Stockport NHS
NHS Foundation Trust

BOARD OF DIRECTORS

PUBLIC MEETING

30 JUNE 2016

Your Health. Our Priority.

Board of Directors - PUBLIC MEETING - 30 June 2016 - agenda pack

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Stockport NHS
NHS Foundation Trust

June 2016

Dear Colleague

You are invited to a meeting of the Board of Directors which will be held on **Thursday 30 June 2016 at 1.15pm in Lecture Theatre A, Pinewood House, Stepping Hill Hospital.**

An agenda for the meeting is detailed below.

Yours sincerely

GILLIAN EASSON
CHAIRMAN

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AGENDA ITEM	TIME
1. Apologies for Absence.	1.15pm – 1.20pm
2. Opening Remarks by the Chairman.	"
3. Declaration of Amendments to the Register of Interests.	"
4. **OPENING MATTERS:**	
4.1 To approve the minutes of the previous meeting of the Board of Directors held on 26 May 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 Annual Safeguarding Report (Report of Director of Nursing & Midwifery attached)	2.00pm – 2.10pm
5.3 Never Events Report (Report of Medical Director attached).	2.10pm – 2.25pm
5.4 Strategic Risk Register (Report of Director of Nursing and Midwifery attached).	2.25pm – 2.35pm
5.5 Maintaining Safe Staffing Levels (Report of Director of Nursing & Midwifery attached)	2.35pm – 2.45pm

AGENDA ITEM	TIME
5.6 Key Issues Reports from Assurance Committees: 5.6.1 Finance & Performance Committee (attached and Malcolm Sugden to report)	2.45pm – 2.55pm
5.7 Finance & Performance Committee – Terms of Reference (Report of Company Secretary attached).	2.55pm – 3.00pm
5.8 Governance Declarations (Report of Company Secretary attached)	3.00pm – 3.10pm
6 **STRATEGY AND DEVELOPMENT:**	
6.1 Report of Chief Executive (attached).	3.10pm – 3.20pm
6.2 For validation: Risk Management Strategy (attached).	3.20pm – 3.25pm
7 **CLOSING MATTERS:**	
7.1 Any Other Urgent Business.	"
7.2 Date of next meeting: • Thursday 28 July 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 26 May 2016 1.15pm in Lecture Theatre A, Pinewood House, Stepping Hill Hospital

Present:

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

In attendance:

Mr P Buckingham	Company Secretary
Mrs S Curtis	Membership Services Manager
Ms E Flesk	Intensive Care Unit Sister
Ms M Gilligan	Matron for Patient Experience

152/16 Apologies for Absence

Apologies for absence were received from Mrs G Easson and Dr M Cheshire. Mr M Sugden advised that Mrs G Easson was speaking at an event at the Royal College of Physicians where she had been invited to by NHS Improvement to give a talk about changes to the Stockport health economy.

153/16 Opening Remarks by the Chairman

Mr M Sugden welcomed members of the Board to the meeting and, in particular, welcomed Mr A Burn, Director of Financial Improvement, and Ms S Toal, Acting Chief Operating Officer, to their first Board meeting.

Mrs A Barnes advised that the Trust had been successful to be one of 16 Trusts in the country to have been accepted onto a Financial Improvement Programme (FIP) run by NHS Improvement. She noted that the Programme would work in three phases; phase one would take four weeks and, only when there was clear evidence that savings were viable, would phase two start, consisting of three months delivering savings. Phase three would see continued work on savings if required. Mrs A Barnes advised that every trust on the Programme had a management consultancy firm working with them and noted that this Trust was working with KPMG. Mr A Burn, Partner at KPMG, had been formally seconded by the Board of Directors as Director of Financial

Improvement for the duration of the Programme and was a non-voting Board member and a member of the Executive Team.

Mrs A Barnes advised that Mr P Orwin, who had started with the Trust in early April in a short term role as Interim Chief Operating Officer, had now left the organisation. She noted that since the commencement of the Financial Improvement Programme it had been clear that there was duplication with regard to performance management and therefore Mr P Orwin's contract had been finished earlier than anticipated. Mrs A Barnes advised that the Trust needed to continue, at least for the short and medium term, to separate at executive level the portfolios around future strategy and partnerships from operational delivery. Mr J Sumner had therefore continued with his focus on strategy, estates & facilities and information as well as being Deputy Chief Executive. Ms S Toal, who was previously Director of Operations, had taken on the role of Acting Chief Operating Officer and was a non-voting Board member and a member of the Executive Team.

154/16 Declaration of Amendments to the Register of Interests

There were no interests declared.

155/16 Minutes of the previous meeting

The minutes of the previous meetings held on 28 April were approved as a true and accurate record of proceedings. The action tracking log was reviewed and annotated accordingly.

156/16 Patient Story

Mrs J Morris welcomed Ms M Gilligan, Matron for Patient Experience, Ms E Flask, Intensive Care Unit Sister and Mrs A Hussey, a former patient at the Intensive Care Unit, to the meeting. Mrs A Hussey briefed the Board of the treatment and care she had received whilst a patient in the Intensive Care Unit due to sepsis. She made reference to the benefit of a patient diary which staff and family members had filled in while she was in the Intensive Care Unit and which had provided useful with regard to filling in gaps and helping her to come to terms with what had happened to her. Mrs A Hussey noted that she had made a full recovery and wished to thank all staff involved.

Ms E Flask advised that the patient diaries, which were completed for all level 3 patients in the Intensive Care Unit, had been introduced a year ago. She noted that following a patient survey, there were plans to establish an informal support group for patients who had been cared for in the Intensive Care Unit. In response to a question from Ms A Smith, Ms E Flask advised that level 3 meant patients in the Intensive Care Unit who were in an induced coma and on a ventilator. In response to a question from Mrs C Anderson who queried whether the diaries were widely used elsewhere, Ms E Flask confirmed that they were and noted that they were included in the NICE guidelines for rehabilitation services.

The Board of Directors thanked Mrs A Hussey and Ms E Flask for the informative and powerful story.

The Board of Directors:

- Received and noted the Patient Story report.

Ms M Gilligan, Ms E Flask and Mrs A Hussey left the meeting.

157/16 Trust Performance Report – Month 1

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

The Board noted that there were two areas of non-compliance in month 1 which were the non-achievement of the Accident & Emergency (A&E) 4-hour target and the Referral to Treatment 92% Incomplete Pathway target. With regard to the A&E 4-hour performance, it was noted that the main factor impacting on patient flow continued to be delayed transfers of care. In addition, Ms S Toal advised that May had seen a sustained and unprecedented increase in attends in the Emergency Department. Ms S Toal provided an overview of the mitigating work ongoing in this area and made specific reference to a review of the Trust's estate to create additional capacity in the Emergency Department.

In response to a question from Mr J Sandford who queried the various mitigation programmes in place to help the Trust recover its A&E performance, 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.

It was noted that non-compliance against the Referral to Treatment (RTT) target was expected to continue throughout Quarter 1. Ms S Toal advised that the ability to begin recovering the position in April had been impeded by the Junior Doctors strike action which had resulted in a loss of 96 elective cases. The Board noted that recovery plans were in place which predicted a return to compliance by month 4 and therefore Quarter 2 onwards.

With regard to finance, Mr F Patel advised that the Trust had a deficit of £2.4m at the end of April 2016 which was in line with the financial plan. The Trust had a planned deficit of £16.9m for the financial year 2016/17 which was after a cost improvement plan of £17.5m. Clinical income in April was behind plan by £418k and it was noted that the most significant variance within this had been the impact of the two-day junior doctors strike. Mr F Patel advised that in April, the Strategic Staircase schemes had been expected to deliver £461k but had only delivered £85k. The Business as Usual schemes had not expected to deliver any savings until Month 3 but had in fact delivered £223k in month. The total adverse variance against plan had therefore been £153k. Mr F Patel advised that cash in the bank at the end of April 2016 had been £27.1m against an operational plan of £28.5m, resulting in a negative variance of £1.4m in April. He briefed the Board of the reasons behind this variance, which

included an unpaid debt of £600k from Tameside Foundation Trust. It was noted that the year-end cash forecast position remained at circa £10m.

In response to a question from Mrs C Anderson, Mr F Patel noted that the delivery of the Business as Usual schemes were predominantly non-recurrent. In response to a question from Mr J Sandford who queried the clinical income, Mr F Patel advised that this was a timing issue and that the position was expected to improve the following month. Mrs J Shaw provided an overview of workforce metrics and made specific reference to the improved position with regard to sickness absence.

Mr J Sandford made reference to Chart 14 and commented on the increased trend of Summary Hospital-level Mortality Indicator (SHMI). Whilst noting that the figures were still well within the expected range, he queried whether anything specific had caused the slight upward trend. Mr C Wasson advised that he was not aware of anything specific that would give cause for concern and noted that the Trust compared well against its peers with regard to the indicator.

The Board of Directors:

- Received and noted the contents of the Trust Performance Report
- Noted the current position for month 1 compliance standards
- Noted the future risks to compliance and mitigating actions
- Noted the key risk areas from the Integrated Performance Report

158/16 Corporate Objectives 2016/17

Mr J Sumner presented a report seeking approval of the Trust's corporate objectives 2016/17. He advised that the Trust's strategic objectives had been identified and aligned to strategic risks and that corporate objectives had then been aligned to each of the strategic objectives to assist with operational delivery. Mr J Sumner noted that, for progress monitoring, the corporate objectives would be incorporated into the Trust's Integrated Delivery Plan.

In response to a question from Mrs C Anderson who commented on the actions from the Strategic Development Committee following the proposal to merge the Committee and the Finance & Investment Committee, Mr J Sumner advised that the Company Secretary was in the process of preparing terms of reference for the new Committee. Mrs A Barnes made reference to the importance of cascading the corporate objectives to business groups and noted that individual staff objectives would then be aligned to the corporate objectives to demonstrate a 'golden thread' approach to objective setting.

The Board of Directors:

- Received and noted the Corporate Objectives 2016/17 report
- Approved the corporate objectives to be incorporated into the Integrated Delivery Plan for 2016/17.

159/16 Patient-Led Assessment of the Care Environment (PLACE) – Q4 Update

Mr J Sumner presented a report and provided an overview of progress against recommendations following the Trust's PLACE assessment in May 2015. Specific reference was made to progress with regard to Estates; Cleanliness, Privacy & Dignity; Portering & Logistics; and Food & Hydration and the Board noted the updated PLACE Action Tracker. Mr J Sumner advised that the 2016 PLACE assessments had been held in April 2016 and noted that initial feedback had been positive.

In response to a question from Mr J Schultz, Mr J Sumner advised that the Executive Team would review Board involvement in mini-PLACE and mini-CQC inspections and would report back to the Board in due course.

The Board of Directors:

- Received and noted the report.

160/16 Board Assurance Framework

Mrs A Barnes presented a report, the purpose of which was to present the revised Board Assurance Framework 2016/17 to the Board of Directors for consideration and approval. She noted that at its meeting on 31 March 2016, the Board had adopted a revised approach to the Board Assurance Framework to ensure that strategic objectives, and the principal risks to the achievement of these objectives, were subject to periodic review in order to maintain currency of the Framework content. Mrs A Barnes advised that some of the wording around risks had been revised following discussion at the Board Development Session in April 2016. Non-Executive Directors were asked to feedback to Mrs A Barnes if they felt that the revised wording did not accurately reflect the risks.

Mr J Sumner commented that he was content with the wording of the risks but queried the risk score of SO3 which he felt was low at 16 given that the Trust was currently in breach with regard to A&E performance. Mr J Sumner confirmed that this risk, including the risk score, would be reviewed and refreshed. In response to a question from Ms A Smith, Mrs A Barnes advised that the Board Assurance Framework would be further refreshed following the report of the Financial Improvement Programme and made reference to the living nature of the Framework. Mr A Burn suggested a need for consistency across the various risk descriptions.

The Board of Directors:

- Considered and approved the content of the Board Assurance Framework at Annex A subject to a review of Risk 3 and consistency across risk descriptions.

161/16 Strategic Risk Register

Mrs J Morris presented the Strategic Risk Register and noted the revised format following comments received from the Board. The Board of Directors welcomed the new format which provided more information. Mrs J Morris advised that the Trust's

management of risk registers had also been revised. She noted that high level risks were reported to the Board through the Strategic Risk Register and advised that each business group considered individual risk registers at the Risk Management Committee to help facilitate realistic risk scores. Mrs A Barnes welcomed the approach to the risk registers by business group and queried whether the same level of scrutiny took place in corporate areas. Mrs J Morris confirmed that this was the case.

The Board of Directors:

- Received the report and noted the content.

162/16 Maintaining Safe Staffing Levels

Mrs J Morris presented a report which provided an overview, by exception, of actual versus planned staffing levels for the month of April 2016. Specific reference was made to the following key points:

- Fill rates for Registered Nurses and care staff remained above 90%
- Staffing challenges remained across Trauma & Orthopaedics whilst staff undertake induction and complete supernumerary period
- Movement of staff from B2 has been an issue and is being monitored.

Mrs J Morris advised the Board that following meetings with the Clinical Commissioning Group, an agreement had been reached to increase the Band 5 nursing establishment. She commented that this was good news and noted that the Trust was in the process of recruiting to these district nursing posts. The Board of Directors received assurance that safe staffing levels had been maintained during April 2016.

The Board of Directors:

- Received the report and noted the content.

163/16 Key Issues Reports

<u>Workforce & Organisational Development Committee</u>

Ms A Smith briefed the Board on matters considered at a meeting of the Workforce & Organisational Development Committee held on 5 May 2016. She advised the Board that the Committee had considered a draft Management & Leadership Development Plan following the Board's approval of the Leadership Strategy. The Committee had also received a report on the final Junior Doctors Contract which it wished to highlight as a key concern to the Board. The Board noted the timetable for the implementation of the new Junior Doctors Contract and received assurance that actions were in place to meet the various deadlines. In response to a question from Mr M Sugden who made reference to performance against key workforce metrics and queried whether improvements were in line with expected trajectories, Mrs J Shaw confirmed that they were and noted that the quarterly report considered by the Committee included further detail about performance against the trajectories.

Audit Committee

Mr J Sandford briefed the Board on matters considered at a meeting of the Audit Committee held on 17 May 2016. He advised the Board that the primary focus of the meeting had been the consideration of a range of statutory reports relating to 2015/16. The Committee had held a comprehensive discussion in relation got the Trust's Going Concern declaration and had agreed that it was appropriate for the 2015/16 accounts to have been prepared on a Going Concern basis. The Committee had also confirmed that the Going Concern principle would remain appropriate for the next 12 months. The Board noted, however, the importance of the Trust's cash position in maintaining this principle and the imperative of ensuring effective cash flow and cash management throughout 2015/16.

The Committee had reviewed both the financial statements and the draft ISA 260 report and on that basis, recommended the Financial Statements 2015/16 to the Board of Directors for approval. The Committee had reviewed a draft Annual Quality Report 2015/16 together with a report detailing outcomes of a Quality Report Assurance Review completed by External Audit. It was noted that content and consistency work completed by External Audit provided assurance that the Quality Report satisfied the relevant regulatory requirements. Specific reference was made, however, to work on mandated indicator testing which had identified issues relating to data validity for the 18 week incomplete Referral to Treatment (RTT) indicator which would result in a qualified opinion being issued. The Committee was aware that work to strengthen data in this area had been undertaken during 2015/16 and had requested an assurance on further actions for consideration at its meeting on 12 July 2016. Mr J Sumner provided an overview of the issues around the RTT data, including multiple entry points, and noted that the Electronic Patient Record (EPR) would help in this area.

Finance & Investment Committee

Mr M Sugden briefed the Board on matters considered at a meeting of the Finance & Investment Committee held on 18 May 2016. He advised the Board that the Committee had received a briefing on the financial outturn for 2015/16 and had noted an outturn deficit of £12.9m against a planned deficit of £13.1m. It was noted, however, that a large proportion of the 2015/16 savings had been delivered on a non-recurrent basis which had added to the financial challenge for 2016/17. Mr M Sugden advised that circa 60% savings in Month 1 had been delivered on a non-recurrent basis and advised that this was an area where management action was necessary to achieve the profiled level of savings in future months.

The Committee had been briefed on a revised approach to conducting performance review meetings with business groups and noted that these meetings would be held with individual business groups on a monthly basis as part of measures to enhance organisation grip. The Committee had also reviewed and revised a draft Financial Strategy and consequently recommended it for Board approval. The Committee had noted plans to review the configuration of the new Surgical Centre as a result of continued pressures on the Emergency Department and Acute Medicine. The Deputy Chief Executive had presented a report providing a summary of matters relating to the Pathology Service and opportunities to generate efficiencies through implementation of recommendations made by the Carter Review.

Finally, the Committee had been briefed by the Deputy Chief Executive on the outcomes of a meeting of Strategic Development Committee members held on 16 May 2016. The purpose of that meeting had been to identify means of improving the quality and content of reports to this particular Committee, with a view to ensuring distinct separation between the functions of the Committee and those of the Finance & Investment Committee. Consequently, those present had concluded that the functions of the two Committees relating to assurance on the Integrated Delivery Plan were intrinsically linked and that a more effective approach would be to merge the two Committees. Members of the Finance & Investment Committee had unanimously endorsed this approach and recommended that merger of the two Committees be formally approved by the Board of Directors. The Board approved this proposal and agreed that Terms of Reference for a merged Committee should be presented to the Board of Directors for approval on 30 June 2016.

Quality Assurance Committee

Ms A Smith provided a verbal update on matters considered at a meeting of the Quality Assurance Committee held on 24 May 2016. She advised that the Committee had considered a summary report of the Never Events which would be considered by the Board of Directors at its meeting in June 2016. The Committee had been informed of the changed format of business group performance review meetings and commended the new format of the Monthly Clinical Governance Report, formerly the High Profile Report. Finally, the Committee had discussed and agreed a work plan and calendar of meetings. In response to a question from Mr J Sandford who queried whether there had been any urgent actions arising from the Never Events report, Dr C Wasson noted that overall the report had been very positive and had provided assurance that the Trust was providing good quality of care.

The Board of Directors:

- Received and noted the Key Issues Reports.

164/16 Independence of Non-Executive Directors

Mr P Buckingham presented a report, the purpose of which was to facilitate a decision by the Board of Directors relating to the independence of Non-Executive Directors. He advised that provision B.1.1 of the NHS Foundation Trust Code of Governance required the Board to identify in the Annual Report each Non-Executive Director that it considered to be independent.

Mr P Buckingham advised that all Non-Executive Directors had certified a 'clean' declaration with the exception of Mrs G Easson and Mrs C Prowse, both of whom declared that they had served on the Board for more than six years. In the case of Mrs G Easson, it was noted that the total time served on the Board included time as Non-Executive Director prior to her appointment as Chairman on 1 November 2012. In the case of Mrs C Prowse, her final one-year appointment as a Non-Executive Director had expired on 31 March 2016. In both cases, tenure of appointment would have been considered, and found not to be a barrier to appointment, by the Council of Governors. The conclusion of the Board of Directors would support an appropriate statement in the Annual Report 2015/16.

The Board of Directors:

- Received and noted the report and confirmed that it considered the Chairman and Non-Executive Directors to be independent.

165/16 Compliance with NHS Foundation Trust Code of Governance

Mr P Buckingham presented a report, the purpose of which was to seek approval from the Board of Directors for compliance statements relating to the NHS Foundation Trust Code of Governance. It was noted that NHS Foundation Trusts were required to provide a specific set of disclosures to meet the requirements of the NHS Foundation Trust Code of Governance which should be submitted as part of the Annual Report.

Mr P Buckingham advised that the Audit Committee had implemented a schedule of six-monthly reviews of the Trust's compliance position against Code of Governance requirements. The reviews had been completed on 8 September 2015 and 1 March 2016 and no issues had been identified as a result of these reviews. A review of the draft Compliance Statements had been completed by the Audit Committee on 17 May 2016 to confirm that there had been no material changes in compliance status in the intervening period.

Mr P Buckingham noted that Audit Committee consideration had been supported by the outcomes of an Internal Audit review of the Trust's processes relating to Code of Governance compliance which had resulted in an assessment of High Assurance. The Audit Committee had consequently recommended the Code of Governance disclosures to the Board of Directors for approval. The Board of Directors commended Mr P Buckingham for the comprehensive report and for the high assurance received from Internal Audit.

The Board of Directors:

- Received and noted the report and approved the Code of Governance disclosures as presented at Appendix 1.

166/16 Annual Governance Statements 2015/16

Mrs A Barnes presented a report, the purpose of which was to present the draft Annual Governance Statement 2015/16 to the Board of Directors for approval. It was noted that, following approval, a signed copy of the Annual Governance Statement would be submitted to Monitor and the approved version would also be incorporated in the Trust's Annual Report & Accounts 2015/16.

Mr P Buckingham advised the Board of the following minor changes to the Statement that would be required:

- Page one, first bullet point: "~~The Quality Assurance Committee as the Board of Directors committee~~ The Board of Directors with responsibility for overseeing all aspects of risk management".

- Page 5, penultimate paragraph (Never Events): "The final report was received on 18 April 2016 and is scheduled for consideration by the Board of Directors on ~~26 May 2016~~ 30 June 2016."

The Board of Directors:

- Received and noted the report and subject to the above amendments, approved the draft Annual Governance Statement 2015/16 at Annex A of the report.

167/16 Year-End Governance Declaration

Mr P Buckingham presented a report, the purpose of which was to allow the Board of Directors to determine a positive declaration against General Condition 6 of the NHS Provider Licence or identify why such a declaration could not be made. It was noted that the requirements of General Condition 6 were reproduced at Appendix 1 of the report and the form of the declaration was included for reference at Appendix 2 of the report.

The Board of Directors:

- Received and noted the report and agreed a positive declaration against General Condition 6.

168/16 Report of the Chief Executive

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

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

Specific reference was made to a Memorandum of Understanding (MOU) that had been included at Annex A of the report, which was being presented to each governing body for adoption as a means of encapsulating and consolidating the intention of the South East Sector partners to find joint solutions to the design and implementation of the Healthier Together changes. The Board of Directors was asked to approve the MOU. Mr A Burn noted that while the MOU document was not legally binding, an amendment to s4.3c) would be advisable in order to protect confidentiality of relevant third party service providers. Mrs A Barnes agreed to seek clarification on this point.

The Board of Directors:

- Received and noted the Report of the Chief Executive and, subject to the above clarification, approved the Memorandum of Understanding.

169/16 Financial Strategy

Mr F Patel presented a report, the purpose of which was to discuss and agree the Financial Strategy as an accompanying document to the Trust's overall Strategy. He advised that the Financial Strategy outlined the challenges facing the Trust in the next five years and the plans to ensure that the Trust was cash resilient in the short-term, moving towards a sustainable position in the medium to long term.

In response to a question from Mr A Burn who queried the Cost Improvement Programme figures in s6 of the Strategy, Mr F Patel confirmed that these were in-year rather than cumulative. In response to a question from Ms A Smith who commented on the level of savings required and queried income opportunities, Mr J Sumner and Mr F Patel provided an overview of plans in this area.

The Board of Directors:

- Received and noted the report and approved the Financial Strategy as an accompanying document to the Trust's overall Strategy.

170/16 Talent Management Strategy

Mrs J Shaw presented a report seeking Board of Directors approval of the Trust's Talent Management Strategy. She advised that this was a new strategy which was underpinned by the Trust's appraisal framework. The Board noted that the Talent Management Strategy had been presented to the Workforce & Organisational Development Committee where it had been recommended for Board approval.

In response to a question from Mr J Schultz who queried the generic nature of the Talent Management Strategy, it was noted that strategies tended to be generic and that the more detailed discussion and scrutiny would take place at the Workforce & Organisational Development Committee. In response to a question from Mr A Burn, Mr J Shaw advised that, in order to track progress, the Strategy would be underpinned by key performance indicators and would be subject to an annual review.

The Board of Directors:

- Received and noted the report and approved the Talent Management Strategy.

171/16 Date, time and venue of next meeting

There being no further business, Mr M Sugden closed the meeting and advised that the next meeting of the Board of Directors would be held on Thursday 30 June 2016 at 1.15pm in Lecture Theatre A, Pinewood House, Stepping Hill Hospital.

Signed: _____ Date: _____

BOARD OF DIRECTORS: ACTION TRACKING LOG

Ref.	Meeting	Minute Ref	Subject	Action	Responsible
15/15	24 Sep 15	228/15	Integrated Performance Report	*Never Events* – Following the completion of the external review undertaken by Professor B Toft, a report, including a presentation, would be provided to the Board of Directors at its meeting in November 2015. **Update on 26 Nov 15** – As the report had not yet been completed, it would be provided to the Board on 28 January 2016. **Update on 26 Jan 16** – The report was not yet ready and would either be presented to the February Board meeting or if still not ready, Dr J Catania would provide an update at that meeting. **Update on 25 Feb 2016** – The Board noted an update provided in the Chief Executive's Report which anticipated presentation of the final Never Events Report in March / April 2016. **Update on 31 Mar 2016** – Dr J Catania advised the Board that the Trust had received a draft report from Prof B Toft which would be checked for factual accuracy. The final report would be considered in detail by the Quality Assurance Committee in May 2016 and would be presented to the public Board meeting in May 2016 via the Committee's Key Issues Report. **Update on 28 April 2016** – As advised at the previous meeting, the final report from Prof B Toft would be considered by the Quality Assurance Committee on 24 May 2016 prior to consideration by the Board of Directors. **Update on 26 May 2016** – The report would be considered at the Board of Directors on 30 June 2016.	Dr J Catania Dr C Wasson
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.	J Sumner / S Toal

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Stockport NHS
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	29th September 2016
Subject:	Patient Experience: Story of Care		
Report of:	Judith Morris – Director of Nursing and Midwifery	**Prepared by:**	Margaret Gilligan – Matron for Patient Experience

REPORT FOR APPROVAL

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

Summary of Report

The purpose of a patient story at the Board of Directors' meetings is to bring the patient's voice to the Board, providing a real and personal example of the issues within the Trust's quality and safety agendas. It may also help to share the experiences of front-line staff and enhance understanding of the human factors involved in episodes of harm.

It is not intended to revisit the specific details of the story but rather to acknowledge that lessons have been learned where necessary and improvements to practice and care made.

Attachments:	None

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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The following story is taken from feedback received via NHS Choices website from the husband of a lady who delivered her baby at Stepping Hill Hospital maternity unit.

The story is as received in their words:

"We had our second baby at stepping hill and we're again really pleased with the facilities and care shown to us.

One issue which I want to highlight is the confusing signs and instructions we received on how to get in when we arrived.

Firstly, my wife had a quick first labour and so I knew we would need to get her there quicker for our second. When we arrived, there was a sign directing us to the birthing suite to triage. When we got there, there was nobody there. We rang both bells repeatedly and called the numbers listed by the door but it took a long time before someone answered and told us we needed to go back down 3 floors and go to the other side. When we got there we were then told again we were in the wrong place and we needed to go to the delivery suite on the first floor.

The whole time my wife was contracting, in agony and vomiting in a tub and there was no help. We finally got in and the midwife we met was snappy with us and told us that we had been given the right instructions on the phone when we went to the birth centre (which was closed). Whether true or not, it wasn't clear to me where you were supposed to go, particularly because there was a sign in reception telling you to go in the opposite direction.

My wife gave birth only 30mins later which shows how urgently we should have been in there. I would like you to review the signs and when the birth centre is closed, replace the sign in reception to explain where triage is open. It may also be sensible to tell people where to go on the phone when you call triage and tell them you are on your way.

Having said that, the care was good and the hospital clean and I would happily recommend to others."

The Matron for Patient Experience shared the feedback with the Head of Midwifery who looked into their concerns. The Head of Midwifery clarified that calls after 1.30 are taken on the Birth Centre and it is the midwife who gives advice to the woman on where to present. This can be either the birth centre or the delivery suite. She acknowledged that occasionally this information can be misunderstood resulting in women presenting to the wrong area, but stated this does not happen frequently.

Signage has been checked and appears correct but the Head of Midwifery stated the feedback was disappointing to hear and she would ensure the importance of giving correct information to women contacting the department would be raised with ward managers and midwives.

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Report to:	Board of Directors	**Date:**	30th June 2016
Subject:	Trust Performance Report – Month 3		
Report of:	Acting 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	☐ Workforce & OD Committee
	☐ Council of Governors	☐ BaSF Committee
	☐ Audit Committee	☐ Charitable Funds Committee
	☒ Executive Team	☐ Nominations Committee
	☒ Quality Assurance Committee	☐ Remuneration Committee
	☐ FSI Committee	☐ Joint Negotiating Council
		☒ Other

1. Introduction

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

2. Compliance against Regulatory Framework

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

	Standard	Weighting	Monitoring Period	Jul-15	Aug-15	Sep-15	Q2	Oct-15	Nov-15	Dec-15	Q3	Jan-16	Feb-16	Mar-16	Q4	Apr-16	May-16	Jun -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	93.4%	92.8%	92.8%	93.0%	92.4%	92.7%	92.1%	92.4%	92.1%	92.0%	91.2%	91.8%	90.7%	91.3%	
maximum waiting time of four hours from arrival to admission/ transfer/ discharge:	95%	1.0	Quarterly	94.8%	92.5%	91.5%	93.0%	91.0%	78.0%	73.7%	80.6%	73.5%	72.8%	72.60%	73.0%	79.3%	81.6%	
All cancers: 62-day wait for first treatment from: urgent GP referral for suspected cancer	85%	1.0	Quarterly	84.7%	94.9%	87.0%	89.4%	78.5%	92.5%	92.6%	87.9%	87.2%	81.6%	90.0%	86.4%	89.5%	85.7%	
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%	100%	100%	100%	100.0%	100.0%	100%	100%	100%	100%	
All cancers: 31-day wait for second or subsequent treatment, comprising:anti-cancer drug treatments	98%			100%	100%	100%	100%	100%	100%	100%	100%	100.0%	100.0%	100%	100%	100%	n/a *	
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	98.7%	97.1%	97.5%	97.9%	98.6%	97.5%	96.1%	97.8%	98.6%	97.4%	98.6%	98.2%	97.3%	100%	
Two week wait from referral to date first seen, comprising:all urgent referrals (cancer suspected)	93%	1.0	Quarterly	97.1%	96.0%	94.7%	95.9%	96.0%	97.3%	97.6%	97.0%	96.8%	98.1%	97.5%	97.5%	96.6%	96.6%	
Two week wait from referral to date first seen, comprising:for symptomatic breast patients (cancer not initially suspected)	93%			96.3%	96.1%	95.9%	96.1%	94.2%	94.7%	98.7%	95.6%	96.4%	98.9%	99.1%	98.1%	98.8%	97.4%	
Meeting the C. difficile objective (< 17 in year due lapse in care)	de minimis applies	1.0	Quarterly	1	2	0	3	0	1	0	1	1	2	0	3	0	0	

- *= no patients treated in month.*

3. Month 1 Performance against Regulatory Framework

There were two areas of non-compliance against the regulatory framework in month 2:

A&E 4hr target

As described in last month's report, the attendances were unprecedentedly high in the first half of May. Statistical special cause variation was acknowledged by the CCG. Performance in the first half was 76.8%, compared to a much improved latter half performance of 87.9% which is above the Monitor submitted trajectory. However, the combined effect resulted in below trajectory performance of 81.6%. At the time of writing, June's performance continues to improve. With Stockport being seen less of an outlier in performance against our GM peers.

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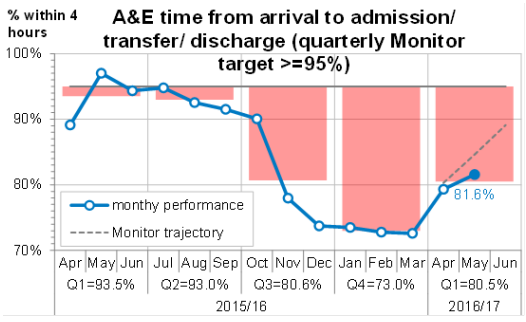


As a result of the process mapping event to review the ECIST 8 high impact changes for discharge, a steering group has been formed to support rapid improvement.

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

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

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

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

4) Pilot of the Acute Physician navigator who triages all referrals to Medicine from ED

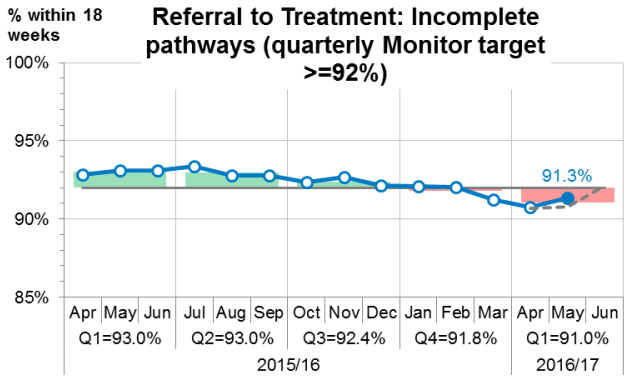
The actions being taken as part of the Urgent Care Plan group are making a positive impact

Other work in support of the above and for future implementation

- Changes to the 10 Pledges to ensure ED referrals to surgical specialties meet agreed KPI's regarding time to be seen(to be measured and monitored by the UCRG weekly).
- Urgent review of estate to create additional capacity in ED to avoid overcrowding.

Referral To Treatment, 92% Incomplete Pathway Target

As described last month, recovery plans are now in place, which predict a return to compliance by month 4 and therefore Q2 onwards. Performance in May (91.3%) was slightly ahead of the planned trajectory of 90.8% which was submitted to Monitor.



A corporate risk assessment has been completed and is awaiting committee approval. The main areas of risk are:

- Ability to reduce the Admitted backlog within action plan timescales, which is dependent on
  - Theatre workforce capacity
  - Outsourcing uptake
  - Rationalization of service provision
- Ability to reduce the Non-admitted backlog within General Surgery and Gastroenterology, which is dependent on:
  - Diagnostic capacity, eg Endoscopy
  - Clinical capacity
- Specialties where there is a capacity and demand gap

Future risks to compliance against Regulatory Framework
A return to compliance is expected for RTT from month 4, and hence quarter 2. The risk to the A&E standard is expected to remain during Q2.

4. Key Risks/hotspots from the Integrated Performance Report

4.1 Quality

- **Discharge Summary**
  Although still below the desired target level, performance for May was the highest achievement since the focused work in this area began. The volume of patients and rotating workforce through acute assessment areas continues to be the main contributing factor to underperformance.

- **Patient Experience**
  The Children's ED response rate was < 1% which remains poor, but actions are now in place to promote this.

4.2 Performance

- **Outpatient Waiting Lists**

  Gastroenterology
  It is expected that the OWL will continue to rise in the short-term whilst innovative pro-active pathways are being implemented. Clinical validation has provided assurance that there is no clinical risk to this patient group.

  The 100 day IBD pathway is being implemented which will:
  - Create additional clinic capacity by reducing the need for multiple follow-up appointments.
  - Reduce future 6 month and 12 month follow-up demand
  - Allow patients rapid access to specialist telephone advice Monday to Friday
  - Allow patients to be discussed virtually between Nurse and Consultant.

  By implementing the above pathways, and empowering patients to self-manage their condition, it is expected that there will be a significant number of patients removed from the waiting list by August.

  Cardiology
  Locums are being appointed to cover the gaps in Medical staffing. Work is ongoing with CCG colleagues to identify patients suitable to be follow-up in Primary Care and initiatives to reduce referrals into the service are also being implemented.

  Additionally, the NHS England 100 day plan initiative is underway which will encompass multi-disciplinary specialty working across Cardiology and Respiratory Medicine, combining care pathways and reducing demand for traditional appointments.

  A revised recovery trajectory will be reflected in next month's Board report, however it is anticipated that the waiting list will steadily decrease from July onwards.

  Respiratory
  The Service has recently lost capacity due to the redistribution of duties within the Medical team and reprioritisation of clinical responsibilities. Additional capacity is currently being provided via Agency locum, this will be reviewed on an on-going basis. Again work is ongoing with CCG colleagues to identify patients suitable to be follow-up in Primary Care and initiatives to reduce referrals into the service are also being implemented.

As above, the 100 day plan will also impact positively on the Respiratory service.

The number of patients on the follow-up OWL has peaked and started to reduce. A revised recovery trajectory will be reflected in next month's Board report.

Ophthalmology
Capacity issues within Ophthalmology will remain until the new Consultants commence in post in September and October respectively. In the interim, short term locum Consultants are being secured. The paediatric element of the service will transfer to Central Manchester from August.

There will an acute increase in the OWL numbers in June due to appointments being temporarily un-booked following a clinical staff vacancy and a maternity leave. Replacement and additional capacity has been secured from July to September which should see the waiting list begin to reduce.

A revised recovery trajectory will be reflected in next month's Board report.

- **Emergency Readmissions**
  The Trust now has a strategic project to look at all re-attends and readmissions. The project will be managed at Senior Management Board led by the Medical Director, Dr Colin Wasson, with support from Chris Foster-McBride, KPMG.

4.3 Finance

- The Trust has a deficit of £5.1m at the end of May 2016 and this is in line with the financial plan; this is an increase of £2.6m in month. The Trust has a planned deficit of £16.9m for the financial year 2016/17 and this is after a cost improvement plan of £17.5m. Following KPMG's phase 1 report, the Trust will continue to monitor against the submitted annual plan until a re-forecast is formally requested by NHS Improvement. This is in-line with the monthly financial submissions required.
- Clinical income has improved significantly in May and is £0.8m ahead of plan in month, of which £0.3m relates to finalisation of April activity as the new tariffs and contracting rules for 2016/17 have been applied. This has brought the year-to-date variance up to £0.4m favourable. Elective activity in particular is above plan, but this is linked to increased out-sourced activity undertaken to reduce the referral to treatment backlog and represents a low or nil margin contribution to the Trust.
- The total Cost Improvement Programme for 2016/17 needs to deliver £17.5m of savings to allow the Trust to deliver the planned £16.9m deficit. This target is not split evenly across the year, and the expected level of savings per month increases as the year progresses, shown in the black target line in this chart. In total £0.3m of CIP has been delivered to date against the planned £0.9m target, leaving a £0.6m shortfall.
- By May the Staircase schemes were expected to save £0.92m but have only delivered £0.17m, a shortfall of £0.75m. Schemes delivering recurrent savings are Supplier Management £0.04m, Medicines Management £0.02m and Site Utilisation £0.02m. The overall deficit is due to non-delivery on Theatre Utilisation and Private Practice £0.42m and Agency reduction £0.30m.
- Cash in the bank at the 31st May 2016 was £26.9m against an operational plan of £26.0m and therefore there is a positive variance of £0.9m. This is due to increased cash receipts for aged debts from local NHS Organisations and a significant VAT refund which was higher than expected. The Trust's new Cash Action Group chaired by the Financial Improvement Director has now been established in order to protect the cash position of the Trust and improve the £10m year-end forecast cash balance.

4.4 Workforce

- **Essentials training**
  Essentials training remains a challenge. The following measures continue to be taken:
  -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**
  The Trust's total appraisal compliance for May 2016 is 86.43%, an increase of 1.54% since April 2016 (84.89%).

- **Turnover**
  The Trust's permanent headcount turnover figure for the 12 months ending May 2016 is 11.49% against a national average rate of 13.93%.

- **Induction**
  Corporate Welcome attendance remains consistently at 100%. Local induction has increased from 40% in April to 63.6% in May.

- **Efficiency**
  Bank & Agency costs
  In May 2016, 3% of total pay costs were attributed to bank staff which is the same as the April 2016 figure, and 6% of total pay costs were attributed to agency staff, a 4% reduction from April 2016. The use of bank and agency staff is closely monitored at Business Group Finance and Performance meetings and the Establishment Control Panel.

  Agency shifts above cap
  May 2016 shows an increase in the number of shifts (28) which are taking place above the agency cap from 1014 in April 2016 to 1042 in May 2016. Work has commenced 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 May 2016 showed a £51,216 overspend, a decrease of £445,414 from the £394,198 underspend reported in April 2015.

5. Recommendations

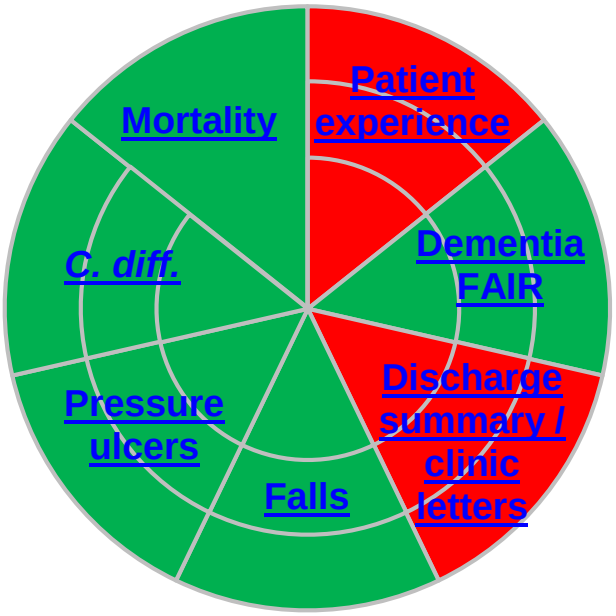
The Board is asked to:

- Note the current position for month 2 compliance against standards.
- Note the future risks to compliance and corresponding actions to mitigate.
- Note the key risks areas from the Integrated Performance Report

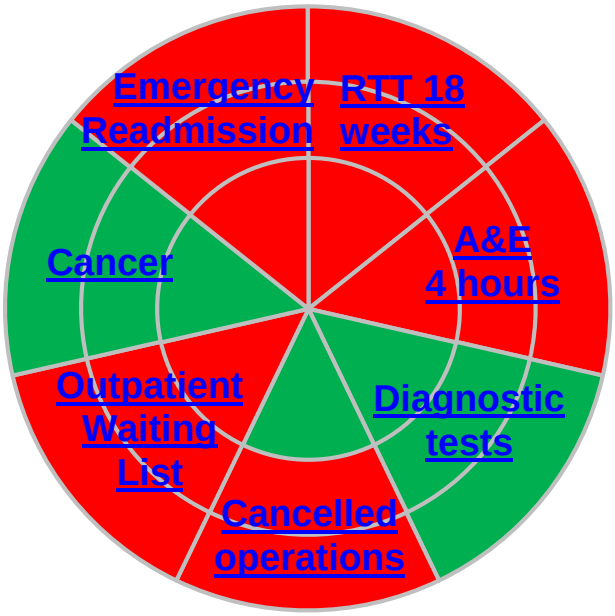
Integrated Performance Report June 2016

Stockport NHS Foundation Trust

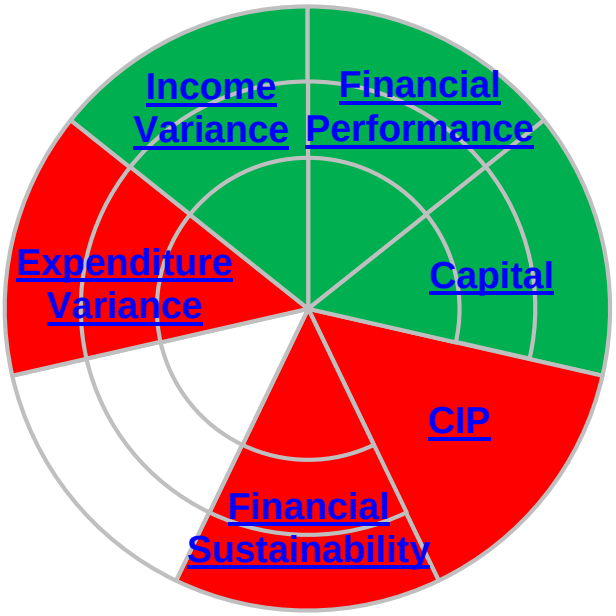
1.Quality



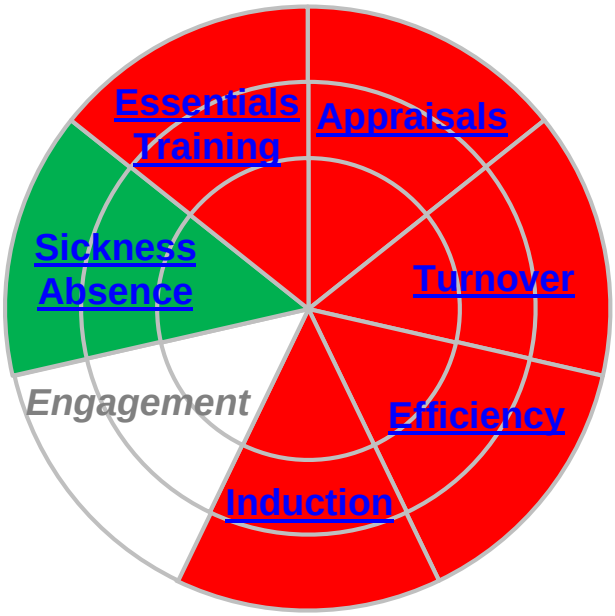
2.Performance



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 – June 2016

- The target for sickness absence has been revised to 4%.
- The Monitor recovery trajectories for RTT and A&E have been reflected in the relevant performance charts.

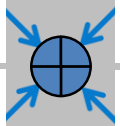
Key to indicators:

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

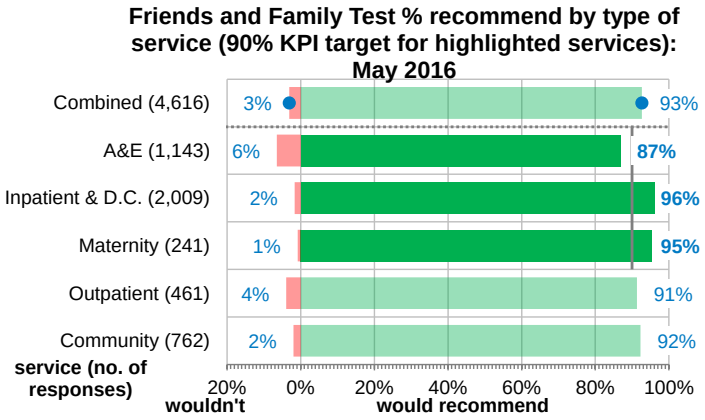
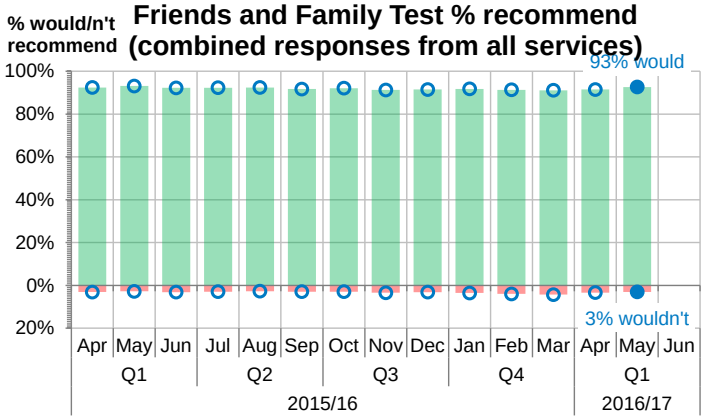


Chart 2



Overall in May, the trust scored 93% extremely likely or likely to recommend, total responses were 4,616. Broken down, May's response rate for adult patients in ED was 24%, an increase of 3 percentage points since April. Children's ED response rate was < 1% which remains poor but actions are in place to promote this. Acute inpatients response rate was 33**%** in May overall.

Feedback Themes (acute):

ED (adult) – Positive comments received for May state that staff continue to be caring, professional, helpful and reassuring. Waiting time has received some positive comments with patients stating they received a 'quick service' and had been kept informed whilst waiting. Alternatively, negative comments around waiting times continue to state waiting time was to long with some patients stating they left the department without being seen. In addition comments were received around poor communication.

Inpatients (adults) Positive comments received included a good staff attitude and that staff were helpful, caring and reassuring. Negative comments included a lack of communication regarding care, noisy wards, and some aspects of cleanliness which will be passed to the domestic supervisor.

Maternity –Overall positive comments received included patients felt supported, reassured with a lot of comments received about good care and questions being answered. Minimal negative comments were received which were around difficulties in car parking.

Daycase - Negative comments continue to report long waiting times when admitted for procedures and having surgery cancelled after waiting. Positive comments reported good care and being treated with consideration. Top themes include staff attitude and care.

Chart 3

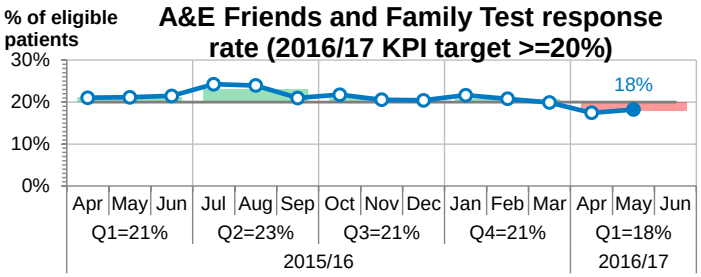
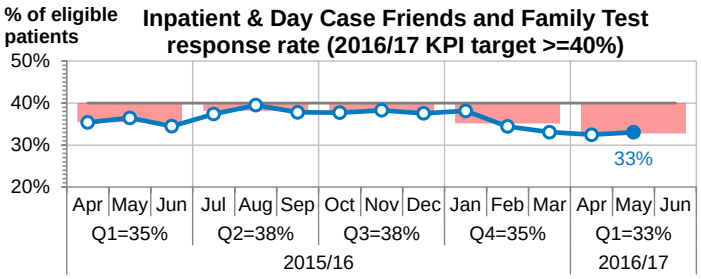


Chart 4



Out Patients - Positive comments received included staff had a good attitude and were friendly, professional and reassuring with detailed information being given. Negative comments report poor car parking making arriving for appointments stressful.

Paediatrics (inpatients) - Positive comments received stated staff kept patients well informed and were reassuring and friendly.

Community Services - Overall positive comments were received which continue to state good care received, that staff were professional, and patients felt well informed. Minimal negative comments were around aspects of care (not specified) and there was a long time to wait for appointments and when arriving at clinic.

IPad Inpatient Surveys

In May **258** inpatient iPad surveys were undertaken, which is a decrease of **22** compared to April. All wards now have log in access to the surveys in order to assist in obtaining patient feedback via the iPads and this continues to be encouraged, but a heavy reliance on volunteers to undertake surveys continues.

All results can be seen via the trust Corporate Information System and continue to be sent to wards on a monthly basis in more detail as a report. Using a RAG rating system the results via CIS are presented in a format which enables an overall trust wide view of where performance is good and where targeted focus is required. Overall, the trust scored 86% positive responses in May which is a marginal increase of 1% since April.

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

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Dementia 16

Chart 5

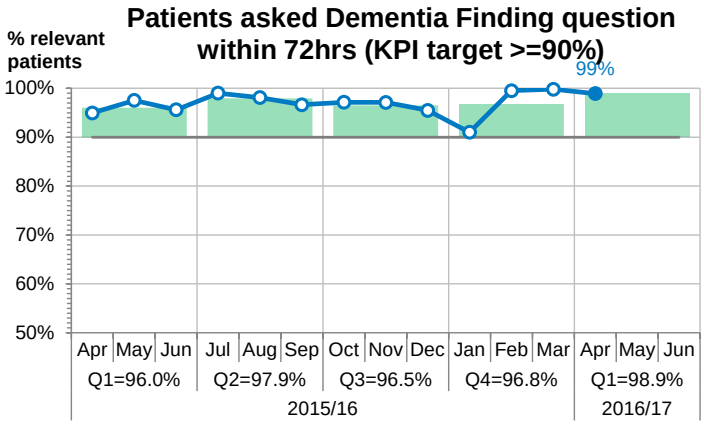


Chart 6

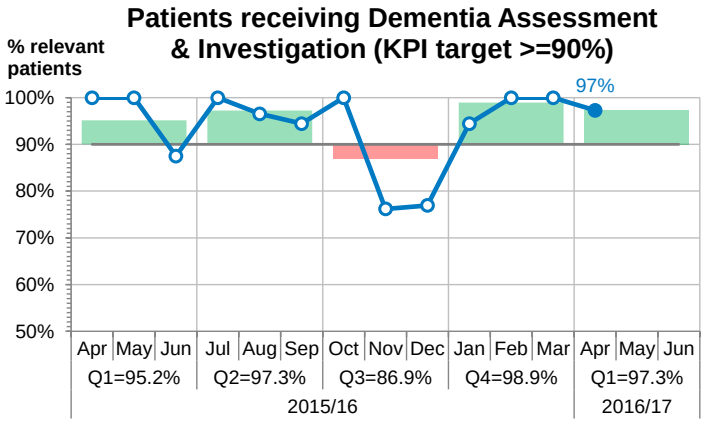
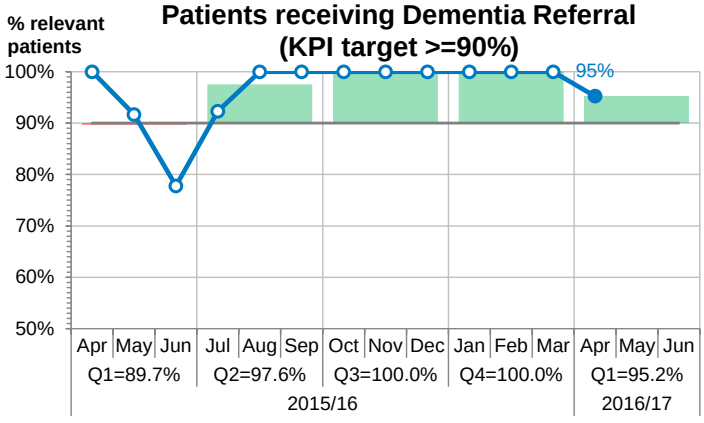


Chart 7



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

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Discharge summary (published within 48 hours)

Chart 8

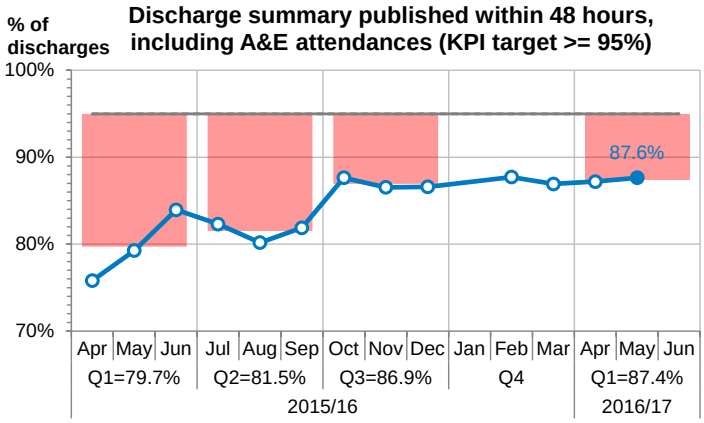

Chart 8 shows compliance with discharge summary completion within 48hrs.

Although still below the desired target level, performance for May was the highest achievement since the focused work in this area began.

The volume of patients and rotating workforce through acute assessment areas continues to be the main contributing factor to underperformance.

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Clinical correspondence (typing backlog)

Chart 9

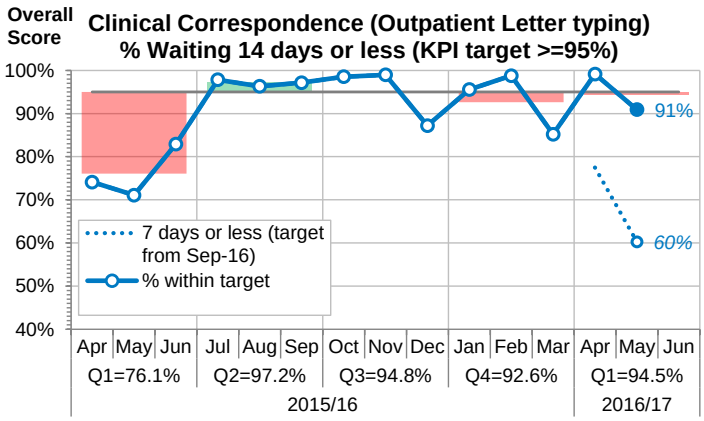

Chart 9 shows the performance against the clinical correspondence standard of 95% of Outpatient letters to be typed within 14 days.

Compliance with standard was not achieved in May. Underperformance is predominantly within two specialty areas, General Surgery and Oral Surgery. Vacancies within Oral Surgery have now been recruited to, and process re-design work is underway to improve efficiencies within the General Surgery secretarial team.

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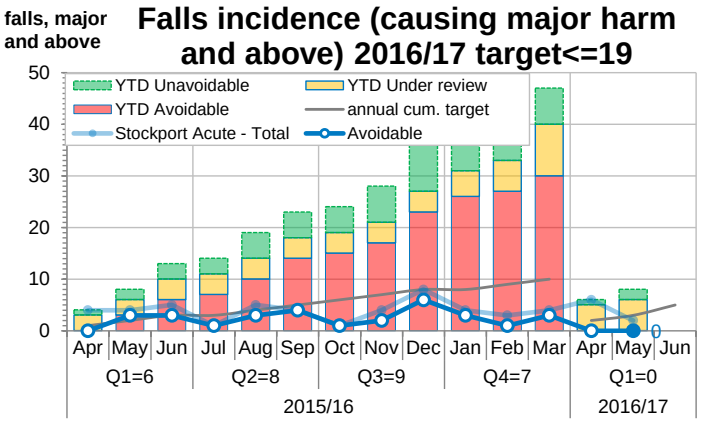
Falls

Chart 10



This year's target is 19 avoidable falls. In May there were 2 severe falls:

- 1 is under review
- 1 has been deemed as unavoidable

A workshop has been held on the 9th June to review current state in relation to falls prevention bundle and to prioirtise actions for the forthcoming year. Action plans will be developed and shared with all Business Groups.

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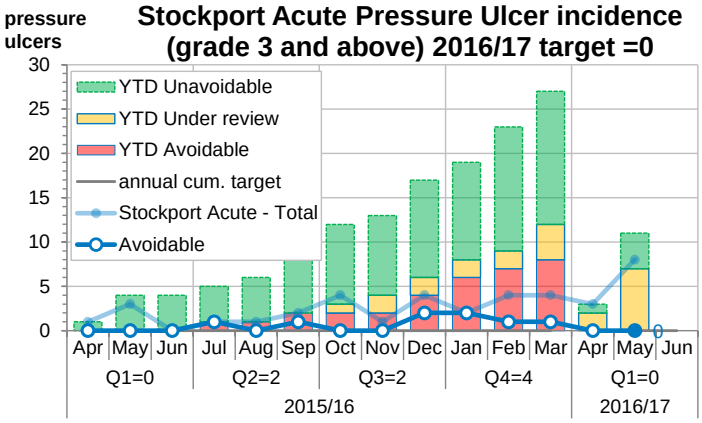
Pressure Ulcers 16

Chart 11

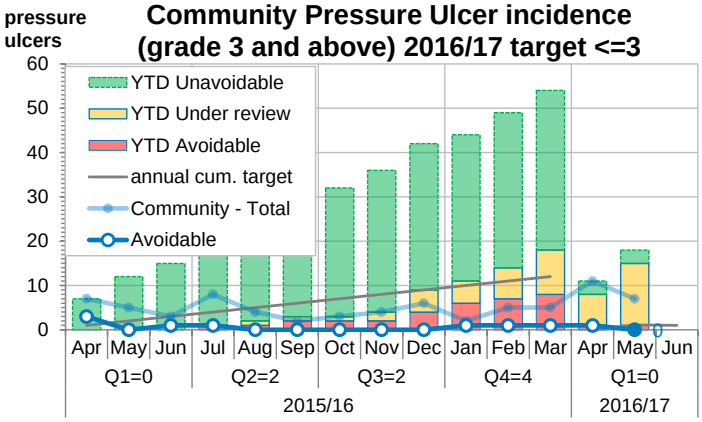


The stretch target for Stockport Acute services is zero tolerance of avoidable pressure ulcers grade 3 and 4 by the end of 2017.

In May there has been 8 avoidable pressure ulcers, 5 are under review and 3 have been deemed as unavoidable.

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

Chart 12



In May there have been 7 grade 3/4 pressure ulcers, all are under review.

Pressure Ulcer numbers have increased across Hospital and Community settings in the last quarter. To address these issues ward or DN base training sessions have been organised to take place over the next 6weeks. There is also going to be an increasing emphasis on ensuring that action plans to address any lapses in care identified following an incident are implemented and audited.

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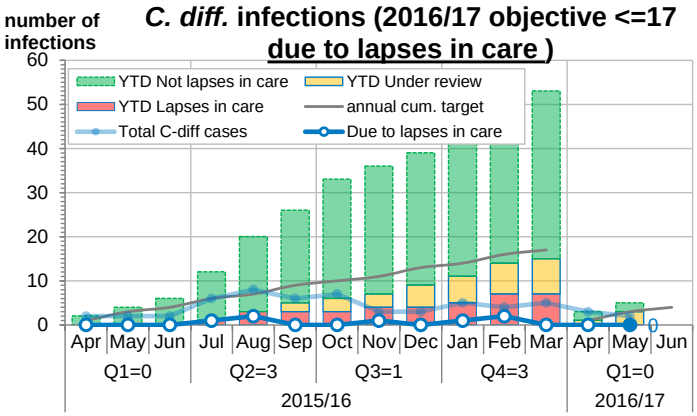
Clostridium difficile (C. diff.) infections

Chart 13



During 2015/16 there were 53 cases of Clostridium difficile, of these, 7 cases were found to have significant lapses in care. Currently there are 8 cases still under review and as a result we are unable to determine whether the trajectory of 17 has been achieved.

For 2016/17 there has been 2 cases of Clostridium difficile in May, the total number YTD is 5. Of these, 3 cases are still under review therefore to date we have had no significant lapses in care counting towards the trajectory of 17.

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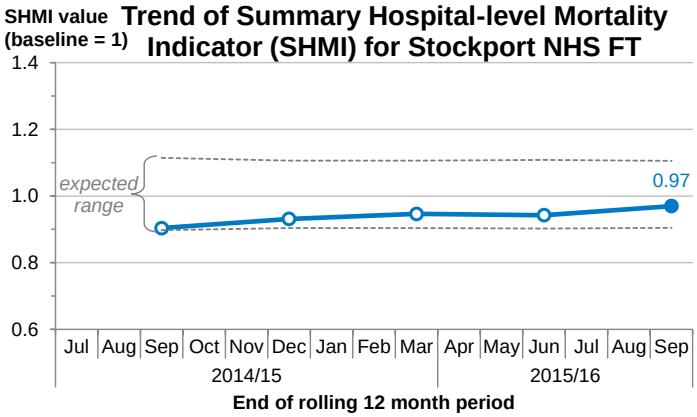
Mortality

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

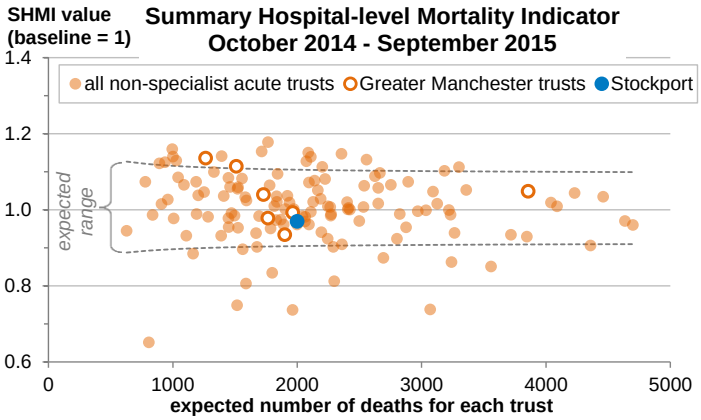
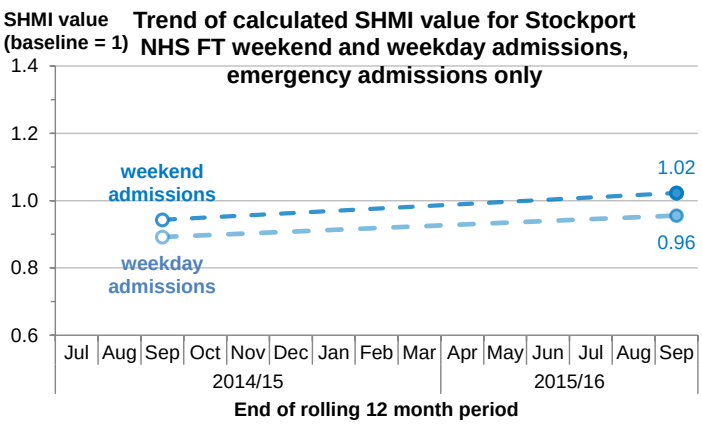


Chart 16



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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

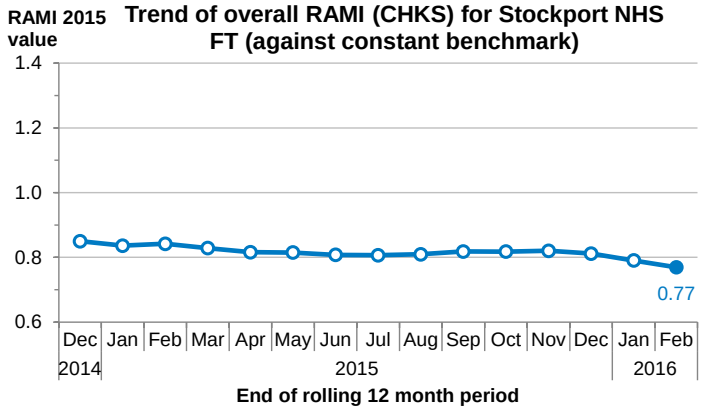


Chart 18

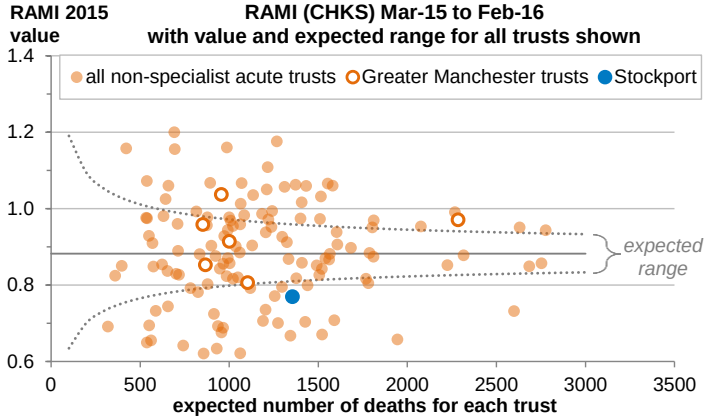
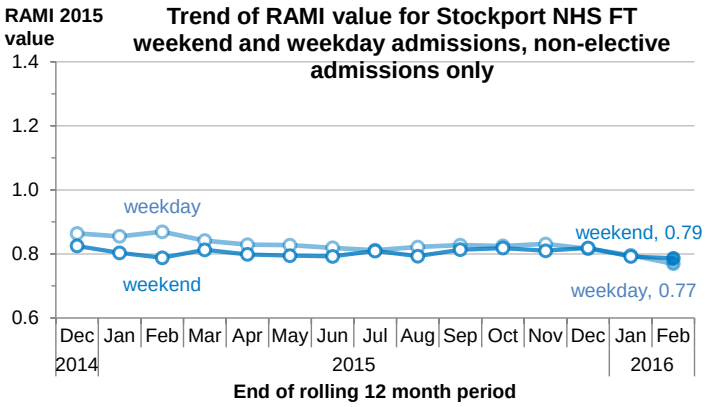


Chart 19



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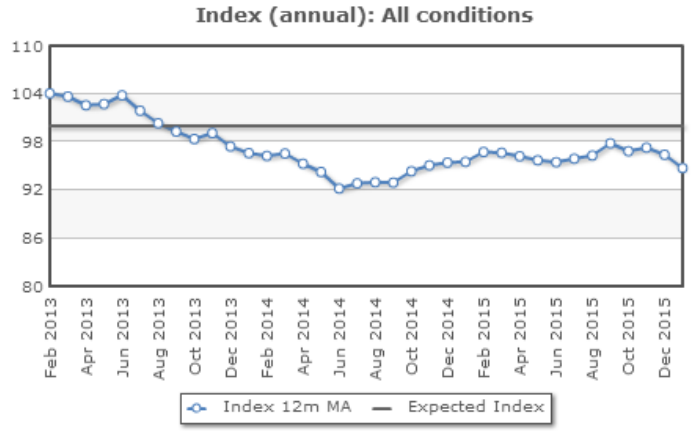
Hospital Standardised Mortality Data (HMSR)

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



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Referral to Treatment (RTT) waiting times

Chart 21

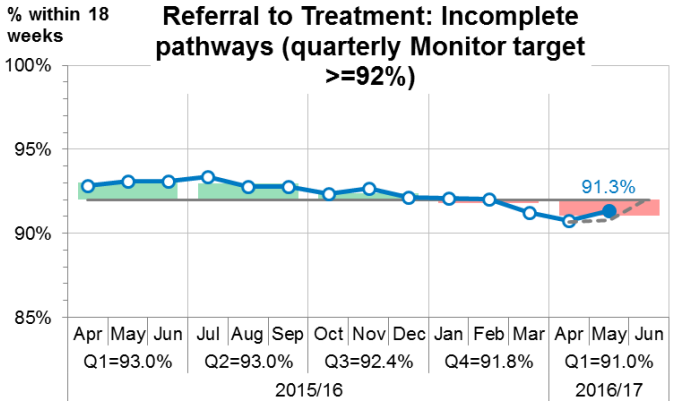

Chart 21 shows performance against the RTT Incomplete standard.

As described last month, recovery plans are now in place, which predict a return to compliance by month 4 and therefore Q2 onwards. Performance in May (91.3%) was slightly ahead of the planned trajectory of 90.8% which was submitted to Monitor.

A corporate risk assessment has been completed and is awaiting committee approval. The main areas of risk are:

- Ability to reduce the Admitted backlog within action plan timescales, which is dependent on
  - Theatre workforce capacity
  - Outsourcing uptake
  - Rationalization of service provision
- Ability to reduce the Non-admitted backlog within General Surgery and Gastroenterology, which is dependent on:
  - Diagnostic capacity, eg Endoscopy
  - Clinical capacity
- Specialties where there is a capacity and demand gap

Chart 22

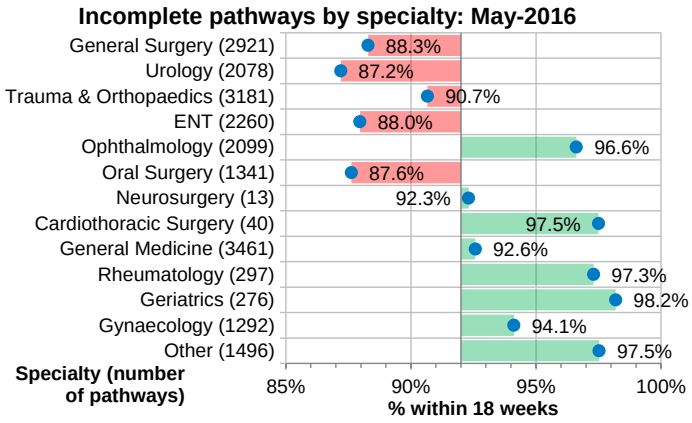

Chart 22 shows performance against the incomplete standard at specialty level.

Chart 23

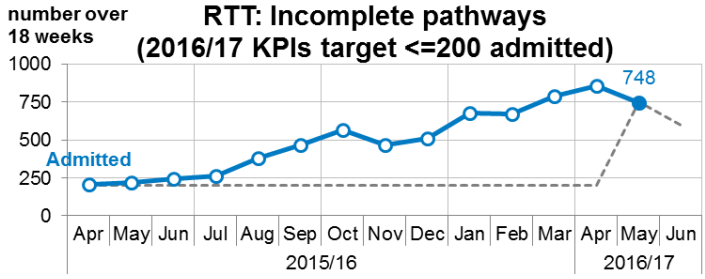

Chart 23 reflects the decrease in the admitted backlog, in-line with trajectory.

Chart 24

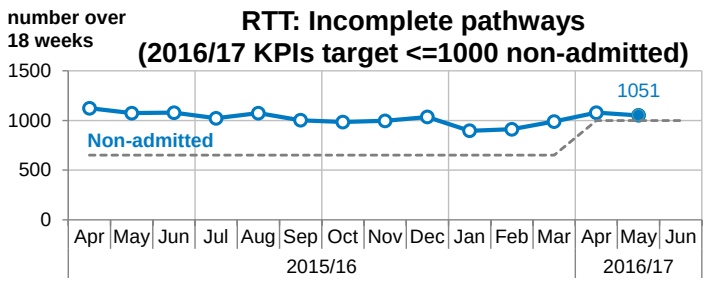

Chart 24 reflects the decrease in the non-admitted backlog now in-line with contract KPI.

Accident & Emergency total time in dept.

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Chart 25

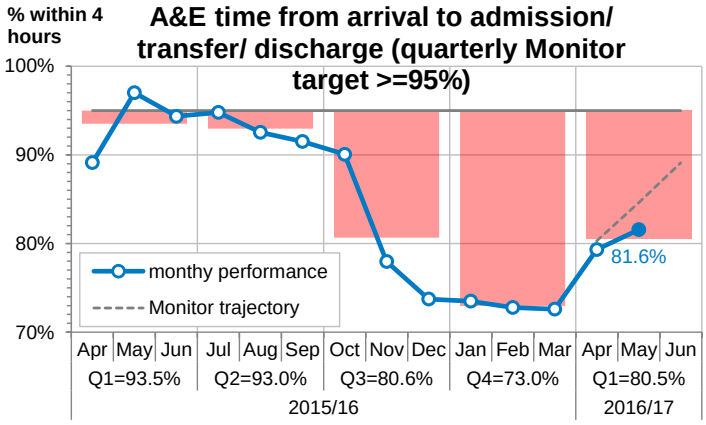


Chart 26

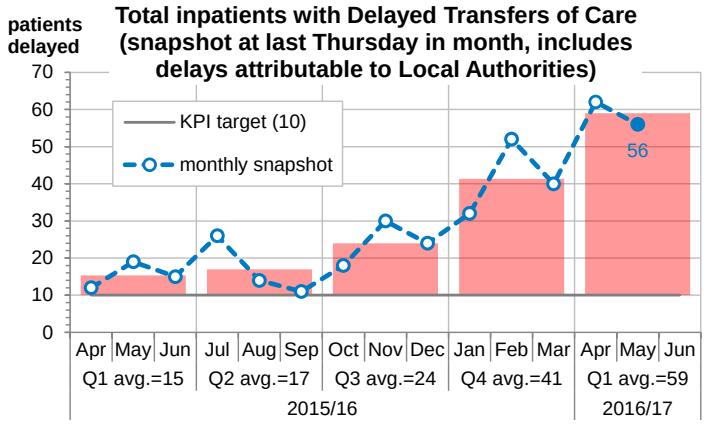


Chart 27

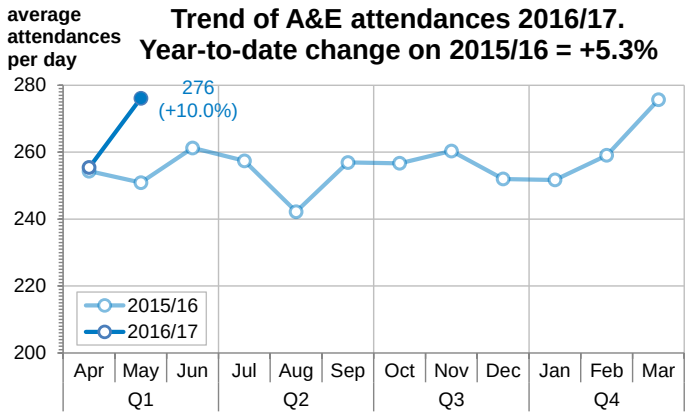


Chart 25 shows compliance against the 4hr A&E standard.

As described in last month's report, the attendances were unprecendently high in the first half of May, with confirmed special cause variation by the CCG. Performcne in the first half was 76.8%, compared to a much improved latter half performance of 87.9%. The combined effect resulted in below trajectory performance of 81.6%.

At the time of writing, June's performance continues to improve. The actions being taken as part of the Urgent Care Plan group are positively impacting.

As a result of the process mapping event to review the ECIST 8 high impact changes for discharge, a steering group has been formed to support rapid improvement.

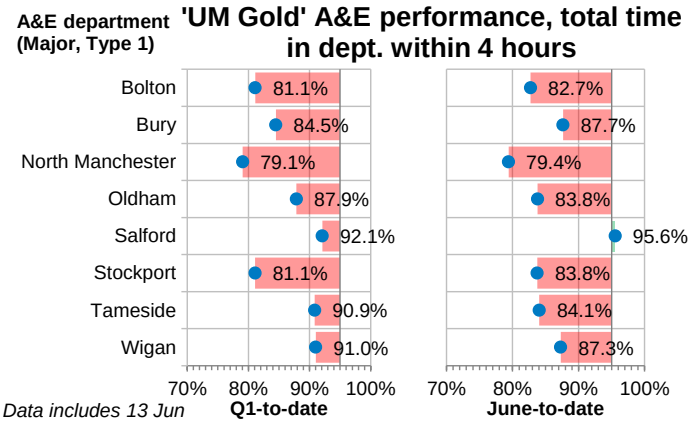
The Urgent Care Review Group (UCRG) have been working towards implementing a series of key changes in the urgent care pathway aimed at improving performance which are clinically led and based on the evidence available from internal and external review. In summary these key changes are:

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

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

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

Chart 28



Data includes 13 Jun

Source: Greater Manchester Academic Health Science Network.

Other work in support of the above and for future implementation

- Changes to the 10 Pledges to ensure ED referrals to surgical specialties meet agreed KPI's regarding time to be seen(to be measured and monitored by the UCRG weekly).
- Urgent review of estate to create additional capacity in ED to avoid overcrowding.

Chart 28 shows ED pressures continue throughout Greater Manchester.

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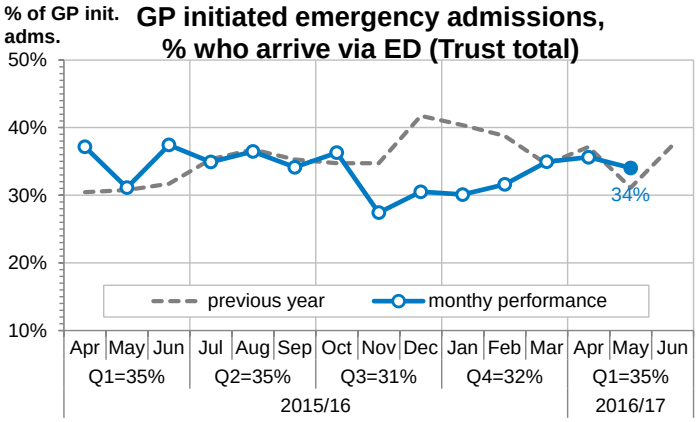
The next four pages show urgent care indicators (Chart 29 to Chart 41)

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

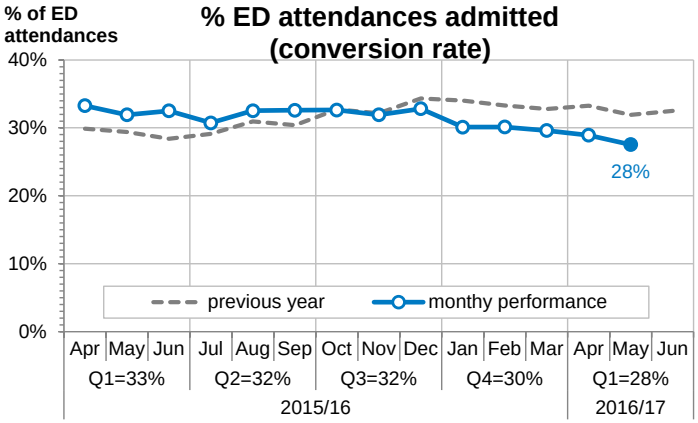


Chart 31

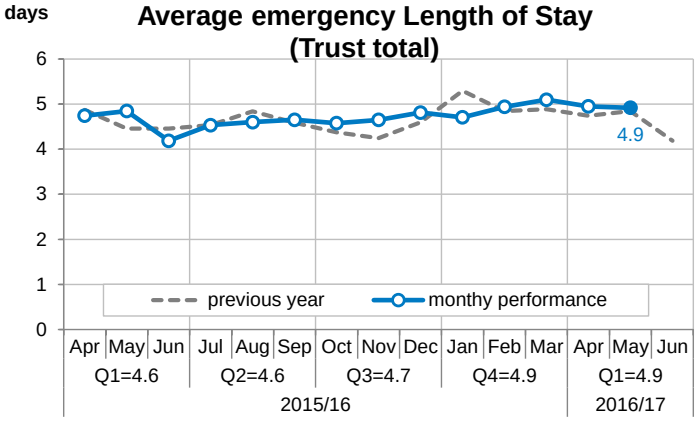


Chart 32

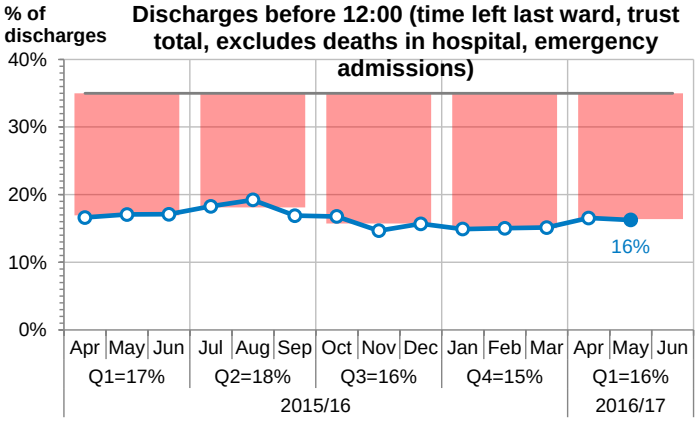


Chart 33

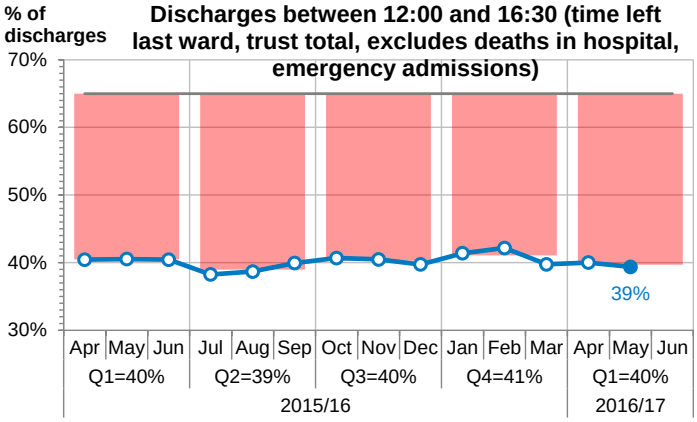
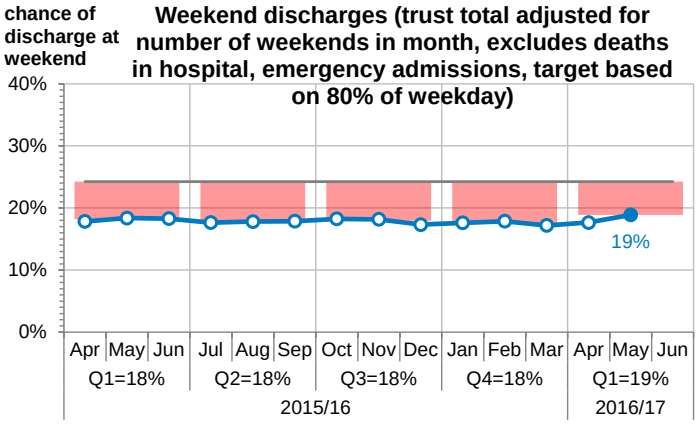


Chart 34



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Trust Urgent Care Key Performance Indicators

Chart 35

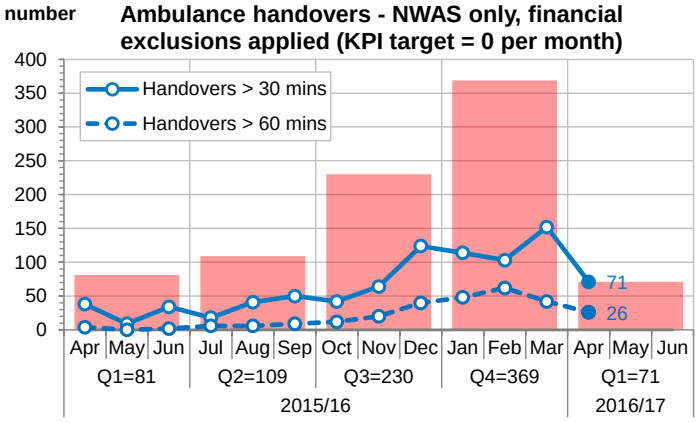


Chart 36

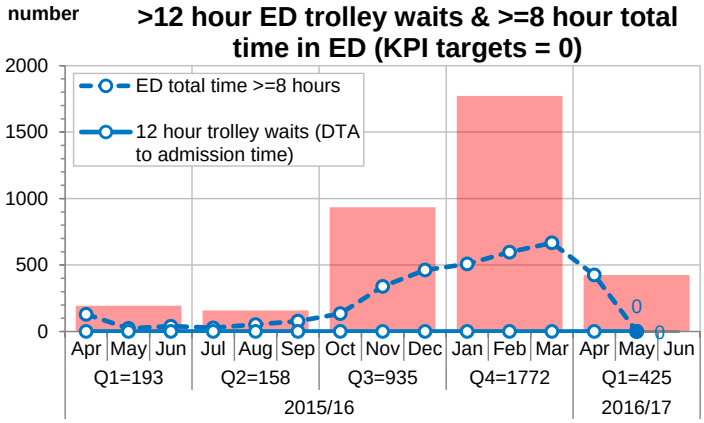


Chart 37

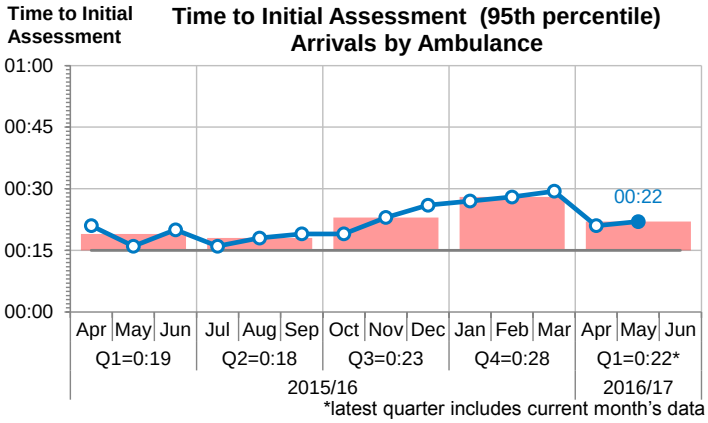


Chart 38

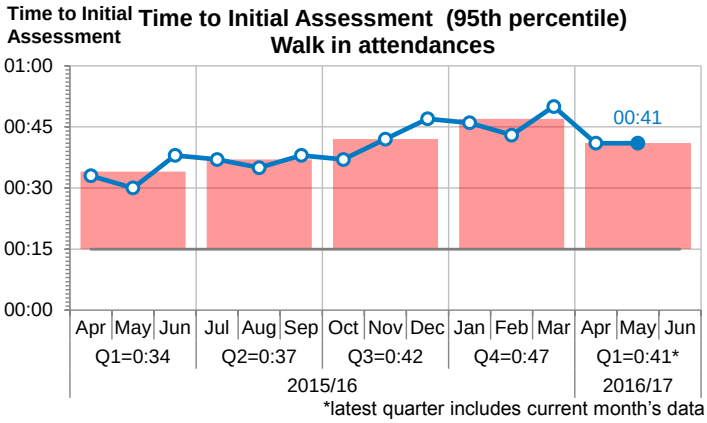


Chart 39

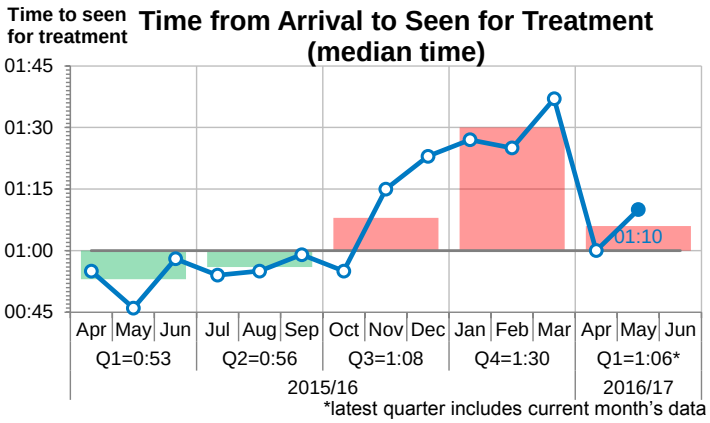


Chart 40

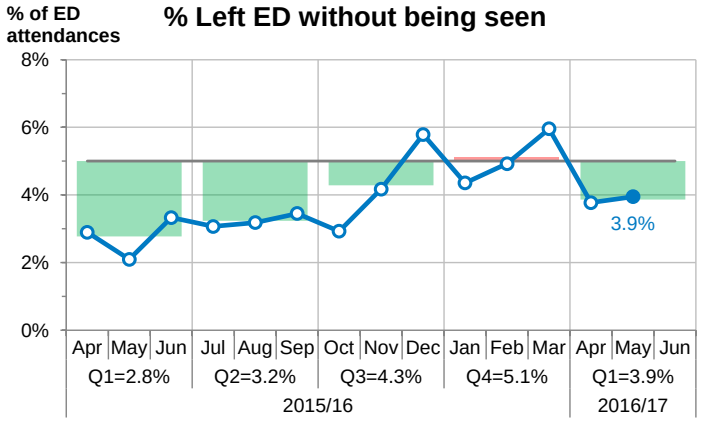
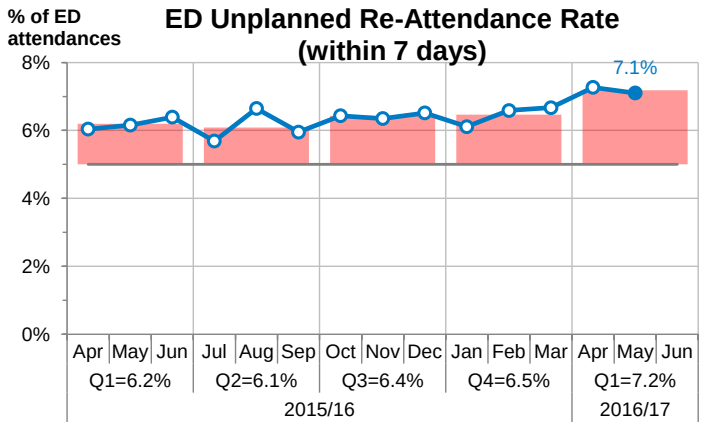


Chart 41



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Diagnostic tests (6 week wait) 16

Chart 42

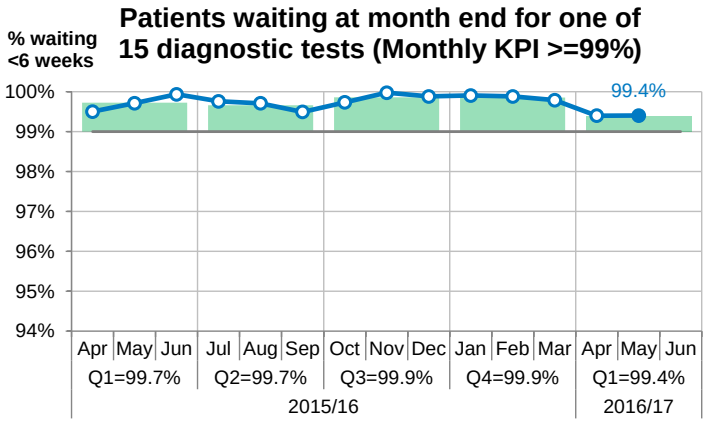

Chart 42 shows performance against the diagnostic standard.

There is a risk to achieving the standard in June, predominantly related to equipment issues within the Cardiology department. Replacement equipment is imminent and plans to recover the position going forward are being implemented.

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Cancelled Operations 20

Chart 43

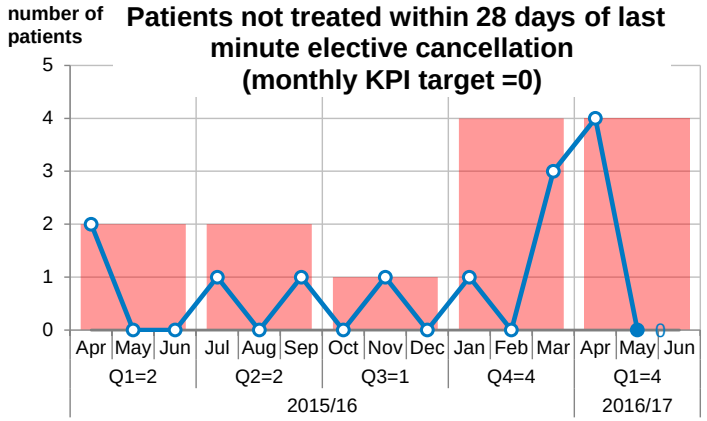

Chart 43 shows no breaches of standard in month.

Chart 44

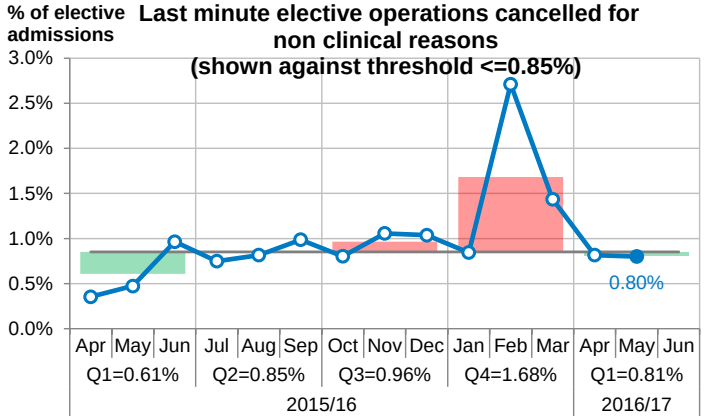

Chart 44 shows compliance against the standard for last minute cancelations in May.

There were a total of 27 cancellations on the day for non-clinical reasons.

The top reasons for cancellation were:

- 7 due to lack of theatre time
- 7 due to no HDU bed availability

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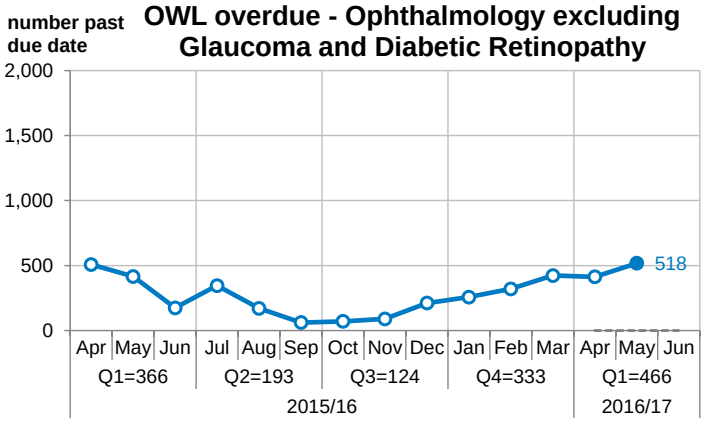
20

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

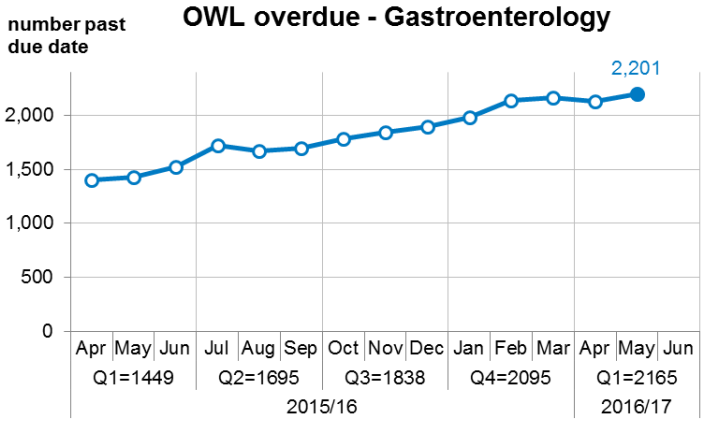
Capacity issues within Ophthalmology will remain until the new Consultants commence in post in September and October respectively. In the interim, short term locum Consultants are being secured.

The paediatric element of the service will transfer to Central Manchester from August.

There will an acute increase in the OWL numbers in June due to appointments being temporarily un-booked following a clinical staff vacancy and a maternity leave. Replacement, and additional capacity has been secured from July to September which should see the waiting list begin to reduce.

A revised recovery trajectory will be reflected in next month's Board report.

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.

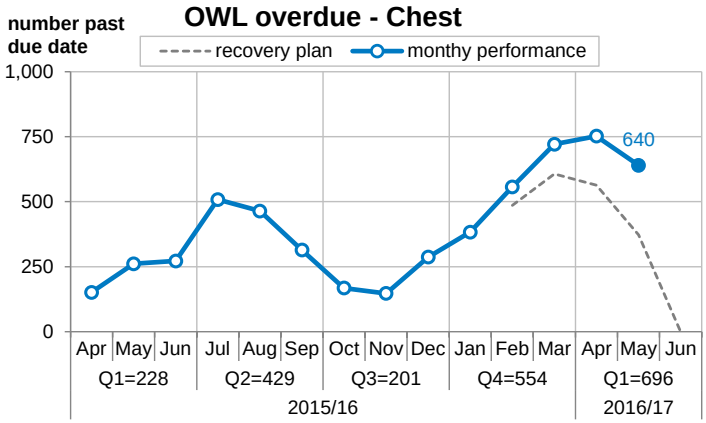
It is expected that the OWL will continue to rise in the short-term whilst innovative pro-active pathways are being implemented. Clinical validation has provided assurance that there is no clinical risk to this patient group.

The 100 day IBD pathway is being implemented which will:

- create additional clinic capacity by reducing the need for multiple follow-up appointments.
- Reduce future 6 month and 12 month follow-up demand
- Allow patients rapid access to specialist telephone advice Monday to Friday
- Allow patients to be discussed virtually between Nurse and Consultant.

By implementing the above pathways, and empowering patients to self-manage their condition, it is expected that there will be a significant number of patients removed from the waiting list by August.

Chart 47 Respiratory Medicine OWLs past due date



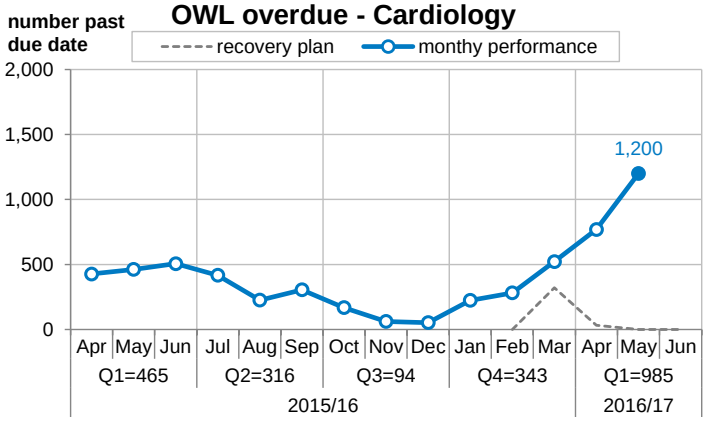
Respiratory Medicine

The Service has recently lost capacity due to the redistribution of duties within the Medical team and reprioritisation of clinical responsibilities. Additional capacity is currently being provided via Agency locum, this will be reviewed on an on-going basis. Again work is ongoing with CCG colleagues to identify patients suitable to be follow-up in Primary Care and initiatives to reduce referrals into the service are also being implemented.

As above, the 100 day plan will also impact positively on the Respiratory service.

The number of patients on the follow-up OWL has peaked and started to reduce. A revised recovery trajectory will be reflected in next month's Board report.

Chart 48 Cardiology OWLs past due date



Cardiology

Locums are being appointed to cover the gaps in Medical staffing. Work is ongoing with CCG colleagues to identify patients suitable to be follow-up in Primary Care and initiatives to reduce referrals into the service are also being implemented.

Additionally, the NHS England 100 day plan initiative is underway which will encompass multi-disciplinary specialty working across Cardiology and Respiratory Medicine, combining care pathways and reducing demand for traditional appointments.

A revised recovery trajectory will be reflected in next month's Board report, however it is anticipated that the waiting list will steadily decrease from July onwards.

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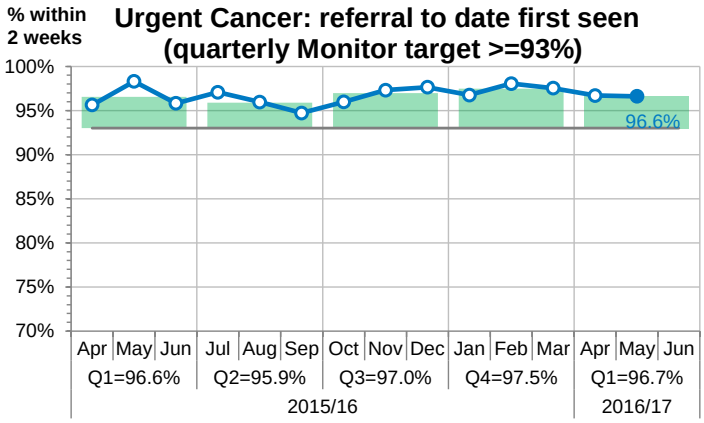
Cancer waiting times M16

Chart 49



Compliance with the urgent referral standard continues.

Chart 50

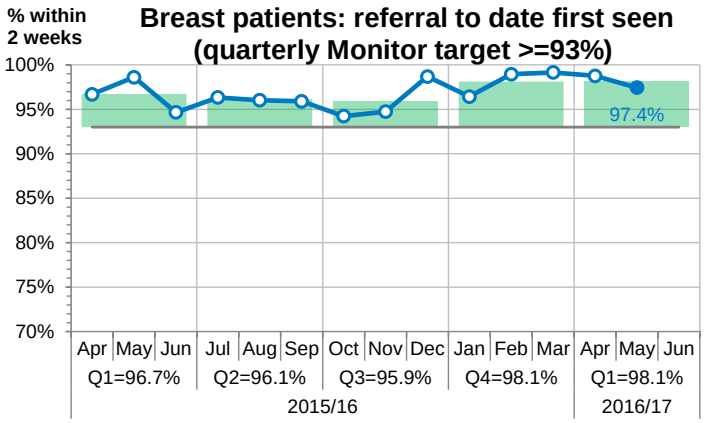


Chart 51

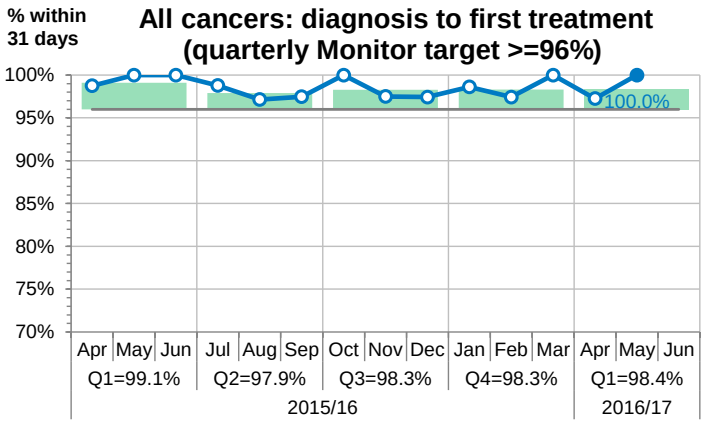


Chart 52

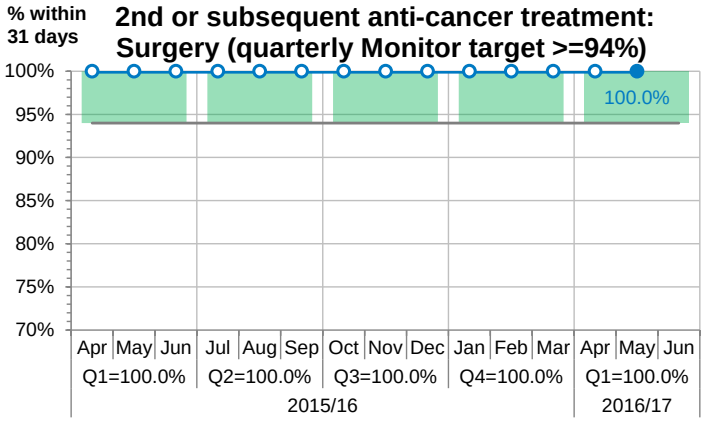


Chart 53

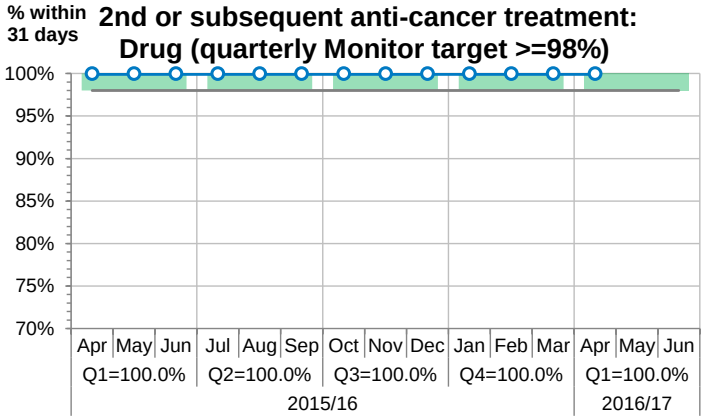


Chart 54

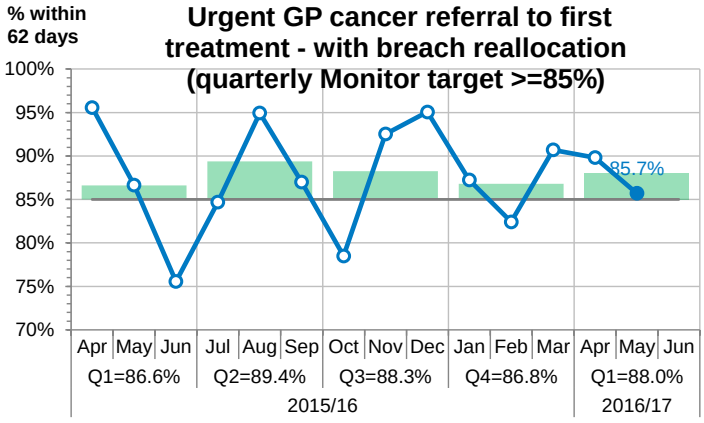


Chart 54 shows performance against the 62 day cancer standard.

Compliance for April has now been confirmed following data upload.

Latest indications are that the standard will be achieved for May, provisional data indicating performance of 85.7%.

The month of June remains a challenge, however early indications suggest that compliance across the quarter should be achieved.

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

Tumour Group (May-16 data)	Number of breaches / cases	Performance (85% target)	Monthly trend
Haematology	3 / 6.5	54%	
Colorectal	2 / 3	33%	
Gynaecology	1 / 3	67%	
Urology	0 / 14.5	100%	
Breast	0 / 11	100%	
Head & Neck	0 / 2.5	100%	
Upper GI	0 / 1.5	100%	
Lung	0 / 0.5	100%	

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

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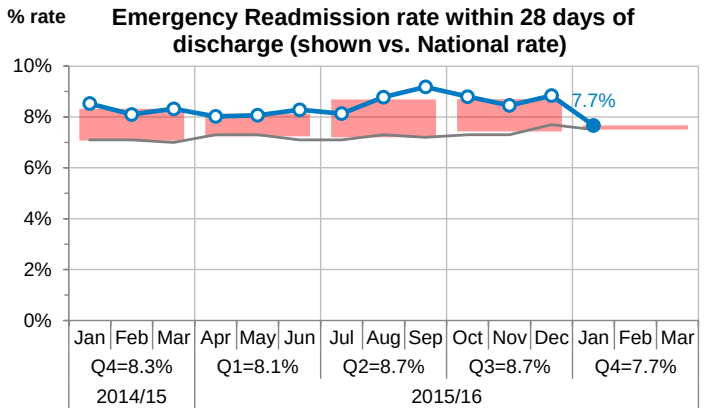
Emergency Readmissions

Chart 56



Data source: CHKS / Health and Social Care Information Centre

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

The organisation now has a strategic project to look at all re-attends and readmissions. The project will be managed at Senior Management Board led by the Medical Director, Dr Colin Wasson, and Chris Foster-McBride, KPMG

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Financial Performance

Chart 57

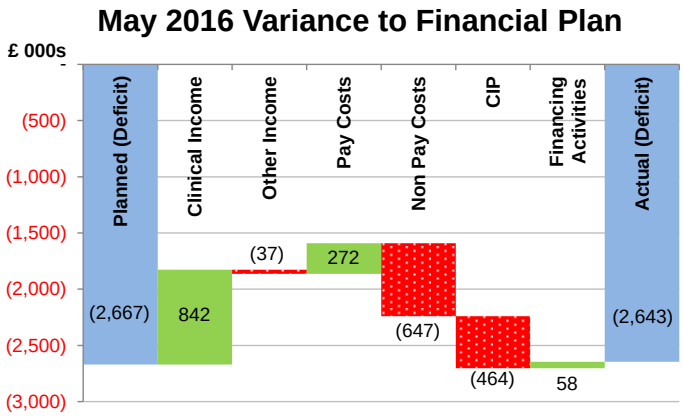


Chart 58

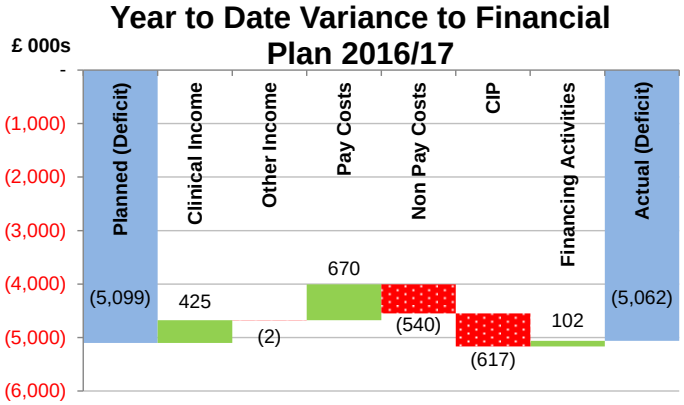
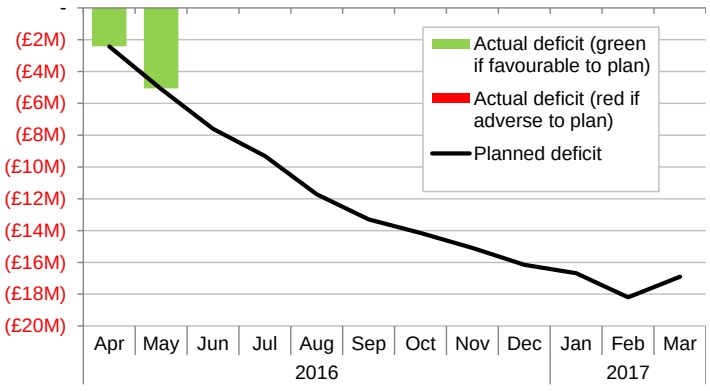


Chart 59



The Trust has a deficit of £5.1m at the end of May 2016 and this is in line with the financial plan; this is an increase of £2.6m in month. The Trust has a planned deficit of £16.9m for the financial year 2016/17 and this is after a cost improvement plan of £17.5m. Following KPMG's phase 1 report, the Trust will continue to monitor against the submitted annual plan until a re-forecast is formally requested by NHS Improvement. This is in-line with the monthly financial submissions required.

Clinical income has improved significantly in May and is £0.8m ahead of plan in month, of which £0.3m relates to finalisation of April activity as the new tariffs and contracting rules for 2016/17 have been applied. This has brought the year-to-date variance up to £0.4m favourable. Elective activity in particular is above plan, but this is linked to increased out-sourced activity undertaken to reduce the referral to treatment backlog and represents a low or nil margin contribution to the Trust.

Expenditure budgets are £0.1m underspent before CIP variances, as the pay underspend offsets non-pay increases. The business groups have continued to underspend by holding vacancies on a non-recurrent basis, but it has been agreed that this fortuitous slippage against budgets cannot count as CIP as this misrepresents reported savings as a cause and effect action has not been taken. The business groups need to focus on removing posts on a permanent basis and identifying additional savings schemes to deliver the transformational CIP savings required.

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Capital Programme

Chart 60

Description	Plan 2016/17 Year £'000	Year to Date May '16 Plan £'000	Actual £'000	Variance £'000
Surgical & Medical Centre - Building	3,740	1,580	1,322	258
Surgical& Medical Centre - Furniture & Fittings	600	0	0	0
Surgical& Medical Centre - Medical Equipment (partly donated)	660	0	0	0
Medical Ward Refurbishments	250	0	0	0
Electronic Patient Records - Purchased Software	598	0	0	0
Electronic Patient Records - Estates Enabling scheme b/f	55	55	78	-23
Facilities Equipment b/f	60	60	0	60
Medical Equipment b/f	52	0	0	0
Aspen House Server Room b/f	0	0	0	0
MRI Estates Enabling works b/f	0	0	5	-5
	6,015	1,695	1,406	289
Medical Equipment	1,290	20	35	-15
Facilities Equipment	75	0	0	0
IT Hardware	503	133	3	130
IT Software	297	63	0	63
Estates -Backlog Maintenance	125	10	-7	17
Estates - Non Backlog Maintenance	710	35	0	35
	3,000	261	31	231
	9,015	1,956	1,436	520
Revenue to Capital	0	0	(5)	5
Capital to Revenue	0	0	0	0
TOTAL (excluding Finance leases)	**9,015**	**1,956**	**1,431**	**525**
New Finance Lease Contracts				
I M & T - Intersystems EPR Software	1,006	0	0	0
I M & T - EMIS Community EPR Software	0	0	0	0
	1,006	0	0	0
TOTAL including new Finance Lease Contracts	10,021	1,956	1,431	525

Planned capital expenditure to the end of May was £2.0m, but actual costs were £1.4m so are below the profiled plan by £0.6m.

The D block Surgical and Medical Centre build is two weeks behind schedule due to delays in piping for the plant room. A new installation plan has been agreed with the contractor to bring this back into line, and the final completion date for the build of 5th August is still expected to be met. This is directly linked to the facility opening date of 3rd October, therefore the underspend at month 2 is a timing issue.

Both acute and community EPR projects are underway although the profiling of expenditure for this is considered under finance leases as shown in the bottom section of table. IT hardware purchases are now expected to be scheduled towards the end of the year to support the roll out of electronic patient records.

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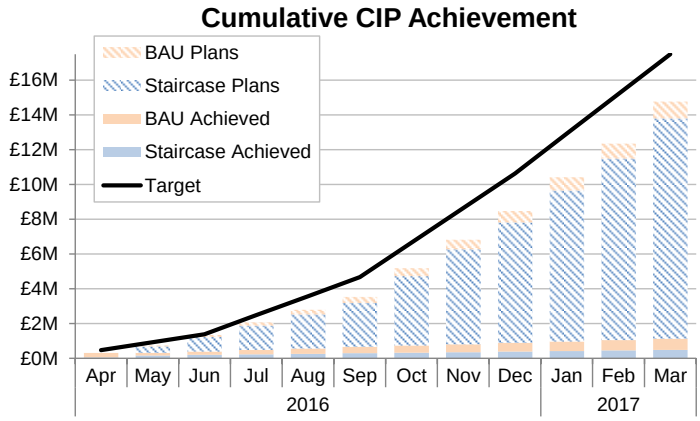
Cost Improvement Programme

Chart 61



The total Cost Improvement Programme for 2016/17 needs to deliver £17.5m of savings to allow the Trust to deliver the planned £16.9m deficit. This target is not split evenly across the year, and the expected level of savings per month increases as the year progresses, shown in the black target line in this chart. In total £0.3m of CIP has been delivered to date against the planned £0.9m target, leaving a £0.6m shortfall.

Two items of note influencing CIP reporting have changed in month: £0.5m Medicines Management scheme has moved from Business as Usual (BAU) into the Strategic Staircase umbrella, and non-recurrent vacancy slippage is no longer classed as CIP.

The BAU schemes are not expected to deliver savings until the second quarter, but last month delivered significant non-recurrent values by removing fortuitous vacancy slippage. This has been reversed in May and leaves BAU £0.14m ahead of plan to date. If the BAU savings targets were phased evenly across the year, BAU would be £0.61m adverse to date. This emphasises the need to take action now to ensure permanent savings are delivered on plan in future months when the targets for BAU commence.

By May the Staircase schemes were expected to save £0.92m but have only delivered £0.17m, a shortfall of £0.75m. Schemes delivering recurrent savings are Supplier Management £0.04m, Medicines Management £0.02m and Site Utilisation £0.02m. The overall deficit is due to non-delivery on Theatre Utilisation and Private Practice £0.42m and Agency reduction £0.30m.

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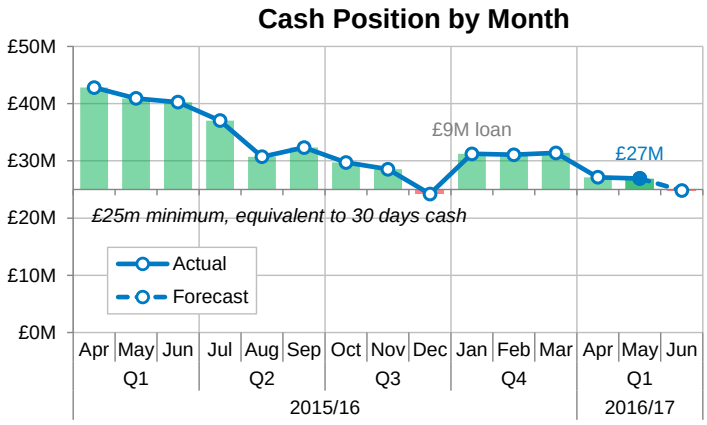
Financial Sustainability Risk Rating

Chart 62

		Actual	Rating	Initiate Override?	Excellent 4	3	2	Poor 1	Weight	Weighted score
Balance Sheet Sustainability	Capital service capacity (times)	(2.6)	1	Yes	2.50	1.75	1.25	< 1.25	25%	0
Liquidity	Liquidity (days)	5.5	4	No	0	-7	-14	< -14	25%	1
Underlying Performance	I&E margin (%)	-10.8%	1	Yes	1.00%	0.00%	-1.00%	<-1.0%	25%	0
Variance from Plan	Variance in I&E margin as a % of income (%)	0.0%	3	No	0.00%	-1.00%	-2.00%	<-2.0%	25%	1
Financial Sustainability & Performance Risk Rating - Calculated										**3**
OVERRIDE INITIATED?				Yes						Yes
Financial Sustainability & Performance Risk Rating - Final Reportable										**2**

Chart 63



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

Cash in the bank at the 31st May 2016 was £26.9m against an operational plan of £26.0m and therefore there is a positive variance of £0.9m. This is due to increased cash receipts for aged debts from local NHS organisations and a significant VAT refund which was higher than expected.

The Trust's new Cash Action Group chaired by the Financial Improvement Director has now been established in order to protect the cash position of the Trust and improve the £10m year end forecast cash balance.

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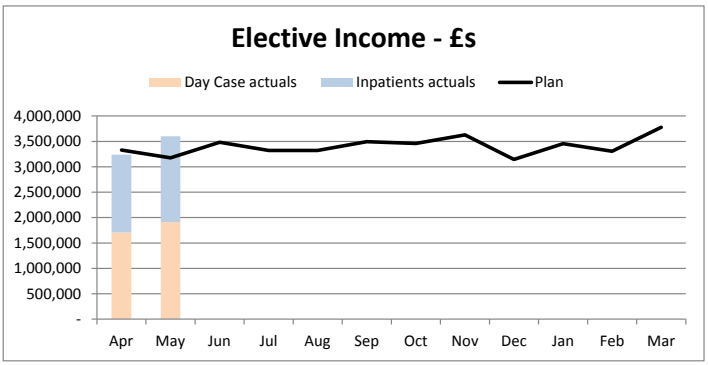
Elective Income vs. Plan

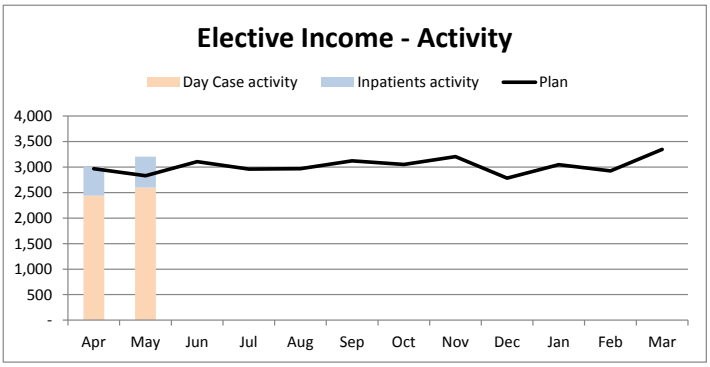
Chart 64



Elective income is above plan by £0.1m to the end of May 2016. This is an improvement of £0.3m from last month, but as referred to in last month's report this includes a pricing catch up on case mix from actual activity in April.

The activity trend over previous years, which informs the plan profile for the current year, has always shown a dip in elective activity due to the school summer half-term holiday. This year the break has fallen into June rather than May, so additional income in May compared to plan may be offset by an unplanned dip in early June.

Chart 65



Surgery have outsourced 106 cases in May 2016 to reduce the referral to treatment backlog and generate additional income, but this represents a low or nil margin contribution to the Trust. Out-sourcing costs to date are £0.4m, primarily in Trauma & Orthopaedics £0.2m, Endoscopy £0.1m and Ophthalmology £0.1m.

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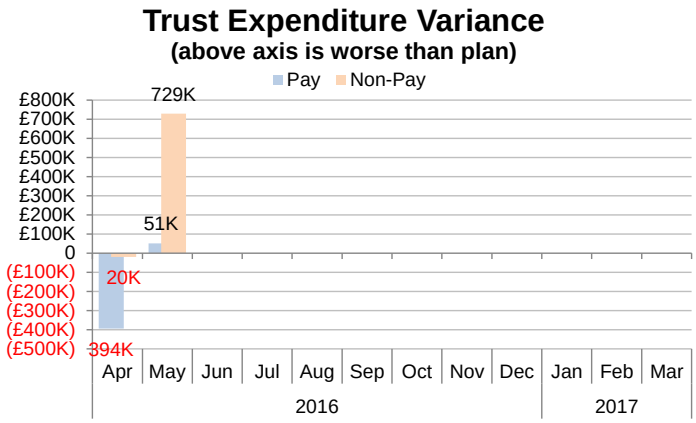
Expenditure Variance

Chart 66

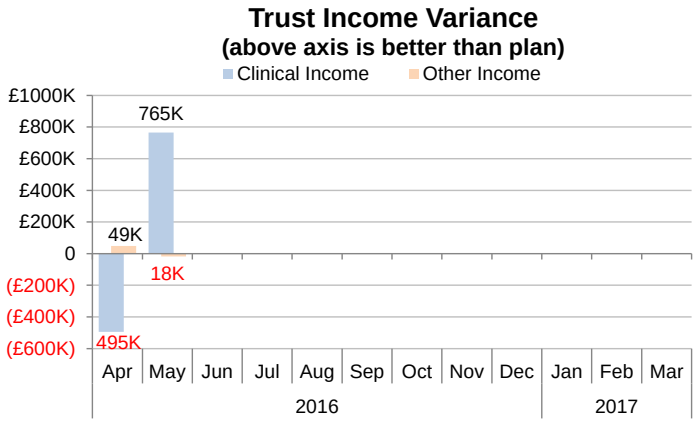


Expenditure budgets overspent by £0.8m in May, so are now £0.4m overspent year to date including a CIP shortfall of £0.5m across expenditure categories. Pay budget underspends from non-recurrent slippage on vacancies are offsetting increased non-pay costs for KPMG consultancy and out-sourcing.

There is a variation across business groups but pay is overspent in Medicine and Surgery, where premium rate medical staff usage continues across many specialties. The new financial improvement temporary staffing group is focusing on action plans for each post to reduce the usage from a financial and operational perspective. The level of vacancies in other business groups is being reviewed to concentrate on removing posts on a permanent basis to contribute to the recurrent CIP required.

Income Variance

Chart 67



Clinical income has improved significantly in May and is £0.8m ahead of plan in month, of which £0.3m relates to finalisation of April activity as the new tariffs and contracting rules for 2016/17 have been applied. This has brought the year-to-date variance up to £0.4m favourable.

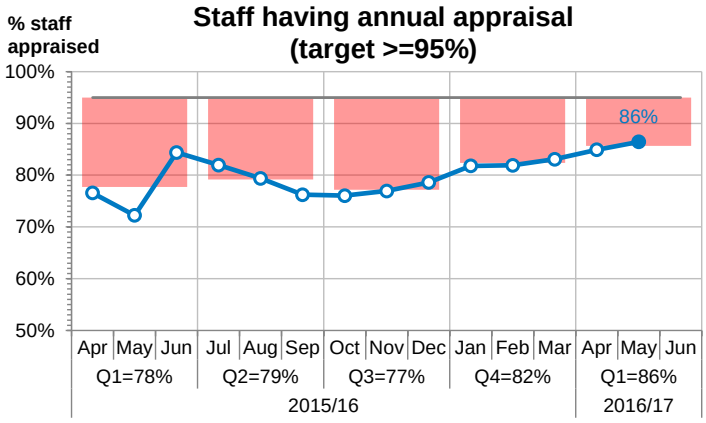
Stockport CCG Block Contract

- Non-elective income for Stockport is in line with plan.
- Emergency Department estimated activity is 8% above plan, and therefore in excess of the 5% threshold agreed with the CCG. This position will be closely monitored and discussed with the CCG as part of the reconciliation of the Q1 overall financial position.
- Out-patient and non-tariff elements of the Stockport CCG block are currently a marginal benefit to the Trust. Activity is slightly behind plan but we are still receiving the standard level of income; this is expected to fluctuate during the year.

See also Financial Income and Expenditure table

Workforce Appraisals

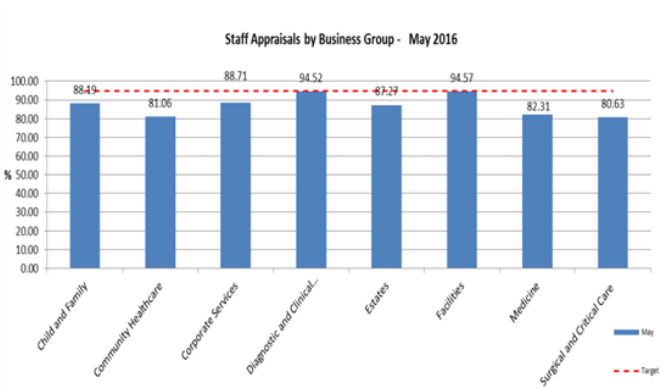
Chart 68



The Trust's total appraisal compliance for May 2016 is 86.43%, an increase of 1.54% since April 2016 (84.89%).

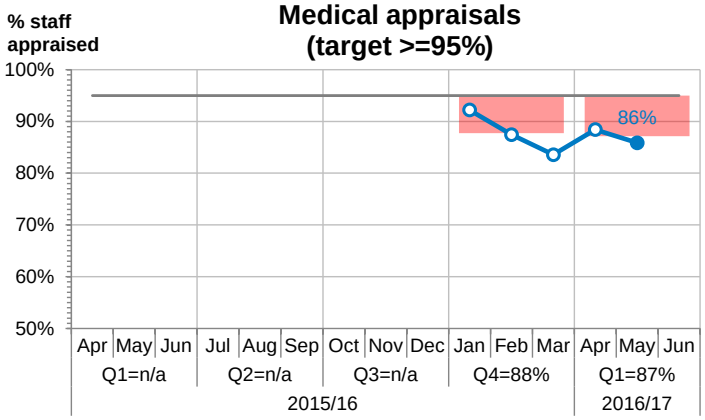
The following Business Groups have seen increases this month; Diagnostic & Clinical Support from 93.89% to 94.52%, and Facilities from 93.73% to 94.57%, Child & Family from 86.87% to 88.19%, Corporate Services from 86.68% to 88.71%, Medicine from 80.86% to 82.31%, Surgical & Critical Care from 79.10% to 80.63% and Community Healthcare from 76.98% to 81.06%. Estates saw no change and remains at 89.2%

Chart 69



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

Chart 70



The medical appraisal rate for May 2016 is 85.86%, a decrease of 2.55% from April 2016 (88.41%).

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 71

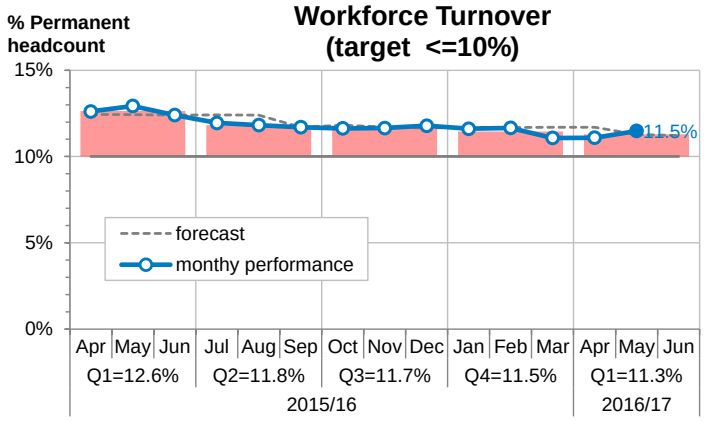
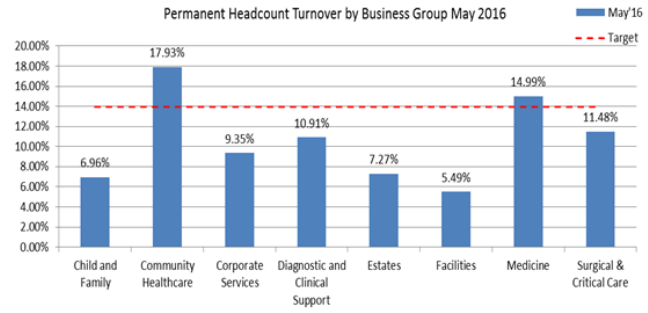


Chart 72



The Trust's permanent headcount turnover figure for the 12 months ending May 2016 is 11.49% against a national average rate of 13.93%. This is an increase of 0.40% compared to the April 2016 figure of 11.09%, showing some stability in the turnover activity. (This does not include the TUPE transfer staff which increases the May 2016 permanent headcount turnover figure to 25.55%). The turnover rate for comparison to May 2015 was 12.93%.

Facilities have the lowest turnover at 5.49%, followed by Child & Family at 6.96% in May 2016. Community Healthcare has the highest turnover rate at 17.93% and Medicine Business Group remains high at 14.99% in May 2016. Community Healthcare and Medicine Business Groups are above the Trust target of 13.93%, which is the National medium size Acute Trust average turnover rate.

Estates Business Group has seen the biggest decrease of 1.50% down to 7.27% in May 2016 from 8.77% in April 2016.

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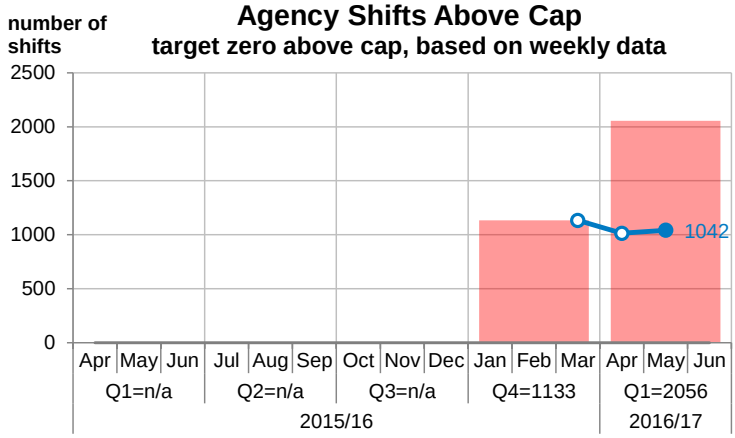
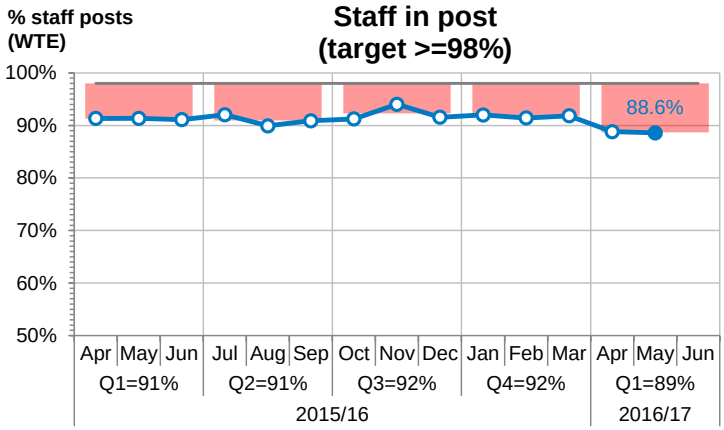
Workforce Efficiency

Chart 73



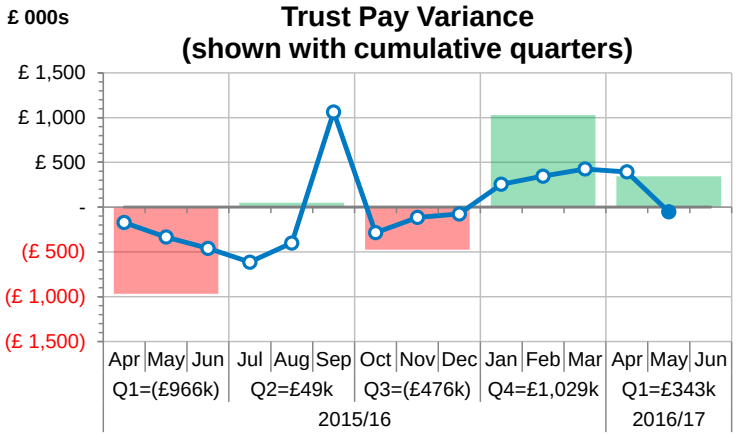
May 2016 shows an increase in the number of shifts (28) which are taking place above the agency cap from 1014 in April 2016 to 1042 in May 2016. Work has commenced in line with the IDP Agency Cap programme to address the level of cap breaches and to model the impact.

Chart 74



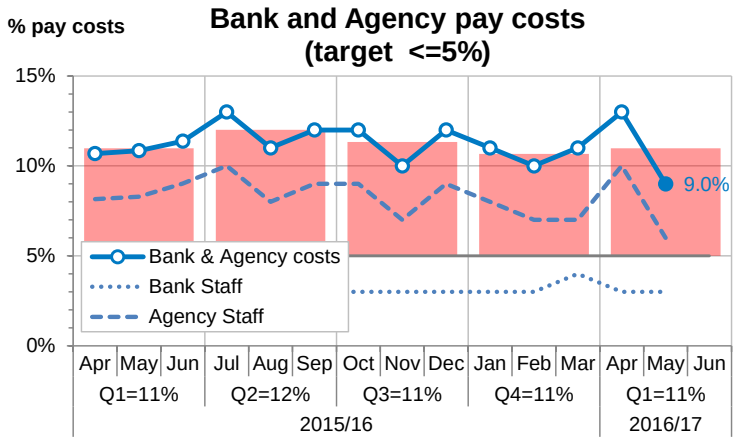
The Trust staff in post for May 2016 is 88.6% of the establishment, which is a decrease of 0.2% from 88.8% in April 2016.

Chart 75



The Trust pay variance, expenditure above the financial envelope of establishment, including vacancies in May 2016 showed a £51,216 overspend, a decrease of £445,414 from the £394,198 underspend reported in April 2015.

Chart 76



The percentage of pay costs spent on bank and agency in May 2016 is 9% (a decrease of 4% from April's position) which equates to £1,679,890 a decrease of £53,634 from £1,733,524 in April 2016.

The Medicine Business Group has the highest spend on bank/agency at £236,982 in May 2016 which equates to 60.11% of the overall spend, a decrease of 2.29% (£6,827) from the 62.4% April 2016 figure.

In May 2016, 3% of total pay costs were attributed to bank staff which is the same as the April 2016 figure, and 6% of total pay costs were attributed to agency staff, a 4% reduction from April 2016. The use of bank and agency staff is closely monitored at Business Group Finance and Performance meetings and the Establishment Control Panel.

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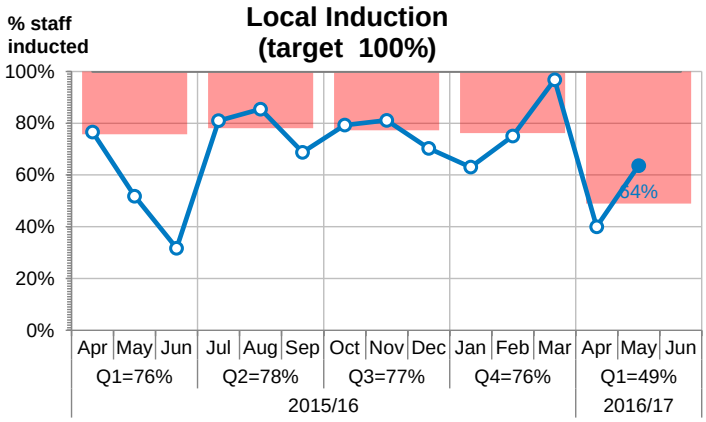
Workforce Induction

Chart 77



Corporate Welcome attendance remains consistently at 100%. Local induction has increased from 40% in April to 63.6% in May

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Staff Engagement

To be developed

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Sickness Absence

Chart 78

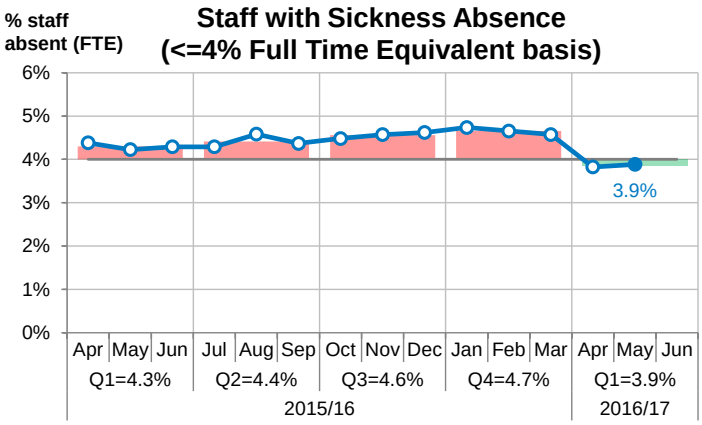
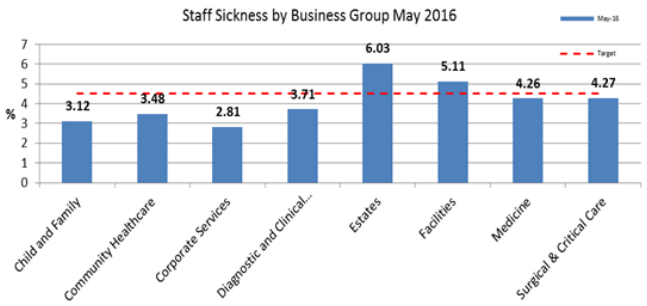


Chart 79



The in-month unadjusted sickness absence figure for May 2016 is 3.88%. This is an increase of 0.05% compared to the April 2016 adjusted figure of 3.83%. The sickness rate for comparison in May 2015 was 4.25%.

The unadjusted cost of sickness absence in May 2016 is £425,224, a decrease of £173,391 from the adjusted figure of £392,086 in April 2016. This does not include the cost to cover the sickness absence.

Community Healthcare, Diagnostics &CS, and Facilities have reported a decrease in sickness absence in May 2016. Only Estates (6.03%) and Facilities (5.11%) are above the target in May 2016.

The top 3 known reasons for sickness in May 2016 are back problems and other musculoskeletal problems including injury/fracture at 31.33% (a 6.62% increase from 24.71% in April 2016), stress at 20.91% (a 2.91% decrease from 23.82% in April 2016), and gastrointestinal problems at 8.14% (a 0.39% increase from 7.75% in April 2016).

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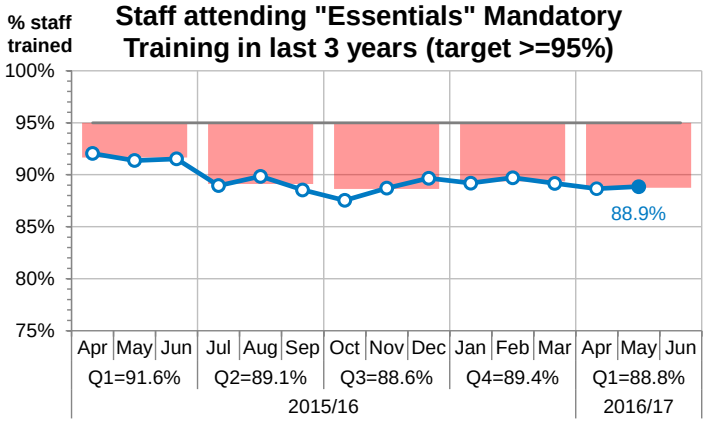
Essentials Training

Chart 80



In May 2016 there was an increase of 0.3% in compliance from the April position, from 88.6% to 88.9%.

Only one of the Business Groups achieved compliance, Estates.

Diagnostics and Clinical Support achieved 93.94%, Child & Family 92.05% and Community 94.14%. The remaining Business Groups are under 90%. The Head of OD and Learning has contacted those Business Groups who are under 90% to ascertain the plans they have in place to achieve 95% compliance.

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

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

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Integrated Performance Report
June 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	6,613	6,737	123
Non Elective	74,730	12,500	12,476	(24)
Outpatient	34,366	5,486	5,533	47
A&E	12,038	1,972	1,993	21
Total Income at Full Tariff	**162,801**	**26,571**	**26,739**	**168**
Community Services	31,891	5,436	5,487	52
Non-tariff income	52,614	8,707	8,896	189
Clinical Income - NHS	**247,306**	**40,713**	**41,122**	**409**
Private Patients	698	116	47	(69)
Other	959	160	90	(70)
Non NHS Clinical Income	**1,656**	**276**	**137**	**(139)**
Research & Development	454	70	61	(9)
Education and Training	7,121	1,200	1,218	18
Stockport Pharmaceuticals/RQC	5,971	969	864	(105)
Other income	14,381	2,888	3,015	127
Other Income	**27,926**	**5,127**	**5,158**	**31**
TOTAL INCOME	**276,888**	**46,117**	**46,418**	**301**
EXPENDITURE				
Pay Costs	(207,435)	(35,603)	(35,260)	343
Drugs	(16,050)	(3,229)	(3,164)	65
Clinical Supplies & services	(19,088)	(3,443)	(3,708)	(265)
Other Non Pay Costs	(36,763)	(6,484)	(6,993)	(509)
TOTAL COSTS	**(279,335)**	**(48,760)**	**(49,126)**	**(366)**
EBITDA	**(2,447)**	**(2,643)**	**(2,708)**	**(65)**
Depreciation	(9,094)	(1,474)	(1,431)	43
Interest Receivable	63	10	14	4
Interest Payable	(936)	(160)	(154)	6
Other Non-Operating Expenses	(706)	(118)	(64)	54
Fixed Asset Impairment Reversal	-	-	-	-
Unwinding of Discount	(30)	-	-	-
Profit/(Loss) on disposal of fixed ass	-	-	(4)	(4)
Donations of cash for PPE	540	-	-	-
PDC Dividend	(4,291)	(715)	(715)	(0)
RETAINED SURPLUS / (DEFICIT) FOR PERIOD	**(16,900)**	**(5,099)**	**(5,062)**	**37**

Stockport NHS
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	30th June 2016
Subject:	Annual Report – Safeguarding Children and Adults 2015-16		
Report of:	Deputy Director of Nursing & Midwifery	**Prepared by:**	Julie Parker – Named Nurse Jane Hopewell – Named Nurse Wendy Stewart – Named Nurse

REPORT FOR APPROVAL

Corporate objective ref: -----	**Summary of Report** This annual report presents an overview of all safeguarding activity relating to 2015/16 across Stockport and Tameside and Glossop. Key highlights include; • The four serious case reviews in Stockport have had significant focus and consideration around all agencies' involvement, including health; the action plans drawn up will require some continued attention and drive in the next 12 months. Some of the key health learning points include the need to consider the impact of trauma (including abuse)in a parent's childhood on their ability to parent a new-born baby; continuity of care in midwifery in order to adequately assess risk and that safeguarding supervision should triangulate risk around parental mental health • There has been intense focus around raising awareness of child sexual exploitation throughout the organisation; school nurses playing an active part in the community with multi-agency colleagues • Midwifery supervision at 85% • Training compliance has significantly improved with Children's securing 86% at level 2 and 83% at level 3. Adults' Safeguarding has achieved 89% and 82% for MCA/DoLS • Applications for Deprivation of Liberty Safeguards(DoLS) have increased from 25 in 14/15 to 214 in 15/16 • A revised Intercollegiate document has been produced for Adult Safeguarding – this is now subject to a critique and gap analysis for the organisation. The Board of Directors are asked to note the significant improvements made in year in relation to Midwifery supervision and safeguarding training across the organisation and to note the contents of the report.
Board Assurance Framework ref: -----	
CQC Registration Standards ref: -----	
Equality Impact Assessment: ☐ Completed ☐ Not required	

Attachments:	Annex A – Definitions

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; QGC

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Annual Children & Adults Safeguarding Report 2015-16

Children's Safeguarding

1.0 INTRODUCTION

This is annual report presenting an overview of all safeguarding related activity, children and adults, for the period 1st April 2015 to 31st March 2016 and including Tameside and Glossop community services.

2.0 Background

An annual children's report is a statutory requirement as per section 11 of The Children Act 2004.

3.0 Current Situation

Tameside community data has been included in this annual report as they were within Stockport NHS Foundation Trust up to March 31st 2016

3.1 Serious Case Reviews

In 2015 a total of 4 Serious Case Reviews (SCR's) were commissioned by Stockport Safeguarding Children Board which is unprecedented in Stockport.

Incident	Status	Progress
Death of a 17 year old Stockport Looked After Child in a road traffic accident (Child placed in Bolton)	SCR (serious case review) complete	Final Report/Action Plan
3 week old twins sustained significant non accidental head injuries (children recovering)	SCR awaiting final report	Health Learning summary and Action plan submitted for midwifery and health
Injury of a 12 week old child whose mother had been a victim of Sexual Exploitation and who had been subject to SCR processes herself (child recovering)	SCR final report awaiting SSCB approval	Health learning summary and action plan produced for midwifery and health
Death of a 16 day old baby; father charged with her death	SCR awaiting final report	Health learning summary and action plan produced for midwifery and health

In the SCR's there was active health involvement including midwifery, health visiting, school nursing and acute paediatric care in three of the cases and less involvement in the 17 year old looked after child's care (the health input was being provided by another health trust as she was placed out of area).

Of note three out of the 4 SCR's involved babies less than 3 months of age. It has been a consistent

feature of national serious case reviews that a large proportion of those conducted relate to infants and babies under one year old, reflecting the particular vulnerability of babies to physical harm. The NSPCC[1] reports that in England and Wales, under-1s face around eight times the average risk of child homicide with those less than 3 months of age being the most vulnerable. Any learning implemented by the Trust must therefore acknowledge the stresses and strains a new-born can place on a family and especially where the care-giver is known to have experienced trauma.

The reviews were conducted by independent authors; panels made up of senior representatives from each organisation. Practitioners involved in each case were given the opportunity to take part; being interviewed by the reviewer and offering their views of what it was like to work with the families and the difficulties presented to them. It is important to remember that "abuse and neglect rarely present with a clear, unequivocal picture (Munro 2011[2]) and this kind of work is never simple and straightforward. There were also 3 multiagency learning reviews where Stockport NHS FT staff had some involvement; action plans have been drawn up and progressed.

All the children's cases were unique; their stories meriting a full review and understanding of what can make good practice more likely. Work over the next year will focus on ensuring the actions within the plans are implemented and the dissemination of learning through a variety of means and with the help of our Stockport Family colleagues. We have a duty to the children and families involved to ensure that we learn from their stories

3.2 Safeguarding Children Supervision In Health Visiting and School Nursing

	2015-16
No of staff requiring supervision (Health visitors & School Nurses)	240
No of staff supervised within timescale	204 (85%)
No of staff supervised from previous month	22
No of staff not supervised within timescale	35
No of individual children's records supervised this quarter	1968

Whilst the figures show a large number of individual children's cases brought to supervision, high numbers may not always promote the conditions necessary for high quality supervision (school nurses supervised formally 3 times a year and health visitors 4 times). Future focus will be on revising the model to spend longer on those cases that are presenting the most difficulties for practitioners. An opportunity to pilot multiagency supervision with Stockport Family colleagues is planned, which is also a fundamental part of the serious case review action plans.

Safeguarding supervision is offered widely across the Trust, acute and community services.

[1] https://www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/learning/hidden-men/

[22] Eileen Munro (2011), Effective Child Protection, Second Edition: Sage Publications

Midwifery Supervision

Safeguarding Champions Summary	Under 4 Sessions	Over 4 Sessions
April 2015 – March 2016	20%	80%

Community Midwives	Under 4 Sessions	Over 4 Sessions
April 2015-March 2016	50%	50%

Trust Midwives	Under 1 Session	Over 1 Sessions
April 2015-March 2016	14%	86%

In 2015 it was agreed that community midwives would have supervision 4 times a year and hospital based Midwives would have one formal session but with opportunities available for supervision around incidents and reviews; this is working well and the uptake of supervision has improved greatly with an opportunity to continue to improve.

Tameside & Glossop Supervision

The Specialist Nurses and the Named Nurse for the Community Safeguarding Team complete Safeguarding Supervision for all community Health practitioners. Every Serious Case Review nationally or locally has emphasised the importance of this, especially for lone-workers and autonomous practitioners.
I have forwarded a copy of the SFT Safeguarding Supervision policy. The measurement is taken from the Supervision for Health Visitors and School Nurses only. This is offered on a one to one every 3-4 months. There is a monthly group safeguarding supervision model offered to all community health practitioners at various venues across Tameside that they book onto via the Safeguarding Team office.

	% of HVs / SNs obtained safeguarding supervision
Q1	85%
Q2	61% (policy introduced)
Q3	71%
Q4	86%

The Safeguarding Community Team also provides Health checks for Fostering / adoption agencies who require health information on individual applicants. Daily telephone advice to all community health practitioners including GPs, education and voluntary agencies.

3.3 Court Reports

	2015-16
No. of Court Reports Produced	73

Court report activity has been higher than in other years. Practitioners have been supported to produce high quality, evidence based reports which show the families' strengths and difficulties. These are often produced with very tight timeframes in order to comply with the court order

Tameside & Glossop Court Reports

The Local Authority Legal Team provides Court Statement requests to the Community Safeguarding Children's Team. This is a sealed court order and requires a member of staff to complete. This could be a School Nurse, Health Visitor or a member of the ISCAN team (Integrated services for children with additional needs -Nurse or allied health professional).

The Safeguarding Team provide support to the individuals completing the statement and the Named Nurse approves the final draft for submission. This is scanned and sent by confidential (GCSX account) to the legal Team.

Quarter	No of court reports completed
1 (April-July)	6
2 (Aug-Oct)	18
3 (Oct-Jan)	6
4 (Jan-Mar)	12

3.4 Stockport Child Protection Case Conference Activity

	2015-16
No. of Initial Case Conferences	120
No. of Review Case Conferences	273

Last year's figures are not available to make a comparison of case conference activity.

Tameside & Glossop Case Conference Activity

There is a statutory responsibility for Health Practitioners to attend Child Protection Case Conferences and provide a report at the Initial Review or thereafter. This section reports how many conferences community health practitioners have attended. Conferences are held every 3 or 6 months. Members of the Safeguarding team do not usually attend unless asked by the practitioner as the escalation process with social care may need to be initiated.

Types of Case Conference	Q1	Q2	Q3	Q4
Initial	49	41	71	53
Review	63	118	88	93

3.5 MARAC (Multi-Agency Risk Assessment Conference for high risk Domestic Abuse Cases) Stockport

MARAC	**2015-16**
No. of Cases	245
No. of Children	376

There is a slight decrease in the number of children discussed in MARAC compared to last year where there were 435 children risk assessed. Future training will continue to focus on helping emergency department practitioners to feel confident to raise a MARAC referral and demonstrate professional curiosity when treating victims of domestic abuse.

Tameside & Glossop MARAC

Tameside has a particular high rate of Domestic abuse. The MARAC is held fortnightly and is an excellent example of multi-agency working in Tameside. The School Nurses, Health Visitors, sexual Health or ISCAN Team may well be approach to feedback any information about this family so that the Community Safeguarding Team can feedback to MARAC. The concluding information or actions from MARAC is then shared with the teams. A letter is also sent to every GP to notify them that an individual has been discussed – this is the victim's GP not routinely the perpetrator.

	Q1	Q2	Q3	Q4
MARAC No of Cases	95	95	73	133
MARAC No of Children	136	75	79	168

3.6 Child Sexual Exploitation (CSE)

Stockport: MASE (Multi- agency Sexual Exploitation)

MASE	2015-16
No. of Cases	91

The planning and risk assessment around children at risk of or having been sexually exploited is partially co-ordinated through the MASE process. There have been 7 more cases this year. Indeed one of the messages from a local SCR was that we must be careful not to sanitise the term of child sexual exploitation; and work hard to ensure that there is an understanding about what has actually happened to these vulnerable children.

Tameside & Glossop MASE

In some areas such as Stockport they have regular MASE (Multi-agency sexual exploitation meetings). In Tameside the police run Phoenix team have all of the open cases of CSE with children less than 18 years. Despite having a Specialist Nurse that works for the Community Safeguarding Team who spends two days with the police, obtaining a list of children who are most vulnerable has been difficult. The Safeguarding Specialist Nurse for Children's homes and CSE attend a weekly multi-agency meeting convened by the Phoenix team where identified CSEs cases are discussed. The Safeguarding Children's Board are aware of this and improvements will be made in the future.

The Quarter reports have reflected the information that health has been told by the team.

Q1	There are approximately 47 children under the age of 18 years at risk of CSE.
Q2	There are 76 children under the age of 18 years at risk of CSE with 7 identified as severe risk.
Q3	There are approximately 50 children identified at risk of CSE in Tameside at the moment. There have been 5 severe cases recently investigated by the Team.

3.7 Safeguarding Children Training

Stockport

	2015-16
Level 1	86%
Level 2	86%
Level 3	83%

Particular focus has been to ensure level 3 practitioners have access to the required level of high quality training through a blended approach alongside the SSCB multiagency programme. At level 3, a total of 574 practitioners have been trained in 26 classroom sessions and two large conferences with multiagency speakers. Training of this type is evaluated well; attendees reporting that they felt more confident about their involvement in safeguarding children and the importance of having up to date knowledge around the more recent concerns such as human trafficking and modern slavery. Volunteers have also been trained formally this year in safeguarding children.

Tameside & Glossop Safeguarding Children Training

Tameside and Glossop Safeguarding Children's training recommendations are taken from the intercollegiate document. The target is for 85% of Practitioners to attend each of the levels.

Level of Safeguarding Training	% obtained Q1	% obtained Q2	% obtained Q3	% obtained Q4
Level 1	89%	77%	93%	96%
Level 2	86%	88%	89%	88%
Level 3	83%	75%	86%	87%

3.8 Causes for Concern

	2015-16
No. of Cause for Concern forms received	2424

This year has seen an increase of around 50 causes for concern a month. Whilst the amount of causes for concern generated around children and their carers (where appropriate) is good evidence that staff are aware of their safeguarding responsibilities it becomes as important to evidence that this is actually making a difference to children's outcomes. An audit is planned for 2015/2016 with the support of Stockport Family colleagues

Tameside & Glossop Causes for Concern

These are the number of cases that community health practitioners have contacted the Community Safeguarding Team to discuss.

Q1	115
Q2	128
Q3	96
Q4	136

3.9 Child Protection Medicals

	2015-16
No. of Child Protection Medicals	167

There has been an increase of 15 child protection medicals this year compared to last. A multiagency audit was completed in November 2015 around the outcomes of the child protection medicals. Whilst it was considered that the request for the medicals was appropriate it is acknowledged that a future audit should include the Named Doctor for Safeguarding children to triangulate and test this hypothesis further. A finding was that health colleagues were not always asked to the strategy meetings; recent evidence shows this has improved.

3.10 Looked after Children (LAC)

Stockport

	2015-2016
Initial Health Assessments Compliance (Target 95%)	89%
Review Health Assessments Compliance (Target 92%)	89.5%

Work is ongoing with our children's social care colleagues to improve the completion of the assessments within the targets. 2016 will also require some ongoing focus on the quality of the assessments. A risk assessment has been in place from 2015 around the specialist looked after children's health service and the capacity to meet all the statutory requirements.

Tameside & Glossop Looked After Children

The Community Safeguarding Team has a Specialist Nurse for LAC and the Named Nurse also has responsibility for this area.

Review Health Assessments need to be completed within a 4-8 week time frame. This is currently a Key Performance Indictor for the CCG and is currently under review. There are currently 800 LAC children in the Tameside region. 450 from Tameside Local authority and 350 are LAC children placed in Tameside from other areas. We currently charge for the LAC Review Health Assessments for those 350 children from out of area – the National tariff is used to calculate. The Glossop school nursing service was taken over by Derbyshire in October 2015 but the LAC children of school age in Glossop are still the responsibility of Tameside & Glossop CCG. We have received no extra monies for this service but are determined to ensure that this vulnerable group are not at increased risk. The CCG are aware of this and it was on the risk register prior to transfer of T&G services.

T&G

	2015-2016
Initial Health Assessments Compliance (Target 95%)	Data not available at time of report
Review Health Assessments Compliance (Target 92%)	Data not available at time of report

4.0 Risk and Assurance

4.1 Service Provision and Developments in 2015/2016

- A revised training strategy was implemented requiring staff in the Emergency Department (ED) to have 6 hours of level 3 training over a 3 year period and ensure staff at level 1 competency receive 3 yearly refresher training
- 2 CCG walk rounds focusing on safeguarding in children's and maternity were generally positive; the reviewers expressing confidence that safeguarding was understood by all levels of staff; measures were implemented to ensure medical staff have the relevant safeguarding children training
- The implementation of Stockport Family where health visitors, school nurses and midwives will work within an integrated model to keep children safe from harm is an exciting opportunity to work more collaboratively and proactively. The access to specialist training around restorative practice has been very useful to help us encourage staff to work with families rather than for or without.
- A child death policy was ratified and implemented across the Trust; making it clearer around the child death overview panel and processes
- A Female Genital Mutilation Policy was written and implemented; collaboration with the SSCB has been crucial for its implementation
- The first wave of the child protection information sharing project (CPIS) was implemented in the Emergency Department (it enables the department to review each child's vulnerability status according to whether the child is subject to a child protection plan, is a Looked after child or an Unborn child subject to a CP plan).This is of course dependent upon whether the Local Authority area that the child lives in (if outside Stockport) is also signed up to the system.
- The CQC action plan and accompanying midwifery action plan (from the December 2014 review of safeguarding children and LAC services) has progressed well.
- A safeguarding and DNA SOP in midwifery was implemented
- Paediatric nursing, medical staff and community staff have been supported to produce high quality chronologies for suspected fabricated illness cases
- Safeguarding midwifery champions have been identified to implement the safeguarding messages and support staff in midwifery
- There were 2 weeks of action around child sexual exploitation; messages were tweeted by the Trust's communication team; school nurses played an active part in the response and worked with GM police and their multiagency colleagues
- Our local MP Ann Coffey presented her findings around children's voices/ child sexual exploitation at a Trust Safeguarding in Sexual Health Conference; evaluations were very positive
- Safeguarding supervision is well embedded into the Family Nurse Partnership programme; evidence is available in the case studies presented to the advisory panel that safeguarding always underpins the assessments
- A business case has been successful around Looked after Children team and should see a more enhanced service when recruitment is completed

5.0 Conclusion

5.1 Future Focus

- Develop the Looked after Children's specialist health team working with the Designated Doctor for LAC to continually improve the quality of the health assessments completed
- Revise the safeguarding supervision model for health visitors and school nurses
- Embed the learning in all departments and including midwifery from the Serious Case reviews and Multiagency Learning Review using Stockport Family colleagues where appropriate
- Consider how health could be best represented at the various multiagency safeguarding children

forums ie MASE/Missing from Home/Channel Panel/MAPPA

- Consider how health could contribute meaningfully in the MASSH (multiagency safeguarding and support hub)
- Roll out the CPIS project into paediatric and midwifery departments and audit its effectiveness with children's social care
- Ensure honorary staff have their relevant safeguarding training attached to their staff record
- Adopt a safe process around the management of adopted children's health records
- Work closely with CAMHS and the mental health transition team to safeguard 16-18 year old children presenting to acute hospital services

ADULT SAFEGUARDING 2015/16

TAMESIDE & GLOSSOP - COMMUNITY HEALTHCARE BUSINESS GROUP

Service Provision

A Core Group of 19 Safeguarding Adult Managers (SAMs), from frontline practice, supported staff and patients in the investigation of safeguarding issues. A rota system was co-ordinated by the Specialist Nurse for Adult Safeguarding. This ensures that safeguarding incidents reported through the Business Group are acted on promptly and a SAM is allocated from the Business Group to take initial lead with investigations in accordance with the Tameside Adult Safeguarding Partnership Board (TASPB) Policy.

There was been a reduction in the number of SAMs in Q4. This was due to staff leaving the organisation and also to a change in SAM eligibility requirements to comply with TASPB Policy. This states that SAMs but be at least first line manager status within the organisation. Therefore, two existing SAMS have become Safeguarding Champions and will assist SAMs with the enquiry process rather than leading on this.

In addition to the SAMs there are 20 Safeguarding Advisors who hold senior management positions within the Business Group and who have completed Safeguarding Adult Manager Training.

Numbers of SAMS across the Business Group

Service	**No. of SAMs**
District Nursing	7
Learning Disability Service	3
Shire Hill	3
Dietetics	1
High Risk Foot Team	1
Community Neuro Rehab Team	1
IUCT	2
Long Term Conditions	1
Total SAMS	19

A wide range of services have contacted the Safeguarding Team to raise a safeguarding concern or for safeguarding advice. These services include: Long Term Conditions Team; District Nurses and the Community Learning Disability Service. Partner organisations have also contacted the Safeguarding Team for advice and support, amongst these organisations are Tameside Hospital, Continuing Health Care and Adult Social Care.

Safeguarding Concerns Raised T&G

	Total No: of safeguarding Concerns/Alerts(Inc BT advice)	**Total No: of referrals to Adult Social Care**
Q4	**20**	**11**
Q3	**23**	**14**
Q2	**39**	**16**
Q1	**26**	**5**
Total	**108**	**46**

Some of the safeguarding concerns raised with the safeguarding team require the application of statutory safeguarding duties in accordance with legislation (Care Act 2014) and Tameside Adult Safeguarding Policy and Procedures. Other concerns require a more proportionate response and preventative interventions such as urgent re assessment of care needs can prevent escalation to Safeguarding.

The Safeguarding Team also receives safeguarding concerns from partner organisations which can implicate our services.

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Supervision

SAM Forum is held every 2 months and provides a forum for sharing best practice through reflection and case studies. It also provides opportunity for information sharing and peer review.

Individual Supervision is provided if required by either the Named Nurse or Specialist Nurse. Reflect and Review post cases is encouraged and the organisation participates in the voluntary reporting of reflective practice to TASP. TASPB Supervision Framework for Safeguarding Adults has now been agreed and will be included in documents supporting Edition 7 of the partnership policy which is currently being drafted.

Handover to Tameside Integrated Care Organisation

The Specialist Nurse for Adult Safeguarding in the Community Healthcare Business Group left her post at the end of December 2015 , an appointment was made on FTC (with a view to becoming permanent) however the post holder was unable to take up the position until February 2016.

From December 2015 there were regular meetings between the Named Nurse Adult Safeguarding and the Safeguarding and Prevent Lead Tameside Hospital in order to effect a safe transition.

STOCKPORT

Adult / MCA &DOLS Safeguarding Training

Compliance is as demonstrated below and includes both Stockport and Tameside and Glossop Community staff. There has been consistent attendance in training maintaining the Trust target of 85% compliance for Adult Safeguarding.

Mental Capacity Act (MCA) & Deprivation of Liberty (DOLS) Training

	Q1 Average	Q2 Average	Q3 Average	Q4 Average	Year-end Position
Safeguarding %	83.77	86.28	87.81	89.67	89.98
MCA & DoLS %		71.25	78.59	82.29	82.49

Safeguarding Concerns Raised by Trust Staff to Safeguarding Team Stockport:

2015/6	Q1	Q2	Q3	Q4	Total
Concerns Raised	86	103	111	90	390
Referred to Adult Social Care (ASC)	57	64	82	53	256

These are the concerns known to the Adult Safeguarding Team (AST), the numbers may be higher as occasionally alerts are sent directly to AST and the team are not informed, this has been raised with managers for action as in some cases referrals are not always appropriate.

All known concerns / alerts are logged onto a database by the team. The highest numbers of alerts are generated, as would be expected, by ED staff however other areas are now showing an increase in reporting concerns which is reflecting increased awareness across all areas. Nursing staff remain the highest reporting group.

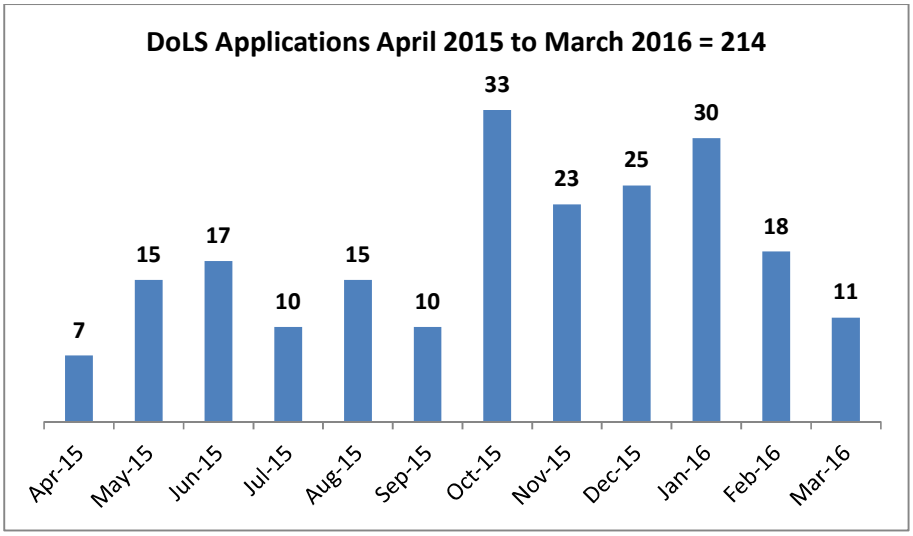
Reporting by Business Group				
Child & Family	Community	D&CS	Medicine	Surgery & CC
13	30	16	239	51

Some of the safeguarding concerns raised with the safeguarding team require the application of statutory safeguarding duties in accordance with legislation (Care Act 2014) and Stockport Multi-agency Safeguarding Policy and Procedures.

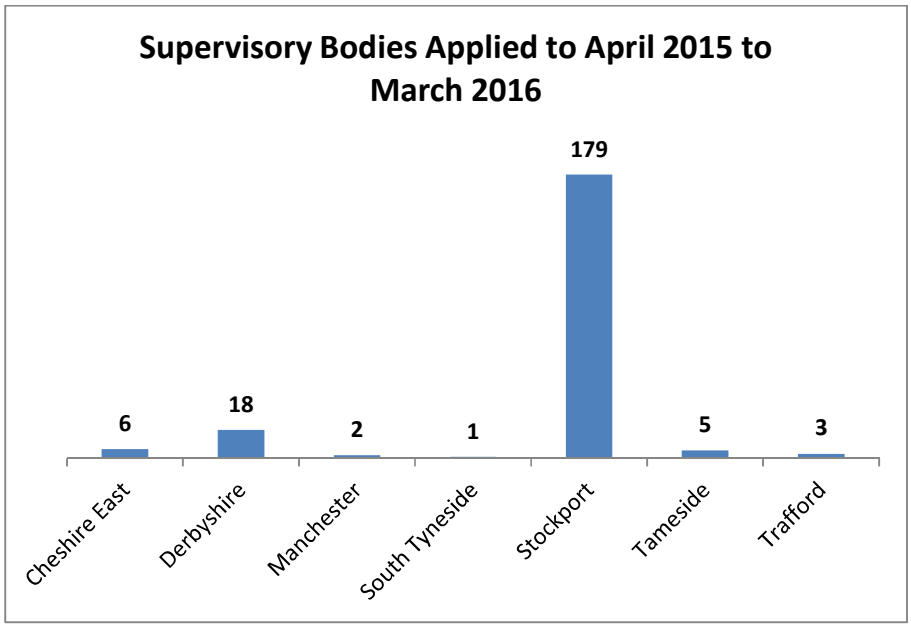
Other concerns require a more proportionate response and preventative interventions such as urgent re assessment of care needs which can prevent escalation to Safeguarding.

Adult Social Care reporting systems in Stockport do not currently give us the reports back that we would like in respect of how many alerts raised by staff go onto investigations and outcomes of these, this is to be addressed via the Safeguarding Adults Board.

MCA/DOLs

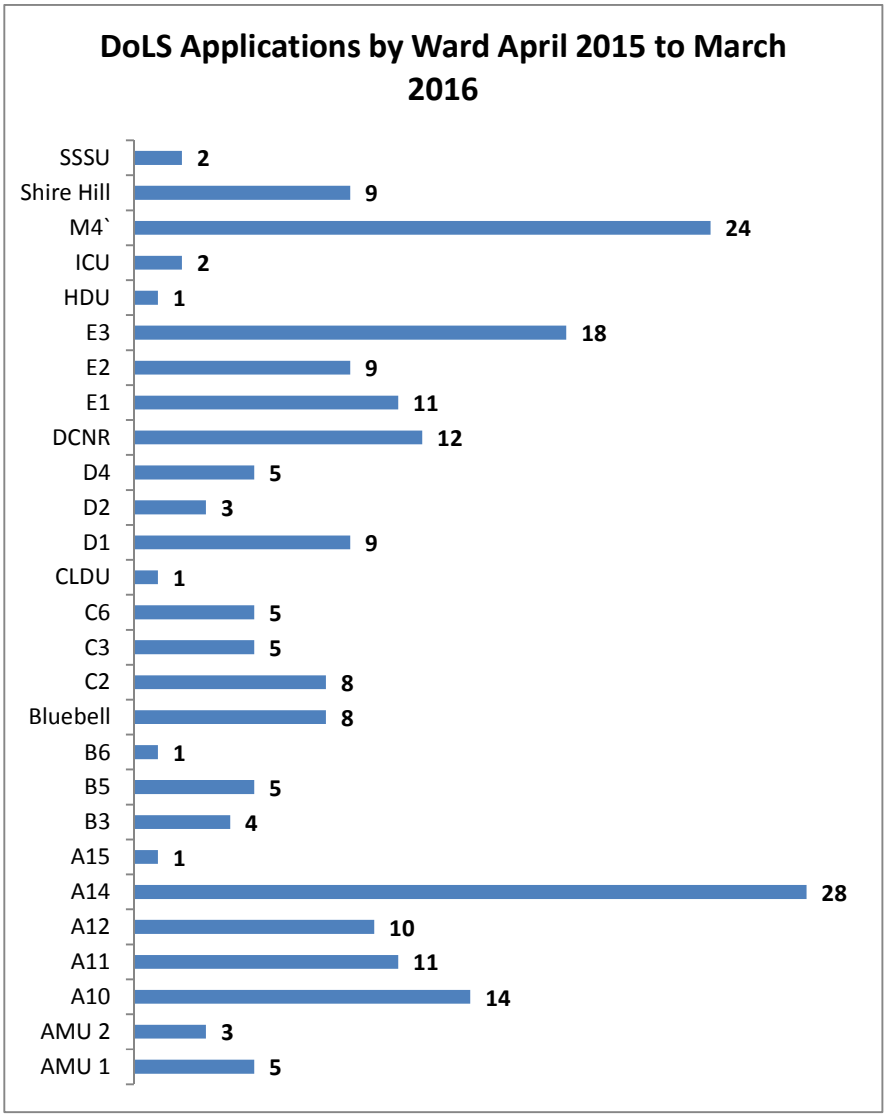


The number of applications for DoLS has increased significantly in the last twelve months with 214 applications being made in 2015/16 compared with 25 applications for 2014/15. There has been an increase in compliance with mandatory Mental Capacity Act (MCA) and DoLS training which has supported this increase in applications. There was also training provided by external facilitators in September 2015 which resulted in an increase in applications in October.

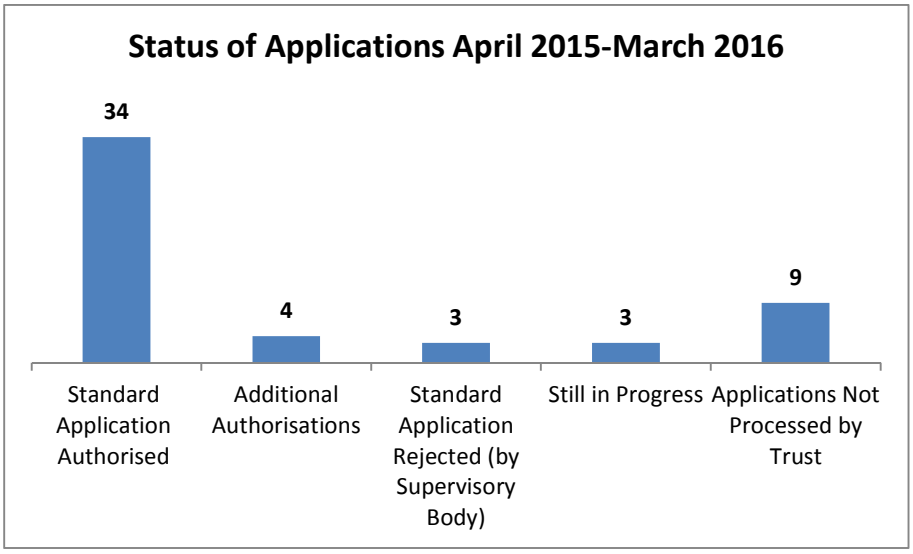


DoLS applications were made to 8 Supervisory Bodies in last 12 months with applications to Derbyshire County Council being highest after Stockport and one application made to South Tyneside Council.

Applications are made to the Supervisory Body where a person normally resides even though they may be being treated or in receipt of care in Stockport.



Applications came from a wide variety of wards from both the medical and surgical directorates with A14 and M4 making the most applications.



Of the 214 applications made, 34 were formally authorised by the Supervisory Body. Additional authorisations were requested and granted for 4 patients who were still receiving care at the time their initial authorisation expired.

3 applications were rejected by the Supervisory Body as the patients were deemed to have capacity to understand their need to be in hospital at the time they were formally assessed.

9 applications were not processed by the safeguarding team. Reasons for these included a lack of information supplied on the application form; information not being available in relation to the patient's mental capacity; patient's having regained capacity and no longer meeting the criteria for DoLS.

Of the 214 applications made, 3 are still in progress and are awaiting responses from the Supervisory Body.

The remainder of applications were either not authorised due to either; a change in the patient's condition and them no longer meeting the criteria for DoLS; or, patients had been discharged or transferred to other care facilities before the process was complete.

Supervision

In Stockport there are 4 planned sessions for locality leads in Community Nursing. Individual Supervision for practitioners is provided if required by either the Named Nurse or Specialist Nurse. There is no agreed supervision framework for Adult Safeguarding in Stockport.

Individual Supervision is provided if required by either the Named Nurse or Specialist Nurse.

Prevent

Prevent is one of the 4 key principles of the CONTEST strategy, which aims to stop people becoming terrorists or supporting terrorism by being drawn into radicalisation. The Health Service is a key partner in Prevent and the principles of this national strategy apply to all parts of the NHS including charitable organisations and private sector bodies which deliver health services directly or indirectly to NHS patients. It refers to anyone with whom the Trust has contact - staff, patients or visitors.

There have been no Prevent referrals made by the adult team in 2015/16.

There is a new North West Coordinator for Prevent , the person will be providing direct support to priority areas , Stockport is not a priority area therefore we will receive indirect support and be invited to attend a quarterly meeting of Prevent leads in order to be updated and to have the opportunity to raise questions about areas of concern.

Concerns have been raised by CCG and NHSE regarding Trust compliance with Prevent training and a plan is in place to address these. The Trust Prevent lead is now recognised as the Named Nurse for Adult Safeguarding with Support from the Trust Resilience Lead.

The Trust is represented on the Stockport Channel Panel by Adult Safeguarding. This is where people who may be at risk of radicalisation are discussed and plans put in place to support them. There is a concern in that the Local Authority are failing to engage the Trust's Children's Safeguarding team by failing to provide information to the children's leads in order for children's safeguarding to be represented at Channel. This is being addressed.

Domestic Abuse

When there is a homicide related to domestic violence the Trust is asked to provide any information we may hold on contacts with the victim and perpetrator. In 2015/16 there has been one review where the Trust had any significant contact with the victim. A date was set for inquest in May 2016 but this has been adjourned.

Training was undertaken for staff, supported by victim support and the PCC, over the course of 3 dates last summer. This is not reported as a compliance figure however 97 staff attended these sessions – predominantly from community. Ongoing domestic abuse training is incorporated into Children's safeguarding training.

The Trust Domestic Abuse policy is currently under review and will incorporate NICE Quality Standards published in February

Learning Disability

The GM CQUIN for Learning Disability continued into 2015/16. Quarter 4 evidence is indicating that we will have achieved compliance with the indicators. Going forward into 2016/17 there will be a KPI related to LD and completion of Reasonable Adjustment Care Plans. There is also a requirement that the Trust will be engaged in the Learning Disabilities Mortality Review Programme managed by the University of Bristol as part of the National Clinical Audit and Patient Outcome Programme. This has not yet been rolled in the Stockport area.

Mental Health

A CQUIN for the Mental Health Crisis Care Concordat was introduced in 2015 / 16. This crosses both acute and community settings. This has proven to be a significant challenge in meeting the requirements of all indicators. In Q1 the organisation did not achieve the requirements but funding was moved to Q2. In Q2 and Q3 the organisation achieved 100%. Q4 evidence is being written.
There is further work needed to increase staff knowledge around Mental Health issues and guidance needs to be developed to assist staff with Mental Health Act issues.

Intercollegiate Document

NHS England has published an Intercollegiate Document relating to Adult Safeguarding; it is not known as yet what implications this will have for Stockport NHS FT. A critique and gap analysis is required of the content of this document.

Autism

DH published statutory Guidance to support the implementation of the Adult Autism Strategy in 2015, there is currently no overarching Autism Strategy across the health and social care economy in Stockport and the Autism Partnership Board no longer meets. This document will need to be assessed for potential impact on the services provided by the Trust.

CONCLUSION

The Adult Safeguarding Team continues to support multi-agency working with colleagues in Adult Social Care to ensure concerns raised are managed and investigated appropriately and lessons learned are fed back to the clinical teams. There has been a significant improvement in both Safeguarding Adults and MCA & DoLS training. Bespoke training has been provided to support staff which has helped contribute to this increase in compliance.

Awareness training and production of support materials in relation to DoLS has contributed to the significant increase in DoLS applications and remains ongoing. Prevent training is ongoing with business groups cascading at team levels. Going forward, training may need to be revised to support NHS England requirements once the intercollegiate document has been reviewed.

RECOMMENDATION

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

Appendix 1

DEFINITIONS:

Serious Case Reviews / Multi agency learning

There are various ways in which we review cases where there have been incidents relating to the safeguarding of a child; the table below highlights the current cases.

- A multiagency learning review is commissioned by the Safeguarding Children Board's Learning and Improvement Panel. The learning could be to share good practice or to consider where actions and multiagency responses could have been done differently in order to protect the child. Practitioners are invited to the review so that learning is more likely to be embedded in future practice

- A Domestic Violence Homicide Review is commissioned where there has been a homicide within a relationship

- A Serious Case Review is commissioned where a child has died or been injured as a result of abuse/neglect or where there are concerns that agencies have not worked together to safeguard the child

Safeguarding Children supervision

Supervision within safeguarding relates to the requirement for all practitioners who are responsible for managing a caseload where vulnerable families/children have been identified. Supervision will consider any risks and strengths within the family and help practitioners to formulate an action plan to increase resilience and reduce risk thereby improving outcomes for children. Health Visitors in Stockport are supervised on their most vulnerable families every 12 weeks and school nurses every term (see Appendix 2).

Court reports

Court reports are produced at the request of a judge at a legal hearing where legal proceedings have been initiated to protect the child

MARAC (Multi-Agency Risk Assessment Conference for high risk Domestic Abuse Cases)

MARAC is a multiagency risk assessment process which in Stockport and in Tameside and Glossop is chaired by the Police; health representatives attend and contribute the relevant health information known about each case; taking actions away where appropriate.

Causes for concern

Causes of concern can be generated by any hospital practitioner who has identified a concern about a child; whether that is relating to the adult caring for the child or about the child. The largest proportion of causes for concern are generated by staff in the Emergency Department and sent through to social care directly if an immediate response is required. They are copied to the paediatric liaison service (part of the safeguarding children team) which ensures the relevant community worker get the information in a timely manner.

Child protection medicals

Child protection medicals are undertaken as part of a joint social care/police and health investigation (Section 47 of The Children Act 1989) where a child presents with a suspected non-accidental injury. The medical examination is always undertaken by a paediatrician.

Looked after children

'Looked after children' refers to those children who are given accommodation away from their families at the request of their parent and those in care as a result of a legal care order. Children

more rarely can be made subject to an order but remain at home. Their health needs are significantly higher than a child who is not looked after.

MAPPA (Multiagency Public Protection Arrangements) a panel that meets to manage violent and sexual offenders

Channel is a programme which focuses on providing support at an early stage to people who are identified as being vulnerable to being drawn into terrorism.

Stockport NHS
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	30 June 2016
Subject:	External Review of Never Events		
Report of:	Medical Director	**Prepared by:**	Colin Wasson

REPORT FOR NOTING

Corporate objective ref:	N/A	**Summary of Report** *Professor Toft has completed an external review of seven 'never events' reported by the Trust between December 2012 and July 2015.* He concludes that only one of the serious incidents qualifies as a 'never event'. The pattern of serious untoward incidents experienced by the Trust is not unusual. Furthermore, following a review of all appropriate documentation, no evidence has been found to suggest that the Trust has an unrecognised systemic patient safety problem. On the contrary, the evidence indicates that the vast majority of the activities undertaken by the Trust, with respect to patient safety, meet the highest standards. 33 actions have been recommended. An action plan to address the recommendations has been prepared and is included for reference at Appendix 1 to the report.
Board Assurance Framework ref:	N/A	
CQC Registration Standards ref:	N/A	
Equality Impact Assessment:	☐ Completed ☐ Not required	

Attachments:	Appendix 1 – External Review of Never Events Action Plan

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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Board Summary

External review of 'never events' in interventional procedures at Stockport NHS Foundation Trust between 31st December 2012 and 22nd July 2015.

The purpose of this paper

Seven patients attended the trust for their healthcare needs between 31st December 2012 and 22nd July 2015, and suffered serious untoward incidents (SUI) later classed as 'Never Events'. An external review of these 'never events' was commissioned by the trust from Professor Toft, a renowned national expert on patient safety. His report, completed in April 2016 provides an independent opinion on the systems, culture and robustness of the investigations carried out at the trust, and provides a number of suggested actions.

This paper provides an overview of Professor Toft's comprehensive report, and suggests who should lead implementation of the report's recommendations.

Key themes

A 'never event' is defined as;

'Serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented'.

In addition to qualify as a 'never event' it must risk serious harm or death, be a previously recognised risk and subject to national safety guidance on how it may be prevented.

Systems theory suggests that risk free medical treatment is impossible to achieve in practice because healthcare organisations and people can behave in unpredictable and unlimited ways. The caution expected of a healthcare professional when administering care to a patient cannot be relied upon to ensure an error free performance.

While Zero harm is a bold and worthy aspiration, the scientifically correct goal is 'continual reduction'. Wherever possible technological aides should be deployed so that reliance on the caution of healthcare practitioners when undertaking tasks is reduced to 'as low as reasonably practicable (ALARP).

If a provider takes every recommended step to prevent occurrence and an incident still occurs this argues strongly that the incident was not preventable and therefore not a 'never event'.

No national body has published detailed guidance on how to prevent swabs, instruments, needles or other sundry items that are used in the vast majority of surgical/invasive procedures from being inadvertently left in a patient's body at the end of such a procedure. The Association for perioperative practice provided detailed guidance to their members, but this is subject to copyright, and cannot be copied into NHS Englands trusts documents. This does not constitute national guidance. In the absence of national guidance that would prevent a retained swab or instrument, it is argued that such SUI's are not never events.

Only one of the seven adverse patient safety incidents reviewed meets all the national criteria to be classified as a 'never event'. The other six SUI's, do not meet the definitions of a '*Never Event*' specified by either the Department of Health or NHS England.

The serious incidents investigated were a result of both systems error and human error.

The reports of the investigations into the SUI's, which were the subject of this report were found to be of poor quality significant concerns are raised as to their thoroughness. The investigations were found to lack a sufficiently forensic approach, and the reports do not conform to the National Patient Safety Agency's guidelines with regards to the writing of reports following a root cause analysis. At the time of these reports, the Trusts policy and guidance on the reporting and management of SUI's only allowed investigators a short time to conclude their report (typically 10 working days), rather than that recommended by the National Patient Safety Agency and NHS England to conduct an investigation and report (45 working days). Therefore it can be strongly argued, that the imposition of extreme time pressures will have had a considerable impact on the ability of the investigating team to carry out their task comprehensively.

The pattern of serious untoward incidents experienced by the Trust is not unusual. Furthermore, following a review of all appropriate documentation, no evidence has been found to suggest that the Trust has an unrecognised systemic patient safety problem. On the contrary, the evidence indicates that the vast majority of the activities undertaken by the Trust, with respect to patient safety, meet the highest standards.

Brief synopsis of the seven never events investigated.

1. **Retained swab after pacemaker insertion**
   Following pacemaker insertion, no swab counts were undertaken and therefor it was not recognised that a swab was left in the patients wound.

   The World Health Organisation Surgical Safety checklist, issued as an alert in 2009 had not been implemented in cardiology.

   Failure of the trust to robustly implement this advice qualifies this incident as a 'never event'.

2. **Wrong lens implanted**

   Immediately prior to initiating cataract surgery it was discovered that the selected lens was not available from stock. To choose a suitable alternative, patient data was required from outside of the operating theatre. The wrong patient details were provided, and an incorrect lens inserted. A second operation was undertaken 21 days later to correct the error.
   Better stock management, checking lens availably prior to the patients arrival in theatre and a formal procedure for checking patients (eye biometry) details from outside theatre may have avoided this incident.

   The operating surgeon and theatre staff appear to have carried out all the currently recommended safety precautions and yet the incident still occurred.

   This was a SUI but not a 'never event'.

3. **Retained swab after abdominal surgery**

Uneventful abdominal surgery for bowel cancer.

Recovery was slow, and three months after surgery a swab retained in the wound was found on CT scan, requiring further surgery to remove it. The surgical and theatre team experienced a 'perceptual error' and lost their situational awareness, hence failed to realise that the swab had been left in the patient's body.

In addition, the trust's swab counting system failed to identify that a swab had been inadvertently left inside the patient's body. The operating surgeon and theatre staff appear to have carried out all the recommended safety precautions and yet the incident still occurred.

This was a SUI, but not a 'never event'.

4. **Retained fragment of metal following urethral procedure**

A bladder neck incision was undertaken in theatre using an optical urethrotome. This equipment includes a small retractable blade. Two weeks after surgery, the patient passed a small fragment of this blade from their urethra. The surgeon and nurse both failed to notice that the retractable blade had been damaged and part of it was missing.

Existing policy at the time did not recommend that instruments should be checked for completeness / integrity, rather only that they should be accounted for. Such guidance dictating may have avoided this incident. The evidence strongly suggests that the scrub nurse and surgeon carried out all their duties as required by trust policy without fault.

This was a SUI, but not a never event.

5. **Biopsy of wrong lung.**

A patient underwent an uneventful ultrasound guided biopsy of the lung in the radiology department. 11 weeks later in clinic, the patient stated that she thought the biopsy was taken from the left, not the right side as had been intended. There is no objective evidence of this error, indeed all objective evidence suggests that this biopsy was taken from the correct lung.

In spite of the perceived error coming to light, it was not reported as a critical incident, SUI or 'never event' at the time, only coming to light on receipt of a litigation claim from the patient one year later. There was a failure of the trusts clinical policy alerting, distribution and training system to perform as envisaged, as the clinician involved did not realise that completion of a critical incident report is mandatory following such an incident, irrespective of whether the problems caused have all already been addressed.

All procedures in place at the time of the intervention were correctly followed. Improvements in the checking process during interventional procedures could have reduced the risk of a wrong sided procedure being undertaken by human error alone.

This was a SUI but not a 'never event'

6. **Retained swab after spinal surgery**

A patient underwent spinal surgery. At the end of surgery, the final swab count identified a swab to be missing. After a search including image intensifier (x ray) image of the patient, a swab was found in one of the theatre waste bags. The wound closed and the patient woken, before it was realised that the swab discovered in the waste bag was from the previous case. The missing swab was still in the patients, wound, necessitating an immediate second procedure for it to be removed.

The previous case on the list had been a local anaesthetic injection procedure, that does not involve a scrub nurse. Roles such as swab checking in such cases are ill defined. This list was running late, and the heavy workload and time pressure put all staff under considerable pressure. The operating surgeon's demeanour may have further compounded this problem. This environment was not conducive to patient safety. Due to time pressure, equipment was being collected in theatre for the second case, before the first case had been completed. This contributed to the failure to dispose of all swabs correctly.

Waste management in theatres does not follow a formal policy. All waste from one case must be effectively removed and suitably labelled before preparation for the next case can start in that theatre. Used swabs should never be placed in a receptacle other than a trust authorised swab bag. Trust policy dictates that image intensifiers are not suitable for searching for missing swabs. Staff did not know of this policy. There is insufficient whole team training on the policies relevant to theatre practice.

On finding a missing swab, staff must establish with certainty that it is the swab that they are looking for before assuming the swab count to be correct. This was not done. The investigation report was not shared with stakeholders prior to publication. While a number of human errors were made during this theatre list, all available safety measures at the trust were implemented, but did not prevent this SUI from taking place.

This was a SUI, but not a 'never event'.

7. Wrong sided local anaesthetic injection

A patient was planned to have shoulder surgery. A local anaesthetic injection was inserted by the anaesthetist before surgery was undertaken, to ensure post-operative pain relief. The injection was administered in the wrong side necessitating the surgery to be deferred to a later date.

Full implementation of the Royal College of Anaesthetists 'stop before you block' campaign may have ensured that the surgical site mark was clearly visible (by exposing the mark from under the gown) and that there were less distractions in the anaesthetic room. This campaign does not constitute national guidance. Wrong sided local anaesthetic blocks done for pain relief are specifically excluded from the list of 'never events'.

This was a SUI but not a 'never event'.

Conclusions

It is clear therefore that the types of SUI's/'*Never Events*' experienced by the Trust during the period covered in this External Review are similar in nature to those which have occurred at numerous other NHS England Trusts. Moreover the published data shows that the number of '*Never Events*' which have been reported by the Trust is significantly lower than other NHS Trusts. Hence, the Trust does not appear to be reporting an atypical or outlier pattern of such events when compared to the other Trusts in NHS England.

In addition, from the reports of the investigations into the SUI's discussed above and the additional enquiries that have been made there appears to be no discernible pattern of behaviour which suggests that the Trust has a systemic problem with patient safety. Each of the '*Never Events*' which took place did so due to a unique set of circumstances prevailing at the time. They also appear to have taken place at random over the period covered by this External Review.

Recommendations

The report makes 27 recommendations, which can be divided into 33 separate actions.

***1a**. The Trust should make a copy or a redacted version of this report available to NHS England so they are made aware of the recommendations specifically*

***1b**. The Trust should consider publishing this report or a redacted version of it on its website so that all those who have an interest in patient safety might benefit from the insights which have been gained.*

***2**. The Trusts should review the additional lessons and recommendations drawn from the SUI's examined during this External Review and determine whether they can be implemented as suggested.*

***3**. All national guidance with regard to patient safety should be incorporated into the Trust's portfolio of policies and made mandatory.*

***4.** All safety precautions should be incorporated into the trust's portfolio of policies and made mandatory.*

***5.** The Trust should make it policy that the senior surgeon or doctor undertaking a surgical/invasive procedure is accountable for the 'Five Steps to Safer Surgery.*

***6**. The Trust should review its policy alerting, distribution and training system and ensure staff have ready access to all patient safety policies and documents facilitated from a central repository on the Trust's intranet.*

***7**. The Trust should make arrangements so as to ensure that all medical staff involved in surgical/invasive procedures and their respective trainees receive formal training on the 'Five Steps to Safer Surgery' and 'Swab Checks' which should be documented on their training records.*

8. The Trust should explore undertaking whole team training for all surgical and operating theatre teams as, for example, that developed by the Association of Perioperative Practitioners.

9. The Trust should consult with other NHS Trusts to ascertain the amount of time they allocate to Morbidity and Mortality meetings. Senior management should then ensure that the medical staff at the Trust are provided with at least the same opportunity to learn from their colleagues.

***10a**. The Trust 'Incident Reporting and Management Policy' and all related documents explicitly concerned with the investigation of serious untoward incidents should state that when an incident is considered to be a potential 'Never Event' the circumstances surrounding it must be compared in detail to the then current definition of 'Never Events' published by NHS England.*

***10b**. All lead investigating officers at the Trust should receive additional training on human factors and how investigations into serious untoward incidents ought to be undertaken.*

***10c**. All members of staff selected to be an investigator into a serious untoward incident should undergo formal training on human factors and how investigations into serious untoward incidents ought to be undertaken.*

***10d**. All investigation teams should be allowed to use the maximum timescale of 60 days as recommended by NHS England when investigating an SUI.*

11. *All SUI investigations at the Trust should have explicit Terms of Reference and a brief discussion on the investigation methodology used by the investigator/s as required by the Serious Incident Framework.*

12a. *It should be made Trust policy that all staff who provided evidence to an SUI investigation be required to check their contribution to the report of an investigation for factual accuracy**.***

12b*.The Trust should verify that the feedback system which provides information to staff who have reported untoward incidents is working as envisaged.*

13. *The Trust should approach the Commissioners of services with a view to implementing the '…commissioning process for never events'854 as advised by the Department of Health and NHS England.*

14*. The Trust should make a submission to the Commissioners of services to have the six serious untoward incidents that were inadvertently misclassified as 'Never Events' downgraded.*

15*. The Trust should enter into discussions with the Commissioners of services with respect to the recovery of any financial penalties imposed on them through the provisions of the NHS Standard Contract as six of the seven serious untoward incidents were inadvertently misclassified as 'Never Events'.*

16. *All SUI should be checked independently by a member of Trust staff not involved in the investigation for accuracy before being submitted to the person who commissioned the investigation.*

17*. An internal review should be undertaken by the Trust to ascertain whether the Action Plans of all the SUI's that are the subject of this External Review have been completed in full.*

18*. The Trust should ensure that all the provisions contained in the NPSA guidance documents NPSA/2009/SPN001 'Reducing the risk of retained throat packs after surgery', are implemented as soon as possible.*

19. *The information on the classification of SUI's as 'Never Events' should be removed from the Trust documents 'Incident Reporting and Management Policy' and 'Standard Operating Procedure for the Management of Serious Incidents', 'and replaced with a direction to consult the appropriate NHS England documents for that information.*

20*. The 'Incident Reporting and Management Policy' should explicitly state the method by which BGD's will inform the Trusts senior management on the compliance rates for which they have responsibility and the frequency of their reports.*

21a*. The Trusts Waste Management Policy regarding the production of an SOP/local waste manual for dealing with healthcare waste at the Trust should be implemented immediately.*

21b. *The Trust document archive should be searched to see whether the 'Cleaning and disinfection policy' cited in the Infection Prevention Policy for Operating Theatres has been archived in error. If the 'Cleaning and disinfection policy' cannot be found a new policy should be developed.*

22*. The Trust should investigate the possibility of introducing new technology such as radio-frequency identification or bar-coding to reduce the risks of patients inadvertently retaining foreign objects following surgical/invasive procedures.*

23*. The automatic computer software which archives documents should be reprogrammed so that it can only archive documents following explicit permission provided by a senior manager in the area concerned with a particular document.*

***24**. The arrangements currently being developed for the introduction of planned audits and spot checks at the Trust with respect to the 'Five steps to Safer Surgery' process and Swab Checks should be implemented as soon as possible.*

***25**. NHS England should as a matter of urgency publish their own or publicly endorse the AfPP's guidance on the management of swabs, instruments, needles and sundry items so that the 'Never Event -'Retained foreign object post-procedure' will apply when such items are inadvertently left in the body of a patient.*

***26.** NHS England should re-consider whether it is appropriate to use the concept of a 'Never Event' in relation to serious untoward incidents since the unthinkable as well as the more obvious events can occur.*

***27.** NHS England should re-consider whether it is appropriate to use the concept of a 'Never Event' as a category in relation to untoward incidents which are caused through an item of medical equipment being inadvertently left in the body of a patient.*

An action plan to address these recommendations has been prepared and is included for reference at Appendix 1 to this report. Progress against the action plan will be monitored by the Quality Assurance Committee.

The Board of Directors is recommended to:

- Note the outcomes of the External Review of Never Events and the associated action plan included at Appendix 1.

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External Review of Never Events
Toft Report Recommendations

The report makes 27 recommendations, which can be divided into 33 separate actions.
Suggested allocation of actions is as follows;

MD	Medical Director	MT	Matron for theatres	HR	Head of Clinical Risk
RM	Risk Management Committee	DF	Director of Finance	DN	Director of Nursing
AMD (s)	Associate Medical Director - Surgery	DE	Director of estates	TS	Trust secretary

	Action	Lead Person	Action Required	Timescale	Completion	Comments
1a	The Trust should make a copy or a redacted version of this report available to NHS England so they are made aware of the recommendations specifically	MD	Send redacted version to NHS England	June 2016		
1b	The Trust should consider publishing this report or a redacted version of it on its website so that all those who have an interest in patient safety might benefit from the insights which have been gained.	JM CM CW	Draft letter to patients Redact report for sharing Publish on intranet	June 2016 June 2016 June 2016	21/06/16 21/06/16	
2	The Trusts should review the additional lessons and recommendations drawn from the SUI's examined during this External Review and determine whether they can be implemented as suggested.	HR	Pull out actions into a formal action plan, to be presented at quality governance committee.	On agenda 10th August		
3	All national guidance with regard to patient safety should be incorporated into the Trusts portfolio of policies and made mandatory.	MD	New national guidance received by the trust is currently reviewed in quality governance committee and where appropriate incorporated into appropriate policy	In place	Established	

	Action	Lead Person	Action Required	Timescale	Completion	Comments
4	All safety precautions should be incorporated into the trusts portfolio of policies and made mandatory.	HR TS	Renew policy on policies. Develop standard operating procedure on policies.	October 16		
5	The Trust should make it policy that the senior surgeon or doctor undertaking a surgical/invasive procedure is accountable for the 'Five Steps to Safer Surgery.	AMD(s)	Review current process at safer interventions group	October 16		
6	The Trust should review its policy alerting, distribution and training system and ensure staff have ready access to all patient safety policies and documents facilitated from a central repository on the Trust's intranet.	HR TS	See item 4	October 16		
7	The Trust should make arrangements so as to ensure that all medical staff involved in surgical/invasive procedures and their respective trainees receive formal training on the 'Five Steps to Safer Surgery' and 'Swab Checks' which should be documented on their training records.	AMD(s)	Development of 'audit and governance' sessions, and review training at safer interventions group.	October 16		
8	The Trust should explore undertaking whole team training for all surgical and operating theatre teams as, for example, that developed by the Association of Perioperative Practitioners.	AMD(s)	As item 7	October 16		
9	The Trust should consult with other NHS Trusts to ascertain the amount of time they allocate to Morbidity and Mortality meetings. Senior management should then ensure that the medical staff at the Trust are provided with at least the same opportunity to learn from their colleagues.	MD	Development of 'audit and governance' sessions will include morbidity and mortality sessions.	October 16		

	Action	Lead Person	Action Required	Timescale	Completion	Comments
10a	The Trust 'Incident Reporting and Management Policy' and all related documents explicitly concerned with the investigation of serious untoward incidents should state that when an incident is considered to be a potential 'Never Event' the circumstances surrounding it must be compared in detail to the then current definition of 'Never Events' published by NHS England.	HR	Policy updated	In place	Established	
10b	All lead investigating officers at the Trust should receive additional training on human factors and how investigations into serious untoward incidents ought to be undertaken.	HR	Training for investigating staff will be costed, and funding sought.	Oct 16		
10c	All members of staff selected to be an investigator into a serious untoward incident should undergo formal training on human factors and how investigations into serious untoward incidents ought to be undertaken.	HR		Oct 16		
10d	All investigation teams should be allowed to use the maximum timescale of 60 days as recommended by NHS England when investigating an SUI.	HR	Policy updated	In place	Established	
11	All SUI investigations at the Trust should have explicit Terms of Reference and a brief discussion on the investigation methodology used by the investigator/s as required by the Serious Incident Framework.	HR	Policy updated	In place	Established	

	Action	Lead Person	Action Required	Timescale	Completion	Comments
12a	It should be made Trust policy that all staff who provided evidence to an SUI investigation be required to check their contribution to the report of an investigation for factual accuracy.	HR	Policy updated	In place	Established	
12b	The Trust should verify that the feedback system which provides information to staff who have reported untoward incidents is working as envisaged.	HR	Policy updated	In place	Established	
13	The Trust should approach the Commissioners of services with a view to implementing the '…commissioning process for never events' as advised by the Department of Health and NHS England.	MD	Contact CCG, share never event report, agree implementation of commissioning process for never events.	Oct 16		
14	The Trust should make a submission to the Commissioners of services to have the six serious untoward incidents that were inadvertently misclassified as 'Never Events' downgraded.	MD	Contact CCG, share never event report, request downgrading of six never events.	Oct 16		
15	The Trust should enter into discussions with the Commissioners of services with respect to the recovery of any financial penalties imposed on them through the provisions of the NHS Standard Contract as six of the seven serious untoward incidents were inadvertently misclassified as 'Never Events'.	MD	As item 14	Oct 16		
16	All SUI should be checked independently by a member of Trust staff not involved in the investigation for accuracy before being submitted to the person who commissioned the investigation.	HR	Policy updated	In place	Established	

	Action	Lead Person	Action Required	Timescale	Completion	Comments
17	An internal review should be undertaken by the Trust to ascertain whether the Action Plans of all the SUI's that are the subject of this External Review have been completed in full.(RM)	HR	Pull out actions into a formal action plan, to be presented at quality governance committee.	On agenda 10th August		
18	The Trust should ensure that all the provisions contained in the NPSA guidance documents NPSA/2009/SPN001 'Reducing the risk of retained throat packs after surgery', are implemented as soon as possible.(AMD(s)	AMD(s)	Implement guidance	In place	Established	
19	The information on the classification of SUI's as 'Never Events' should be removed from the Trust documents 'Incident Reporting and Management Policy' and 'Standard Operating Procedure for the Management of Serious Incidents', 'and replaced with a direction to consult the appropriate NHS England documents for that information .(RM)	HR	Documents now direct staff to national documents.	In place	Established	
20	The 'Incident Reporting and Management Policy' should explicitly state the method by which BGD's will inform the Trusts senior management on the compliance rates for which they have responsibility and the frequency of their reports.(RM)	DN	To review current process and management of high profile report.	Oct 16		

	Action	Lead Person	Action Required	Timescale	Completion	Comments
21a	The Trusts Waste Management Policy regarding the production of an SOP/local waste manual for dealing with healthcare waste at the Trust should be implemented immediately. (DE)	DE	Produce an SOP or local waste manual	Oct 16		
21b	The Trust document archive should be searched to see whether the 'Cleaning and disinfection policy' cited in the Infection Prevention Policy for Operating Theatres has been archived in error. If the 'Cleaning and disinfection policy' cannot be found a new policy should be developed.(MT)	MT	Find existing policy, or introduce a new one.	Oct 16		
22	The Trust should investigate the possibility of introducing new technology such as radio-frequency identification or bar-coding to reduce the risks of patients inadvertently retaining foreign objects following surgical/invasive procedures.	MT	Appraise options and cost implications. If appropriate, develop business case.	Oct 16		
23	The automatic computer software which archives documents should be reprogrammed so that it can only archive documents following explicit permission provided by a senior manager in the area concerned with a particular document.	HR	Established.	In place	Established	
24	The arrangements currently being developed for the introduction of planned audits and spot checks at the Trust with respect to the 'Five steps to Safer Surgery' process and Swab Checks should be implemented as soon as possible.	AMD(s) MT	Established	In place	Established	

	Action	Lead Person	Action Required	Timescale	Completion	Comments
25	NHS England should as a matter of urgency publish their own or publicly endorse the AfPP's guidance on the management of swabs, instruments, needles and sundry items so that the 'Never Event -'Retained foreign object post-procedure' will apply when such items are inadvertently left in the body of a patient.	MD	Share redacted report with NHS England	June 16		
26	NHS England should re-consider whether it is appropriate to use the concept of a 'Never Event' in relation to serious untoward incidents since the unthinkable as well as the more obvious events can occur.	MD		June 16		
27	NHS England should re-consider whether it is appropriate to use the concept of a 'Never Event' as a category in relation to untoward incidents which are caused through an item of medical equipment being inadvertently left in the body of a patient.	MD		June 16		

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Report to:	Board of Directors	**Date:**	30th June 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 • 2 strategic risk have been mitigated and managed to below a risk score of 15 this month • Currently there are 10 severe strategic risk scoring 20. • One new strategic risk is added this month; *2969-Reduce the number and harm of Major to Catastrophic Patient Falls-2016–2017* • One risk (*2742- Poor level of investigation into serious incident*) has had its current risk rating increased from a score of 16 to 20.
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	☐ Workforce & OD Committee
	☐ Council of Governors	☐ BaSF Committee
	☐ Audit Committee	☐ Charitable Funds Committee
	☐ Executive Team	☐ Nominations Committee
	☐ Quality Assurance Committee	☐ Remuneration Committee
	☐ FSI Committee	☐ Joint Negotiating Council
		☒ Other

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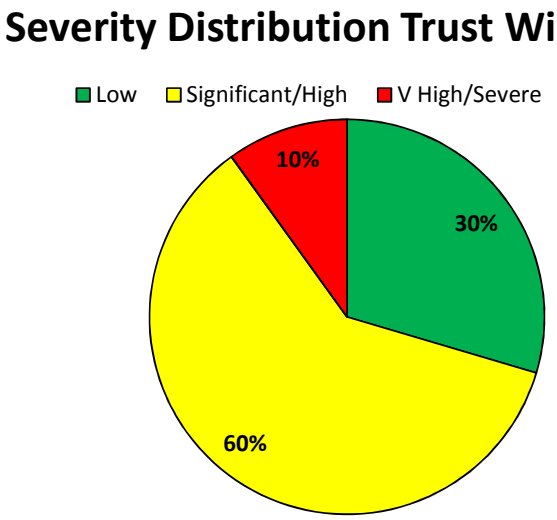
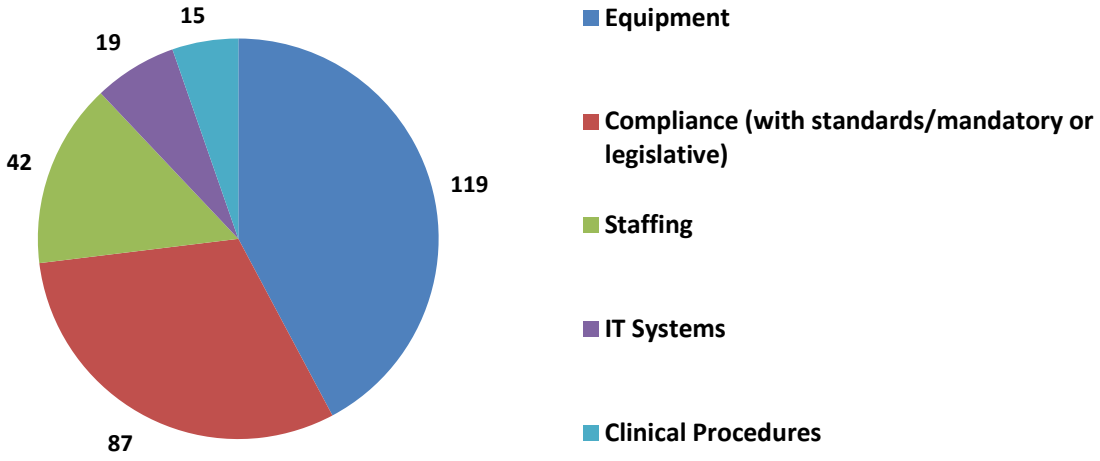
Trust wide Risk and Severity Distribution

1.1 There are currently 382 live risks recorded on the Trust Risk Register system compared to 373 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
May	0	16	32	65	4	30	45	34	5	100	9	20	13	0
June	0	18	31	64	4	30	47	38	5	109	9	27	15	0



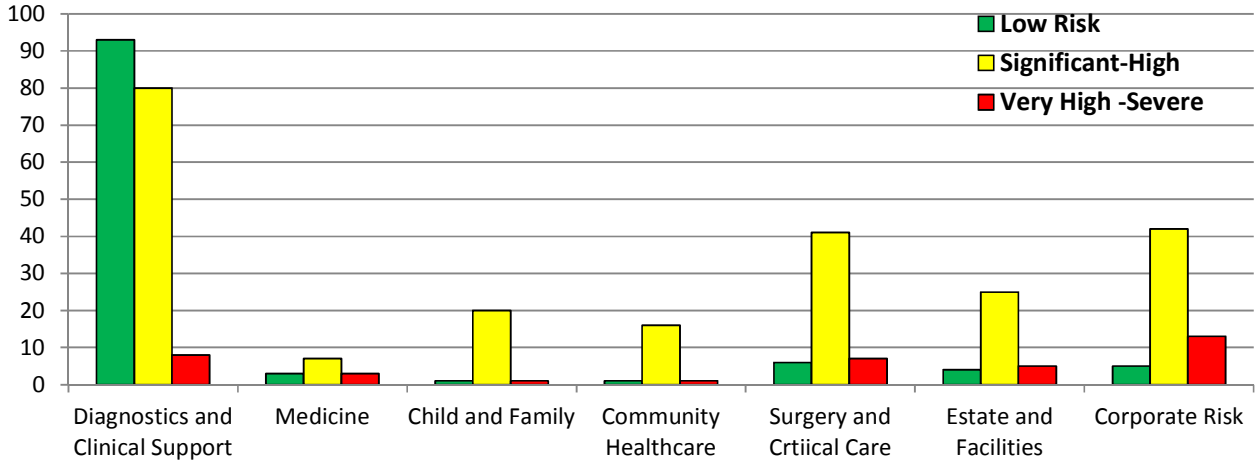
1.2 Top Five Sources of Risk across the Trust



2.1 Strategic risk distribution across Business Groups

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

2.2 Severity distribution in Business Groups



3.1 Closed risks and mitigated risks

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

- *2060- Out of hours consultant provision – Paediatrics*
- *2888- Failure to achieve Trust falls targets for 2015 & 2016*

3.2 New Strategic Risk

There is one new strategic risks added this month

- *2969-Reduce the number and harm of Major to Catastrophic Patient Falls-2016–2017*

3.3 Changes in risk rating

All strategic risks are reviewed monthly. Currently there are 19 strategic risk, 10 of these are considered severe. One risk (*2742- Poor level of investigation into serious incident*) has had its current risk rating increased from a score of 16 to 20.

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

Strategic Risk Register

Business Group	ID	Source	Risk Owner	Risk Type	Risk	Existing Controls	Initial Rating	Current Consequence	Current Likelihood	Current Rating	Mitigating actions to be completed	Date for action plan completion	Target Risk Score	Key Indicators	Progress Arrow Key: Red = increase in current rating Green = reduction in current rating Yellow = no change	Exec Owner/ Committee (See Key above)
Corporate Nursing	2742	Analysis & Improvement	Cathie Marsland	Strategic	**Poor level of investigation into serious incident** *A number of investigations which have not been felt to be robust, and some investigations where poor engagement by clinicians both nursing and medical has led to considerable delays and inadequately completed investigations* .	Standard Operating procedure which clearly details the requirements for a robust investigation Guidelines for all staff conducting investigations Training offered via training brochure on how to undertake an investigation Number of governance and senior management staff have undertaken the NPSA root cause analysis training.	16	4	4	20	Review roles and responsibilities in risk team. Develop specific training for validators. Develop further training for all involved in RCA	31/08/2016	**8**	Reduced amount of reinvestigation and reduced criticism from external regulator	↑	JM/QAC
Corporate Nursing	2806	Compliance	Cathy Gibson	Strategic	**Non Compliance with the Trust Alert & Hazards SOP** *Lack of staff awareness of the Trust Risk Management Alerts and their requirements*	Trust process in place to circulate alerts through Risk & Safety Team	16	4	4	16	Further spot checks to be completed and results to Risk Committee	30/07/2016	**8**	Staff compliance with Alert and Hazard notices SOP	↔	JM/QAC

Business Group	ID	Source	Risk Owner	Risk Type	Risk	Existing Controls	Initial Rating	Current Consequence	Current Likelihood	Current Rating	Mitigating actions to be completed	Date for action plan completion	Target Risk Score	Key Indicators	Progress Arrow Key: Red = increase in current rating Green = reduction in current rating Yellow = no change	Exec Owner/ Committee (See Key above)
Corporate Nursing	2969	Falls	Cathy Gibson	Strategic	**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 meets 6 weekly to review corporate falls data report. Severe and catastrophic falls reported to Trust Incident Review Meeting, reported to commissioners and full root cause investigation undertaken by business groups. Policies and procedures in place regarding falls prevention and management. Initiatives to assist in the management and prevention of falls - low profiling beds, sensor alarms, slipper project etc. Risk and Safety Team review falls incidents and escalate as and when required for investigation. Wards notify Risk & safety team/business group of falls which result in fracture or serious injury. Specialisted falls prevention and management training mandatory every three years for nursing and therapy staff.	16	4	4	16	Deep dive workshop to be arranged to agree and prioritise for this year. Non exec Director to be a member of hospital falls group. Post falls action chart for medical staff to be developed. Trust falls SOP to be reviewed and launched. Continue with slipper project. Undertake trial of slipper socks. Complete Trust Falls Alarm Programme, to include purchase of additional alarms.	31/08/2016	12	To have less than 19 avoidable falls in a year.	⟷	JM/QAC
Corporate Nursing	2194	Infection Prevention and Control	Nesta Featherstone	Strategic	**Reduction in number of single rooms for isolation of patients** *With the rising trend and increased outbreaks during 2014-15 from Carbapenemase producing Entrobacteriaceae cases, the requirement and recommendations for single room isolation facilities continues to be a challenge across the Trust. No Robust Alert system in place across the Trust to highlight previous patients with Health care associate infections.*	SOP for isolation of patients	16	4	4	16	Bed managers following training will take over side room database. opening of D block	31/10/2016	8	A robust system is in place to ensure patients are appropriately managed in single rooms	⟷	JM/QAC

Business Group	ID	Source	Risk Owner	Risk Type	Risk	Existing Controls	Initial Rating	Current Consequence	Current Likelihood	Current Rating	Mitigating actions to be completed	Date for action plan completion	Target Risk Score	Key Indicators	Progress Arrow Key: Red = increase in current rating Green = reduction in current rating Yellow = no change	Exec Owner/ Committee (See Key above)
Diagnostic & Clinical Support	2718	Medication	Paul Buckley	Strategic	**Medication Errors Occurring as a Result of Having Different Systems for Prescribing** *Prescribing on different systems inevitably leads to confusion and errors occurring. There have already been incidents on Datix where patients had the potential to be harmed. At the present time prescribing may take place on Advantis ED, on a paper prescription chart or on EPMA.*	A notice has been put on the front page of the ePMA screen and on the intranet alerting staff to the risks of having different systems for prescribing and that all drugs prescribed must be transferred to ePMA as soon as possible after admission. A warning on this risk added to the nurses' essential training.	16	4	4	16	Implementation of new EPR system.	01/09/2016	**12**	Implementation of new EPR system.		JS/QAC
Diagnostic & Clinical Support	2130	Clinical procedures	Sara Wilson	Strategic	**Insufficient capacity in Endoscopy to meet the current demand** *The Trust is at risk of not achieving its target*	Flexible use of existing staff to cover as many unused lists as possible. A plan to review the utilisation of the unit and the changes needed to meet demand. Mediscan have been commissioned to conduct 10 additional weekend lists per month. There is close monitoring of the breaching of targets and the Senior Team are alerted to any immediately. Introduced new role of Inpatient co-ordinator to manage all inpatient referrals to prioritise referrals and maximise use of capacity. Endoscopy Cancellation escalation procedure developed.	20	4	5	20	Continue to support estates/procurement in establishing plans for unit expansion Improve sessional productivity, adding 1 unit to each list by developing case pre-assessment and additional nurses allocated to procedure rooms	31/08/2016	**12**	Endoscopy target to be achieved		JS/QAC
Diagnostic & Clinical Support	2877	Compliance	Grace Davie	Strategic	**Continued operation and sustainability of existing AOS.** *AOS is currently operating as a single-handed nurse-led model and 3.5 PAs of oncologist time which is provided by 4 visiting oncologists from The Christie Hospital and is non-compliant with the requirement.*	Service pager held by non-clinical staff in times of absence as a message relaying service only to the visiting oncologists. Staff training in acute areas on management of neutropenic sepsis and MSCC. Options paper prepared for Trust consideration to increase staffing. 24 hour advice line available at The Christie	16	4	4	16	Await outcome of options paper. Action plan to be developed following QST review	31/08/2016	**12**	To be compliant with requirement		JS/QAC

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

Business Group	ID	Source	Risk Owner	Risk Type	Risk	Existing Controls	Initial Rating	Current Consequence	Current Likelihood	Current Rating	Mitigating actions to be completed	Date for action plan completion	Target Risk Score	Key Indicators	Progress Arrow Key: Red = increase in current rating Green = reduction in current rating Yellow = no change	Exec Owner/ Committee (See Key above)
Estates and Facilities	2748	Environment	Russell James	Strategic	**Corridor obstruction** *Obstruction of corridors 9the Hospital Street) compromising means of escape by : obstructing freedom of movement into and through corridor fire compartments, obstructing access by the emergency services in getting to any fire and preventing automatic fire doors from closing*	Additional Storage space including the bed store. Two dedicated corridor agency porters. Corridor Review Group has been established - however due to capacity pressures representation from all business groups have proved difficult. The action tracker outlining the work of the group so far is attached for.	15	5	3	15	Engage with ward and departmental managers/clinical leads through a user group Consider any infection prevention issues that might arise from mattrasses /beds/medical equipment review and report any possible options for the implementation of a trustwide asset management system to the risk management committee Implement agreed corridor actions and ensure where apprpropraite that operational procedures are developed and embedded	30/07/2016	**10**	Fire service compliance		JS/QAC

Business Group	ID	Source	Risk Owner	Risk Type	Risk	Existing Controls	Initial Rating	Current Consequence	Current Likelihood	Current Rating	Mitigating actions to be completed	Date for action plan completion	Target Risk Score	Key Indicators	Progress Arrow Key: Red = increase in current rating Green = reduction in current rating Yellow = no change	Exec Owner/ Committee (See Key above)
Finance	2896	Financial	Kay Wiss	Strategic	**Delivery of 2016/17 CIP** *The Annual Plan of the Trust for 2016/17 needs to deliver a break-even position and in order to achieve this significant transformational savings needs to be realised.*	As part of the Board Assurance Framework Structure performance (including finance and standards) are reported through the committees. This has been enhanced by a second tier of performance and CIP escalation meetings.	20	5	4	20	Financial analysis of staircase projects and deliverability over 5 years. Formation of Strategic Planning Team with appropriate resources in corporate areas. StraSys consultancy engaged to provide a Trust Strategy and a method for delivery of future savings: Identifying patient cohorts to inform strategy and decision making. Identification of projects for "strategic staircase" for savings. Design and introduction of innovation projects to deliver transformational change. Series of new meetings to support workstreams within thenew environment including a fortnightly FInancial Improvement Group. A weekly Senior Management Group has been established and will receive updates from the Programme Managerto help resolve issues.	30/04/2017	**15**	CIP delivery	⟷	FP/FS&I

Business Group	ID	Source	Risk Owner	Risk Type	Risk	Existing Controls	Initial Rating	Current Consequence	Current Likelihood	Current Rating	Mitigating actions to be completed	Date for action plan completion	Target Risk Score	Key Indicators	Progress Arrow Key: Red = increase in current rating Green = reduction in current rating Yellow = no change	Exec Owner/ Committee (See Key above)
Human Resources	2879	Finance	Tracey Bradshaw	Strategic	**Use of Temporary Staffing** *Risk to patient care through ongoing or increasing use of temporary staffing*	Twice yearly train the trainer updates at the CPF workshops Bi monthly report to the medical devices committee regarding compliance New RNs being taught at clinical induction from September 2015	20	4	5	20	Development of Temporary Staffing Policy.	31/07/2016	**9**	Reduction in cost and use of Temporary Staffing	⟷	JSh/WOD
Medicine	2470	Other	Stuart Rogers	Strategic	**Gastroenterology service provision** *Insufficient capacity to adequately deliver all service areas within Gastroenterology* Failure to meet NICE guidance	OWL Backlog patients are being clinically validated by one of the substantive team to ensure the safety of patients with extended waits. Reliance on Locum medical staff is reducing as substantive recruitment continues, this is improving the quality and continuity of clinical care, as well as pathway management. The 6th Substantive Consultant post is back out to advert to allow the implementation of the COW model.	20	4	5	20	6th Consultant confirmed as starting in post August 2016. Remaining patients to be appointed	31/08/2016	**8**	Nice guidance compliance	⟷	CW/QAC

Business Group	ID	Source	Risk Owner	Risk Type	Risk	Existing Controls	Initial Rating	Current Consequence	Current Likelihood	Current Rating	Mitigating actions to be completed	Date for action plan completion	Target Risk Score	Key Indicators	Progress Arrow Key: Red = increase in current rating Green = reduction in current rating Yellow = no change	Exec Owner/ Committee (See Key above)
Medicine	2721	National Recommendation	Rebecca Barker	Strategic	**Trauma Unit External Peer Review Serious Concerns** *Following the Trauma Unit Peer review , serious concerns were expressed in terms of three aspects of the Emergency Department and Trust delivering Trauma Care*	Currently there is an ED Consultant on call for trauma 24/7. The ED Consultant is on site between 09.00 and 22.00, they are then on call and respond within 30 minutes. Currently every patient has a named Nurse could take this role. Current baseline is that less than 16% are seen by a consultant within 30 minutes, according to data.	20	4	5	20	Conduct quarterly practice Trauma call activation via switchboard at differing times of the day and week. 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 co-ordinator 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.	30/09/2016	**8**	Trauma unit peer review compliance	⟷	CW/QAC

Business Group	ID	Source	Risk Owner	Risk Type	Risk	Existing Controls	Initial Rating	Current Consequence	Current Likelihood	Current Rating	Mitigating actions to be completed	Date for action plan completion	Target Risk Score	Key Indicators	Progress Arrow Key: Red = increase in current rating Green = reduction in current rating Yellow = no change	Exec Owner/ Committee (See Key above)
Surgery and Critical Care	2824	Staffing	Pauline Enstone	Strategic	**Safe Staffing Surgery and Critical Care Wards** *There is currently a lack of Trust registered nurses and nursing assistants on wards to ensure consistent, safe staffing levels. This is contributed to by vacancies, long term sick and maternity leave*	Matron shift by shift safety huddle reviews to equalising staffing daily. 1135 senior nurse reviews out of hours. Utilisation of Trust safe staffing escalation policy utilising, when authorised Pulse/Thornbury. Surgery now recruiting in November internationally. Revised rosters now in place from 21st September to maximise roster benefits. Adherence to roster policy. Robust absence management. Proposed recruitment UK day Nov 2015. Offer all students that work in the Trust positions. Embraced apprentice scheme. Embraced CSWd trainee scheme. Requesting funding for a pool of band 2 staff to relieve pressure on wards and backfill long term sick and maternity leave. DoN has supported and approved NHSP NTL and NTM rates to encourage senior nurses to undertake in charge shifts to stabilise the wards where gaps in off duties require senior support. Non front line nurse provided refresher training to support wards in escalation.	16	4	5	20	Follow up leads from Manchester university student nurse event attended sept 2015	07/07/2016	12	Maintain safe staffing level		JSh/WOD

Business Group	ID	Source	Risk Owner	Risk Type	Risk	Existing Controls	Initial Rating	Current Consequence	Current Likelihood	Current Rating	Mitigating actions to be completed	Date for action plan completion	Target Risk Score	Key Indicators	Progress Arrow Key: Red = increase in current rating Green = reduction in current rating Yellow = no change	Exec Owner/ Committee (See Key above)
Surgery and Critical Care	2826	Finance	Karen Hatchell	Strategic	**Non-delivery of S&CC CIP/Income targets 2015-2016** *The Trust is unable to deliver the £11.8 million Monitor CIP savings required in 2015/16*	Monthly reporting finance and performance. Weekly local meeting with Accountants for income & activity and finance & CIP. Monitor and tracking of project KPI's. Monthly information produced by BG Accountant. All vacant posts to be scrutinised by BG Director prior to approval to recruit. Restructures across departments and specialties Headcount reduction/MARs. Income generation opportunities	20	4	5	20	Reduce Outsourcing. Review of capacity to maximise income potential from targeted specialties eg., weekend, evening, Trust Health. Reduce Locum/Agency and WLI spend. SLR/PLiCs review. Improving staff productivity schemes. Departmental efficiency schemes. On-going work with the Procurement team to review prosthetic usage, to realise extra savings and longer term savings on tenders. Work closely with Corporate Teams to ensure target delivery of project work-streams relevant to Business Group e.g., outpatients, drugs, HR. 15/16 Headcount reduction	07/07/2016	**12**	Achieve Business Group CIP Target for 2015/2016.	⟷	FP/FS&I

Business Group	ID	Source	Risk Owner	Risk Type	Risk	Existing Controls	Initial Rating	Current Consequence	Current Likelihood	Current Rating	Mitigating actions to be completed	Date for action plan completion	Target Risk Score	Key Indicators	Progress Arrow Key: Red = increase in current rating Green = reduction in current rating Yellow = no change	Exec Owner/ Committee (See Key above)
Trust Executive Team	2889	Compliance	Collin Wasson	Strategic	**7 day working** *The Keogh Review has recommended 10 standards to support the NHS in improving clinical outcomes and patient experience at weekends. 4 of these standards have been prioritised and there is a risk that at present the trust cannot achieve them in the given timeframes:*	Extending palliative care team support for community and hospital over Saturday and Sunday, 8am to 430pm. Rota changes of consultants in Medicine Business Group to provide Consultant Physical presence on AMU from 8am to 5pm on Saturday and Sunday; to provide Consultant delivered ward rounds on B2/E1 (stroke unit) on Saturday and Sunday; to provide in reach Consultant Cardiology input to AMU and CCU on Saturday and Sunday Radiology staff on site 24/7 to provide plain film x rays, mobile x rays, theatre imaging and CT scans. There is now continuous CT provision on site providing swifter patient access to CT scanning for trauma and stroke patients out of hours.	20	4	5	20	All actions to be taken through Stockport Together Transformational Project	30/07/2016	**12**	Achievement of standards in 7/7 working	⟷	CW/QAC
Trust Executive team	2644	Compliance	Colin Wasson	Strategic	**Upper GI Bleed Service Provision (Non Compliance with NCEPOD Gastrointestinal Haemorrhage (Time to Get Control) published in 2015 and NICE Guidance 141)** *NICE Clinical Guidance 141 has 9 quality standards at present the Trust is fully compliant with 2 standards, partially compliant with 3 standards and non-compliant with 4 (claim of breach of duty).*	*There is guidance for the management of those patients who are haemodynamically unstable to receive endoscopy this plan is different for in hours and out of hours (Standard 2). Endoscopy within 24 hours can be offered to patients with the exception of those being admitted on Saturdays and on Sundays preceding bank holidays In hours, the appropriate endoscopic treatment for non variceal bleeding can be offered. Aspirin and antibiotic therapy advice is a given as per guidance*	20	4	4	16	Identify a Clinical Lead for GI Bleeding Separate rota for endoscopy staff and organisation of Endoscopy list to prioritise blood Development of a separate "bleeder rota" to provide 24/7 provision of endoscopic diagnostic and treatment service	30/07/2016	**8**	Full compliance with the NICE/NCEPOD guidance	⟷	CW/QAC

Business Group	ID	Source	Risk Owner	Risk Type	Risk	Existing Controls	Initial Rating	Current Consequence	Current Likelihood	Current Rating	Mitigating actions to be completed	Date for action plan completion	Target Risk Score	Key Indicators	Progress Arrow Key: Red = increase in current rating Green = reduction in current rating Yellow = no change	Exec Owner/ Committee (See Key above)
Trust Executive team	1881	Compliance	Sue Toal	Strategic	**Deliver 4 hour Performance Target within ED** *Failure to achieve this target would represent a significant corporate risk to the Foundation Trust both financially and reputation.*	Existing internal escalation processes Daily monitoring of staffing rotas in ED and on-call The trust Unscheduled Care Plan- monthly meetings Whole health economy collaboration to deliver this target	20	5	4	20	Ownership of longer term issues DTOCs - Ownership of longer term issues. DTOCs - Formalised outputs with clear escalation where required. Clear escalation where required. DTOCs - 11:30 Meeting Structure/ Agenda. CAIR - Leadership/ Presence? CAIR - Daily processes. CAIR - Clarity of Roles and Responsibilities. Clarity of Roles and Responsibilities. Junior Doctors Batching of jobs e.g. TTO's Acutes entering EDD into Advantis. Surgery escalation - SOP (Co-ordination/ Leadership) Surgery escalation - SOP (Roles and responsibilities). RAT Model - 1hr from arrival to consultant (95th Centile). Triage Plus Model - 15 min to Triage (95th Centile)	30/07/2016	10	Achieving 95% in the 4 hour Performance Target within ED	⟷	JS/QAC

6. RISK ASSESSMENT SCORING/RATING MATRIX

LIKELIHOOD OF HAZARD

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

QUALITATIVE MEASURES OF CONSEQUENCE OF RISK

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

The risk factor = severity x likelihood

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

	CONSEQUENCE				
	1	2	3	4	5
LIKELIHOOD	**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)*

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Stockport NHS
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	30th June 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 May 2016. Key points of note as follows; • Fill rates for Registered Nurses (RN) and care staff remain above 90% • Staffing challenges remain across two wards in Trauma and Orthopaedics, D2 and M4, and one in surgery B3, whilst staff undertaken induction and complete their supernumerary period. A15 and Bluebell Wards in medicine are supported by the Matrons whilst awaiting new recruits. • Movement of staff from B2 has been an issue and continues to be closely monitored by the Matron and Head of Nursing The Board of Directors is asked to note the contents of this report with assurance given that Safe Staffing was maintained during May 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 May 2016

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

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i INTRODUCTION

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

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

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

2. BACKGROUND

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

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

3. CURRENT SITUATION

3.1 Registered Nurse/Midwife

3.2 Overall Performance

Whilst May 2016 has continued to report further favorable staffing levels on day and night shifts overall, there has been continued pressure on wards D2, M4 and B3 within the Surgery and Critical Care Business Group and on wards A15, B2 and Bluebell within the Medicine Business Group. Theatres are reporting a 15.4% vacancy level at band 5 .

3.3 Temporary Staffing

Registered Nursing agency reliance figures are 2 months in arrears and so are reported here for April 2016. Overall reliance on Registered Nursing agencies is 2.5% in April 2016 which is a favorable reduction from 4.7% in February and March 2016. Our compliance with the introduction of capped rates for agency nursing staff is now reported as 87% for all general areas and this will rise to 100% by the 1st July 2016. Two of the critical care areas, the emergency department and coronary care, are showing reduced reliance on agency. Focus work with theatres is underway.

3.4 Surgery and Critical Care

Surgery has continued to report sub-optimal staffing levels across D2, M4 and B3 .It is pleasing to now report that staff have been recruited and are working in their supernumerary period. Safe staffing has been maintained due to the daily actions put in place by the Matrons. Theatres continue to be a focus for recruitment.

3.5 **Medicine**

Wards A15, Bluebell and B2 continue to report reductions In May 2016. B2 relates to some retention issues and movement of staff. This has been flagged as a concern and continues to be closely monitored. B2 requires the increased staffing levels as part of the hyper acute staffing model. The Head of Nursing has put actions in place to ensure that Matron support is ensured for this ward, while recruitment is ongoing.

3.6 **Community**

The second meeting with the CCG took place in April 2016 to discuss the Staffing review paper presented in February. Discussions continue with the Stockport CCG with respect to the community nurse budgets. Noteworthy improvements have been made with significantly reduced vacancies.

3.7 **Recruitment**

EU and non EU recruitment continues as per agreed plan. A further open day has been planned for June. The current focus is centred on theatre recruitment with alternative options explored to maximise local recruitment.

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

May'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 May 2016, our report shows an average CHPPD of 8.0.

4. RISK & ASSURANCE

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

5. CONCLUSION

5.1 Safe staffing levels have been maintained and reliance on agency staffing significantly reduced.

6. RECOMMENDATIONS

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

Appendix A – Previous months staffing fill rates

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: May_2016-17

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

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

Hospital Site Details		Ward name	Main 2 Specialties on each ward		Day				Night				Day		Night		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		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	NNU - Neonatal Unit	420 - PAEDIATRICS		2325	2235	0	0	1627.5	1438.5	0	0	96.1%	n/a	88.4%	n/a	165	22.3	0.0	22.3	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	TH - Tree House	420 - PAEDIATRICS		3255	3150	465	465	2170	1917	0	0	96.8%	100.0%	88.3%	n/a	573	8.8	0.8	9.7	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	JW - Jasmine Ward	502 - GYNAECOLOGY		930	914	465	465	620	620	0	0	98.3%	100.0%	100.0%	n/a	193	7.9	2.4	10.4	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	BC - Birth Centre	560- MIDWIFE LED CARE	501 - OBSTETRICS	1860	1815	465	465	1240	1230	310	310	97.6%	100.0%	99.2%	100.0%	73	41.7	10.6	52.3	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	M1 - Delivery Suite	501 - OBSTETRICS		2790	2715	465	390	1860	1730	310	310	97.3%	83.9%	93.0%	100.0%	201	22.1	3.5	25.6	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	M2 - Maternity 2	501 - OBSTETRICS	560- MIDWIFE LED CARE	1627.5	1605	930	922.5	620	620	310	310	98.6%	99.2%	100.0%	100.0%	542	4.1	2.3	6.4	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	ICU & HDU	192 - CRITICAL CARE MEDICINE		4650	4517	775	775	4092	3894	0	0	97.1%	100.0%	95.2%	#DIV/0!	347	24.2	2.2	26.5	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	SSSU	101 - UROLOGY	100 - GENERAL SURGERY	1801.5	1669.5	535	457	580	591	300	300	92.7%	85.4%	101.9%	100.0%	290	7.8	2.6	10.4	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	B3	100 - GENERAL SURGERY	101 - UROLOGY	1395	1215	1162.5	1306.5	682	671	682	814	87.1%	112.4%	98.4%	119.4%	660	2.9	3.2	6.1	New starters in post, awaiting registrations, safety assure as never less than 2 Registered Nurses on per shift and daily Matron assurance
RWJ09	STEPPING HILL HOSPITAL - RWJ09	B6	100 - GENERAL SURGERY	101 - UROLOGY	1395	1171.5	1162.5	1530	682	693	682	968	84.0%	131.6%	101.6%	141.9%	727	2.6	3.4	6.0	New starters in post, awaiting registrations, safety assure as never less than 2 registered nurses on per shift and daily Matron assurance
RWJ09	STEPPING HILL HOSPITAL - RWJ09	C3	100 - GENERAL SURGERY	101 - UROLOGY	1627.5	1567.5	1116	1065	868	868	682	682	96.3%	95.4%	100.0%	100.0%	314	7.8	5.6	13.3	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	C6	101 - UROLOGY	100 - GENERAL SURGERY	1395	1266	1395	1713.5	682	671	682	957	90.8%	122.8%	98.4%	140.3%	685	2.8	3.9	6.7	Increased care staff hours to support high falls risk patient.
RWJ09	STEPPING HILL HOSPITAL - RWJ09	D1	110 - TRAUMA & ORTHOPAEDICS		1627.5	1485	1395	1401	682	682	682	726	91.2%	100.4%	100.0%	106.5%	631	3.4	3.4	6.8	Increased care staff hours to support high falls risk patients at night.
RWJ09	STEPPING HILL HOSPITAL - RWJ09	D2	110 - TRAUMA & ORTHOPAEDICS		1395	1187.5	1162.5	1128	682	682	682	682	85.1%	97.0%	100.0%	100.0%	526	3.6	3.4	7.0	New starters in post, awaiting registrations. Safety assure as never less than 2 Registered Nurses on per shift and daily Matron assurance.
RWJ09	STEPPING HILL HOSPITAL - RWJ09	D4	110 - TRAUMA & ORTHOPAEDICS		934.5	934.5	994.5	979.5	682	682	473	484	100.0%	98.5%	100.0%	102.3%	443	3.6	3.3	7.0	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	M4	110 - TRAUMA & ORTHOPAEDICS		2092.5	1318.5	2092.5	3056.2	1023	979	1023	1419	63.0%	146.1%	95.7%	138.7%	783	2.9	5.7	8.6	New starters recruited, awaiting registration and start date Care staff increased to support sub optimal days register Nurse levels. Safety assured by Matron . Care staff increased to support high falls risk, dependent patients and high acuity at night.
RWJ09	STEPPING HILL HOSPITAL - RWJ09	AMU1	300 - GENERAL MEDICINE		2794.5	2539.5	1953	1968	2046	1859	1705	1853.25	90.9%	100.8%	90.9%	108.7%	995	4.4	3.8	8.3	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	AMU2	300 - GENERAL MEDICINE		1953	1731	1581	1713	1705	1694	1364	1364	88.6%	108.3%	99.4%	100.0%	665	5.2	4.6	9.8	Ward monitored by Matron for safety.Registered Nurse posts now recruited to, awaiting a start date . Registered Nurse allocated from the EU recruitment programme.
RWJ09	STEPPING HILL HOSPITAL - RWJ09	A10	430 - GERIATRIC MEDICINE		1780.6	1758.1	1674	1847	682	682	682	2046	98.7%	110.3%	100.0%	300.0%	856	2.9	4.5	7.4	Additional care staff to support high falls risk and high dependency patients on the ward.
RWJ09	STEPPING HILL HOSPITAL - RWJ09	A11	300 - GENERAL MEDICINE		1922	1734.5	1441.5	1486.5	682	694	682	1366	90.2%	103.1%	101.8%	200.3%	820	3.0	3.5	6.4	Increased care staff hours on days attributed to Register Nurse awaiting registration . Additional care staff hours on night duty are to support the increased patient dependency.
RWJ09	STEPPING HILL HOSPITAL - RWJ09	A12	300 - GENERAL MEDICINE		1734	1576.5	1457	1397	682	682	682	682	90.9%	95.9%	100.0%	100.0%	785	2.9	2.6	5.5	Registered Nurse vacancy being recruited to. Ward monitored by Matron and safety assured.
RWJ09	STEPPING HILL HOSPITAL - RWJ09	A14	300 - GENERAL MEDICINE		1665.5	1470.5	1209	1164	682	682	682	990	88.3%	96.3%	100.0%	145.2%	786	2.7	2.7	5.5	Increased care staff hours on nights are to support increased patient dependency levels .Suboptimal Registered Nurse days levels are monitored by Matron and safety assured.
RWJ09	STEPPING HILL HOSPITAL - RWJ09	A15	300 - GENERAL MEDICINE		1760	1190	1209	1730	682	688	682	902	67.6%	143.1%	100.9%	132.3%	778	2.4	3.4	5.8	Increased care staff hours on days and reduced Register Nurse hours are attributed to 1 registered Nurse awaitin registration . Remaining Registered Nurse vacancies are being recruited to.The ward is monitored by Matron and safety is assured .
RWJ09	STEPPING HILL HOSPITAL - RWJ09	B2	430 - GERIATRIC MEDICINE		1674	1338	837	999	1364	908	682	706	79.9%	119.4%	66.6%	103.5%	457	4.9	3.7	8.6	Ongoing recruitment continues. The ward is monitored by Matron and safety is assured. Never less than 2 Register Nurses on duty.
RWJ09	STEPPING HILL HOSPITAL - RWJ09	B4	320 - CARDIOLOGY		1085	1053.4	837	959.3	682	671	341	601	97.1%	114.6%	98.4%	176.2%	490	3.5	3.2	6.7	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	B5	300 - GENERAL MEDICINE		1085	1115.5	837	861	682	682	682	637.25	102.8%	102.9%	100.0%	93.4%	443	4.1	3.4	7.4	
RWJ88	THE MEADOWS - RWJ88	BW	318- INTERMEDIATE CARE		1209	864.3	2449	2419	682	682	682	1243	71.5%	98.8%	100.0%	182.3%	783	2.0	4.7	6.7	Additional care staff at night to special patients with high dependant needs. Suboptimal Registered Nurse day shi but the unit is monitored by Matron and safety is assured
RWJ09	STEPPING HILL HOSPITAL - RWJ09	C2	300 - GENERAL MEDICINE		1085	1005	837	992.25	682	682	682	716.5	92.6%	118.5%	100.0%	105.1%	490	3.4	3.5	6.9	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	C4	320 - CARDIOLOGY		1069.5	1054.5	837	867	682	660	341	341	98.6%	103.6%	96.8%	100.0%	455	3.8	2.7	6.4	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	CCU	320 - CARDIOLOGY		837	837	465	433	682	682	341	330	100.0%	93.1%	100.0%	96.8%	169	9.0	4.5	13.5	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	CLDU	300 - GENERAL MEDICINE		496	496	496	496	310	310	310	310	100.0%	100.0%	100.0%	100.0%	167	4.8	4.8	9.7	
RWJ03	CHERRY TREE HOSPITAL - RWJ03	DCNR	314 - REHABILITATION		1147	1123	1999.5	1909.5	682	682	682	682	97.9%	95.5%	100.0%	100.0%	590	3.1	4.4	7.5	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	E1	430 - GERIATRIC MEDICINE		2015	1835	2309.5	2024.5	1023	858	1364	1408	91.1%	87.7%	83.9%	103.2%	935	2.9	3.7	6.6	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	E2	430 - GERIATRIC MEDICINE		2376	2360.7	1674	1700.6	1023	1001	1023	1364	99.4%	101.6%	97.8%	133.3%	1029	3.3	3.0	6.2	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	E3	430 - GERIATRIC MEDICINE		2376	2368.5	1674	1865	1023	979	1023	1419	99.7%	111.4%	95.7%	138.7%	1096	3.1	3.0	6.1	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	SSOP	430 - GERIATRIC MEDICINE		837	732	465	435	682	682	341	341	87.5%	93.5%	100.0%	100.0%	380	3.7	2.0	5.8	Registered Nurse vacancy recruited to, staff in post at th end of May. The ward is monitored by Matron and safety assured .
		Total			62002.1	56949	40822	43385.85	36152.5	34428.5	21791	27264	91.9%	106.3%	95.2%	125.1%	20322	4.5	3.5	8.0	

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Stockport NHS
NHS Foundation Trust

Board of Directors' Key Issues Report

Report Date: 30/06/16		**Report of:** Finance & Performance Committee
Date of last meeting: 22/06/16		**Membership Numbers:** Quorate
1.	Key Issues Highlighted:	The Committee considered an agenda which included the following: • Draft Committee Terms of Reference • Flash Results • Month 2 Finance Report 2016/17 • Phase 1 KPMG Report - Financial Improvement Group Governance Structure - Cash Action Group Terms of Reference and Actions • Sustainability & Transformation Fund Update • Tender Log This was the first meeting of the Committee following the merger of the former Finance & Investment Committee and the Strategic Development Committee. With regard to matters to bring to the attention of the Board, the Committee considered and subsequently recommended the draft Committee terms of reference for approval by the Board of Directors. This is a separate agenda item for the Board of Directors meeting on 30 June 2016. The Committee also considered and endorsed the format and content of the Flash Results information which would be circulated to the Board on a monthly basis in advance of its submission to NHSI. It was noted that the Committee would continue to receive full financial reports. The Director of Finance briefed the Committee on the Trust's financial position and it was noted that for May 2016, the Trust was in line with the financial plan for a deficit of £5.1m. The Committee noted that clinical income had improved significantly in May and was £0.8m ahead of plan in month. Elective activity in particular was above plan but it was noted that this was linked to increased outsourced activity undertaken to reduce the referral to treatment backlog and therefore represented a low or nil margin contribution to the Trust. It was further noted that non-elective income was in line with plan with regard to the Stockport CCG Block Contract. Emergency Department estimated activity was 8% above plan and was therefore in excess of the 5% threshold agreed with the CCG. It was noted that the position would be closely monitored as part of the reconciliation of the Q1 overall contract position. With regard to expenditure, it was noted that the pay budget underspends from non-recurrent slippage on vacancies were offsetting increased non-pay costs for KPMG consultancy and outsourcing to deliver additional elective activity. The Committee was advised that the total CIP plan of £17.5m for 2016/17 had been

		profiled according to the schemes within the strategic staircase and the likelihood for delivery of business as usual targets. The Committee noted that at month 2, £0.3m had been delivered against the profiled plan of £0.92m. Based on the information available, the Committee could not gain assurance on the delivery of the Cost Improvement Programme. It was the intention, however, to provide a report to the July meeting which would seek to provide assurance on CIP deliverability. The Director of Finance provided an update with regard to the Cost Improvement Programme, Business Group positions, Agency costs, Financial Risk Rating and Cash position. The Committee was advised that a new Cash Action Group chaired by the Financial Improvement Director had been established and noted its terms of reference. It was noted that successes to date included negotiations with NHSLA and Stockport CCG to amend the payment profile of the Trust's clinical negligence premium and rates charges. The Committee was advised that Capital costs to the end of May were £1.4m which was £0.6m below the profiled plan of £2.0m. It was noted that the D Block Surgical and Medical Centre build was two weeks behind schedule but that mitigating plans were in place to bring the plan back into line. The Committee considered an update report with regard to the Financial Improvement Programme and was advised of achievements to date, further initiatives that were underway and the initial observations and recommendations made by the Financial Improvement Director. The Financial Improvement Director briefed the Committee of recommendations and actions with regard to culture, strategy, Executive responsibilities, workforce, budget and PMO. The Committee was advised of new governance arrangements and reporting lines to support the Trust's financial improvement objectives, including the establishment of a Financial Improvement Group. It was noted that Non-Executive Directors had an open invitation to meetings of the Financial Improvement Group. Reference was made to the importance of clear and transparent communication to staff with regard to the financial challenges and consequences. Finally, the Committee considered a Tender Log and was advised that future reports would be more detailed and include explanatory information.		
2.	Risks Identified	Delivery of 2016/17 cost improvement programme		
3.	Actions to be considered at the *(insert appropriate place for actions to be considered)*	Nil		
4.	Report Compiled by	Malcolm Sugden, Chair	Minutes available from:	Company Secretary

Stockport NHS
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	30 June 2016
Subject:	Finance & Performance Committee - Terms of Reference		
Report of:	Company Secretary	**Prepared by:**	P Buckingham

REPORT FOR APPROVAL

Corporate objective ref:	N/A	**Summary of Report** *Identify key facts, risks and implications associated with the report content.* The purpose of this report is to present draft Terms of Reference for a Finance & Performance Committee to the Board of Directors for approval.
Board Assurance Framework ref:	N/A	
CQC Registration Standards ref:	N/A	
Equality Impact Assessment:	☐ Completed X Not required	

Attachments:	Annex A – Finance & Performance Committee - Draft Terms of Reference

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

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1. INTRODUCTION

1.1 The purpose of this report is to present draft Terms of Reference for a Finance & Performance Committee to the Board of Directors for approval.

2. BACKGROUND

2.1 At its meeting held on 18 May 2016, the Finance & Investment Committee considered a proposal to merge the Committee with the Strategic Development Committee. This proposal emerged from a meeting of Strategic Development Committee members held on 16 May 2016 to consider more effective means of Committee reporting. However, those present concluded that continued separation of the financial and programme elements of the Integrated Delivery Programme was no longer sustainable. This conclusion was consistent with views developed by KPMG LLP during the early stages of the Financial Improvement Programme.

2.2 The proposal was endorsed by the Finance & Investment Committee and was subsequently reported to the Board of Directors on 26 May 2016. The Board of Directors approved the proposed merger and agreed that Terms of Reference for the merged Committee should be presented to the Board for approval on 30 June 2016.

3. CURRENT SITUATION

3.1 Draft Terms of Reference for a merged Committee were prepared by the Company Secretary based on the functions undertaken by the constituent Committees. The draft Terms of Reference were circulated to Executive Team members for comment on 2 June 2016 and were formally considered at an Executive Team meeting on 14 June 2016. Amendments made at that meeting have been incorporated in the revised draft which is included for reference at Annex A to this report.

3.2 The draft Terms of Reference were subsequently presented for consideration at the initial meeting of a merged Finance & Performance Committee held on 22 June 2016 and was recommended to the Board of Directors for approval.

4. LEGAL IMPLICATIONS

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

5. RECOMMENDATIONS

5.1 The Board of Directors is recommended to:

- Approve the establishment of a Finance & Performance Committee together with the draft Terms of Reference included at Annex A.
- Formally approve disestablishment of the Finance & Investment and Strategic Development Committees.

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Stockport NHS
NHS Foundation Trust

FINANCE & PERFORMANCE COMMITTEE

DRAFT TERMS OF REFERENCE

1. CONSTITUTION

1.1 The Board of Directors hereby resolves to establish a Committee, to be known as the Finance & Performance Committee *(hereinafter referred to as 'the Committee')*. The Committee has no executive powers, other than those specifically delegated within these terms of reference.

2. REMIT AND FUNCTIONS OF THE COMMITTEE

2.1 The Committee is established to seek assurance on all aspects of the Trust's financial performance, financial strategy, investment and commercial activities. The Committee will seek assurance on matters relating to planning and delivery of the Trust's strategic change programmes which incorporate the Trust Strategy and the Innovation Programme.

2.2 The Committee will also seek assurance on the Trust's response, and the effectiveness of this response, to strategic developments in the local and/or regional health economy.

2.3 The main functions of the Committee are to:

i. obtain assurance on the development and effectiveness of the Trust's financial plans
ii. review performance against key financial metrics and advise on Executive action to address any adverse trends
iii. seek assurance on both the planning of cost improvement programmes and delivery of in-year programmes
iv. review draft Capital programmes, recommend to the Board of Directors for approval and obtain assurance on delivery of approved in-year Capital schemes
v. obtain assurance on the effectiveness of controls to mitigate high level Finance-related risks

vi. review proposed transactions that fall within the Monitor definition of significant and material transactions and make recommendations as appropriate to the Board of Directors

vii. seek assurance on the effectiveness of the Trust's investment and borrowing policies

viii. seek assurance on the effectiveness and sustainability of the Trust's commercial activities

ix. receive, review and recommend business cases with an investment value in excess of £1m (capital and/or revenue) to the Board of Directors as appropriate

x. consider the outcomes of post-implementation reviews for investments with a value in excess of £1m and seek assurance from management that any identified learning has been effectively addressed

xi. review and recommend to the Board of Directors, any formal financial submissions to Monitor outside of normal monthly and/or quarterly returns

xii. receive, review and recommend Finance-related strategy documents to the Board of Directors as appropriate

xiii. validate Finance-related and IM&T-related policy documents

xiv. obtain assurance on the preparation of annual plans for delivery of the Trust's Strategy

xv. obtain assurance on progress with strategic change programmes detailed in the annual Integrated Delivery Plan

xvi. seek assurance on benefits realisation from strategic change programmes and/or Innovation projects through consideration of post-implementation reviews.

xvii. advise on Executive action to address barriers to progress and/or mitigate risks to programme delivery.

xviii. obtain assurance on the effectiveness of controls to mitigate high level risks associated with strategic change programmes and / or Innovation projects.

xix. seek assurance on the Trust's participation, and the effectiveness of participation, with external strategic change programmes such as; Stockport Together, Healthier Together and Greater Manchester Devolution

xx. receive, review and recommend documents relating to the Trust's overarching strategy to the Board of Directors as appropriate

xxi. obtain assurance that the strategic planning activities of the Trust meet the requirements of any relevant regulatory standards or best practice guidance.

3. COMPOSITION AND CONDUCT OF THE COMMITTEE

3.1 The Committee shall comprise the following membership:

- Non-Executive Director (Chair)
- 3 x Non-Executive Directors (one of whom shall be Deputy Chair)
- Deputy Chief Executive
- Director of Finance
- Chief Operating Officer
- Director of Workforce & Organisational Development
- Director of Nursing & Midwifery
- Financial Improvement Director

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

3.2 Nominated deputies shall attend in the event of absence of any member; however this shall be in an advisory capacity only and attendance of a deputy shall not count towards the attendance level set out in s3.1.

3.3 Other Officers of the Trust shall attend at the request of the Committee in order to present and provide clarification on issues, and with the consent of the Chair will be permitted to participate in the debate. However, only members of the Committee are permitted to vote. The Chairman of the Trust and the Chief Executive will have a standing invitation to attend Committee meetings but are not permitted to vote.

3.4 ***Quorum***. No business shall be transacted unless at least five members, to include at least one Non-Executive Director and at least one Executive Director, are present. Deputies in attendance do not count towards the quorum.

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

3.6 ***Frequency of meetings***. The Committee will, as a minimum, meet nine times a year. The Chair may, however, call a meeting at any time provided that notice of the meeting is given as specified in s. 3.5 above.

3.7 ***Minutes***. The minutes of meetings shall be formally recorded by a member of the Corporate Governance team, checked by the Chair and submitted for agreement at

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

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

4. DELEGATED AUTHORITY

4.1 The Committee is authorised by the Board of Directors to:

i. investigate any activity within its terms of reference
ii. seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

5. RELATIONSHIP WITH THE BOARD OF DIRECTORS

5.1 The Committee will report to the Board of Directors by means of a Key Issues Report summarising business conducted by the Committee together with key actions and/or risks. A Key Issues Report will be forwarded to the Board of Directors following each Committee meeting.

6. RELATIONSHIP WITH OTHER COMMITTEES / GROUPS

6.1 The Committee will receive reports, in the form of Key Issues Reports, from the following Committees / Groups:

- Financial Improvement Group
- Cash Action Group
- Health Informatics Strategy Board

The Committee will also receive reports from any task and finish groups which may be established from time to time.

7. REVIEW

7.1 The Committee will evaluate its own membership and review the effectiveness and performance of the Committee on an annual basis. The Committee must review its terms of reference annually and recommend any changes to the Board of Directors for approval.

7.2 Compliance with the Terms of Reference will be monitored on an ongoing basis by the member of the Corporate Governance team providing support to the Committee. Any concerns in relation to compliance will be reported to the Chair of the Committee. In addition, the annual review described in s7.1 will include a summary on compliance with the Terms of Reference.

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Stockport NHS
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	30 June 2016
Subject:	Governance Declarations		
Report of:	Company Secretary	**Prepared by:**	P Buckingham

REPORT FOR APPROVAL

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

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

The purpose of this report is to present draft Governance Declarations for consideration and approval by the Board of Directors.

Attachments: Appendix 1 – Draft Governance Declarations

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 draft Governance Declarations for consideration and approval by the Board of Directors.

2. BACKGROUND

2.1 Declarations relating to the Corporate Governance Statement, Academic Health Science Centres (AHSC) and Governor Training are required to be certified by the Board of Directors for submission to Monitor by the deadline of 30 June 2016. The Corporate Governance Statement is used to inform Monitor's assessment of the Governance Rating and s4.4 of the Risk Assessment Framework states that:

Under their governance condition, NHS foundation trusts will submit a corporate governance statement within three months of the end of each financial year. The governance condition requires boards to confirm:

- *Compliance with the governance condition at the date of the statement*
- *Forward compliance with the governance condition for the current financial year, specifying (i) any risks to compliance and (ii) any actions proposed to manage such risks*

Where the corporate governance statement indicates risks to compliance with the governance condition, Monitor will consider whether any actions or other assurance are required at the time of the statement or whether it is more appropriate to maintain a watching brief.

3. CURRENT SITUATION

3.1 The Trust's position against the required declarations is scheduled to be considered by Executive Directors during the Executive Team meeting on 28 June 2016. Draft declarations are included for reference at Appendix 1 to this report.

4. RECOMMENDATIONS

4.1 The Board of Directors is recommended to:

- Note any feedback which may be provided by Executive Directors as a result of Executive Team consideration on 28 June 2016.
- Consider and approve the draft declarations included at Appendix 1 to the report.

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Self-Certification Template

FT Name: Stockport NHS Foundation Trust

NHS Foundation Trusts are required to make the following declarations to NHS Improvement:

1 & 2 *Systems for compliance with licence conditions - in accordance with General condition 6 of the NHS provider licence*
3 *Availability of resources and accompanying statement - in accordance with Continuity of Services condition 7 of the NHS provider licence*
4 *Corporate Governance Statement - in accordance with the Risk Assessment Framework*
5 *Certification on AHSCs and governance - in accordance with Appendix E of the Risk Assessment Framework*
6 *Certification on training of Governors - in accordance with s151(5) of the Health and Social Care Act*

Declarations 1 and 2 above are set out in a separate template, which is required to be returned to NHS Improvement by 31 May 2016.
Declaration 3 is included in the APR 2015/16 Final Financial Template, which is required to be returned to NHS Improvement per communications on final operational plan submissions.
Declarations 4, 5 and 6 above are set out in this template, which is required to be returned to NHS Improvement by 30 June 2016.

Templates should be returned via the Trust portal, marked as a Trust Return with the activity type set to Annual Plan Review.

How to use this template

1) Copy this file to your Local Network or Computer.
2) Select the name of your organisation from the drop-down box at the top of this worksheet.
3) In the Corporate Governance Statement and Other Certifications worksheets, enter responses and information into the yellow data-entry cells as appropriate.
4) Once the data has been entered, add signatures to the document, as described below.
5) Use the Save File button at the top of this worksheet to save the file to your Network or Computer - note that the name of the saved file is set automatically - please do not change this name.
6) Copy the saved file to your outbox in your NHS Improvement Portal.

Notes: *NHS Improvement will accept either:*
1) electronic signatures inserted into this worksheet (save signature file locally and use 'Insert - Picture' from the toolbar/ribbon to do this) or
2) hand written signatures on a paper printout of this declaration posted to NHS Improvement to arrive by the submission deadline.

In the event than an NHS foundation trust is unable to fully self certify, it should NOT select 'Confirmed' in the relevant box. It must provide commentary (using the section provided at the end of this declaration) explaining the reasons for the absence of a full self certification and the action it proposes to take to address it.

Worksheet "Corporate Governance Statement"

Corporate Governance Statement

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

4	Corporate Governance Statement	Response	Risks and mitigating actions
1	The Board is satisfied that the Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	The Board has continued to embed principles and standards arising from an independent governance review which was completed by Deloitte LLP in March 2015. The Board will respond proactively to any governance recommendations that may arise from a Financial Improvement Programme which is currently in progress.
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	
3	The Board is satisfied that the Trust implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	A review of Board and Committee arrangements was carried out in 2015/16 which resulted in an increased frequency of Board meetings and amendment to Committee meeting cycles. The Board will ensure that arrangements are subject to regular review to maintain effectiveness in the context of changes in both the internal and external environments.
4	The Board is satisfied that the Trust effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and NHS Improvement delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	The Board confirms that the Trust meets this requirement in the context of continued application of an additional licence condition relating to achievement of the 4-hour A&E standard. The Trust's progress in addressing risks associated with the areas covered by the additional licence condition remains subject to regular review by NHS Improvement.
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Trust, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	With regard to requirement 5c, the Board notes that the limited assurance report on the Annual Quality Report 2015/16 resulted in a qualified opinion on the Referral to Treatment incomplete mandated indicator. While the audit identified improvements in this area, the qualified opinion was made on the basis of weaknesses in data management process and practice. The Board will obtain assurance on progress to address identified weaknesses through regular monitoring by the Audit Committee.
6	The Board is satisfied that there are systems to ensure that the Trust has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	Robust recruitment and selection processes are in place for both Non-Executive Director and Executive Director positions to mitigate risks associated with delays in appointment or failure to appoint suitable individuals.

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

Signature **Signature**

Name **Name**

The board are unable make one of more of the above confirmations and accordingly declare:

A

B

C

Worksheet "Other declarations"

Certification on AHSCs and governance and training of governors

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.

5	**Certification on AHSCs and governance**	**Response**
	For NHS foundation trusts: • that are part of a major Joint Venture or Academic Health Science Centre (AHSC); or • whose Boards are considering entering into either a major Joint Venture or an AHSC.	
	The Board is satisfied it has or continues to: • ensure that the partnership will not inhibit the trust from remaining at all times compliant with the conditions of its licence; • have appropriate governance structures in place to maintain the decision making autonomy of the trust; • conduct an appropriate level of due diligence relating to the partners when required; • consider implications of the partnership on the trust's financial risk rating having taken full account of any contingent liabilities arising and reasonable downside sensitivities; • consider implications of the partnership on the trust's governance processes; • conduct appropriate inquiry about the nature of services provided by the partnership, especially clinical, research and education services, and consider reputational risk; • comply with any consultation requirements; • have in place the organisational and management capacity to deliver the benefits of the partnership; • involve senior clinicians at appropriate levels in the decision-making process and receive assurance from them that there are no material concerns in relation to the partnership, including consideration of any re-configuration of clinical, research or education services; • address any relevant legal and regulatory issues (including any relevant to staff, intellectual property and compliance of the partners with their own regulatory and legal framework); • ensure appropriate commercial risks are reviewed; • maintain the register of interests and no residual material conflicts identified; and • engage the governors of the trust in the development of plans and give them an opportunity to express a view on these plans.	**N/A**
6	**Training of Governors**	
	The Board is satisfied that during the financial year most recently ended the Trust has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	**Confirmed**

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

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

Where boards are unable to self-certify, they should make an alternative declaration by amending the self-certification as necessary, and including any significant prospective risks and concerns the foundation trust has in respect of delivering quality services and effective quality governance

The Board are unable make one of more of the confirmations on the preceding page and accordingly declare:

A

B

C

Stockport NHS
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	30 June 2016
Subject:	Report of the Chief Executive		
Report of:	Chief Executive	**Prepared by:**	P Buckingham

REPORT FOR NOTING

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

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

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

- Junior Doctors Contract – Appointment of Guardian for Safe Working
- Stockport Together
- Healthier Together
- Care Quality Commission - Draft Inspection Report
- Changes to Executive Team Portfolios
- Publications

Attachments:

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&I 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. JUNIOR DOCTORS CONTRACT – APPOINTMENT OF GUARDIAN FOR SAFE WORKING

2.1 As part of the new junior doctor contract implementation, all Trusts are required to introduce an independent Guardian of Safe Working Hours to oversee the new working patterns. The role includes providing regular reports on the safety of doctors' working hours to the Board of Directors for incorporation into annual reports. To this end, Dr Simon Rendell, one of our ED Consultants, has been appointed to the role with effect from 26 July 2016. The role attracts 1 additional programmed activity per annum.

3. STOCKPORT TOGETHER

3.1 Stockport Together is continuing at pace. The programme is finalising business cases on the new neighbourhood model, intermediate tier services and the acute hospital interface programmes during June /July 2016. The Board will have an opportunity to review these at the July meeting subject to completion on deadline.

4. HEALTHIER TOGETHER

4.1 Regional meetings to support the development of the Healthier Together surgical model continue, this month with a focus on ambulatory care. Our sector was represented by surgeons from Tameside and Stockport, and the Associate Medical Director from Stockport. On Tuesday 28 June 2016 interviews were carried out to appoint a sector clinical champion for Healthier Together. The outcome of these interviews will be updated verbally at the Board. This post will have protected time to facilitate collaborative work with our partner hospitals, to support the development and implementation of the Healthier Together model of care in our sector, and to engage with leads in other sectors of Manchester for mutual support and shared learning.

4.2 In addition on 15 June 2016, there was a further meeting of representatives of the 12 CCG's, previously called the 'committees in common', now termed the 'joint committee'. Provisional feedback from this meeting is that the joint committee have formally agreed that major planned abdominal surgery will only be commissioned in specialist hospitals from next year. We await the exact details of how and when this will be implemented, but anticipate that this will focus attention on the development of a single service solution across our sector.

5. CARE QUALITY COMMISSION (CQC) - DRAFT INSPECTION REPORT

5.1 Board members will be aware that it is now some time since the CQC inspection was carried out in January 2016 and the Trust has been proactively engaging with CQC representatives to determine the timetable for production of the inspection report. We have been advised that the draft inspection report will be forwarded to the Trust for factual accuracy checking at some point during week commencing 27 June 2016. A verbal update on any further

developments will be provided at the Board of Directors meeting on 30 June 2016.

6. CHANGES TO EXECUTIVE TEAM PORTFOLIOS

6.1 Following consideration by the Remuneration and Terms of Service Committee on 16 June 2016, the following changes to Executive Team portfolios were agreed:

- A Deputy Chief Operating Officer to be appointed on a nine month contract commencing September 2016
- Responsibility for Estates and Facilities to be transferred to the Acting Chief Operating Officer during July 2016
- Responsibility for Procurement, Programme Management Office and the Strategic Planning Team to be temporally transferred to the Financial Improvement Director for the duration of his contract with the Trust. On expiry of the contract the current arrangements will be re-instated.
- Responsibility for the newly established Cash Committee will be transferred to the Director of Finance

7. PUBLICATIONS

7.1 Could I draw the attention of the Board of Directors to the following items from issue 81 of the NHS England 'Informed' publication.

- **A New national framework for nursing, midwifery and care staff – Leading Change, Adding Value**

  On 18 May 2016, Professor Jane Cummings, Chief Nursing Officer for England, launched Leading Change, Adding Value - a framework for nursing, midwifery and care staff. The framework sets out how to lead on delivering better outcomes, better experiences for patients and staff, in addition to making better use of resources. The framework is also intended to help staff close the three gaps identified in the NHS Five Year Forward View - the health and wellbeing gap, the care and quality gap, and the funding and efficiency gap.

- **NHS England sets out local NHS funding growth to 2020**

  NHS England has published indicative figures for how much each part of England could see its NHS budget grow by 2020, and the funding available for transformation. This will help local NHS and care leaders develop their Sustainability and Transformation Plans, showing how the NHS Five Year Forward View will be implemented locally, using the growing funding envelope available to each area. NHS England also announced that it would invest around £112 million (2016/17) in the vanguard projects which are leading the way and road testing new models of care in different parts of the county.

- **New Integral Personal Commissioning Emerging Framework**

  NHS England, in partnership with the Local Government Association published The Integrated Personal Commissioning (IPC) Emerging Framework. Setting out the future model of care for patients with some of the most complex needs in England, the framework is based on learning from the programme so far and sets out the changes

required to deliver more joined up health and social care, and enable patients and families to commission their own care through personal budgets. It signals the start of national rollout of IPC, with new areas being asked to signal their interest in becoming early adopters of IPC through local Sustainability and Transformation Plans.

- **Achieving world class cancer services**

  The NHS in England has set out its plan to deliver world class cancer services, which includes a fund to find new ways of speeding up diagnosis with the potential to save thousands more lives every year. The plan, published by the National Cancer Transformation Board which is led by Cally Palmer, National Cancer Director for NHS England, is designed to increase prevention, speed up diagnosis, improve the experience of patients and help people living with and beyond cancer. This will include the rollout of a recovery package throughout the county to ensure that the individual needs of all people going through cancer treatment and beyond are met by tailored support and services.

8. RECOMMENDATIONS

8.1 The Board of Directors is recommended to:

- Receive and note the content of the report.

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Stockport NHS
NHS Foundation Trust

Report to:	Board of Directors	**Date:** 30 June 2016	
Subject:	Risk Management Strategy (Version 1, Issue 4)		
Report of:	Director of Nursing & Midwifery	**Prepared by:** Head of Risk & Customer Services	

REPORT FOR APPROVAL

Corporate objective ref:	**Summary of Report**
Board Assurance Framework ref:	A revised version of the Risk Management Strategy is presented for validation by the Board of Directors following approval by the Risk Management Committee on 27 May 2016. Board members are requested to note that the only changes to document content relate to s6.10 Project Management – Management of Risk.
CQC Registration Standards ref:	
Equality Impact Assessment: Not required	

Attachments:

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
	x Other Risk Management Committee

Stockport NHS
NHS Foundation Trust

RISK MANAGEMENT STRATEGY	
State whether the document is: ☑ **Trust wide** ☒ Business Group ☒ Local	**State Document Type:** ☑ **Strategy** ☒ Standard Operating Procedure ☒ Guideline ☒ Protocol
APPROVAL **VALIDATION**	Risk Management Committee Audit Committee
DATE OF APPROVAL **DATE OF VALIDATION**	April 2016 RMC for version 4 Chair approval Audit Committee April 2016
INTRODUCTION DATE	April 2016
DISTRIBUTION	Risk & Safety Team microsite Governance Leads / Risk Coordinators
REVIEW	**Original Issue Date** April 2003 **Review Date** November 2017
CONSULTATION	Risk Management Committee Executive Team Members
EQUALITY IMPACT ASSESSMENT **INCLUDED AS APPENDIX**	Yes ☑ No ☐
RELATED APPROVED TRUST DOCUMENTS	All Risk Management Standard Operating Procedures/Guidance/Protocols found on the Risk & Safety Team microsite Being Open Policy Complaints Policy Raising Concerns at Work/Whistleblowing Policy Essentials Training SOP BS 10008 – Evidential weight and legal admissibility of electronic information
AUTHOR/FURTHER INFORMATION	Head of Risk and Customer Services Ext 4315
THIS DOCUMENT REPLACES	Risk Management Policy – V8 Rev 3

Document Change History:

Issue No	Page	Changes made (include rationale and impact on practice)	Date
Version 1	All	Full review	September – November 2014
Version 1 Issue 2	6.10	Addition of project management risk management and name changes	September 2015
Version 1 Issue 3	2	Addition of Statement of Intent	Dec 2015
Version 1 Issue 3	15 & 20 24	Changes regarding project management risks and appropriate committee E&D Impact assessment	April 2016

Alignment to the Trust Strategy

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

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

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

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

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

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

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

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

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

*Ref: Full Operational Plan, Monitor submission, 24/4/15

STATEMENT OF INTENT

1.1 This statement provides confirmation of Stockport NHS Foundation Trust's commitment to ensuring effective arrangements for the management and control of all risks in relation to people, structures, assets, reputation and any other issue(s), that could impact upon or compromise the ability to carry out its normal activities and achieve its strategic and organisational objectives.

1.2 The Trust recognises the importance of applying the principles of risk management and the significant values to the organisation by taking a proactive strategic and comprehensive approach to the accountability and organisational arrangements for the management of risk.

1.3 There is a range of benefits that will be achieved. These include: improved patient care, safety of the workplace environment for staff, patients, visitors and stakeholders, managed clinical, financial, strategic, corporate and operational risk.

1.4 The Trust acknowledges that risk is inherent in all aspects of the Trust's activities, including the treatment and care it provides to its patients, the determining of service priorities, the projects and developments it manages, the equipment it purchases, the decisions taken on future strategies, or indeed deciding when no action is to be taken.

1.5 Stockport NHS Trust is required under Section 2(3) Health and Safety at Work Act 1974 (HSWA) to have an annual Board approved strategy and policy for managing risk, that identifies accountability arrangements. It must also contain guidance on what may be regarded as acceptable risk within the organisation.

The Health and Safety Executive have published HSG 65 as a guide to help achieve effective health and safety planning and management. Additionally it provides the benchmark against which we would be externally audited should the Health and Safety Executive become involved with the Trust for whatever reason. The main measurement criteria laid down by HSG 65 can be divided into the following:

i) Policy
ii) Organising
iii) Planning and implementing
iv) Measuring performance
iv) Reviewing and monitoring
v) Audit

The guidance indicates health and safety is a management function. In order to manage this function successfully, the Trust needs to devise and implement a robust management structure responsible for formulating health and safety aims and objectives, developing policies and procedures and assigning responsibilities for implementing the aims and objectives. Finally, the system needs to be monitored with relevant checks and balances to enable the organisation to measure its success. This policy therefore also affects the guidance contained within HSG 65.

1.6 To effectively manage the risk, that is inherent in health care organisations, requires a management culture that engages ALL staff, as everyone is a risk taker. Risk Management is therefore not an addition to our every day work, but must be an integral part of clinical activity, service delivery, operational decisions, business, management, planning cycles, and service development.

1.7 The Trust will ensure deployment of best risk management practices as specified in the NHSLA Standards and other external agencies HSE etc and there are performance management, monitoring and review arrangements in place for its Risk Management Systems.

1.8 The Risk Management Strategy will be reviewed annually, and submitted to the Board of Directors (or delegated sub-board committee) for approval.

1.9 The Trust promotes an open, supportive management culture and uses the management of risk as an opportunity for learning and improvement.

1.10 It encourages the reporting of risks, incidents, hazards and near misses, and will consider disciplinary action only in cases where there is evidence of a breach of law, professional misconduct, malpractice, repetitious incidents, falsehood, deliberate non-reporting of incidents or collusion with the non-reporting of such incidents.

1.11 The management of risk is the responsibility of everyone within the Trust and requires commitment and collaboration from all staff.
Fundamental to the management of risk are the following held values:

- That effective risk management is dependent upon embracing a "fair blame" culture, which encourages open reporting of incidents and near misses from which lessons are learnt.
- That effective risk management systems are an integral part of good practice, and should be incorporated into all aspects of Trust activity.
-

1.12 **Whistleblowing and Being Open:** All employees should be familiar with the Trust's guidance to staff on raising concerns as directed in the Whistleblowing and Being Open Policies.

1.13 This Strategy is directly referenced to BS 1008 and any changes to procedure need to be checked for compliance.

1.14 **Emergency Preparedness, Resilience and Response** (EPRR): Emergency and Business Continuity incidents also represent an organisational risk. The Trusts is designated as a Category 1 responder under the Civil Contingencies Act 2004 and this requires us to adequately plan for and manage a whole range of risks and threats that might occur. Policy and guidance for these types of risk are dealt with separately within the following documents:

- Emergency Preparedness and Business Continuity Management Policy;
- Corporate Emergency Response Guidance;
- Major Emergency Guidance;
- Emergency Preparedness Resilience & Response Threat Assessment & Risk Register; and
- individual plans for specific types of incident.

These documents are available on the Emergency Planning microsite.

2.0 INTRODUCTION

2.1 This document is the strategy for the management of risk at Stockport NHS Foundation Trust. Risk management is an integral component of the Trust's Quality Governance Framework. By complying with the organisational arrangements described in this document, services will ensure the effective identification, assessment and control of risk thereby promoting and supporting the achievement of objectives.

2.2 The achievement of the Trust's strategic objectives is subject to uncertainty, which gives rise to both opportunities (desirable risk) and threats (undesirable risk). Uncertainty of outcome helps to define risk. Risk management includes identifying and assessing risks, and responding to them in an effective and resilient manner.

2.3 At all times the Trust will take all reasonably practicable steps to protect patients, staff, visitors and contractors from the risk of harm.

2.4 The Trust's governance framework shall be supported by an effective risk management system that delivers continuous improvements in safety and quality, and maximises opportunity for growth and

development. Risk management provides a solid foundation upon which to build a culture of high reliability wherein clinical and organisational excellence can flourish.

3.0 PURPOSE

3.1 The overall purpose of risk management at Stockport NHS Foundation Trust is to:

a) Reduce the level of exposure to harm for patients, colleagues or visitors by proactively identifying and managing personal risk to a level as low as reasonably practicable

b) Promote success and protect everything of value to the Trust, such as high standards of patient care, safe working environment, the Trust's safety record, reputation, community relations, equipment or sources of income

c) Continuously improve performance by proactively adapting and remaining resilient to changing circumstances or events.

3.2 The Trust will establish an effective risk management system which ensures that it complies with all relevant Health and Safety Legislation and also:

- All risks that have a potential adverse effect on quality of care, safety and wellbeing of people, and on the business, performance and reputation of the Trust are proactively identified and managed well
- Priorities are determined, continuously reviewed and expressed through objectives that are owned and understood by all staff
- Controls are put in place, effective in their design and application to manage risks, and risk treatment is understood by those expected to apply control
- The operation of controls is monitored by management
- Gaps in control are rectified by management
- Management are held to account for the effective operation of controls
- Assurances are reviewed regularly and acted on
- Staff continuously learn and adapt to improve safety, quality and performance
- Risk management systems and processes are embedded locally across operational localities and in corporate services including business planning, service development, financial planning, project and programme management and education

3.3 The Trust shall achieve this by:

- Developing and driving a clear strategy to meet patient needs
- Actively engaging with patients and the public, colleagues and stakeholders
- Anticipation of opportunities or threats and responsive adaptation through an explicit risk management process
- Regular, effective and sufficient assessments of risk are carried out in all areas of the Trust's operations
- Providing training to keep risk under prudent control
- Investigating thoroughly, learning and acting on defects in care
- Liaising with enforcing authorities, regulators and assessors
- Effective oversight of risk management through team and committee structures
- Formulation and implementation of policies and procedures for all significant hazards arising from the Trust's undertakings
- Effective reporting and arrangements to hold staff to account

3.4 Risk management is everyone's responsibility. This Strategy applies to all employees, contractors and volunteers. All employees are required to co-operate with the Trust in managing and keeping risk under prudent control. Specific responsibilities are placed on members of the management team for ensuring the requirements of this policy are met within their respective areas of control. These are summarised under specific and generic responsibilities on pages 5.

RISK CULTURE – UNDERPINNING OUR VALUES AND BEHAVIOURS

3.5 Effective employee engagement is vital to our success and vision to provide care all of us would recommend to family and friends. Our values and behaviours set out "*the way we do things around here*" and is the result of the widespread adoption of a range of values and behaviours that guide our work. Our guiding values and behaviours are:

- We work together for the benefit of people who use our services;
- We treat people with dignity and respect and place a high value on diversity;
- We are caring and compassionate;
- We are wholly committed to continuously improving the quality of care by striving for excellence in all that we do, and improving lives by being highly ambitious for our patients, our services and our teams;
- We engage and involve everyone in all our activities;
- We learn, are open to challenge and continuously improve.

3.6 By wholeheartedly embracing our values and behaviours in all risk management activity, this policy supports high performance and fosters a culture that is confident about resilience; respects diversity of opinion; involves staff, patients and partners in all that we do; and improves capacity to manage risk at all levels of the organisation.

4.0 ROLES AND RESPONSIBILITIES:

The Board of Directors: The Board of Directors have the overall responsibility and accountability for risk management, for ensuring a sound system of internal control that supports the achievement of the organisations objectives and for reviewing its effectiveness.

The Chief Executive has delegated specific Executive Directors to provide assurance, strengthen accountability and provide support and comprehensive risk management arrangements.

Non Executive Directors: Have responsibility for reviewing the maintenance of an effective system of integrated governance, risk management and internal control across the whole of the organisations activities, clinical and non clinical, which support the achievement of the organisations objectives.

Audit Committee, as members of the Audit Committee, Non Executive Directors will review the adequacy of Risk Management and provide verification to the Board of Directors on the systems in place for the management of risk within the Trust.

Director of Nursing, Midwifery: The Director of Nursing and Midwifery is the nominated Executive Director of the Trust with responsibility for the management of risk, and in partnership with the Medical Director has responsibility for the management of Clinical Governance. They are also the designated Caldicott Guardian for the Trust with responsibility for patient confidentiality and Information sharing issues.

Medical Director: The Medical Director is the nominated Board Member with responsibility for the management of Clinical Governance within the Trust in partnership with the Director of Nursing and Midwifery.

Chief Operating Officer: The Chief Operating Officer is designated as the Accountable Emergency Officer (AEO) with responsibility for all aspects of EPRR risk planning and response management. They are also

the designated Senior Information Risk Owner (SIRO) with responsibility for ensuring the effective management of Information risk and that appropriate assurance mechanisms exist to safeguard the Trust's Information assets and ensuring that this essential element of broader Information Governance is embedded into business processes and functions.

Responsibility for the key Information assets will be assigned to Information Asset Owners (IAOs) to ensure that risk assessments and associated mitigation plans are undertaken for the Information assets that they "own" and, will provide assurance to the SIRO on the security and use of these assets. Information Asset Administrators (IAAs) will provide support to their IAO in managing risks to their Information assets.

Director of Finance: The Director of Finance has overall responsibility for the management of financial risk within the Trust.

Director of Workforce and Organisational Development: The Director of Workforce and Organisational Development is responsible for ensuring staff are recruited within relevant statutory employment legislation and mandatory NHS requirements.

Director of Information: The Director of Information has overall responsibility for the management of Information and IT Infrastructure services including Information Governance (IG) within the Trust. The Information Governance Assurance Framework ensures that organisational information, in particular the personal and sensitive information of patients and staff, is dealt with legally, securely, efficiently and effectively, in order to deliver the best possible care.

Assistant Director of Information Governance and IT Security: Is the nominated Data Protection Lead for the Trust and will support the Director of IM&T in the management of Information Governance across the Trust, including compliance with the annual NHS IG Toolkit assessment that has to be undertaken by the Trust covering the following key areas of assurance

a) Information Governance Management
b) Confidentiality and Data Protection Assurance
c) Information Security Assurance
d) Clinical Information Assurance
e) Secondary Use Assurance
f) Corporate Information Assurance

Deputy Director of Nursing and Midwifery has the overall managerial responsibility for the line management of the Trust's Head of Risk and Customer Services.

Head of Risk and Customer Services:

a) Assist The Director of Nursing in setting the strategic direction for the management of risk across the Trust.
b) Ensure an annual report is submitted to the board on Risk Management.
c) Ensure regular reports are submitted to Assurance Risk Committee on risk management activity with focus on exceptions.
d) Monitor the co-ordination of all Trust activity in the preparation for external risk management reviews.
e) Monitor progress against action plans generated as a result of identified risks
f) Ensure that the Trust risk register is maintained in accordance with the Trusts Risk Register Procedure.
g) Managing the Risk and Safety Team and department.
h) Providing advice, support and training on risk management issues and co-ordinate risk management activities**.**
i) Providing regular reports on risk management activity to the risk management groups/committees.
j) Developing in liaison with managers written safe systems of work.

k) Ensuring an effective and timely dissemination of all risk related communication across the organisation.
l) Monitoring and reviewing risk management performance.
m) Lead and co-ordinate Trust activity for the management and preparation of the Trust for all external risk management accreditation, review and inspection
n) Produce a Risk Management Annual Report for submission to the Trust Board.
o) Ensuring there are systems in place to ensure Trust staff receive appropriate non patient manual handling training and instruction which will include the completion of manual handling risk assessments.
p) Produce Corporate risk register to Assurance Risk Committee for discussion and to highlight over due reviews
q) Production of monthly high profile report detailing high profile inquests, incidents complaints and claims.

Risk and Safety Team Manager:
The Risk and Safety Team manager will, so far as is reasonably practicable assist the Head of Risk and Safety in fulfilling his/her responsibilities.

Patient and Customer Services Team Manager:
a) The Complaints Manager is responsible for ensuring the Trust operates the NHS Complaints regulations effectively and within specified targeted expectations.
b) Monitoring and reporting on the Trusts performance in respect of procedure and outcomes.

Associate Directors, Deputy and Assistant Directors of Nursing/ Head of Midwifery/Governance Facilitators/Ward/Departmental Managers/All Trust Senior Managers:
a) They will encourage the proactive management of risks through effective implementation and monitoring of risk education and training programmes and effective functioning of risk management. Ensuring all Risk Management related policies, procedures and guidelines are implemented and monitored in their area of responsibility.
b) Ensure there are sound communication networks for the distribution of this management information, including feedback mechanisms for incidents and alerts.
c) Ensure that risk management responsibilities are properly assigned, recorded and accepted at all levels.
d) Ensure the assessment of all significant risks associated within their area of responsibility and ensure that the results of these assessments are communicated to staff and that the risks have been effectively controlled.
e) Ensure that procedures relating to their area of responsibility are periodically reviewed for continued effectiveness, and that the timescales for review are included within the procedure documents.
f) Ensure the review of the effectiveness of risk management within their area of responsibility and take action to eliminate deficiencies
g) Ensure that all staff receives appropriate information, instruction and training in accordance with the Trusts risk management training strategy, so that they are aware of and understand risk management support of risk reduction.
h) Ensure that safe systems of work are in place and that their effectiveness is monitored in line with operational management practice.
i) Ensure appropriate monitoring of risk assessments for their area of responsibility and that the Business Group Risk Register is presented to the Business Group Quality Boards or equivalent committee in accordance with the Trusts Risk Register Procedure.
j) Ensure that the Risk and Safety Team is made aware of those accidents, occupational illnesses or dangerous occurances that are defined by RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations) as soon as possible after knowledge of the incident is gained.
k) Ensure that all reported incidents are graded according to severity and likelihood of re-occurrence and where appropriate investigated to determine underlying causes, as specified in the incident reporting policy.

l) Ensure the analysis of incident activity data and identify adverse and favourable trends, formulating action plans as appropriate.
m) Ensure that all employees requiring health surveillance are identified and receive appropriate management.
n) Make adequate provision to ensure that fire and other emergencies situations including first aid requirements are appropriately dealt with.

All Clinical Consultants:

a) Ensure the implementation of risk management principles and promote risk management as a key responsibility.
b) To be aware of and comply with the Trusts mechanisms for incident reporting and risk assessment.
c) Have a responsibility to assess the risks of the clinical services they offer, and in addition inform patients of all common or serious risks relevant to the treatment offered.
d) Ensure that all new medical procedures are assessed for risks and approval obtained before they are commissioned.
e) Ensure all Risk Management related policies, procedures, and guidelines are implemented and adhered to in their area of responsibility.

Responsibilities of Supervisors of Midwives:

a) Supporting women in their choices.
b) Supporting midwives in their practice,
c) Providing a 24 hr. on call rota.
d) Attend SUI/SAE meetings where midwifery practice is a contributory factor
e) Undertaking supervisory investigations of clinical incidents using a format devised by the Local supervising Authority (LSA)
f) Providing a debrief service for service users.
g) Supporting staff through the investigation process.
h) The Contact Supervisor is responsible for receiving the LSA midwifery officers action plan and presenting it to the Business group Quality and governance board.
i) The Contact Supervisor is responsible for ensuring the LSA Annual Report is submitted to the Director of Nursing and Midwifery for inclusion on a Trust Board agenda.

Responsibilities of all Employees, Contractors and Agency Staff:

a) Be familiar with and comply with the Trusts and local risk management policies, standard operating procedures (SOP's) and guidelines.
b) Report incidents and near misses using the recognised channels as set out in the Trust's incident reporting policy.
c) Ensure safe practice in all aspects of work activity.
d) Be aware that they have a duty to take reasonable care of their own health and safety and the safety of all others who may be affected by the Trusts and/their own activities.
e) Comply with all the Trusts rules, regulations and instructions to protect health, safety and welfare of anyone affected by the Trust and/or their own activities
f) Neither intentionally or recklessly interferes with nor misuse any work equipment.
g) Be aware of and understand their role in emergency procedures e.g. resuscitation, fire evacuation and fire precaution procedures.
h) Where Trust staff are working either permanently or temporarily in premises that are managed by another employer, then they must ensure that they make themselves aware of and co-operate with that employers risk management policies and procedures as well as the Trust's.

Trust Resilience Manager: The role of the Trust Resilience Manager involves three risk related responsibilities:

a) To ensure that the Trust is prepared to respond appropriately in the event of a business continuity incident or emergency either internally or externally and to ensure that the Trust is fulfilling its duties as

a category 1 responder under the Civil Contingencies Act 2004 and the Emergency Preparedness, Resilience and Response (EPRR) requirements of NHS England;

b) With regard to The Regulatory Reform Order and all other Fire Safety Issues to fulfil the role of Fire Safety Adviser as defined in HTM 05/01 and to advise the Trust's responsible person under the Management of Health & Safety at Work Regulations; and

c) In conjunction with the Trust Security Manager to ensure that all aspects of personal and property security are fully discharged in accordance with legislation and appropriate guidance from NHS Protect.

Trust Security Manager: - The Trust Security Manager is the nominated competent person to advise the Trust and its Managers on matters of security.

a) Provide security advice/support and training to all Trust staff in accordance with the Trusts Security Policy
b) Review all incidents and risks identified in relation to security matters and undertake risk assessments, either solely or in conjunction with appropriate staff and monitor management plans.
c) Ensure that significant risks and trends in relation to security issues are reported to the Risk Management Committee.
d) Proactively support all levels of management in the development of comprehensive security risk assessments and their review and monitoring arrangements.
e) Develop security performance management standards.
f) Develop in liaison with Managers written safe systems of work relating to security.
g) Ensure an effective and timely dissemination of written communication to all levels of the organisation in relation to security issues.
h) Provide information in relation to security issues in the annual risk management report to the board.

Fire Safety Officer: The Trust Resilience Manager is the nominated competent person to advise the Trust and its Managers on matters of fire safety. The Trust Resilience Manager is supported by Resilience Officer (Fire and Safety) who has responsibility to:

a) Provide fire advice/support and training to all Trust staff.
b) Review all incidents and risks identified in relation to fire matters and undertake risk assessments, either solely or in conjunction with appropriate staff and monitor management plans.
c) Ensure that significant risks and trends in relation to fire issues are reported to the Risk Management Committees.
d) Proactively support all levels of management in the development of comprehensive fire risk assessment.
e) Develop fire performance management standards.
f) Develop in liaison with managers written safe systems of work relating to fire.
g) Ensure an effective and timely dissemination of written communication to all levels of the organisation in relation to fire issues.
h) Provide information in relation to fire issues in the annual risk management report to the board.

Professional Development Specialist: Is the nominated competent person to provide advice and support for all training and development issues to all Trust staff.

a) Provide advice and support on matters relating to risk management training.
b) Ensure Trust staff receive appropriate patient manual handling training and instruction which will include the completion of manual handling risk assessments.
c) Ensure that significant risks and trends in relation to training are reported to the Risk Management Committee.
d) Work with Managers in the development of training strategies and standards of performance.

5.0 COMMITTEES ROLES AND RESPONSIBILITIES:

Through its various management boards, committees and groups the Trust aims to ensure that all risk management issues are dealt with in a co-ordinated manner. (See Appendix 2 Assurance Structure)

Board of Directors: The Board of Directors has the overall responsibility and accountability for risk management, for ensuring a sound system of internal control that supports the achievement of the organisations objectives and for reviewing its effectiveness. The Board of Directors will receive monthly reports from the Sub-Board Committees below to provide assurance of the organisation wide review of the risk register and review process. They will also receive the annual report presented by the Risk and Safety Team.
The Chief Executive has delegated specific Executive Directors to provide assurance, strengthen accountability and provide support and comprehensive risk management arrangements.

Sub-Board Committees: The Trust has a number of Sub-Board Committees who report to the Trust Board of Directors: Four of these (Finance, Strategy & Investment Committee, Quality Assurance Committee BaSF and Workforce and Organisational Development Committee) will have an overall responsibility for the co-ordination and prioritisation of risk management issues within the Trust by ensuring:

- That the Risk Management Strategy is being effectively implemented
- Monitor and review the Trusts corporate risk register and performance indicators
- Give advice on how to manage areas of high or difficult risk
- Oversee the Trusts compliance with strategy and other guidance such as that relevant to Care Quality Commission, Infection Prevention and Control, Medical Devices, Health and Safety, Emergency Planning, Human Resource Issues and Financial Risks
- Provide regular risk management reports to the Board of Directors
- Monitor Corporate Risk Register content and reviews which will have been circulated with the agenda by the Risk and Safety Team as per the requirements of the Trust Risk Register SOP
- Review of monthly high profile report presented by the Risk and Safety Team and develop any required action plans

Quality Governance Committee
The Quality Governance Committee which meets monthly reports directly to the Quality Assurance Committee which in turn reports to the Trust Board of Directors this committee is chaired by the Medical Director and will provide the Quality Committee with assurance that key organisational risks and objectives related to Clinical Quality and Safety (externally and internally set) are being identified and managed effectively.

Risk Management Committee:
The Risk Management Committee meets monthly, chaired by the Director of Nursing and Midwifery, and is the co-ordinating body for all identified risks from across the Trust. The Risk Management Committee will monitor the Trust's management of health and safety, environmental and clinical risk issues.

Information Governance Steering Group/Committee:
Meets every two months, chaired by the Director of IM&T, and is the co-ordinating body to provide a robust Information Governance framework for the current and future management of Information, as part of the Trust's assurance framework. To demonstrate to the Board of Directors and provide assurance that the Trust is meeting its corporate objectives in relation to compliance with the NHS Information Governance Toolkit (IG) and its legal obligations under the Data Protection Act and Freedom of Information Act.

Business Quality Governance Boards:
Must ensure that the requirements in the Risk Management Strategy are adhered to and that all staff are aware of their risk management responsibilities. To review current risk issues, local risk registers and action plans to approve risk assessments for addition to the risk register. Review of monthly high profile report and development of any required group specific action plans.

6.0 RISK MANAGEMENT PROCESS

Management Level of Authority to Treat Risk:

The level of authority, responsibility and the management of risks are clearly defined in the Trust Risk Assessment and the Trust Risk Register Standard Operating Procedures.

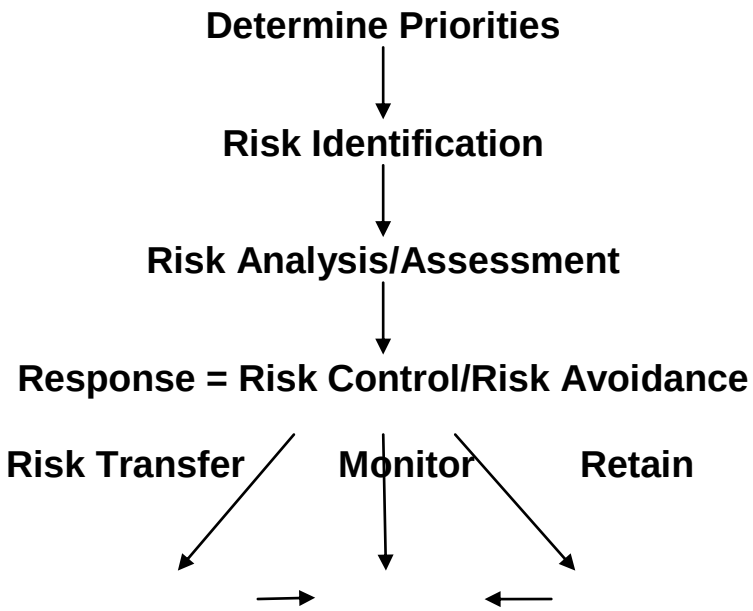
- Executive Directors: are responsible for agreeing the risk assessment score, and the risk treatment plan for risks rated 15 and over in conjunction with the Assurance Risk Committee.
- Risk with a score of either 20 or 25 should be forwarded to the relevant Exec as soon as possible (refer to Risk Assessment Procedure).
- Associate Directors/Directors: are responsible for ensuring with Executive Directors the risk assessment score and the Risk Treatment Plan for risks rated 15 and above. They are also responsible for ensuring suitable and sufficient controls/management of all risks identified in their area, regardless of score
- Senior Managers/Departmental Managers/Ward Sisters: are responsible for ensuring that systems are in place for the identification, evaluation, management and monitoring of risk within their area of responsibility. They are also responsible for attending business group quality boards as required.

Although all systems within healthcare need to be robust and well managed in order to reduce risk, the infrastructure that enables the Trust to function is particularly important to providing a safe well-controlled environment. The primary purpose of the Risk Management Process is to help staff to:

- Improve the quality of care and treatment
- Protect patients and staff from harm
- Eliminate or reduce unnecessary costs

It also provides the mechanism through which the Chief Executive can assure all stakeholders that the Trusts internal controls are effective for managing risk and safety and through which the Trust can learn from mistakes and share best practice.

Risk Management is a proactive approach that addresses every element of the organisations activities and comprises of a determination of properties for the Trust followed by a four-phase cycle as detailed below



Step 1: Determine Priorities

6.1 Risk is defined as the effect of uncertainty on the objective (for a summary of definitions see Appendix 1). The Board of Directors and Senior Management will be clear about objectives for each service and express these in specific, measurable, achievable ways with clear timescales for delivery.

Step 2: Identify Risk

6.2 Risk will be identified by anticipating what is stopping, or could stop, the Trust from achieving stated objectives/strategic priorities. Risk identification concerns future events; it involves anticipation of failure and is based upon consideration of strengths, weaknesses, opportunities or threats. The identification of risk is an ongoing process and is never static, but is particularly aligned to the annual planning process. Staff may draw on a systematic consideration of reasonably foreseeable failures alongside incident trends, complaints, claims histories, patient/staff surveys, observations, formal notices, audits or national reports to identify risk. In order to do this the Board of Directors, senior leaders and locality teams should identify what is uncertain; consider how it may be caused and what impact it may have on the objective.

Risk will be identified from a variety of sources, the following list, whilst not exhaustive, demonstrates many of these;

- Risk Assessments – Strategic, Organisational, Financial, Clinical, Operational
- Incidents and “near misses” reporting
- Claims and Complaints
- Hazards and Safety Alerts and Notices (CAS)
- Internal assessment e.g.: Audit
- External Assessments.
- Lessons learnt, e.g.: Adverse incidents that introduced change
- Inquests.
- Training needs analysis
- Hazard Identification Checklists
- EPRR Threat Assessment and Risk Register

Step 3: Assess Risk

6.3 Evaluate the magnitude of a risk by multiplying the severity of impact by the likelihood of the risk occurring. Be realistic in the quantification of severity and likelihood and use, where appropriate, relative frequency to consider probability. A guide to calculating residual risk and risk scoring matrix guidance is provided in the Risk Assessment SOP available on the Intranet.

6.4 Risks will be routinely analysed to determine their cause, their severity/consequences on the business of the Trust, the likelihood/probability of them occurring or reoccurring and how they may be appropriately managed within Risk Treatment Plans via the business group quality boards

6.5 Levels of Risk the trust has identified criteria by which the level of risk is determined. (Please see the Risk Assessment Process document which is available on the Trust's intranet under Risk and Safety).

Risks are evaluated based on their potential severity and likelihood of the stated severity/consequence occurring. When the Risk Assessment rating criteria is applied a score between 0 and 25 is given.

The actual score is not the most significant factor. The vital element is the Risk Treatment Plan that confirms how that risk will be managed/monitored/minimised and/or eliminated.

Step 4: Respond to the Risk/Risk Control

6.5 Having identified the risk, and agreed a risk score, risk treatment plans are developed by those assessing the risk. This is to eliminate, or minimise risk to its lowest reasonably practicable level possible.

6.6 The main options most likely to be used as treatment plans include:

- Seek - this strategy is used when a risk is being pursued in order to achieve an objective or gain advantage. Seeking risk must only be done in accordance with the Board's appetite for taking risk.
- Accept - this strategy is used when no further mitigating action is planned and the risk exposure is considered tolerable and acceptable. Acceptance of a risk involves maintenance of the risk at its current level (any failure to maintain the risk may lead to increased risk exposure which is not agreed).
- Avoid - this strategy usually requires the withdrawal from the activity that gives rise to the risk.
- Transfer - this strategy involves transferring the risk in part or in full to a third party. This may be achieved through insurance, contracting, service agreements or co-production models of care delivery. Staff must take advice from the Executive Team before entering into any risk transfer arrangement.
- Modify - this strategy involves specific controls designed to change the severity, likelihood or both. *This is the most common strategy adopted for managing risk at the Trust*. For this reason, we expand on the nature of control as follows:

There are three types of control used to modify risk and comprise of:

- **Prevention/Treatment** - these controls are core controls and are designed to prevent a hazard or problem from occurring. They typically involve policies, procedures, standards, guidelines, training, protective equipment/clothing, pre-procedure checks etc.

- **Detection** - these controls provide an early warning of core control failure, such as a smoke alarm, incident reports, complaints, performance reports, audits

- **Contingency** - these controls provide effective reaction in response to a significant control failure or overwhelming event. Contingency controls are designed to maintain resilience.

A combination of all 3 types of control is usually required to keep risk under prudent control.

For more information please refer to the Risk Assessment Procedure on the Trust's Risk and Safety Intranet site.

Step 5: Report Risk

6.7 Key outputs from the risk management system shall be reported to relevant staff/committees depending on the residual risk score as follows:

All Risks Assessments
All risk assessments must receive initial approval from their relevant business group quality governance board. In the case of a specialist committee or the Corporate Team completing a risk assessment this is not required however initial approval should be sought from the relevant committee or Executive.

Risks 15 or above
All risk assessments scoring 15 must then be presented at the next Risk Management Committee for validation of the score. This then will be noted as having corporate approval and will be included in the Corporate Risk Register as well as the Finance and Strategic Risk Registers as appropriate.

Risks scoring 25
Once any risk has been identified as scoring 25 it must be immediately reported to the relevant Associate Director/Exec Director and discussed as soon as possible with the Director of Operations.

See appendix 3

Step 6: Review Risk

6.8 Review risk at a frequency proportional to the residual risk.. As a guideline it is suggested, as a minimum, risk is reviewed as follows:

- All Risks 15 or above – at least monthly
- All Risk 10-14 – at least quarterly
- All Risks 8-10 at least bi-annually
- All risks 6-8 – annually.

EPRR Risk Management

6.9 It is important to recognise that the process of risk assessment for emergency preparedness and business continuity purposes is similar to but subtly different from the risk assessment process undertaken for health and safety purposes.

The reasons for the difference are that:

i. As an organisation we are unable to directly affect the likelihood of some threats materialising (e.g. a terrorist attack on the city centre or severe weather) – we can only have mitigation plans in place to minimise the consequence;
ii. For business continuity events such as disruption to off-site utilities supply we are similarly unable to reduce likelihood, whereas we can reduce the likelihood of incidents affecting our on-site infrastructure. With regard to consequence we are able to mitigate either off-site or on-site incidents by provision of appropriate contingencies;
iii. Whilst every effort must be made to prevent events that would disrupt "business as usual", the starting point for effecting business continuity and recovery is the point at which the event

has happened. Therefore the application of the conventional 5x5 Likelihood against Consequence Matrix needs to be applied differently. Because the event has happened, Likelihood must always be scored as 5 and therefore the possible Trust scores for EPRR risk assessment can only ever be 5, 10, 15, 20 or 25. The rules for scores of 15 and 25 as outlined in Paragraph 6.7 do not therefore apply to EPRR risks.

From point iii. above, it is important to recognise that the Trust's approach to EPRR is both reactive and proactive. Most published documentation provides policy guidance on what to do when an event has happened. However, whilst it is important and wholly appropriate to have such contingencies in place, the real key to effective EPRR is to ensure that the likelihood of any threat is minimised and wherever possible eliminated. As referenced in point ii. above, this is only really achievable for matters under our direct control. As EPRR is defined as anything that does or has the potential to disrupt service delivery, this must be seen as extending to include all business management processes and systems.

Project Management – management of risk

6.10 Innovation and development is an essential part of improving patient care and the sustainability portfolio contains a number of projects to deliver this ambition. These projects are overseen by the Portfolio Management Office (PMO) and monitored by the Strategic Development Committee. The PMO manages the Integrated Delivery Plan risk register which includes the Sustainability Portfolio (replacing the BaSF portfolio)

It is recognised that project development needs to include robust risk identification and management and risk monitoring. To achieve this in a timely and robust manner all projects will include monthly review of all identified risks.

Risks which score below 12 will not be required to be entered on the Datix risk management system but will be recorded on the PMO Risk Register. These risks will be monitored monthly whether by meeting or by chair review. Project managers are expected to regularly review these risks and ensure there are robust and timely actions in place.

Risks which are scored at 13 and above will be required to be added to the Datix Risk Management system and then will be requried to be monitored and recorder as per the standard process for risk assessment.

Risks which score 15 or above will become "corporate" risks as per this policy and associated SOP and should be managed as such.

Close liaison between the Project Management Office and the Risk and Customer Services is essential to this process.

7.0 RISK REGISTERS

A Risk Register is a management tool that contains current risks facing the organisation enabling the Trust to review and manage its comprehensive risk profile. It can be described as a "repository of risks" of all kinds that threatens the Trust's success in achieving its declared aims and objectives. It is a dynamic living document which is populated through the organisations risk assessment and evaluation process. This enables risk to be quantified, ranked and information about the risks to be collated and analysed. Providing a structured methodology to decision making and ensures consistency in the treatment of all risk. Risk registers used within the trust include:

Corporate Risk Register – presented to the Risk Management Committee and Quality Governance Committee monthly, which includes <u>all</u> current risks scoring 15 or above.

Strategic Risk Register – presented to the Board of Directors monthly, which includes all current risks scoring 15 or above which relate to the strategic aims of the Trust.

Finance Risk Register – presented to the Finance, Strategy & Investment Committee monthly, which includes all current risks scoring 15 or above which relate to Finance, IM & T and Estates.

Business Group Risk Register – presented to the business group quality governance board monthly, which includes all business group current risks.

Emergency Preparedness Resilience & Response Threat Assessment & Risk Register – presented to the Trust Resilience Group and approved by the Chief Operating Officer

8.0 RISK MANAGEMENT FUNDING

The Trust has a variety of budgets to address risk:

a) **Trust Capital Annual Programme:** This budget is used to address any business cases submitted. All Business cases are supported by a risk assessment.

b) **Risk Management Issues (Risk and Health and Safety Budget):** Divisions are able to submit for consideration/approval statements of need to the Risk Management Committee. The definition of 'statement of need' in this instance is a Risk Assessment of an identified Health and Safety issue which includes or is accompanied by an explanation of the 'need', a risk treatment plan and full costing.

It must also meet the following criteria:-

- The cost must be between £1,000 and £5,000, inclusive of VAT.
- The cost must be of a non-recurrent nature.
- The risk must be unforeseen (e.g. not planned or predictable items/issues/replacements).

Further information can be found in the 'Criteria for bids' document, found on the Trust's Risk and Safety Intranet site.

c) **Emergency Reserves:** In the event of an unplanned emergency that requires funding, the Executive Team can approve this.

9.0 RISK MANAGEMENT TRAINING

The Risk and Safety Team will determine what risk management training provision is required for the Trust following the annual review of the Training Matrix (part of the Mandatory Training Standard Operating procedure available on the training microsite) It is the responsibility of Deputy and Assistant Directors of Nursing/Clinical Governance Facilitators/Ward/Departmental Managers/All Trust Senior Managers who are aware of training requirements for their staff, to work with the Training and Risk and Safety Team in monitoring compliance.

10.0 AUDIT - INTERNAL

In compliance with the Department of Health, the Trust's Internal Auditors will provide an annual opinion to the Chief Executive and the Stockport NHS Foundation Trust Board (via the Audit Committee) on the effectiveness of the system of internal control. An essential element of this assurance will include a review of the Trust's risk management framework.

The Trust appointed Internal Auditors will undertake a range of audits, as detailed in the Trust approved annual Audit Plan, submitted by the Audit Committee. The Chief Internal Auditor will annually undertake a Risk Management Audit, and provide an opinion statement to Quality Assurance Committee.

11.0 AUDIT - EXTERNAL

The Chief Executive is responsible for nominating, delegating, or appointing a suitable individual to co-ordinate and report on any audits or reviews carried out by external agencies. These can include: NHSLA; PLACE, HSE, etc. (please see the External Recommendations SOP available on the Risk and Safety Microsite.

12.0 STRATEGY COMMUNICATION

The Policy is available to all staff and relevant stakeholders via the intranet on the Trust Risk and Safety Intranet Microsite or local management procedures to staff who do not have access to the intranet.

13.0 ASSURANCE FRAMEWORK:

The Trust's Assurance Framework will be reviewed and monitored by the Quality Assurance Committee. A summary report of this committee meeting will be forwarded to the Board of Directors.

14.0 MONITORING:

A range of key performance indicators have been identified. These will assist in the monitoring of this strategy.

Process for monitoring e.g. audit	**Responsible individual/ group/ committee**	**Frequency of monitoring**	**Responsible individual/ group/ committee for review of results**	**Responsible individual/ group/ committee for development of action plan**	**Responsible individual/ group/ committee for monitoring of action plan**
Risk Management Report	Risk and Safety Team	Annual	Risk Management Committee	Risk and Safety Team	Risk Management Committee
Compliance Monitoring Annual adherence to policy: snapshot audit (which will include all business groups) to confirm	Risk and Safety Team	Annual	Risk Management Committee	Risk and Safety Team	

that over the previous year a. that the risk management structure is adhered to b. that the process for board or high level committee review of the risk register c. process for the management of risk locally reflects the organisation wide risk management strategy d. duties as listed are adhered to e. monitoring is adhered to					
ISO 22301 Accreditation	Resilience Team	Annual	Trust Resilience Group/AEO	Resilience Team	Trust Resilience Group/AEO

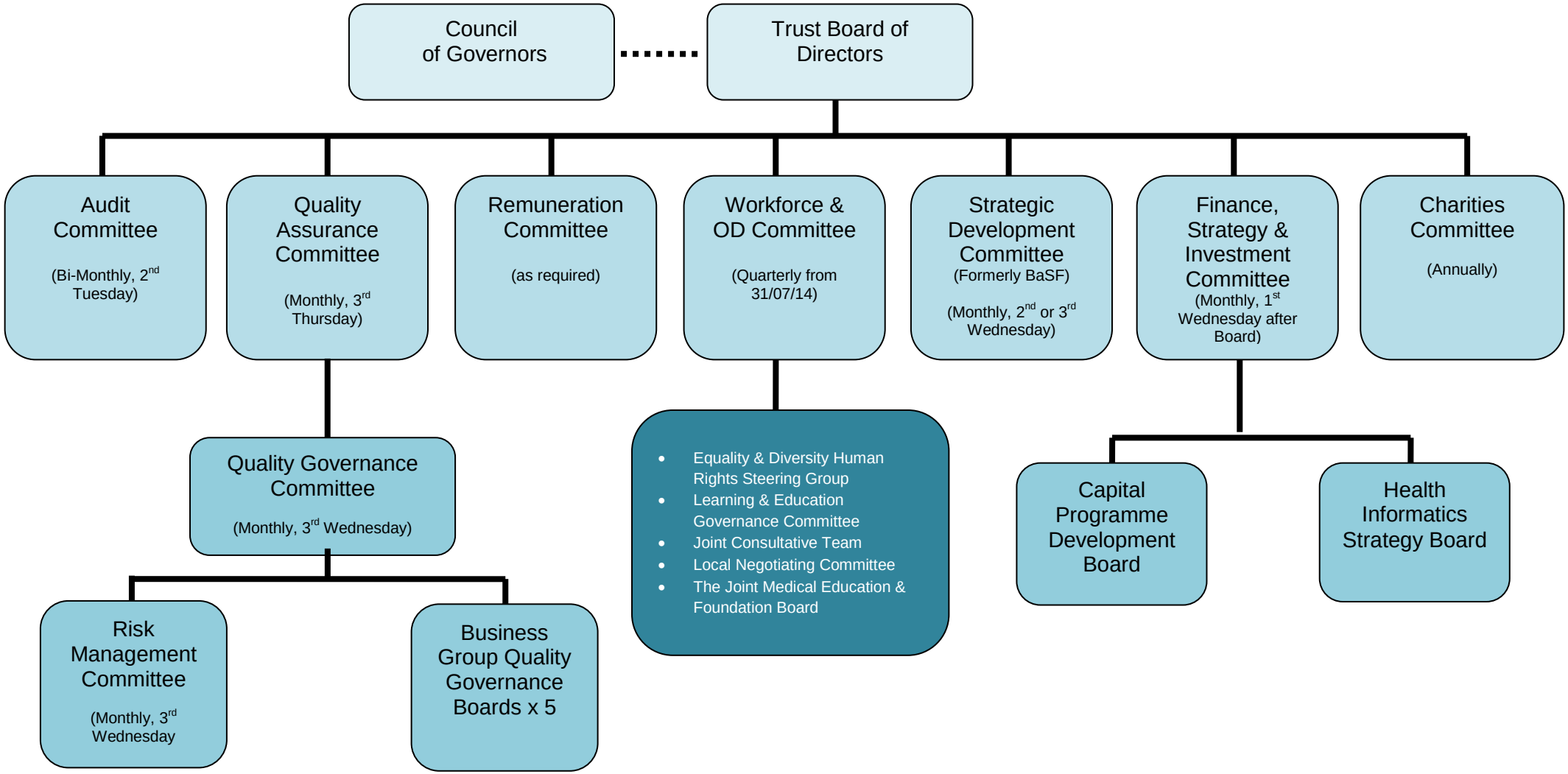
Appendix 1: Glossary of Terms

Risk management will operate under a common language. Adopting standard risk management terms and definitions set out in the Risk Management Code of Practice (BS 31100:2008) will improve consistency and avoid confusion. Common terms may include:

Board Assurance Framework	**A document assuring the operation of controls to manage material risk to the business as a whole**	**Risk**	**Effect of uncertainty on objectives**
Control	**Intervention used to modify risk**	**Risk acceptance**	**Informed decision to take a particular risk**
Exposure	**Extent to which the organisation is subject to an event**	**Risk aggregation**	**Process to combine individual risks to obtain more complete understanding of risk**
Hazard	**Anything that has potential for harm**	**Risk analysis**	**Process to comprehend the nature of risk and to determine the level of risk**
Incident	**Event in which a loss occurred or could have occurred regardless of severity**	**Risk appetite**	**Amount and type of desirable risk the organisation is prepared to seek, accept or tolerate**
Inherent risk	**Exposure arising from a specific risk before any intervention to manage it**	**Risk assessment**	**Overall process of risk identification, risk analysis and risk evaluation**
Level of Risk	**Magnitude of a risk expressed in terms of the combination of consequences and their likelihood**	**Risk avoidance**	**Decision not to be involved in, or to withdraw from, an activity based on the level of risk**
Material Risk	**Most significant risk or those on which the Board or equivalent focuses**	**Risk management**	**Coordinated activities to direct and control the organisation with regard to risk**
Near Miss	**Operational failure that did not result in a loss or give rise to an inadvertent gain**	**Risk owner**	**Person or entity with the specific accountability and authority for managing the risk and any associated risk treatments**
Operational Risk	**The risk of loss or gain, resulting from inadequate or failed internal processes, people and systems or from external events**	**Risk Register**	**A record of information about identified risks.**
Programme Risk	**Risk associated with transforming strategy into solutions via a collection of projects**	**Target Risk**	**A level of risk being planned for**
Residual risk	**Current Risk – The Risk remaining after risk**		

	treatment		

Appendix 2 (Risk Management Structure)



Appendix 2, continued

Quality Assurance Committee

Report	Person Responsible	Frequency
Quality Governance Committee Key Issues	Medical Director	Monthly
High Profile Report	Head of Risk and Customer Services	Monthly
Corporate Risk Register (Q&P)	Director of Nursing and Midwifery	Monthly

Workforce & Organisational Development Committee

Report	Person Responsible	Frequency
Equality Diversity & Human Rights Steering Group	Equality and Diversity Manager	Quarterly
Engagement & Culture Programme	Head of OD and Learning	Quarterly
Learning & Education Governance Committee	Head of OD and Learning	Quarterly
Joint Consultative Team	Director of Workforce and OD	Quarterly
Local Negotiating Committee	Medical Director	Quarterly
Cultural Dashboard	Director of Workforce and OD	Quarterly
IPR-Workforce (C&BG)	Director of Workforce and OD	Quarterly
Annual Staff Survey Report	Director of Workforce and OD	Annual
Friends & Family Staff Survey	Director of Workforce and OD	Quarterly
The Joint Medical Education & Foundation Board	Medical Director	Quarterly

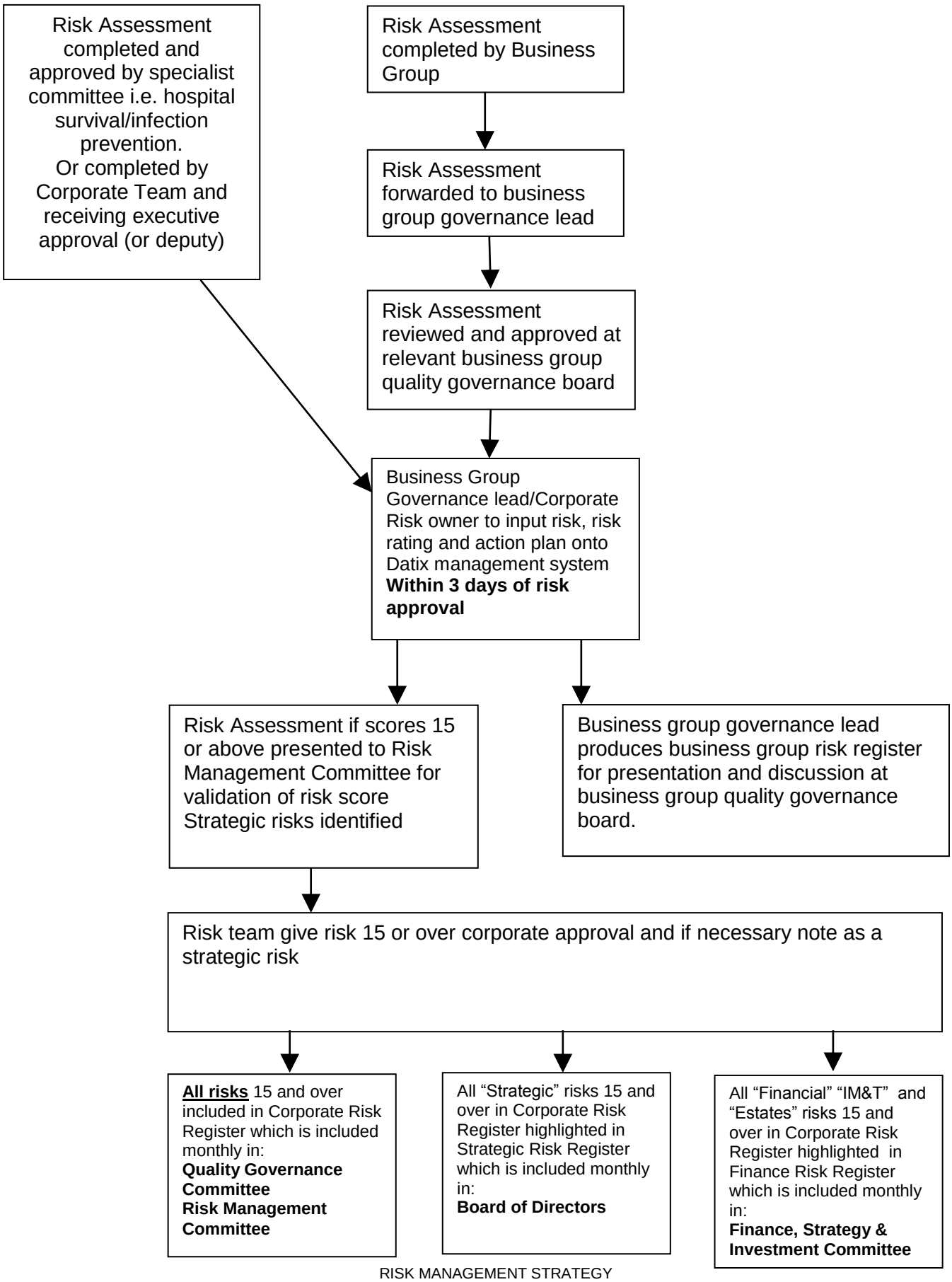
Finance, Strategy & Investment Committee

Report	Person Responsible	Frequency
Capital Programme Development Board	Director of Estates and Facilities	Monthly
Finance Report Suite	Director of Finance	Monthly
CIP Report	Director of Finance	Monthly
Annual Plan and Progress Reports	Director of Finance	Annually & as required
KPIs for Commercial Activities	Director of Finance	Monthly
Treasury Management Report	Director of Finance	1/2ly
IM&T Issues Report	Director of IG	Monthly

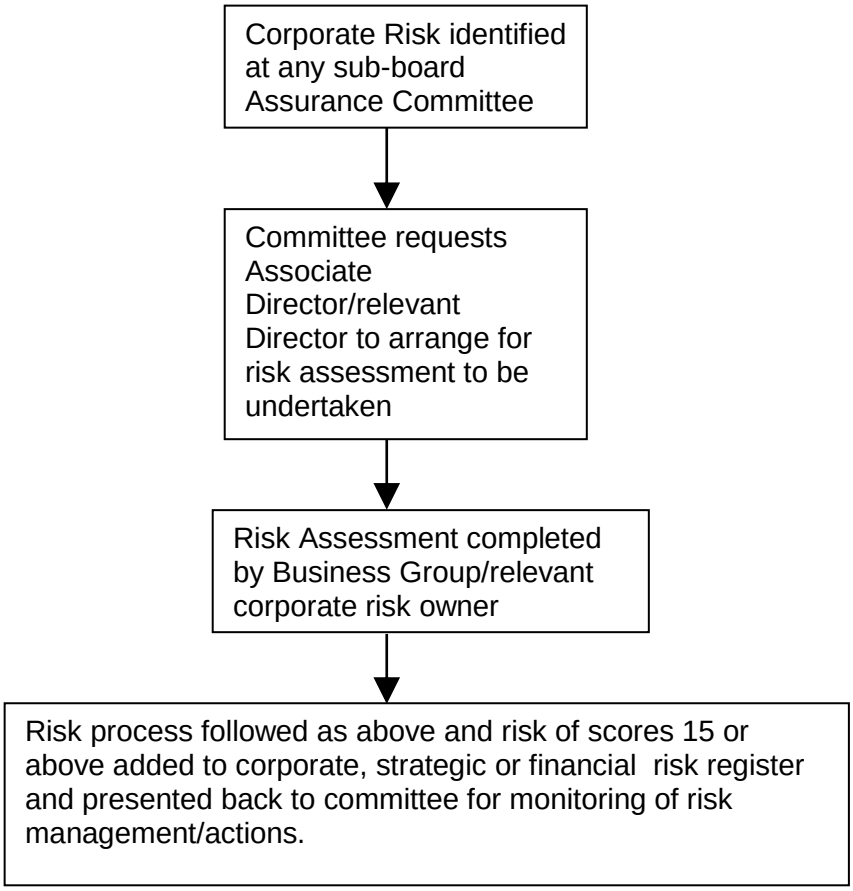
Appendix 3

Governance arrangements: reporting processes

1. Assurance process for escalation and notification of risk



1. Process for the notification of concern or risk and request for action from Quality Assurance Committee and Board of Directors



Appendix 1 **Equality Impact Assessment**

1	**Name of the Policy/SOP/Service**	Risk Management Strategy	
2	**Department/Business Group**	Nursing	
3	**Details of the Person responsible for the EIA**	**Name:** **Job Title:** **Contact Details:**	Cathie Marsland Head of Risk and Customer Services 4315
4	**What are the main aims and objectives of the Policy/SOP/Service?**	This strategy details the process for the management of risk across all services to ensure the effective identification, assessment and control of risk thereby promoting the achievement of objectives	

For the following question, please use the EIA Guidance document for reference:

5	**A) IMPACT** **Is the policy/SOP/Service likely to have a <u>differential</u> impact on any of the protected characteristics? If so, is this impact likely to be positive or negative?** **Consider:** • Does the policy/SOP apply to all or does it exclude individuals with a particular protected characteristic e.g. females, older people etc? • What does existing evidence show? E.g. consultation from different groups, demographic data, questionnaires, equality monitoring data, analysis of complaints. Are individuals from one particular group accessing the policy /SOP /Service more/less than expected?	**B) MITIGATION** **Can any potential negative impact be justified? If not, how will you mitigate any negative impacts?** ✓ Think about reasonable adjustment and/or positive action ✓ Consider how you would measure and monitor the impact going forward e.g. equality monitoring data, analysis of complaints. ✓ Assign a responsible lead. ✓ Designate a timescale to monitor the impacts. ✓ Re-visit after the designated time period to check for improvement.	**Lead**
Age	No impact as applies to all staff regarding all users and staff		
Carers / People with caring responsibilities	No impact		
Disability	No impact		

Race / Ethnicity	No impact		
Gender	No impact		
Gender Reassignment	No impact		
Marriage & Civil Partnership	No impact		
Pregnancy & Maternity	No impact		
Religion & Belief	No impact		
Sexual Orientation	No impact		
General Comments across all equality strands	The Risk Management Strategy can be equality monitored by age, gender, ethnicity etc.		

EIA Sign-Off	**Your completed EIA should be sent to Sue Clark , Equality and Diversity Manager for approval and publication:** Susan.clark@stockport.nhs.uk **0161 419 4784**

If you would like this policy in a different format, for example, in large print, or on audiotape, or for people with learning disabilities, please contact:
Sue Clark, Equality & Diversity Manager, Aspen House, Stepping Hill Hospital.
Tel: 0161 419 4784. Email: susan.clark@stockport.nhs.uk

This information can be provided in other languages and formats if you are unable to read English. Please contact the Patient and Customer Services department and inform them of your preferred language. The department telephone number is 0161 419 5678. You could also email PCS@stockport.nhs.uk.

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