and delivery of the Trust's Five Year Strategy 2015-20.**	
Risk 1	**Emphasis on day to day operational delivery, in response to environmental pressures, results in lack of focus on strategic change programmes with consequent impairment or failure to deliver the Trust's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

Board Risk Rating

	L	C	Level
Initial	*2*	*4*	*8*
Current	3	4	12

L x C = Level

Opened Date	01/04/2016
Review Date	14/07/2016
Review Date	22/09/2016
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.
- Resources identified to ensure detailed work up of the Strategic Staircase and Innovation Programmes projects.
- Assurance reports to the Finance & Performance Committee on financial delivery of the strategic projects.
- Assurance reports to the Finance and Performance 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.
- Deputy Chief Executive leaving the Trust will create a gap in the strategy and transformation work at executive level

GAPS IN ASSURANCE

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

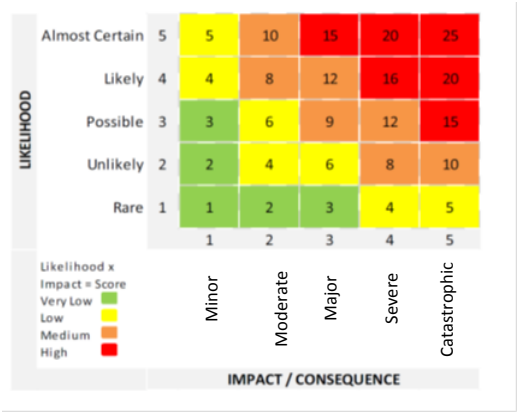
ACTION PLAN	*Assigned to*	*Action Detail*	*Progress to Date*	*Due Date*
	Chief Executive	Board to be given dedicated time for strategic discussion	Board to hold monthly strategy sessions	Ongoing
	Deputy Chief Executive	Monitor engagement with staff and facilitate workshop with Child and Family Business Group	Business Group performance review monitoring communication plan delivery. Further workshop held and future workshops scheduled.	Ongoing
	Chief Executive	To ensure appropriate and sufficient executive capacity is put in place to mitigate the loss of the Deputy Chief Executive from the Trust	Consideration underway on how to provide capacity and capability of all the Deputy Chief Executive responsibilities.	Oct/Nov 2016

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	x C	= Level
Initial	*2*	*4*	*8*
Current	2	4	8

Opened Date	01/04/2016
Review Date	14/07/2016
Review Date	22/09/2016
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
- Board involvement and agreements required on all strategic decisions relating to MCP including in scope functions and options for organisational form
- Council of Governors to be kept informed of all strategic matters relating to the MCP and to be a key partner in decisions on organisational form
- GM Health and Social Care Partnership agreed in principle to funding of £19M transitional monies over 3 years from the Transformation Fund – details tbc

	• Regulators appraised on potential options for MCP function and form and discussions taking place as appropriate on regulatory change issues
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. • Clarity on future organisational structure of FT resulting from future organisational form of MCP to be considered and agreed.	• 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
	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 organisational management arrangements being actively considered by partner organisations for discussion within the Trust	Nov 2016
	Deputy Chief Executive	Actively involved in the production of the options on form Business case as required by Commissioners through the procurement exercise.	Board to receive reports monthly on progress and to approve final Outline Business Case on options on form.	Sept-Nov 2016

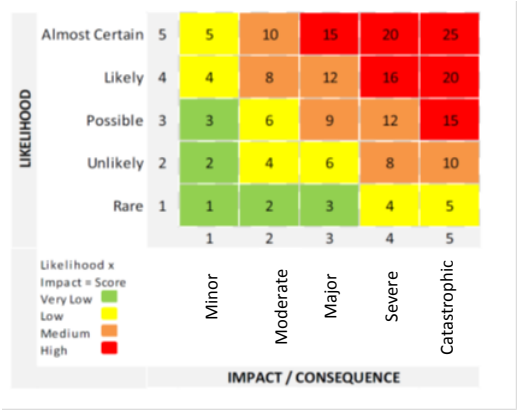
SO3	**To secure full compliance with requirements of the NHS Provider Licence through fit for purpose governance arrangements.**
Risk3	**Failure to achieve sustainable delivery of the 4-hour A&E target impairs quality of patient care and results in further regulatory intervention.**

Risk Owner: Chief Operating Officer

Board Risk Rating

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

Opened Date	01/04/2016
Review Date	27/07/2016
Review Date	22/09/2016
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 Acting Chief Operating Officer**
- **Weekly Urgent Care Task & Finish Group implementing and tracking actions**
- **Plans for Medicine Bed reconfiguration to enhance flow and ED capacity**
- **Daily Breach validation**
- **'Hot Clinics' pilot.**

BOARD ASSURANCE

- **Key Issues Reports from Quality Assurance Committee**
- **Escalation process to Board via Integrated Performance Report (IPR)**
- **Monthly Business Group performance reviews**
- **External reports on areas of underperformance, e.g. Cancer or ED through ECIST or other bodies**
- **'Deep Dive' session on ED initiatives with Board members 18 July 2016**
- **NHSI & NHS England support for medium/long term plans for Stockport Together as sustainable solution.**
- **NHSI approval of revised trajectory for 4-hour standard in 2016/17.**

GAPS IN CONTROLS

- **Ability to maintain sustainable levels of DToC. Continuing increases impact on hospital flow during periods of high demand.**
- **Emergency Department standard is still reliant on reduced demand which has not yet manifested despite actions taken by commissioners.**

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; to avoid admissions and discharge to assess.**

ACTION PLAN	Assigned to	Action Detail	Progress to Date	Due Date
	Acting 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 in place and meeting monthly**	**Ongoing**
	Acting Chief Operating Officer	**Introduction of effective assurance reporting of outcomes from the monthly Performance & Planning meeting to the Quality Assurance Committee.**	**Action superseded by introduction of monthly Business Group performance reviews which are now fully established.**	

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	*4*	*4*	*16*

Opened Date	01/04/2016
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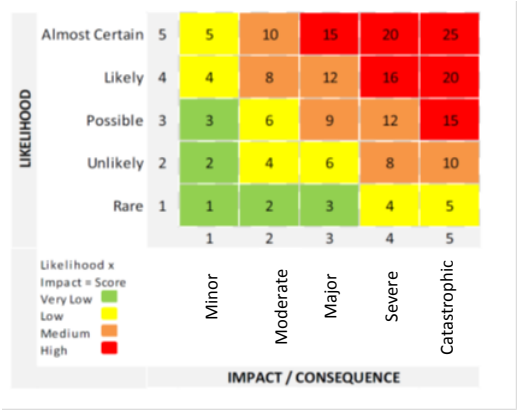

RISK CONTENT

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. The 'Requires Improvement' rating received in August 2016 has the potential to impact adversely on public confidence and staff morale

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

- **Mock CQC inspection proforma to be incorporated into development of accreditation process for clinical areas**
- **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**
- **Implementation of Trust Quality Improvement Strategy**

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**
- **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**
- **Monitoring of CQC Action Plan 2016**

GAPS IN CONTROLS

- **Ongoing recruitment issues for some areas of nursing and medical workforce may jeopardise compliance with CQC standards**

GAPS IN ASSURANCE

- **Overall rating for the Trust is 'Requires Improvement'**

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 received 12 July 2016; factual accuracy response returned 27 July.** **Action plan developed for all outstanding actions and presented to Board of Directors**	**Completed** **September 2016**
	Director of Nursing & Midwifery	**Lead on the implementation of the CQC action plan and monitoring progress against timescales.** **Monitoring will be through business group quality boards and regular updates to Quality Governance Committee and Quality Assurance Committee, with key issues to the Board of Directors**	**To commence 1st October 2016**	
	Director of Nursing & Midwifery	**Establish preparation needed for return CQC inspection**	**To commence 1st October 2016**	
	Director of Nursing & Midwifery	**Arrange bi-monthly engagement meetings with local CQC managers to update on progress with action plan and other relevant issues**	**Commence 21st October 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 the required level of cost improvement to deliver the agreed control total and receipt of STF with a consequent impact on patient services, increasing 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
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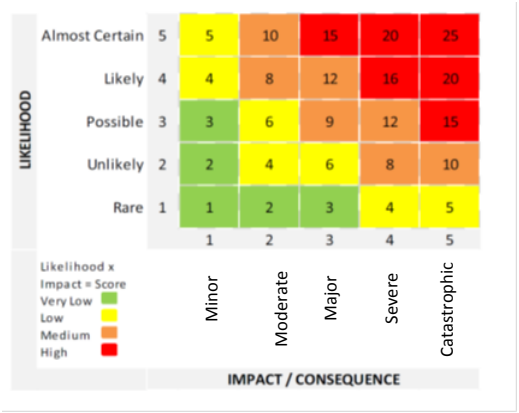


RISK CONTENT

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 cost improvement and significantly challenging 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**
- **Participation in the NHSI Financial Improvement Programme**
- **Implementation of a CIP Governance Framework with Executive-level monitoring**
- **Performance Management Framework and Performance Review Meetings**
- **Establishment Control Panel & Staff Absence Panel**
- **Detailed financial report to F&P Committee**

BOARD ASSURANCE

- **Finance and CIP Performance reports**
- **Budget and Plan approval**
- **CQUIN update**
- **Finance & Performance Committee review of progress reported to Board**
- **Strategic Development Committee reporting to Board**
- **Financial Improvement Programme**
- **Financial Improvement Group – monthly monitoring**
- **Appointment of Financial Improvement Director on secondment**

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 • Prioritisation of capital investment for Medical Equipment replacement • Financial impact of final CQC report.	• 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 • Transfer of skills from KPMG personnel to substantive staff.

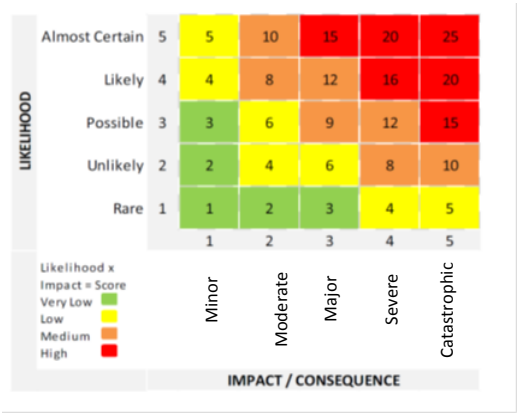
ACTION PLAN	*Assigned to*	*Action Detail*	*Progress to Date*	*Due Date*
	Acting Chief Operating Officer	**Hold Business Group Directors to account for delivery of their financial and activity plans**	**Performance Review meetings established, supported by KPMG representatives.**	
	Director of Workforce & OD	**Develop and deliver a clinical and non-clinical engagement programme to ensure that staff across the Trust understand the financial challenges facing the organisation.**	**Communication plan to be implemented from 27 July 2016. Development of an engagement plan and supporting communications to reflect transformational change programme developments**	**Ongoing**
	Director of Finance	**Progress application for a further loan as normal course of business with the ITFF.**	**Meeting with ITFF scheduled to be held on 21 July 2016.**	
	Director of Finance / Financial Improvement Director	**Work with the Financial Improvement Programme to identify and deliver cost savings to meet the NHSI control total.**	**Significantly challenging projects to be scoped and assessed**	
	Acting COO / Director of Finance	**Develop a demand and capacity model incorporating growth, impact of CIP/strategic programmes and impact of delivering agreed trajectories.**		
	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.**	**Implementation of headcount tracker in conjunction with KPMG. Further development of future needs planning subject to development of demand and capacity plans.**	**Ongoing**

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	22/07/2016
Review Date	22/09/2016
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**
- **Performance Appraisal Policy**
- **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.**
- **Pay Progression Policy**
- **Recruitment and Retention Implementation Plan**
- **Centralised temporary staffing processes**
- **Absence and temporary staffing performance meetings**

BOARD ASSURANCE

- **Workforce & OD Committee / People Performance 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 approved by Board of Directors**
- **NHS England Annual Organisational Audit – Comparator Report 2015/16**

• Revised terms of reference for Establishment Control Panel	
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
• Succession Plan • Staff Engagement Plan • Workforce Plan	• Engagement Strategy

	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.**	**Ongoing**
	Deputy Director of Workforce	**Workforce planning cycle to be aligned to business planning and workforce numbers monitored monthly.**	**Workforce planning update shared with People Performance Committee. HEE workforce planning return submitted and reviewed by PP Committee Sep 16. Business group planning template approved. Refreshed approach to workforce planning in partnership with KPMG.**	**Ongoing**
	Head of Organisational Development and Leadership	**Engagement strategy to be developed to support the Financial Improvement Programme and organisational change and transformation.**	**Initial work focused on FIP with strategic oversight of the transformational change agenda inc Stockport Together & Healthier Together.**	**Ongoing**
	Director of Workforce and Organisational Development	**Terms of reference for People Performance Committee and Workforce Efficiency Group to be agreed.**	**Terms of reference for both Groups approved.**	**Complete**

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.**

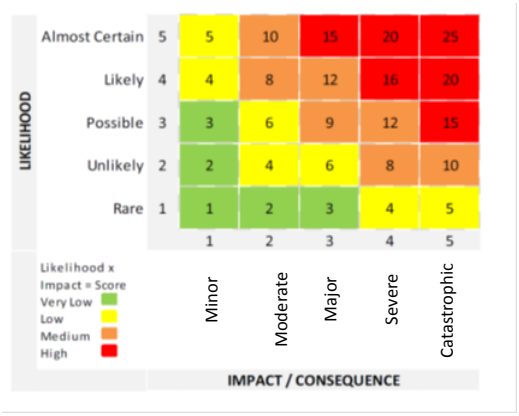
Risk Owner: Deputy Chief Executive

Board Risk Rating

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

L x C = Level

Opened Date	01/04/2016
Review Date	27/07/2016
Review Date	22/09/2016
Review Date	



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

- **EPR programme board chaired by CEO**
- **Programme and project governance**
- **Policies and procedures**
- **Audit programme**
- **IG Toolkit**

BOARD ASSURANCE

- **External and internal audit reporting of design and operation of plans**
- **External 'gateway' review process prior to key stages of implementation**
- **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**
- **Difficulty in recruitment of Benefits Analysts**

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** **First two meetings held. Risk Register and programme reporting now in place.**	**July 2016**
		Ensure a process for developing benefits realisation is in place	**Intersystems (strategic partner) have brought in Channel 3 to work with the EPR programme on benefits realisation process. Presentation on approach endorsed by July EPR programme Board.**	**Sept 2016**
		Benefits analyst recruitment has been unsuccessful. Need to look at alternative methods of recruitment through either different scope or terms and conditions.	**Acting Director of IM&T and EPR Programme Lead are reviewing this and talking to other sites. Also looking at recruitment agency support.**	**Oct 2016**

Report to:	Board of Directors	**Date:**	29 September 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. A new format of Risk Register is being trialled this month for the board's approval. The changes have been made in order to improve quality of information and to assist in providing assurance, regarding risk ownership and management. Improvement to the report will be further supported with the launch of the new Datix Web based risk module. Work is currently underway designing this and it is anticipated that all current risks will be transferred over by the end of December 2016 with all new risks to be added to the data base from the first week in December. A new version of this report will be submitted for January Board of Directors Meeting; the plan is to include information regarding the impact of the risks against the strategic aims of the trust with greater clarity. The headlines for this report are: • One strategic risk has been mitigated and managed to below a risk score of 15 this month • Currently there are 7 severe strategic risks scoring 20 • Three new strategic risks are this month; 3000 - Delivery of Sustainability and Transformation Fund 3003 - RTT Pathway recording – Compliance 3006- Emergency Department Pressures The Board of Directors is asked to approve the new format and note the contents of the risk register
Board Assurance Framework ref:	
CQC Registration Standards ref:	
Equality Impact Assessment: Not required	

Attachments:	Strategic Risk Register

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

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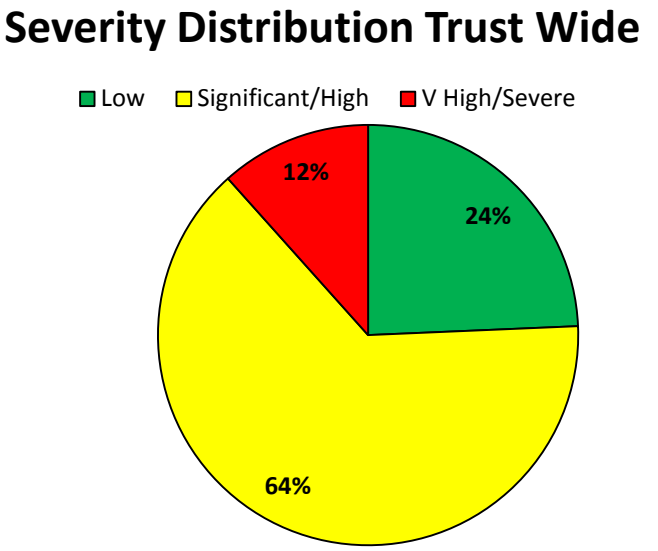
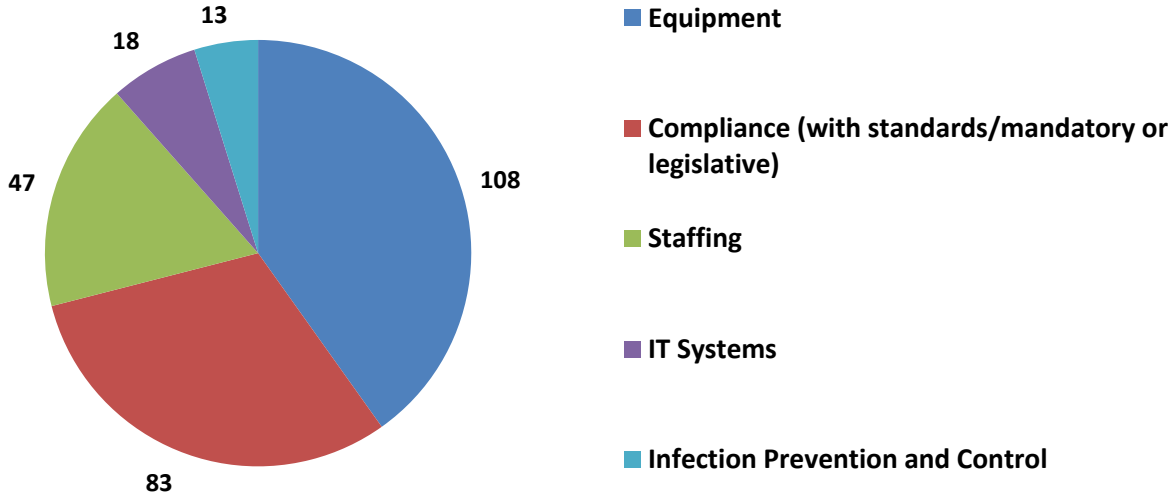
Trust wide Risk and Severity Distribution

1.1 There are currently 349 live risks recorded on the Trust Risk Register system compared to 361 the previous month. Trust wide distribution of risk is shown below.

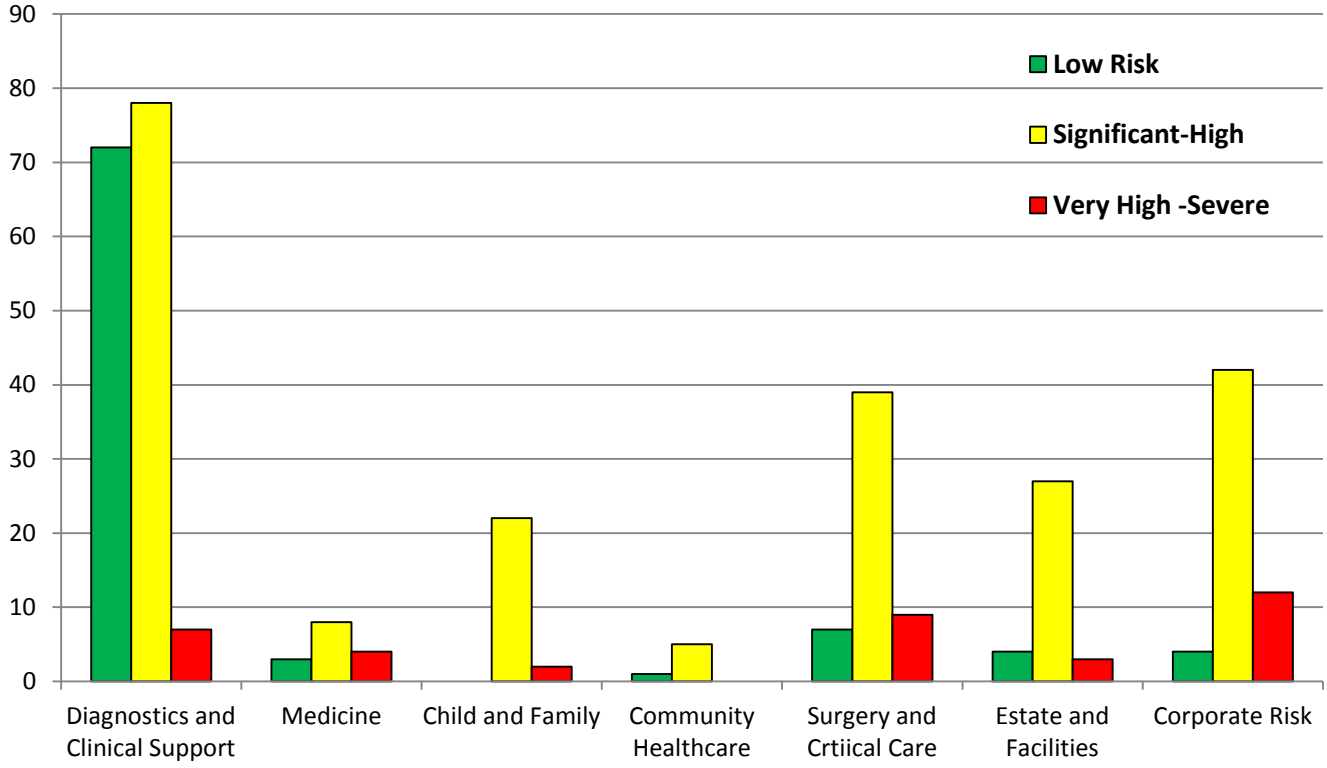
	Low				Significant			High			Very High		Severe	Unacceptable
	1	2	3	4	5	6	8	9	10	12	15	16	20	25
August	0	12	27	58	3	31	44	34	5	104	6	22	15	0
September	0	8	23	59	2	34	48	35	7	111	4	22	11	0



1.2 Top Five Sources of Risk across the Trust



2.1 Severity Distribution in Business Groups



2.2 Strategic risk (approved) distribution across Business Groups.

Very High		Severe	Unacceptable
15	16	20	25
Medicine			
0	2	2	0
Child and Family			
0	0	0	0
Community Healthcare			
0	0	0	0
Surgery and Critical Care			
0	0	0	0
Estate and Facilities			
0	0	0	0
Corporate Risk (Nursing, Finance, I.T. Executive Team, HR.)			
1	8	4	0
Diagnostics and Clinical Support			
0	2	1	0

3.1 Closed risks and mitigated risks.

The strategic risk below has been reviewed and either closed or mitigated to a lower risk rating.

- *2730 - Pharmaceutical waste*

3.2 New strategic risks.

There are three new strategic risks added this month.

- *3000 - Delivery of Sustainability and Transformation Fund*
- *3003 - RTT Pathway recording – Compliance*
- *3006 - Emergency Department Pressures*

3.3 Changes in risk rating

All strategic risks are reviewed monthly. Currently there are 20 strategic risks, 7 of these are considered severe. In this month, 2 risks have had their current risk rating reduced based upon the actions carried out and assurances received. They are:

- *2971- "Non-compliance with Nursing and Midwifery Revalidation" now reduced from a risk score of 20 to 15*
- *2879- "Use of Temporary Staffing" now reduced from a risk score of 20 to 16*

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	Date Risk First Reported	Risk Owner	Executive Committee	Executive Owner	Risk	Existing Controls	Initial Rating	Current Consequence	Current Likelihood	Current Rating	Mitigating actions to be completed	Target Risk Score	Key Indicators	Risk Journey 2016
Corporate Nursing	2742	Analysis & Improvement	**19-May-2015**	Head of Risk and Customer Services	QAC	JM	**Poor level of investigation into serious incident** .	Standard Operating procedure 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	Develop specific training for validators Develop further training for all involved in RCA Training for Medicine - re RCA Report regarding quality of investigations for QGC	**8**	Reduced amount of reinvestigation and reduced criticism from external regulator	Jan 2016 20 June 2016 20 Sept 2015 16
Corporate Nursing	2806	Compliance	**23-Oct-2015**	Head of Risk and Customer Services	QAC	JM	**Non Compliance with the Trust Alert & Hazards SOP**	Trust process in place to circulate alerts through Risk & Safety Team	16	4	4	16	Spot Check Audits to Recommence Introduction of new datix module to monitor alerts	**8**	Staff compliance with Alert and Hazard notices SOP	Jan 2016 16 June 2016 16 Sept 2015 16

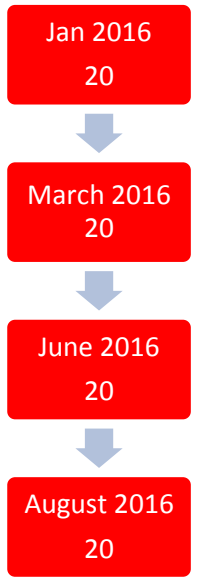
Business Group	ID	Source	Date Risk First Reported	Risk Owner	Executive Committee	Executive Owner	Risk	Existing Controls	Initial Rating	Current Consequence	Current Likelihood	Current Rating	Mitigating actions to be completed	Target Risk Score	Key Indicators	Risk Journey 2016
Corporate Nursing	2969	Falls	**9-Jun-2016**	Cathy Gibson	QAC	JM	**2969-Reduce the number and harm of Major to Catastrophic Patient Falls-2016–2017** *A number of major to catastrophic falls has increased in 2015-2016. Target of avoidable falls was not met.*	Hospital falls group Unavoidable Severe and catastrophic falls managed as SI = full RCA Policies and procedures in place regarding falls prevention and management. Specialised falls prevention and management training mandatory every three years for nursing and therapy staff.	16	4	4	16	Complete Trust Falls Alarm Programme, to include purchase of additional alarms Post falls action chart for medical staff to be developed Trust falls SOP to be reviewed and launched	**12**	To have less than 19 avoidable falls in a year.	June 2016 16 ↓ Sept 2016 16
Corporate Nursing	2194	Infection Prevention and Control	**29-Oct-2012**	Nesta Featherstone	QAC	JM	**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.*	SOP for isolation of patients	16	4	4	16	Bed managers following training will take over side room database. Opening of D block	**8**	A robust system is in place to ensure patients are appropriately managed in single rooms	Jan 2016 16 ↓ March 2016 16 ↓ May 2016 16 ↓ Aug 2016 16

Business Group	ID	Source	Date Risk First Reported	Risk Owner	Executive Committee	Executive Owner	Risk	Existing Controls	Initial Rating	Current Consequence	Current Likelihood	Current Rating	Mitigating actions to be completed	Target Risk Score	Key Indicators	Risk Journey 2016
Corporate Nursing	2971	Compliance	**10-Jun-2016**	Carole Sparks	QAC	JM	**Non-compliance with Nursing and Midwifery Revalidation.** *Risk that some staff will not be ready in time for revalidation which will have impacts both for the Trust and the individual.*	All nurses and midwives have been contacted directly by the NMC to inform them of their responsibilities. Trust Professional Registration Standing Operating Procedure	20	5	3	15	Undertake ongoing awareness raising via Team Brief/ circulation of information leaflets/ monthly updates to Strategic Heads of Nursing/ awareness raising sessions in Pinewood House and at team meetings Devise and circulate quarterly monitoring reports to show compliance of Trust staff and present at the Workforce and Organisational Development Committee. (April-June Figures) presented at August Meeting. (July-September Figures) present at November mtg Heads of Nursing to ensure anyone who is non-compliant is seen and has a plan in place to achieve revalidation asap	**10**	Comply with revalidation requirement.	April 2016 20 Sept 2016 16

Business Group	ID	Source	Date Risk First Reported	Risk Owner	Executive Committee	Executive Owner	Risk	Existing Controls	Initial Rating	Current Consequence	Current Likelihood	Current Rating	Mitigating actions to be completed	Target Risk Score	Key Indicators	Risk Journey 2016
Diagnostic & Clinical Support	2718	Medication	**19-Mar-2015**	Paul Buckley	QAC	JS	**Medication Errors Occurring as a Result of Having Different Systems for Prescribing**	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	Implementation of new EPR system.	**12**	Implementation of new EPR system.	

Business Group	ID	Source	Date Risk First Reported	Risk Owner	Executive Committee	Executive Owner	Risk	Existing Controls	Initial Rating	Current Consequence	Current Likelihood	Current Rating	Mitigating actions to be completed	Target Risk Score	Key Indicators	Risk Journey 2016
Diagnostic & Clinical Support	2877	Compliance	**7-Jan-2016**	Grace Davie	QAC	JS	**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. Action plan to be developed following QST review	**12**	To be compliant with requirement	March 2016 16 → June 2016 16 → Sept 2015 16
Finance	2896	Financial	**26-Jan-2016**	Kay Wiss	FS&I	FP	**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	Financial Improvement Programme - Phase 2. Financial analysis of staircase projects and deliverability over 5 years. Financial Improvement Programme Phase 3. Implementation of actions detailed in staff briefings on 27th July. Design and introduction of innovation projects to deliver transformational change	**15**	CIP delivery	June 2016 20 → Sept 2016 20

Business Group	ID	Source	Date Risk First Reported	Risk Owner	Executive Committee	Executive Owner	Risk	Existing Controls	Initial Rating	Current Consequence	Current Likelihood	Current Rating	Mitigating actions to be completed	Target Risk Score	Key Indicators	Risk Journey 2016
Human Resources	2879	Finance	**7-Jan-2016**	Emma Cain	WOD	JSh	**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	4	16	All actions completed. Risk assessment to be reviewed.	**12**	Reduction in cost and use of Temporary Staffing	Jan 2016 20 August 2016 20 August 2016 16

Business Group	ID	Source	Date Risk First Reported	Risk Owner	Executive Committee	Executive Owner	Risk	Existing Controls	Initial Rating	Current Consequence	Current Likelihood	Current Rating	Mitigating actions to be completed	Target Risk Score	Key Indicators	Risk Journey 2016
Medicine	2470	Other	**26-Sep-2013**	Stuart Rogers	QAC	CW	**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 Reliance on Locum medical staff is reducing as substantive recruitment continues The 6th Substantive Consultant post is back out to advert to allow the implementation of the COW model.	20	4	5	20	Provisional agreement made to re-recruit to FTC Locum Cons post - using vacancies Currently writing bottom up business case in line with current service pressures / national guidance Outsource New referrals to BMI / CMFT Review nursing establishment for service and propose any changes both within budget and those that require funding support Implement IBD pharmacist clinics to provide capacity for reviewing biologics patients Implement 2nd ERCP list to reduce surgical patient wait time and need for NHSP and agency staff to escort patients to UHSM CNS teams to re-review all cohorted patients monthly. Release locum at earliest, safest opportunity to reduce financial pressures Recruit 6th consultant in post	**8**	Nice guidance compliance	

Business Group	ID	Source	Date Risk First Reported	Risk Owner	Executive Committee	Executive Owner	Risk	Existing Controls	Initial Rating	Current Consequence	Current Likelihood	Current Rating	Mitigating actions to be completed	Target Risk Score	Key Indicators	Risk Journey 2016
Medicine	2721	National Recommendation	**9-Apr-2015**	Rebecca Barker	QAC	CW	**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	Conduct quarterly practice Trauma call activation via switchboard at differing times of the day. Review the process of recording of the CT reporting within 1 hour to assure demonstrates performance indicator is reached for appropriate patients. Examine current Triage standards & if any Trauma identified assure seen by Consultant in 30 minutes. Develop a plan to enable a robust Trauma coordinator service 7 days a week that can demonstrate the use of Rehabilitation prescriptions. Audit whether CT within 30 minutes of request for Major Trauma & timing of verbal reporting.	**8**	Trauma unit peer review compliance	Jan2016 20 → March 2016 20 → May 2016 20 → June 2016 20

Business Group	ID	Source	Date Risk First Reported	Risk Owner	Executive Committee	Executive Owner	Risk	Existing Controls	Initial Rating	Current Consequence	Current Likelihood	Current Rating	Mitigating actions to be completed	Target Risk Score	Key Indicators	Risk Journey 2016
Medicine	2990	Staffing	**21-Jul-2016**	Rebecca Barker	QAC	CW	**Registered Nurse staffing in Emergency Department.** *The Emergency department currently has a deficit of 11 WTE Registered Nurses.*	Daily monitoring of staffing levels Forward review of advancing weeks rosters Shifts out to bank and agency in a timely manner Pay incentive for NHSP workers picking up shifts in ED Own staff being paid flat rate overtime as agreed. Continual recruitment plus Face the Music campaign currently running for Experienced ED nurses Staff pulled from other front end wards to support but not trained in ED Advantis and uncomfortable to work in ED environment.	20	4	4	16	Consider the use of Block booked agency. Track incoming starters and ensure no hold up. To consider further FTM recruitment. Track incoming starters and ensure no hold up. Forward review of rosters and movement of staff to keep numbers well spread. Ensure safety of Paediatric unit. All shifts out to NHSP as soon as roster approved and as soon as gap is identified i.e. sickness. Every day a safety staffing huddle will take place; this will also be undertaken throughout the shift. Increased presence of 1090 and SMOC out of hours. Matron and Nurse Consultant to undertake shifts in ED	**8**	Improved staffing levels	**New July 2016 no review since (initial rating was challenged so reduced to 16 In July**

Business Group	ID	Source	Date Risk First Reported	Risk Owner	Executive Committee	Executive Owner	Risk	Existing Controls	Initial Rating	Current Consequence	Current Likelihood	Current Rating	Mitigating actions to be completed	Target Risk Score	Key Indicators	Risk Journey 2016
Trust Executive Team	2889	Compliance	**13-Jan-2016**	Collin Wasson	QAC	CW	**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	**12**	Achievement of standards in 7/7 working	**No reviews since January 2016 formally**

Business Group	ID	Source	Date Risk First Reported	Risk Owner	Executive Committee	Executive Owner	Risk	Existing Controls	Initial Rating	Current Consequence	Current Likelihood	Current Rating	Mitigating actions to be completed	Target Risk Score	Key Indicators	Risk Journey 2016
Trust Executive team	2644	Compliance	**4-Nov-2014**	Colin Wasson	QAC	CW	**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 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 Training of theatre staff in the management of bleeding upper GI patients to ensure a 24/7 7 days a week service or 2. 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	**8**	Full compliance with the NICE/NCEPOD guidance	Nov 2014 20 ↓ Jan 2016 16

Business Group	ID	Source	Date Risk First Reported	Risk Owner	Executive Committee	Executive Owner	Risk	Existing Controls	Initial Rating	Current Consequence	Current Likelihood	Current Rating	Mitigating actions to be completed	Target Risk Score	Key Indicators	Risk Journey 2016
Trust Executive team	2977	Compliance	**28-Jun-2016**	Sue Toal	QAC	JS	**Compliance with RTT 92% Incomplete Monitor Standard.** *Failure to achieve the RTT 92% Incomplete standard at the end of March 2016, as such failing the standard for Q4 of 2015/16.*	*Weekly Trust-wide PTL meeting – captures performance overview and tracks progress against recovery trajectory*	20	4	5	20	ENT/Oral Surgery-Address residual capacity & demand deficit for both specialties following impact analysis of previous actions. -Review pathway for micro-suctioning with CCG and further review of agreed pathway. GS/Urology-Address residual capacity & demand deficit for both specialties. Theatres-Extending staff mode for theatres/wards to be explored to maximise weekend theatre capacity. Diabetes/Endocrinology-Temporarily increase consultant PA for on-call to 1.4 both substantive consultants to offer increase in PM clinics when on-call. Gastro-6th Consultant appointed to commence. Gastro-Prioritise booking of new patients>18wks. ENT/Oral Surgery-Continue to offer choice of alternative provider to new ENT referrals. T&O-Implement longer term service redesign for spinal pathway.	**12**	Achieve the RTT target	**New June 2016 no formal reviews**

Business Group	ID	Source	Date Risk First Reported	Risk Owner	Executive Committee	Executive Owner	Risk	Existing Controls	Initial Rating	Current Consequence	Current Likelihood	Current Rating	Mitigating actions to be completed	Target Risk Score	Key Indicators	Risk Journey 2016
Trust Executive team	1881	Compliance	**23-Jun-2011**	Sue Toal	QAC	JS	**Failure to 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)	**10**	Achieving 95% in the 4 hour Performance Target within ED	**4th January 2016 transferred to Executive team ownership and has not formally been reviewed since this time**

Business Group	ID	Source	Date Risk First Reported	Risk Owner	Executive Committee	Executive Owner	Risk	Existing Controls	Initial Rating	Current Consequence	Current Likelihood	Current Rating	Mitigating actions to be completed	Target Risk Score	Key Indicators	Risk Journey 2016
Diagnostic & Clinical Support	2130	Clinical procedures	**22-Aug-2012**	Sara Wilson	QAC	JS	**Insufficient capacity in Endoscopy to meet the current demand**	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. Close monitoring of the breaching of targets Introduced new role of Inpatient coordinator to manage all inpatient referrals to prioritise referrals and maximise use of capacity. Endoscopy Cancellation escalation procedure developed.	20	4	5	20	Improve sessional productivity, adding 1 unit to each list by developing case pre-assessment and additional nurses allocated to procedure rooms. Continue to support estates/procurement in establishing plans for unit expansion. Develop process to feedback incomplete and inappropriate referrals to evidence issue and inform future improvement. Identify data required to support utilisation and performance management, explore potential for report development. Confirm last year's activity and project anticipated demand. Use department staffing model to anticipate impact of increased medical endoscopist workforce. Progression of unit infrastructure change as directed by exec board. Efficiently recruit to vacant posts.	**12**	Endoscopy target to be achieved	Jan2016 16 March 2016 20 June 2016 20 Sept 2016 20

Business Group	ID	Source	Date Risk First Reported	Risk Owner	Executive Committee	Executive Owner	Risk	Existing Controls	Initial Rating	Current Consequence	Current Likelihood	Current Rating	Mitigating actions to be completed	Target Risk Score	Key Indicators	Risk Journey 2016
Trust Executive Team	3003	Compliance	**17-Aug-2016**	Joanne Pemrick	QAC	CW	**RTT Pathway recording - Compliance**	RTT training - however very limited resource to deliver and sustain regular update training across all staff groups. Pathway validation - limited due to resource required to sustain.	16	4	4	16	Invite external RTT training provider to discuss possible delivery options Secure funding to support training costs Review and improve internal processes that support RTT delivery	**9**	Compliance with RTT Pathway recording-	**New August 2016**

Business Group	ID	Source	Date Risk First Reported	Risk Owner	Executive Committee	Executive Owner	Risk	Existing Controls	Initial Rating	Current Consequence	Current Likelihood	Current Rating	Mitigating actions to be completed	Target Risk Score	Key Indicators	Risk Journey 2016
Finance	3000	Financial	**12-Aug-2016**	Kay Wiss	FS&I	FP	**Delivery of Sustainability and Transformation Fund**	As part of the Board Assurance Framework Structure performance (including finance and standards) are reported through the committees. This has been enhanced by a revised committee structure and performance meetings as part of the Financial Improvement Programme. Monthly regulatory reporting to NHS Improvement is in place.	16	4	4	16	Completion of Phase 2 of Financial Improvement Programme -Phase 2 is to identify £25.7m of savings Forecast of Achievement of STF in future months to be undertaken on a monthly basis and submitted to NHSI Monitoring of Agency costing through Workforce Efficiency Group Completion of Phase 3 of Financial Improvement Programme	**12**	Achieve STF requirement	**New August 2016**

Business Group	ID	Source	Date Risk First Reported	Risk Owner	Executive Committee	Executive Owner	Risk	Existing Controls	Initial Rating	Current Consequence	Current Likelihood	Current Rating	Mitigating actions to be completed	Target Risk Score	Key Indicators	Risk Journey 2016

Business Group	ID	Source	Date Risk First Reported	Risk Owner	Executive Committee	Executive Owner	Risk	Existing Controls	Initial Rating	Current Consequence	Current Likelihood	Current Rating	Mitigating actions to be completed	Target Risk Score	Key Indicators	Risk Journey 2016
Medicine	3006	Incidents	**19-Sep-2016**	Jane Drummond	QAC	CW	**Emergency Department Pressures** *Current pressures within Emergency Medicine manifest themselves as an overcrowded Emergency Department. Despite actions related to increased staffing both medical and nursing and physical improvements to the department there remains a risk of reduced patient and staff safety.*	Daily monitoring of both medical and nursing staffing with movement of staff as required. Daily reviews of all actions which can be taken to move patients into the hospital from ED Current work with Stockport Together and the CCG in relation to reducing avoidable admissionsOver recruitment to current trained nurse vacancies Development of band 3 HCA roles for some current band 2 to increase roles responsibility 2 additional nurses to be added to each shift (Trained) via PULSE Change of internal process to allow use of Pulse agency Loan of two x defibrillators from EBME whilst purchase underway Meeting with HON, Head of Risk, ED CD and business manager for ED 22-9-16 to further develop risk assessment Staff to be allowed drinks in main base to ensure hydration due to building work reducing air circulation and current weather	16	4	4	16	Review of transfer unit staffing at weekend Costing and order of x 4 vital sign monitors Costing and Order of new defibrillator to increase numbers Building work to be completed to ensure more space available within the department	**8**	Reduction in incidents related to ED overcrowding	**New September Actions being reviewed and more detailed risk assessment being written**

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

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**	**2**	**3**	**4**	**5**
	Low	**Minor**	**Moderate**	**Major**	**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)*

QUALATIVE MEASURE OF CONSEQUENCE

Impact Score	1	2	3	4	5
Domains / Description	**NEGLIGIBLE / LOW**	**MINOR**	**MODERATE**	**MAJOR**	**CATASTROPHIC**
Impact on the safety of patients, staff or public (physical / psychological harm)	Minimal injury requiring no intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for <7 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 7-14 days Increase in length of hospital stay by 4-15 days RIDDOR / agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity / disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects Fatality Multiple permanent injuries/irreversible health effects	An event which impacts on a large number of patients Multiple Fatalities
Quality / complaints / audit	Peripheral element of treatment or service suboptimal Informal complaint / inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints / independent review Low performance rating Critical report Inquest / ombudsman negative finding	Totally unacceptable level or quality of treatment / service Gross failure of patient safety if findings not acted on Gross failure to meet national standards
Human resources / organisational development / staffing / competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective / service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory / key training	Uncertain delivery of key objective / service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory / key training	Non-delivery of key objective / service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training / key training on an ongoing basis
Statutory duty / inspections	No or minimal impact or breech of guidance / statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations / improvement notice Register concern	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity / reputation	Local Press >1 Potential for public concern	Local media coverage >1 Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. Full Public Inquiry MP concerned (questions in the House) Total loss of public confidence
Business objectives / projects	Insignificant cost increase / schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims / cost	Small loss Risk of claim remote < £2k	Loss of 0.1–0.25 per cent of Trust budget Claim / cost less than £2- 20k	Loss of 0.25–0.5 per cent of Trust budget Claim(s) / cost between £20k -£1M	Uncertain delivery of key objective / Loss of 0.5–1.0 per cent of Trust budget Claim(s) / cost between £1m and £5m Purchasers failing to pay on time	Non-delivery of key objective / Loss of >5 per cent of Trust budget Failure to meet specification / slippage Loss of contract / payment by results Claim(s) >£5 million
Service / business interruption Environmental impact	Loss / interruption of >1 hour Minimal or no impact on the environment	Loss / interruption of >8 hours Minor impact on environment	Loss / interruption of >1 day Moderate impact on environment	Loss / interruption of >1 week Major impact on environment in more than one critical area	Permanent loss of service or facility Catastrophic impact on environment
Project related	Insignificant impact on planned benefits	Variance on planned benefits <5% and <£50k	Variance on planned benefits >5% or >£50k	Variance on planned benefits >10% or >£500k	Variance on planned benefits >25% or >£1m

Stockport NHS
NHS Foundation Trust

Board of Directors' Key Issues Report

Report Date: 29/09/16		**Report Of:** Audit Committee
Date of last meeting: 13/09/16		**Membership Numbers:** Quorate
1.	Key Issues Highlighted:	The Committee considered an agenda which included the following: ▪ Internal Audit Progress Report ▪ Internal Audit Follow-Up Report ▪ External Audit Technical Update ▪ Raising Concerns at Work Report ▪ Referral to Treatment Report ▪ Board Assurance Framework ▪ Waiver Report ▪ Code of Governance Compliance Report With regard to matters to bring to the attention of the Board, the Committee considered a Progress Report from Internal Audit which was focused on the outcomes of a review of the process for procurement of clinical services. The review recommended means of strengthening internal controls where procurement was subject to a Waiver of Standing Financial Instructions and this finding was fully endorsed by the Committee. The subject matter of this report was incorporated in a general Waiver Report which was considered later in the agenda. The report provided assurance that instances of Waiver action are being authorised correctly at the appropriate level. The Committee also noted the introduction of a revised Procurement Policy which includes a provision for any breaches of Standing Financial Instructions to be reported to the Committee. This would include Waiver action, if appropriate, and is an area which the Committee will subject to close scrutiny. The Committee also considered a report which detailed the outcomes of a 6-monthly follow-up of Internal Audit recommendations and was assured that good progress is being made with the implementation of actions to address recommendations arising from Internal Audit reviews. Board members should note that the Trust's auditor commented positively on performance in this area in comparison with other client organisations. The Committee reviewed a Technical Update Report presented by the Trust's External Auditor and noted in particular a briefing on NHS Improvement's consultation on a single oversight process for NHS providers. Coincidentally, the Single Oversight Framework (SOF) which resulted from this consultation was published just prior to the Committee meeting. The SOF will replace the current Risk Assessment Framework on 1 October 2016 and is based on five theme areas as follows: ▪ Quality of Care

		▪ Finance and Use of Resources ▪ Operational Performance ▪ Strategic Change ▪ Leadership and Improvement Capability (well-led) Board members will need to quickly develop an understanding of the SOF, and the segmentation approach which will determine the level of provider autonomy and requirement, or not, for mandated support. Board members will recall that the External Audit review of the Annual Quality Report 2015/16 resulted in a qualified opinion relating to the nationally mandated Referral to Treatment indicator. The Committee considered a report on this subject which advised of continuing data accuracy issues in this area. The Committee noted that root cause analysis had identified a training need for staff groups involved in the multiple input points to this particular pathway and endorsed a recent Executive Team decision to introduce a mandatory training package for relevant staff groups. Board members should note that, due to challenges to this particular indicator on a national basis, the indicator is likely to be mandated for review in 2016/17. Consequently, there is currently a risk that the Trust's review will again result in a qualified opinion. The Director of Workforce & OD attended the meeting to present an assurance report on the effectiveness of the systems and processes in place relating to Raising Concerns at Work. The Committee noted the assurance provided on current systems with thematic analysis of issues and concerns raised with the Freedom to Speak Up Guardian being reviewed by the People Performance Committee. The Committee also noted a requirement to review the Trust's policy to ensure consistency with the National Whistleblowing Policy and has requested assurance that the review will be completed by the target date of 1 April 2017. The Committee reviewed the Board Assurance Framework (BAF) and recommended a review of the risk related to SO4 to reflect outcomes of the CQC Inspection. The Committee also considered its practice in relation to BAF reviews and agreed to introduce a process of 'deep dives' on the controls and assurance aligned to specific risks at future meetings. Finally, the Committee noted assurance provided by the positive outcomes of a 6-monthly review of compliance with the various elements of the NHS Foundation Trust Code of Governance.		
2.	Risks Identified	Qualified opinion on the RTT indicator for 2016/17		
3.	Actions to be considered at the Audit Committee	Nil		
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: 29/09/16		**Report of:** Finance & Performance Committee
Date of last meeting: 21/09/16		**Membership Numbers:** Quorate
1.	Key Issues Highlighted:	The Committee considered an agenda which included the following: ▪ Strengthening Financial Performance & Accountability 2016/17 ▪ Finance & Operations Flash Results - Month 5 ▪ Month 5 Finance Report 2016/17 ▪ Fair & Transparent Pricing Report ▪ Update on Financial Improvement Programme ▪ Impairment Review ▪ Operational Performance Report ▪ Root Cause Analysis – 52 Week Breaches ▪ Tender Log - August 2016 With regard to matters to bring to the attention of the Board, the Committee considered a report regarding a document titled *Strengthening Financial Performance & Accountability in 2016*/17 which was jointly published by NHS Improvement and NHS England on 21 July 2016. The document, which applies to both CCGs and Provider trusts sets out a wide-ranging set of actions which include; organisation-specific performance improvement trajectories, financial control totals, introduction of new intervention regimes, new controls relating to interim manager, back office and agency costs and introduction of a two-year NHS planning and contracting round for 2017/18 – 2018/19. With regard to the latter, the Committee was advised that planning guidance is due to be published in the near future and noted that the timescales for preparation of the two-year plans would be challenging. Additional implications for the Trust relate to the performance framework for achievement of Sustainability & Transformation Funding (STF). The report detailed financial benefits for the wider health economy, based on service improvement assumptions included in the overarching Stockport Together business case, and the Committee noted that these assumptions would need to be validated as plans for MCP development progress. The Committee reviewed ``Flash Reports' for both Financial and Operational performance which summarise performance data submitted to NHS Improvement in mid-monthly returns. The Committee again endorsed use of these reports, which are routinely circulated to Board members for information, and supported a suggestion from the Chief Executive that a session aimed at improving awareness and understanding of the nuances associated with individual performance metrics be incorporated in the next Board development day.

		The Committee considered in detail a comprehensive Month 5 Finance Report which presented the Trust's financial position as at 31 August 2016. The Committee noted a deficit position of £10m, which was £1.9m better than plan, of which £1.1m related to timing of STF funding. Committee discussion and debate concentrated on; the cost improvement programme, agency staffing and the Trust's cash position. With regard to Business Group performance, the Committee again noted poor financial performance by the Medicine Business Group and was briefed on the escalation measures taken by the Executive Team which included recent consideration of a financial recovery plan for the Business Group. The Director of Finance briefed the Committee on the financial implications of non-elective activity and noted the effect on income of increased bed days resulting from delayed transfer of care (DTOC). The Chief Executive advised the Committee of recent developments to facilitate joint working on this area by the Stockport and South Manchester health economies and the Committee endorsed this approach. With regards to the cost improvement programme, the Committee noted a positive variance against plan of circa £700k at 31 August 2016 and a more detailed report on the Financial Improvement Programme was considered later in the meeting. The Committee also noted continued positive performance against the Agency Ceiling trajectory while acknowledging the challenge of maintaining such positive performance through the winter period. The Director of Finance then briefed the Committee on the challenges to achievement of the year-end forecast and delivery of the deficit £6m control total for 2016/17 and advised of limited assurance on delivery in the context of the position at 31 August 2016. After considerable discussion, the Committee accepted this assurance level but requested that the Executive Team prepare proposals for means of reporting and assessing assurance levels for consideration at the next meeting. The Committee then considered a similarly comprehensive Operational Performance Report and noted the impact of DTOC on performance against the 4-hour A&E standard with performance some way off the 95% standard at 77.1% for August 2016. The Committee was advised that DTOC levels had averaged 60 per day during August and noted initiatives mandated in the NHSI / NHS England A&E Improvement Plan which included; Streaming at the front door, Improved flow and Mandated discharge to assess. The Committee also considered performance challenges relating to; 62 day cancer standard, referral to treatment (RTT) and Outpatient waiting lists. The recently-appointed interim Deputy Chief Operating Officer attended the meeting and advised the Committee that she had identified a number of areas where there was scope for strengthening performance management practices which were scheduled for consideration by the Acting Chief Operating Officer and Chief Executive. The Committee reviewed a separate report which detailed root cause analysis on three 52 week breaches against the 18-week Referral to Treatment pathway which had occurred in June and July 2016. The Committee was assured that none of the affected patients had suffered harm as a result of the breaches and noted plans to introduce a bespoke RTT e-learning package, completion of which will be mandatory for relevant staff groups, to address training needs identified through the root cause analysis. Finally, the Financial Improvement Director presented a report which summarised progress against the Financial Improvement Programme and the Committee noted good progress and a positive level of assurance associated with identification of circa £16m savings as at 16 September 2016. Board members should note that, while a proportion of the identified savings (circa 38%) relate to pipeline schemes, the £16m figure does not incorporate savings expected to accrue

		from the 'bold actions'. However, full delivery of 'bold actions' remains imperative to achievement of the Trust's financial plan for 2016/17. The Committee also supported management plans to brief managers on FIP progress at the Team Brief session on 28 September 2016.		
2.	Risks Identified	Delivery of 2016/17 control total Achievement of operational performance trajectories for; A&E, 62 day cancer and RTT.		
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

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Stockport NHS
NHS Foundation Trust

Board of Directors' Key Issues Report

Report Date: 29/09/2016		**Report of:** People Performance Committee
Date of last meeting: 22/09/2016		**Membership Numbers:** Quorate

1.	Key Issues Highlighted:	The Committee considered an agenda which included the following:
		
		• Staff Story
		• Workforce Race Equality Standard (WRES)
		• Staff Friends & Family Test Update
		• Workforce Plan Update
		• Apprenticeship Scheme – Update
		• Learning & Development Plan
		• Core Skills Framework Update
		• Workforce Streamlining Programme – Update
		• Corporate Risk Register
		• Policies for Validation
		  - Performance Appraisal Policy
		  - Work Experience Policy
		• Key Issues Reports from Sub-Groups
		
		With regard to matters to bring to the attention of the Board, the Committee received a presentation from Ms J Shone (Clerical Assistant) and Mrs S Clark (Equality & Diversity Manager). Ms J Shone, who had initially joined the Trust as a Volunteer, was now a full-time employee, working as a Receptionist in the Radiology Department. Ms J Shone, who suffered from profound hearing loss, briefed the Committee of the difficulties she had encountered due to her disability, noted the positive support she received from colleagues and advised of her involvement in a number of developments to improve staff and patient experience.
		
		The Chief Executive advised the Committee that the Health Education England North West (HEENW) had undertaken an assessment visit to the Trust on 21 September 2016. She noted that, although the initial feedback had been largely positive, some concerns had been raised which included issues in the Emergency Department due to staffing levels. Mrs A Barnes noted that the HEENW would write to the Trust with regard to the concerns and advised that a full report was expected in approximately 12 weeks' time.
		
		Following the consideration of a Workforce Race Equality Standard (WRSE) report at the Committee's meeting in August 2016, the Equality & Diversity Manager presented a follow up report which detailed proposals for relevant metrics to measure progress against the action plan. Particular reference was made to

		Metrics 1 and 2 and the Committee considered the key messages with regard to the communication of the action plan. The Committee received a verbal update from the Head of Learning & Development with regard to the Staff Friends & Family Test and discussed the proposed target which was to be agreed with the CCG and noted the link with the Health & Wellbeing CQUIN. The Committee considered a Workforce Plan Update Report which was presented by the Workforce Transformation Manager. The Committee noted the submission of the Workforce Plan to Health Education England by the deadline date of 24 May 2016 and was advised of the key factors which had impacted upon the plan. The Committee considered an update report on the Apprenticeship Scheme, presented by the Head of OD & Learning, which provided an outline on the current position and an overview of the new apprenticeship standards, levy and organisational targets. Reference was made to the challenges in meeting the new apprenticeship target of 2.3% of headcount, which was a significant increase in numbers, 123, compared to the 18 apprentices currently at the Trust. It was noted that a detailed plan on how to achieve the new apprenticeship standards would be considered at the Committee meeting in December 2016. The Committee considered a draft Learning & Development Plan. Committee members were asked to provide feedback on the draft plan to the Head of OD & Learning which would be incorporated in a further version to be considered at the Committee's next meeting. The Committee also considered a report by the Head of OD & Learning with regard to the move to adopt the Core Skills Framework in line with the North West Workforce Streamlining Programme. The Committee noted the considerable benefits that could be realised through the streamlining of recruitment and induction processes in the North West. It was further noted that with the adoption of the Core Skills Framework, which was due to 'go live' on 1 January 2017, the majority of staff would be expected to complete all core skills topics via e-learning. The Committee discussed the importance of effective rostering to ensure that staff were given protected time to undertake the e-learning. The Committee noted the Corporate Risk Register and was advised of the need to update workforce related risks 2880 and 2879. The Committee validated the Performance Appraisal Policy and Work Experience Policy and received key issues reports from the Joint Consultative & Negotiating Committee, Workforce Health & Wellbeing Group and the Workforce Efficiency Group.		
2.	Risks Identified	• Outcome of the Health Education England North West Visit • Achievement of Health & Wellbeing CQUIN targets • Implementation of Workforce Plan.		
3.	Report Compiled by	Angela Smith, Chair	Minutes available from:	Company Secretary

Stockport NHS
NHS Foundation Trust

Board of Directors' Key Issues Report

Report Date: 29/09/16		**Report of:** Quality Assurance Committee
Date of last meeting: 27/09/16		**Membership Numbers:** Quorate
1.	Key Issues Highlighted:	The Committee considered an agenda which included the following: ▪ CQC Report & Trust Response ▪ Never Event External Review – Progress Report ▪ CQUIN Progress Report ▪ Monthly Clinical Governance Report ▪ Quality Improvement Strategy Dashboard ▪ Nursing & Midwifery Strategy - Progress Report ▪ National Standards on 7 Day Services - Progress Report ▪ Clinical Audit Annual Report 2015/16 ▪ Patient Engagement / Complaints & Claims Report ▪ Incident Reporting ▪ Patient Safety Assurance Report With regard to matters to bring to the attention of the Board, the Director of Nursing & Midwifery presented a draft CQC Action Plan for review by the Committee prior to consideration by the Board of Directors on 29 September 2016. The Committee noted the comprehensive nature of the plan, which includes circa 250 individual actions and received assurance from the Director of Nursing & Midwifery that plans were in place to ensure robust progress monitoring and reporting through Business Group Quality Boards, the Quality Governance Committee, the Quality Assurance Committee and from there to the Board of Directors. The Committee also requested details of the arrangements in place to facilitate ongoing monitoring of compliance. Clearly, the Board of Directors will expect to be regularly briefed on progress against this key action plan and be assured on Trust preparedness in advance of a follow-up inspection by the Care Quality Commission. The Committee considered a report from the Medical Director which detailed progress against the action plan to address recommendations from the External Review of Never Events. The Committee noted that good progress has been made with 23 of the 34 actions fully completed and work in progress to address the remainder of the actions. The Committee received assurances from the Medical Director that all actions will be completed in the next 2-3 months. The Committee received similarly positive assurance on progress with the 2016/17 CQUIN Programme, with a report from the Director of Nursing & Midwifery detailing 95% delivery of Quarter 1 milestones. Delivery at this level has a financial benefit of circa £1.05m and represents a good start to the programme for the year.

		The Committee reviewed a Clinical Governance Report which summarised serious incidents and matters relating to the Coroner and the Health Service Ombudsman. The report also provided trend information on areas of concern during 2016/17 and the Committee noted advice provided by the Director of Nursing & Midwifery of work being undertaken to facilitate practical application to policies. This related in particular to areas of concern regarding adherence to the Falls Policy and Ulcer Policy. The Director of Nursing & Midwifery also presented a report which detailed progress against the Quality Strategy Delivery Plan 2016/17 and the Committee noted positive assurance on progress made against the objectives aligned to the 11 projects in the Quality Strategy. The Committee considered a report which provided a comprehensive overview of Safeguarding Children and Adults activity during Quarter 1 2016/17. The Committee noted in particular good levels of training compliance with targets for training in both Children and Adult Safeguarding exceeded during the Quarter. However, the challenges which impaired performance against the targets for Prevent training were also noted. The Committee also considered a report from the Medical Director, which detailed progress against the four priority standards for improving 7-day services, and noted that good progress has been made in each of the areas. The Committee also noted the challenges to completing consultant daily reviews in non-acute areas and acknowledged that this was a challenge facing many organisations due to the potential impact on consultant numbers. Finally, the Committee received and noted the Clinical Audit Annual Report 2015/16 and a Patient Engagement Report presented by the Medical Director and Director of Nursing & Midwifery respectively.		
2.	Risks Identified	Patient / Staff safety in relation to the CQC Action Plan		
3.	Actions to be considered at the *(insert appropriate place for actions to be considered)*	Nil		
4.	Report Compiled by	Mike Cheshire, Chair	Minutes available from:	Company Secretary

Stockport NHS
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	29 September 2016
Subject:	Chief Executive's Report		
Report of:	Chief Executive	**Prepared by:**	Ann Barnes

REPORT FOR NOTING

Corporate objective ref:	S4
Board Assurance Framework ref:	S05
CQC Registration Standards ref:	N/A
Equality Impact Assessment:	☐ Completed ☐ Not required

Summary of Report

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

- Stockport Together
- Winter Planning & Escalation
- Publications

Attachments: Annex A – Greater Manchester Combined Authority Letter dated 21 September 2016

This subject has previously been reported to:	☐ Board of Directors ☐ Council of Governors ☐ Audit Committee ☐ Executive Team ☐ Quality Assurance Committee ☐ F&P 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 advise the Board of Directors of national and local strategic and operational developments.

2. STOCKPORT TOGETHER

2.1 The four provider organisations in Stockport Together (Stockport NHS FT, Stockport MBC, Pennine Care NHS FT and Viaduct GP Federation) are currently consulting their organisations and stakeholders on the creation of a new provider form to deliver a Multi-Specialty Community Provider (MCP) in Stockport. The options appraisal, which will explore different types of form, will be completed by 17 October 2016 and outcomes will then be shared with governing bodies of the provider organisations leading to an intended decision on a preferred option at the end of November 2016. For Stockport FT this process has been shared at a briefing for Governors and the options appraisal will be considered at the October Council of Governors meeting and the November Board of Directors meeting.

3. WINTER PLANNING & ESCALATION

3.1 In a letter dated 21 September 2016, the Greater Manchester Health & Social Care Partnership have signalled their commitment to a robust approach to improving Urgent & Emergency Care performance and their intention to produce a single conurbation wide document setting out the plan to manage Winter this year. A copy of the correspondence is included for reference at Annex A to the report.

3.2 The NHS Stockport CCG Governing Body will be considering a paper on Tuesday 27 September 2016 outlining the significant transformation taking place in the Stockport Urgent Care system over the coming months which will form the basis of our plans for managing Winter this year. Many of you will be actively involved with this work. The paper will be jointly presented by the Trust and the Chair of the Stockport Urgent Care Delivery Group, Dr Catherine Briggs. It brings together the improvement schemes and wider transformation plans for urgent care through the work of Stockport Together, the Urgent Care Improvement Plan and the Winter Schemes for 2016/17.

3.3 Alongside this work, we are now commencing the more detailed planning for our own internal assurance and escalation processes this Winter, learning from the lessons of last year and capitalising on the improvements to the urgent care system and patient flow we expect to see as a result. We will keep Board members informed and engaged throughout this process.

4. PUBLICATIONS

4.1 Could I draw the attention of the Board of Directors to the following items from issues 84 and 85 of the NHS England 'Informed' publication.

- **NHS framework shares learning from the multispecialty community provider vanguards**
  NHS England has published a multispecialty community provider (MCP) emerging care

model and contract framework. The framework outlines how place-based partnerships can replicate the successful work of the 14 MCP vanguards, when establishing their own programmes. A milestone for the new care models programme and the implementation of the NHS Five Year Forward View, the document defines what being an MCP means by taking features from the vanguards to create a common framework. Commissioners and providers can follow the framework when establishing MCPs, and the vanguards themselves will adopt or adapt it for their own local communities. The MCP vanguards are transforming care by moving specialist services out of hospitals and into the community.

- **Increasing responses to the NHS Staff Survey**
  NHS England has written to chief executives of NHS trusts, human resources directors and staff survey leads to encourage a census approach, where all staff are given the opportunity to take part, for their annual NHS Staff Survey. Last year, most trusts asked all staff to participate in the survey, which resulted in a significant increase in response rates when compared to previous years where only a sample of staff were asked to take part.

- **New dementia awareness films published**
  New films by Health Education England aim to improve dementia diagnosis and care through greater awareness. Finding Patience supports a culturally appropriate approach to the dementia pathway. It aims to improve early diagnosis and support for people within African Caribbean communities by improving awareness amongst both health and care professionals, and those within the community. Focusing on dementia in care homes, Finding Patience – The Later Years raises awareness of how dementia can affect people differently. It encourages health and care professionals to reflect on the care they provide and calls for person-centred care that focuses on the individual, not the condition.

- **Health and Care Innovation Expo 2016: At a glance**
  Health and Care Innovation Expo 2016 returned to Manchester Central last week. Opening its doors to over 5,000 delegates, this year's conference focused on implementation of the Five Year Forward View. The packed agenda included a host of high profile speakers across two main stages, four specialist feature zones, more than 100 expert-led workshops and dedicated learning sessions and satellite events enabling in-depth, peer-to-peer discussion on priority areas.

  In his opening address, Professor Sir Bruce Keogh, National Medical Director for NHS England said: "Part of the solution to improving quality of care and meeting demand lies in awareness of emerging science and technology, embracing innovation and constantly asking is there a better way of delivering the service? This is what Expo is all about."

  Read about key NHS England announcements made over the two day conference.

  Tell us about your #Expo16NHS experiences on Twitter @ExpoNHS or send us a blog about how you are taking on ideas from Expo 2016 in your own team or organisation, at england.expo@nhs.net

- **Global Digital Exemplars – The hospital trusts inspiring a digital revolution**

NHS England has announced 12 hospital trusts that will pioneer new ways of using digital technology to drive radical improvements in patient care. Known as Global Digital Exemplars, they are the most digitally advanced hospitals in the NHS and will each receive up to £10 million from NHS England to inspire a digital revolution across the health service. This follows the recommendations of an independent review, by health IT expert Professor Bob Wachter on how the NHS can use technology to improve services.

- **Plans launched for seven day hospital pharmacy services**
  NHS England delivered its first report on enhancing the quality of care and improving access to seven day pharmacy services for patients in hospital, at the Royal Pharmaceutical Society Annual Conference, on 5 September 2016. Transformation of Seven Day Clinical Pharmacy Services in Acute Hospitals sets out a vision where hospital pharmacy services could operate more efficiently and safely, and 13 key recommendations of how clinical pharmacy services in hospitals can be strengthened, particularly at weekends, to benefit patients.

- **New generic role templates support the redesign of the learning disability workforce**
  Health Education England has produced a set of five generic role templates to support the development of new and different roles in learning disability community services. The templates will help commissioners and providers of health and care services build a flexible workforce capable of delivering the aims of the Building the Right Support agenda. Divided into educational levels, the templates outline a range of activity-specific competences that organisations can select, based on the features and focus of the role that is being designed.

5. RECOMMENDATIONS

5.1 The Board of Directors is recommended to:

- Receive and note the content of the report.

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Greater Manchester Health & Social Care Partnership
4th Floor
3 Piccadilly Place
London Road
Manchester M1 3BN

Ref: **Winter planning and improvement assurance**
21st September 2016

Su Long, Chair, UEC Delivery Board
Kim Godsman, Chair, Wigan Borough System Resilience Group
Dr Ross Seaton, Chair, Salford UEC Delivery Board
Dr Ian Wilkinson, Chair, Oldham A&E Delivery Board
Dr Naveed Riyaz, Chair, Tameside & Glossop A&E Delivery Board
Cath Briggs, Chair, Stockport A&E Delivery Board
Ed Dyson, Chair, City-Wide Urgent Care Transformation & Delivery Board
Dr Martin Whiting, Chair, North East Sector UEC Delivery Board

Dear Colleague

We all fully recognise the importance of a robust and effective response to the challenges faced by health & social care systems during the winter months. In addition we also fully support the national drive to improve Urgent & Emergency Care performance through the 5 initiatives within the A&E Improvement Plan.

Current performance, as measured by the A&E Standard of 95% continues to be extremely fragile in many systems. There is a high degree of variability across the patch with significant difference between the highest and lowest. Colleagues will be very familiar with the annual winter planning and reporting processes and also how this has historically been managed.

In respect of this winter 2016-17, Greater Manchester intends to provide regional and national colleagues with a single conurbation wide document that sets out our shared intentions and direction of travel in relation to winter and the delivery of the A&E Improvement Plan. I envisage that document to reflect the needs of your local systems and seek your active engagement in ensuring we can successfully achieve that. To that end I ask that you update us in respect of your planning;

- To manage the system pressures this winter (including escalation and oversight)
- To deliver progress against the 5 priorities in the A&E Improvement Plan

Ideally these will reflect clear timelines and milestones so we can identify how GM, as a whole, will deliver. At the UEC Workshop on the 9th September the discussions focused attention on the pressures and actions required to improve our collective position so you will no doubt already be moving on the respective planning at your system level.

That being the case I am hopeful that you will be able to provide your local system overview to us by the **30th September** to enable us to assure colleagues that GM is well prepared to meet the challenges.

Please direct your returns, and any questions on the issues raised in this letter or the overall process, to colin.kelsey@nhs.net.

Yours faithfully

Jon Rouse
Chief Officer
Greater Manchester Health & Social Care Partnership

Cc

CCG Chief Officers
Trust Chief Executives
LA DASS
GM UEC Task Force