Stockport NHS
NHS Foundation Trust

# BOARD OF DIRECTORS

# PUBLIC MEETING

## 31 MARCH 2016

Your Health. Our Priority.

Board of Directors Meeting 31 March 2016

This page has been left blank

Stockport NHS
NHS Foundation Trust

March 2016

Dear Colleague

You are invited to a meeting of the Board of Directors which will be held on **Thursday 31 March 2016 at 1.15pm in Lecture Theatre B, Pinewood House, Stepping Hill Hospital.**

An agenda for the meeting is detailed below.

Yours sincerely

**GILLIAN EASSON**
**CHAIRMAN**

**********

| AGENDA ITEM | TIME |
|---|---|
| 1. Apologies for Absence. | 1.15pm – 1.20pm |
| 2. Declaration of Amendments to the Register of Interests. | " |
| 3. **OPENING MATTERS:** | |
| 3.1 To approve the minutes of the previous meeting of the Board of Directors held on 25 February 2016 (attached). | 1.20pm – 1.25pm |
| 3.2 Patient Story (Report of Director of Nursing and Midwifery attached). | 1.25pm – 1.35pm |
| 3.3 Report of the Chairman. | 1.35pm - 1.45pm |
| 4. **TRUST ASSURANCE / GOVERNANCE:** | |
| 4.1 Trust Performance Report – Month 11 (Report of Chief Operating Officer attached). | 1.45pm – 2.00pm |
| 4.2 Board Assurance Framework (report of Chief Executive attached). | 2.00pm – 2.10pm |
| 4.3 Strategic Risk Register (Report of Director of Nursing and Midwifery attached). | 2.10pm – 2.20pm |
| 4.4 Maintaining Safe Staffing Levels (Report of Director of Nursing & Midwifery attached) | 2.20pm – 2.30pm |
| 4.5 Key Results of Staff Survey 2015 (Report of Director of Workforce & OD attached) | 2.30pm – 2.40pm |
| 4.6 Revenue Budgets 2016/17 (Report of Director of Finance attached) | 2.40pm – 3.00pm |

| AGENDA ITEM | TIME |
|---|---|
| 4.7 Operational Plan 2016/17 (Report of Chief Operating Officer attached) | 3.00pm – 3.10pm |
| 4.8 Key Issues Reports from Assurance Committees:<br>4.8.1 Workforce & Organisational Development Committee - 29 February 2016 (attached and Carol Prowse to report)<br>4.8.2 Audit Committee - 1 March 2016 (attached and Malcolm Sugden to report)<br>4.8.3 Finance & Investment Committee - 2 March 2016 (attached and Malcolm Sugden to report)<br>4.8.4 Quality Assurance Committee - 24 March 2016 (to follow and Mike Cheshire to report) | 3.10pm – 3.30pm |
| 4.9 Amendments to the Constitution (Report of Company Secretary attached) | 3.30pm – 3.35pm |
| 5 **STRATEGY AND DEVELOPMENT:** | |
| 5.1 Report of Chief Executive (attached). | 3.35pm – 3.40pm |
| 5.2 Leadership Strategy (Report of Director of Workforce & OD attached). | 3.40pm – 3.45pm |
| 5.3 Shadow Provider Board – Memorandum of Understanding (Report of Chief Operating Officer attached). | 3.45pm – 3.55pm |
| 6 **CLOSING MATTERS:** | |
| 6.1 Any Other Urgent Business. | " |
| 6.2 Date of next meeting:<br>• Thursday 28 April 2016, 1.15pm, in Lecture Theatre B, Pinewood House, Stepping Hill Hospital. | " |

**STOCKPORT NHS FOUNDATION TRUST**

**Minutes of a meeting of the Board of Directors held in public on Thursday 25 February 2016 1.15pm in Lecture Theatre A, Pinewood House, Stepping Hill Hospital**

**Present:**

| | |
|---|---|
| Mrs G Easson | Chairman |
| Mrs C Anderson | Non-Executive Director |
| Dr M Cheshire | Non-Executive Director |
| Mrs C Prowse | Non-Executive Director |
| Mr J Sandford | Non-Executive Director |
| Mr J Schultz | Non-Executive Director |
| Mr M Sugden | Non-Executive Director |
| Mr F Patel | Director of Finance |
| Mrs J Shaw | Director of Workforce & Organisational Development |

**In attendance:**

| | |
|---|---|
| Mr P Buckingham | Company Secretary |
| Mrs S Curtis | Membership Services Manager |
| Mrs A Gaukroger | Director of Strategy and Planning |
| Mr T Roberts | Deputy Director of Nursing and Midwifery |
| Ms S Toal | Director of Operations |

**50/16 Apologies for Absence**

Apologies for absence had been received from Mrs A Barnes, Dr J Catania, Mrs J Morris, Ms A Smith and Mr J Sumner.

**51/16 Declaration of Amendments to the Register of Interests**

No interests were declared.

**52/16 Minutes of the previous meeting**

The minutes of the previous meeting held on 28 January 2016 were approved as a true and accurate record of proceedings subject to one amendment to minute number 27/16 'Maintaining Safe Staffing Levels'. Mrs C Prowse advised that she had visited Shire Hill with Mrs J Morris and Dr M Cheshire in December 2015, not with Mrs A Barnes as had been stated in the minutes.

The action tracking log was reviewed and annotated accordingly.

**53/16 Patient Story**

Mr T Roberts presented this report and reminded the Board that the purpose of patient stories was to bring the patient's voice to the Board, providing a real and personal example of the issues within the Trust's quality and safety agendas. He noted

that this story of care was a good example of patient centred care and care planning and joined up working with families and carers.

Mr J Schultz noted that patient stories should be celebrated as well as used to improve care and queried whether this was commonplace across the Trust. Mr T Roberts confirmed that this was the case but agreed that the process could be enhanced. Mrs C Prowse noted that she had found the story uplifting and commended the individual care provided to the patient which was a credit to all staff involved.

The Board of Directors:

- Received and noted the Patient Story report.

**54/16 Report of the Chairman**

Mrs G Easson informed the Board of the following recent developments:

- Funeral of Mr K Brennan, Director of IM&T – Mrs G Easson reported the sad death of Mr K Brennan who had passed away the previous week. Mr K Brennan had worked at the Trust for over 30 years and had made an immense contribution to IM&T, clinical IT system such as Advantis and paperless ED. Mrs G Easson noted that Mr K Brennan would be greatly missed by all who worked with him and wished to offer condolences on behalf of the Board to Mr Brennan's family. Mrs G Easson advised that the funeral was being held that afternoon and noted that Mrs A Gaukroger, Mr T Roberts and Ms S Toal were in attendance at the Board meeting to deputise for colleagues attending the funeral.

- Emergency Department Performance – the Board was advised of the continued pressures faced by the Emergency Department and it was noted that delayed transfers of care along with a high number of elderly and frail patients remained the main area of concern. Mrs G Easson noted that patient safety remained the key priority.

- Junior Doctors' Strike – the Board was briefed about the contingency plans in place for the planned industrial action in March 2016.

- NHS Improvement Workshop – held on 22 February 2016 regarding the Emergency Department Performance.

- CQC Inspection – the Board noted that the final report following the CQC inspection held in January 2016 was awaited in a few months' time.

The Board of Directors:

- Received and noted the verbal report.

**55/16 Trust Performance Report – Month 10**

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

The Board noted that there was one area of non-compliance in month 10 which was the non-achievement of the Accident & Emergency (A&E) 4-hour target. It was noted that the main factor impacting on patient flow continued to be the delayed transfers of care which had led to the lack of available beds. Ms S Toal advised that currently an average of 36 medical outliers per day were occupying surgical and escalation beds. The Board noted that in addition to this issue, there had been a 10% increase in Emergency Department (ED) attendances in January 2016 compared to this time last year.

The Board was advised that the Trust had attended an escalation meeting in February with NHS Improvement regarding its A&E performance and was attending another meeting in London on 1 March 2016 where the 30 most challenged providers were coming together to look at ways to resolve the current situation. Ms S Toal advised that the Trust had submitted an improvement trajectory to NHS Improvement on 19 February 2016.

Ms S Toal noted that despite the delays in discharge which were largely out of the Trust's control, it was recognised that there were internal improvements that could be made and all staff were being engaged in a campaign to make incremental small changes in an effort to avoid breaches of the standard. The Board noted that the Trust had also engaged senior leaders in the health economy to look at system-wide processes.

In reply to a question from Mrs G Easson, Mr T Roberts briefed the Board with regard to the Trust's Length of Stay Project. Mr J Schultz noted the encouraging direction of the length of stay work which, he advised, was a result of the Trust's innovation work. In reply to a question from Mr J Sandford, Mr T Roberts advised that as well as considering new processes, the Trust was reviewing areas of current best practice and ensure it was cascaded throughout the Trust. Reference was also made to a forthcoming process mapping event, alignment of the work with the Trust's strategic staircase and a Task & Finish Group which had been established regarding earlier discharges.

Mrs C Prowse made reference to the Board's frustration of the continued non-achievement of the A&E 4-hour target despite staff working relentlessly. She noted the need for smarter working and keeping staff morale up whilst maintaining patient safety. Dr M Cheshire made reference to the enormous amount of work that needed to be done and advised that the Quality Assurance Committee would continue to keep the issue under close review.

Mrs G Easson noted the high level of concern with regard to the Emergency Department performance and made reference to the issues in social care, delayed

discharge and non-achievement of the target across Greater Manchester. Mrs G Easson commented that Stockport Together would be key to longer term improvement and, in shorter term, welcomed the Length of Stay Project and incremental work. Mr P Buckingham reminded the Board that they should not lose sight of the fact that, apart from the A&E 4-hour target, the Trust was compliant in all other areas of the regulatory framework.

In reply to a question from Mrs C Prowse who queried the continued deterioration of the Gastroenterology waiting list, Ms S Toal advised the Board that the Trust had recently appointed two Gastroenterology Consultants, one of whom had already started in post. Ms S Toal also made reference to a review undertaken with General Practitioners with regard to pathway changes and noted that this, combined with the commencement of the two new Consultants, would lead to improvement in Gastroenterology.

Mrs C Anderson made reference to chart 84 of the Integrated Performance Report which showed the rate of misadventure against National Hospital Episodes Statistics (HES) peer group and queried whether this was a coding issue. Mr P Buckingham agreed to find out the answer to Mrs C Anderson's question outside of the meeting.

In reply to a question from Mr M Sugden who queried the robustness of the financial forecast assurance, Mr F Patel advised the Board that the Clinical Commissioning Group (CCG) had agreed not to invoke penalties for 2015/16 and noted that this would contribute £1.4m towards the expected £1.7m reinvestment of penalties included in the refreshed Annual Plan. He also noted that significant amounts of money were attached to the performance against the national and local CQUIN targets and that guaranteed overall achievement of minimum of 85% could benefit the Trust's financial position for the year end.

With regard to the High Profile Report, Mr T Roberts advised that the theme noted in month had been non-adherence to policies and processes with regard to Falls. He briefed the Board on mitigating actions which included a peer review and a robust monthly audit. In response to a question from Mr J Sandford who queried incident ID 132649 (Delayed diagnosis / treatment), Mr T Roberts provided assurance that this was not a systematic issue.

The Board of Directors:

- Received and noted the contents of the Trust Performance Report
- Noted the current position for month 10 compliance standards
- Noted the future risks to compliance and mitigating actions
- Noted the key risk areas from the Integrated Performance Report.

**56/16 Registration Authority Annual Report 2015/16**

Mrs A Gaukroger presented the Registration Authority Annual Report 2015/16 which provided assurance that the Trust was compliant with the requirements against the Information Governance Toolkit and National Registration Authority Policy. In reply to a question from Mr J Schultz, Mrs A Gaukroger advised that NHS Smart Cards provided certain members of staff with different levels of authority in accessing patient records.

The Board of Directors:

- Received the report and noted the positive assurance provided on Trust compliance with Information Governance requirements.

**57/16 Strategic Risk Register**

The Board of Directors considered the Strategic Risk Register as at February 2016. Dr M Cheshire made reference to the 'Top Five Sources of Risk across the Trust' pie chart and queried the discrepancy between the highlighted risks in the pie chart and the risks detailed in the narrative of the report. Mr T Roberts advised that the pie chart outlined the top five sources of risks across the Trust whereas the risks included in the narrative had a risk score of 15 or above. It was proposed that Mr P Buckingham and Mr T Roberts would review the presentation of future reports.

The Board of Directors undertook a page by page review of the Strategic Risk Register. In reply to a question from Mr J Sandford with regard to risk ID 2777 ('Maternity Safeguarding Practice'), Mr T Roberts advised that the risk was being monitored through the Risk Management Group and noted that the two open actions had taken place but were yet to be audited. In reply to a question from Mrs G Easson who made reference to the high risk score (25) of risk ID 2899 ('Delivery of the Sustainability and Transformation Fund Conditions'), Mr F Patel briefed the Board on mitigating actions and noted that the Board would receive a further update with regard to this risk at the next meeting.

Mr J Sandford made reference to the risks that were no longer on the Strategic Risk Register and noted that two of these had a risk rating of 15 or above. It was proposed that future reports should include further information about risks that were no longer on the Strategic Risk Register, including the residual risk rating, to confirm that the risk score had reduced to less than 15.

The Board of Directors:

- Received the report and noted the content.

**58/16 Maintaining Safe Staffing Levels**

Mr T Roberts presented a report which provided an overview, by exception, of actual versus planned staffing levels for the month of January 2016. The Board of Directors received assurance that safe staffing levels had been maintained during January 2016. Mr T Roberts made reference to the following key points in the report:

- Fill rates had improved across all areas compared to December 2015.
- Registered Nurse fill rates across night duty remained favourable indicating effective rostering practices.
- Staffing within Surgery had been a challenge and would be further mitigated via an interim reconfiguration of the bed base.
- Agency Registered Nurse utilisation for December 2015 had peaked at 4.7% compared to 3.4% in November 2015 and particular reference was made to high numbers of agency staff in Surgery. An agency cap of 4% had been agreed until 31 March 2016.

- The Trust's meeting with the CCG regarding Community Nurse Staffing review.

In reply to a question from Mrs C Prowse who queried the staffing issues in Surgery, Mr T Roberts advised that these had been a consequence of a number of issues but provided assurance that there were no concerns with regard to leadership in the business group. In reply to a question from Mr J Sandford who queried rostering, Mr T Roberts briefed the Board on mitigating actions in this area.

The Board of Directors:

- Received the report and noted the content.

**59/16 Key Issues Reports**

Charitable Funds Committee

Mr J Sandford briefed the Board on matters considered at a meeting of the Charitable Funds Committee held on 28 January 2016. He made reference to the Committee's review and approval of the Charitable Funds Annual Report and Accounts 2014/15 which had been submitted to the Charities Commission by the due date of 31 January 2016 and which had been included on the Board agenda for information. Mr J Sandford advised that the Committee had also approved the Charitable Funds expenditure plans for 2015/16. Mr J Sanford made reference to the potential of developing fundraising within charitable funds and Mrs A Gaukroger noted that the Communications Strategy, previously approved by the Board of Directors, included plans for fundraising.

Strategic Development Committee

Mr J Schultz briefed the Board on matters considered at a meeting of the Strategic Development Committee held on 18 February 2016. He advised that the meeting had coincided with a day when the Trust had faced particular pressures with regard to the Emergency Department and the meeting had therefore been shorter than usual. Mr J Schultz noted that the Committee continued to be encouraged by the development of the Innovation Programme but was not yet in a position to be able to provide financial assurance to the Board.

The Board of Directors:

- Received and noted the Key Issues Reports.

**60/16 Charitable Funds Annual Report and Accounts 2014/15**

Mr F Patel presented the Charitable Funds Annual Report and Accounts 2014/15 which had been approved by the Charitable Funds Committee at its meeting on 28 January 2016. Mr P Buckingham noted that the Committee had recommended that in future the Charitable Funds Annual Report and Accounts would be submitted for approval by the Board of Directors rather than the Charitable Funds Committee.

The Board of Directors:

- Received and noted the Charitable Funds Annual Report and Accounts for 2014/15.

**61/16 Report of the Chief Executive**

Mrs J Shaw 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:

- CQC Inspection Feedback
- Never Events – External Review
- Monitor / NHS Improvement Communications
- 2015 National NHS Staff Survey
- Publications.

The Board of Directors:

- Received and noted the Report of the Chief Executive.

**62/16 Recruitment & Retention Strategy**

Mrs J Shaw presented a report seeking Board of Directors approval of the Trust's first Recruitment & Retention Strategy. She noted that progress with regard to the development of the strategy had been monitored by the Workforce & Organisational Development Committee who had recommended the final draft of the strategy for Board approval. The Board was advised that a detailed Implementation Plan for the new strategy would be considered by the Workforce & Organisational Development Committee on 29 February 2016.

Mrs C Anderson commended the strategy but queried the lack of detail with regard to the re-training of staff following major changes to healthcare provision. Mrs J Shaw confirmed that work was underway with regard to this area and would ensure that more information was included in the Implementation Plan. Mr M Sugden welcomed the report and queried the approximate timescales for the delivery of the Greater Manchester Healthier Together programme which he noted was a critical element in the Trust's success. Mrs J Shaw advised that the pace of the Healthier Together agenda had increased following the outcome of the judicial review and noted that the Board would be updated on developments.

In reply to a question from Mr F Patel who queried the recruitment and retention pressures with regard to Doctors and Nurses, Mrs J Shaw advised the Board that this issue was considered by both Stockport Together and Healthier Together and that plans were required for short, medium and long term. In reply to a question from Mr J Sandford who queried the 11% staff turnover ratio, Mrs J Shaw advised that this was a fairly average figure for the north of England. There followed a discussion about the need for a turnover target and the Board was advised of a research project undertaken by NHS England which had suggested that a target for turnover might not be helpful as there was an expectation to have turnover in a vibrant organisation. Mrs G Easson noted that the Board welcomed the Recruitment & Retention Strategy as a key enabler for transformational change.

The Board of Directors:

- Received and noted the report and approved the Recruitment & Retention Strategy included at Annex A.

**63/16 Date, time and venue of next meeting**

There being no further business, Mrs G Easson closed the meeting and advised that the next meeting of the Board of Directors would be held on Thursday 31 March 2016 at 1.15pm in Lecture Theatre B, 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.<br><br>**Update on 26 Nov 15** – As the report had not yet been completed, it would be provided to the Board on 28 January 2016.<br><br>**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.<br><br>**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. | Dr J Catania |
| 1/16 | 25 Feb 16 | 57/16 | Strategic Risk Register | Mr P Buckingham and Mr T Roberts would review the presentation of future reports. | Mr P Buckingham / Mr T Roberts |

This page has been left blank

Stockport NHS
NHS Foundation Trust

| | | | |
|---|---|---|---|
| **Report to:** | Board of Directors | **Date:** | 31st March 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<br>√☐ 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<br>☐ Council of Governors<br>☐ Audit Committee<br>☐ Executive Team<br>☐ Quality Assurance Committee<br>☐ FSI Committee | ☐ Workforce & OD Committee<br>☐ BaSF Committee<br>☐ Charitable Funds Committee<br>☐ Nominations Committee<br>☐ Remuneration Committee<br>☐ Joint Negotiating Council<br>☐ Other |

**- THIS PAGE IS INTENTIONALLY BLANK -**

The following story is taken from a very recent event involving a gentleman who collapsed outside Beech House, Stepping Hill Hospital, on 25th February.

Bill is a frequent visitor to the Trust as he is an active member of the ED patient user group. On this day Bill had been attending training in the Facilities meeting room and had been making his way home through the hospital site; he collapsed outside Beech House (IT department). Bill fell backwards onto the ground and was quite unwell. This was witnessed by a member of our domestic staff, Gillian, who promptly alerted staff in Birch House (Corporate Nursing department, opposite Beech House).

Meanwhile, Jack, a member of our maintenance staff, had attended to Bill to make him comfortable whilst waiting for assistance and stayed with him to give reassurance. Initial first-aid was given by Jeanette Meadowcroft, senior nurse for adult safeguarding, who made an initial assessment as Bill was struggling to breathe and was semi-conscious. Jack assisted Jeanette to move Bill onto his side to support a clear airway. Staff in Birch House rang for an ambulance.

Further help was given by staff from IT and the Matron for Patient Experience, Margaret Gilligan.

Blankets and fleeces were obtained and a hot water bottle to ensure Bill's comfort and safety as it was extremely cold and Bill was lying on a concrete surface.

He was kept reassured throughout by all in attendance. The ambulance arrived soon afterwards and Bill was taken to the Emergency Department from where he was admitted to AMU 2.

Margaret and Jeanette visited Bill the day after on the ward. Bill appeared much better and was sat out in a chair. He stated he felt much better and thanked everyone for helping. Bill described how he had never seen ED that busy before but everyone during his visit had been kind.

Bill's recollection of the collapse was hazy but he stated he didn't know 'where everyone had appeared from' but was relieved.

Bill was happy for his story to be shared.

**Action:**

The incident was shared with the Director of Estates and Facilities with regards thanking Jack and Gillian as they left before they could be thanked. The story is also to be shared with ED staff and those who helped Bill and supported each other.

This page has been left blank

| | | | |
|---|---|---|---|
| **Report to:** | Board of Directors | **Date:** | 31 March 2016 |
| **Subject:** | Trust Performance Report – Month 11 | | |
| **Report of:** | Chief Operating Officer | **Prepared by:** | Joanne Pemrick, Head of Performance |

# REPORT FOR APPROVAL

| | | |
|---|---|---|
| **Corporate objective ref:** | ----- | **Summary of Report**<br><br>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<br>☒ Not required | |

**Attachments:** **Appendix 1 – Short Term Plan A&E Standard**

**Appendix 2 – Draft Improvement Trajectory**

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

## 1. Introduction

This report provides a summary of performance against Monitors Compliance Framework for the month of February 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 February is also indicated by a red (non compliant) or green (compliant) box.

| | | Standard | Weighting | Monitoring Period | Apr-15 | May-15 | Jun-15 | Q1 | Jul-15 | Aug-15 | Sep-15 | Q2 | Oct-15 | Nov-15 | Dec-15 | Q3 | Jan-16 | Feb-16 | Mar-16 (f/c) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| RTT | Maximum time of 18 weeks from point of referral to treatment in aggregate: Patients on an incomplete pathway | 92% | 1.0 | Quarterly | 92.9% | 92.9% | 93.1% | 93.0% | 93.4% | 92.8% | 92.8% | 93.0% | 92.4% | 92.7% | 92.1% | 92.4% | 92.1% | 92.0% | |
| A&E: | maximum waiting time of four hours from arrival to admission/ transfer/ discharge: | 95% | 1.0 | Quarterly | 89.1% | 97.0% | 94.3% | 93.5% | 94.8% | 92.5% | 91.5% | 93.0% | 91.0% | 78.0% | 73.7% | 80.6% | 73.5% | 72.8% | |
| Cancer | All cancers: 62-day wait for first treatment from: urgent GP referral for suspected cancer | 85% | 1.0 | Quarterly | 95.9% | 86.8% | 72.4% | 85.9% | 84.7% | 94.9% | 87.0% | 89.4% | 78.5% | 92.5% | 92.6% | 87.9% | 87.2% | 81.6% | |
| | 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 | 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% | 100% | 100% | 100% | 100.0% | 100.0% | |
| | All cancers: 31-day wait for second or subsequent treatment, comprising:anti-cancer drug treatments | 98% | | | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100.0% | 100.0% | |
| | All cancers: 31-day wait for second or subsequent treatment, comprising:radiotherapy | 94% | | | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a |
| | All cancers: 31-day wait from diagnosis to first treatment | 96% | 1.0 | Quarterly | 97.3% | 98.2% | 96.8% | 98.1% | 98.7% | 97.1% | 97.5% | 97.9% | 98.6% | 97.5% | 96.1% | 97.8% | 97.0% | 100.0% | |
| | Two week wait from referral to date first seen, comprising:all urgent referrals (cancer suspected) | 93% | 1.0 | Quarterly | 95.5% | 98.3% | 95.8% | 96.6% | 97.1% | 96.0% | 94.7% | 95.9% | 96.0% | 97.3% | 97.6% | 97.0% | 96.8% | 98.1% | |
| | Two week wait from referral to date first seen, comprising:for symptomatic breast patients (cancer not initially suspected) | 93% | | | 96.7% | 98.6% | 94.7% | 96.7% | 96.3% | 96.1% | 95.9% | 96.1% | 94.2% | 94.7% | 98.7% | 95.6% | 96.4% | 98.9% | |
| Clostridium (C.) difficile | Meeting the C. difficile objective (< 17 in year due lapse in care) | de minimis applies | 1.0 | Quarterly | 0 | 0 | 0 | 0 | 1 | 2 | 0 | 3 | 0 | 1 | 0 | 1 | 1 | 0 | |

## 3. Month 11 Performance against Regulatory Framework

There were two areas of non-compliance against the regulatory framework in month 11:

### A&E 4hr target

Patient flow as a result of delayed transfers of care continues to be the main contributing factor to the deteriorating A&E 4-hour performance. All escalation capacity within the Trust remained open in February and yet medical outliers blocking surgical beds and assessment areas remained high.

In addition, February continued to see the increase in ED attendances noted in January when compared to the same period of last year. This is a significant change as the year to date position had been relatively similar to last year up to the end of December.

Despite the increase in direct admissions to MAU the Trust's admission rate remains higher than most of our GM peers and has been as high as 36% on some days in February.

The Trust has been to escalation meetings in February and March with NHS Improvement and Monitor regarding A&E performance and has accepted that the sustainable solution should be system wide and 3 fold:

1. Short term impact plan

Opportunities for immediate improvement. These been summarized within the plan at Appendix 1 and includes associated KPIs with accountable owners. These will be monitored weekly by ET

2. Medium Plan and Transformation
   The resilient solution for ED performance is for Stockport together design to be fully implemented. Some elements of this are already being put in place e.g. the development of neighborhoods and piloting of consultant connect. However, significant impact on urgent care is probably 18 months + away.
   Therefore, a medium term plan is required which will be based upon the projects within the strategic staircase strategy work streams;
   - Improvements in Length of stay
   - Resilient staffing levels
   - Improving discharge processes and reducing delays
   - Diagnostic delays

The Trust is required to develop an improvement trajectory for 16/17 which is to be submitted to Monitor by the end of the month. The attached is the final draft to be agreed at the Board meeting. To date the Trust is on track to achieve above 80 % by April 2016

The Trust continues to engage with the senior leaders from the Local Authority and CCG who have, with the Chief Operating Officer, met with the Systems Resilience Group and Monitor/NHS England to drive an urgent collective response to the issue of delays. This system wide response and plan was shared with the regulators and accepted as the right approach to a sustainable solution.

**Cancer 62day target**
February was predicted to be below target against the 62day cancer standard. The main contributor to this position was the effect of increased patient choice in delaying out-patient and diagnostic appointments over the Christmas period which inevitably extended the pathway.

Performance for the quarter remains very challenging, particularly with the continued junior doctor strike actions, winter pressures and its impact on HDU bed capacity.

## 4. Future risks to compliance against Regulatory Framework

Future risks to compliance are as follows:

**Referral to Treatment Targets (RTT)**

Whilst the standard has been achieved at an aggregate level, the surgical specialties are below the required performance level following the reduction of routine elective activity due to the emergency pressures outlined above. The Business Groups are working on contingency plans to recover this, however, the impact of the junior doctors' strike and continued winter pressures are affecting the rate of recovery.

## 5. Key Risks/hotspots from the Integrated Performance Report

### 5.1 Clinical

**Pressure Ulcers**
The stretch target for Stockport Acute services is zero tolerance of avoidable pressure ulcers grade 3 and 4 by the end of 2016. To date there have been 3 avoidable pressure ulcers, this means the stretch target of zero tolerance grade 3 /4 pressure ulcers will not be achieved for 2015/16.

The incidence of new pressure ulcers reported in the Hospital for February remains the same as the previous month at 0.57%.

Further work is being undertaken in relation to:

- A medical device bundle has been devised due to the increase in device related pressure ulcers eg due to NG tubes/ oxygen tubing.
- Evaluation of silicone dressings is being undertaken to minimize friction and shear
- The number of pressure relieving cushions has been increased

**5.2 Access**

**Outpatient Waiting Lists**

- The main area of risk continues to be Gastroenterology. In this specialty there is a process underway for clinical review of the patients waiting and so far this is demonstrating that a significant proportion do not require a further appointment. New recruitments of consultants will start to show a reduction in this in future months. The directorate will continue to balance the clinical and financial risks in managing the recovery. It is confident that there is little clinical risk in the OWL backlog

**Discharge Summary**

- The most significant factor now affecting performance is the high volume of patients coupled with a rotating workforce particularly through assessment areas. To address this problem, checks of outstanding HCR documents are now done at 24hrs post patient discharge to enable the clinician to be alerted and allow for HCR completion within the 48hr deadline.

**Cancelled operations on the day**

- February saw an unprecedented number of operations cancelled on the day. The two main contributing factors were acute staff availability due to sickness absence, and the continued winter pressures impacting on both HDU and general surgical bed capacity.

**5.3 Partnership & Efficiency**

**Workforce quality standards**

- Sickness/Absence is at 4.57% which is higher than the Trust target of 4%, however, this is an improvement on the previous month and compares favourably to the same period last year.

- Mandatory training compliance has seen an improvement in February. The action plan will continue to be implemented fully over the coming months.

- Whilst appraisals are still under the desired target level, February is now the fifth month in succession where this has continued to improve.

**Financial Performance**

- The Trust has now achieved £11.2m of savings against the full year £11.8m plan. This leaves £0.6m of CIP to be actioned in the final month of the year. The outstanding CIP planned is linked to reduced run-rates agreed by each business group as part of the annual plan refresh process. These focused on reducing pay costs, mainly through reductions in agency staff and planning for winter capacity.

- The Cash position is has only decreased by £0.2m to £31.07m at 29th February 2016, which is £0.8m lower than planned at the start of the year.

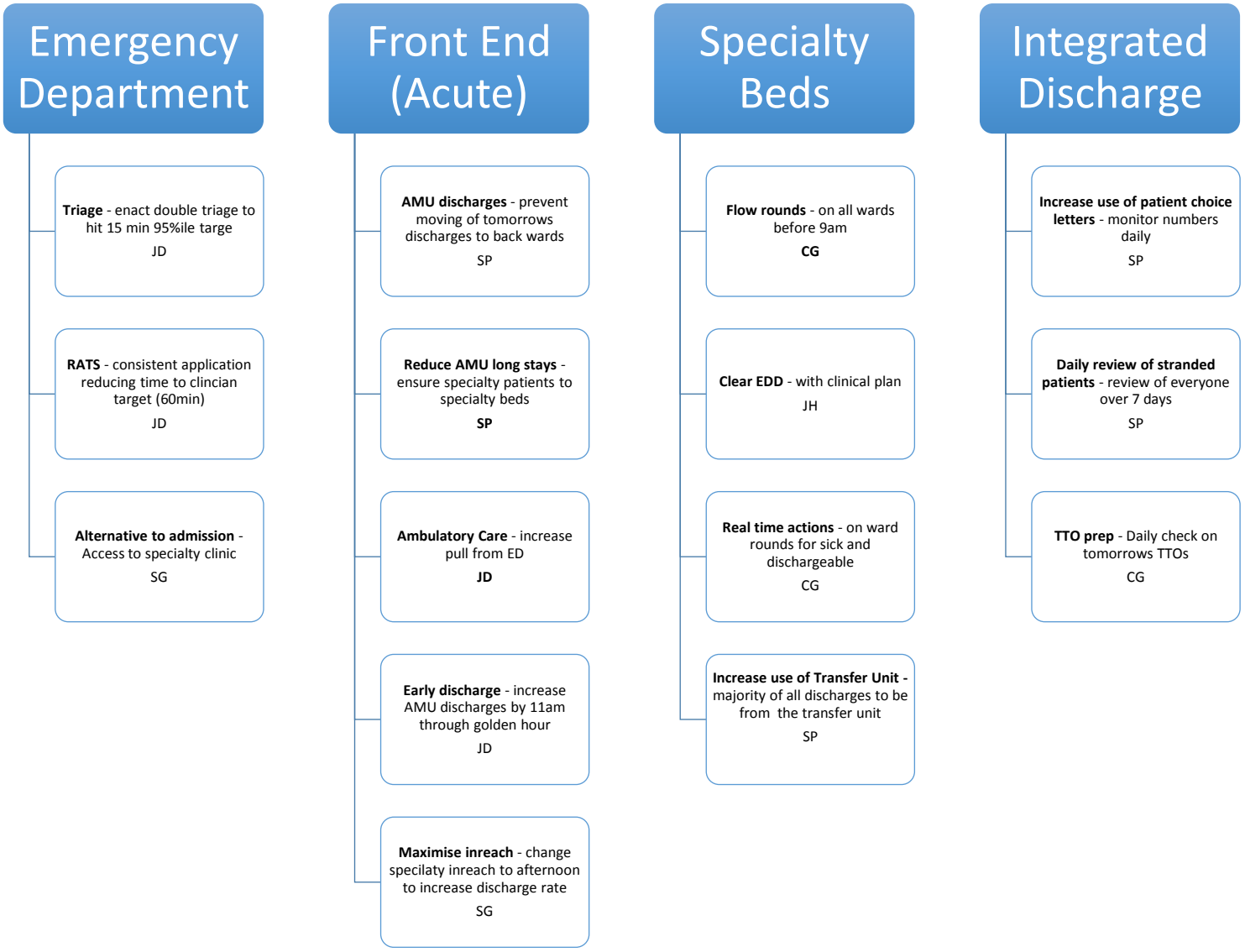
## 6. Recommendations

The Board is asked to:

- Note the current position for month 11 compliance standards
- Note the future risks to compliance and corresponding actions to mitigate.
- Note the key risks areas from the Integrated Performance Report

This page has been left blank

**Key Actions**


Emergency Department
Triage - enact double triage to hit 15 min 95%ile targe
JD
RATS - consistent application reducing time to clincian target (60min)
JD
Alternative to admission - Access to specialty clinic
SG
Front End (Acute)
AMU discharges - prevent moving of tomorrows discharges to back wards
SP
Reduce AMU long stays - ensure specialty patients to specialty beds
SP
Ambulatory Care - increase pull from ED
JD
Early discharge - increase AMU discharges by 11am through golden hour
JD
Maximise inreach - change specilaty inreach to afternoon to increase discharge rate
SG
Specialty Beds
Flow rounds - on all wards before 9am
CG
Clear EDD - with clinical plan
JH
Real time actions - on ward rounds for sick and dischargeable
CG
Increase use of Transfer Unit - majority of all discharges to be from the transfer unit
SP
Integrated Discharge
Increase use of patient choice letters - monitor numbers daily
SP
Daily review of stranded patients - review of everyone over 7 days
SP
TTO prep - Daily check on tomorrows TTOs
CG

## Emergency Department

- 95% ile triage 15 min target
- Time to clinician 60 min target
- Number of patiets sent to RACP clinic

## Front End (Acute)

- Number of discharges from AMU daily
- AMU length of stay
- Number of inreach sessions per week
- 11am discharge rate from AMU
- Number of patients from ED to AMU (daily)

## Specialty Wards

- Number of flow rounds per week/day
- % of medical patients per ward with EDD
- Audit of TTO and diagnostic requests per AM per ward
- Increased use of the Transfer Unit as a % of all discharges

## Integrated Discharge

- Number of patients on stage 1 letter and progression through levels
- Reduction in stranded patients - % over 7 days length of stay
- Number of TTOs ordered day before

## Proposed Trajectories for SFT 2016/17

**RTT** **Baseline data = end of January 2016 submission data** **Assumptions - profile will follow previous years seasonal trend.**

Standard = 92%

| | Baseline | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total pts waiting | 19846 | 19900 | 19900 | 19950 | 20000 | 20100 | 19950 | 19900 | 19850 | 19800 | 19900 | 19900 | 19800 |
| Patients > 18 weeks wait | 1572 | 1560 | 1540 | 1550 | 1580 | 1600 | 1550 | 1500 | 1450 | 1450 | 1500 | 1450 | 1400 |
| Performance | 92.1 | 92.2 | 92.3 | 92.2 | 92.1 | 92.0 | 92.2 | 92.5 | 92.7 | 92.7 | 92.5 | 92.7 | 92.9 |

**Cancer 62 day** **Baseline data = December 2015**

**Assumptions - 1.Treatment values have been used as opposed to patients seen - to account for GM reallocation policy**

Standard = 85% **2. Total treatment activity will match this years**

| | Baseline | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total patients seen | 40.5 | 55 | 48 | 46 | 47 | 42 | 46 | 47 | 56 | 42 | 44 | 55 | 57 |
| > 62 day patients | 2 | 8 | 5 | 5 | 6.5 | 6 | 6 | 7 | 7 | 5 | 6.5 | 8 | 7 |
| Performance | 95.1 | 85.5 | 89.6 | 89.1 | 86.2 | 85.7 | 87.0 | 85.1 | 87.5 | 88.1 | 85.2 | 85.5 | 87.7 |

**Diagnostics** **Baseline data = January 2016**

**Assumptions - Assume similar wl size and performance next year.**

Standard = 99%

| | Baseline | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total pts waiting | 4253 | 4350 | 4570 | 4850 | 5000 | 4560 | 4000 | 4300 | 4280 | 4352 | 4330 | 4250 | 4220 |
| Pts waiting < 6 weeks | 4249 | 4346 | 4565 | 4845 | 4995 | 4556 | 3986 | 4296 | 4276 | 4348 | 4327 | 4241 | 4213 |
| Performance | 99.9 | 99.9 | 99.9 | 99.9 | 99.9 | 99.9 | 99.7 | 99.9 | 99.9 | 99.9 | 99.9 | 99.8 | 99.8 |

**ED**

**Standard = 95%**

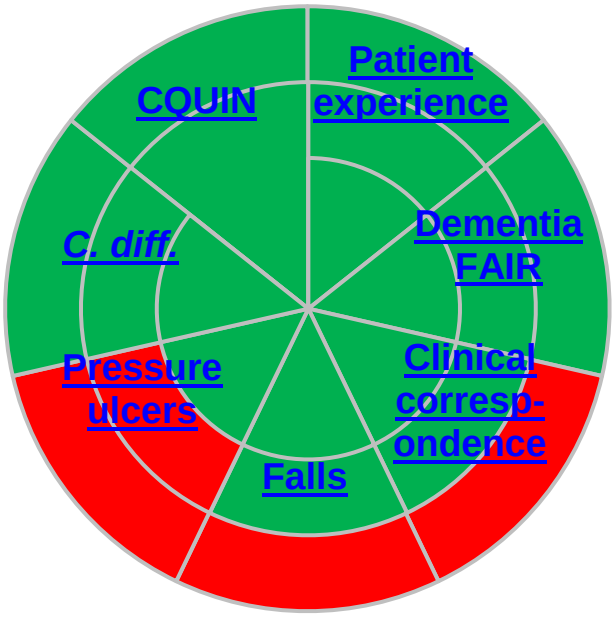
| | Baseline | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total attendances | 7803 | 7600 | 7800 | 7800 | 8000 | 7500 | 7700 | 8000 | 7800 | 7800 | 7800 | 7500 | 7800 |
| Pts waiting < 4 hrs | 2068 | 1500 | 1200 | 850 | 800 | 500 | 375 | 375 | 375 | 500 | 500 | 500 | 375 |
| **Performance** | **73.5** | **80.3** | **84.6** | **89.1** | **90.0** | **93.3** | **95.1** | **95.3** | **95.2** | **93.6** | **93.6** | **93.3** | **95.2** |

This page has been left blank

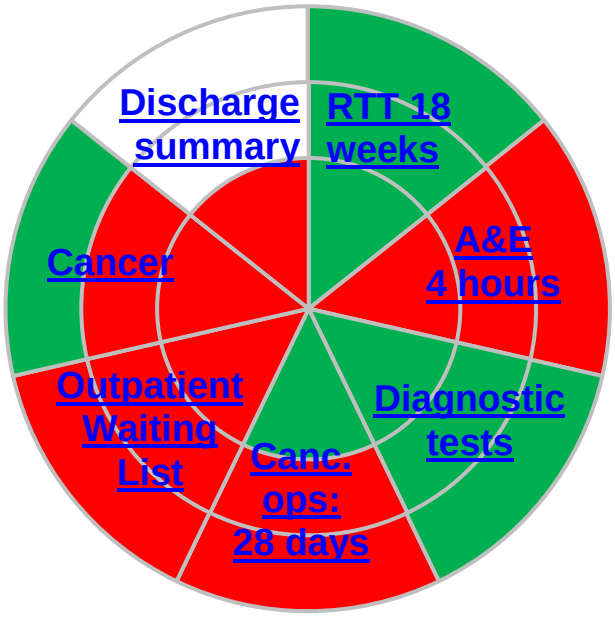
# Integrated Performance Report February 2016

Stockport NHS Foundation Trust

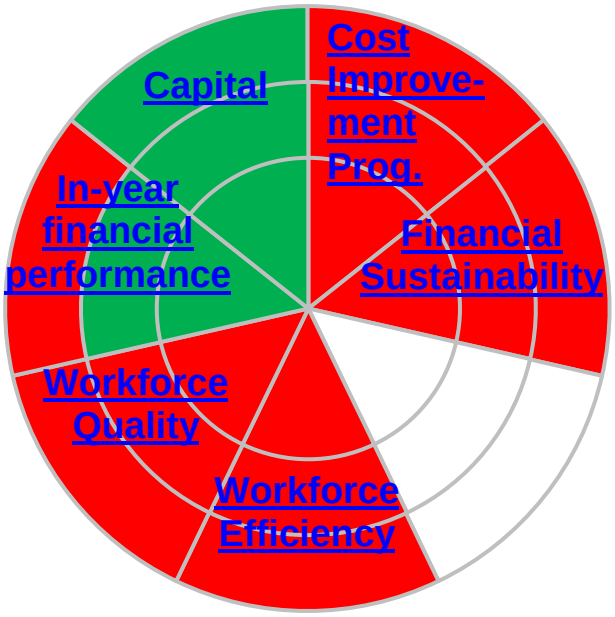
## 1.Clinical



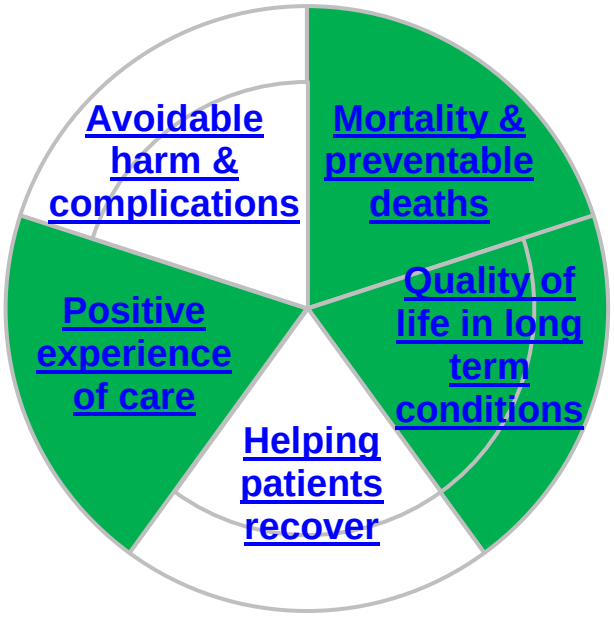

## 2.Access




## 3.Partnership & Efficiency




## 4.Quality




## Key to wheels:

**Wheels 1,2 and 3:** Outer ring; Year-to-date performance. Middle ring, latest quarter. Inner ring, latest month

**Wheel 4**: Outer ring; Year-to-date performance. Inner ring, latest quarter.

Your Health. Our Priority.

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

No changes to the report this month.

## 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 |

# Integrated Performance Report

# Full Performance Report: All Indicators, including Hot Spots

## February 2016

This section includes data, definition and commentary for all of the performance indicators shown on the front page of the Integrated Performance Report.

# Patient Experience

*Chart 1*

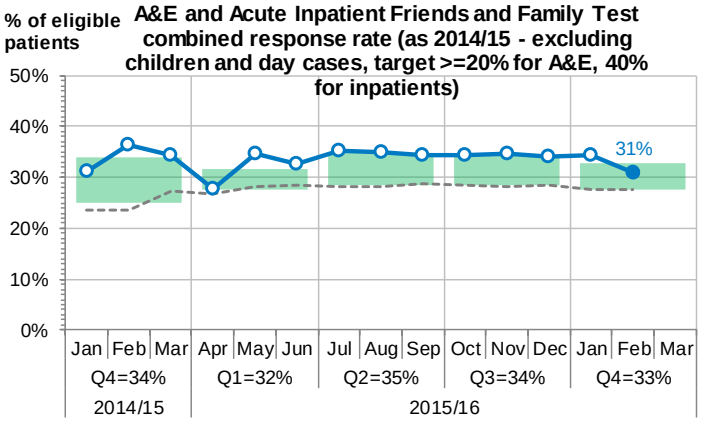



*Chart 2*

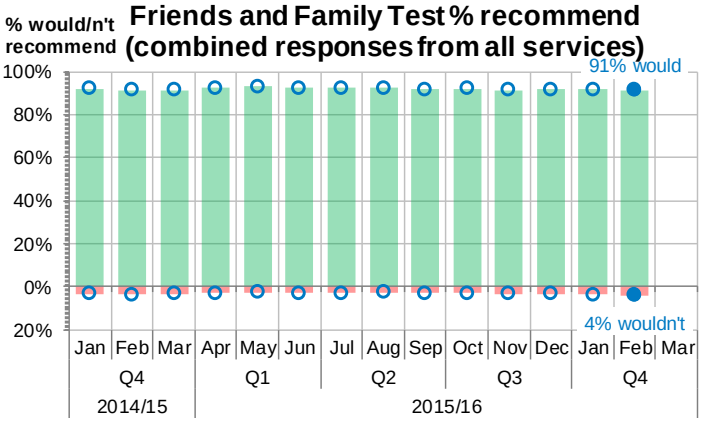
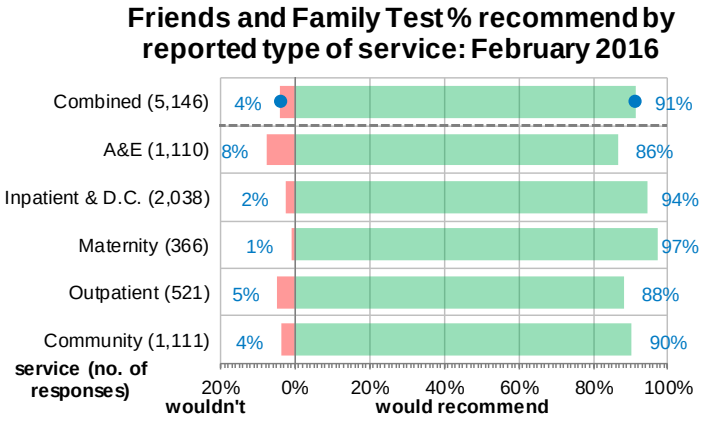



*Chart 3*




Overall in February, the trust scored 91% extremely likely or likely to recommend, total responses were 5,146. Broken down, February response rate solely for adult patients in ED was 86%, a decrease of 2 percentage point (p.p.) since January. Children's ED response rate was 1.2% which is an increase on January. The Treehouse unit shows a 4% response rate which is a decrease of 6 p.p. since January. Overall acute inpatients response rate dropped to 34**%** in February and the maternity response rate for birth showed a small decrease to 40% since January.

In February day case areas and outpatient services figures saw a response rate of 40% of patients surveyed and 39% respectively. In these areas, IVM (Interactive Voice Messaging and SMS) were the dominant methods used to seek patient feedback and in relation to OPD areas patients continue to be targeted only after they have been discharged.

**Feedback Themes (acute):**

**ED (adult)** – Positive comments continue to state a good staff attitude and this is the top theme for ED for February. Comments state staff were friendly, Kind and patients felt treated with dignity. Negative comments continue to include long / excessive waiting times, especially waiting for results and this is the top presenting theme for February.

**Inpatients (adults)** Positive comments received included overall a good staff attitude and staff were caring, kind and attentive. Some positive comments were also noted with regards to food. Negative comments included excessive waiting times to see a Dr (C3), a lack of communication and some staff poor attitude.

**Maternity** – Overall positive comments received included staff were caring, friendly and patients felt well monitored and reassured. Minimal negative comments were received which included a poor birth experience (C Section) and lack of information given.

**Daycase** - Negative comments continue to state long waiting times when admitted for procedures and not enough updates being given with regards to progress. Positive comments included staff were cheerful, informative, and patients were made to feel comfortable.

**Out Patients** - Positive comments received included staff were caring, kind and considerate with information being explained. This appeared to be all disciplines of staff. Negative comments continue to report long waits in clinics and this is the top presenting theme in February.

**Paediatrics (inpatients)** - Positive feedback on the whole continues to be received stating staff were kind, caring and empathetic

**Neonatal Unit** – comments continue to be positive and include nurses were caring, dedicated and supportive giving outstanding emotional support

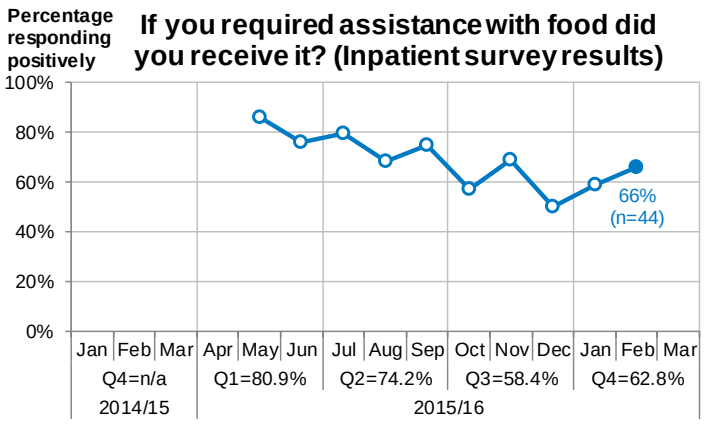
**iPad Survey – in-patient surveys:**
In February 193 inpatient iPad surveys were undertaken, which is a decrease of **50** compared to January. All wards now have log in access to the surveys in order to assist in obtaining patient feedback via the iPads and this continues to be encouraged, although uptake by wards remains minimal.

Results continue to show minimal progress is being made with regards to assistance with nutrition and eating and being provided with napkins. However, In February results show wards A11 and D1 achieved 100% of patients saying they received a napkin with their meal.

Actions being taken to address the issues raised:-

1) Increase in the number of volunteers trained to support wards at mealtimes with feeding patients.
2) Assistance with eating and drinking / napkin scores (iPad surveys) continues to be monitored as part of Nutrition and Hydration group. Nutrition standards are currently being finalised for wards to follow and will include handing out of napkins. In addition the medicine business group has implemented its own action plan which is being monitored by the Business group.
3) Patient communication continues to form part of patient experience training to various staff groups, and reports are circulated to staff in the training department to influence staff training sessions as appropriate.

*Chart 4*



Return to FRONT page

# Dementia 16

*Chart 5*

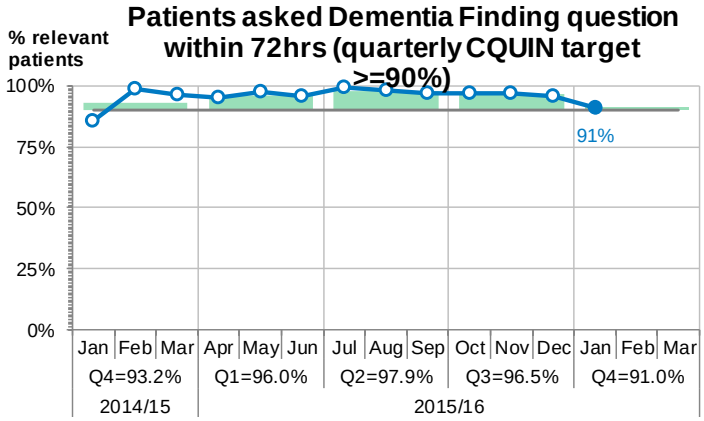



*Chart 6*

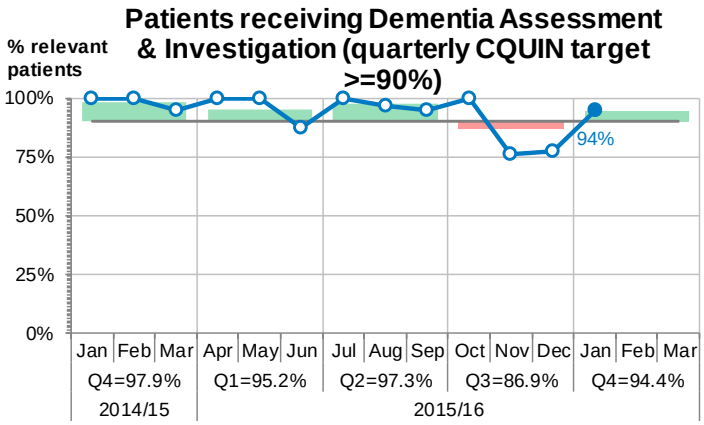
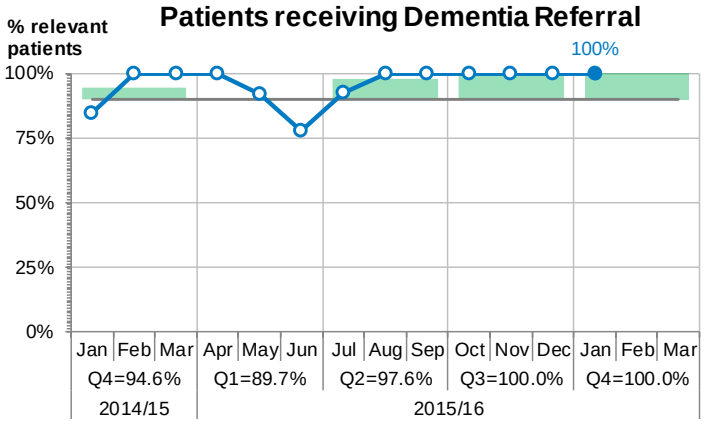



*Chart 7*




Charts 5 to 7 show performance against the dementia standards.

Return to FRONT page

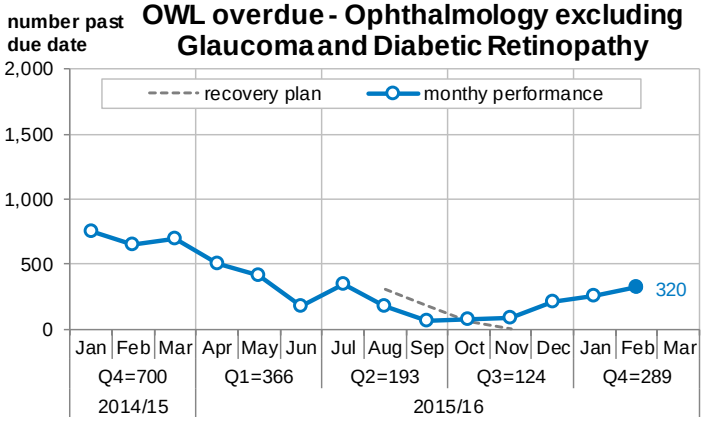
# Outpatient Waiting List (OWL) patients past due date 20

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.

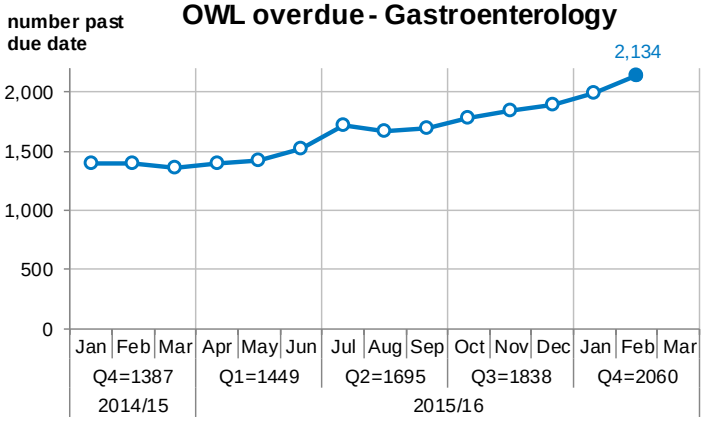
*Chart 8 Ophthalmology OWLs past due date*




## Ophthalmology

The clearance trajectory for Ophthalmology remains behind plan in month. A locum Consultant was appointed in January to help address the capacity gap.

*Chart 9 Gastroenterology OWLs past due date*



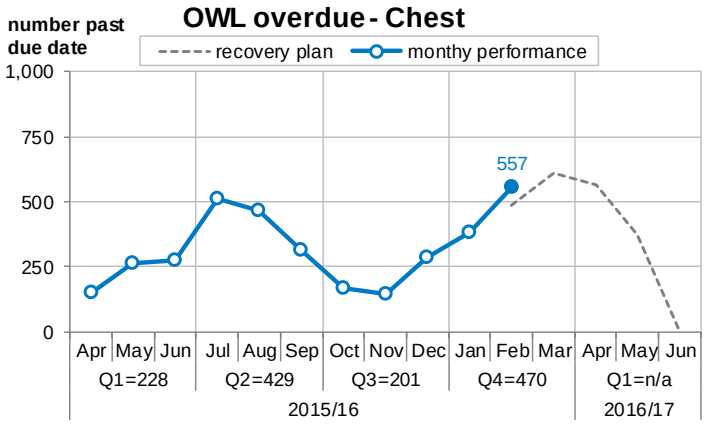

## Gastroenterology

Chart 9 shows the number of Gastroenterology patients on the Outpatient waiting list beyond their due date. Actions include:

- Ongoing clinical validation
- Actioning of safe discharge of appropriate patients following the agreed protocols.

The Clinical team has also implemented a change in practice to reduce future follow-up demand on the service.

*Chart 10 Respiratory Medicine OWLs past due date*



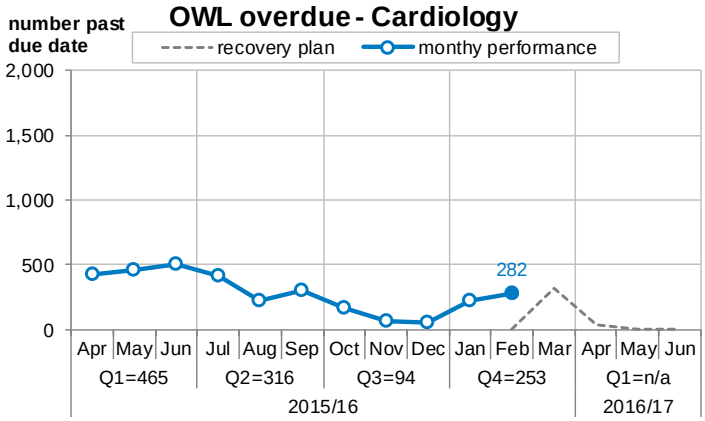

## Respiratory Medicine

The recovery trajectory has been revised in light of changes within the service.
Key features are:

- Template standardisation effective in April 2016.
- Improved management of surveillance patients.
- Additional capacity from Agency Locums (for OWL overdue backlog as well as the recurrent capacity gap)

Recovery is still at risk from agency locum staff leaving due to the implementation of agency cap rates.

*Chart 11 Cardiology OWLs past due date*




## Cardiology

The recovery trajectory has been revised in light of changes within the service.
Key features are:

- Template standardisation effective in April 2016.
- Backfilling maternity leave (Agency or Trust Locum)
- New Consultant from May
- Additional capacity from Agency Locums

Recovery is still at risk from agency locum staff leaving due to the implementation of agency cap rates.

Return to FRONT page

# Clinical correspondence (typing backlog)

*Chart 12*

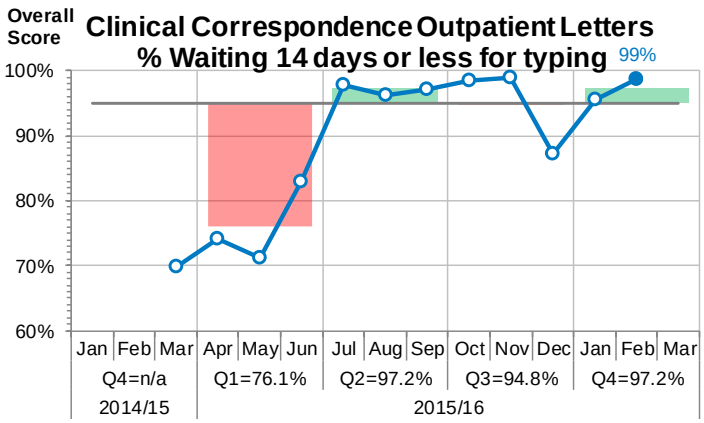


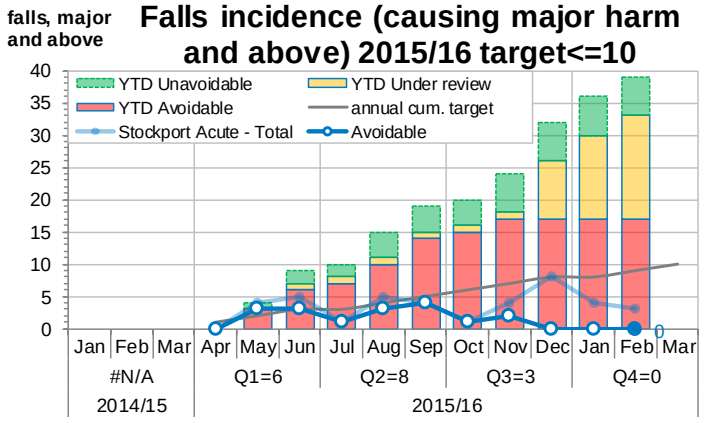

Chart 12 shows the performance against the clinical correspondence standard of 95% of Outpatient letters to be typed within 14 days.

Action plans are being developed within each Business Group to enable turn-round of clinical correspondence to reduce to 5 working days by the end of Q2.

Return to FRONT page

# Falls

*Chart 13*




This year's target is 10 avoidable falls. In February there were 3 severe falls.
To date there have been 39 falls major and above, out of these 39:

- 7 are under review
- 24 are deemed avoidable
- 8 have been deemed as unavoidable

A Trust risk management alert has been circulated in relation to non-compliance with the falls SOP.
Common themes highlighted from serious incident investigations include:

- Falls assessment not always completed within 6hrs
- Lying and standing BP not recorded if patient is unwell and not followed up when patient improves
- Post fall action chart not followed

The Trust Falls Action Plan continues to be followed and the Hospital Falls group continues to meet to review actions in order to reduce harm from falls.

Return to FRONT page

# Pressure Ulcers 16

*Chart 14*

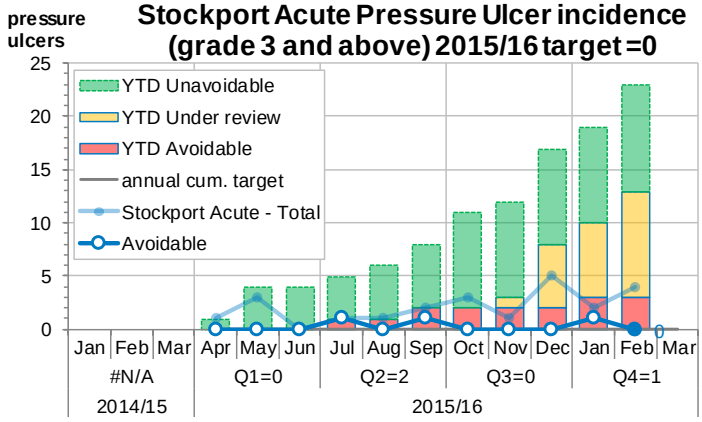
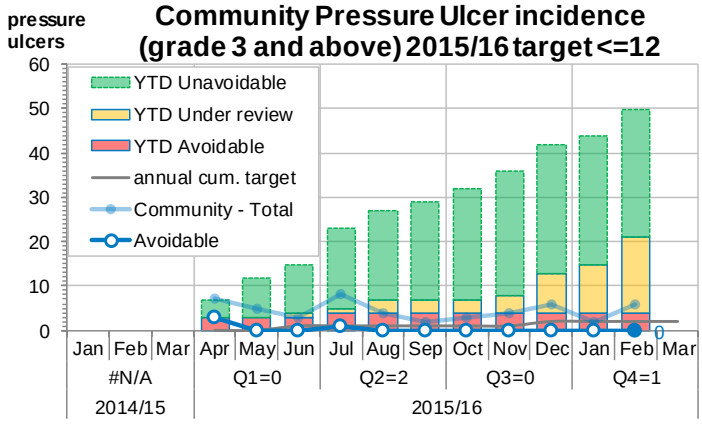



*Chart 15*




The stretch target for Stockport Acute services is zero tolerance of avoidable pressure ulcers grade 3 and 4 by the end of 2016.

To date there have been 3 avoidable pressure ulcers, this means the stretch target of zero tolerance grade 3 /4 pressure ulcers will not be achieved for 2015/16.

The incidence of new pressure ulcers reported in the Hospital for February remains the same as the previous month at 0.57%.

Further work is being undertaken in relation to:

- A medical device bundle has been devised due to the increase in device related pressure ulcers eg due to NG tubes/ oxygen tubing.
- Evaluation of silicone dressings is being undertaken to minimize friction and shear
- The number of pressure relieving cushions has been increased

The stretch target for Stockport Community is 50% reduction in grade 3 and 4 avoidable pressure ulcers by end of 2016. The target is 12 avoidable pressure ulcers.

In February there have been 6 grade 3/4 pressure ulcers which are under review at present.

To date there have been 4 avoidable grade 3 /4 pressure ulcers.

# Referral to Treatment (RTT) waiting times

Return to FRONT page

*Chart 16*

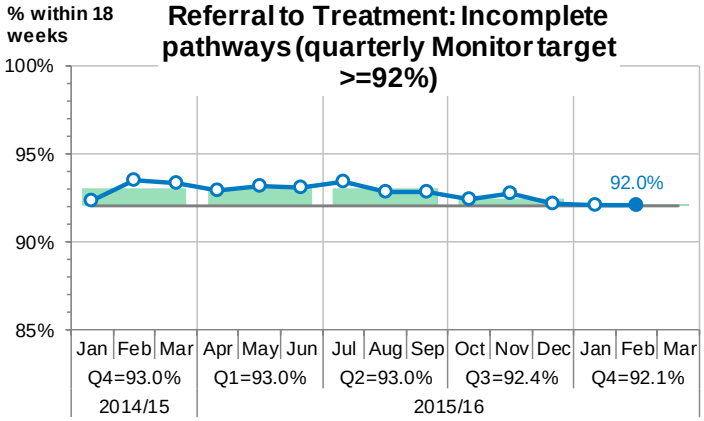



Chart 16 shows that performance against the incomplete pathways remains compliant. Whilst this is satisfactory, the continued impact of cancellations of elective operating activity may begin to impact on this in the coming months.

*Chart 17*

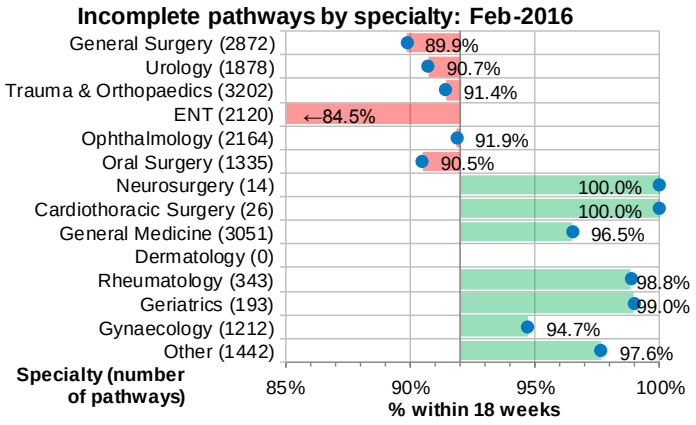



Chart 17 shows performance against the incomplete standard at specialty level.

Non-compliance with the standard is seen across all the surgical specialties following the reduction of routine elective activity.

The Business Groups continue to prioritise cancer and urgent elective activity during the period of reduced elective programme, as well as those specialties where recovery of the waiting list will be particularly challenging.

The Business Groups are working on contingency plans to recover this, however, the impact of the junior doctors strike and continued winter pressures are affecting the rate of recovery.

*Chart 18*

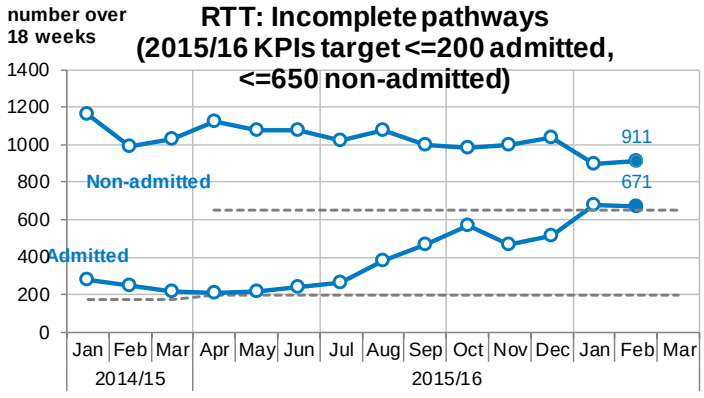



Chart 18 reflects the increase in the admitted waiting list.

# Accident & Emergency total time in dept.

*Chart 19*

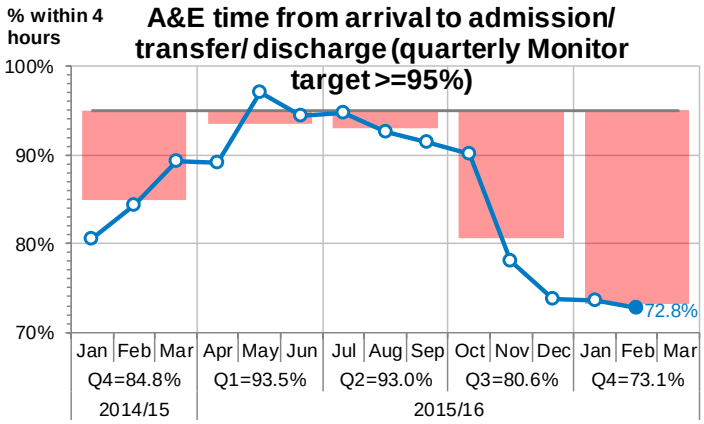



*Chart 20*

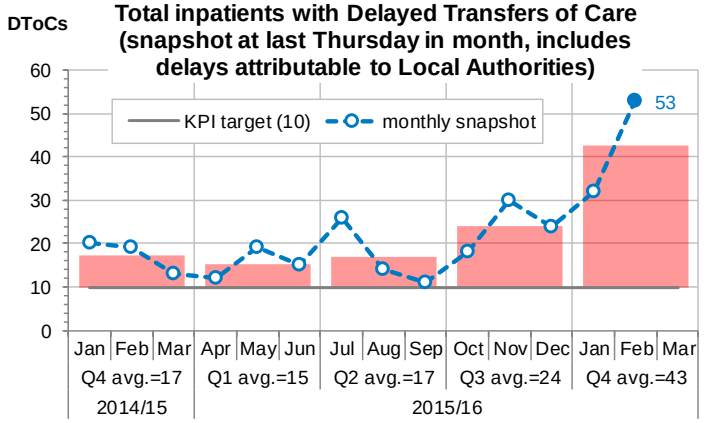



*Chart 21*

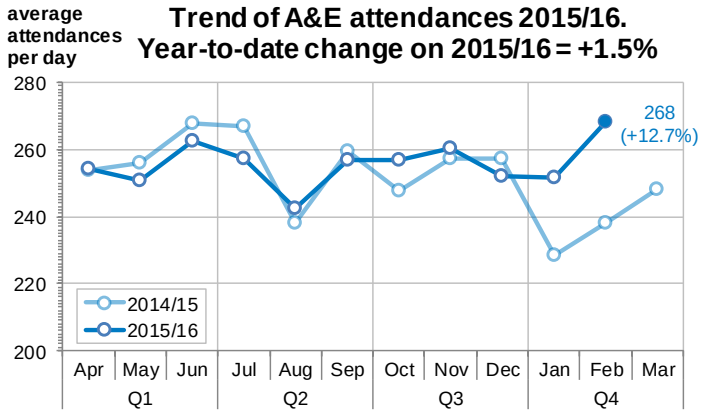



*Chart 19* shows compliance against the 4hr A&E standard.

Patient flow as a result of delayed transfers of care continues to be the main contributing factor to the deteriorating A&E 4-hour performance. All escalation capacity within the Trust remained open in February and yet medical outliers blocking surgical beds and assessment areas remained high.

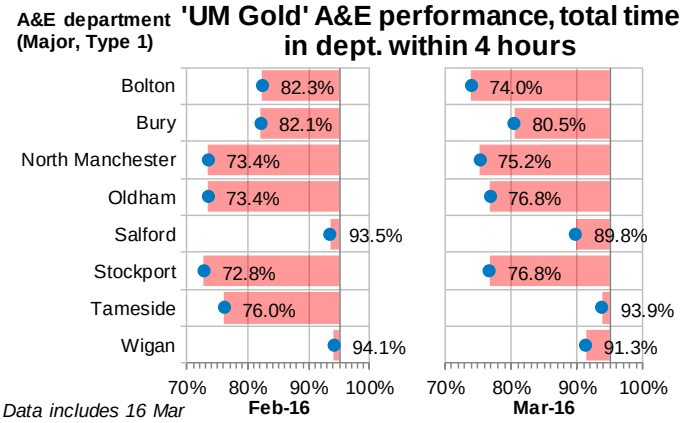
In addition, February continued to see the increase in ED attendances noted in January when compared to the same period of last year. This is a significant change as the year to date position had been relatively similar to last year up to the end of December.

Despite the increase in direct admissions to MAU the Trust's admission rate remains higher than most of our GM peers and has been as high as 36% on some days in February.

The Trust has been to escalation meetings in February and March with NHS Improvement and Monitor regarding it's A&E performance and has accepted that the sustainable solution should be system wide and 3 fold:

1. Short term impact plan
   Opportunities for immediate improvement have been identified and will be monitored weekly by ET.
2. Medium Plan and Transformation
   The resilient solution for ED performance is for Stockport together design to be fully implemented. Some elements of this are already being put in place e.g. the development of neighborhoods and piloting of consultant connect. However, significant impact on urgent care is probably 18 months + away.

*Chart 22*




*Data includes 16 Mar*

*Source: North West Commissioning Support Unit.*

Therefore, a medium term plan is required which will be based upon the projects within the strategic staircase strategy work streams;

- Improvements in Length of stay
- Resilient staffing levels
- Improving discharge processes and reducing delays
- Diagnostic delays

The Trust continues to engage with the senior leaders from the Local Authority and CCG who have, with the Chief Operating Officer, met with the Systems Resilience Group and Monitor/NHS England to drive an urgent collective response to the issue of delays.

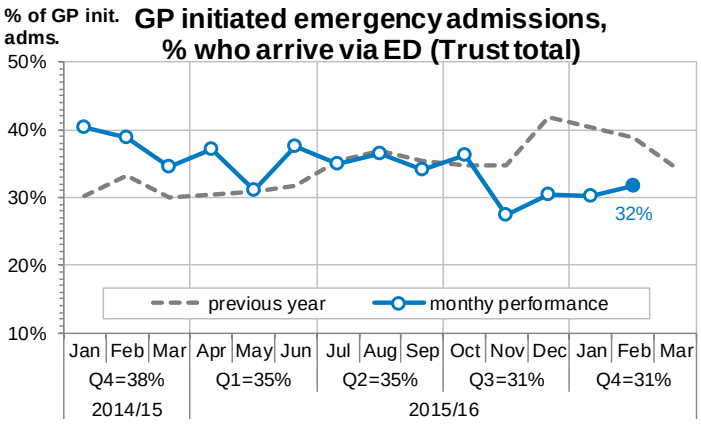
This system wide response and plan was shared with the regulators and accepted as the right approach to a sustainable solution.

Return to FRONT page

*The next four pages show urgent care indicators (Chart 23 to Chart 35)*

# Urgent Care Key Performance Indicators

*Chart 23*




The following charts (23 to 28) are the high level KPIs to measure progress realized through the implementation of the Urgent care 90 day plan.

*Chart 24*

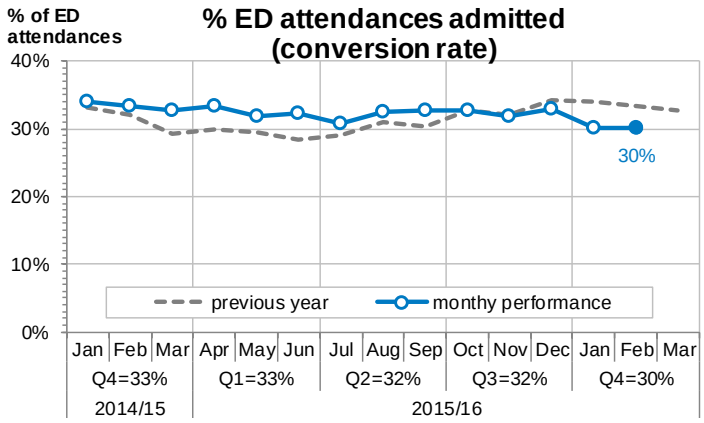



*Chart 25*

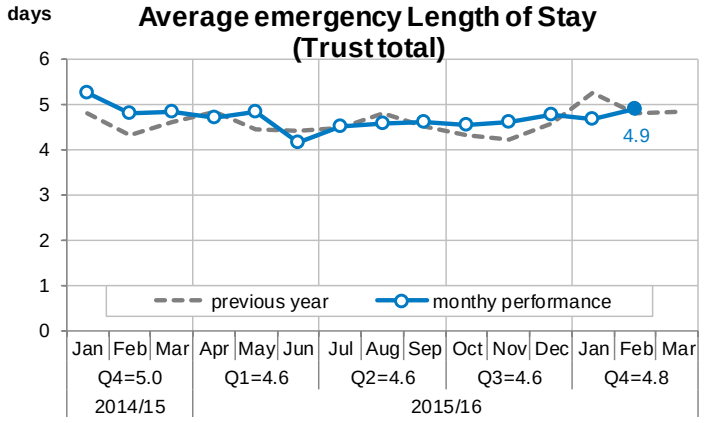



*Chart 26*

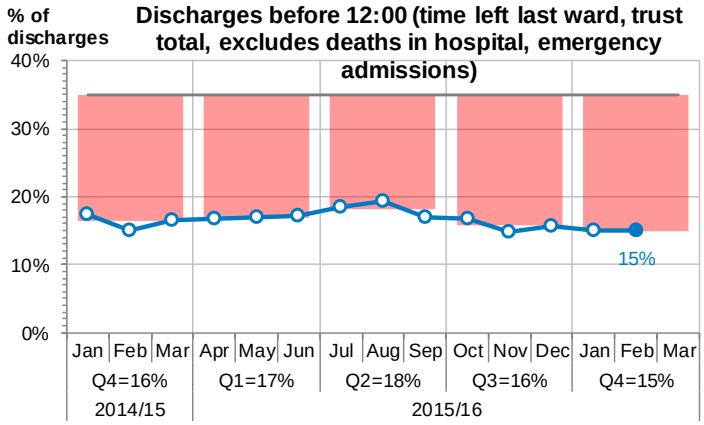


*Chart 27*

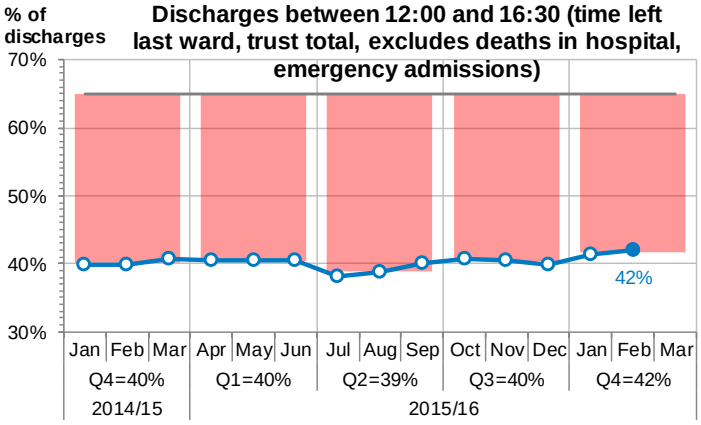
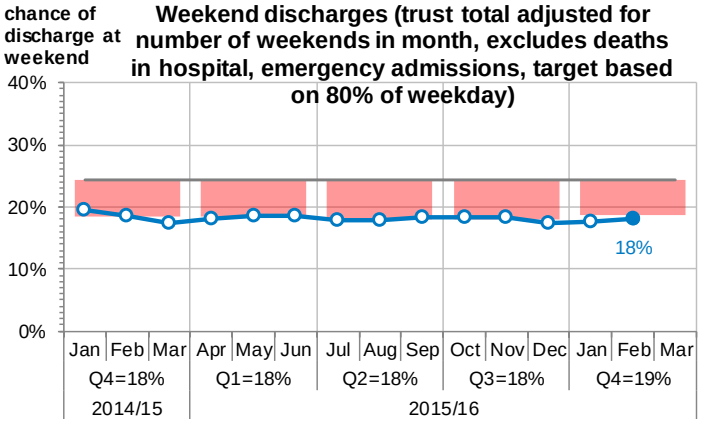



*Chart 28*




Return to FRONT page

# Trust Urgent Care Key Performance Indicators

*Chart 29*

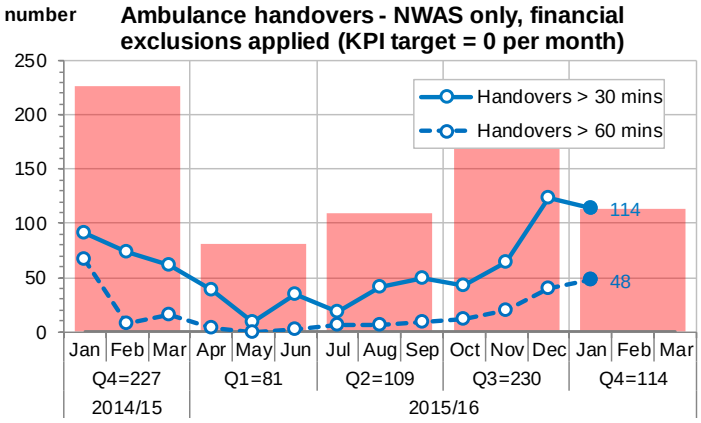



*Chart 30*

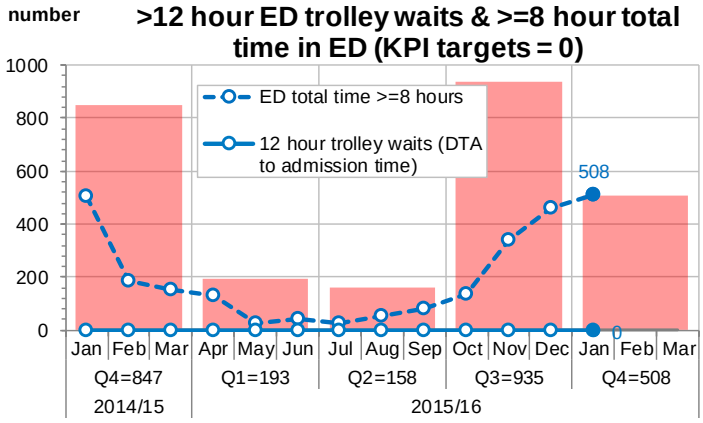


*Chart 31*

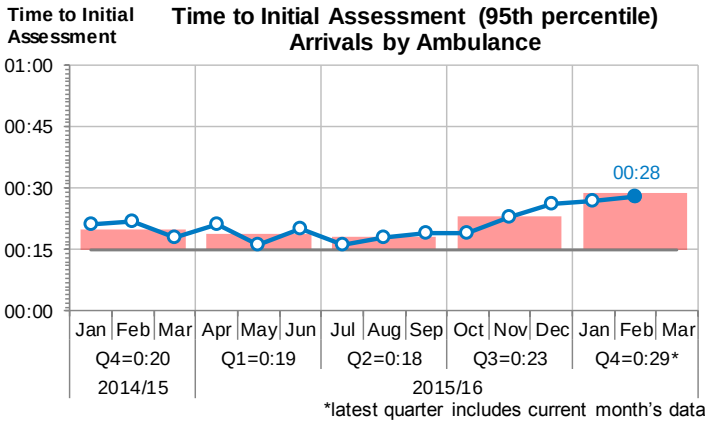



*Chart 32*

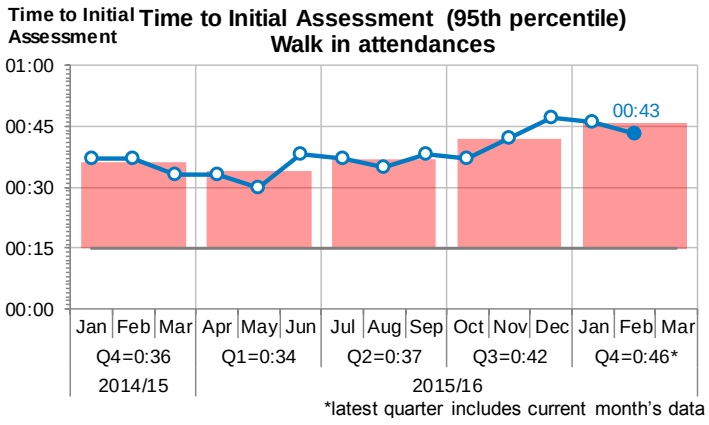



*Chart 33*

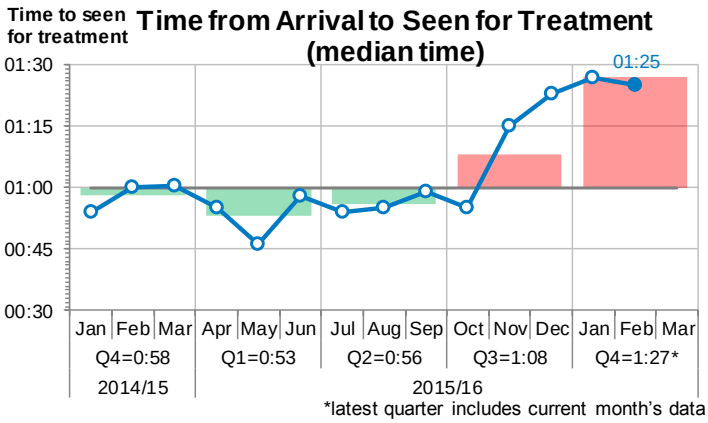



*Chart 34*

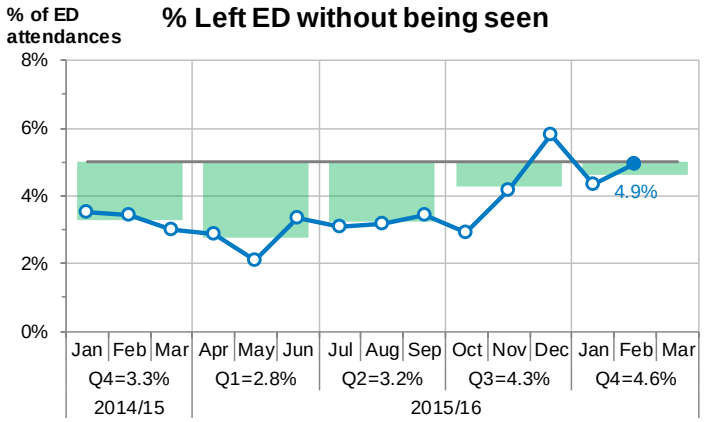
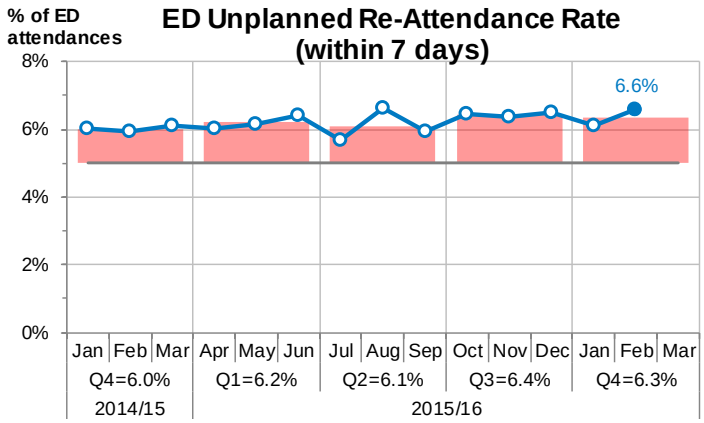



*Chart 35*





Return to FRONT page

## Cancelled Operations 20

*Chart 36*

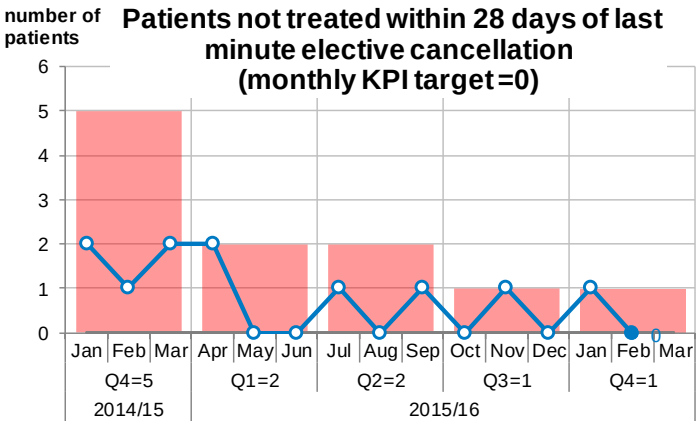
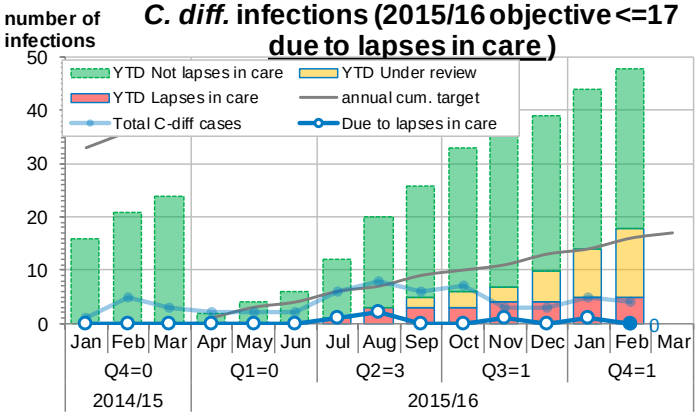



Chart 36 shows compliance against standard was achieved in February.

Return to FRONT page

## *Clostridium difficile (C. diff.)* infections M 20

*Chart 37*




There has been 4 cases of Clostridium difficile in February, the total number YTD is 48. Of these 48 cases 35 have been reviewed with the other 13 cases still under review.

We have been advised by the CCG that the thirty cases reviewed by them do not have significant lapses in care and do not reach the threshold for reporting; however 5 cases do have significant lapses in care and do reach the threshold for reporting. Therefore 30 cases would not count towards the trajectory of 17 significant lapses in care but 5 cases will.

Return to FRONT page

# Discharge summary (48 hours)

*Chart 38*

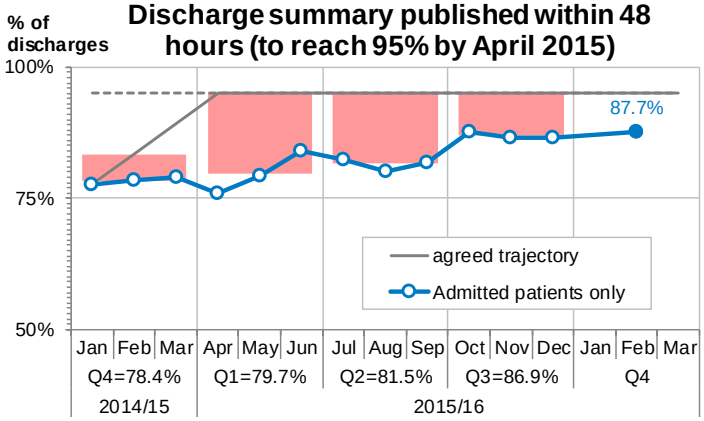



Chart 38 shows compliance with discharge summary completion within 48hrs.

The most significant factor in performance below trajectory is due to volume of patients, and rotating workforce through assessment areas.

To address this problem, checks of outstanding HCR documents are now done at 24hrs post patient discharge to enable the clinician to be alerted and allow for HCR completion within the 48hr deadline.

Lack of evening ward clerk hours has also led to difficulty in timely recording of discharges which has a negative impact on subsequent HCR auto publication. This is being addressed with the Heads of Nursing and those responsible for discharge related activities in the absence of a dedicated clerk.

Return to FRONT page

# Diagnostic tests (6 week wait) 16

*Chart 39*

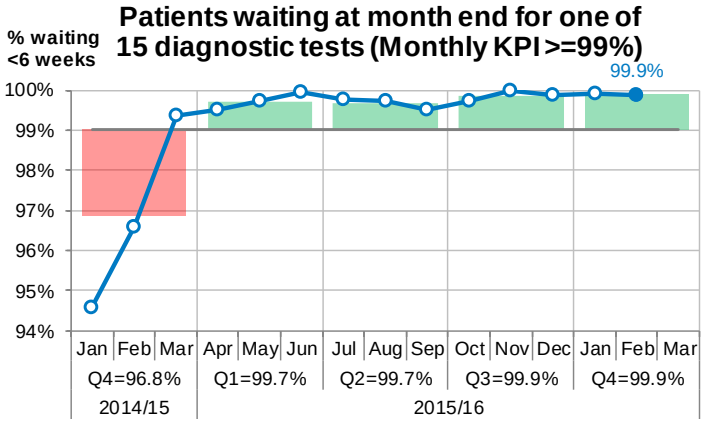
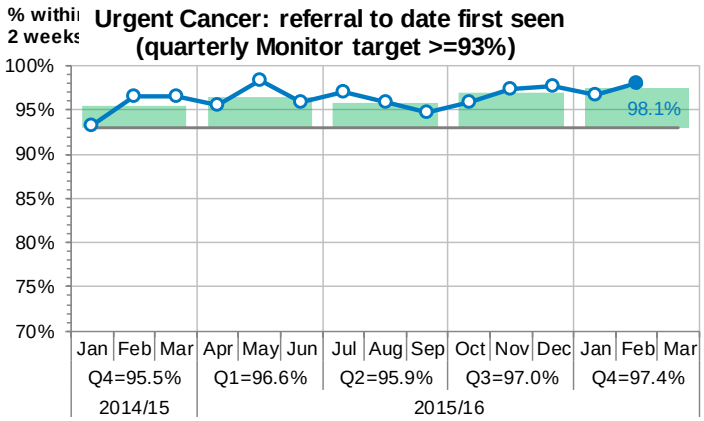



Chart 39 shows performance against the diagnostic standard. It is forecast that compliance with this standard will continue.

Return to FRONT page

# Cancer waiting times M 16

*Chart 40*




Compliance with the urgent referral standard continues.

*Chart 41*

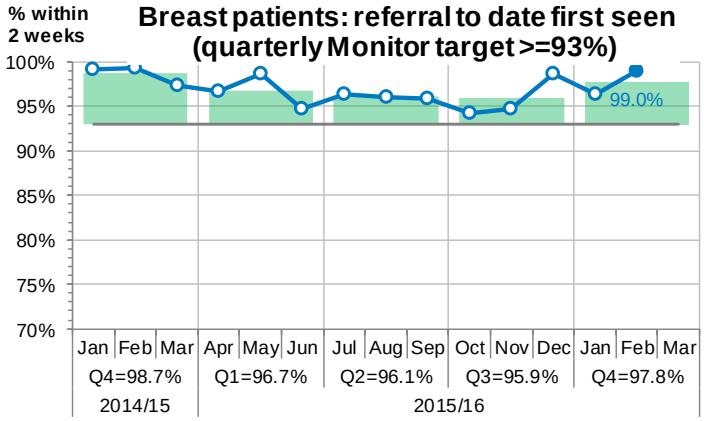
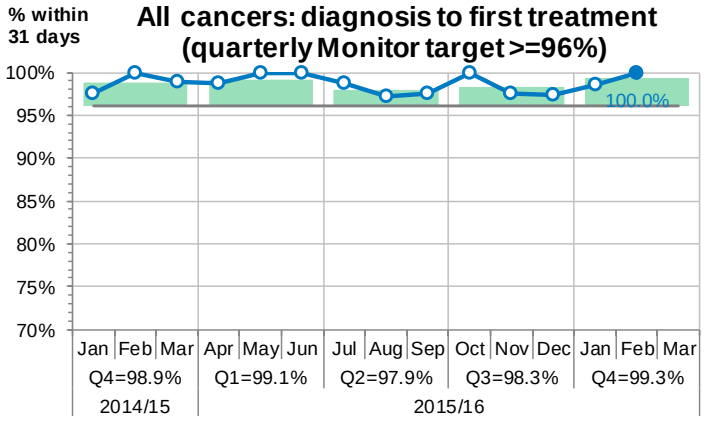



*Chart 42*



*Cancer waiting times indicators continue below:*

*Chart 43*

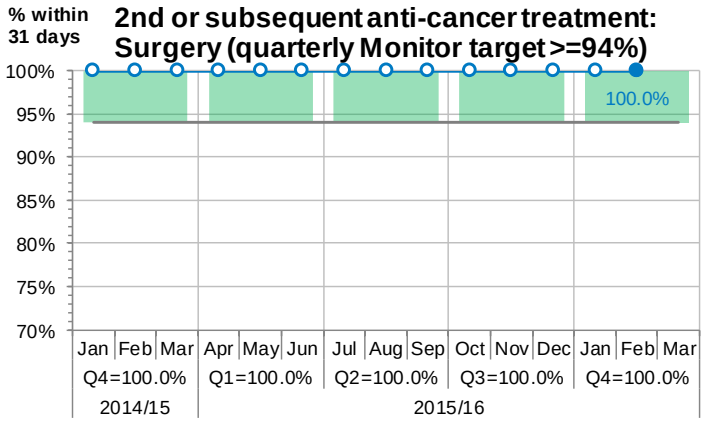



*Chart 44*

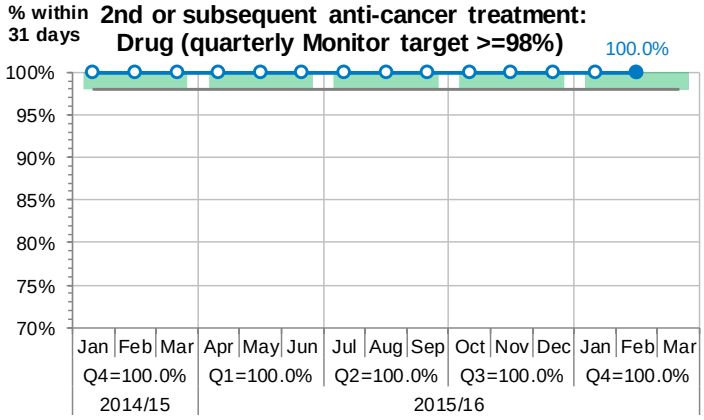


*Chart 45*

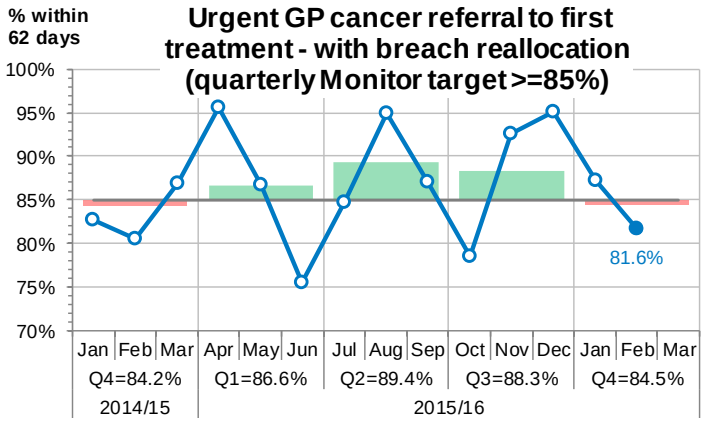



Chart 45 shows performance against the 62 day cancer standard.

February was predicted to be below target against the 62day cancer standard. The main contributor to this position was the effect of increased patient choice in delaying out-patient and diagnostic appointments over the Christmas period which inevitably extended the pathway.

Performance for the quarter remains very challenging, particularly with the continued junior doctor strike actions, winter pressures and its impact on HDU bed capacity.

*Chart 46 GP referral to first treatment with breach reallocation, by tumour group.*

| Tumour Group (Feb-16 data) | Number of breaches / cases | Performance (85% target) | Monthly trend |
|---|---|---|---|
| Upper GI | 2 / 2.5 | 20% | |
| Urology | 1 / 13 | 92% | |
| Haematology | 1 / 3 | 67% | |
| Colorectal | 0.5 / 6.5 | 92% | |
| Head & Neck | 0.5 / 2.5 | 80% | |
| Lung | 0.5 / 1 | 50% | |
| Breast | 0 / 9 | 100% | |
| Gynaecology | 0 / 2 | 100% | |

Chart 46 shows performance against the 62 day standard by tumour group.


Return to FRONT page

# In-Year Financial Performance

*Chart 47*

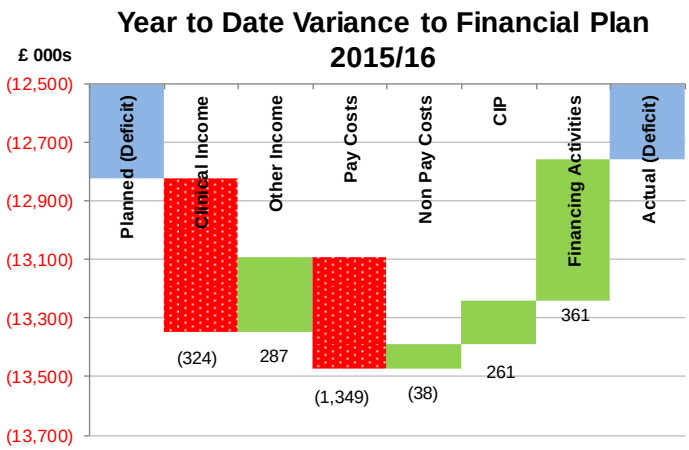
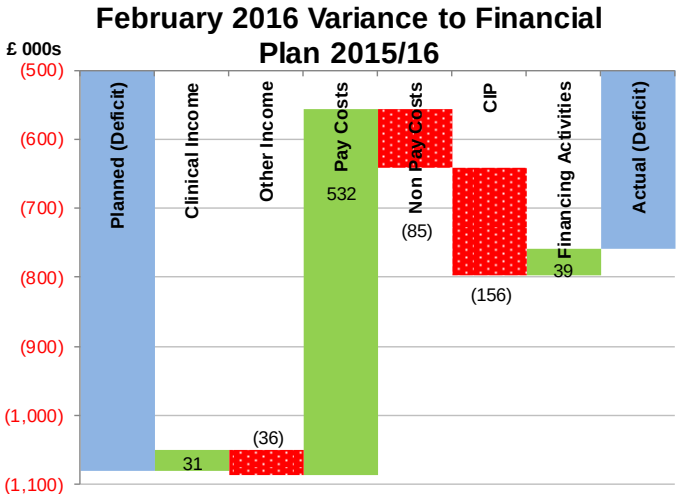



*Chart 48*




Eleven months into the financial year the deficit is £13.7m, which is £0.9m worse than the planned deficit of £12.8m. Of this, £1.0m relates to the technical accounting transaction of a legacy donation for medical equipment. This is a timing issue only and the impact will now be split across the current and next financial year. It does not impact the EBITDA.

The Trust has improved by £0.3m from the last month's position.

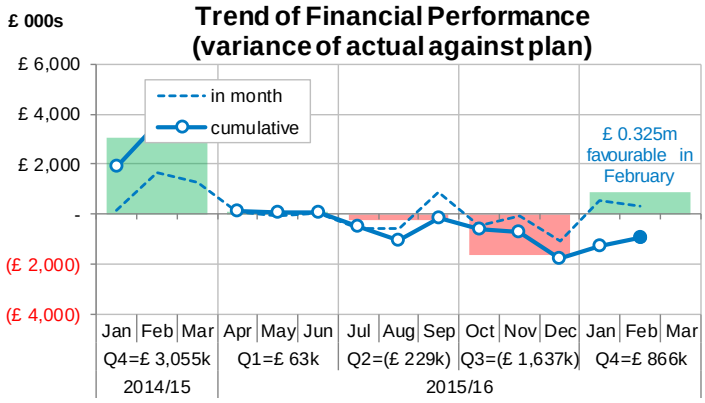
Clinical income in February was in line with plan, increasing the year-to-date shortfall against plan to £0.3m. The Trust has continued to cancel elective patients in February due to constraints on beds within the hospital; however plans are being put in place to ensure that the patients are re-booked in order to achieve the RTT target. A&E income was £0.1m above plan in month.

The financial position includes the refund of penalties from Stockport CCG and an estimate for the other CCGs; this will be finalised at year-end. The Trust is currently assessing the performance against the CQUIN targets and how this will affect the year-end financial position.

Pay costs have improved in month, including a reduction in temporary staffing costs of £0.3m and non-recurrent vacancies of £0.2m.

To achieve the year-end position mandated by NHS Improvement (Monitor and the NHS Trust Development Authority) the Trust is forecasting to utilise £1.2m of technical one-off measures. These adjustments to the balance sheet are one-off benefits deployed to achieve the position, and offset the failure of business groups to reduce the expenditure run-rate as required.

*Chart 49*



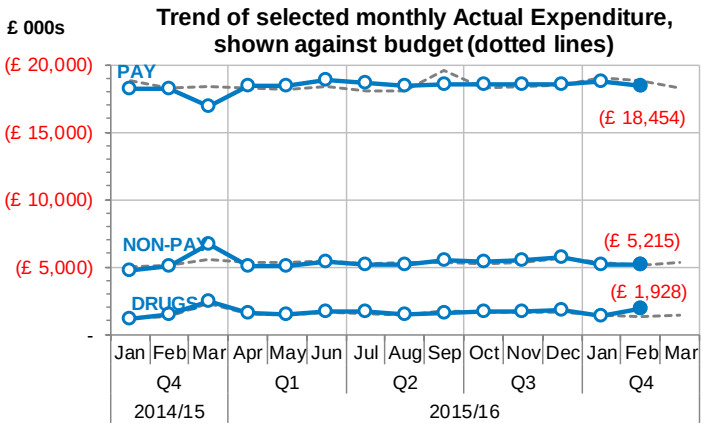

To deliver the "best possible financial out-turn 2015/16" required by NHS Improvement, each business group must spend less than their agreed control total. CIP is discussed in more detail later in this report, but it is imperative that the Trust delivers the cost improvement plans approved to the end of the financial year and each business groups delivers its agreed financial position as a minimum. Escalation meetings continue to take place with the business groups to ensure agreed actions are being delivered.

Pay costs in February 2016 were £18.5m, which is in line with the average of the year so far. Whilst implementation of the agency cap is underway across the Trust, this has not noticeably reduced costs at this stage. However plans of £2.0m savings are included in the CIP plans for 2016/17, which include a focus on recruiting to key shortage medical posts and a continuation of international recruitment.

Agency expenditure has reduced marginally in February 2016 to £1.2m and this is 6.4% of the total pay bill. Bank staff including NHS Professionals is a further cost of £0.6m in month, and increase the temporary staff costs to £1.8m in month; a reduction of £0.3m in month. Therefore the cumulative percentage of bank and agency staff to total staff costs has been reduced to 9.2% in January.

Non-pay costs of £5.2m follow the annual trend, but drug costs were very high at £1.9m in month compared to an average of £1.6m to date. However this has not caused an overspend as the majority of costs were covered by specific income received for high cost drugs for patients on certain care pathways.

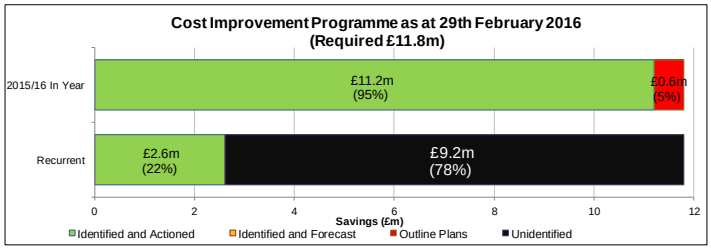
*Chart 50*




Return to FRONT page

# Cost Improvement Programme

*Chart 51*

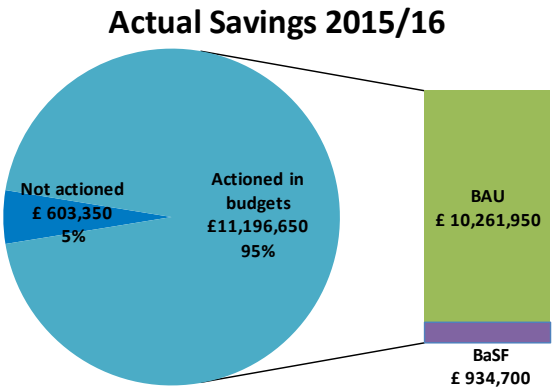



The Trust has now achieved £11.2m of savings against the full year £11.8m plan. This leaves £0.6m of CIP to be actioned in the final month of the year, shown in the red box of the chart to the left. Of the planned £1.7m to come from performance penalties not being invoked by CCGs, £1.4m has so far been agreed from Stockport CCG and the position with the other CCGs will be agreed by year end.

The outstanding CIP planned is linked to reduced run-rates agreed by each business group as part of the annual plan refresh process. These focused on reducing pay costs, mainly through reductions in agency staff and planning for winter capacity.

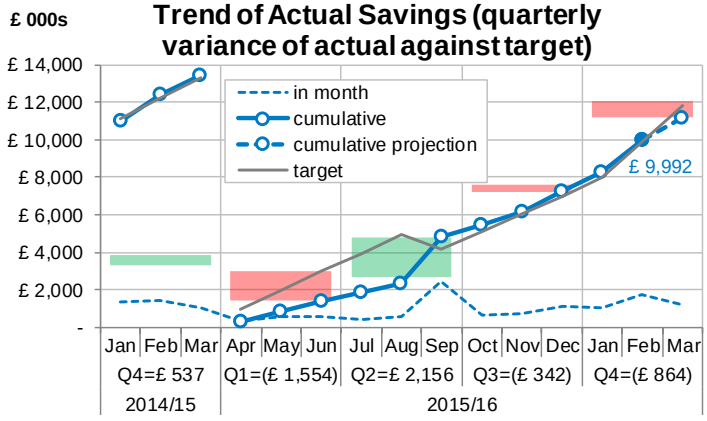
Recurrent CIP delivery remains low at £2.6m against the required £11.8m and therefore this shortfall has impacted on planning for 2016/17 and will increase the CIP required next year

*Chart 52*




The Trust has to deliver the financial savings in the rest of this year in order to achieve its financial plan. As the year progresses, the expenditure run-rate has not significantly reduced as intended from October 2015, therefore increased focus will be placed on business group actions to deliver the shortfall in line with NHS Improvement's expectations.

*Chart 53*




The plan for the eleven months to February 2016 requires £9.9m of the annual £11.8m to be delivered. Due to significant non-recurrent savings the Trust has achieved £10.0m to date, which is £0.1m ahead of plan.

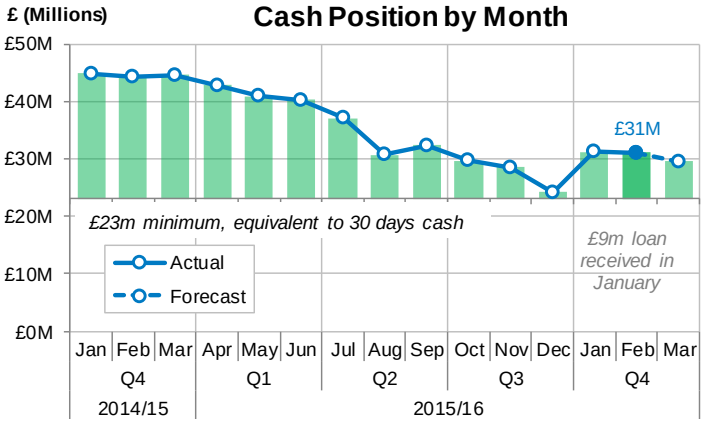

Return to FRONT page


## Financial Sustainability Risk Rating

*Chart 54*

| | | Actual | Rating | Initiate Override? | Excellent 4 | 3 | 2 | Poor 1 | Weight | Weighted score |
|---|---|---|---|---|---|---|---|---|---|---|
| Balance Sheet Sustainability | Capital service capacity (times) | (0.21) | 1 | Yes | 2.50 | 1.75 | 1.25 | < 1.25 | 25% | 0 |
| Liquidity | Liquidity (days) | 9 | 4 | No | 0 | -7 | -14 | < -14 | 25% | 1 |
| Underlying Performance | I&E margin (%) | -4.48% | 1 | Yes | 1.00% | 0.00% | -1.00% | <-1.0% | 25% | 0 |
| Variance from Plan | Variance in I&E margin as a % of income (%) | 0.33% | 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 55*




The Trust's overall Financial Sustainability Risk Rating (FSR) is 2, classified by Monitor as a material risk. There is no change to any of the metrics within the rating again this month.

The graph shown to the left highlights the cash benefit of the ITFF loan received in January, though since then cash has only decreased by £0.2m to £31.07m at 29th February 2016. The year-end cash forecast is expected to be below £30m; however as debtor and creditor positions are resolved this figure has the potential to increase.

There are over £1.2m of technical financial adjustments to the balance sheet included in the forecast year-end position of £13.3m. This means that although the Trust intends to hit the bottom line position for 2015/16 required by NHS Improvement as part of the national £1.8bn control total, there is still a negative impact on the cash position. Cash at the end of February 2016 is £0.8m lower than planned at the start of the year.

For the FSR to be a 3, the Trust position would need to improve by £13m.

Return to FRONT page

# Capital Programme

*Chart 56*

| Description | Original Plan 2015/16 Year £'000 | Revised Plan 2015/16 Year £'000 | Month 10 -Year to Date February 2015/16 Revised Plan £'000 | Actual £'000 | Variance £'000 |
|---|---|---|---|---|---|
| **Property & Estates Schemes** | | | | | |
| Surgical Centre | 10,565 | 9,900 | 9,200 | 8,837 | 363 |
| Priority Schemes | 500 | 200 | 150 | 66 | 84 |
| Invest to Save Schemes | 100 | 200 | 200 | 62 | 138 |
| Site Security Upgrade | 47 | 29 | 29 | 30 | (1) |
| Catering Strategy | 0 | 4 | 4 | 1 | 3 |
| Minor Projects | 672 | 524 | 494 | 609 | (116) |
| Backlog Maintenance/Site Infrastructure | 140 | 133 | 98 | 114 | (16) |
| Statutory Compliance | 258 | 309 | 269 | 229 | 40 |
| Environmental /CMIP | 177 | 166 | 142 | 55 | 87 |
| Corporate Facilities | 145 | 130 | 120 | 21 | 99 |
| | 12,604 | 11,595 | 10,705 | 10,023 | 682 |
| **Equipment Schemes** | | | | | |
| Medical Equipment | 1,505 | 1,492 | 1,442 | 1,269 | 174 |
| C T Scanner | 650 | 325 | 325 | 0 | 325 |
| Urology Robot | 1,200 | 1,500 | 1,500 | 1,500 | 0 |
| | 3,355 | 3,317 | 3,267 | 2,769 | 499 |
| **I M & T Projects** | | | | | |
| EPR | 969 | 48 | 48 | 43 | 5 |
| Aspen House Server Room | 351 | 448 | 448 | 387 | 61 |
| Other IM &T | 969 | 830 | 754 | 691 | 63 |
| | 2,289 | 1,326 | 1,250 | 1,121 | 128 |
| **Revenue to Capital** | 0 | 5 | 5 | 172 | (167) |
| **Capital to Revenue** | 0 | 0 | 0 | (109) | 109 |
| **TOTAL (excluding Finance leases)** | 18,248 | 16,243 | 15,227 | 13,976 | 1,141 |

To the end of February capital expenditure is behind plan by £1.1m, but intends to reach a balanced position at the end of the financial year.

Installation of the replacement CT scanner is underway following completion of the enabling works, with final acceptance testing to be complete by 28th March. Enabling works for the modular MR facility provided by Alliance Medical is shown under Priority Schemes. The Trust's capital involvement in this is now complete, allowing for delivery of the scanner in the coming weeks and expected go live on 18th April.

The Surgical Centre contractor reports progress is on schedule, but expenditure currently running £0.4m behind plan. Delivery is awaited in March on various furniture and equipment items being built on site.

Under medical equipment, orders have not yet been fulfilled for a new laboratory C Difficile testing machine, replacement colonoscope and a specialised C-spine surgical microscope. Delivery of these items will return the current underspend of £0.2m to plan.

IM&T projects have increased expenditure in month to £0.1m behind plan, including work on the Community WiFi project which is a facilitator for the Community EPR (EMIS) project.

Return to FRONT page

See also Financial Income and Expenditure table

# Workforce Quality

## Staff sickness absence

*Chart 57*

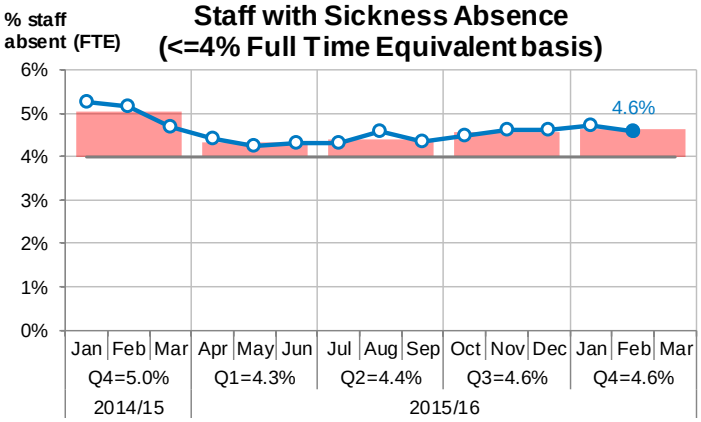
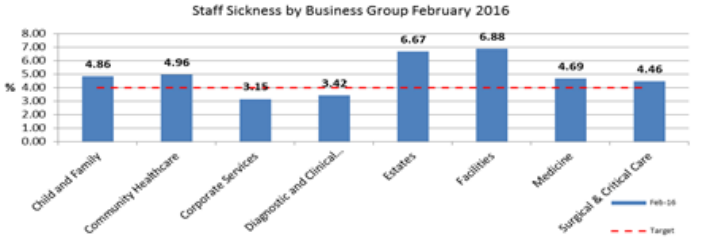



*Chart 58*




The in-month unadjusted sickness absence figure for February 2016 is 4.57%. This is a decrease of 0.15% compared to the January 2016 adjusted figure of 4.72%. The sickness rate for comparison in February 2015 was 5.17%.

The unadjusted cost of sickness absence in February 2016 is £516,767, a decrease of £59,532 from the adjusted figure of £576,299 in January 2016. This does not include the cost to cover the sickness absence.

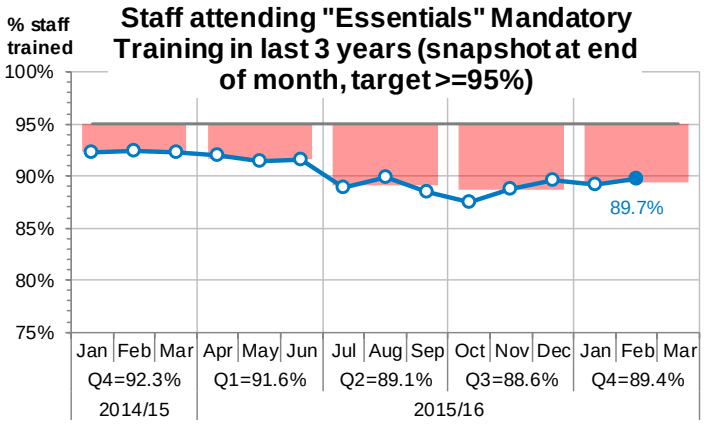
Community Healthcare, Diagnostic & Clinical Support, Medicine and Surgical & Critical Care have reported a reduction in sickness absence in January 2016. Corporate Services and Diagnostic & Clinical Services are below the 4% target in February 2016. Facilities has the highest sickness rate at 6.88% in Februaryy 2016, a 0.23% increase from 6.65% in January 2016. Estates has seen an increase to 6.67% in February 2016 from 3.15% in January 2016.

The top 3 known reasons for sickness in February 2016 are stress at 22.43% (a 1.97% increase from 20.46% in January 2016), back problems and other musculoskeletal problems including injury/fracture at 21.15% (a 1.92% increase from 19.23% in January 2016), and cough, cold, flu, chest, respiratory problems at 10.27% (a 2.38% decrease from 12.65% in January 2016).

Return to FRONT page

# Essentials training

*Chart 59*




In February 2016 there was an increase of 0.5% in compliance from the January position, from 89.2% to 89.7%.

Two of the Business Groups achieved compliance; Estates and Community Services.

Diagnostics and Clinical Support achieved 94.61%. The remaining Business Groups are under 90%. The Head of OD and Learning has contacted those Business Groups who are under 90% to ascertain the plans they have in place to achieve 95% compliance.

- External training will only be approved if a member of staff is fully compliant with their Essentials Training and has an up to date appraisal.
- Monthly emails reminders are sent to all staff that are non-compliant.
- Improved use of the Core Skills Framework e-learning packages. Supported by Health Education North West the Core Skills e-learning modules are easier to access and quicker to complete. The framework can be adapted for all Trust staff to use in place of the existing e-learning catalogue of topics and covers a wider range of topics.

Return to FRONT page

# Staff appraisals

*Chart 60*

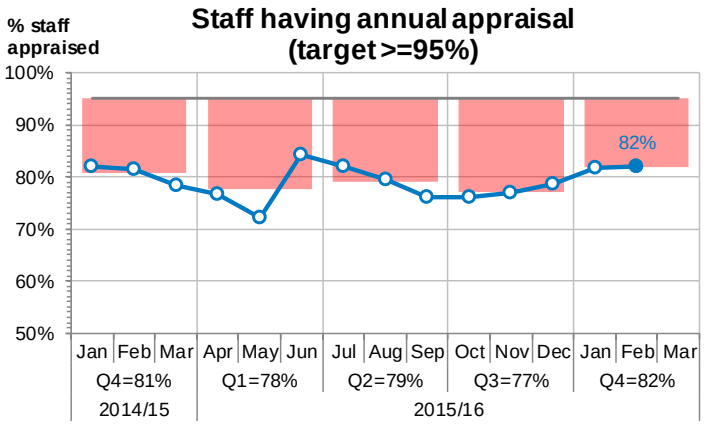
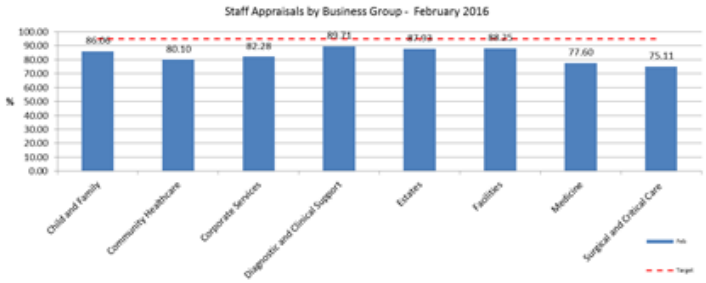



*Chart 61*




The Trust's total appraisal compliance for February 2016 is 81.91%, an increase of 0.12% since January 2015 (81.79%).

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

The following Business Groups have seen increases this month; Child & Family from 84.87% to 86.06%, Corporate Services from 81.55% to 82.28%, Estates from 84.48% to 87.93%, Facilities from 82.25% to 88.25%, and Surgical & Critical Care from 74.92% to 75.11%. Three Business Groups saw a drop in compliance from last month; Community Healthcare from 80.93% to 80.10%, Diagnostic and Clinical Services from 90.95% to 89.71% and Medicine from 78.49% to 77.60%. There has been a change to the way the appraisal percentage is calculated. Those members of staff who are on maternity leave, external secondments, or career breaks are no longer included in the figures.

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

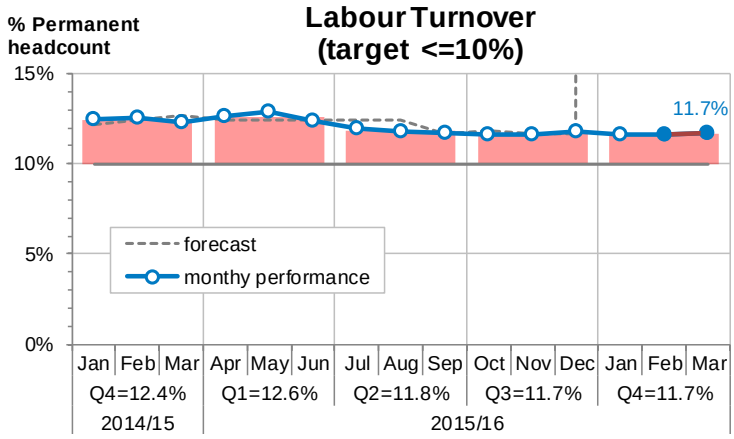
The medical appraisal rate for February 2016 is 87.45%, a decrease of 4.74% from January 2016 (92.19%).

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

Return to FRONT page

# Workforce Efficiency

*Chart 62*

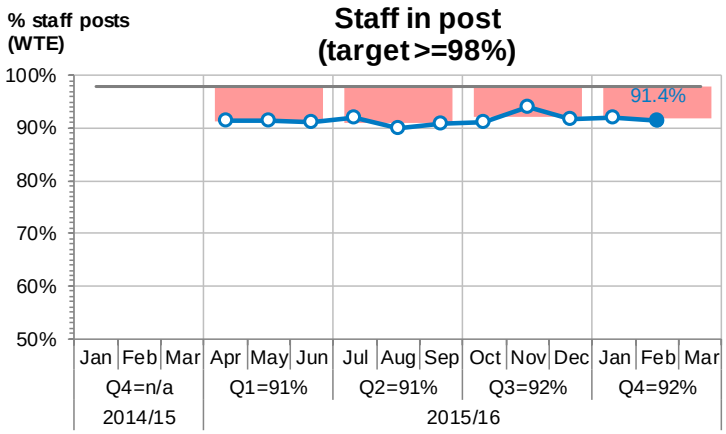



The Trust's permanent headcount turnover figure for the 12 months ending February 2016 is 11.66%. This is a marginal increase of 0.05% compared to the January 2016 figure of 11.61%, showing some stability in the turnover activity. The turnover rate for comparison to February 2015 was 12.54%. The Trust target is based on the NHS average of 10%.

Child & Family, Corporate Services, and Facilities are the only Business Groups below the 10% target in February 2016. Community Healthcare continues to have the highest turnover rate at 16.13% in February 2016. Corporate Services have seen the biggest decrease of 1.39% to 7.83% in February 2016 (from 9.22% in January.

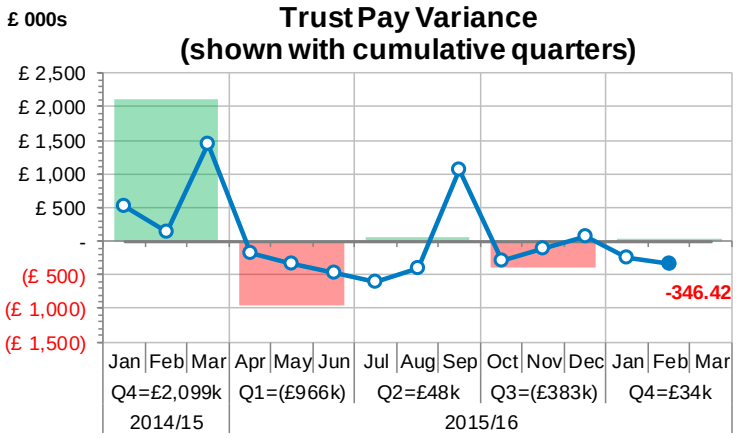
*Chart 63*

*Chart 64*



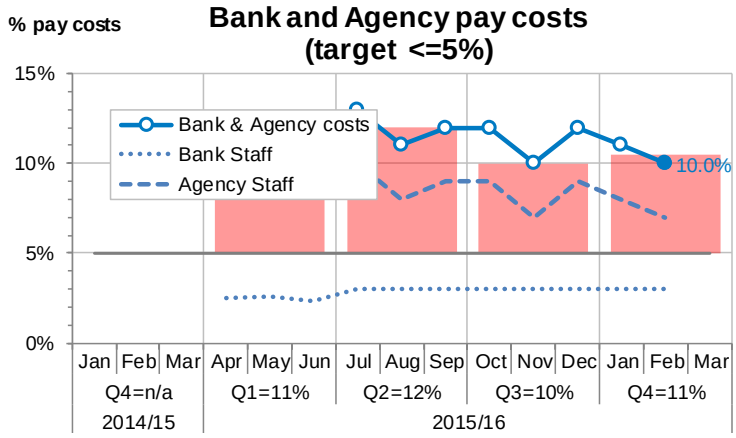

The Trust staff in post for February 2016 is 91.4% of the establishment, which is a decrease of 0.6% from 92.0% in January 2016.

*Chart 65*




The Trust pay variance, expenditure above the financial envelope of establishment, including vacancies in February 2015 showed a £346,420 overspend, an increase of £90,677 from the £255,743 overspend reported in January 2015.

*Chart 66*




The percentage of pay costs spent on bank and agency in February 2016 is 10% (a decrease of 1% from January's position) which equates to £1,790,140 a decrease of £282,694 from £2,072,834 in January 2016.

The Medicine Business Group has the highest spend on bank/agency at £1,038,858 in February 2016 which equates to 58% of the overall spend.

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


Return to FRONT page

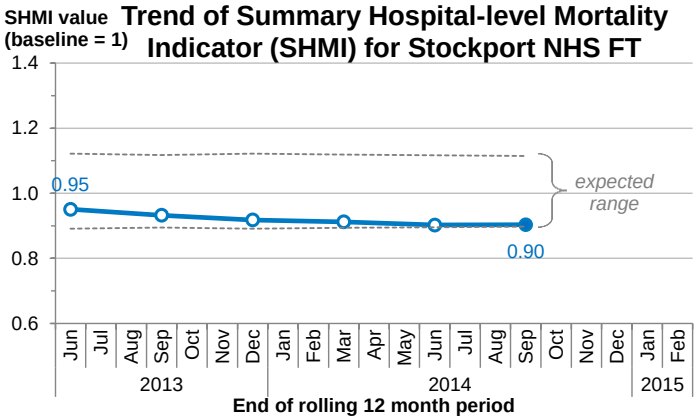
***The following sets of Quality indicators are updated on either a quarterly or annual basis. This section will describe the actions being taken to improve performance across these areas.***

# Mortality and preventable deaths

## 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 67*




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 69*

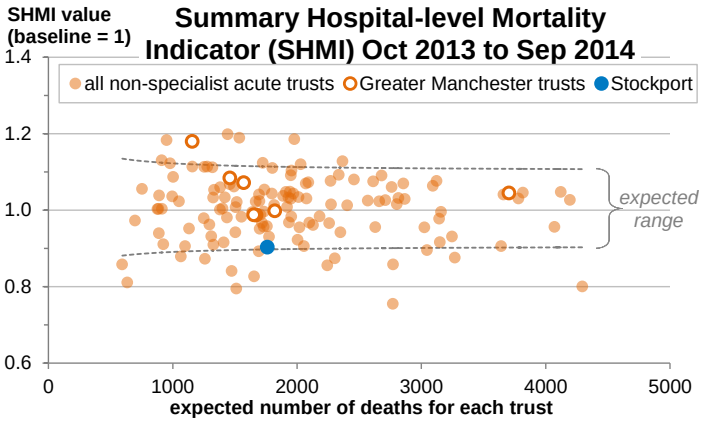
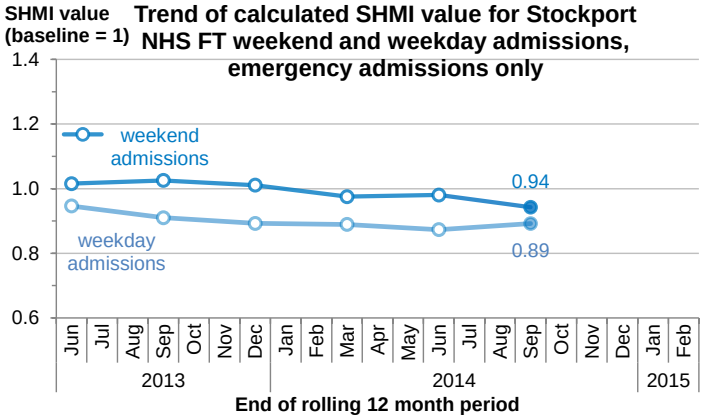



*Chart 68*




Return to FRONT page

# Risk Adjusted Mortality Index (RAMI)

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

*Chart 70*

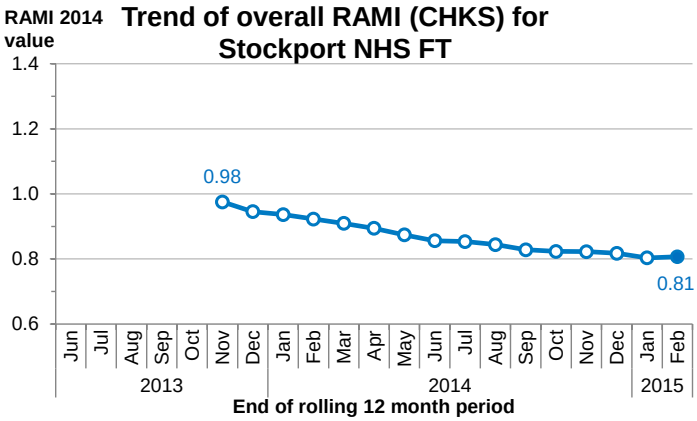



*Chart 71*

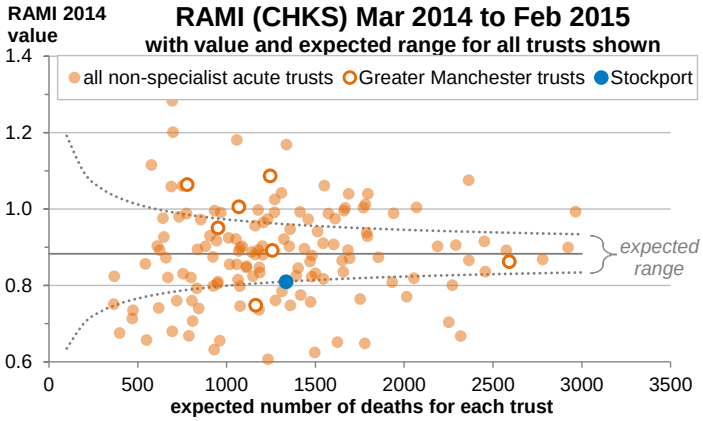
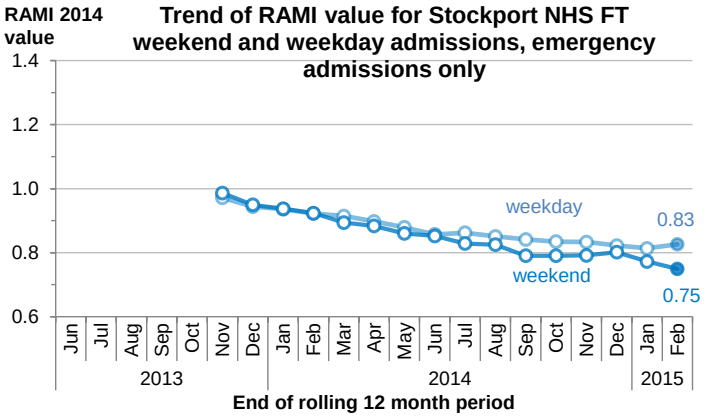



*Chart 72*



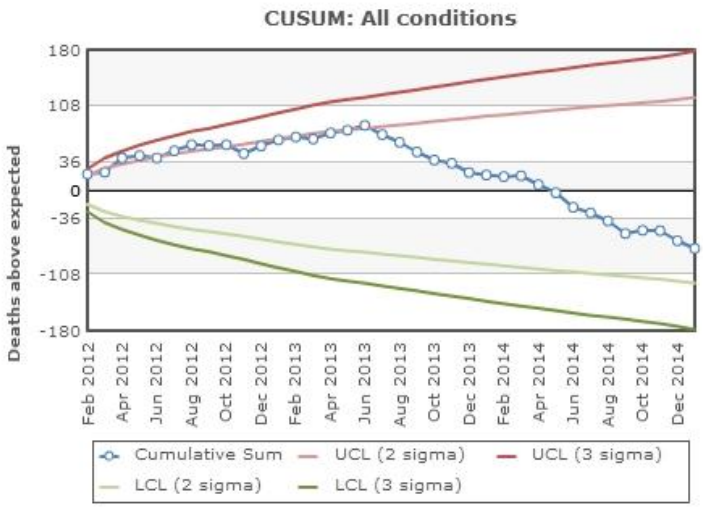

Return to FRONT page

# Hospital Standardised Mortality Data (HMSR)

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

*Data source: CHKS (using Dr Foster Intelligence methodology)*

*Chart 73*




Return to FRONT page

# Cardiac arrest outside of Emergency Department

*Data source: CHKS*

*Trust Peer Group (as measured by case mix) for comparative analyses:* Bolton; Burton Hospitals ; Countess Of Chester Hospital ; Kingston Hospital; Medway; Mid Cheshire Hospitals ; North Cumbria University Hospitals ; Northern Lincolnshire & Goole Hospitals ; St Helens And Knowsley Hospitals; University Hospital of South Manchester University Hospitals Of Morecambe Bay

*Chart 74*

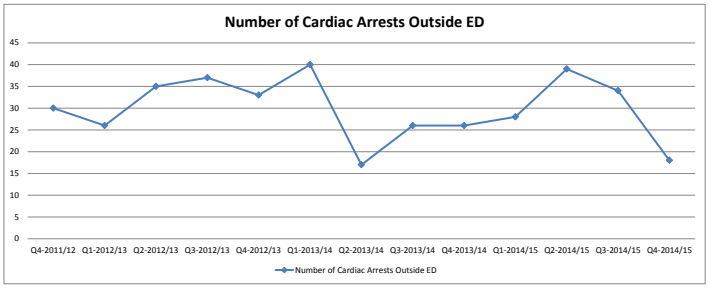



*Chart 74* shows absolute number of arrests for patients who were admitted and arrest was not the primary diagnosis. This data is being reconciled with the 2222 cardiac arrest calls for further accuracy – audit began August 15 due to end October 15

Monitoring of patients using EWS is well established via Patientrack in most medical ward areas to identify the deteriorating patient. A working group to look at automated escalation and alerting of medical staff has now been convened.

*Chart 75*

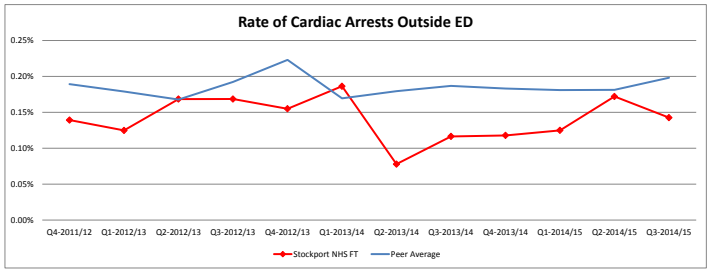



Chart 75 shows the Trust rate of arrests as a proportion of all admissions compared to peer which demonstrating a rate consistently lower than peer for the last 12 months. The escalation and alert group would aim to see a further reduction in arrest on implementation of the new process and policy to be designed and agreed. Next meeting October 15

Return to FRONT page

# Hypoglycaemia outside of Emergency Department

*Chart 76*

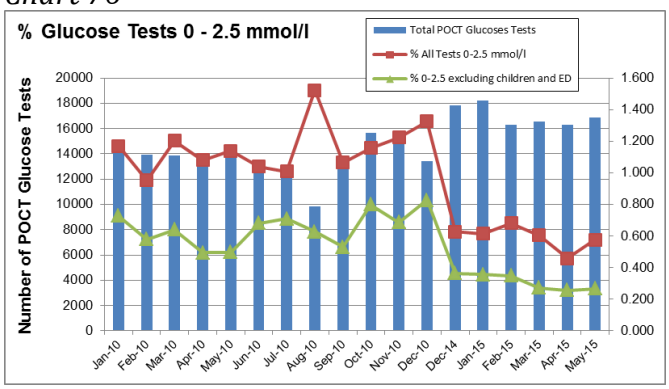


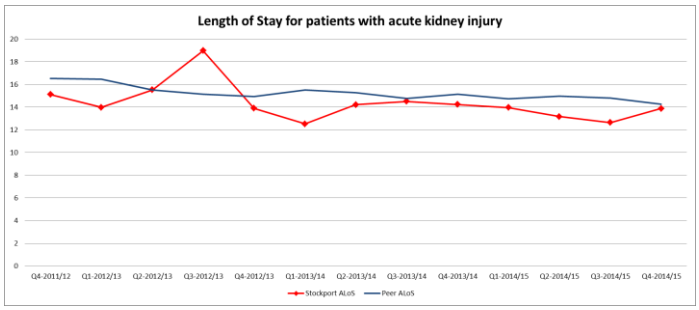

Chart 76 shows the reduction in Point of Care recorded episodes of Hypoglycaemia with the green line representing those occurances outside emergency and medical acute areas. A review of the data with the diabetic team has been requested to identify where further improvements might be made and if adherence to local policy has been audited.

# Quality of life in long term conditions

## Length of stay for patients with acute kidney injury

*Data source: CHKS for all Quality of life in long term conditions indicators*

*Chart 77*




Blue line indicates peer comparison. The Trust appear to do well when compared to peer. AKI is now a mandatory requirement of all discharge summaries with associated drop downs depending on stage of AKI. Interview for an AKI specialist nurse to take place December 15

Return to FRONT page

# Length of stay for patients >65 years with falls

*Chart 78*

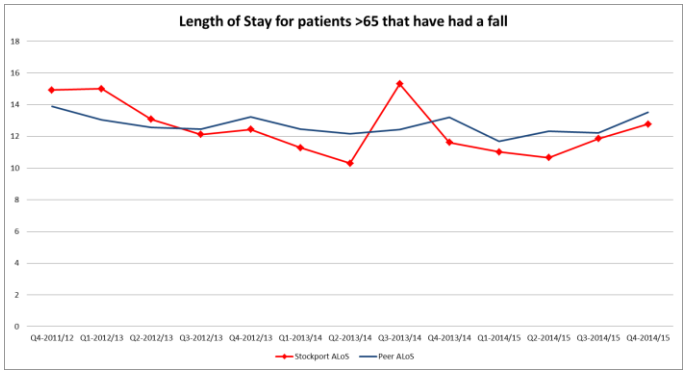



*Chart 78* shows data for all inpatients coded with falls either on admission or during spell.

Rate shown against Trust peer group. Data would imply the Trust continues to perform below the peer group average but that this is not consistent. Need to understand the factors involved in poor performance and whether this is an indicator for measuring improvements in Quality of Life for those with long term conditions

*Chart 79*

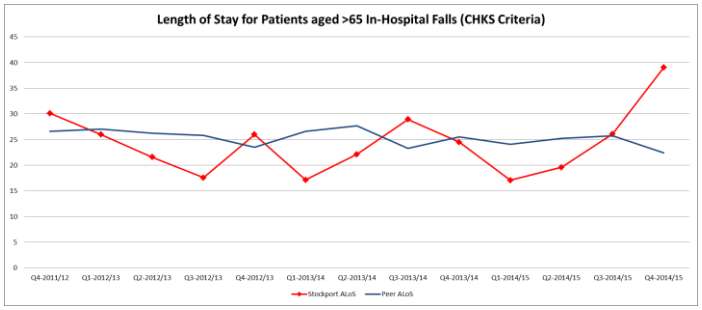



Chart 79 shows data for all inpatients coded with fall **while in hospital** but not admitted for falls.
Rate shown against peer group. A spike in Q4 will be investigated to identify case(s) and a root cause analysis performed for LoS.

The Trust innovation team have devised an action plan to address the increase loS for all Non-elective patients driven by the data provided here

Return to FRONT page

# Length of stay for patients with Chronic Obstructive Pulmonary Disease (COPD)

*Chart 80*

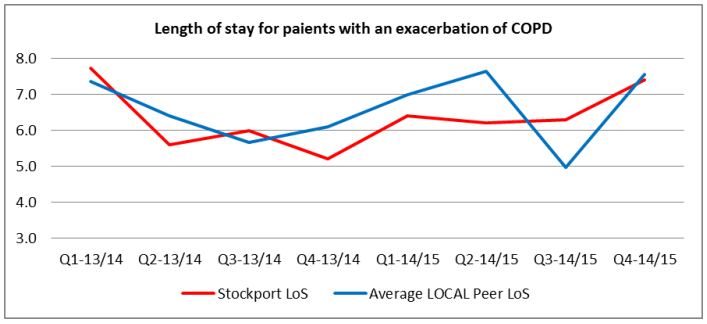



Chart 80 has been updated to now show the length of stay (LoS) for patients admitted with an exacerbation of their COPD. Data has been considered in tandem with readmission rates based on the Making Safety Visible work as COPD has been identified in previous readmission root cause analysis and case-note review. A new model has been adopted via the clinical lead to avoid admission and readmission of COPD patients with a community nursing model. Assessment of this model to take place in Feb 16

Return to FRONT page

# Helping patients recover

*Data source: CHKS*

*Chart 81*

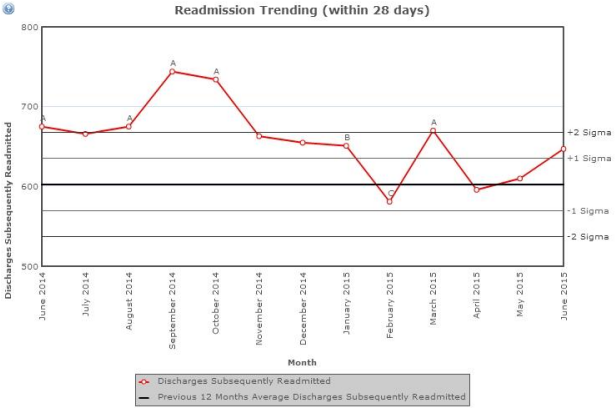


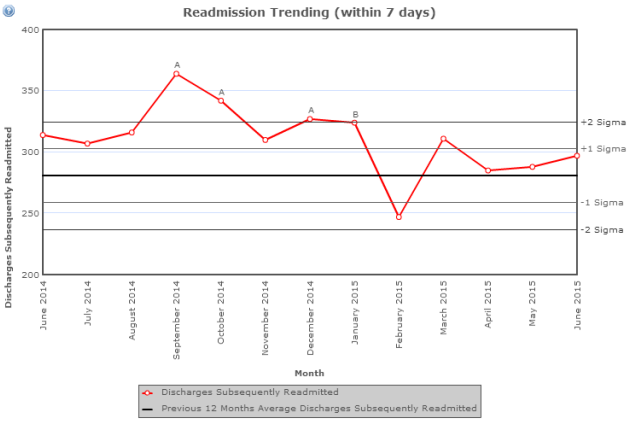

Chart 81 and 82 demonstrate the rate of readmissions shown against the Trust average for the preceding year. Within 28 and 7 days of original admission.

Readmissions rates have fallen since the winter period of 2014/15

An audit in 13/14 of over 500 cases identified themes for reasons behind readmission and made suggestions as to improvements in service. A working group has been identified to action the recommendations of the Medical Director and measure improvements specific to these themes and actions as follows:

1. THEME - Recurrent relapse of chronic condition(s)
2. THEME - Pain post procedure (links with day case CQUIN)
3. Benchmark position against Peer and identify 'gap' to achieve top Quartile performance
4. Assurance over coding practice and the effect on readmissions
5. To quantify the effect of diagnostic waits on readmissions
6. To provide evidence based daycase advice and readmission avoidance literature

*Chart 82*




A recent Innovation group has been set up specifically to look at causes of readmissions within the Surgical business group starting with daycase and short stay patients. The actions of this group will inform the CQUIN also

Return to FRONT page

# Positive experience of care

## Cancelled Operations

*Chart 83*

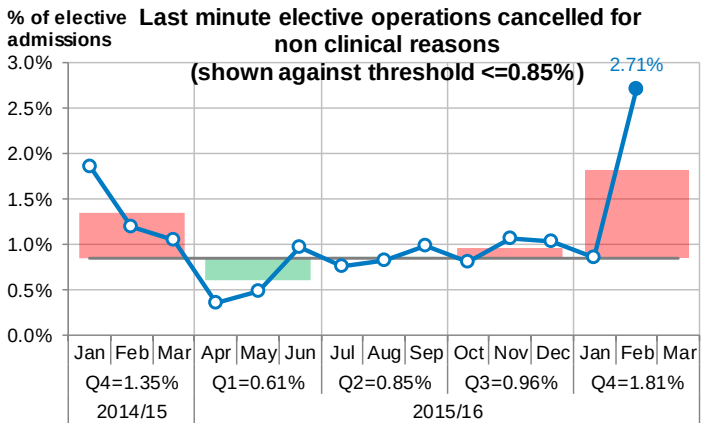



Chart 83 shows the standard for last minute cancelations was met in January.

There were a total of 89 cancellations on the day for non-clinical reasons.

The top reasons for cancellations were:

- 39 due to staff availability/sickness absence
- 28 due to lack of bed availability
- 13 due to no HDU beds.

## Patient experience of pain

A multi professional group has now been convened to address the patient experience of pain across all business groups and specialties. The group meets monthly and direct actions against the following set of Key Themes – the detailed actions and outcomes are reported quarterly to Quality Governance.

- Improve staff understanding regarding patient experience of pain and pain management – establish a culture of Pain as a Priority
- Integrated approach to Trust wide learning regarding Pain Management in Palliative and Actue settings
- Provide a greater understanding of pain relief prescribing, administration & monitoring
- Ensure timely access to analgesia
- Seek and monitor feedback on pain management from patient and staff
- Improve patient communication information in relation to pain control in various settings (palliative, acute, chronic)
- Ensure resources to maintain a culture of Pain as a Priority are regularly reviewed and meet the requirements of the patients and Trust strategy

Return to FRONT page

# Avoidable harm and complications

*Data source: CHKS*

*Chart 84*

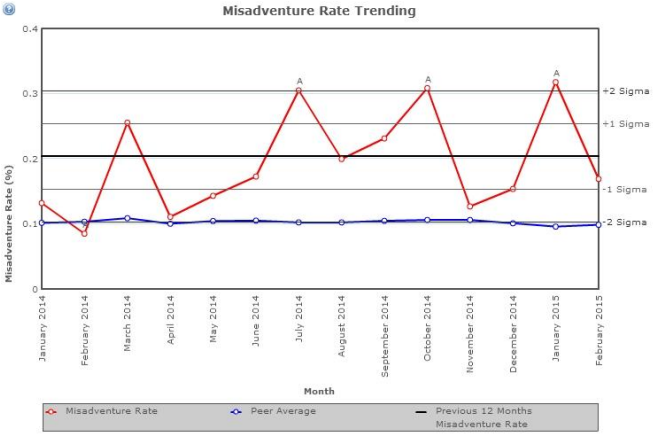



Chart 84 shows rate of misadventure against National HES peer group. There is variance about the mean of the previous year on a month to month basis but significantly higher than National HES peer

Misadventure rates are significantly higher than peer comparators in 4 areas. A project group has been convened to look at specific misadventure codes to identify coding practice improvements where needed and clinical intervention if required

Feedback from the project group expected Feb 16

*Chart 85*

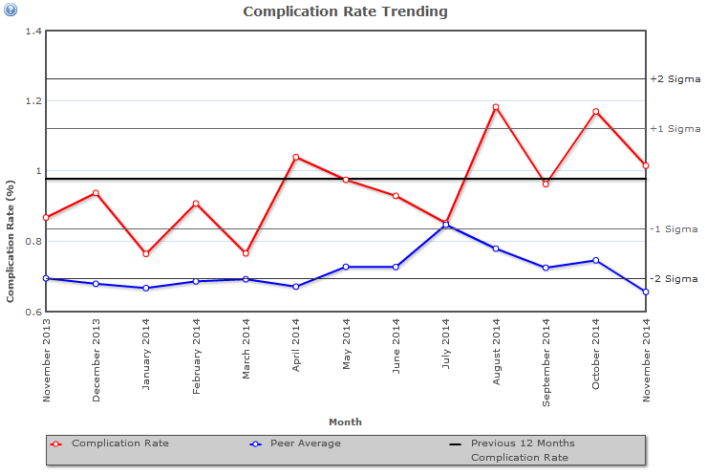



Chart 85 shows the "Complications Attributed" rate; that is complications based on the initial episode of care that the complication potentially relates to, as opposed to "complications treated" regardless of the potential cause. Rate shown against National HES Peer Group

Further investigation into coding has already led to training and coding improvements with regards misadventure. A working group is being convened to extend this practice across all above areas of misadventure and complication

Feedback from the project group expected Feb 16

Return to FRONT page

# Integrated Performance Report
# February 2016 Financial Table

Stockport NHS Foundation Trust

## Income and Expenditure Statement

Return to FRONT page

| | Trust Annual Plan | Year-to-date | | |
|---|---|---|---|---|
| | | Plan | Actual | Variance |
| | £k | £k | £k | £k |
| **INCOME** | | | | |
| Elective | 40,157 | 36,815 | 36,462 | (353) |
| Non Elective | 73,059 | 67,117 | 67,001 | (116) |
| Outpatient | 30,805 | 28,225 | 28,197 | (28) |
| A&E | 11,351 | 10,209 | 10,449 | 239 |
| **Total Income at Full Tariff** | **155,373** | **142,366** | **142,109** | **(257)** |
| Community Services | 60,735 | 55,640 | 55,678 | 38 |
| Non-tariff income | 53,993 | 48,876 | 48,186 | (691) |
| **Clinical Income - NHS** | **270,100** | **246,882** | **245,973** | **(909)** |
| Private Patients | 349 | 312 | 180 | (133) |
| Other | 968 | 887 | 1,109 | 222 |
| **Non NHS Clinical Income** | **1,317** | **1,199** | **1,288** | **89** |
| Research & Development | 443 | 398 | 351 | (47) |
| Education and Training | 7,765 | 7,123 | 7,238 | 115 |
| Stockport Pharmaceuticals/RQC | 5,755 | 5,215 | 5,041 | (174) |
| Other income | 19,698 | 18,323 | 19,316 | 992 |
| **Other Income** | **33,661** | **31,059** | **31,945** | **886** |
| | | | | |
| **TOTAL INCOME** | **305,079** | **279,140** | **279,206** | **66** |
| **EXPENDITURE** | | | | |
| Pay Costs | (221,637) | (203,340) | (204,132) | (792) |
| Drugs | (19,092) | (17,711) | (17,940) | (229) |
| Clinical Supplies & services | (21,752) | (19,953) | (20,156) | (204) |
| Other Non Pay Costs | (42,464) | (38,963) | (38,223) | 740 |
| **TOTAL COSTS** | **(304,945)** | **(279,967)** | **(280,452)** | **(484)** |
| **EBITDA** | **134** | **(827)** | **(1,246)** | **(418)** |
| Depreciation | (8,914) | (8,133) | (7,881) | 253 |
| Interest Receivable | 63 | 57 | 87 | 30 |
| Interest Payable | (1,019) | (935) | (712) | 223 |
| Other Non-Operating Expenses | (371) | (334) | (301) | 33 |
| Fixed Asset Impairment Reversal | - | - | (9) | (9) |
| Unwinding of Discount | (30) | - | - | - |
| Profit/(Loss) on disposal of fixed ass | 30 | 30 | (18) | (48) |
| Donations of cash for PPE | 1,000 | 1,000 | - | (1,000) |
| PDC Dividend | (4,011) | (3,677) | (3,677) | 0 |
| **RETAINED SURPLUS / (DEFICIT) FOR PERIOD** | **(13,118)** | **(12,819)** | **(13,755)** | **(936)** |

# Integrated Performance Report
# CQUIN Statement

Stockport NHS Foundation Trust

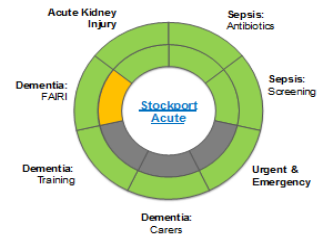
Return to FRONT page

**IPR: CQUIN Milestone Performance:** Quarter 3 (15-16)

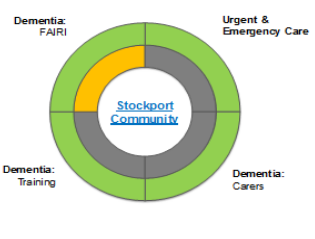
Achieved | Partially Achieved | Not Achieved | Not Applicable | Not Confirmed

*Not final. Position based on initial CCG feedback*

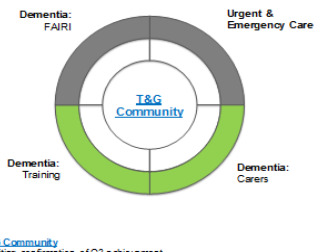
## NATIONAL CQUINs




Stockport Acute:
**Dementia FAIR:** Trust to provide further information.

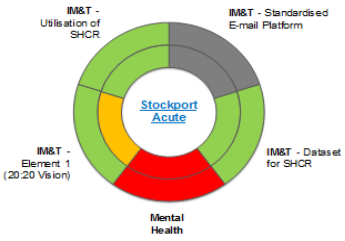



Stockport Community:
**Dementia FAIR:** As per Acute.



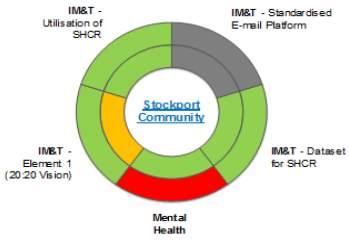

T&G Community
Awaiting confirmation of Q3 achievement.

## GREATER MANCHESTER CQUINs

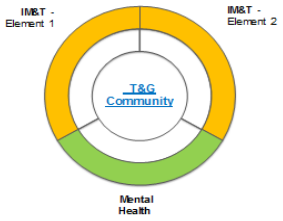



Stockport Acute:
**IM&T - Element 1 (20:20 Vision):** Trust to provide further information.

**Mental Health:** Not achieved. CQUIN Lead to review.

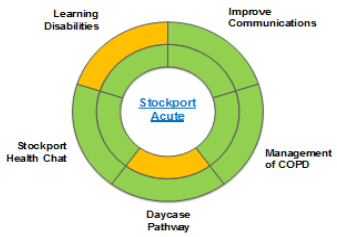


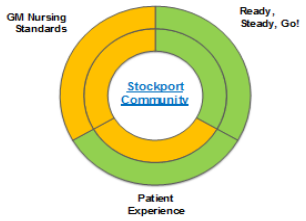

Stockport Community:
**IM&T - Element 1 (20:20 Vision):** As per Acute.

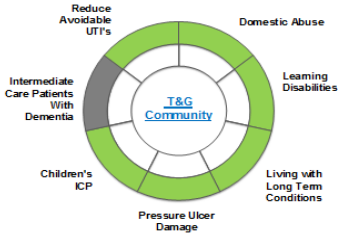


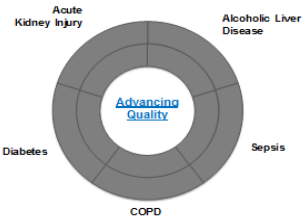

T&G Community
Awaiting confirmation of Q3 achievement.

## LOCAL CQUINs




Stockport Acute:
**Daycase Pathway:** Trust to provide further information.

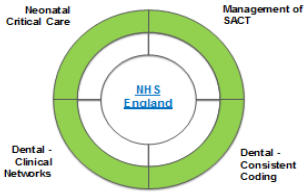
Stockport Community:

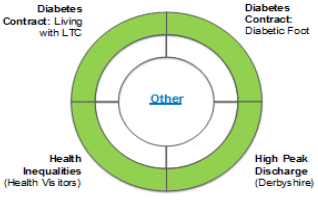
**GM Nursing Standards:** Trust to provide further information.
**Patient Experience:** Trust to provide further information.

Advancing Quality
AQ programme is based on end of year targets.
COPD will achieve, AKI & Sepsis are at amber and ALRD & Diabetes are at red.

T&G Community
Awaiting confirmation of Q3 achievement.

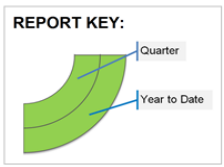
## OTHER CQUINs




NHS England:
Awaiting confirmation of Q3 achievement.

Other:
Awaiting confirmation of Q3 achievement.



# Integrated Performance Report
# February 2016 Nursing Dashboard

Stockport NHS Foundation Trust

**February 2016 Data**

| | Clinical | | | | | | | Patient Experience | | | Workforce | | Overall | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Care Indicators | Internal CQC Inspections | Nursing Medication Related Incidents | Falls * | Pressure Ulcers | Confirmed Avoidable Stage 3-4 (Nov data) | C. Dificile | FFT % Positive Responses | FFT Response Rate | Complaints | Appraisals | Sickness Absence | **Total Performance | Total Perf *last* Mth |
| **Trust Total** | 97% | | 0 | 3 | 27 | 0 | 4 | | 47.9% | 11 | 81.7% | 5.0% | 8.2 | 9.8 |

NB: FFT Response Rate and Score is an input Total & not calculated.

**Business Groups Performance:**

| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| C&F | 97.4% | | 0 | 0 | 0 | 0 | 0 | | 20.0% | 2 | 86.5% | 5.5% | 8.4 | 9.2 |
| Medicine | 97.9% | | 0 | 3 | 16 | 0 | 4 | | 58.2% | 8 | 80.7% | 5.5% | 8.0 | 9.2 |
| S & CC | 94.3% | | 0 | 0 | 9 | 0 | 0 | | 30.4% | 1 | 83.4% | 3.8% | 8.3 | 11.0 |
| Community | 97.7% | | 0 | 0 | 2 | 0 | 0 | | | 0 | 60.4% | 5.4% | 10.0 | 12.0 |

NB: Trust & Business Group RAG rating proportionate to that of the Wards

**Wards by Business Group:**

**Child & Family**

| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Jasmine | 100.0% | Good | | 0 | 0 | 0 | 0 | 96% | 20.0% | 1 | 100.0% | 5.1% | 12 | 12 |
| M2 | 100.0% | Good | | 0 | 0 | 0 | 0 | | | 1 | 94.1% | 8.0% | 9 | 7 |
| M3 | 94.2% | | | 0 | 0 | 0 | 0 | | | | 79.2% | 0.4% | 4 | 2 |
| NNU | 95.7% | | | 0 | | | | | | | 64.9% | 5.5% | 10 | 15 |
| Tree House | 97.0% | | | 0 | 0 | 0 | 0 | | | | 94.5% | 8.7% | 7 | 10 |

**Medicine**

| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| A1 AMU | 99.5% | Good | | 0 | 1 | 0 | 0 | | | 1 | 82.0% | 5.2% | 9 | 22 |
| A3 AMU | 97.7% | | | 0 | 3 | 0 | 0 | | | 1 | 81.0% | 5.2% | 9 | 9 |
| A10 | 99.0% | Good | | 2 | | 0 | 0 | 90% | 48.0% | | 89.5% | 4.0% | 12 | 7 |
| A11 | 99.3% | Req. Improv't | | 1 | 0 | 0 | 0 | 100% | 31.0% | 1 | 94.1% | 1.5% | 11 | 2 |
| A12 | 98.6% | | | 0 | 1 | 0 | 0 | 97% | 74.0% | | 83.9% | 2.7% | 2 | 2 |
| A14 | 100.0% | Req. Improv't | | 0 | 0 | 0 | 0 | 95% | 79.0% | | 100.0% | 0.6% | 0 | 7 |
| A15 | 96.2% | Good | | 0 | 0 | 0 | 0 | 100% | 38.0% | | 29.0% | 1.5% | 10 | 7 |
| CDU | 90.2% | | | 0 | 0 | 0 | 0 | 95% | 26.0% | | 48.3% | 3.1% | 12 | 22 |
| B2 | 99.3% | | | 0 | 0 | 0 | 0 | 96% | 53.0% | | 90.3% | 13.2% | 7 | 7 |
| B4 | 97.2% | | | 0 | 0 | 0 | 0 | 100% | 62.0% | | 70.0% | 5.7% | 7 | 12 |
| B5 | 98.1% | Req. Improv't | | 0 | 0 | 0 | 0 | 108% | 87.0% | | 94.1% | 15.7% | 7 | 12 |
| Bluebell | 100.0% | Good | | 0 | 0 | 0 | 0 | | | | 100.0% | 7.4% | 5 | 0 |
| C2 | 89.0% | | | 0 | 0 | 0 | 0 | 96% | 100.0% | | 95.7% | 7.5% | 10 | 10 |
| C4 | NIL RETURN | | | 0 | | 0 | 0 | 100% | 14.0% | | 83.3% | 1.0% | 7 | 2 |
| C5 | 100.0% | Req. Improv't | | 0 | | 0 | 0 | | | | | | 0 | 0 |
| CCU | 99.3% | Inadequate | | 0 | | 0 | 0 | 100% | 50.0% | 1 | 47.4% | 0.2% | 7 | 15 |
| D'shire | 100.0% | | | 0 | 0 | 0 | 0 | 100% | 60.0% | | 97.0% | 7.4% | 5 | 7 |
| E1 | 100.0% | | | 0 | 1 | 0 | 2 | 100% | 57.0% | | 75.9% | 5.1% | 12 | 9 |
| E2 | 98.8% | Good | | 0 | 2 | 0 | 2 | 92% | 81.0% | | 85.0% | 7.0% | 12 | 14 |
| E3 | 100.0% | Req. Improv't | | 0 | 8 | 0 | 0 | 98% | 100.0% | 1 | 88.1% | 5.4% | 9 | 11 |
| ED | 92.8% | | | 0 | 0 | 0 | 0 | 86% | 27.0% | 2 | 76.9% | 7.7% | 14 | 16 |
| SSOP | 100.0% | Req. Improv't | | 0 | 0 | 0 | 0 | 100% | 61.0% | 1 | 83.3% | 8.5% | 9 | 9 |

**Surgical & Critical Care**

| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| B3 | 94.0% | Req. Improv't | | 0 | 0 | 0 | 0 | 100% | 27.0% | | 60.9% | 4.6% | 17 | 17 |
| B6 | 97.0% | Good | | 0 | 0 | 0 | 0 | 98% | 44.0% | 1 | 100.0% | 2.5% | 2 | 9 |
| C3 | 98.2% | Good | | 0 | 1 | 0 | 0 | 67% | 20.0% | | 82.8% | 3.5% | 7 | 12 |
| C6 | CLOSED | | | 0 | | 0 | 0 | 100% | 11.0% | | 85.2% | 0.3% | 7 | 12 |
| D1 | 87.7% | Req. Improv't | | 0 | 0 | 0 | 0 | 100% | 20.0% | | 91.4% | 1.3% | 12 | 11 |
| D2 | 92.2% | | | 0 | 0 | 0 | 0 | 95% | 56.0% | | 100.0% | 2.3% | 2 | 5 |
| D4 | 97.8% | | | 0 | 1 | 0 | 0 | 96% | 54.0% | | 96.0% | 1.9% | 0 | 10 |
| D5 | | | | 0 | 0 | 0 | 0 | | | | 88.0% | 6.3% | 7 | 7 |
| ICU/HDU | 100.0% | Good | | 0 | 4 | 0 | 0 | | | | 56.6% | 3.6% | 5 | 9 |
| M4 #NOF | 98.8% | Req. Improv't | | 0 | 0 | 0 | 0 | 100% | 25.0% | | 69.2% | 6.1% | 15 | 10 |
| Sh Stay Surg | 82.7% | | | 0 | 3 | 0 | 0 | 92% | 17.0% | | 87.5% | 9.4% | 17 | 19 |

**Community Services**

| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Shire Hill | 97.7% | | | 0 | 2 | 0 | 0 | | | | 60.4% | 5.4% | 10 | 12 |

RAG Ratings (Per Ward):

| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 0-89% | Inadequate | 1 | 2 | 1 | 1 | 3 | | <40% | 4 | 0-69% | >4% | >=15 | >10% Worse |
| | 90-94% | Req. Improv't | NA | 1 | NA | NA | 2 | | NA | 1 | 70-94% | NA | 10-14 | 0-10%Worse |
| | 95%+ | Good | 0 | 0 | 0 | 0 | 0 | | >=40% | 0 | 95%+ | <=4% | <10 | Better |

(20% for ED)

= Not Applicable

* Falls - Consist of Major, severe & Catastrophic

**NB: Total Performance is rated on a point system for each indicator (excluding Internal CQC Inspections and BOTH Pressure Ulcer indicators) Red = 5, Amber = 2, Green = 0 . Trust & Business Group Totals show ward average

NB: Friends and Family Test results will not match the figures shown by ward in the Dashboard due to Escalation wards being included in the Trusts total and not in the Nursing Dashboard

NB: Data for "Pressure Ulcer Confirmed avoidable Stage 3 to 4 " will be 3 months in hand, to allow time for investigation

This page has been left blank

| | | | |
|---|---|---|---|
| **Report to:** | Board of Directors | **Date:** | 31st March 2016 |
| **Subject:** | High Profile report | | |
| **Report of:** | Director of Nursing and Midwifery | **Prepared by:** | Cathie Marsland, Head of Risk and Customer Services |

# REPORT FOR APPROVAL

| | | |
|---|---|---|
| **Corporate objective ref:** | ----- | **Summary of Report**<br>*Highlight of all high profile incidents and inquests over the preceding month to share lessons learned and identify developing patterns and trends* |
| **Board Assurance Framework ref:** | ----- | **Themes noted in month are:**<br>Non adherence to policy/process – Falls and Pressure ulcer prevention. |
| **CQC Registration Standards ref:** | ----- | One Ombudsman report received regarding failure to follow national guideline and two reports to prevent future deaths received from H.M Coroner regarding system compatibility issue and diabetes management in February 2016 |
| **Equality Impact Assessment:** | ☐ Completed<br>☑ Not required | |

**Attachments:**

| | | |
|---|---|---|
| **This subject has previously been reported to:** | ☐ Board of Directors<br>☐ Council of Governors<br>☐ Audit Committee<br>☐ Executive Team<br>☑ Quality Assurance Committee<br>☐ FSI Committee | ☐ Workforce & OD Committee<br>☐ BaSF Committee<br>☐ Charitable Funds Committee<br>☐ Nominations Committee<br>☐ Remuneration Committee<br>☐ Joint Negotiating Council<br>☑ Other RMC |

**- THIS PAGE IS INTENTIONALLY BLANK -**

## 1. INTRODUCTION-

1.1 This report provides further information on the outcomes of high profile inquests held in the preceding month of February 2016.

This report also provides information regarding the month's Serious Incidents

Themes which have become apparent in these areas are highlighted and are for discussion and relevant action plan development

## 2. BACKGROUND

2.1 This is a monthly report prepared by the Risk and Safety Team

## 3. CURRENT SITUATION

3.1 **Themes noted in month**

If themes noted previously, denoted by the number of times identified in the year March 15 – March 16)

| Theme |
|---|
| Non adherence to policy/process – falls (10) |
| Non adherence to policy/process – Pressure ulcer prevention (9) |

**Lessons Learned for Sharing across all business groups**

1. Pressure sore prevention process is persistently not being adhered to. All nursing staff to be familiar with and to follow Red Rules and Standard Operating Procedure for the Prevention and Management of Pressure Ulcers (July 2015). Staff should also explore other alternative strategies when a patient is non-compliant with their plan of care.
2. Continued failure to adhere to falls risk management process. Falls risk assessments must be completed as soon as possible after the patient has transferred ward. (Within 6 hours or sooner). All staff reminded of importance of completing falls risk assessments as per Policy.

3.2 Report Details

## High profile inquests held in February 2016

| Name Date of death | Risk High Moderate | Inquest Date | Synopsis | Business Group Ward Dept. | Verdict | Key Lessons Learnt |
|---|---|---|---|---|---|---|
| 1720 | High | 8th February 2016 | Patient was admitted following a fall at home, the patient initially declined any investigations in hospital, but her family raised concerns that she was not getting enough nutrition; she deteriorated and lost capacity to make her own decision. Her family wished her to have further investigations, a best interest meeting was held and the clinicians decided to continue with her initial wishes and commence palliative care. Her family did not agree with this. There have been several formal complaints from the family. | Medicine | Natural Causes | The Coroner is to send a letter to the Trust regarding a concern that was raised during inquest around confusion when junior doctors request gastroenterology procedures. |

## Serious Incident (S.I) confirmed in February 2016

| Datix | S.I Date | Location | Description | Care and Service Delivery problems/Root Causes | Key Actions |
|---|---|---|---|---|---|
| 134343 | 2nd February 2016 | Community Tameside | Pressure Ulcer | Failure to follow Pressure Ulcer Prevention Bundle - Incorrect grading of pressure ulcer and incorrect type of mattress in place. | Embed use of new nursing assessment. Re-iterate need for care plans to be updated regularly. Introduce spot checks and provide feedback.<br>All staff to be reminded of obligations under Trust Policy.<br>All staff to be reminded that all patient contacts must be captured in patient records and IPM.<br>All staff to be reminded of the need to file "chitties" in chronological order. |
| 136274 | 2nd February 2016 | Community Tameside | Pressure Ulcer | Triage of referral was not completed within 24 hours.<br>Nursing assessment not completed at first meeting with patient.<br>Nursing assessment and care plans were not present for first 6 contacts. | Review of processes to ensure referrals are completed within timescales.<br>Staff to be reminded that clinical interventions are not to be undertaken in the absence of nursing assessment and care plans.<br>CSPs to undertake spot checks of DN records. |
| 134708 | 2nd February 2016 | Community Tameside | Pressure Ulcer | Review of patient not planned.<br>Patient not provided with appropriate pressure relieving equipment.<br>Equipment was not checked by staff<br>No record of screening tools being completed to support healing process.<br>No transfer of care communication between district nursing and care homes | Equipment not checked to be raised with staff by Team Leads/Quality Leads.<br>Staff to ensure that reviews are booked in a timely manner and to be discussed by Team Leads/Quality Leads.<br>Team leads to ensure that all staff are completing screening tools – audit to be undertaken.<br>Staff to re-introduce communication form. |

| | | | | | |
|---|---|---|---|---|---|
| 126831 | 2nd February 2016 | Community Stockport | Pressure Ulcer | Pressure Ulcer Assessment not completed on admission to caseload.<br>Lack of continuity of Band 6 cover<br>Delay in ordering equipment.<br>Datix not completed.<br>Potential failure in discharge planning by Hospital. | Staff to be made aware of correct procedure when admitting patients onto caseload.<br>Caseload to monitor compliance of staff with mandatory pressure ulcer training.<br>Delegation of work to appropriate members of teams.<br>District Nursing Service to be reminded to complete incident forms. |
| 136764 | 5th February 2016 | S&CC | Fall | Staff member left bay unattended<br>Bloods were taken/ECG performed – not reviewed by Doctor | Staff member formally counselled following incident.<br>Doctor reflected on incident with Educational Supervisor. |
| 137131 | 9th February 2016 | Medicine | Fall | Falls Risk Assessment not updated after fall.<br>Bed rails assessment not completed at time of post fall review.<br>Formal x-ray report not reviewed by Doctor for 5 days. | All staff reminded of importance of completing falls risk assessments as per Policy. **Completed**<br>All staff to be reminded to completed bed rails assessment post fall. **Completed**<br>Educational Supervisor to be provided with investigation report to feedback findings to Doctors regarding timely review of x-ray reports.<br>Educational supervisor to be provided with investigation report for feedback to FY1 who failed to handover lack of x-ray review following fall.<br>File Note to be completed for staff who failed to follow falls policy. |
| 135919 | 9th February 2016 | Medicine | Missed neck fractures | Patient brought to ED following accident on bike – did not receive CT despite significant neurological problems in limbs, neck fractures were missed. | Reiteration of the CDU SOP and that the correct pathway must be authorised by most Senior Clinician in ED prior to transfer to CDU, to be cascaded via ED Quality Board, ED Sister's Meeting and CDU Ward Meeting.<br>Incident Decision Tree was reviewed for Trust Doctor.<br>Formal feedback post investigation to be given to the Deanery and to the Medical Director<br>Incident Decision Tree was reviewed for Agency Doctor.<br>Formal feedback post investigation to be given to the Agency and the Medical Director |
| 134470 | 11th February 2016 | Medicine | Failure to review results | Patient not reviewed by Doctor when EWS 5.<br>Patient's blood results not reviewed when available.<br>Patient not reviewed by medical doctor over weekend on Surgery Ward.<br>Poor communication<br>Poor documentation | Laminated signs to be displayed reminding staff to ensure that all outstanding investigations have been reviewed before patients are transferred to another ward.<br>All patients must have internal hospital transfer form completed. Verbal handovers to be concise and accurate and include investigations results outstanding.<br>System to be implemented on AMU1 and AMU2 to ensure that all medical staff are aware which surgical wards have medical outliers over a weekend. |

| | | | | | |
|---|---|---|---|---|---|
| 137482 | 19th February 2016 | S&CC | Fall | Patient noted to be intermittently confused however not observed<br>Bed rails were used despite patient being confused and mobile. | Awareness to be raised with ward staff around patient's mental capacity and ability to retain information.<br>Falls training records for ward to be reviewed and arrangements made for staff if not up to date with training.<br>Staff identified to be file noted, and reflective practice undertaken.<br>Staff to be booked on dementia awareness course. |
| 136193 | 19th February 2016 | D&CS | Haematoma | Patient sustained a large haematoma to her leg during 'PATslide' transfer to CT table<br>Out of hours (weekend) less staff available in the room to undertake the task.<br>There was a lack of compliance with this policy | Practical training session in PAT Sliding to be undertaken for Radiology staff<br>Investigate other options for moving and handling in Radiology, Review staffing availability in Radiology OOH for patients who need moving on PAT slides |
| 137697 | 25th February 2016 | Medicine | Confidentiality | Failure to follow Trust Information Security Policy – no process at DCNR for checking that handovers were safely disposed of at end of each shift | Staff member counselled and asked to reflect on incident.<br>All staff instructed to shred handovers at end of each shift. |
| 137678 | 25th February 2016 | Child and Family | Neonatal Death | Confusion over testing Capnograph but this did not contribute to patient death. | Awareness to be raised to both medical and nursing staff |
| 137996 | 26th February 2016 | Medicine | Fall | Falls Risk Assessment not completed as per Policy.<br>No review of falls risk assessment post fall.<br>No Lying and standing blood pressure undertaken<br>No I-bleep request for Doctor following near miss falls.<br>No x-ray requested at time of review | Lack of lying and standing blood pressure readings or rationale to be discussed on Wards<br>Lack of understanding of falls risk assessments and timescales to be discussed at Ward Meeting and Safety Huddles.<br>Case to be discussed at Sisters Governance Meeting.<br>Lack of post fall I-Bleep Requests to be discussed at Ward Meeting and Safety Huddles.<br>Feedback of investigation to FY1 Doctor that x-ray should have been requested. |
| 137903 | 26th February 2016 | Medicine | Fall | Lack of documentation/rationale for not completing lying and standing blood pressure<br>No clear documentation regarding frequency of neurological observations post fall.<br>No documented handover between nursing staff around frequency of neurological observations post fall.<br>Unsupervised mobility | Read and sign memo to be sent to all staff regarding completion of lying and standing blood pressure, and documenting handovers.<br>Consider putting a prompt on Patientrack to check frequency of observation. |
| 137313 | 26th February 2016 | Medicine | IV Fluids administered too quickly | Patient with Heart Failure attended ED, was treated for sepsis, IV Fluids given by SN from verbal prescription, given too quickly. Patient became extremely short of breath due to fluid overload and required IV diuretics and NIPPV. | Incident decision tree reviewed for both Doctor and Nurse, as Trust Policies were not followed, counselling and formal feedback to be given |

## Reports to prevent future deaths received from H.M Coroner in February 2016 (previous Rule 43)

| Datix | Date Received | Inquest date | Location/ Speciality | Areas of concern | Response due | Areas to be addressed by Trust |
|---|---|---|---|---|---|---|
| 1740 | 17th February 2016 | 13th January 2016 | Medicine | Doctor discharged a patient without seeing them and the patient's insulin was omitted by mistake. | 16th March 2016 | Medicine Governance Team currently reviewing issues and compiling response. |
| 1655 | 17th February 2016 | 29th September 2016 | Surgery | Different 'systems' at Buxton and SNHSFT prevent diagnostic results being available for review at SHH The responsibility for following up information therefore falls to Buxton GPs but action is not always taken | 24th March 2016 | The Trust is reviewing ways to allow diagnostic and clinic results to be available by all clinicians responsible for patient. |

## Cases where investigation completed by Health Service Ombudsman in February 2016

| Datix No. | Date Original complaint | Date Completed by Ombudsman | Location/ Speciality | Description | Decision | Changes to Practice |
|---|---|---|---|---|---|---|
| OMB58216 | 7th January 2014 | 24th February 2016 | Medicine | Failure to follow national rehabilitation guidelines following stroke | Partially upheld | £1000 compensation for distress. Action plan required within 3 months indicating learning from failures. |

This page has been left blank

Stockport NHS
NHS Foundation Trust

| | | | |
|---|---|---|---|
| **Report to:** | Board of Directors | **Date:** | 31 March 2016 |
| **Subject:** | Board Assurance Framework | | |
| **Report of:** | Chief Executive | **Prepared by:** | P Buckingham |

# REPORT FOR APPROVAL

| | |
|---|---|
| **Corporate objective ref:** | N/A |
| **Board Assurance Framework ref:** | BAF Risk 2 |
| **CQC Registration Standards ref:** | N/A |
| **Equality Impact Assessment:** | ☐ Completed<br>X Not required |

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

The purpose of this report is to present the current Board Assurance Framework for consideration and approval by the Board of Directors and to propose adoption of a revised approach for 2016/17.

**Attachments:** Annex A – Board Assurance Framework

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

**- THIS PAGE IS INTENTIONALLY BLANK -**

## 1. INTRODUCTION

1.1 The purpose of this report is to present the current Board Assurance Framework for consideration and approval by the Board of Directors and to propose adoption of a revised approach for 2016/17.

## 2. BACKGROUND

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

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

2.3 However, the content of the Board Assurance Framework, in terms of risk areas has, in the main, remained unchanged since the current format was introduced approximately 18 months ago. In that time, the strategic context and the Trust's operating environment have changed considerably and, consequently, it would be an opportune moment to review strategic objectives and associated risks to maintain currency of the basis for the Board Assurance Framework.

## 3. CURRENT SITUATION

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

3.2 As noted at s2.3 of the report a review of strategic objectives and associated risks is proposed. Board members will note the need to ensure that risks documented in the Board Assurance Framework continue to accurately reflect the principle risks to achievement of strategic objectives. It is proposed that the current Board Assurance Framework be closed at 31 March 2016 with a revised Framework being opened on the basis of strategic objectives and associated risks as follows:

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

**SO2**

To achieve best outcomes for patients through full and effective participation in local strategic change programmes including; Stockport Together, Healthier Together & Greater Manchester Devolution.

**Risk 2 – Risk Owner: Chief Executive**

Failure to plan, resource and engage effectively with strategic change programme impairs level of control and influence with a consequent detrimental impact on patient services

**SO3**

To secure full compliance with requirements of the NHS Provider Licence through fit for purpose governance arrangements.

**Risk 3 – Risk Owner: Chief Operating Officer**

Failure to achieve sustainable delivery of the 4-hour A&E target impairs quality of patient care and results in further regulatory intervention.

**SO4**

To achieve, and maintain, a minimum 'Good' rating under the Care Quality Commission inspection regime.

**Risk 4 – Risk Owner: Director of Nursing & Midwifery**

Inability to maintain and improve compliance with Care Quality Commission standards impairs patient experience, damages Trust reputation and results in regulatory intervention.

**SO5**

To achieve the level of financial sustainability necessary to ensure provision of good quality services and facilitate delivery of the Trust's Five Year Strategy

**Risk 5 – Risk Owner: Director of Finance**

Failure to deliver annual cost improvement programmes and realise planned benefits from strategic transformation projects impairs the Trust's financial position, with a consequent impact on patient services, and increases the likelihood of regulatory intervention.

**SO6**

To develop, and maintain, a flexible, motivated and proficient workforce.

**Risk 6 – Risk Owner: Director of Workforce & Organisational Development**

Failure to prepare and deliver effective workforce plans supported by continuous professional development impairs the availability of workforce resources with a consequent impact on the delivery of patient services.

**SO7**

To implement and embed an Electronic Patient Record (EPR) system.

**Risk 7 – Risk Owner: Chief Operating Officer**

Failure to ensure efficient management of the EPR project results in data loss from current systems and the inability to realise the benefits expected to accrue from implementation of a comprehensive electronic system.

3.3 This approach, and the above draft strategic objectives and risks, was endorsed by the Executive Team at a meeting held on 22 March 2016. It is considered that the draft strategic objectives are clearly defined and accurately reflect the current environment. While it is expected that strategic objectives would remain valid over an extended period, this approach would provide the Board with the opportunity to re-assess the strategic objectives on an annual basis. From an objective-setting point of view, annual corporate objectives would contribute to delivery of the strategic objectives and inform content of departmental / individual objectives.

## 4. LEGAL IMPLICATIONS

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

## 5. RECOMMENDATIONS

5.1 The Board of Directors is recommended to:

- Consider and approve the content of the Board Assurance Framework at Annex A.
- Agree to close the current Board Assurance Framework and open a revised Framework based on the draft strategic objectives and associated risks included at s3.2 of the report.

This page has been left blank

BAF

## Risk Category: Strategy

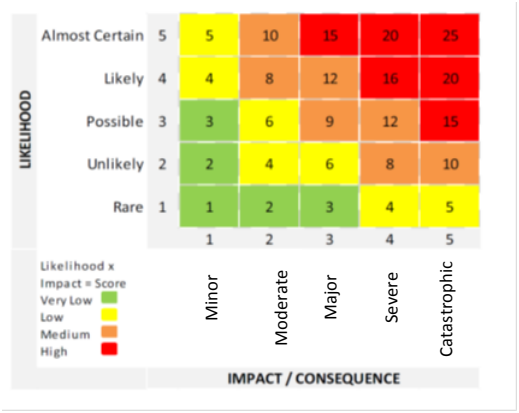
**Owner:** Chief Executive

**RISK 1** — **Failure to deliver the approved strategic plan resulting in a lack of focus on developing the right service changes resulting in a detriment to influence, decision-making, engagement and appropriate utilisation of resources.**

### Board Risk Rating

| | L | x | C = Level |
|---|---|---|---|
| Initial | 2 | 4 | 8 |
| Current | 2 | 4 | 8 |

| | |
|---|---|
| Opened Date | 12-06-14 |
| Review Date | 17-11-14 |
| Review Date | 31-12-14 |
| Review Date | 12-03-15 |
| Review Date | 14-05-15 |
| Review Date | 08-07-15 |
| Review Date | 16-10-15 |
| Review Date | 17-11-15 |
| Review Date | 19-01-16 |
| Review Date | 23-03-16 |




### RISK CONTEXT

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

### BOARD RISK APPETITE

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

### CONTROLS

- Dedicated Board Strategy sessions
- Communications Plan for Strategy developed, implemented & monitored via Planning and Performance Group.
- Resources identified to ensure detailed work up of the Strategic Staircase and Innovation Programmes projects.
- Chief Executive and other executives (especially Finance and HR) participation in Greater Manchester Devolution developments.
- Chief Executive and Executive Director involvement in the Stockport Together programme.
- COO spending 3/5 days x 6 wks during October/November 2015 in the CCG to ensure Stockport Together/Vanguard and Trust Strategy are aligned and utilises the same segmentation information

### BOARD ASSURANCE

- Vision and strategy work completed and the 5 year plan submitted end June to Monitor Further work on Operational plan 2015/16 and underpinning strategies plus reforecast for next 3 yrs on 23 November 2015
- Chief Executive and Clinical Lead involvement in revised Healthier Together governance arrangements for implementation in South East Sector
- Staff sessions to launch Strategy held in August/September
- Stakeholders – CCG ( Board to Board and Executive to Executive) and LA – briefed in August & September
- Monitor Annual Plan review completed July 2015.
- Board to Board meeting with CCG December 2015
- Positive outcome of the Healthier Together Judicial Review.
- Regular CEO reports on progress with strategic programmes.

| | |
|---|---|
| ▪ Assurance reports to the Finance Committee on financial delivery of the strategic projects<br>▪ Assurance reports to the SDC Committee on operational delivery of the strategic projects<br>▪ CEO, COO and clinical lead attendance at South East Sector Healthier Together Planning Committee.<br>▪ Director of Partnership designated as Programme Director for SE Sector Healthier Together implementation with consultancy resource support<br>▪ Locality plan for Stockport consistent with Trust Strategic Plan and planning assumptions | ▪ Quarterly review of progress against key organisational objectives<br>▪ Stockport Together adoption of the Trust's patient segmentation approach<br>▪ Strategy 2016/17 presentation to senior managers and clinical managers 16/3/16<br>▪ Start the Year: 3 & 5 May and rollout for all staff planned<br>▪ Increased capacity at senior level on strategy and Stockport Together planned from April 2016<br>▪ GM Devolution governance arrangements approved |
| **GAPS IN CONTROLS** | **GAPS IN ASSURANCES** |
| ▪ Monitor assessment of 5 year plan received and taken account of in operational plan submission on 8 February and final submission of plan on 11 April.<br>▪ Resource pressure associated with Stockport Together<br>▪ Clarity on future organisational form of MCP provider – alternative models being considered | ▪ Risk that concurrent strategic programmes will impair senior management capacity. |

| ACTION PLAN | *Assigned to* | *Action Detail* | *Progress-to-Date* | *Due Date* |
|---|---|---|---|---|
| | Chief Executive | Board to be given dedicated time for strategic discussion | Board to hold monthly strategy sessions | Completed |
| | Chief Executive/Chair | Board to Board meetings & relationship session with executives | Held | Completed |
| | Chief Executive/Director of Finance | Working with GM Devolution Director of Finance on information to support the CSR update and Business case | Information provided as required | Completed |
| | Director of Finance/Director of Workforce and OD | Information requirements from Trust as result of the Provider efficiency programmes Directors of Finance are undertaking at the request of the Provider Federation Board | Ongoing | As requested |
| | Chief Operating Officer | Monitor engagement with staff and facilitate workshop with Child and Family Business Group. | Performance and Planning Committee monitoring communication plan delivery. | Completed |

| | | | | |
|---|---|---|---|---|
| | **Chief Operating Officer** | **Member of newly established Executive Committee for Stockport Together to ensure delivery of programme and member of shadow Provider Board to ensure Trust as key stakeholder in future organisational form, contract arrangements and delivery** | **Child and Family Workshop scheduled to be held 13 January 2016.**<br>**Further workshop held and future workshops scheduled.**<br><br>**Revised Governance arrangements developed and agreed by Senior Leaders Group** | **13 January 2016**<br><br>**March 2016 onwards**<br><br>**Complete** |

BAF

## Risk Category: Governance

**Owner:** Chief Executive

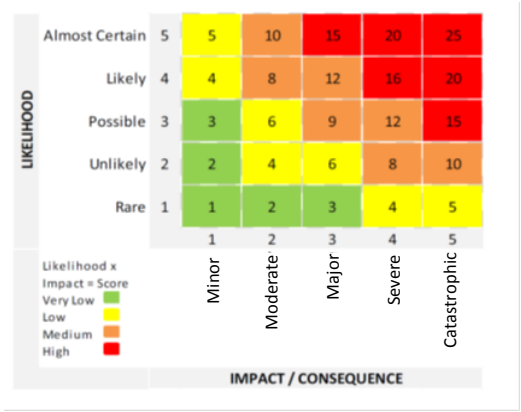
**RISK 2** Failure to continue to establish, engage and update effectively with, appropriate governance arrangements resulting in loss of influence and effectiveness.

### Board Risk Rating

| | | | |
|---|---|---|---|
| Initial | 3 | 4 | 12 |
| Current | 2 | 4 | 8 |

L x C = Level

| | |
|---|---|
| Opened Date | 12-06-14 |
| Review Date | 17-11-14 |
| Review Date | 31-12-14 |
| Review Date | 12-03-15 |
| Review Date | 14-05-15 |
| Review Date | 08-07-15 |
| Review Date | 16-10-15 |
| Review Date | 17-11-15 |
| Review Date | 19-01-16 |
| Review Date | 23-03-16 |




### RISK CONTEXT

Failure to meet regulatory governance standards can jeopardise performance of the Trust and lead to breaches of Provider Licence. Failure to engage in governance arrangements with Healthier Together, Stockport Together or GM Devolution work could adversely affect the Trusts ability to play a significant role in service provision and could damage reputation and influence.

### BOARD RISK APPETITE

The need to create new governance arrangements that can operate with some agility in a different setting requires the Board to take risks rather than default to existing governance design. Red rating by a regulator would require immediate review and action. Hot spots or themes/trends identified in Board IPR would require immediate review and action.

### CONTROLS

- Board sign off of governance arrangements
- Annual review of Committee terms of reference
- Assurance committee oversight
- PMO structure implemented
- Stakeholder governance engagement plan
- Revised assurance meeting structure implemented from July 2014 onwards
- Chief Executive has been working with GM Devolution colleagues on governance arrangements including the overarching arrangements and Provider Federation arrangements. This has included meetings with all national regulators and overseer organisations.
- CEO Chairs the shadow GM Provider Federation pending appointment of a substantive independent Chair

### BOARD ASSURANCE

- Review that governance and accountability arrangements have been appropriately designed to handle future challenges and are operating effectively.
- Routine executive and assurance committee board reporting
- Executive involvement and engagement in stakeholder governance and decision making forums
- Stockport Together Governance Arrangements approved
- MIAA commissioned to provide joint report to Trust Board and CCG Board regarding operational contracting arrangements with view to improvements for 2015/16 and future
- COO's work with CCG in developing the Strategy segmentation information into the Proactive Care and Vanguard transformation programmes will support new models of contracting as appropriate to the MCP Vanguard pilot.

| | |
|---|---|
| ▪ Chairman is a member of the GM Provider Trusts Chairs meeting<br>▪ Risk-based Internal Audit work plan<br>▪ Board Development on governance practice<br>▪ All GM Provider Trusts have endorsed the Provider Reference Board case for change, terms of reference and decision making process<br>▪ Chair and Chief Executive are members of the formal GM Devolution governance structure and attend meetings as appropriate | ▪ Board and Council receive regular updates on progress with GM Devolution, Stockport Together and Healthier Together<br>▪ Board approval of Terms of Reference following annual review<br>▪ Internal Audit review of Fit & Proper Person requirements resulted in Significant Assurance<br>▪ MIAA review of contracting arrangements submitted to both CCG and Trust Boards and accepted. Learning to be taken forward in contracting for 16/17<br>▪ Code of Governance audit by MIAA received Significant Assurance |
| **GAPS IN CONTROLS** | **GAPS IN ASSURANCES** |
| ▪ Governance arrangements will require regular review to ensure to fit with future challenges<br>▪ Detailed work on the GM Devolution Governance arrangements is continuing with the Regulators to determine revised guidance<br>▪ GM Provider Trusts working on a risk/gain share arrangement for submission to the Provider Federation Board | ▪ Internal Audit review of PMO arrangements to be completed in Quarter 1 2016/17<br>▪ Trust continues to not be a member of the Stockport Health and Wellbeing Committee |

| ACTION PLAN | Assigned to | Action Detail | Progress-to-Date | Due Date |
|---|---|---|---|---|
| | Company Secretary | Board Sub Committee Terms of Reference to be reviewed and Governor Sub Committee Terms of Reference to be reviewed for approval at Board of Directors and Council of Governors as appropriate | In progress. Remaining revised Terms of Reference scheduled for approval by the Board on 28 January 2016. | Completed |
| | Chief Executive | Chair of shadow Provider Federation up to April 2016 working on shadow governance arrangements to protect the continued involvement of this Trust and other Provider Trusts in the production of the GM Devolution Strategic Case and request for transitional funding. | Governance arrangements signed off at CEOs Provider federation meeting in December 2015 for formal sign of by individual Boards in January/February 2016. | Completed |
| | Chair & Chief Executive | Engagement in governance meetings with Chairs and CEOs of Provider Trusts to help influence and shape the substantive governance arrangements to allow for full participation of Provider Trusts in the GM Devolution programme with effect from April 2016. | Meetings being held to develop appropriate governance arrangements for approval by Trust Boards – subject to final regulatory approval of supplementary conditions to Licence – and participate fully from April 2016. | Completed subject to guidance from Regulators |

| | | | | |
|---|---|---|---|---|
| | **Chief Executive** | **Regulators guidance to Foundation Trusts around Licence and its application to GM Devolution** | **Guidance to Foundation Trusts being discussed between GM Devo representatives and Monitor.** | **2016/17** |

BAF

## Risk Category: Quality and regulatory compliance

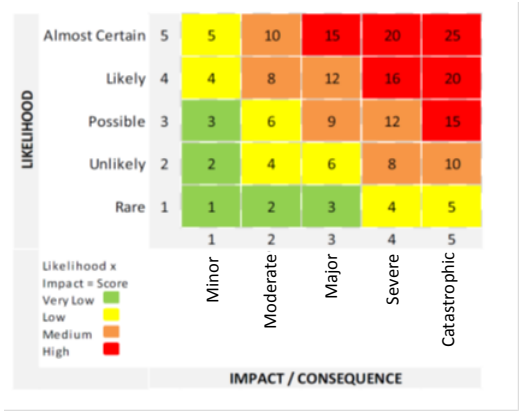
**Owner:** Chief Operating Officer

**RISK 3** — *Failure to meet all access and other targets resulting in an adverse impact upon patient experience, reputation, provider license/RAF and contractual payments.*

### Board Risk Rating

| | L | C | Level |
|---|---|---|---|
| Initial | 4 | 5 | 20 |
| Current | 4 | 4 | 16 |

| L x C = Level | |
|---|---|
| Opened Date | 12-06-14 |
| Review Date | 17-11-14 |
| Review Date | 31-12-14 |
| Review Date | 12-03-15 |
| Review Date | 21-05-15 |
| Review Date | 15-07-15 |
| Review Date | 16-10-15 |
| Review Date | 17-11-15 |
| Review Date | 23-03-16 |




### RISK CONTEXT

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

### RISK APPETITE

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

### CONTROLS

- Executive accountability
- Business group quality governance meetings and IPRs
- Monthly Performance and Planning meeting
- Standard specific groups i.e. cancer board, 18 week meeting etc
- New Performance Management Framework to proactively monitor all standards

### BOARD ASSURANCE

- Risk issues to Quality Assurance Committee
- Integrated Performance Report (IPR) to Board
- Escalation process to Board through IPR report
- External reports on areas of underperformance e.g. Cancer or ED through ECIST or other bodies

### GAPS IN CONTROLS

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

### GAPS IN ASSURANCES

- Matching capacity and demand within clinical services to best mitigate failure
- Do not have assurance that whole health and social care economy has the resources and capabilities to deliver appropriate support to ED in order to deliver the 4hr target

| | Assigned to | Action Detail | Progress-to-Date | Due Date |
|---|---|---|---|---|
| ACTION PLAN | Director of Nursing & Midwifery supported by Chief Operating Officer | Establishment of Quality Committee with overall view of performance against quality standards | Completed | |
| | Chief Operating Officer supported by Director of Performance | Development of Business Group level Integrated Performance Report linked to the Trust Board aggregated position | Completed | |
| | Chief Operating Officer supported by Director of Performance | Trajectories to be included to show required improvement for all areas of performance under required standard | In progress, in place for circa 50% of actions to date | |
| | Chief Operating Officer, Chief Executive & Director of Finance | Continue to work with the Health and Social Care Economy leaders on the gaps in Urgent Care Provision across the health economy to enable achievement of the ED target | Systems Resilience Group now in place and meeting monthly | Ongoing |
| | Chief Operating Officer supported by Director of Performance | Continue to refine IPR quarterly with more data items that give early warning of potential risks to performance | In progress quarterly. Most recent items include outpatient demand and clinical correspondence. | Quarterly |
| | Chief Operating Officer supported by Director of Performance | New IPR 'wheel' in development on patient safety and quality metrics for introduction in February 2015 | Completed in July 2015 | |
| | Director of Operations & Director of Performance | New Performance Management Framework in place with weekly meetings to review action plans where standards are not being met. Reports to a new monthly Performance & Planning meeting which reports to the Quality Assurance Committee | New performance assurance structure implemented in July 2015 and will be reviewed. | October 2015 |
| | Director of Operations | Performance structure revised in October/November and new Performance & Planning meeting with full balanced scorecard in place from January 2016 | Commences January 27th and will be reviewed for effectiveness in May 2016 | May 2016 |

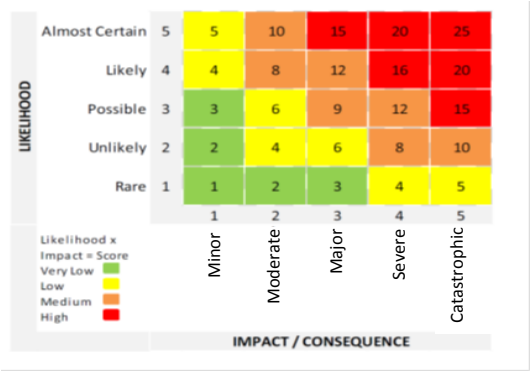
## Risk Category: Quality and regulatory compliance — Owner: Director of Nursing and Midwifery

| RISK 4 | Inability to deliver CQC compliance resulting in poor patient experience, loss of reputation and regulatory intervention |
|---|---|

### Board Risk Rating

| | L | x | C | = Level |
|---|---|---|---|---|
| Initial | 3 | | 4 | 12 |
| Current | 4 | | 4 | 16 |

| | |
|---|---|
| Opened Date | 12-06-14 |
| Review Date | 17-11-14 |
| Review Date | 31-12-14 |
| Review Date | 12-03-15 |
| Review Date | 19-05-15 |
| Review Date | 13-07-15 |
| Review Date | 16-10-15 |
| Review Date | 13-11-15 |
| Review Date | 20-01-16 |
| Review Date | 22-03-16 |




### RISK CONTEXT

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

### BOARD RISK APPETITE

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

### CONTROLS

- *Executive accountability*
- *Quality Improvement Matron in post – lead for implementing CQC compliance policy (mock CQC inspections to checks compliance, action planning and re-inspections)*
- *CQC assurance manager in post – lead for evidence and learning from other organisations' CQC inspections*
- *New CQC fundamental standards gap analysis performed in readiness for inspection*
- *CQC Key Lines of Enquiry Implementation Group established May 2015*
- *Monitoring of performance with commissioners*
- *Programme of activity forward to board assurance through visibility and structured clinical activity for senior nursing staff*
- *Nursing & Midwifery Dashboard and escalation process for agreed triggers, including action plans for 'turnaround' wards*

### BOARD ASSURANCE

- *Reports to Quality Governance Committee and Quality Assurance Committee*
- *Patient stories/Complaints/incidents/patient experience quarterly report/High profile report- shared widely throughout organisation*
- *Quality elements of Integrated Performance Report*
- *Annual Quality Account*
- *Infection prevention and control reports*
- *Mock CQC inspection results to ADs and Heads of Nursing/Midwifery*
- *Independent internal reviews of ongoing compliance*
- *CQC Intelligent Monitoring Report(now stopped by CQC)*
- *CQC inspection results and any resultant action plans*
- *Quarterly reports to Audit Committee*
- *Twice yearly nursing and midwifery staffing reviews*

| | |
|---|---|
| ▪ *CQC mock inspections and action plans included on business group quality governance committees and process redefined to include automatic escalation to Quality Governance Committee for areas identified as 'requires improvement' or 'inadequate'*<br>▪ *CQC Mock inspection action plans monitoring outside business group – included in revised Strategic Heads of Nursing meeting structure for scrutiny* | |
| **GAPS IN CONTROLS** | **GAPS IN ASSURANCES** |
| ▪ *Ongoing recruitment issues for some areas of nursing and medical workforce may jeopardise compliance with CQC standards* | ▪ *Peer review – CQC mock inspection of whole Trust held October 2015 used staff from other organisations.* |

| | Assigned to | Action Detail | Progress-to-Date | Due Date |
|---|---|---|---|---|
| ACTION PLAN | *Deputy Director of Nursing & Midwifery* | *Ensure that mock CQC inspection action plans are completed and there is learning to improve patient care and outcomes* | *All Medicine Business Group inspections now complete and for overall review* | *Completed* |
| | *Director of Nursing & Midwifery* | *Ensure that the Trust is adequately prepared for a CQC inspection by undertaking a gap analysis against the new fundamental standards* | *Gap analysis has been completed with outcomes scheduled for consideration by the Quality Governance Committee on 18 March 2015.* | *Completed* |
| | | *CQC Key Lines of Enquiry (KLOE) Implementation Group established to provide draft internal self-assessment and arrange Executive-led staff road shows celebrating performance and ensuring communication of areas for improvement* | *Group established and timeframes adhered to* | *Completed* |
| | *Deputy Director of Nursing & Midwifery* | *Revised programme of mock CQC inspections to be agreed and ratified by the Risk Management Committee* | *Programme to be finalised as part of policy review.* | *Completed* |
| | *Director of Nursing & Midwifery* | *Trust inspection dates now set as 19th – 22nd January 2016. Existing CQC KLOE Group now Inspection Preparation Group and chaired by the Head of Risk and Customer Services.* | *Group meeting weekly – Head of Risk has been seconded into the CQC Inspection lead role for 4 days/week until the inspection date. Plan developed for 'countdown' to inspection which includes revised programme of 'mock' inspections.* | *Completed* |
| | *Director of Nursing & Midwifery* | *Lead the action planning required following the CQC inspection* | *Draft report not received as at 22/03/16* | *TBC* |

## Risk Category: Quality and regulatory compliance

**Owner:** Medical Director/Director of Nursing & Midwifery

**RISK 5**

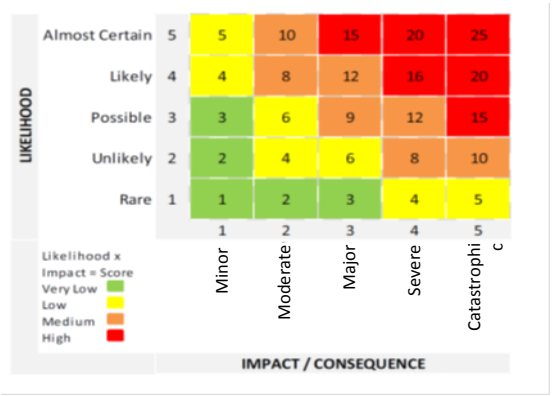
***Failure to maintain and enhance the quality and safety of the patient experience resulting in poor outcomes, loss of reputation, loss of market share, and regulatory and commissioner concerns.***

### Board Risk Rating

| | | | |
|---|---|---|---|
| Initial | 3 | 4 | 12 |
| Current | 3 | 4 | 12 |

L x C = Level

| | |
|---|---|
| Opened Date | 12-06--14 |
| Review Date | 17-11-14 |
| Review Date | 31-12-14 |
| Review Date | 12-03-15 |
| Review Date | 19-05-15 |
| Review Date | 13-07-15 |
| Review Date | 16-10-15 |
| Review Date | 21-01-16 |
| Review Date | 23-03-16 |




### RISK CONTEXT

***Context of Francis, Keogh and Berwick – 'Putting the patient first' and evidence to show that poor patient safety and experience has a huge impact on organisational 'health'***

### BOARD RISK APPETITE

***Risk averse in areas of quality, patient safety and patient experience***

***A review would be triggered by any of the following:***

- ***IPR >50% segments in red***
- ***Adverse CQC Inspection report***
- ***Dr Foster official notification of a mortality issue***
- ***Outlier on a key risk issue on a national audit***
- ***A theme emerging from the Trust High Profile Report not subject to regular monitoring***

### CONTROLS

- ***Standards of care***
- ***Incident Reporting and Management Policy / Weekly Incident Review Meetings***
- ***Audits***
- ***Safety Thermometer***
- ***Monthly Nursing & Midwifery care indicators***
- ***Monthly Nursing & Midwifery Dashboard***
- ***Patient and Family Experience measures***
- ***Duty of candour/ Being Open/ Raising Concerns policies***
- ***Safeguarding***
- ***Appraisal/Revalidation of Medical Staff***
- ***NICE guidance compliance***
- ***Quality Improvement Strategy now aligned and underpinning Trust strategy***

### BOARD ASSURANCE

- ***Trust Quality Improvement Strategy***
- ***Assurance reporting from groups and committees***
- ***High profile report***
- ***Quality elements of IPR / Hot Spots***
- ***Patient Stories/Patient Experience / Complaints reports***
- ***Patient experience measures and stories reported via Open and Honest Care for Trust***
- ***Executive Walkabouts***

| GAPS IN CONTROLS | GAPS IN ASSURANCES |
|---|---|
| | ▪ *Identification of triggers resulting from quality compliance and prompting further review* |

| | Assigned to | Action Detail | Progress-to-Date | Due Date |
|---|---|---|---|---|
| ACTION PLAN | *Medical Director / Director of Nursing & Midwifery* | *To ensure effective reporting of quality and safety to Board of Directors and Board Quality Committee to enable full understanding and effective management* | *New Integrated Performance Report Quality Assurance Committee established* | *Completed* |
| | *Senior Nursing Team* | *To improve robustness of systems and processes for holding ward and team managers to account for patient experience* | *Included in CQUIN Clinical Leadership indicator To be addressed as part of supervisory role of ward managers*<br><br>*Escalation process for nursing and midwifery dashboard and workforce dashboard embedded with clear action plans discussed at monthly Strategic Heads of Nursing meetings.* | *Completed* |
| | *Medical Director / Director of Nursing & Midwifery* | *Identify the thresholds for quality reporting that would trigger further review and risk assessment* | *Trigger process in development* | *Completed* |
| | *Medical Director / Director of Nursing & Midwifery* | *Due to the patient safety risks of continuing to fail the national ED 4 hour target, develop a daily escalation process for 'Is care safe today?'* | *Daily escalation process implemented in January / February 2015.* | *Completed* |
| | *Medical Director / Director of Nursing & Midwifery* | *Following completion of the Board level Making Safety Visible Programme, use the resulting pathway work as a 'springboard' for further clinical pathway development with the CCG* | *Starting in October 2015, extra time added to existing Quality and Performance Contract meeting to allow for clinical discussions* | *October onwards* |
| | *Medical Director / Director of Nursing & Midwifery* | *Continue to monitor progress of the Year 1 actions of the Trust Quality Improvement Strategy* | *Quality Improvement Strategy dashboard considered each month at Quality Governance Committee* | *Monthly* |

| | | | | |
|---|---|---|---|---|
| | ***Medical Director*** | ***Independent review of never events by Prof B Toft*** | ***Due February 2016 – now due end March 2016*** | ***March 2016*** |
| | ***Medical Director*** | ***CQC / Dr Foster Mortality Alert for Intracranial Injury*** | ***Response submitted within timescales*** | ***Completed*** |
| | ***Medical Director / Director of Nursing & Midwifery*** | ***Set and monitor Year 2 objectives for the Quality Improvement Strategy*** | ***For review at Quality Governance Committee in April 2016*** | |
| | ***Director of Nursing & Midwifery*** | ***Ensure all CQUIN 2016/17 objectives are communicated to relevant staff and leads identified to maximise quality improvement*** | ***For review at Quality Governance Committee in April 2016*** | |

BAF

## Risk Category: Resource, resilience and sustainability

**Owner: Director of Finance**

**RISK 6**

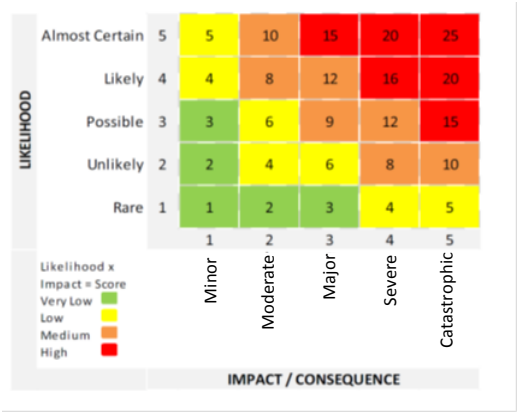
***Inability to deliver financial recovery through cost improvement and innovation leading to reduced working capital and therefore impacting on safe and effective services and the ability to fund the strategic investment programme.***

### Board Risk Rating

| | | | |
|---|---|---|---|
| *Initial* | 4 | 4 | 16 |
| *Current* | 4 | 5 | 20 |

*L x C = Level*

| | |
|---|---|
| *Opened Date* | ***01-06-14*** |
| *Review Date* | ***17-11-14*** |
| *Review Date* | ***31-12-14*** |
| *Review Date* | ***12-03-15*** |
| *Review Date* | ***21-05-15*** |
| *Review Date* | ***15-07-15*** |
| *Review Date* | ***16-10-15*** |
| *Review Date* | ***17-11-15*** |
| *Review Date* | ***23-03-16*** |




### RISK CONTEXT

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

***Not meeting Monitor's Financial Sustainability Risk Rating (FSRR) triggering escalation process and possible external intervention.***

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

### BOARD RISK APPETITE

***Necessity to take risks to deliver the strategic and innovation programmes to deliver resilience and sustainability.***

### CONTROLS

- ***Detailed financial planning process including activity, workforce and capital planning***
- ***Monitor Forward Plan***
- ***Implementation of a CIP Governance Framework with Executive-level monitoring***
- ***Performance review, reporting and financial controls***

### BOARD ASSURANCE

- ***Finance and CIP Performance reports***
- ***Budget and Plan approval***
- ***Annual report sign off***
- ***CQUIN update***
- ***Finance committee review of progress reported to board***
- ***Strategic Development Committee reporting to board***

| | |
|---|---|
| ▪ *"Business as usual" performance tracking with business group (monthly)*<br>▪ *Building a Sustainable Future programme – continuous improvement*<br>▪ *Establishment Control Panel*<br>▪ *Business Case Panel*<br>▪ *Detailed financial report to FSI Committee* | |

| GAPS IN CONTROLS | GAPS IN ASSURANCES |
|---|---|
| ▪ *Wider clinical ownership and accountability for programme delivery*<br>▪ *CQUIN objectives need to devolved to those charged with delivery* | ▪ *Well defined and realistic efficiency programme for 2016/17*<br>▪ *Appropriate targeting and deployment of additional resources to deliver savings and improvements – capacity and capability*<br>▪ *Potential conflict between Trust plans and those of wider health economy* |

| | Assigned to | Action Detail | Progress-to-Date | Due Date |
|---|---|---|---|---|
| ACTION PLAN | *Chief Executive* | *Agree the CIP Governance Process including successful implementation of an Executive CIP Meeting.*<br><br>*Agree the capacity and capability of the Programme Management Office.* | *Complete* | *October 2015* |
| | *Medical Director* | *An engagement event to be arranged with medical staff aimed at developing wider ownership and accountability for programmed delivery* | | *January 2016* |
| | *Deputy Chief Executive* | *Fully establish BaSF programme for delivery in 2016/17.*<br><br>*Agree the Performance Management Framework to hold Business Group Directors to account to deliver cost improvement and strategic transformation programmes.* | *BaSF Committee meets bi-monthly to review progress.* | *January 2016* |
| | *Director of Finance* | *Ensure resources are identified and available in the PMO.*<br><br>*Hold Business Group Directors to account for delivery of their financial and activity plans.*<br><br>*Formalise the CIP Governance Framework including Quality Impact Assessments.*<br><br>*Ensure financial capacity and capability is developed to provide* | *PMO resources agreed by ET with financial resources identified for the PMO.*<br><br>*Capital investment envelope agreed for 2016/17.*<br><br>*Contract Governance Framework being* | *January 2016* |

| | | | | |
|---|---|---|---|---|
| | | ***support to the PMO and provide expert financial advice to Business Group Directors.***<br><br>***Agree the capital investment envelope for communication to the Capital Planning Development Group.***<br><br>***Develop a plan for effective engagement with Commissioners including clinical interface.*** | ***developed with the CCGs. Non-tariff elements of the contract is being assessed for discussion at 2016/17 contract negotiations.*** | |
| | ***Director of Nursing and Midwifery*** | ***Establish a robust forecast of CQUIN delivery and a plan for each business group to improve performance to secure 90% of CQUIN income in 2015/16.*** | ***CQUIN measures agreed with commissioners and key areas for further improvement by business group identified. Q1 & Q2 performance in line with expectations, measures need to continue to deliver the same going forward*** | ***March 2016*** |
| | ***Director of Workforce & OD*** | ***To develop an Organisation Development Programme to meet the Trust's transformation programme.*** | ***BDO engaged to support and improve engagement with commissioners. This work is now in its second phase and is planned to incorporate support for the contract process to reduce the potential for conflicting objectives.***<br><br>***Contract agreed with provision to review all non-tariff activity.*** | ***March 2016*** |

BAF

## Risk Category: Resource, resilience and sustainability

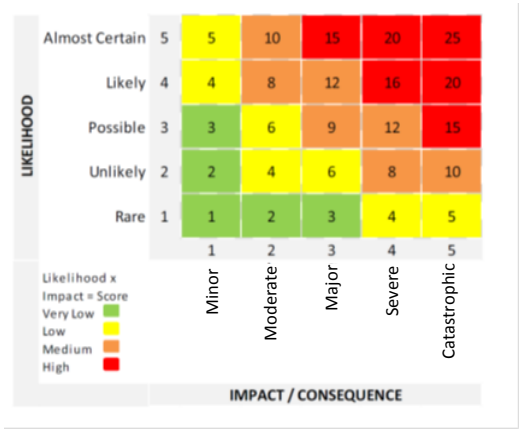
**Owner:** Chief Operating Officer

**RISK 7** — **Poor planning and execution of infrastructure plans to deliver IT and Estates and Facilities strategies**

### Board Risk Rating

| | | | |
|---|---|---|---|
| Initial | 3 | 4 | 12 |
| Current | 3 | 4 | 12 |

| | |
|---|---|
| Opened Date | 12-06-14 |
| Review Date | 31-12-14 |
| Review Date | 12-03-15 |
| Review Date | 21-05-15 |
| Review Date | 15-07-15 |
| Review Date | 16-10-15 |
| Review Date | 17-11-15 |
| Review Date | 23-03-16 |




### RISK CONTEXT

- *Redesign of clinical and operational workflows will need to be enabled by IT both within the Trust and across GM to ensure a sustainable future.*
- *Technology is key to delivering clinical services in terms of quality, safety and outcomes.*
- *Estate rationalisation is a key part of future cost saving plans*
- *The Trust must continue to develop its estate and not fall behind in maintenance creating future risk*
- *The Board needs to be sighted on key projects.*

### BOARD RISK APPETITE

*The Board is prepared to take decisions on investments at scale in IT and Estate infrastructure provided that there is a reasonable level of assurance that there is the ability to recover costs through efficiencies.*

### CONTROLS

- *Health Informatics programme*
- *Programme and project governance through Health Informatics Strategy Board*
- *Executive accountability – chaired by COO*
- *Policies and procedures*
- *Audit programme*
- *IGT*

### BOARD ASSURANCE

- *External and internal audit reporting of design and operation of plans*
- *Approval of strategies and plans through Finance, Strategy & Investment Committee*
- *Data integrity assurance – through data quality strategy*
- *IGT assurance – through HIS Board*
- *Project and programme assurance – through HIS Board & Capital Programme Development Group*

| | |
|---|---|
| **GAPS IN CONTROLS** | **GAPS IN ASSURANCES** |
| ▪ *Gaps in IT systems*<br>▪ *Gaps in Estate rationalisation plan* | ▪ *Benefits realisation on large scale IT projects – further work required*<br>▪ *Estate strategy – scheduled for Board approval Jan 2016* |

**ACTION PLAN**

| Assigned to | Action Detail | Progress-to-Date | Due Date |
|---|---|---|---|
| *Director IM&T* | *To confirm and finalise IM&T Strategy against Trust objectives in readiness for sign off by Board;* | *First draft complete; Board signed off the Annual Plan, incorporating IM&T 3 year plans Gap identified – Now going to Board in November* | *Completed* |
| *Executive Team* | *Clarifying governance arrangements in sub board structure.* | *Health Informatics Strategy Board developed* | *Completed* |
| *Director of Performance* | *Strengthening the links with the PMO* | *Reporting arrangements formalised* | *31/8/14* |
| *Asst Dir IM&T - Programme Mgt* | *Developing Business case for replacement of Community system* | *Requirements defined and project in place* | *Jan' 15* |
| *BASF Committee* | *Formalise approach to benefits realisation* | *In progress – IT work stream merged with Service Transformation to work on benefits realisation* | *March 2015* |
| *Chief Operating Officer* | *Development of Board to oversee the implementation of the IM&T strategy and report to the Finance, Strategy and Investment Committee* | *Terms of reference for HISB in place and approved by FSI, meetings dates being established.* | *Completed* |
| *Chief Operating Officer* | *Ensure delivery of IT Strategy through HISB* | *HISB in place and meeting monthly. Project plan and risk log in place for all projects.* | *Ongoing* |

| | | | | |
|---|---|---|---|---|
| | *Chief Operating Officer* | *Ensure Electronic Patient record programme has suitable governance process in place.* | *Programme Board in place with terms of reference and executive leadership.* | *Ongoing* |
| | *Chief Operating Officer* | *Ensure delivery of an Estates Strategy which focuses on the continued development of an efficient and effective site in line with the Trusts strategic vision* | *Strategy to Board of Directors in November 2015* | *November 15* |
| | *Chief Operating Officer* | *Health Informatics Strategy to Board in January 2016. This outlined the next five years of IM&T plans. This will be monitored through the Health Informatics Strategy Board and reported quarterly to Finance and Investment Committee.* | *Strategy to Board in January 2016*<br>*Plans reviewed quarterly in HISB* | *Quarterly* |

BAF

## Risk Category: Culture and Organisational Development

**Owner:** Director of Workforce and Organisational Development

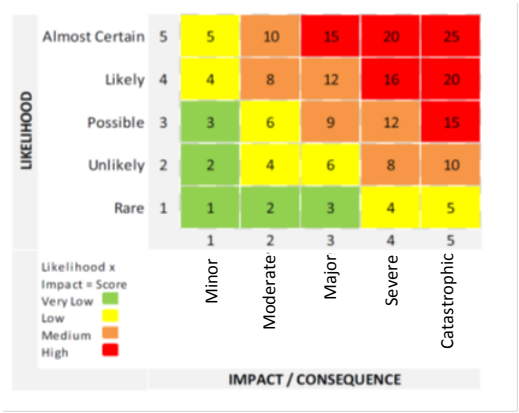
**RISK 8** Not having the right number of staff who have the right skills and are engaged, developed and motivated to deliver services now and into the future and is affordable

### Board Risk Rating

| | | | |
|---|---|---|---|
| Initial | 4 | 4 | 16 |
| Current | 3 | 4 | 12 |

L x C = Level

| | |
|---|---|
| Opened Date | 12-06-14 |
| Review Date | 17-11-14 |
| Review Date | 31-12-14 |
| Review Date | 12-03-15 |
| Review Date | 21-05-15 |
| Review Date | 13-07-15 |
| Review Date | 16-10-15 |
| Review Date | 21-01-16 |
| Review Date | 23-03-16 |




### RISK CONTEXT

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

### BOARD RISK APPETITE

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

*Triggers for consideration:*

1. *>50% of the KPI's in the Integrated Workforce report are outside of a 15% threshold*
2. *The Trusts staff engagement score in the annual staff survey falls below 2.5*

### CONTROLS

- *Executive accountability/Head of OD & Deputy Director*
- *Policies and procedures*
- *Appraisals*
- *Mandatory training*
- *Establishment Control Panel*
- *Quarterly Pulse Surveys*

### BOARD ASSURANCE

- *Workforce & OD Committee*
- *Business Group assurance reporting*
- *Assurance reporting on attendance, sickness, absence, mandatory training, turnover and medical appraisal & temporary staffing spend*
- *Annual Staff survey results & Friends & Family results (X3 per year)*
- *Freedom to Speak up Guardian appointed (commenced in post February 2016)*
- *Health & Well Being Strategy*
- *Recruitment & Retention Strategy approved by Board of Directors*
- *OD Strategy approved by Board of Directors*

| GAPS IN CONTROLS | GAPS IN ASSURANCES |
|---|---|
| ▪ *Leadership programme*<br>▪ *Engagement Plan* | ▪ *Engagement strategy*<br>▪ *Assurance on being "well led"*<br>▪ *Leadership Strategy* |

| | Assigned to | Action Detail | Progress-to-Date | Due Date |
|---|---|---|---|---|
| ACTION PLAN | *Director of Workforce & Organisational Dev.* | *Establishment of Workforce & Organisational Development Committee that is effective and compliant with all of its duties.* | *Workforce & OD Committee in place and operational* | *Complete* |
| | *Director of Workforce & Organisational Development* | *Embedding of all required performance reports to assist relevant committees and assurance meetings to support improvements in performance management* | *Further development& refinement of the workforce IPR will be informed by WOD and led by Deputy Director of Workforce.* | *Ongoing* |
| | *Head of Organisational Development & Learning* | *To ensure staff survey results are widely shared and robust action plans are developed in response to the annual staff survey and quarterly pulse surveys* | *Quarterly Staff engagement pulse check completed quarterly and reported to WOD* | *Quarterly* |
| | | | *Revised and refreshed arrangements in place for 2015 staff survey including:-*<br><br>*1.All staff surveyed*<br>*2. Business Group targets agreed* | *Complete* |
| | | | *3.CQC results to be shared at WOD & BOD* | *Complete* |
| | *Head of Organisational Development & Learning* | *Leadership Strategy Development* | *Draft Leadership Strategy presented and approved at WOD Committee in February 2016. Final approval by Board on 31 March 2016.* | *March 2016* |
| | *Head of Organisational Development & Learning* | *Engagement Plan Development* | *Draft engagement plan developed and presented to WOD bringing together the various strands of staff engagement & further actions required.* | *May 2016* |
| | *Deputy Director of Workforce* | *Recruitment & Retention Strategy Development* | *Recruitment & Retention Strategy approved by WOD prior to Board approval* | *Complete* |

This page has been left blank

Stockport NHS
NHS Foundation Trust

| | | | |
|---|---|---|---|
| **Report to:** | Board of Directors | **Date:** | 31st March 2016 |
| **Subject:** | Strategic Risk Register | | |
| **Report of:** | Director of Nursing & Midwifery | **Prepared by:** | Cathie Marsland<br>Head of Risk & Customer Services |

# REPORT FOR APPROVAL

| | |
|---|---|
| **Corporate objective ref:** | ----- |
| **Board Assurance Framework ref:** | ----- |
| **CQC Registration Standards ref:** | ----- |
| **Equality Impact Assessment:** | ☐ Completed<br>☒ Not required |

**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
- There were no new strategic risks added this month and two risks are no longer on the Strategic Risk Register:
  - 2764 - Non-compliance of manual handling training
  - 2579 - Vacant Hours Health Records
- 2130 - Insufficient capacity in Endoscopy to meet the current demand has increased from a score of 16 in last month to a score of 20 this month. Accordingly new actions have been added.

**Attachments:**

**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 |

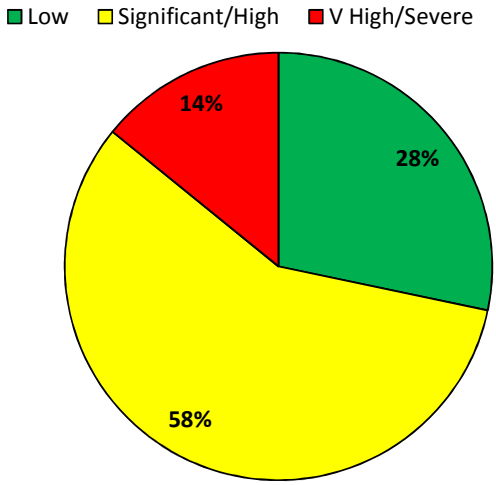
**- THIS PAGE IS INTENTIONALLY BLANK -**

## Trust wide Risk and Severity Distribution

1.1. There are currently 410 live risks recorded on the Trust Risk Register system compared to 413 last 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 |
| February | 1 | 15 | 32 | 65 | 5 | 40 | 45 | 35 | 6 | 108 | 14 | 31 | 15 | 1 |
| March | 0 | 16 | 34 | 66 | 5 | 37 | 43 | 35 | 6 | 110 | 13 | 30 | 14 | 1 |

## Severity Distribution




| Diagnostics and Clinical Support – 185 Live Risks | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Low | | | | Significant | | | High | | | Very High | | Severe | Unacceptable |
| 1 | 2 | 3 | 4 | 5 | 6 | 8 | 9 | 10 | 12 | 15 | 16 | 20 | 25 |
| 0 | 13 | 28 | 54 | 2 | 20 | 23 | 12 | 1 | 21 | 0 | 11 | 0 | 0 |

| Medicine – 16 Live Risks | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Low | | | | Significant | | | High | | | Very High | | Severe | Unacceptable |
| 1 | 2 | 3 | 4 | 5 | 6 | 8 | 9 | 10 | 12 | 15 | 16 | 20 | 25 |
| 0 | 1 | 2 | 2 | 0 | 1 | 1 | 0 | 0 | 5 | 1 | 1 | 2 | 0 |

| Child and Family –24 Live Risks | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Low | | | | Significant | | | High | | | Very High | | Severe | Unacceptable |
| 1 | 2 | 3 | 4 | 5 | 6 | 8 | 9 | 10 | 12 | 15 | 16 | 20 | 25 |
| 0 | 0 | 2 | 0 | 1 | 2 | 2 | 3 | 0 | 10 | 1 | 3 | 0 | 0 |

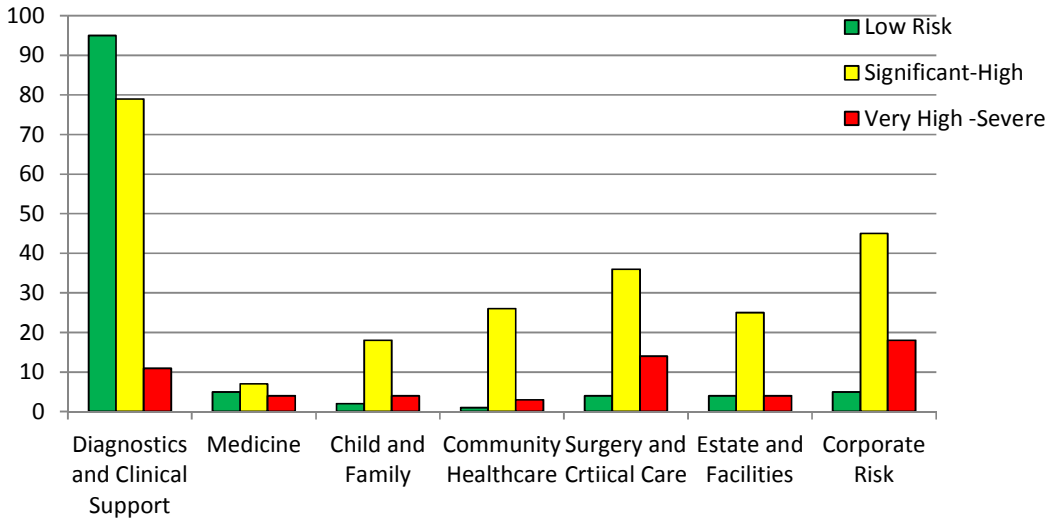
| Community Healthcare – 30 Live Risks | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Low | | | | Significant | | | High | | | Very High | | Severe | Unacceptable |
| 1 | 2 | 3 | 4 | 5 | 6 | 8 | 9 | 10 | 12 | 15 | 16 | 20 | |
| 0 | 0 | 0 | 1 | 0 | 2 | 0 | 4 | 0 | 20 | 2 | 0 | 1 | 0 |

| Surgery and Critical Care – 54 Live Risks | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Low | | | | Significant | | | High | | | Very High | | Severe | Unacceptable |
| 1 | 2 | 3 | 4 | 5 | 6 | 8 | 9 | 10 | 12 | 15 | 16 | 20 | 25 |
| 0 | 1 | 2 | 1 | 0 | 1 | 2 | 2 | 0 | 31 | 3 | 5 | 6 | 0 |

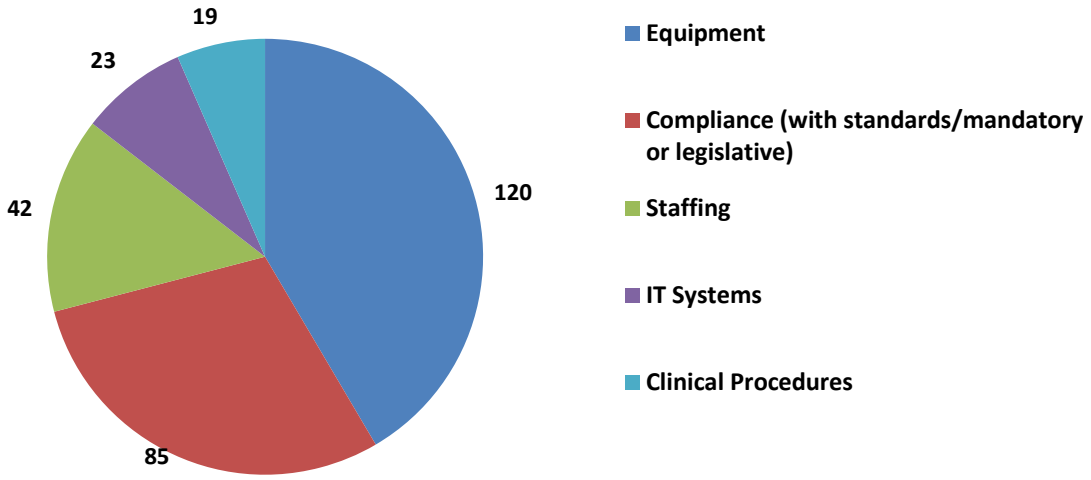
| Estate and Facilities – 33 Live Risks | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Low | | | | Significant | | | High | | | Very High | | Severe | Unacceptable |
| 1 | 2 | 3 | 4 | 5 | 6 | 8 | 9 | 10 | 12 | 15 | 16 | 20 | 25 |
| 0 | 0 | 0 | 4 | 1 | 5 | 6 | 6 | 0 | 7 | 3 | 1 | 0 | 0 |

| Corporate Risk (incl. Nursing, Finance, I.T , Executive team TT and Human Resources) – 68 Live Risks | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Low | | | | Significant | | | High | | | Very High | | Severe | Unacceptable |
| 1 | 2 | 3 | 4 | 5 | 6 | 8 | 9 | 10 | 12 | 15 | 16 | 20 | 25 |
| 0 | 1 | 0 | 4 | 1 | 6 | 9 | 8 | 5 | 16 | 3 | 9 | 5 | 1 |

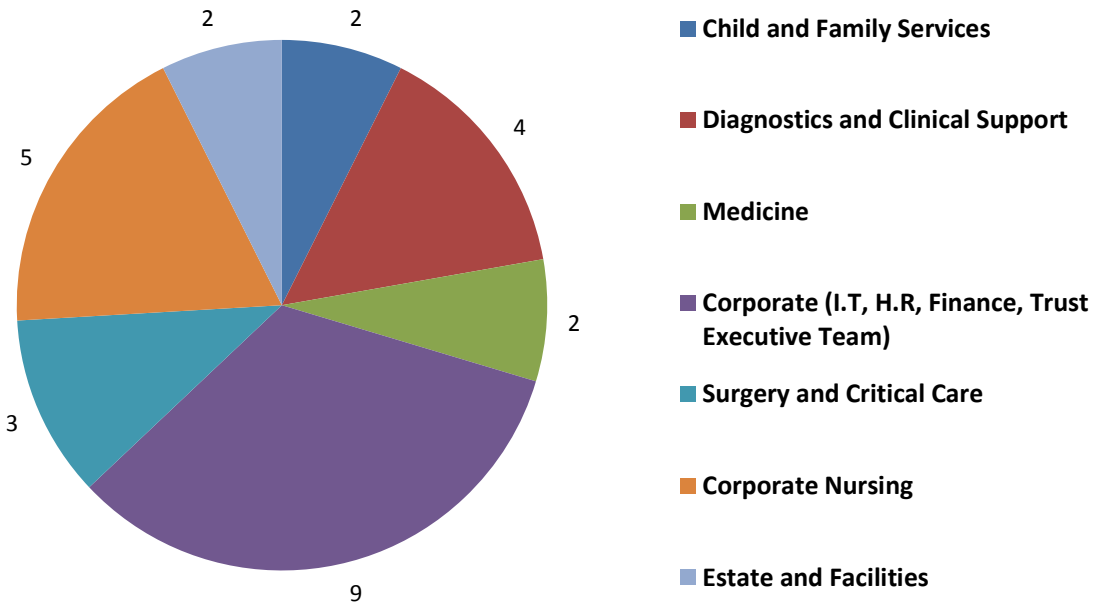
## Severity Distribution in Business Groups




## Top Five Sources of Risk across the Trust



## Distribution of Strategic Risk across Business Groups



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

Stockport NHS
NHS Foundation Trust

## Strategic Risk Register

| Business Group | ID Source | Risk | | Consequence | Rating (initial) (CxL) | Rating (residual risk after all mitigating actions) | Outstanding Actions | Rating (current or residual – *after controls but before mitigating actions)* *(CxL)* | Open Actions | Date for action plan completion | Progress Arrow Key: Red = increase in current rating Green = reduction in current rating Yellow = no change | Exec Owner / Committee (see key at end of report) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Child and Family | 2060 Staffing | **Out of hours consultant provision – Pediatrics** | *Inadequate senior cover in three acute areas simultaneously for seriously unwell children or neonate* | Potential harm to patients | 16 (4x4) | 12 | Formally review new arrangements - consider invited review from RCPCH | **16 (4x4)** | 1/6 | 30/04/2016 | ⟺ | JC/WOD |
| Child and Family | 2777 Compliance | **Maternity Safeguarding Practice** | *There have been four multi agency reviews over the past 12mths, which have identified concerns relating to midwifery safeguarding practice.* | Failure to meet national guidelines | 16 (4x4) | 12 | CQC and QC Action Plan / Multi Agency Review Action Plan / Local Safeguarding Action Plan with updated actions to be presented at Governance & Risk Meetings. | **16 (4x4)** | 2/11 | 29/04/2016 | ⟺ | JM/QAC |
| Corporate Nursing | 2194 Infection Prevention | **Reduction in number of single rooms for isolation of patients** | *In view of new and emerging resistant organisms, the requirements for increased isolation facilities remains a challenge across the NHS, with Stockport Foundation Trust being no exception to this. Delay in patients being isolated promptly increases the risk of cross contamination and could potentially amplify the risk to other patients developing the same or similar infection.* | Failure to meet national trajectory for healthcare acquired infections | 16 (4x4) | 8 | To review processes around data input for the side room database. Bed Managers to be included in receiving the toolbox training sessions which are delivered by the Infection prevention team to understand the significance of emerging resistant organisms, modes of spread, Infection prevention precautions and the important To work through action plans devised by single room workshop. | **16 (4x4)** | 3/30 | 30/04/2016 | ⟺ | JC/QAC |

| Business Group | ID Source | Risk | | Consequence | Rating (initial) (CxL) | Rating (residual risk after all mitigating actions) | Outstanding Actions | Rating (current or residual – *after controls but before mitigating actions) (CxL)* | Open Actions | Date for action plan completion | Progress Arrow Key: Red = increase in current rating Green = reduction in current rating Yellow = no change | Exec Owner / Committee (see key at end of report) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Corporate Nursing | 2806 Compliance | **Non Compliance with the Trust Alert & Hazards SOP** | *Lack of staff awareness of the Trust Risk Management Alerts and their requirements.* | Failure to meet national and internal standards in relation to compliance with alerts | 16 (4x4) | 8 | Further spot checks to be completed and results to Risk Committee | **16 (4x4)** | 1/4 | 30/04/2016 | ⟷ | JM/QAC |
| Corporate Nursing | 2860 Training | **Safeguarding / Fire Prevention training access for all volunteers working at SFT** | *Established not all volunteers working in various areas/wards/departments of the trust have received Fire and Safeguarding training as required for their role.* | Risk of failure to meet national standards/ Health and Safety Standard | 16 (4x4) | 4 | 4 fire sessions planned spanning December/January/February for volunteers to access in order to meet mandatory requirements. Volunteers to access fire safety awareness at SFT staff induction sessions. A number of places to be identified for volunteers to attend on a regular basis - new existing volunteers. Safeguarding information newsletter to be devised for existing volunteers to update them on safeguarding awareness and requirements. Newsletter to be given to all volunteers. Local training records to be kept recording records of attendance and compliance | **16 (4x4)** | 5/5 | 30/04/2016 | ⟷ | JM/QAC |

Stockport NHS
NHS Foundation Trust

| Business Group | ID Source | Risk | | Consequence | Rating (initial) (CxL) | Rating (residual risk after all mitigating actions) | Outstanding Actions | Rating (current or residual – *after controls but before mitigating actions)* *(CxL)* | Open Actions | Date for action plan completion | Progress Arrow Key: Red = increase in current rating Green = reduction in current rating Yellow = no change | Exec Owner / Committee (see key at end of report) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Corporate Nursing | 2888 Falls | **Failure to Achieve Trust Falls Targets for 2015/16** | *Failure to meet Trust Falls Targets (data as of end of November 2015 – 24 major and above gone or going through investigation to determine if avoidable – lapses in care identified* | Failure to Achieve Trust Falls Targets for 2015/2016 | 16 (4x4) | 12 | Meeting with Ward Sisters regarding alarm upgrade and complete programme. Review of Corporate data reports presented to group. Falls Policies to be reviewed with Falls Quality Standards. Medication Review to be reviewed and implemented. Lying and Standing BP Assessment to be clarified and implemented. Continue slipper project with Age UK, undertake trial of slipper socks | **16 (4x4)** | 6/13 | 29/04/2016 | ⟷ | JM/QAC |
| Diagnostic & Clinical Support | 2718 Medication | **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 medication error could result in death | 16 (4x4) | 12 | Implementation of new EPR system. | **16 (4x4)** | 1/15 | 01/09/2016 | ⟷ | JS/QAC |

| Business Group | ID Source | Risk | | Consequence | Rating (initial) (CxL) | Rating (residual risk after all mitigating actions) | Outstanding Actions | Rating (current or residual – *after controls but before mitigating actions) (CxL)* | Open Actions | Date for action plan completion | Progress Arrow Key: Red = increase in current rating Green = reduction in current rating Yellow = no change | Exec Owner / Committee (see key at end of report) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Diagnostic & Clinical Support | 2130 Clinical procedures | **Insufficient capacity in Endoscopy to meet the current demand** | *The Trust is at risk of not achieving its target* | A cancer diagnosis could be delayed for a patient and/or the Trust could incur financial penalties | 20 (4x5) | 12 | Improve sessional productivity, adding 1 unit to each list by developing case pre-assessment and additional nurses allocated to rooms Review Endoscopy lists and how they are allocated. Taking into account the additional consultants being appointed within Gastroenterology and General Surgery. Continue to support estates/procurement in establishing plans for unit expansion | **20 (4x5)** | 3/19 | 28/04/2016 | ↑ | JS/QAC |
| Diagnostic & Clinical Support | 2877 Compliance | **Continued operation and sustainability of existing AOS** | *National Peer Review minimum standards require a minimum of 2 nurses and 5 consultant oncology Direct Clinical Care sessions (DCCs) to operate a 5 day AOS. The Trust 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.* | Failure to meet national standards and extended loss of essential service | 16 (4x4) | 12 | Manage staff sickness absence Await outcome of options paper | **16 (4x4)** | 2/5 | 07/04/2016 | ↔ | JS/QAC |

Stockport NHS
NHS Foundation Trust

| Business Group | ID Source | Risk | | Consequence | Rating (initial) (CxL) | Rating (residual risk after all mitigating actions) | Outstanding Actions | Rating (current or residual – *after controls but before mitigating actions) (CxL)* | Open Actions | Date for action plan completion | Progress Arrow Key: Red = increase in current rating Green = reduction in current rating Yellow = no change | Exec Owner / Committee (see key at end of report) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Finance | 2809 Financial | **Delivery of CRP** | *The Trust is unable to deliver the £11.8 million Monitor CRP savings required in 15.16.* | The Trust will not meet its financial targets and this may reduce Monitor's Financial Sustainability Risk Rating to a score of 2 or below. | 20 (4x5) | 15 | Planned reviews with the Executive Team for Business Groups who are not meeting their CRP. The CIP is reported to the Board on a monthly basis and to each FSI Committee. Review of balance sheet Revised Business Group CIP meetings to be held with Director of Operations and Deputy Director of Finance | **20 (4x5)** | 4/10 | 23/04/2016 | ⟷ | FP/FS&I |
| Finance | 2808 Financial | **Management of Working Capital** | *The Trust has insufficient cash reserves in order to play its staff and suppliers.* | The Trust will not meet its financial obligation | 15 (5x3) | 10 | Revised payment profile to be agreed with CCG for 2016/17 contract | **15 (5x3)** | 1/8 | 21/04/2016 | ⟷ | FP/FS&I |

| Business Group | ID Source | Risk | | Consequence | Rating (initial) (CxL) | Rating (residual risk after all mitigating actions) | Outstanding Actions | Rating (current or residual – *after controls but before mitigating actions) (CxL)* | Open Actions | Date for action plan completion | Progress Arrow Key: Red = increase in current rating Green = reduction in current rating Yellow = no change | Exec Owner / Committee (see key at end of report) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Finance | 2899 Financial | **Delivery of the Sustainability and Transformation Fund Conditions** | *In order to receive the £8.4m STF the Trust has to meet 3 predetermined conditions: The Trust has to deliver a break even financial performance. The Trust has to agree a credible plan with NHS England and NHS Improvement to maintain and improve performance for national standards. Trust has to work closely with Stockport Health and Social colleagues to deliver an integrated STP* | Loss of £8.4m of funding to the Trust | 25 (5x5) | 20 | Negotiate transitional funding for T&G Community Transfer<br>Sensitivity modelling of tariff for 2016/17<br>Contract negotiations with commissioners to include inflation and growth<br>Negotiations with commissioners for cash profiling for 2016/17<br>Negotiate further investment and support from Stockport Together colleagues<br>Project Plan in place by Director of Strategy to deliver an STP for Stockport which will become part of the STP for Greater Manchester<br>Application to the GM Transformation Fund<br>Full implementation of Agency cap in line with NHS Improvement Guidelines<br>Explore other sources of financing<br>Establish cash management group to monitor reduce level of cash and agree as series of actions including extending payment terms and changing frequency. | **25 (5x5)** | 10/13 | 31/07/2016 | ⟷ | FP/FS&I |

Stockport NHS
NHS Foundation Trust

| Business Group | ID Source | Risk | | Consequence | Rating (initial) (CxL) | Rating (residual risk after all mitigating actions) | Outstanding Actions | Rating (current or residual – *after controls but before mitigating actions)* *(CxL)* | Open Actions | Date for action plan completion | Progress Arrow Key: Red = increase in current rating Green = reduction in current rating Yellow = no change | Exec Owner / Committee (see key at end of report) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Finance | 2896 Financial | **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.* | Failure to achieve financial balance and therefore would be subject to regulatory action by NHS Improvement | 20 (4x5) | 15 | Strasys consultancy engaged to provide a Trust Strategy and a method for delivery of future savings:<br>Identifying patient cohorts to inform strategy and decision making<br>Design and introduction of innovation projects to deliver transformational change<br>Identification of projects for "strategic staircase" for savings<br>Formation of Strategic Planning Team with appropriate resources in corporate areas<br>Financial analysis of staircase projects and deliverability over 5 years<br>Annual planning guidance to be assessed and implications of tariff and other changes assessed | **20 (4x5)** | 4/8 | 30/04/2016 | ⟷ | FP/FS&I |
| Human Resources | 2879 Finance | **Use of Temporary Staffing** | *Risk to patient care through ongoing or increasing use of temporary staffing. .* | *Financial risk due to cost and action for failing to adhere with the monitor agency cap rules* | 20 (4x5) | 12 | Development of action plan.<br>Completion of Agency Diagnostic Tool.<br>Deliver identified actions and report progress at WODC.<br>Evaluation and Learning of action taken | **20 (4x5)** | 4/4 | 30/06/2016 | ⟷ | JSh/WOD |

| Business Group | ID Source | Risk | | Consequence | Rating (initial) (CxL) | Rating (residual risk after all mitigating actions) | Outstanding Actions | Rating (current or residual – *after controls but before mitigating actions) (CxL)* | Open Actions | Date for action plan completion | Progress Arrow Key: Red = increase in current rating Green = reduction in current rating Yellow = no change | Exec Owner / Committee (see key at end of report) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| IM&T | 2567 IT Systems | **Loss of Aspen House Server Room** | In the event of losing Beech House, Aspen House will not be able to host adequate computer services in the future | This will severely impact on our ability to deliver acceptable patient care. | 16 (4x4) | 8 | Migration of all the equipment from the old server room | **16 (4x4)** | 1/3 | 29/04/2016 | ⟷ | JS/FS&I |
| Trust Executive team | 1881 Compliance | **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.* | Significant impact on corporate objectives/ reputation and finance | 20 (4x5) | 10 | 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 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). | **20 (4x5)** | 14/41 | 30/04/2016 | ⟷ | JS/QAC |

Stockport NHS
NHS Foundation Trust

| Business Group | ID Source | Risk | | Consequence | Rating (initial) (CxL) | Rating (residual risk after all mitigating actions) | Outstanding Actions | Rating (current or residual – *after controls but before mitigating actions) (CxL)* | Open Actions | Date for action plan completion | Progress Arrow Key: Red = increase in current rating Green = reduction in current rating Yellow = no change | Exec Owner / Committee (see key at end of report) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Trust Executive Team | 2889 Compliance | **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:* | Failure to meet national standard – contractual failure | 20 (4x5) | 12 | All actions to be taken through Stockport Together Transformational Project | **20 (4x5)** | 1/2 | 30/04/2016 | ⟷ | JC/QAC |
| Medicine | 2470 Other | **Gastroenterology service provision** | *Insufficient capacity to adequately deliver all service areas within Gastroenterology* Failure to meet NICE guidance. | Failure to meet national standards. High risk to patients who are waiting past their due date. Very high risk to TNF patients. | 20 (4x5) | 8 | Management Validate 1800 patients. Begin CNS Validation | **20 (4x5)** | 2/15 | 30/06/2016 | ⟷ | JC/QAC |

| Business Group | ID Source | Risk | | Consequence | Rating (initial) (CxL) | Rating (residual risk after all mitigating actions) | Outstanding Actions | Rating (current or residual – *after controls but before mitigating actions)* *(CxL)* | Open Actions | Date for action plan completion | Progress Arrow Key: Red = increase in current rating Green = reduction in current rating Yellow = no change | Exec Owner / Committee (see key at end of report) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Medicine | 2721 | **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* | Loss of Trauma status, loss of reputation and this may impact on patient safety, experience and staff well-being | 20 (4x5) | 8 | Review the process of recording of the CT reporting within 1 hour to assure demonstrates performance indicator is reached for appropriate patients<br>Develop a Yearly Trauma Audit plan and findings to be fed into Quality Board meetings<br>Develop a plan to enable a robust Trauma coordinator service 7 days a week that can demonstrate the use of Rehabilitation prescriptions | **20 (4x5)** | 9/9 | 30/04/2016 | ⟷ | JC/QAC |
| Corporate Nursing | 2742 Analysis & Improvement | **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.* | *Failure to meet national DOH standard regarding investigation of serious incident (63 days)* | 16 (4x4) | 8 | Risk team to be given further training in investigating incident to ensure they are able to challenge poor practice<br>Monitor quality of patient safety reports on a random basis by CM | **16 (4x4)** | 2/9 | 30/04/2016 | ⟷ | JM/QAC |

Stockport NHS
NHS Foundation Trust

| Business Group | ID Source | Risk | | Consequence | Rating (initial) (CxL) | Rating (residual risk after all mitigating actions) | Outstanding Actions | Rating (current or residual – *after controls but before mitigating actions)* *(CxL)* | Open Actions | Date for action plan completion | Progress Arrow Key: Red = increase in current rating Green = reduction in current rating Yellow = no change | Exec Owner / Committee (see key at end of report) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Corporate Nursing | 2644 Compliance | **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).* | *Non-compliance with NICE Standard* | 16 (4x4) | 8 | Identify a Clinical Lead for GI Bleeding<br>Separate rota for endoscopy staff and organisation of Endoscopy list to prioritise blood<br>Development of a separate "bleeder rota" to provide 24/7 provision of endoscopic diagnostic and treatment service | **16 (4x4)** | 3/8 | 30/04/2016 | ⟷ | JC/QAC |
| Surgery and Critical Care | 2785 Staffing | **Operating Theatre Staffing** | *Current inability of theatres staffing levels to deliver business group service requirements, resulting in elective surgical cancellations. Over the last 3 consecutive weeks 56 sessions have been cancelled* | Trust failure to meet performance targets, 18 week RTT and Cancer targets | 20 (4x5) | 16 | Quality & Safety - Balance theatre activity with current staffing levels | **20 (4x5)** | 1/9 | 01/05/2016 | ⟷ | JSh/WOD |

| Business Group | ID Source | Risk | | Consequence | Rating (initial) (CxL) | Rating (residual risk after all mitigating actions) | Outstanding Actions | Rating (current or residual – *after controls but before mitigating actions) (CxL)* | Open Actions | Date for action plan completion | Progress Arrow Key: Red = increase in current rating Green = reduction in current rating Yellow = no change | Exec Owner / Committee (see key at end of report) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Surgery and Critical Care | 2826 Finance | **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.* | The Trust will not meet its financial targets and this may reduce Monitor's Financial Sustainability Risk rating to 2 or below. | 20 (4x5) | 12 | Reduce Outsourcing Review of capacity to maximise income potential from targeted specialties eg., weekend, evening, Trust Health<br>Reduce Locum/Agency and WLI spend.<br>SLR/PLiCs review<br>Improving staff productivity schemes.<br>Departmental efficiency schemes.<br>On-going work with the Procurement team to review prosthetic usage, to realise extra savings and longer term savings on tenders.<br>Work closely with Corporate Teams to ensure target delivery of project work-streams relevant to Business Group e.g., outpatients, drugs, HR<br>15/16 Headcount reduction | **20 (4x5)** | 9/12 | 20/05/2016 | ⟷ | FP/FS&I |

Stockport NHS
NHS Foundation Trust

| Business Group | ID Source | Risk | | Consequence | Rating (initial) (CxL) | Rating (residual risk after all mitigating actions) | Outstanding Actions | Rating (current or residual – *after controls but before mitigating actions) (CxL)* | Open Actions | Date for action plan completion | Progress Arrow Key: Red = increase in current rating Green = reduction in current rating Yellow = no change | Exec Owner / Committee (see key at end of report) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Surgery and Critical Care | 2824 Staffing | **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.* | Trust failure to meet waiting list targets as we cannot offer safely staffed beds at weekends. | 16 (4x4) | 12 | UK recruitment event Follow up leads from Manchester University student nurse event attended sept 2015 International recruitment event | **20 (4x5)** | 1/6 | 28/04/2016 | ⟷ | JSh/WOD |
| Estates and Facilities | 2730 Compliance | **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.* | Failure to meet national standard Hazardous Waste Regulations 2005, Waste Regulations 2011 and the guidance HTM 07-01: Safer Management of Healthcare Waste | 15 (3x5) | 6 | 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 | **15 (3x5)** | 2/4 | 30/05/2016 | ⟷ | JS/QAC |

| Business Group | ID Source | Risk | | Consequence | Rating (initial) (CxL) | Rating (residual risk after all mitigating actions) | Outstanding Actions | Rating (current or residual – *after controls but before mitigating actions) (CxL)* | Open Actions | Date for action plan completion | Progress Arrow Key: Red = increase in current rating Green = reduction in current rating Yellow = no change | Exec Owner / Committee (see key at end of report) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Estates and Facilities | 2748 | **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* | The current situation would impede a timely and efficient evacuation and multiple patients could die, loss of multiple essential services in critical areas, failure to meet professional standards, with costs in excess of 5 million pounds and potential imprisonment of Trust Executive | 15 (5x3) | 10 | 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 | **15 (3x5)** | 4/5 | 30/05/2016 | ⟷ | JS/QAC |

Stockport NHS
NHS Foundation Trust

## Risks no longer on the Corporate Strategic Risk Register

| Business Group | ID Source | Risk | | Consequence | Rating (initial) (CxL) | Rating (residual risk after all mitigating actions) | Rating (current or residual – *after controls but before mitigating actions) (CxL)* | Reason |
|---|---|---|---|---|---|---|---|---|
| Human Resource | 2764 Compliance | **Non-compliance of manual handling training** | *Injury to staff and patients will probably occur when approved practical techniques have not been demonstrated in a safe training environment* | Failure to meet national HSE standard /Regulations. Possible litigation cases, injury to staff and patients | 16 4x4 | 12 | **12 (4x3)** | **The likelihood of risk is now reduced.** |
| Diagnostic & Clinical Support | 2579 Staffing | **Vacant Hours Health Records** | *Inability to locate, retrieve and provide records in time for patient care. Inability to provide adequate outpatient reception service* | Risk to patient care | 20 (4x5) | 12 | **12 (4x3)** | **The likelihood of risk is now reduced.** |

## 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<br>Local press <1 day coverage |
| 2 | Minor | First aid treatment<br><3 days absence<br><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<br>Local press <1 day coverage |
| 3 | Moderate | Medical treatment required<br>>3 days absence<br>>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<br>Criminal prosecution<br>Prohibition notice served | Regulatory concern<br>Local media <7 day of coverage |
| 4 | Major | Fatality<br>Permanent disability<br>Multiple injuries | Extended loss of essential service in more than one critical area | Failure to meet national standards | £1M-£5M | Criminal prosecution - no defence<br>Executive officer fined | National media <3day coverage<br>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<br>MP concern<br>Questions in the House<br>Full public enquiry |

### *The risk factor = severity x likelihood*

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

| | CONSEQUENCE | | | | |
|---|---|---|---|---|---|
| **LIKELIHOOD** | **1**<br>**Low** | **2**<br>**Minor** | **3**<br>**Moderate** | **4**<br>**Major** | **5**<br>**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)* |

This page has been left blank

Stockport NHS
NHS Foundation Trust

| | | | |
|---|---|---|---|
| **Report to:** | Board of Directors | **Date:** | 31 March 2016 |
| **Subject:** | Safe Staffing | | |
| **Report of:** | Director of Nursing & Midwifery | **Prepared by:** | Deputy Director of Nursing & Midwifery |

# REPORT FOR APPROVAL

| | |
|---|---|
| **Corporate objective ref:** ----- | **Summary of Report**<br>There is now a requirement following the publication of the Francis report, 2013 and subsequent National Quality Board recommendations, that all NHS organisations will take a 6 monthly staffing report to their Board of Directors.<br><br>The Board of Directors is asked to note the contents of the report and to note the significant improvements in staffing levels and changes to shift patterns that have been introduced over the last 6 months. |
| **Board Assurance Framework ref:** ----- | |
| **CQC Registration Standards ref:** ----- | |
| **Equality Impact Assessment:** ☐ Completed ☐ Not required | |

**Attachments:**

**This subject has previously been reported to:**

| | |
|---|---|
| ☐ Board of Directors | ☐ 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 |

**- THIS PAGE IS INTENTIONALLY BLANK -**

## 1. INTRODUCTION

There is now a requirement following the publication of the Francis report (2013) and subsequent National Quality Board recommendations, that all NHS organisations will take a 6 monthly report to their Board of Directors on the nurse and midwifery staffing levels within their organisation and whether they are adequate to meet the acuity and dependency of their patient population.

This report builds on the findings presented to the Board of Directors in September 2015 and provides further analysis in respect of community nursing and care contact time.

## 2. BACKGROUND

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

## 3. CURRENT SITUATION

### 3.1 Our approach to assuring safe staffing levels on our adult wards and within ED

**i.** There is no one recommended method to calculate establishment setting but the utilisation of a range of approaches from using an acuity based tool which measures patient dependency and acuity, to a crude staffing ratio per bed, supported by professional judgement of the ward leader and their senior Nursing and Midwifery staff, is the preferred approach.

**ii.** The organisation continues to use the Safer Nursing Care Tool (SNCT) as an evidence-based acuity assessment, and this is used in conjunction with the seniority of staff and their experience and ward layout differences.

**iii.** All adult acute inpatient wards have also been reviewed against their compliance with NICE guidance on achieving a maximum of 8 patients per registered nurse on day duty.

**iv.** The Emergency Department has now undertaken two acuity reviews using the BEST evidence based tool and has also now commenced a consultation to make changes to shift patterns to meet European Working Time Regulations and Health & Safety Executive guidance. The proposals will also convert some temporary posts into substantive posts.

**Triangulation of Quality metrics and staffing outputs**

Care contact audits (which record the % of value added and non-value added care delivery by banding and skill) have been repeated but, due to I.T issues, are not available for this report.

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

- Red flag reporting – red flag events are used to report an issue which staff feel is due to reduced staffing levels and/or increased patient acuity and covers issues such as delays in administering pain relief to a reduction of staffing greater than 25%. During the period of

this report (August 2015 to Jan 2016) a total of 61 incidents were reported with only 1 relating to a reduction to 1 RN on duty and 6 wards reporting a deficit of 25% or greater

- Safe staffing figures for the 6 month period since August 2015 show an overall fill rate of over 91.3% against both RN and HCA day and night shifts, against funded establishments. This is an improvement from the last report
- Nurse sensitive indicators – nationally evidenced indicators which deteriorate in the absence of registered nurse presence. These include falls, pressure ulcers and medication errors, measured per 1000 bed days. For this period, the top 5 locations are as follows;

Table 1; Harm data per 1000 bed days

| | Pressure Ulcer per 1000 bed days | Falls per 1000 bed days | Medication incidents relating to Nursing error per 1000 bed days |
|---|---|---|---|
| 1 | ICU | CDU | CDU |
| 2 | D4 | SSOP | ICU |
| 3 | D2 | A11 | NEONATES |
| 4 | A1 | A10 | ACORN |
| 5 | A10 | B5 | M1 |

It should be noted that some areas, e.g. Paediatrics have higher reporting of some metrics than compared to adult areas (e.g. Medication incidents). The data presented is largely in line with expectations when taking into consideration patient groups on the wards highlighted (e.g. Rehab, and elderly frail unit). Reassuringly, despite wards E2, E3 and D1 showing an unfavourable staffing deficit this audit, the nurse sensitive indicators confirm that quality has been maintained.

- Patient experience - The NICE in-patient guidance recommended that acuity results also be triangulated against 7 specific questions from the national in-patient survey. Table 2 provides the most recent results from the Picker survey, with previous year's results also shown.

Table 2; National in-patient surgery Staffing related Questions

☺ Indicates improved position

| Q | | 2011 | 2012 | 2013 | 2014 | 2015 | |
|---|---|---|---|---|---|---|---|
| **Q23** | Hospital: did not always get enough help from staff to eat meals | **33%** | **37%** | **46%** | **38%** | **36%** | ☺ |
| **Q27** | Nurses: did not always get clear answers to questions | **39%** | **33%** | **30%** | **34%** | **31%** | ☺ |
| **Q30** | Nurses: sometimes, rarely or never enough on duty | **43%** | **44%** | **44%** | **39%** | **39%** | **-** |
| **Q36** | Care: could not always find staff member to discuss concerns with | **70%** | **62%** | **65%** | **67%** | **64%** | ☺ |
| **Q37** | Care: not always enough emotional support | **51%** | **42%** | **47%** | **45%** | **43%** | ☺ |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | From hospital staff | | | | | | |
| **Q41** | Care: staff did not do everything to help control pain | **33%** | **33%** | **37%** | **34%** | **32%** | ☺ |
| **Q42** | Care: more than 5 minutes to answer call button | **12%** | **17%** | **16%** | **15%** | **15%** | **-** |

**Safer Nursing Care Tool Outputs February 2016**

**Medicine**

- From the 21st September 2015, all in-patient areas were in receipt of revised shift patterns and staffing numbers, following the extensive review that commenced in 2014. This is therefore the first acuity review following these revised establishments
- It is the second time that AMU 1 and 2 were included (due to changes made to the tool). The gap between the recommended and established levels has reduced and as with all acuity audits, these results will be 'averaged' once three audits have been completed, over the span of a 12 month period
- Investment during 2015 into A10 and A11 has been welcomed with the establishment deficit decreasing
- Wards A12, A14 and A15 all report slightly higher gaps between established and recommended funding, but this is likely to be due to the time of year as opposed to a significant and sustained shift in acuity
- Cardiology – establishments now much more closely resemble recommended levels following movement of some of these establishments to support under-established areas in 2015
- Wards E2 and E3 continue to show an unfavourable deficit and will be subject now to a closer review of skill mix and staffing numbers

**Surgery and Critical care**

- Surgery and Critical care reported a largely similar performance to all previous audits undertaken in 2014/15 and gives further assurance that the establishments are correct
- Ward D1 reported a higher acuity; this was observed at the time of audit and linked to a specific surgical procedure. This will be monitored going forward

**Intermediate care**

- The two intermediate care wards at Shire Hill Hospital have now completed the implementation of the revised shift patterns which resulted in increased levels of Registered Nurses on night shifts and also an increase in HCAs during the day. Recruitment remains a challenge, with safe staffing levels supported by agency also

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

**i.** The workforce requirements for the maternity unit have been calculated using the national Birth-rate Plus tool and professional judgement.

**ii.** Birth-rate Plus is based upon the principle of providing one to one care during labour and delivery to all women, with additional hours being identified for more complex deliveries.

**iii.** The Birth-rate Plus overall recommended ratio is 1:29.5. Our funded Midwife to Birth ratio is agreed at 1:30, taking into account the role of the Assistant Practitioners in our workforce. For the period of reporting, the Midwife to Birth ratio was 1:29.4

**iv.** NICE maternity guidance published in 2015 has been reviewed and our Maternity service is compliant against the various parameters set

**v.** In the same way as for adult in-patient wards, Maternity services are recommended to triangulate staffing data as follows;

- Red flag staffing events – 29/61 red flag events were reported by Delivery Suite. These will be reviewed by the Head of Midwifery
- Safe staffing – fill rates for the period report achievement of above 95%

**3.3 Our approach to delivery safe community nursing levels**

**i.** The September 2015 Board staffing report highlighted the review of Greater Manchester (GM) district nursing services that was commissioned by NHS England North on behalf of the twelve Clinical Commissioning Groups (CCGs) in partnership with eight community providers, including this organisation. The review was led by Keith Hurst, Independent Researcher, who has been instrumental in developing tools to measure staffing levels on acute wards. It looked at patient dependency/acuity, staff activity, workload, and quality and establishment data.

**ii.** This acuity review was then repeated during May/June 2015, and again in autumn 2015, to ensure access to two sets of results (in the same way as for adult inpatient areas) to then inform subsequent proposals.

**iii.** A review of Stockport community nursing has also revealed that no uplift is built into the establishment. Uplift is essential to cover release of staff for mandatory training and also to cover annual leave and sickness, in line with National Quality Board recommendations.

**Community Acuity Review Outputs**

**Caseload**

Stockport's nursing caseload is consistently higher than the England average with Stockport nursing staff seeing an average of 9.68 patients per day, compared to 8.25 nationally. The workload index (calculated using daily visits, case load (dependency/acuity), and face to face time) shows the Stockport Nursing service as 'stretched' when compared to the England average, with a workload index of 1.27 compared to 1.08 nationally. (A workload index of 1 is seen as comfortable)

**Activity**

Activity was recorded over 24 hours over 7 days, and analysed by direct activity (face to face), indirect (documentation, referral – integral elements of care), associated work (teaching, clerical, administration, meetings), and travelling. Stockport staff were recorded as more patient centred than their England counterparts (43.5% direct care compared to 38.5% for England).

Stockport's travel time is shown as significantly higher than England average, with 12.2% spent travelling compared to 5.3% for their England counterparts

**Quality**

Utilising a workload-sensitive 175 item questionnaire, all community nursing teams were scored against service structure (staffing, equipment), treatment and processes (how teams and individuals work) and outputs and outcomes (patient, carer and staff satisfaction). Stockport scored 66.6% compared to 66.2% nationally. In consideration of the higher workload for Stockport, this should be applauded

**Skill Mix**

The Stockport service records a RN skill mix of 77% compared to 79% for England. The acuity reviews also reported a deficit of between 24% and 30% WTE.

The Trust is currently in discussion with Stockport CCG regarding the output of the community acuity review, the uplift position and the future community nursing staffing within Stockport Together.

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

**Neonatal Unit ward staffing**

National guidance suggests nursing requirements at the following ratios:-
NICU (neonatal) – 1:1
HDU – 2:1
SCBU (special care babies) – 4:1

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

i. Current nurse staffing levels are showing a total of 28.94 WTE nursing workforce (this does not include the supervisory unit manager at band 7 and Matron post)
ii. Each shift needs to have at least 2 nurses qualified in speciality (QIS) on every shift; this is usually at least one Band 6 or 7 and a Band 5 nurse who has completed a specialist training course. A deep dive into acuity and staffing as part of the CQC inspection showed that we have the correct number of staff qualified in speciality for the acuity of the babies on the unit.
iii. Our current workforce is very flexible and adapts well to fluctuations in activity; there is some flexing of workforce between Paediatrics and Neonates, but the unpredictability of neonatal activity makes this difficult to plan for. Neither NHS Professionals nor any of our agencies can provide any additional suitably qualified staff for either Neonates or Paediatrics

**Paediatric Ward staffing establishment**

Guidance around staffing a paediatric ward is less robust with no statutory guidance beyond an aspirational document produced by the RCN in 2013. The Treehouse Children's unit consists of the following areas:-

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

The RCN document "Defining staffing levels for children and young people's services" was

updated in 2013 but a survey of our peers showed that against most of the guidance there was no unit that was fully compliant. The headlines from this document are:-

- Supernumerary shift supervisor on all shifts
    - We have a full time supervisory Ward Manager and a Matron post in addition to a team of Band 6 team leaders who are highly competent at managing the flow of paediatric patients across the unit and from ED and GP's
- At least one RN on every shift be APLS trained
    - Over the past 2 years we have recognised that the HDU module and the Paediatric AIMs course is much more appropriate and useful to nurses working on our unit – this means that we are not compliant with APLS trained nurses on each shift, but we maintain compliance by having all of our registrars and Consultant medical staff APLS compliant and this covers the 24 hour service
- Minimum staffing ratio of 70:30 Registered: Unregistered
    - Our current ratio of Registered to Unregistered is 80:20 with a high proportion of the unregistered being Assistant Practitioners who are paediatric trained
- Minimum of 2 qualified RN (Child) in every setting where children are in patients or day cases
    - Fully Compliant – we have an average of 6 RN (Child) staff on every shift
- Nurses working with children should be registered children's nurses.
    - All of our registered nurses are RN (Child)
- Support workers should have additional training in working with Children and Young People
    - All our Assistant Practitioners have been trained to look specifically after children in hospital
- Additionally there should be at least 1 play specialist, but ideally one per day shift 7 days per week
    - We have 3 full time qualified hospital play specialists who work on the Treehouse
- There is also the expectation within a DGH of a senior children's nurse in a minimum of a band 8a position to advise the organisation and the nursing team in relation to nursing sick children
    - We have a full time 8a Matron's post as well as a Head of Children's Nursing post.

The higher percentage of registered nursing staff establishment enables us to deliver a safe level of care across all of the Treehouse unit areas – we have flexibility built in around HDU activity, Assessment beds and the day case surgical workload. It is difficult to measure day to day acuity and nurse: patient ratios as our average length of stay is just over 1 day. We aim broadly to deliver a 1:5 ratio for the general ward patients and 1:2 for high dependency in line with the guidance.

In the past 6 months we have increased our paediatric senior nursing cover with a new Matron post in addition to the ward manager – this gives us 5 day per week supervisory status for the unit. We do not have Band 6 nurses on during the night shift, but we do have very competent and experienced band 5 nursing staff who rotate across night shifts.

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

- **i.** Effective recruitment – at present, the number of substantive vacancies has again reduced significantly with Medicine reporting circa 26WTE from a figure of 90+ in September 2014 and Surgery reporting single figures (excluding theatres). Local recruitment remains a challenge, and commissioning increases in student nurse training places will not yield an outcome for 3 years
- **ii.** Rotational posts – the organisation will run a rotational post for newly qualified registered nurses (Medicine, Surgery and Community). This has already been recruited to and starts in September 2016
- **iii.** Effective rostering – the organisation utilises 'Health Roster' for nursing staff. The diagnostic review referenced in the September 2015 report has been completed. The outputs support an effective rostering compliance, supported by a robust monthly key performance management framework
- **iv.** Reducing the use of agency staff – the organisation is working in partnership with four neighbouring acute providers. The agency ceiling for registered nurses and midwives was set at 4% for 15/16. This was achieved with the exception of December 2015 (4.7%) and January 2016 (4.1%)
- **v.** International recruitment is expected to be required during 2016 and 2017 to maintain the progress made and to off-set the annual deficit between current turnover rates and the numbers of newly qualified staff available each year

## 4 RISK & ASSURANCE

This paper is designed to assure the Board of Directors that there are safe staffing levels within the Trust.

There is a risk due to recently implemented national changes to EU recruitment. This will be monitored and a further update on further international recruitment will be provided within the September 2016 report.

## 5 CONCLUSION

The report highlights the outputs from various comprehensive reviews into Nursing and Midwifery staffing levels. Whilst staffing levels are dynamic, and dependent on both changes in acuity and dependency and operational pressures, the changes made to date will result in significant improvements across the organisation.

## 6 RECOMMENDATIONS

The Board of Directors is asked to;

- note the contents of this report

This page has been left blank

Stockport NHS
NHS Foundation Trust

| | | | |
|---|---|---|---|
| **Report to:** | Board of Directors | **Date:** | 31st March 2016 |
| **Subject:** | Safe Staffing report | | |
| **Report of:** | Director of Nursing and Midwifery | **Prepared by:** | Deputy Director of Nursing and Midwifery |

# REPORT FOR APPROVAL

| | |
|---|---|
| **Corporate objective ref:** ----- | **Summary of Report**<br><br>The report provides an overview, by exception, of actual versus planned staffing levels, for the month of February 2016.<br><br>Key points of note as follows;<br>• Night RN cover remains significantly improved<br>• Trauma and Orthopaedics remain a challenge and await start dates of new staff<br>• Non EU recruitment was successful, with 90 offers made for 60 posts<br>• EU recruitment also continues but numbers are reducing to recent national changes in the process<br>•<br>The Board of Directors is asked to note the contents of this report with assurance given that Safe Staffing was maintained during February 2016. |
| **Board Assurance Framework ref:** ----- | |
| **CQC Registration Standards ref:** ----- | |
| **Equality Impact Assessment:** ☐ Completed ☐ Not required | |

**Attachments:** Annex A – UNIFY submission

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

- THIS PAGE IS INTENTIONALLY BLANK -

## 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 February 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.

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

## 3. CURRENT SITUATION

### 3.1 Registered Nurse/Midwife - Overall

February 2016 has continued to report further favorable staffing levels on night shifts overall, signifying the effective rostering in place and the need to ensure appropriate skill mix and numbers out of hours. In-hours reports some deficits across RN day duties –these are always mitigated with the support of non-ward-based Registered Nurses (including Matrons). Care staff fill rates remain favorable against plan.

Overall reliance on Registered Nursing agencies rose to 4.7% in December 2015, compared to 3.4% in November 2015. This has decreased to 4.1% for January. It is expected that February may report a higher rate due to the interim bed reconfiguration in Surgery ceasing and therefore reliance on agency increasing. It is envisaged that this should plateau/reduce March/April after further new RNs commence employment.

### 3.2 Surgery

Surgery has continued to report sub-optimal staffing levels across B6, D1, and M4. Safe staffing has been maintained due to the daily actions put in place. 4 beds have been temporarily closed on M4 to maintain safe staffing levels.

### 3.3 Medicine

Ward A15 and A11 both reported sub optimal staffing levels. Staff have recently been recruited but are currently in their supernumerary period. Improvements are expected from March data onwards as reported in the last update. Safe staffing has been maintained.

### 3.4 Community

Registered Nursing fill rates for Shire Hill continue to report an improved and maintained position.

3.5 **Care Staff**

Continued deployment of additional care staff to support both increased acuity and additional beds is reflected in fill rates of over 100%.

3.6 **Community Nurse Staffing**

The January 2016 report highlighted the ongoing reviews of Community Nursing. A discussion has taken place with the CCG on the 3rd February 2016 which highlights a request for additional funding. It has been agreed to convene a further meeting to review further and agree interim steps to improve funded staffing levels.

3.7 **Recruitment**

The Non EU (India) recruitment event took place on the 4th-11 March. 130 Nurses were interviewed with 90 offers made. Assuming some attrition this should enable the agreed number of 60 to start during 2016/17. The quality of nursing and candidates was exemplary. Interviews were undertaken by representatives from Medicine, Surgery and Community along with the Deputy Director of Nursing, representing an 'integrated' approach.

EU recruitment is slowing due to recent national changes to the process. This will be monitored over the coming months and a review undertaken over Q2/3 with regard to ongoing international recruitment requirements in 2017, to ensure progress to date is maintained.

## 4. RISK & ASSURANCE

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

## 5. CONCLUSION

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

## 6. RECOMMENDATIONS

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

Appendix A – Previous months staffing fill rates

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Org:** RWJ - Stockport NHS Foundation Trust

**Period:** February_2015-16

**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 | | Head of Nursing Comment |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | 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 (%) | |
| 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 | | 2175 | 1995 | 0 | 0 | 1522.5 | 1302.5 | 0 | 0 | 91.7% | n/a | 85.6% | n/a | Activity and nurse skill mix remain within safe limits this month. |
| RWJ09 | STEPPING HILL HOSPITAL - RWJ09 | TH - Tree House | 420 - PAEDIATRICS | | 3045 | 2782.5 | 435 | 435 | 2030 | 1799 | 0 | 0 | 91.4% | 100.0% | 88.6% | n/a | 5 current staff nurse vacancies out to advert - capacity adjusted when staffing numbers are reduced, Unit remains safe. |
| RWJ09 | STEPPING HILL HOSPITAL - RWJ09 | JW - Jasmine Ward | 502 - GYNAECOLOGY | | 870 | 866 | 435 | 435 | 580 | 580 | 0 | 0 | 99.5% | 100.0% | 100.0% | n/a | |
| RWJ09 | STEPPING HILL HOSPITAL - RWJ09 | BC - Birth Centre | 501 - OBSTETRICS | 560- MIDWIFE LED CARE | 1305 | 1305 | 435 | 435 | 870 | 870 | 290 | 290 | 100.0% | 100.0% | 100.0% | 100.0% | |
| RWJ09 | STEPPING HILL HOSPITAL - RWJ09 | M1 - Delivery Suite | 501 - OBSTETRICS | | 2610 | 2497.5 | 435 | 412.5 | 1740 | 1660 | 290 | 250 | 95.7% | 94.8% | 95.4% | 86.2% | |
| RWJ09 | STEPPING HILL HOSPITAL - RWJ09 | M2 - Maternity 2 | 501 - OBSTETRICS | | 1522.5 | 1492.5 | 870 | 855 | 580 | 580 | 290 | 290 | 98.0% | 98.3% | 100.0% | 100.0% | |
| RWJ09 | STEPPING HILL HOSPITAL - RWJ09 | ICU & HDU | 192 - CRITICAL CARE MEDICINE | | 4350 | 4242 | 725 | 641 | 3190 | 3190 | 290 | 279 | 97.5% | 88.4% | 100.0% | 96.2% | |
| RWJ09 | STEPPING HILL HOSPITAL - RWJ09 | SSSU - Short Stay Surgical Unit | 101 - UROLOGY | 100 - GENERAL SURGERY | 1771.5 | 1585.5 | 537.5 | 493.5 | 590 | 719 | 290 | 452 | 89.5% | 91.8% | 121.9% | 155.9% | ward merged with C6 for 3 weeks to assist with safe staffing levels. Safety assured . |
| RWJ09 | STEPPING HILL HOSPITAL - RWJ09 | B3 | 430 - GERIATRIC MEDICINE | | 1305 | 1269 | 1087.5 | 913.5 | 638 | 594 | 638 | 638 | 97.2% | 84.0% | 93.1% | 100.0% | Ward acuity changed skill mix appropriate . Safety assured |
| RWJ09 | STEPPING HILL HOSPITAL - RWJ09 | B6 | 100 - GENERAL SURGERY | | 1305 | 1039.5 | 1087.5 | 1374 | 638 | 638 | 638 | 828 | 79.7% | 126.3% | 100.0% | 129.8% | Escalation beds open skill mix appropriate . Safe staffing |
| RWJ09 | STEPPING HILL HOSPITAL - RWJ09 | C3 | 100 - GENERAL SURGERY | 101 - UROLOGY | 1522.5 | 1414.5 | 1044 | 976 | 812 | 750 | 638 | 616 | 92.9% | 93.5% | 92.4% | 96.6% | |
| RWJ09 | STEPPING HILL HOSPITAL - RWJ09 | C6 | 300 - GENERAL MEDICINE | 101 - UROLOGY | 1305 | 1263 | 1305 | 1335 | 638 | 638 | 638 | 704 | 96.8% | 102.3% | 100.0% | 110.3% | |
| RWJ09 | STEPPING HILL HOSPITAL - RWJ09 | D1 | 110 - TRAUMA & ORTHOPAEDICS | | 1522.5 | 1094 | 1305 | 1615.5 | 638 | 638 | 638 | 1221 | 71.9% | 123.8% | 100.0% | 191.4% | suboptimal registered nurses days. Always 2 registered nurses. Care staff increased to support dependency . |
| RWJ09 | STEPPING HILL HOSPITAL - RWJ09 | D2 | 110 - TRAUMA & ORTHOPAEDICS | | 1305 | 1188.5 | 1087.5 | 1056.5 | 638 | 638 | 638 | 799 | 91.1% | 97.1% | 100.0% | 125.2% | |
| RWJ09 | STEPPING HILL HOSPITAL - RWJ09 | D4 | 110 - TRAUMA & ORTHOPAEDICS | | 870 | 862.5 | 870 | 878.5 | 638 | 594 | 638 | 759 | 99.1% | 101.0% | 93.1% | 119.0% | |
| RWJ09 | STEPPING HILL HOSPITAL - RWJ09 | M4 | 110 - TRAUMA & ORTHOPAEDICS | | 1957.5 | 1258.5 | 1957.5 | 2165.75 | 957 | 893.75 | 957 | 1155 | 64.3% | 110.6% | 93.4% | 120.7% | RN days suboptimal. 4 beds closed to assure safe staffing, care staff levels increased to support dependency . |
| RWJ09 | STEPPING HILL HOSPITAL - RWJ09 | AMU1 | 300 - GENERAL MEDICINE | | 2755 | 2620 | 2001 | 1933.5 | 1740 | 1338.5 | 1450 | 1571 | 95.1% | 96.6% | 76.9% | 108.3% | |
| RWJ09 | STEPPING HILL HOSPITAL - RWJ09 | AMU2 | 300 - GENERAL MEDICINE | | 2146 | 1780 | 1682 | 1900 | 1450 | 1351 | 1160 | 1215 | 82.9% | 113.0% | 93.2% | 104.7% | |
| RWJ09 | STEPPING HILL HOSPITAL - RWJ09 | A10 | 430 - GERIATRIC MEDICINE | | 1566 | 1258.5 | 1566 | 1476 | 580 | 635 | 580 | 1178 | 80.4% | 94.3% | 109.5% | 203.1% | Suboptimal registered nurses days. There are always 2 registered nurses on each shift. Increased Care support shifts to support increase in dependency,maintain safety and address increased falls risk . |
| RWJ09 | STEPPING HILL HOSPITAL - RWJ09 | A11 | 300 - GENERAL MEDICINE | | 986 | 633.5 | 1305 | 1327.5 | 580 | 580 | 870 | 1218 | 64.2% | 101.7% | 100.0% | 140.0% | Currently 3 Rn vacancies 2 appointed to commence March, Plan in place to actively recruit.remainder. Are safe min 2 RN per shift. Care staff increased to support dependency. |
| RWJ09 | STEPPING HILL HOSPITAL - RWJ09 | A12 | 300 - GENERAL MEDICINE | | 1624 | 1496.5 | 1363 | 1280.5 | 580 | 580 | 580 | 580 | 92.1% | 93.9% | 100.0% | 100.0% | |
| RWJ09 | STEPPING HILL HOSPITAL - RWJ09 | A14 | 300 - GENERAL MEDICINE | | 1044 | 894 | 1682 | 1734.5 | 580 | 580 | 580 | 722 | 85.6% | 103.1% | 100.0% | 124.5% | |
| RWJ09 | STEPPING HILL HOSPITAL - RWJ09 | A15 | 300 - GENERAL MEDICINE | | 1537 | 997.5 | 1305 | 1727 | 580 | 586 | 580 | 650 | 64.9% | 132.3% | 101.0% | 112.1% | 2 WTE RN vacancies, active recruitment ongoing. Care staff increased to support ward dependency. |
| RWJ09 | STEPPING HILL HOSPITAL - RWJ09 | B2 | 430 - GERIATRIC MEDICINE | | 1334 | 1010 | 1218 | 1206 | 580 | 280 | 580 | 550 | 75.7% | 99.0% | 48.3% | 94.8% | |
| RWJ09 | STEPPING HILL HOSPITAL - RWJ09 | B4 | 320 - CARDIOLOGY | | 1160 | 1062.5 | 899 | 879.5 | 580 | 580 | 580 | 690 | 91.6% | 97.8% | 100.0% | 119.0% | Care staff increase on nights to support increased dependency |
| RWJ09 | STEPPING HILL HOSPITAL - RWJ09 | B5 | 300 - GENERAL MEDICINE | | 1015 | 1002 | 783 | 779.25 | 580 | 581.75 | 580 | 562.25 | 98.7% | 99.5% | 100.3% | 96.9% | |
| RWJ88 | THE MEADOWS - RWJ88 | BW - Bluebell Ward | 318- INTERMEDIATE CARE | | 1044 | 756.5 | 1943 | 1637 | 580 | 580 | 580 | 1020 | 72.5% | 84.3% | 100.0% | 175.9% | Sub-optimal Rn Cover on days due to sickness . Daily assurance. Minimum 2 RN per shift. Care support increased to support dependency |
| RWJ09 | STEPPING HILL HOSPITAL - RWJ09 | C2 | 300 - GENERAL MEDICINE | | 1015 | 947.5 | 783 | 666.75 | 580 | 569 | 580 | 646 | 93.3% | 85.2% | 98.1% | 111.4% | |
| RWJ09 | STEPPING HILL HOSPITAL - RWJ09 | C4 | 320 - CARDIOLOGY | | 1160 | 1122.5 | 899 | 921.5 | 580 | 558 | 580 | 569 | 96.8% | 102.5% | 96.2% | 98.1% | |
| RWJ09 | STEPPING HILL HOSPITAL - RWJ09 | CCU | 320 - CARDIOLOGY | | 1305 | 1305 | 435 | 397.5 | 580 | 580 | 319 | 319 | 100.0% | 91.4% | 100.0% | 100.0% | |
| RWJ09 | STEPPING HILL HOSPITAL - RWJ09 | CLDU | 300 - GENERAL MEDICINE | | 464 | 464 | 464 | 464 | 290 | 290 | 290 | 290 | 100.0% | 100.0% | 100.0% | 100.0% | |
| RWJ03 | CHERRY TREE HOSPITAL - RWJ03 | DCNR - Devonshire Centre | 314 - REHABILITATION | | 1189 | 1044 | 2117 | 1969.25 | 580 | 558 | 580 | 679 | 87.8% | 93.0% | 96.2% | 117.1% | |
| RWJ09 | STEPPING HILL HOSPITAL - RWJ09 | E1 | 430 - GERIATRIC MEDICINE | | 2436 | 2263.5 | 2639 | 2414 | 1160 | 1072 | 1160 | 1215 | 92.9% | 91.5% | 92.4% | 104.7% | |
| RWJ09 | STEPPING HILL HOSPITAL - RWJ09 | E2 | 430 - GERIATRIC MEDICINE | | 2494 | 2478.5 | 1566 | 1932.5 | 870 | 848 | 870 | 1178 | 99.4% | 123.4% | 97.5% | 135.4% | Care staff increase on all shifts to support increased dependency |
| RWJ09 | STEPPING HILL HOSPITAL - RWJ09 | E3 | 430 - GERIATRIC MEDICINE | | 2494 | 2486.5 | 1566 | 1581 | 870 | 826 | 870 | 1167 | 99.7% | 101.0% | 94.9% | 134.1% | Care staff increase on all shifts to support increased dependency |
| RWJ09 | STEPPING HILL HOSPITAL - RWJ09 | SSOP - Short Stay Older People | 430 - GERIATRIC MEDICINE | | 783 | 660 | 406 | 364 | 580 | 539.5 | 290 | 267 | 84.3% | 89.7% | 93.0% | 92.1% | Recruitment of RN posts completed start dates confirmed. Ongoing monitoring of Unit by Matron for safety. Min 2 Rn per shift. |
| RWJ97 | SHIRE HILL HOSPITAL - RWJ97 | Shire Hill | 318- INTERMEDIATE CARE | | 1450 | 1444 | 870 | 936 | 2900 | 2889 | 870 | 877 | 99.6% | 107.6% | 99.6% | 100.8% | |
| | | **Total** | | | 59742.5 | 53882 | 41108.5 | 41549 | 34099.5 | 32486 | 21402 | 25444.25 | 90.2% | 101.1% | 95.3% | 118.9% | |

This page has been left blank

| | | | |
|---|---|---|---|
| **Report to:** | Board of Directors | **Date:** | 31st March 2016 |
| **Subject:** | Key Results of the 2015 Annual Staff Survey | | |
| **Report of:** | Director of Workforce and Organisational Development | **Prepared by:** | Vanessa Trimble, Head of OD and Learning |

# REPORT FOR NOTING

| | |
|---|---|
| **Corporate objective ref:** ----- | **Summary of Report**<br><br>The purpose of this report is to provide the Board of Directors with an overview of the 2015 Staff Survey results.<br><br>The report will outline the top five and bottom five rankings as compared with all NHS acute and community Trusts. It will also provide the Trust's engagement scores, additional key findings and outline the next steps.<br><br>The Board are requested to note the content of the report. |
| **Board Assurance Framework ref:** ----- | |
| **CQC Registration Standards ref:** ----- | |
| **Equality Impact Assessment:** ☐ Completed ☒ Not required | |

**Attachments:** **2015 Staff Survey Results Full Report**

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

**- THIS PAGE IS INTENTIONALLY BLANK -**

## 1. Introduction

The purpose of this report is to present the key findings of the 2015 Staff Survey.
The annual staff survey is a vital component in finding out the views of staff and helping to identify where improvements can be made at corporate, business group and staff group levels to improve the staff experience and further enhance engagement and staff satisfaction.

In order to improve the response rate for 2015, a number of measures were introduced including; all staff were invited to complete a staff survey, a blended approach was adopted for ways to complete the survey, either on-line or a paper copy. In addition, and further to agreement at the Workforce and OD Committee, incentives for completing a survey were introduced.

In total, 1856 staff completed the survey, a response rate of 34%. This is a 5% increase from the 2014 survey and compares with a national average of 41% for combined acute and community Trusts.

## 2. Key Findings

Of the 32 key findings in the survey, the Trust has scored better than the national average in 11 areas, average in 19 areas and worse than the national average in 2 areas. The two areas are; percentage of staff having had an appraisal (78%) and staff satisfaction with the quality of work and patient care they are able to deliver (3.90 out of 5).

Staff engagement has increased from 3.75 to 3.82. The national average is 3.75
The only key finding to deteriorate from 2014 is appraisals. This had dropped from 89% in 2014 to 78% this year. The national average is 86%.

In addition to inviting all staff to complete a survey, there was also the opportunity to ask questions specific to Stockport NHS Foundation Trust. These included

- I have been informed about the new Trust Strategy (Yes=71% No=29%)
- My personal objectives are aligned to the corporate objectives (Yes=72% No=28%)

The tables below provide an overview of the best and worst scores when compared to all acute and community Trusts. A copy of the full survey results is embedded at the end of this report.

| **Key Findings** | **2015** | | **2014** |
|---|---|---|---|
| | **Our Trust** | **National Average** | **Our Trust** |
| Care of patients is my organisation's top priority | 76% | 73% | 69% |
| My organisation acts on concerns raised by patients | 73% | 72% | 71% |
| I would recommend my organisation as a place to work | 61% | 58% | 56% |
| If a friend or relative needed treatment, I would be happy with the standard of care provided by the Trust | 73% | 67% | 65% |
| Staff recommendation of the organisation as a place to work or receive treatment | 3.79 ***(out of 5)*** | 3.71 | 3.67 |

**Top 5 Ranking Scores for 2015**

| Five questions we scored BEST in | 2015 | |
|---|---|---|
| | Our Trust | National Average |
| % of staff experiencing harassment, bullying or abuse from patients, relative or the public in the last 12 months **(the lower the score the better)** | 22% | 27% |
| % of staff experiencing harassment, bullying or abuse from staff in the last 12 months **(the lower the score the better)** | 21% | 24% |
| % of staff experiencing discrimination at work in the last 12 months **(the lower the score the better)** | 7% | 10% |
| Effective use of patient feedback | 3.75 (out of 5) | 3.65 |
| % of staff experiencing physical violence from patients, relatives or the public in the last 12 months **(the lower the score the better)** | 11% | 14% |

**Bottom 5 Ranking Scores for 2015**

| Five questions we scored WORST in | 2015 | |
|---|---|---|
| | Our Trust | National Average |
| % of staff appraised in the last 12 months | 78% | 86% |
| Staff satisfaction with the quality of work and patient care they are able to deliver | 3.90 (out of 5) | 3.94 |
| % of staff 'reporting' most recent experience of violence | 50% | 52% |
| Staff motivation at work | 3.90 (out of 5) | 3.92 |
| % of staff agreeing that their roles makes a difference to patients | 90% | 91% |

**Key Finding Comparisons with local Acute Trusts**

| Trust | Response Rate | Engagement Score | Recommend as a Place to Work | Appraisal Rate | Recognised & Valued | Care of Patient is Top Priority |
|---|---|---|---|---|---|---|
| Stockport | 34% | 3.82 | 61% | 78% | 3.47 | 76% |
| Salford | 44% | 3.80 | 59% | 86% | 3.37 | 85% |
| Tameside | 41% | 3.94 | 72% | 92% | 3.60 | 83% |
| Pennine Acute | 29% | 3.67 | 49% | 82% | 3.29 | 62% |
| UHSM | 37% | 3.76 | 60% | 85% | 3.42 | 73% |
| WWL | 36% | 4.00 | 78% | 90% | 3.73 | 79% |

**3. Next Steps**

- Thematic analysis aligned to Listening Boxes responses
- Set up a representative group from Nursing, E&D, Communications, Health & Safety, OH, HR & OD to analyse results in detail and agree action plan
- Business Group specific reports shared with Directors in order to develop bespoke action plans.
- Agree Communications Plan prior to launch of full results
- Facilitate Focus Groups to share results with key groups of staff to generate feedback and ideas on actions to be taken to enhance the staff experience

**4. Recommendations**

The Board is asked to note the content of the report and the next steps to be taken in response.

This page has been left blank

# 2015 National NHS staff survey

# Results from Stockport NHS Foundation Trust

## Table of Contents

## 1. Introduction to this report

This report presents the findings of the 2015 national NHS staff survey conducted in Stockport NHS Foundation Trust.

In section 2 of this report, we present an overall indicator of staff engagement. Full details of how this indicator was created can be found in the document ***Making sense of your staff survey data***, which can be downloaded from www.nhsstaffsurveys.com.

In sections 3, 4, 6 and 7 of this report, the findings of the questionnaire have been summarised and presented in the form of 32 Key Findings.

In section 5 of this report, the data required for the Workforce Race Equality Standard (WRES) is presented.

These sections of the report have been structured around four of the seven pledges to staff in the NHS Constitution which was published in March 2013 (http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution) plus three additional themes:

- Staff Pledge 1: To provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities.
- Staff Pledge 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.
- Staff Pledge 3: To provide support and opportunities for staff to maintain their health, well-being and safety.
- Staff Pledge 4: To engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families.
- Additional theme: Equality and diversity
- Additional theme: Errors and incidents
- Additional theme: Patient experience measures

Please note, the questionnaire, key findings and benchmarking groups have all undergone substantial revision since the previous staff survey. For more detail on these changes, please see the ***Making sense of your staff survey data*** document.

As in previous years, there are two types of Key Finding:

- percentage scores, i.e. percentage of staff giving a particular response to one, or a series of, survey questions

- scale summary scores, calculated by converting staff responses to particular questions into scores. For each of these scale summary scores, the minimum score is always 1 and the maximum score is 5

Responses to the individual survey questions can be found in Appendix 3 of this report, along with details of which survey questions were used to calculate the Key Findings.

## Your Organisation

The scores presented below are un-weighted question level scores for questions Q21a, Q21b, Q21c and Q21d and the un-weighted score for Key Finding 1. The percentages for Q21a – Q21d are created by combining the responses for those who “Agree” and “Strongly Agree” compared to the total number of staff that responded to the question.

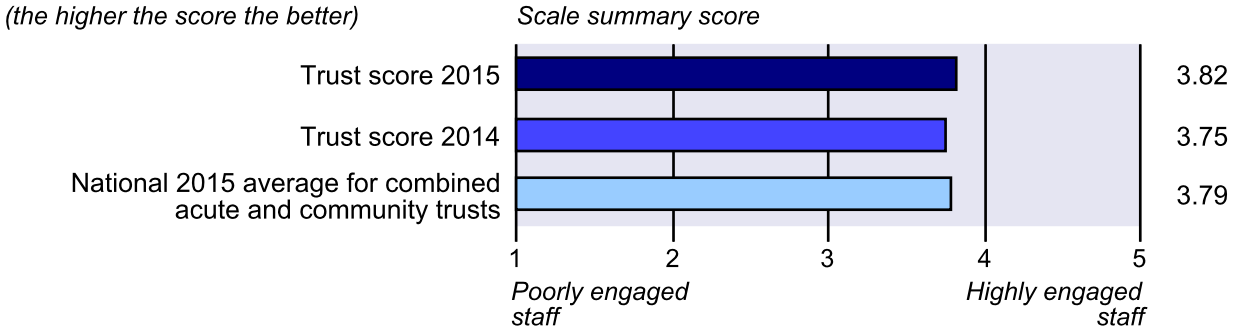
Q21a, Q21c and Q21d feed into Key Finding 1 “Staff recommendation of the organisation as a place to work or receive treatment”.

| | | Your Trust in 2015 | Average (median) for combined acute and community trusts | Your Trust in 2014 |
|---|---|---|---|---|
| Q21a | "Care of patients / service users is my organisation's top priority" | 76% | 73% | 69% |
| Q21b | "My organisation acts on concerns raised by patients / service users" | 73% | 72% | 71% |
| Q21c | "I would recommend my organisation as a place to work" | 61% | 58% | 56% |
| Q21d | "If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation" | 73% | 67% | 65% |
| KF1. | Staff recommendation of the organisation as a place to work or receive treatment (Q21a, 21c-d) | 3.79 | 3.71 | 3.67 |

## 2. Overall indicator of staff engagement for Stockport NHS Foundation Trust

The figure below shows how Stockport NHS Foundation Trust compares with other combined acute and community trusts on an overall indicator of staff engagement. Possible scores range from 1 to 5, with 1 indicating that staff are poorly engaged (with their work, their team and their trust) and 5 indicating that staff are highly engaged. The trust's score of 3.82 was average when compared with trusts of a similar type.

### OVERALL STAFF ENGAGEMENT




This overall indicator of staff engagement has been calculated using the questions that make up Key Findings 1, 4 and 7. These Key Findings relate to the following aspects of staff engagement: staff members' perceived ability to contribute to improvements at work (Key Finding 7); their willingness to recommend the trust as a place to work or receive treatment (Key Finding 1); and the extent to which they feel motivated and engaged with their work (Key Finding 4).

The table below shows how Stockport NHS Foundation Trust compares with other combined acute and community trusts on each of the sub-dimensions of staff engagement, and whether there has been a change since the 2014 survey.

| | Change since 2014 survey | Ranking, compared with all combined acute and community trusts |
|---|---|---|
| **OVERALL STAFF ENGAGEMENT** | • No change | • Average |
| **KF1. Staff recommendation of the trust as a place to work or receive treatment** *(the extent to which staff think care of patients/service users is the trust's top priority, would recommend their trust to others as a place to work, and would be happy with the standard of care provided by the trust if a friend or relative needed treatment.)* | • No change | ✓ Above (better than) average |
| **KF4. Staff motivation at work** *(the extent to which they look forward to going to work, and are enthusiastic about and absorbed in their jobs.)* | • No change | • Average |
| **KF7. Staff ability to contribute towards improvements at work** *(the extent to which staff are able to make suggestions to improve the work of their team, have frequent opportunities to show initiative in their role, and are able to make improvements at work.)* | • No change | • Average |

Full details of how the overall indicator of staff engagement was created can be found in the document ***Making sense of your staff survey data***.

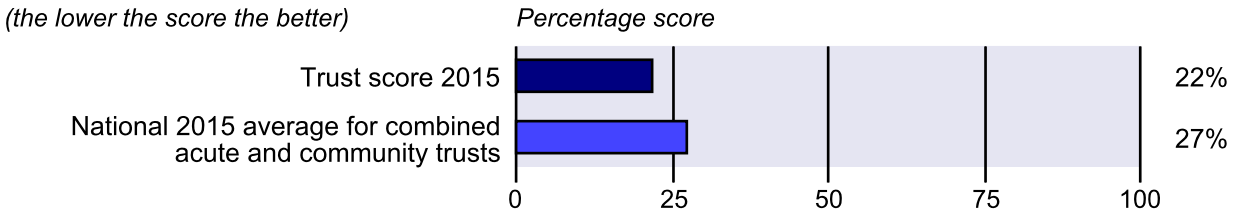
## 3. Summary of 2015 Key Findings for Stockport NHS Foundation Trust

### 3.1 Top and Bottom Ranking Scores

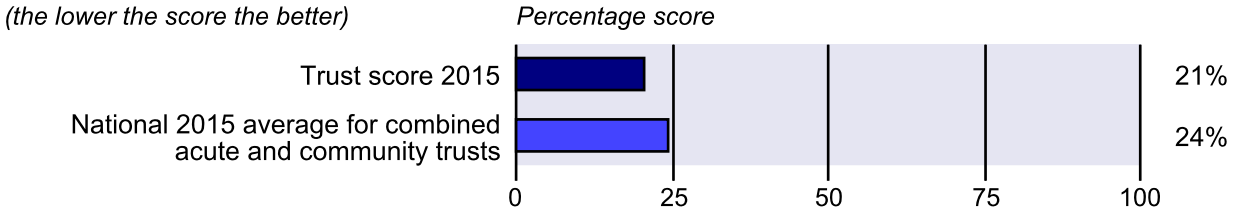
This page highlights the five Key Findings for which Stockport NHS Foundation Trust compares most favourably with other combined acute and community trusts in England.

**TOP FIVE RANKING SCORES**

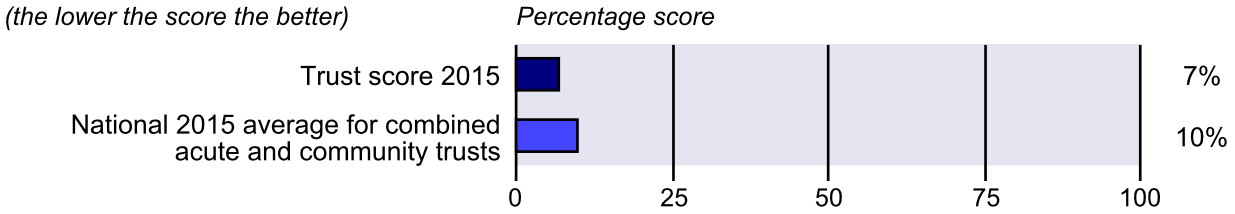
**✓KF25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months**



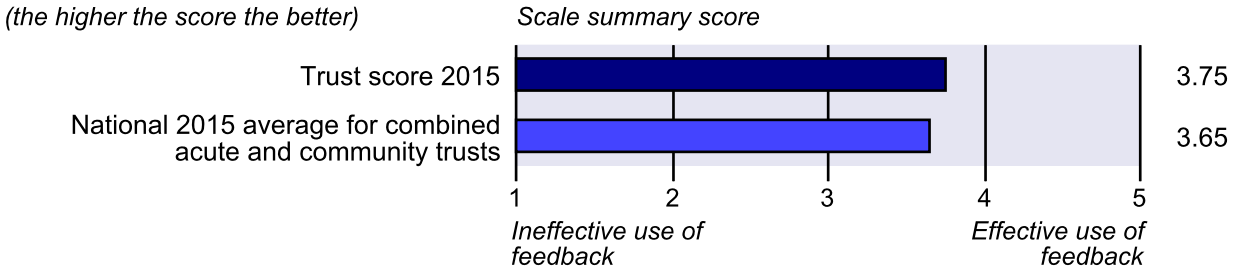

**✓KF26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months**



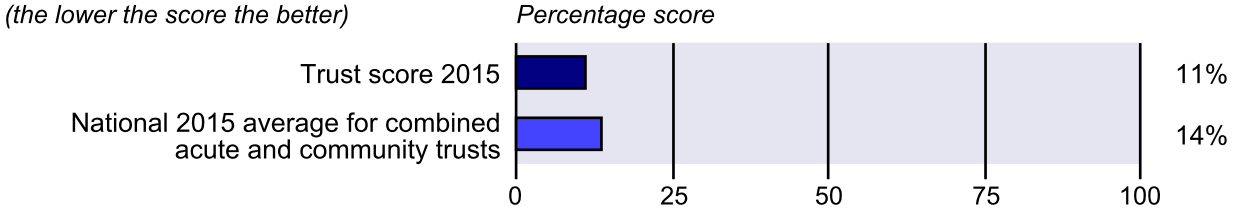

**✓KF20. Percentage of staff experiencing discrimination at work in last 12 months**




**✓KF32. Effective use of patient / service user feedback**




**✓KF22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months**



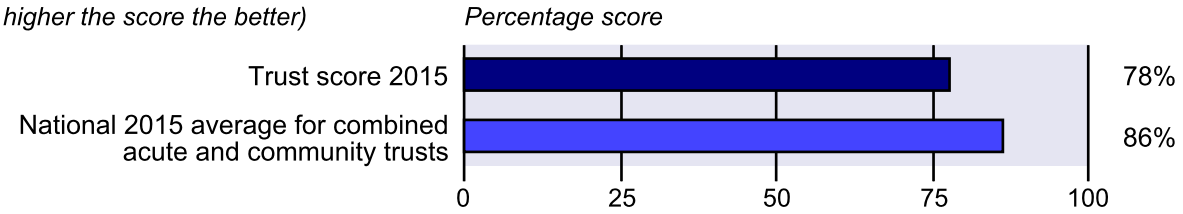

For each of the 32 Key Findings, the combined acute and community trusts in England were placed in order from 1 (the top ranking score) to 39 (the bottom ranking score). Stockport NHS Foundation Trust's five highest ranking scores are presented here, i.e. those for which the trust's Key Finding score is ranked closest to 1. Further details about this can be found in the document ***Making sense of your staff survey data***.

This page highlights the five Key Findings for which Stockport NHS Foundation Trust compares least favourably with other combined acute and community trusts in England. It is suggested that these areas might be seen as a starting point for local action to improve as an employer.

## BOTTOM FIVE RANKING SCORES

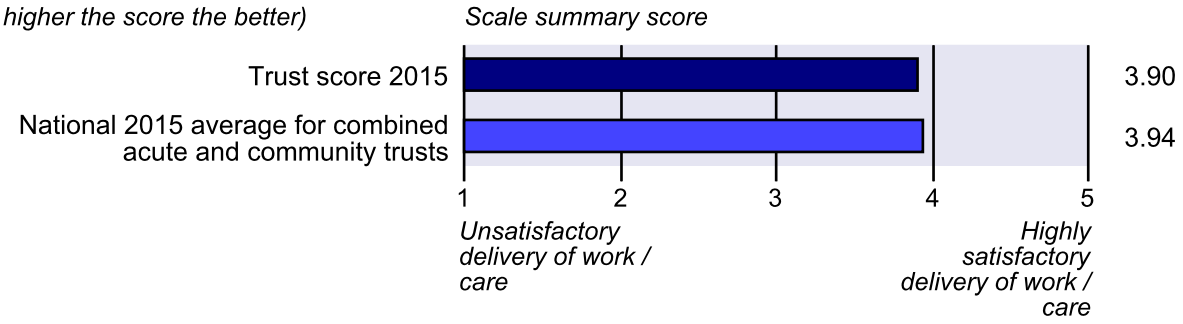
### ! KF11. Percentage of staff appraised in last 12 months

*(the higher the score the better)*



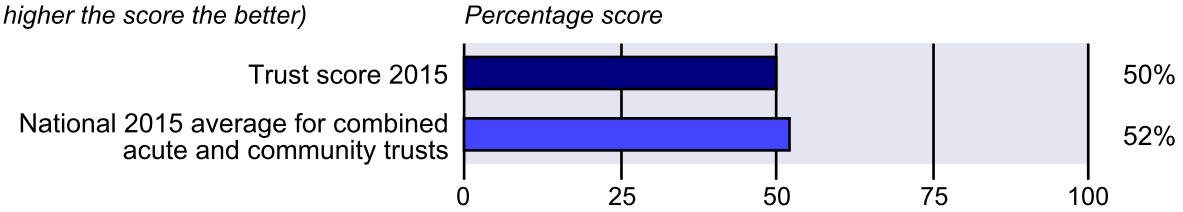

### ! KF2. Staff satisfaction with the quality of work and patient care they are able to deliver

*(the higher the score the better)*



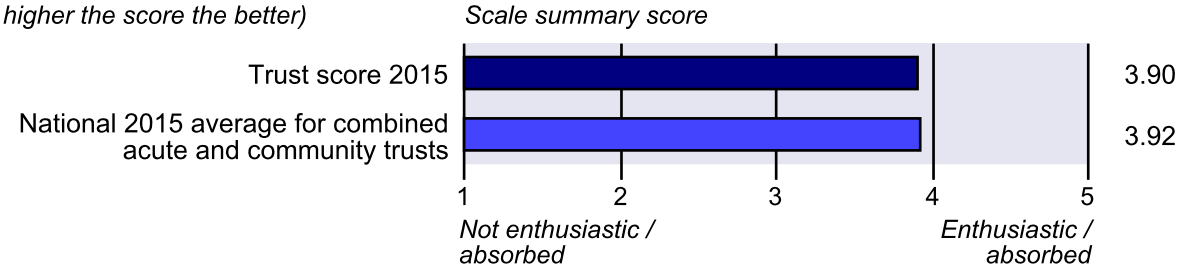

### ! KF24. Percentage of staff / colleagues reporting most recent experience of violence

*(the higher the score the better)*



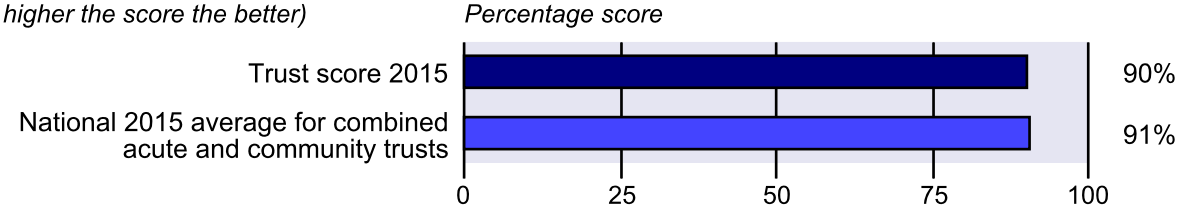

### ! KF4. Staff motivation at work

*(the higher the score the better)*




### ! KF3. Percentage of staff agreeing that their role makes a difference to patients / service users

*(the higher the score the better)*




For each of the 32 Key Findings, the combined acute and community trusts in England were placed in order from 1 (the top ranking score) to 39 (the bottom ranking score). Stockport NHS Foundation Trust's five lowest ranking scores are presented here, i.e. those for which the trust's Key Finding score is ranked closest to 39. Further details about this can be found in the document ***Making sense of your staff survey data***.

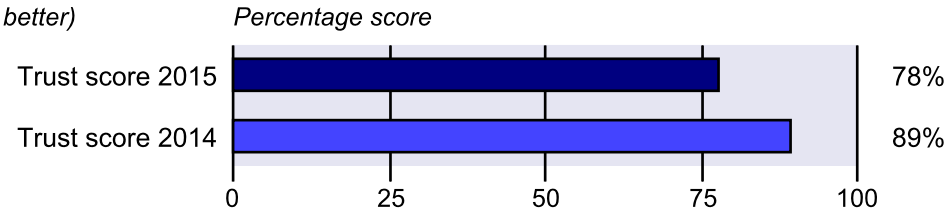
## 3.2 Largest Local Changes since the 2014 Survey

This page highlights the Key Finding that has deteriorated at Stockport NHS Foundation Trust since the 2014 survey. It is suggested that this might be seen as a starting point for local action to improve as an employer.

**WHERE STAFF EXPERIENCE HAS DETERIORATED**

### ! KF11. Percentage of staff appraised in last 12 months

*(the higher the score the better)*



## 3.3. Summary of all Key Findings for Stockport NHS Foundation Trust

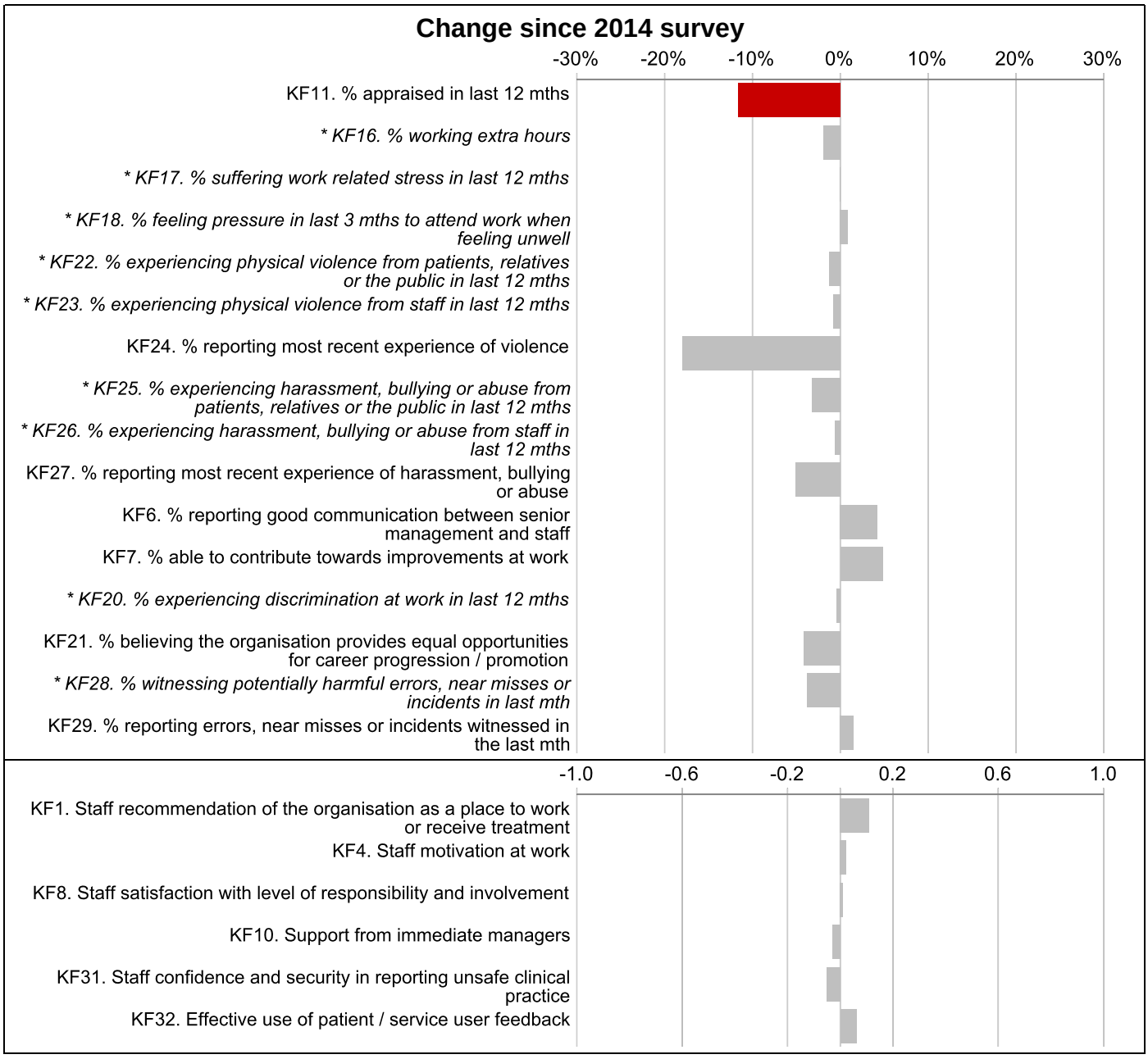
KEY

Green = Positive finding, e.g. there has been a statistically significant positive change in the Key Finding since the 2014 survey.

Red = Negative finding, e.g. there has been a statistically significant negative change in the Key Finding since the 2014 survey.

Grey = No change, e.g. there has been no statistically significant change in this Key Finding since the 2014 survey.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.



## 3.3. Summary of all Key Findings for Stockport NHS Foundation Trust

KEY

Green = Positive finding, e.g. better than average.

Red = Negative finding, e.g. worse than average.

Grey = Average.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.

### Comparison with all combined acute and community trusts in 2015

## 3.3. Summary of all Key Findings for Stockport NHS Foundation Trust

KEY

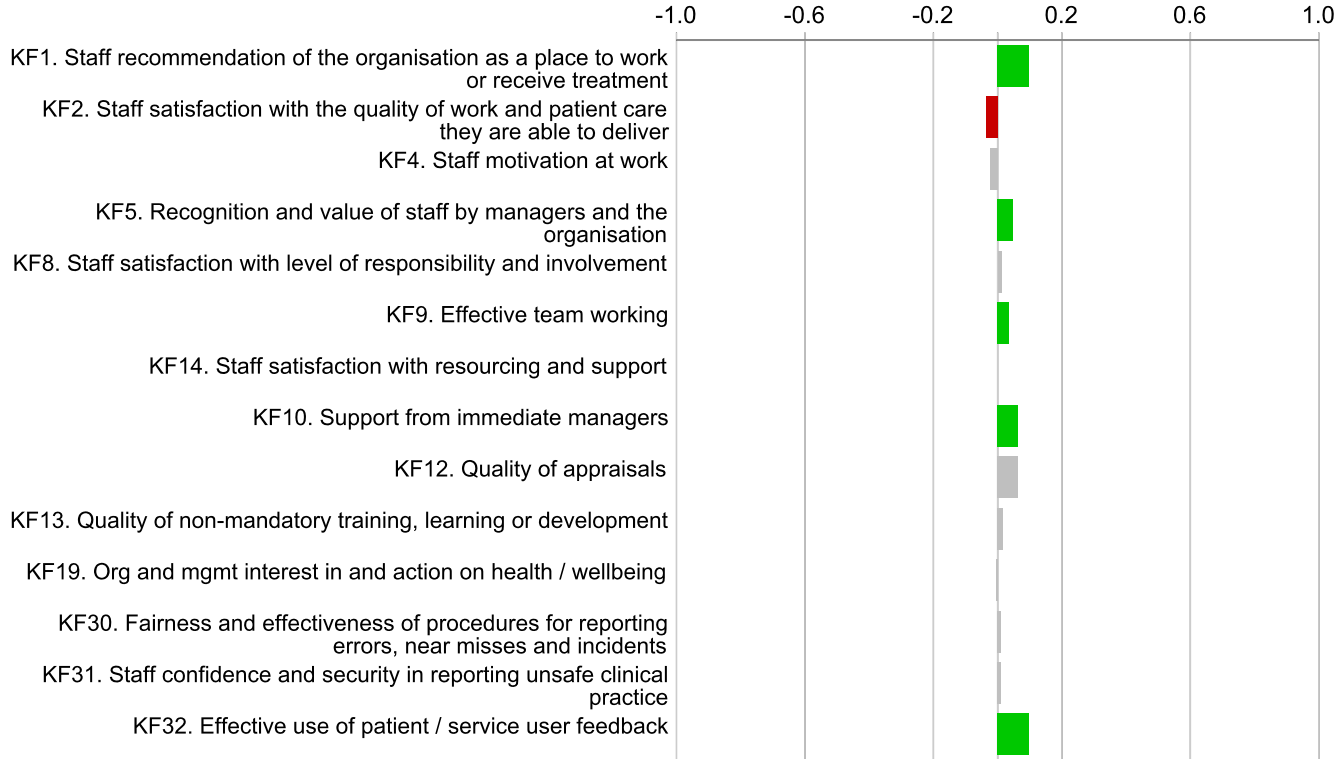
Green = Positive finding, e.g. better than average.

Red = Negative finding, e.g. worse than average.

Grey = Average.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.

### Comparison with all combined acute and community trusts in 2015 (cont)



## 3.4. Summary of all Key Findings for Stockport NHS Foundation Trust

KEY

✓ Green = Positive finding, e.g. better than average, better than 2014.

! Red = Negative finding, e.g. worse than average, worse than 2014.

'Change since 2014 survey' indicates whether there has been a statistically significant change in the Key Finding since the 2014 survey.

-- Because of changes to the format of the survey questions this year, comparisons with the 2014 score are not possible.

* For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.

| | Change since 2014 survey | Ranking, compared with all combined acute and community trusts in 2015 |
|---|---|---|
| **STAFF PLEDGE 1: To provide all staff with clear roles, responsibilities and rewarding jobs.** | | |
| KF1. Staff recommendation of the organisation as a place to work or receive treatment | • No change | ✓ Above (better than) average |
| KF2. Staff satisfaction with the quality of work and patient care they are able to deliver | -- | ! Below (worse than) average |
| KF3. % agreeing that their role makes a difference to patients / service users | -- | • Average |
| KF4. Staff motivation at work | • No change | • Average |
| KF5. Recognition and value of staff by managers and the organisation | -- | ✓ Above (better than) average |
| KF8. Staff satisfaction with level of responsibility and involvement | • No change | • Average |
| KF9. Effective team working | -- | ✓ Above (better than) average |
| KF14. Staff satisfaction with resourcing and support | -- | • Average |
| **STAFF PLEDGE 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.** | | |
| KF10. Support from immediate managers | • No change | ✓ Above (better than) average |
| KF11. % appraised in last 12 mths | ! Decrease (worse than 14) | ! Below (worse than) average |
| KF12. Quality of appraisals | -- | • Average |
| KF13. Quality of non-mandatory training, learning or development | -- | • Average |
| **STAFF PLEDGE 3: To provide support and opportunities for staff to maintain their health, well-being and safety.** | | |
| **Health and well-being** | | |
| KF15. % of staff satisfied with the opportunities for flexible working patterns | -- | • Average |
| * *KF16. % working extra hours* | • No change | • Average |
| * *KF17. % suffering work related stress in last 12 mths* | • No change | • Average |
| * *KF18. % feeling pressure in last 3 mths to attend work when feeling unwell* | • No change | ✓ Below (better than) average |
| KF19. Org and mgmt interest in and action on health / wellbeing | -- | • Average |

## 3.4. Summary of all Key Findings for Stockport NHS Foundation Trust (cont)

| | Change since 2014 survey | Ranking, compared with all combined acute and community trusts in 2015 |
|---|---|---|
| **Violence and harassment** | | |
| * *KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths* | • No change | ✓ Below (better than) average |
| * *KF23. % experiencing physical violence from staff in last 12 mths* | • No change | ✓ Below (better than) average |
| KF24. % reporting most recent experience of violence | • No change | • Average |
| * *KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths* | • No change | ✓ Below (better than) average |
| * *KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths* | • No change | ✓ Below (better than) average |
| KF27. % reporting most recent experience of harassment, bullying or abuse | • No change | • Average |
| **STAFF PLEDGE 4: To engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services.** | | |
| KF6. % reporting good communication between senior management and staff | • No change | • Average |
| KF7. % able to contribute towards improvements at work | • No change | • Average |
| **ADDITIONAL THEME: Equality and diversity** | | |
| * *KF20. % experiencing discrimination at work in last 12 mths* | • No change | ✓ Below (better than) average |
| KF21. % believing the organisation provides equal opportunities for career progression / promotion | • No change | • Average |
| **ADDITIONAL THEME: Errors and incidents** | | |
| * *KF28. % witnessing potentially harmful errors, near misses or incidents in last mth* | • No change | • Average |
| KF29. % reporting errors, near misses or incidents witnessed in the last mth | • No change | • Average |
| KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents | -- | • Average |
| KF31. Staff confidence and security in reporting unsafe clinical practice | • No change | • Average |
| **ADDITIONAL THEME: Patient experience measures** | | |
| KF32. Effective use of patient / service user feedback | • No change | ✓ Above (better than) average |

## 4. Key Findings for Stockport NHS Foundation Trust

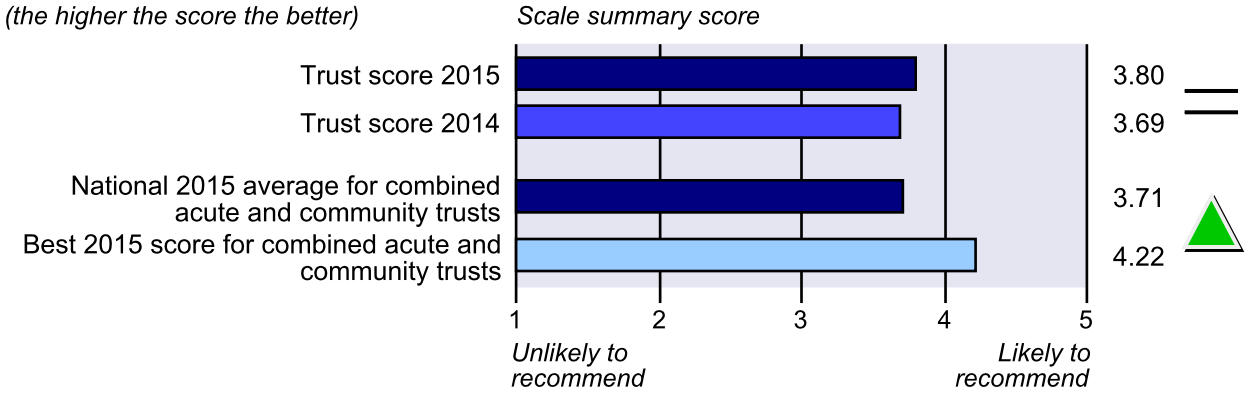
1856 staff at Stockport NHS Foundation Trust took part in this survey. This is a response rate of 34%[1] which is below average for combined acute and community trusts in England, and compares with a response rate of 29% in this trust in the 2014 survey.

This section presents each of the 32 Key Findings, using data from the trust's 2015 survey, and compares these to other combined acute and community trusts in England and to the trust's performance in the 2014 survey. The findings are arranged under seven headings – the four staff pledges from the NHS Constitution, and the three additional themes of equality and diversity, errors and incidents, and patient experience measures.

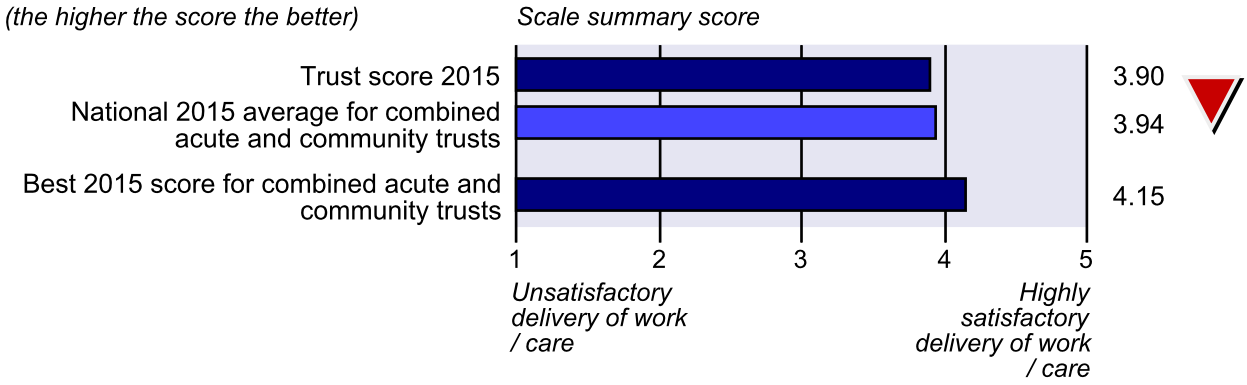
Positive findings are indicated with a green arrow (e.g. where the trust is better than average, or where the score has improved since 2014). Negative findings are highlighted with a red arrow (e.g. where the trust's score is worse than average, or where the score is not as good as 2014). An equals sign indicates that there has been no change.

### STAFF PLEDGE 1: To provide all staff with clear roles, responsibilities and rewarding jobs.

#### KEY FINDING 1. Staff recommendation of the organisation as a place to work or receive treatment



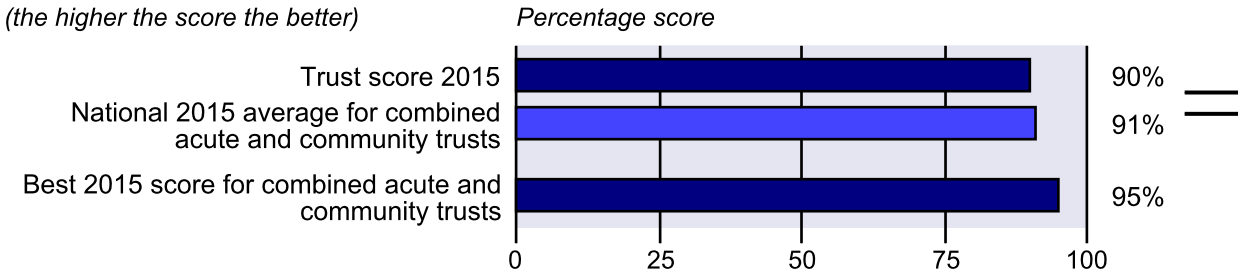

#### KEY FINDING 2. Staff satisfaction with the quality of work and patient care they are able to deliver




[1]Questionnaires were sent to all 5405 staff eligible to receive the survey. This includes only staff employed directly by the trust (i.e. excluding staff working for external contractors). It excludes bank staff unless they are also employed directly elsewhere in the trust. When calculating the response rate, questionnaires could only be counted if they were received with their ID number intact, by the closing date.

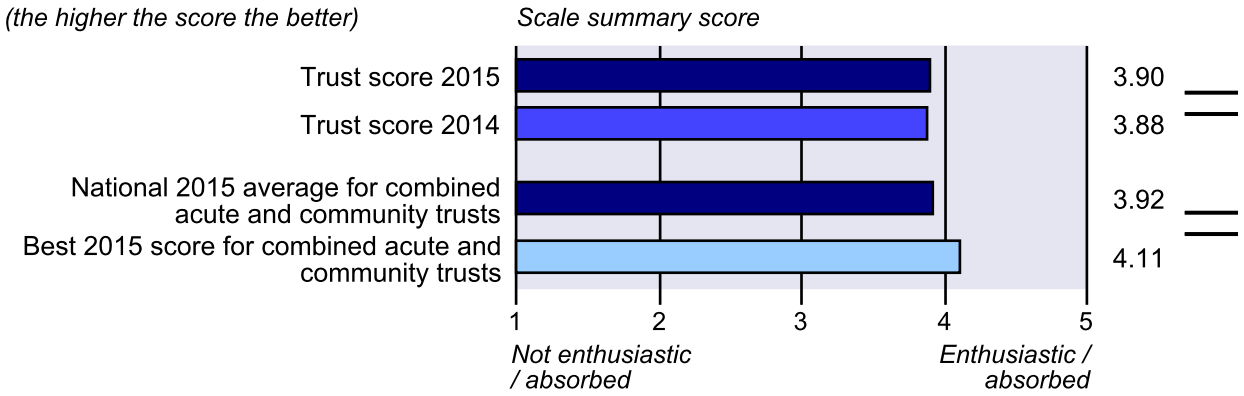
## KEY FINDING 3. Percentage of staff agreeing that their role makes a difference to patients / service users

*(the higher the score the better)*



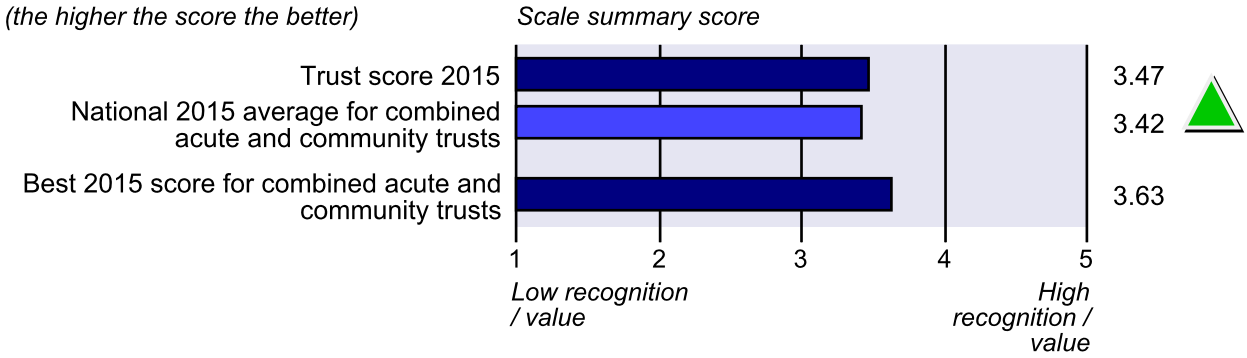

## KEY FINDING 4. Staff motivation at work

*(the higher the score the better)*



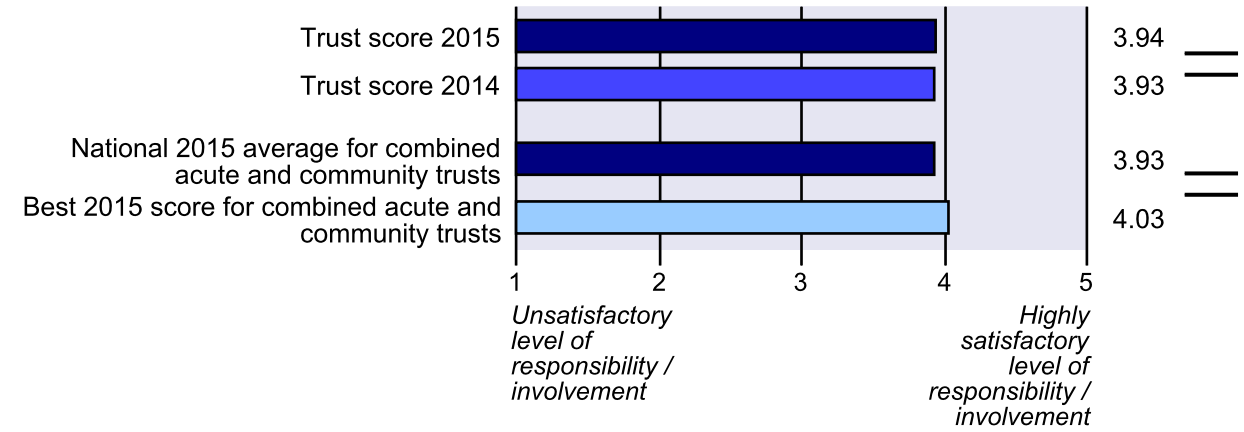

## KEY FINDING 5. Recognition and value of staff by managers and the organisation

*(the higher the score the better)*

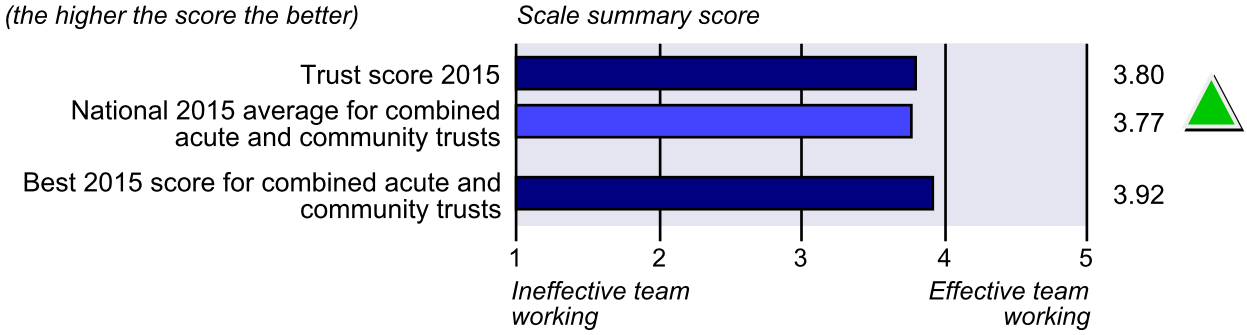



## KEY FINDING 8. Staff satisfaction with level of responsibility and involvement

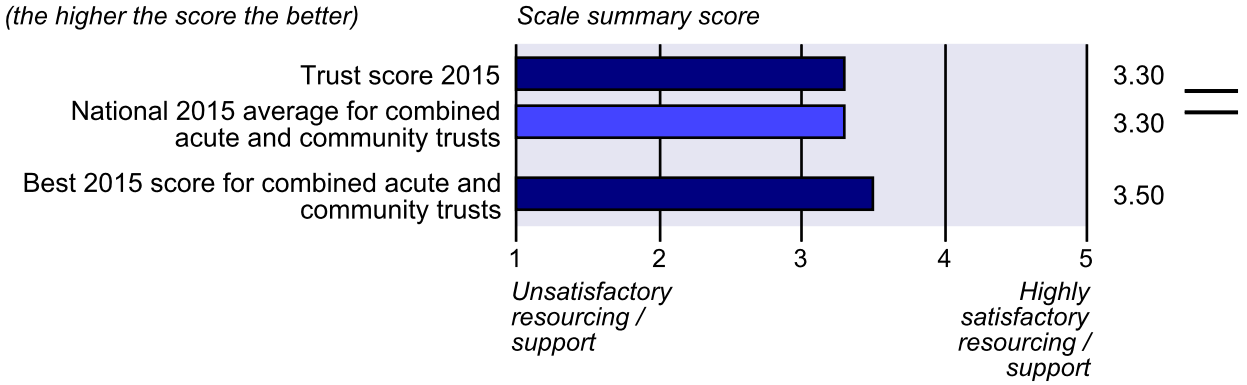
*(the higher the score the better)*



### KEY FINDING 9. Effective team working

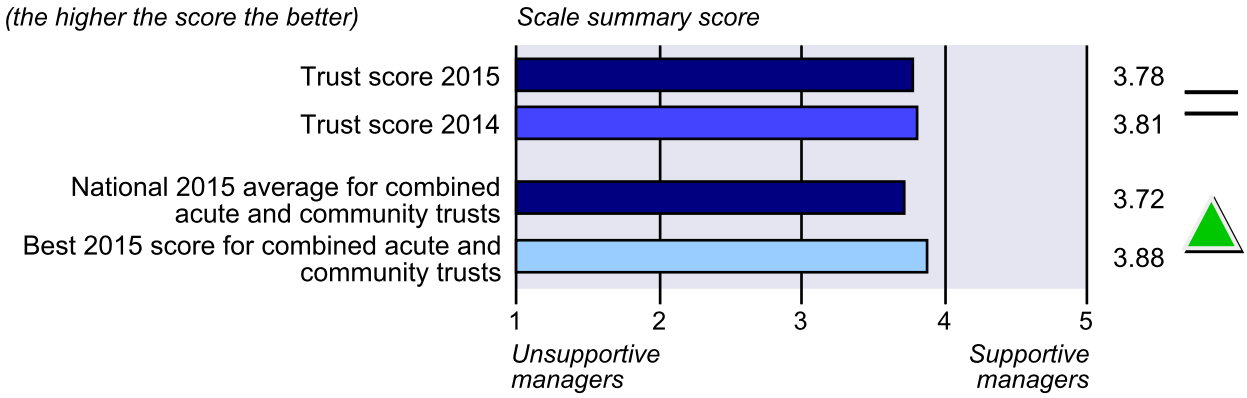



### KEY FINDING 14. Staff satisfaction with resourcing and support

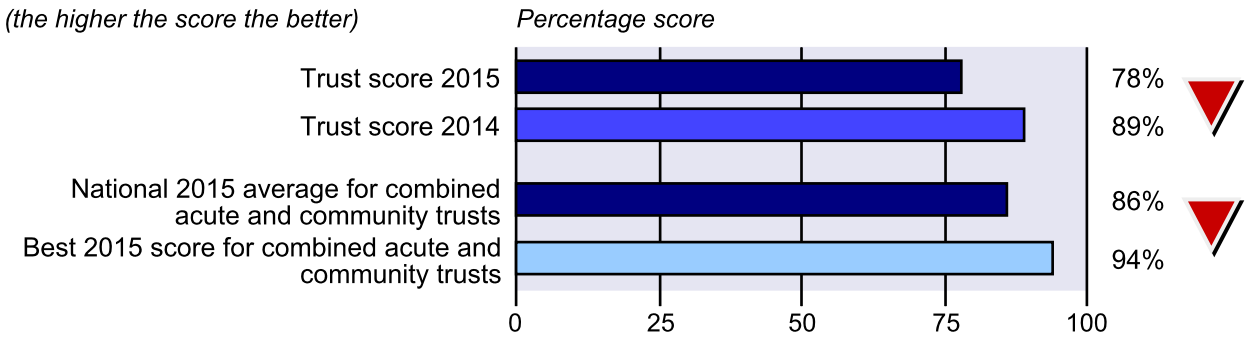



## STAFF PLEDGE 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.

### KEY FINDING 10. Support from immediate managers

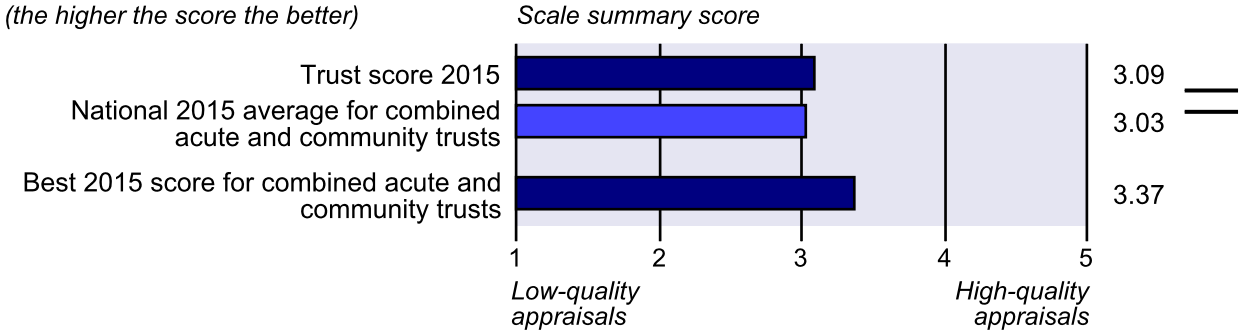



### KEY FINDING 11. Percentage of staff appraised in last 12 months



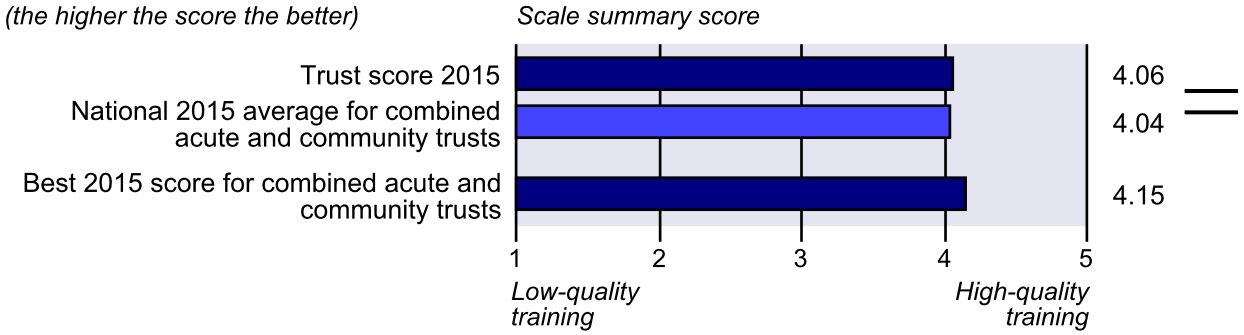
### KEY FINDING 12. Quality of appraisals

*(the higher the score the better)*




### KEY FINDING 13. Quality of non-mandatory training, learning or development

*(the higher the score the better)*

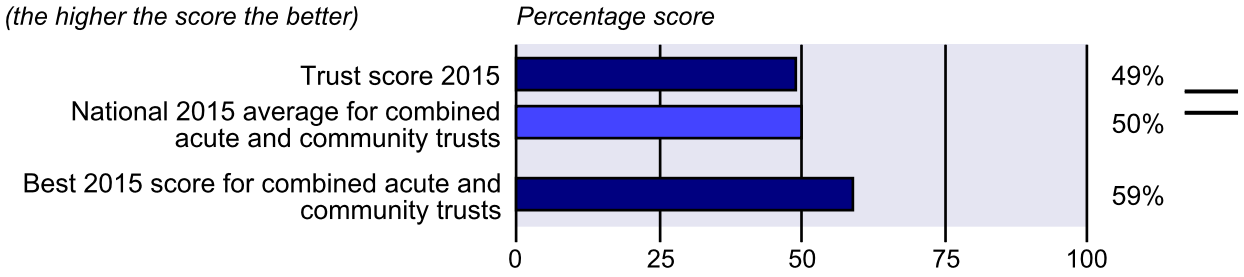



## STAFF PLEDGE 3: To provide support and opportunities for staff to maintain their health, well-being and safety.

### Health and well-being

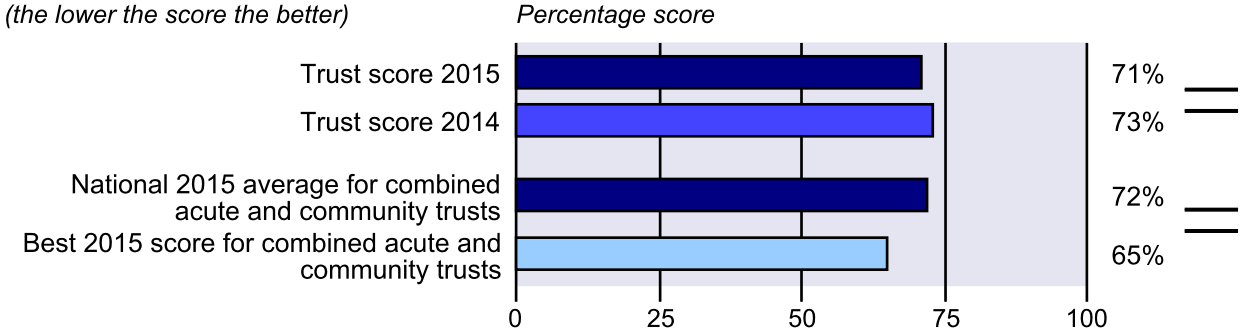
### KEY FINDING 15. Percentage of staff satisfied with the opportunities for flexible working patterns

*(the higher the score the better)*



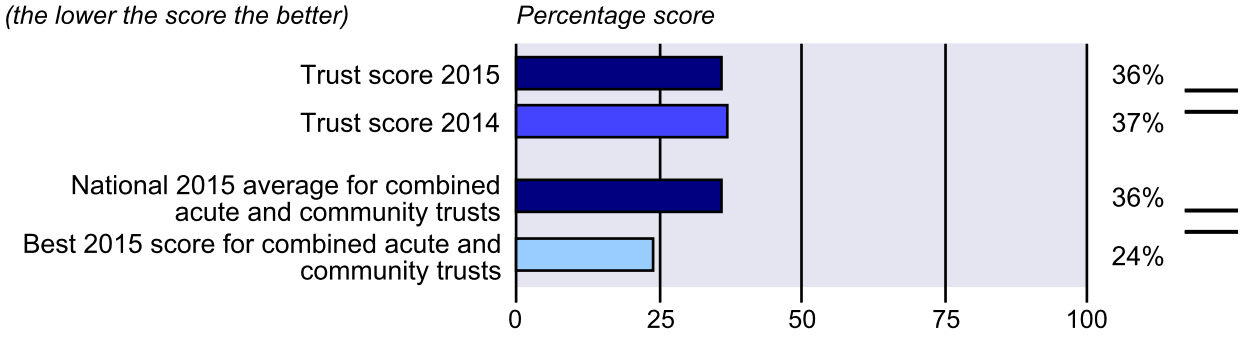

### KEY FINDING 16. Percentage of staff working extra hours

*(the lower the score the better)*



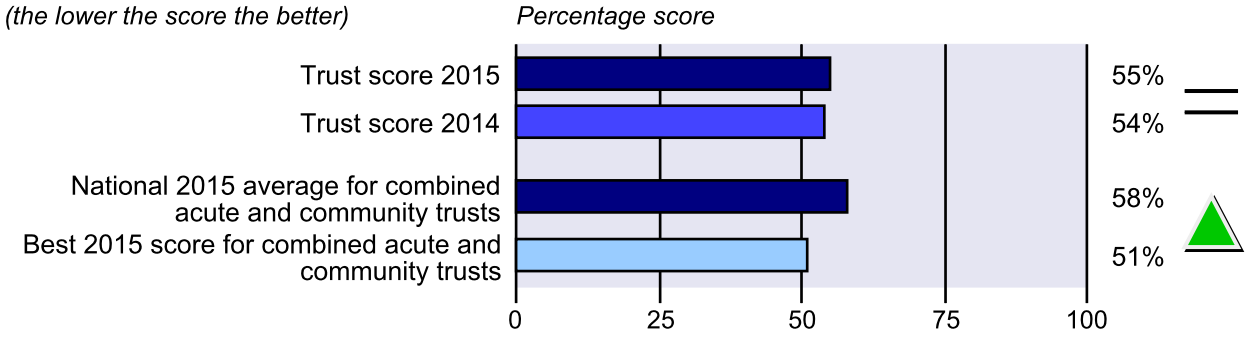
### KEY FINDING 17. Percentage of staff suffering work related stress in last 12 months

*(the lower the score the better)*



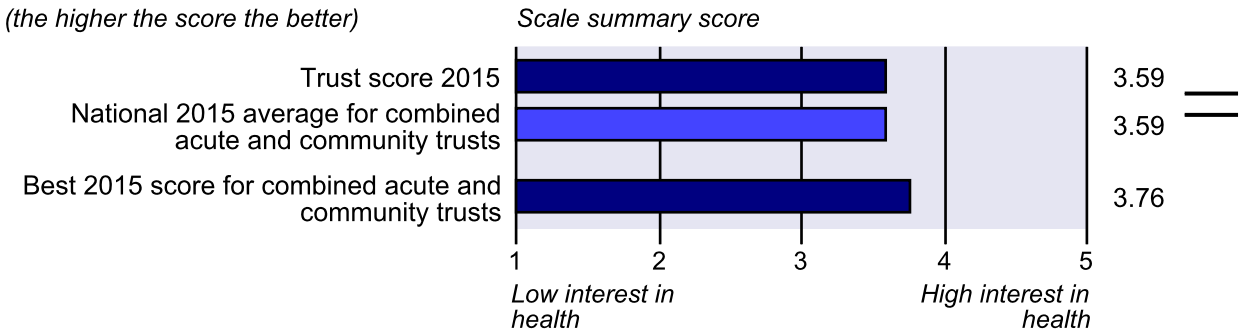

### KEY FINDING 18. Percentage of staff feeling pressure in the last 3 months to attend work when feeling unwell

*(the lower the score the better)*




### KEY FINDING 19. Organisation and management interest in and action on health and wellbeing

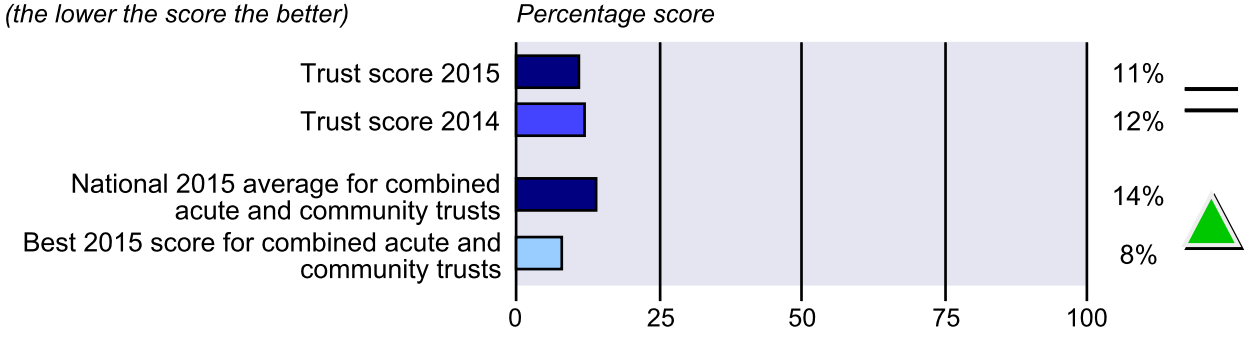
*(the higher the score the better)*




## Violence and harassment

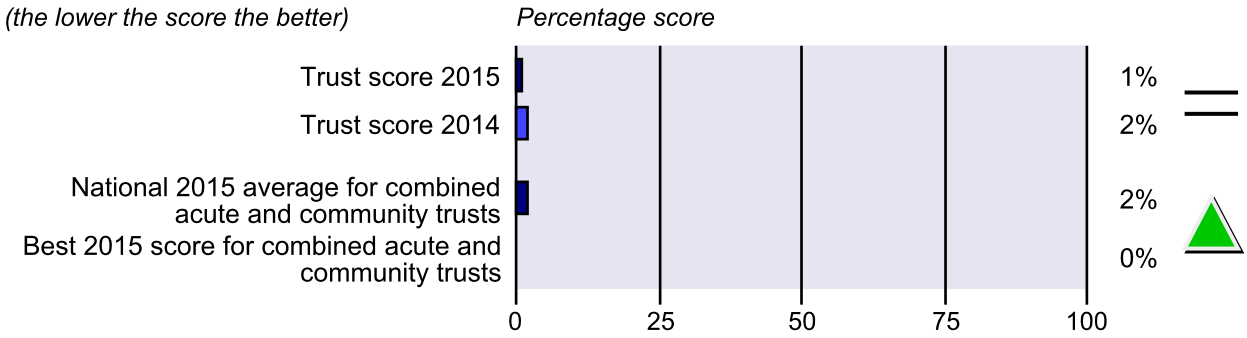
### KEY FINDING 22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months

*(the lower the score the better)*



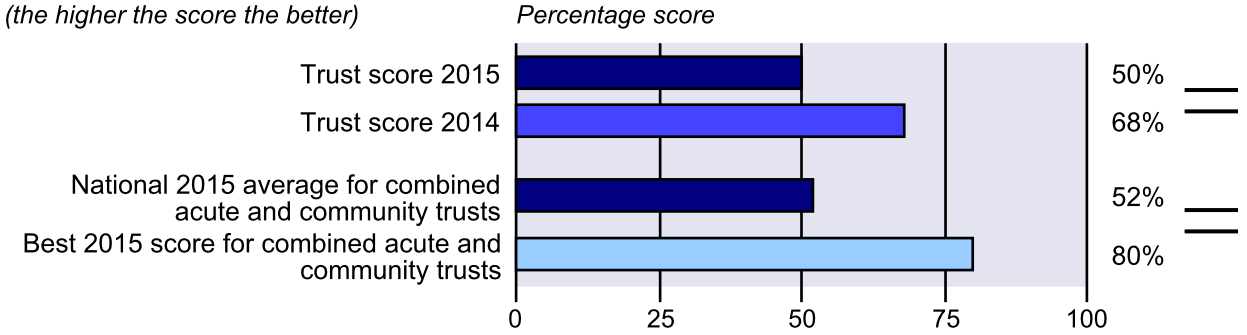
## KEY FINDING 23. Percentage of staff experiencing physical violence from staff in last 12 months

*(the lower the score the better)*



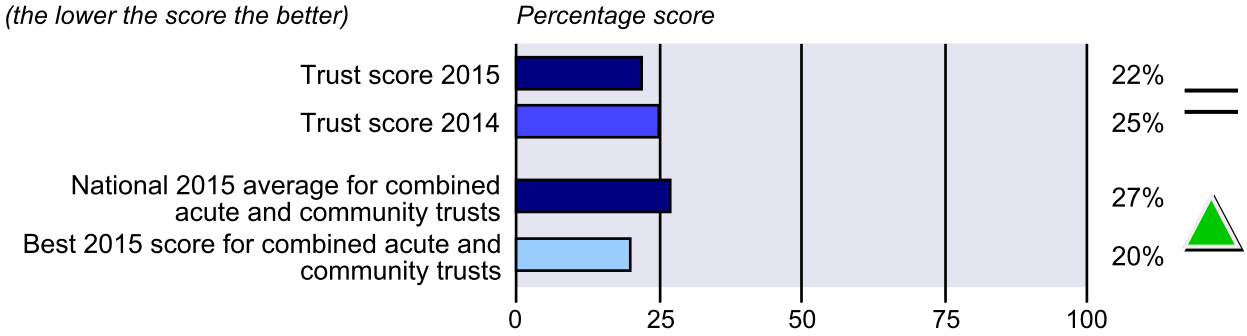

## KEY FINDING 24. Percentage of staff / colleagues reporting most recent experience of violence

*(the higher the score the better)*



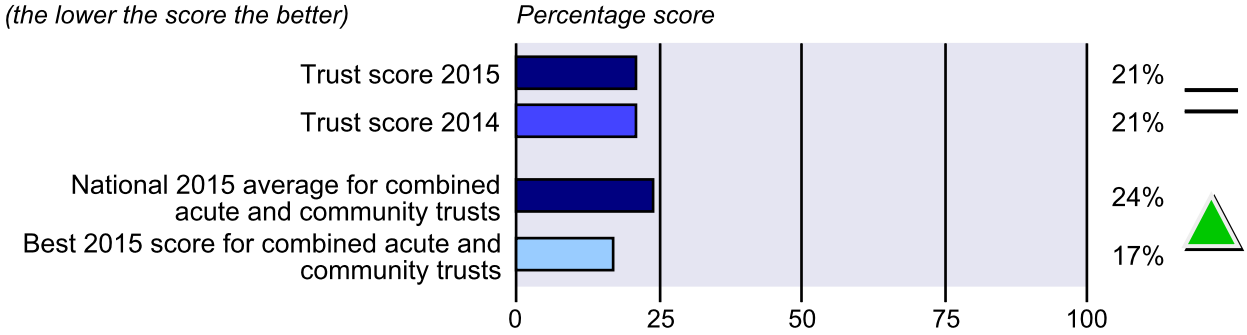

## KEY FINDING 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

*(the lower the score the better)*



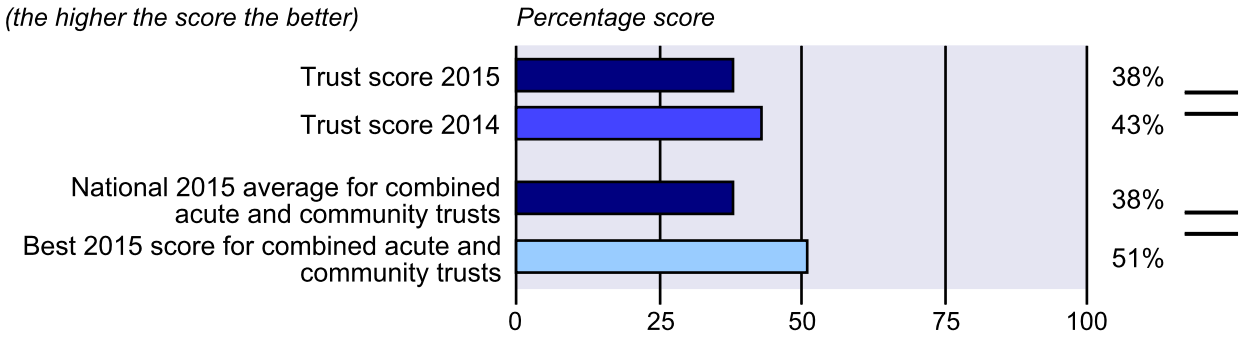

## KEY FINDING 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

*(the lower the score the better)*



### KEY FINDING 27. Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse

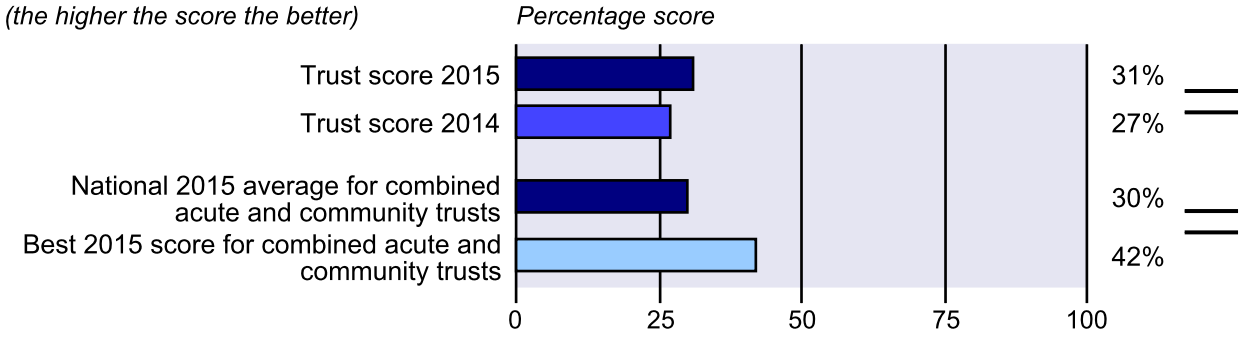
*(the higher the score the better)*




## STAFF PLEDGE 4: To engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services.

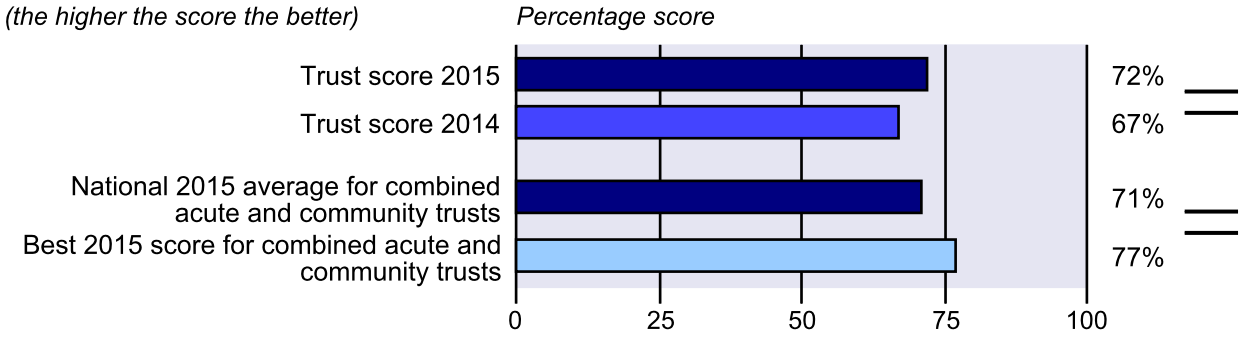
### KEY FINDING 6. Percentage of staff reporting good communication between senior management and staff

*(the higher the score the better)*




### KEY FINDING 7. Percentage of staff able to contribute towards improvements at work

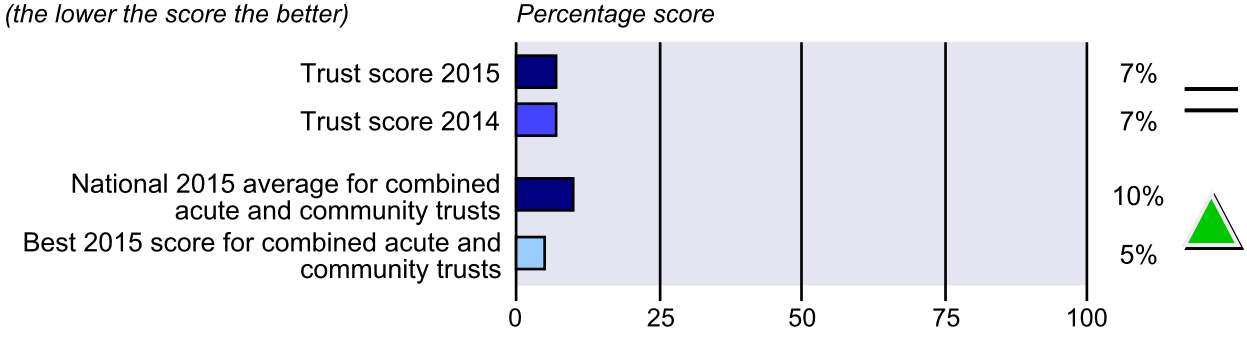
*(the higher the score the better)*




## ADDITIONAL THEME: Equality and diversity

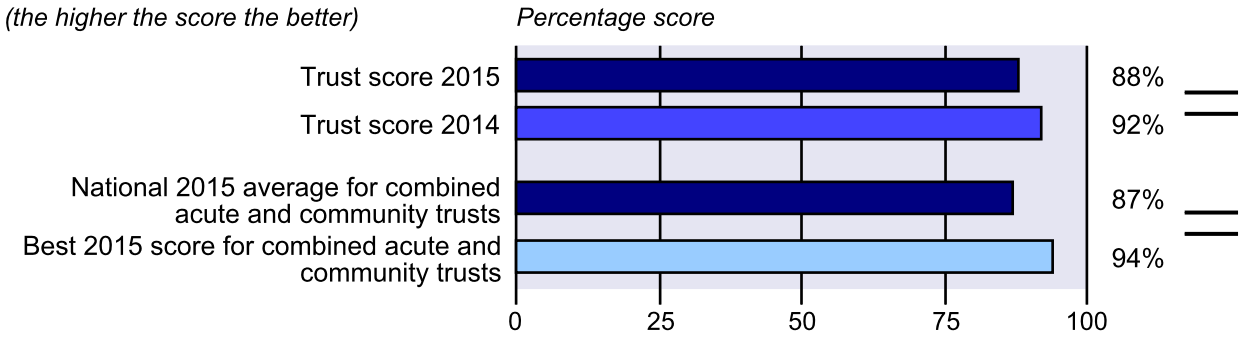
### KEY FINDING 20. Percentage of staff experiencing discrimination at work in last 12 months

*(the lower the score the better)*



## KEY FINDING 21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion

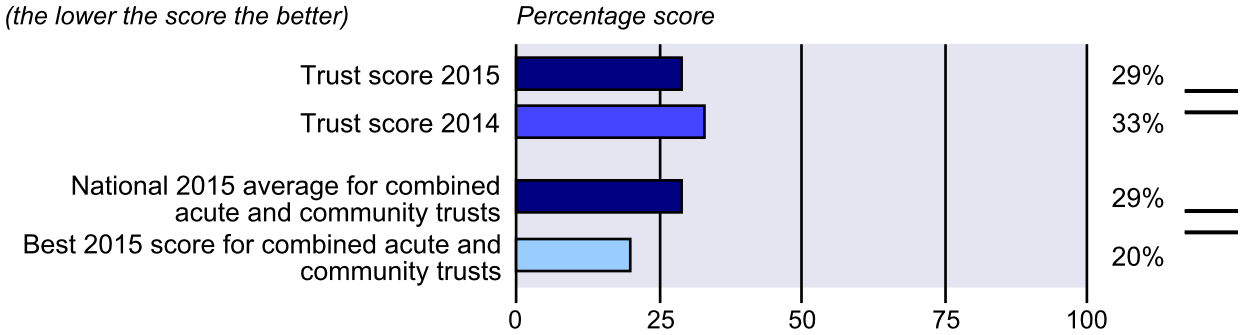
*(the higher the score the better)*




# ADDITIONAL THEME: Errors and incidents

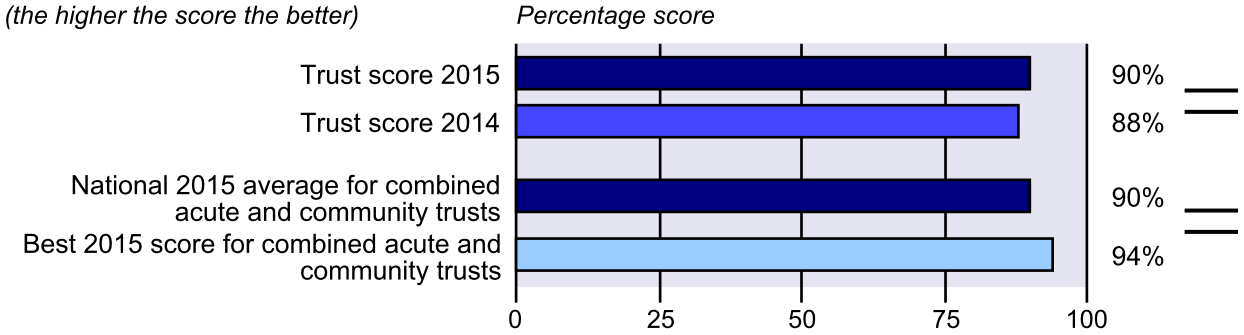
## KEY FINDING 28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month

*(the lower the score the better)*



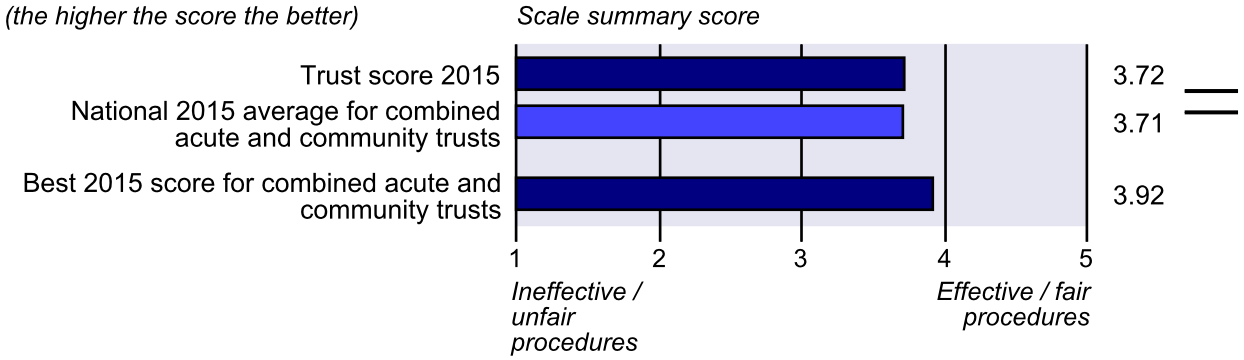

## KEY FINDING 29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month

*(the higher the score the better)*

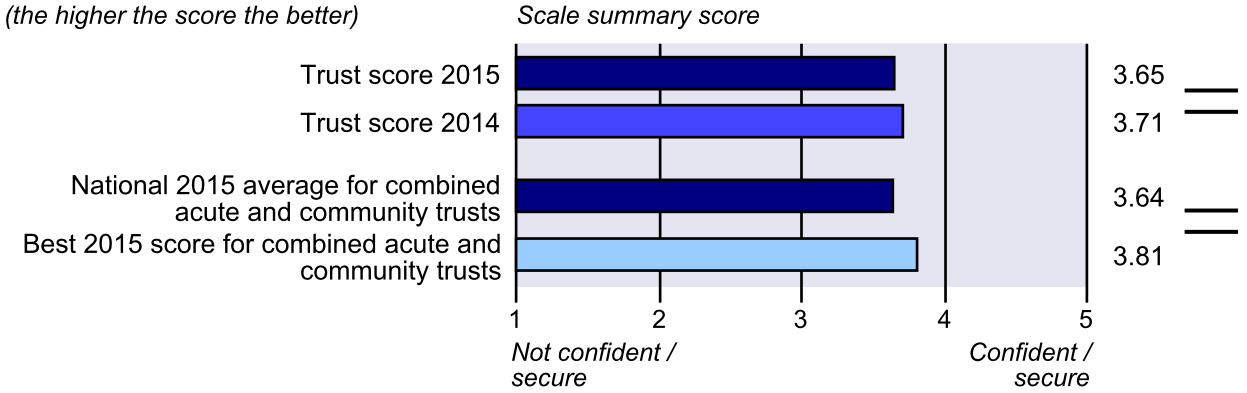



## KEY FINDING 30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents

*(the higher the score the better)*

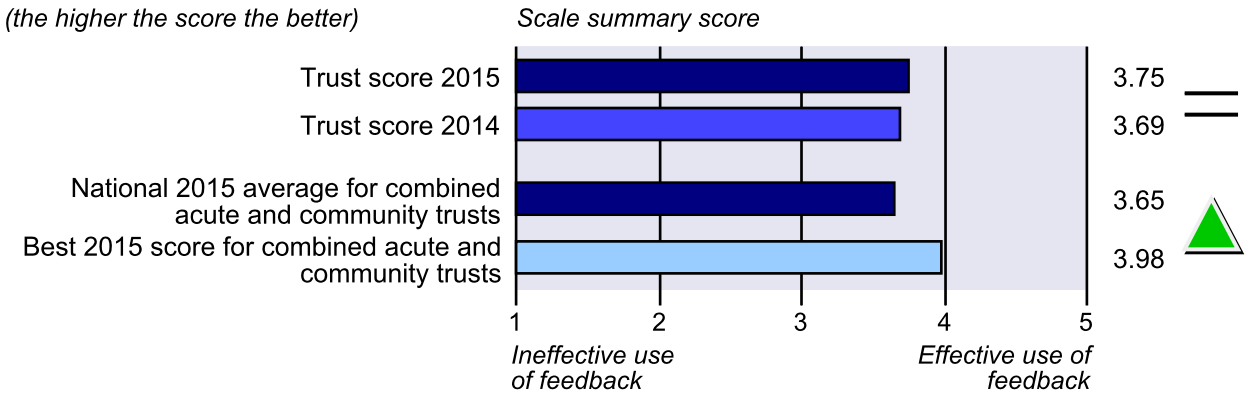


## KEY FINDING 31. Staff confidence and security in reporting unsafe clinical practice




# ADDITIONAL THEME: Patient experience measures

## KEY FINDING 32. Effective use of patient / service user feedback



## 5. Workforce Race Equality Standard (WRES)

The scores presented below are the un-weighted question level score for question Q17b and un-weighted scores for Key Findings 25, 26, and 21, split between White and Black and Minority Ethnic (BME) staff, as required for the Workforce Race Equality Standard.

Note that for question 17b, the percentage featured is that of "Yes" responses to the question. Key Finding and question numbers have changed since 2014.

In order to preserve the anonymity of individual staff, a score is replaced with a dash if the staff group in question contributed fewer than 11 responses to that score.

| | | | Your Trust in 2015 | Average (median) for combined acute and community trusts | Your Trust in 2014 |
|---|---|---|---|---|---|
| KF25 | Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months | White | 21% | 28% | 25% |
| | | BME | 23% | 26% | 15% |
| KF26 | Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months | White | 20% | 24% | 20% |
| | | BME | 27% | 26% | 36% |
| KF21 | Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion | White | 88% | 89% | 92% |
| | | BME | 78% | 74% | - |
| Q17b | In the 12 last months have you personally experienced discrimination at work from manager/team leader or other colleagues? | White | 3% | 5% | 3% |
| | | BME | 16% | 13% | - |

## 6. Key Findings by work group characteristics

Tables 6.1 to 6.4 show the Key Findings at Stockport NHS Foundation Trust broken down by work group characteristics: occupational groups, directorates, staff groups and full time/part time staff.

Technical notes:

- As in previous years, there are two types of Key Finding:
    - percentage scores, i.e. percentage of staff giving a particular response to one, or a series of, survey questions
    - scale summary scores, calculated by converting staff responses to particular questions into scores. For each of these scale summary scores, the minimum score is always 1 and the maximum score is 5
- For most of the Key Findings presented in tables 6.1 to 6.4, the higher the score the better. However, there are some Key Findings for which a high score would represent a negative result. For these Key Findings, marked with an asterisk and shown in italics, the lower the score the better.
- Care should be taken not to over interpret the findings if scores differ slightly. For example, if for 'KF11. % appraised in the last 12 months' staff in Group A score 45%, and staff in Group B score 40%, it may appear that a higher proportion of staff in Group A have had appraisals than staff in Group B. However, because of small numbers in these sub-groups, it is probably not statistically significant. A more sensible interpretation would be that, on average, similar proportions of staff in Group A and B have had appraisals.
- Please note that, unlike the overall trust scores, data in this section are not weighted.
- Please also note that all percentage scores are shown to the nearest 1%. This means scores of less than 0.5% are displayed as 0%.
- In order to preserve anonymity of individual staff, a score is replaced with a dash if the staff group in question contributed fewer than 11 responses to that score.

## Table 6.1: Key Findings for different occupational groups

| | Adult / General Nurses | Other Registered Nurses | Nursing / Healthcare Assistants | Medical / Dental | Occupational Therapy | Physiotherapy | Radiography | Other Allied Health Professionals | General Management | Other Scientific & Technical | Admin & Clerical | Central Functions / Corporate Services | Maintenance / Ancillary |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **STAFF PLEDGE 1: To provide all staff with clear roles, responsibilities and rewarding jobs.** | | | | | | | | | | | | | |
| KF1. Staff recommendation of the organisation as a place to work or receive treatment | 3.76 | 3.72 | 4.03 | 3.89 | 3.52 | 3.60 | 4.02 | 3.58 | 3.85 | 3.95 | 3.76 | 3.96 | 3.92 |
| KF2. Staff satisfaction with the quality of work and patient care they are able to deliver | 3.86 | 3.70 | 4.23 | 3.88 | 3.52 | 3.59 | 4.18 | 3.77 | 3.78 | 4.05 | 4.01 | 3.96 | 4.12 |
| KF3. % agreeing that their role makes a difference to patients / service users | 93 | 92 | 93 | 92 | 91 | 99 | 93 | 92 | 89 | 91 | 81 | 86 | 92 |
| KF4. Staff motivation at work | 4.03 | 3.95 | 4.10 | 3.93 | 3.99 | 3.86 | 3.83 | 3.88 | 4.11 | 3.81 | 3.70 | 3.78 | 4.07 |
| KF5. Recognition and value of staff by managers and the organisation | 3.51 | 3.43 | 3.65 | 3.48 | 3.43 | 3.41 | 3.68 | 3.40 | 3.78 | 3.42 | 3.34 | 3.59 | 3.56 |
| KF8. Staff satisfaction with level of responsibility and involvement | 4.10 | 3.95 | 3.94 | 4.10 | 4.00 | 3.94 | 3.97 | 3.81 | 4.13 | 3.91 | 3.77 | 3.93 | 3.89 |
| KF9. Effective team working | 3.82 | 3.90 | 3.82 | 3.85 | 4.04 | 3.92 | 3.90 | 3.92 | 4.05 | 3.76 | 3.63 | 3.83 | 3.54 |
| KF14. Staff satisfaction with resourcing and support | 3.26 | 3.14 | 3.42 | 3.27 | 3.13 | 3.21 | 3.30 | 3.17 | 3.40 | 3.30 | 3.42 | 3.47 | 3.44 |
| **STAFF PLEDGE 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.** | | | | | | | | | | | | | |
| KF10. Support from immediate managers | 3.81 | 3.87 | 3.88 | 3.70 | 4.04 | 4.00 | 3.98 | 3.82 | 3.91 | 3.67 | 3.65 | 3.89 | 3.60 |
| KF11. % appraised in last 12 mths | 72 | 80 | 78 | 91 | 100 | 95 | 83 | 93 | 67 | 72 | 73 | 65 | 65 |
| KF12. Quality of appraisals | 3.33 | 3.11 | 3.35 | 3.13 | 2.95 | 2.85 | 3.31 | 2.99 | 3.10 | 3.08 | 2.88 | 3.15 | 3.02 |
| KF13. Quality of non-mandatory training, learning or development | 4.20 | 4.22 | 4.09 | 4.10 | 3.81 | 4.02 | 4.09 | 4.06 | 4.07 | 4.04 | 3.76 | 3.89 | 3.84 |
| **STAFF PLEDGE 3: To provide support and opportunities for staff to maintain their health, well-being and safety.** | | | | | | | | | | | | | |
| **Health and well-being** | | | | | | | | | | | | | |
| KF15. % of staff satisfied with the opportunities for flexible working patterns | 45 | 53 | 55 | 34 | 60 | 57 | 34 | 52 | 64 | 36 | 46 | 69 | 53 |
| * *KF16. % working extra hours* | 85 | 79 | 58 | 90 | 80 | 76 | 72 | 68 | 92 | 68 | 51 | 71 | 58 |
| * *KF17. % suffering work related stress in last 12 mths* | 42 | 46 | 32 | 40 | 36 | 39 | 41 | 38 | 34 | 26 | 33 | 29 | 31 |
| * *KF18. % feeling pressure in last 3 mths to attend work when feeling unwell* | 60 | 62 | 60 | 42 | 56 | 65 | 55 | 52 | 57 | 50 | 58 | 45 | 52 |
| KF19. Org and mgmt interest in and action on health / wellbeing | 3.59 | 3.47 | 3.67 | 3.49 | 3.47 | 3.65 | 3.76 | 3.61 | 3.85 | 3.53 | 3.58 | 3.67 | 3.71 |
| **Number of respondents** | 250 | 205 | 111 | 94 | 45 | 79 | 29 | 145 | 53 | 103 | 384 | 101 | 98 |

Due to low numbers of respondents, no scores are shown for the following occupational groups: Mental Health Nurses, Social Care Staff, Public Health / Health Improvement and Emergency Care Assistant. Due to an error in the 2014 calculation, data for the following occupational groups in table 6.1 are not comparable to those in the equivalent table (5.1) in the 2014 reports: Other Allied Health Professionals, Other Scientific and Technical.

## Table 6.1: Key Findings for different occupational groups (cont)

| | Adult / General Nurses | Other Registered Nurses | Nursing / Healthcare Assistants | Medical / Dental | Occupational Therapy | Physiotherapy | Radiography | Other Allied Health Professionals | General Management | Other Scientific & Technical | Admin & Clerical | Central Functions / Corporate Services | Maintenance / Ancillary |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Violence and harassment** | | | | | | | | | | | | | |
| * *KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths* | 28 | 7 | 32 | 12 | 7 | 10 | 21 | 9 | 0 | 2 | 3 | 1 | 9 |
| * *KF23. % experiencing physical violence from staff in last 12 mths* | 3 | 1 | 1 | 0 | 0 | 1 | 0 | 1 | 0 | 2 | 1 | 0 | 8 |
| KF24. % reporting most recent experience of violence | 53 | 69 | 66 | 45 | - | - | - | 36 | - | - | 67 | - | 33 |
| * *KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths* | 35 | 28 | 36 | 25 | 23 | 18 | 24 | 21 | 8 | 7 | 18 | 4 | 12 |
| * *KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths* | 25 | 18 | 18 | 26 | 11 | 15 | 21 | 22 | 25 | 17 | 21 | 16 | 24 |
| KF27. % reporting most recent experience of harassment, bullying or abuse | 41 | 35 | 47 | 41 | 31 | 36 | - | 28 | 56 | 23 | 36 | 53 | 44 |
| **STAFF PLEDGE 4: To engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services.** | | | | | | | | | | | | | |
| KF6. % reporting good communication between senior management and staff | 32 | 39 | 39 | 33 | 24 | 22 | 21 | 24 | 51 | 34 | 26 | 28 | 26 |
| KF7. % able to contribute towards improvements at work | 79 | 78 | 68 | 68 | 78 | 75 | 76 | 73 | 94 | 78 | 62 | 80 | 64 |
| **ADDITIONAL THEME: Equality and diversity** | | | | | | | | | | | | | |
| * *KF20. % experiencing discrimination at work in last 12 mths* | 10 | 5 | 9 | 11 | 7 | 4 | 3 | 11 | 4 | 7 | 5 | 2 | 6 |
| KF21. % believing the organisation provides equal opportunities for career progression / promotion | 89 | 86 | 85 | 93 | 86 | 85 | 100 | 88 | 93 | 90 | 83 | 93 | 87 |
| **ADDITIONAL THEME: Errors and incidents** | | | | | | | | | | | | | |
| * *KF28. % witnessing potentially harmful errors, near misses or incidents in last mth* | 38 | 37 | 29 | 50 | 34 | 23 | 21 | 22 | 17 | 42 | 18 | 6 | 18 |
| KF29. % reporting errors, near misses or incidents witnessed in the last mth | 90 | 96 | 90 | 93 | 93 | 88 | - | 84 | - | 95 | 84 | - | 94 |
| KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents | 3.83 | 3.67 | 3.79 | 3.69 | 3.66 | 3.75 | 4.03 | 3.64 | 3.86 | 3.88 | 3.60 | 3.66 | 3.78 |
| KF31. Staff confidence and security in reporting unsafe clinical practice | 3.76 | 3.74 | 3.60 | 3.64 | 3.60 | 3.82 | 3.52 | 3.64 | 3.94 | 3.70 | 3.48 | 3.54 | 3.55 |
| **ADDITIONAL THEME: Patient experience measures** | | | | | | | | | | | | | |
| KF32. Effective use of patient / service user feedback | 3.85 | 3.67 | 3.81 | 3.94 | 3.67 | 3.64 | 3.61 | 3.68 | 3.93 | 3.77 | 3.63 | 3.69 | 3.46 |
| **Overall staff engagement** | 3.90 | 3.84 | 3.92 | 3.85 | 3.76 | 3.74 | 3.93 | 3.72 | 4.08 | 3.86 | 3.68 | 3.92 | 3.85 |
| **Number of respondents** | 250 | 205 | 111 | 94 | 45 | 79 | 29 | 145 | 53 | 103 | 384 | 101 | 98 |

Due to low numbers of respondents, no scores are shown for the following occupational groups: Mental Health Nurses, Social Care Staff, Public Health / Health Improvement and Emergency Care Assistant. Due to an error in the 2014 calculation, data for the following occupational groups in table 6.1 are not comparable to those in the equivalent table (5.1) in the 2014 reports: Other Allied Health Professionals, Other Scientific and Technical.

## Table 6.2: Key Findings for different directorates

| | 362 Child & Family (3) | 362 Community Healthcare L3 | 362 Corporate Services (3) | 362 Diagnostic and Clinical Support (3) | 362 Estates (Operations Division) (3) | 362 Facilities (Operations Division) (3) | 362 Medicine (3) | 362 Surgical & Critical Care (3) |
|---|---|---|---|---|---|---|---|---|
| **STAFF PLEDGE 1: To provide all staff with clear roles, responsibilities and rewarding jobs.** | | | | | | | | |
| KF1. Staff recommendation of the organisation as a place to work or receive treatment | 3.91 | 3.55 | 3.96 | 3.81 | 3.73 | 3.90 | 3.73 | 3.87 |
| KF2. Staff satisfaction with the quality of work and patient care they are able to deliver | 3.72 | 3.85 | 3.98 | 3.95 | 3.99 | 4.15 | 3.84 | 4.00 |
| KF3. % agreeing that their role makes a difference to patients / service users | 92 | 92 | 83 | 89 | 96 | 89 | 89 | 91 |
| KF4. Staff motivation at work | 3.97 | 3.84 | 3.86 | 3.79 | 3.98 | 4.02 | 4.00 | 3.89 |
| KF5. Recognition and value of staff by managers and the organisation | 3.60 | 3.37 | 3.68 | 3.42 | 3.54 | 3.49 | 3.39 | 3.38 |
| KF8. Staff satisfaction with level of responsibility and involvement | 4.04 | 3.81 | 3.95 | 3.89 | 4.05 | 3.85 | 3.95 | 3.99 |
| KF9. Effective team working | 4.02 | 3.82 | 3.90 | 3.80 | 3.93 | 3.35 | 3.69 | 3.67 |
| KF14. Staff satisfaction with resourcing and support | 3.21 | 3.21 | 3.58 | 3.31 | 3.48 | 3.43 | 3.22 | 3.30 |
| **STAFF PLEDGE 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.** | | | | | | | | |
| KF10. Support from immediate managers | 4.01 | 3.73 | 3.92 | 3.81 | 4.08 | 3.50 | 3.66 | 3.62 |
| KF11. % appraised in last 12 mths | 89 | 82 | 67 | 84 | 79 | 66 | 64 | 75 |
| KF12. Quality of appraisals | 3.34 | 2.87 | 3.23 | 3.01 | 2.45 | 3.11 | 3.25 | 3.00 |
| KF13. Quality of non-mandatory training, learning or development | 4.11 | 4.04 | 4.05 | 3.96 | 3.73 | 3.87 | 4.13 | 4.08 |
| **STAFF PLEDGE 3: To provide support and opportunities for staff to maintain their health, well-being and safety.** | | | | | | | | |
| **Health and well-being** | | | | | | | | |
| KF15. % of staff satisfied with the opportunities for flexible working patterns | 64 | 46 | 66 | 40 | 63 | 47 | 49 | 41 |
| * *KF16. % working extra hours* | 70 | 67 | 68 | 69 | 70 | 61 | 72 | 77 |
| * *KF17. % suffering work related stress in last 12 mths* | 33 | 43 | 28 | 35 | 30 | 32 | 39 | 40 |
| * *KF18. % feeling pressure in last 3 mths to attend work when feeling unwell* | 54 | 62 | 47 | 57 | 47 | 54 | 55 | 58 |
| KF19. Org and mgmt interest in and action on health / wellbeing | 3.70 | 3.42 | 3.79 | 3.64 | 3.82 | 3.65 | 3.47 | 3.52 |
| **Number of respondents** | 217 | 374 | 254 | 394 | 30 | 112 | 217 | 257 |

Please note that the directorates classification was provided by Stockport NHS Foundation Trust

## Table 6.2: Key Findings for different directorates (cont)

| | 362 Child & Family (3) | 362 Community Healthcare L3 | 362 Corporate Services (3) | 362 Diagnostic and Clinical Support (3) | 362 Estates (Operations Division) (3) | 362 Facilities (Operations Division) (3) | 362 Medicine (3) | 362 Surgical & Critical Care (3) |
|---|---|---|---|---|---|---|---|---|
| **Violence and harassment** | | | | | | | | |
| * *KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths* | 7 | 6 | 2 | 5 | 0 | 12 | 34 | 17 |
| * *KF23. % experiencing physical violence from staff in last 12 mths* | 1 | 1 | 0 | 1 | 0 | 8 | 1 | 3 |
| KF24. % reporting most recent experience of violence | 61 | 57 | - | 29 | - | 31 | 54 | 55 |
| * *KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths* | 18 | 24 | 7 | 19 | 7 | 13 | 31 | 33 |
| * *KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths* | 12 | 22 | 16 | 20 | 14 | 25 | 25 | 25 |
| KF27. % reporting most recent experience of harassment, bullying or abuse | 42 | 35 | 42 | 33 | - | 48 | 43 | 38 |
| **STAFF PLEDGE 4: To engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services.** | | | | | | | | |
| KF6. % reporting good communication between senior management and staff | 42 | 25 | 39 | 26 | 37 | 23 | 27 | 31 |
| KF7. % able to contribute towards improvements at work | 79 | 71 | 82 | 70 | 73 | 56 | 70 | 66 |
| **ADDITIONAL THEME: Equality and diversity** | | | | | | | | |
| * *KF20. % experiencing discrimination at work in last 12 mths* | 2 | 5 | 3 | 7 | 3 | 8 | 14 | 10 |
| KF21. % believing the organisation provides equal opportunities for career progression / promotion | 93 | 84 | 92 | 87 | 77 | 85 | 89 | 84 |
| **ADDITIONAL THEME: Errors and incidents** | | | | | | | | |
| * *KF28. % witnessing potentially harmful errors, near misses or incidents in last mth* | 24 | 27 | 12 | 33 | 24 | 14 | 38 | 33 |
| KF29. % reporting errors, near misses or incidents witnessed in the last mth | 96 | 91 | 87 | 92 | - | 71 | 93 | 80 |
| KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents | 3.89 | 3.60 | 3.72 | 3.76 | 3.65 | 3.69 | 3.67 | 3.70 |
| KF31. Staff confidence and security in reporting unsafe clinical practice | 3.87 | 3.61 | 3.66 | 3.62 | 3.50 | 3.53 | 3.60 | 3.61 |
| **ADDITIONAL THEME: Patient experience measures** | | | | | | | | |
| KF32. Effective use of patient / service user feedback | 3.83 | 3.62 | 3.72 | 3.73 | - | 3.39 | 3.78 | 3.89 |
| **Overall staff engagement** | 3.93 | 3.70 | 3.94 | 3.76 | 3.85 | 3.77 | 3.82 | 3.81 |
| **Number of respondents** | 217 | 374 | 254 | 394 | 30 | 112 | 217 | 257 |

Please note that the directorates classification was provided by Stockport NHS Foundation Trust

## Table 6.3: Key Findings for different staff groups

| | Add Prof Scientific and Technic | Additional Clinical Services | Administrative and Clerical | Allied Health Professionals | Estates and Ancillary | Healthcare Scientists | Medical and Dental | Nursing and Midwifery Registered |
|---|---|---|---|---|---|---|---|---|
| **STAFF PLEDGE 1: To provide all staff with clear roles, responsibilities and rewarding jobs.** | | | | | | | | |
| KF1. Staff recommendation of the organisation as a place to work or receive treatment | 3.94 | 3.92 | 3.80 | 3.57 | 3.90 | 3.85 | 3.91 | 3.76 |
| KF2. Staff satisfaction with the quality of work and patient care they are able to deliver | 3.95 | 4.19 | 3.97 | 3.62 | 4.16 | 4.12 | 3.85 | 3.78 |
| KF3. % agreeing that their role makes a difference to patients / service users | 92 | 90 | 83 | 96 | 87 | 92 | 91 | 94 |
| KF4. Staff motivation at work | 3.88 | 3.95 | 3.75 | 3.88 | 4.07 | 3.92 | 3.95 | 4.00 |
| KF5. Recognition and value of staff by managers and the organisation | 3.45 | 3.48 | 3.43 | 3.46 | 3.54 | 3.35 | 3.50 | 3.50 |
| KF8. Staff satisfaction with level of responsibility and involvement | 3.97 | 3.82 | 3.83 | 3.98 | 3.87 | 3.86 | 4.10 | 4.06 |
| KF9. Effective team working | 3.71 | 3.84 | 3.71 | 4.01 | 3.36 | 3.50 | 3.87 | 3.89 |
| KF14. Staff satisfaction with resourcing and support | 3.17 | 3.42 | 3.43 | 3.11 | 3.42 | 3.36 | 3.28 | 3.19 |
| **STAFF PLEDGE 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.** | | | | | | | | |
| KF10. Support from immediate managers | 3.77 | 3.78 | 3.71 | 3.96 | 3.58 | 3.61 | 3.70 | 3.85 |
| KF11. % appraised in last 12 mths | 78 | 78 | 71 | 96 | 71 | 58 | 91 | 77 |
| KF12. Quality of appraisals | 2.91 | 3.17 | 2.94 | 3.00 | 2.89 | 3.13 | 3.18 | 3.25 |
| KF13. Quality of non-mandatory training, learning or development | 4.01 | 4.09 | 3.84 | 4.01 | 3.87 | 4.05 | 4.11 | 4.22 |
| **STAFF PLEDGE 3: To provide support and opportunities for staff to maintain their health, well-being and safety.** | | | | | | | | |
| **Health and well-being** | | | | | | | | |
| KF15. % of staff satisfied with the opportunities for flexible working patterns | 33 | 50 | 51 | 56 | 51 | 50 | 35 | 49 |
| * *KF16. % working extra hours* | 80 | 56 | 58 | 77 | 64 | 78 | 89 | 84 |
| * *KF17. % suffering work related stress in last 12 mths* | 29 | 30 | 34 | 40 | 29 | 26 | 38 | 43 |
| * *KF18. % feeling pressure in last 3 mths to attend work when feeling unwell* | 54 | 63 | 56 | 52 | 48 | 53 | 41 | 60 |
| KF19. Org and mgmt interest in and action on health / wellbeing | 3.52 | 3.58 | 3.61 | 3.63 | 3.71 | 3.65 | 3.51 | 3.55 |
| **Number of respondents** | 66 | 227 | 651 | 223 | 110 | 38 | 94 | 447 |

Please note that the staff groups classification was provided by Stockport NHS Foundation Trust

## Table 6.3: Key Findings for different staff groups (cont)

| | Add Prof Scientific and Technic | Additional Clinical Services | Administrative and Clerical | Allied Health Professionals | Estates and Ancillary | Healthcare Scientists | Medical and Dental | Nursing and Midwifery Registered |
|---|---|---|---|---|---|---|---|---|
| **Violence and harassment** | | | | | | | | |
| * *KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths* | 6 | 20 | 2 | 10 | 10 | 3 | 11 | 19 |
| * *KF23. % experiencing physical violence from staff in last 12 mths* | 2 | 1 | 0 | 0 | 9 | 3 | 0 | 2 |
| KF24. % reporting most recent experience of violence | - | 60 | 61 | 36 | 21 | - | - | 54 |
| * *KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths* | 11 | 25 | 15 | 19 | 11 | 16 | 23 | 33 |
| * *KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths* | 21 | 18 | 21 | 16 | 26 | 26 | 24 | 21 |
| KF27. % reporting most recent experience of harassment, bullying or abuse | 31 | 45 | 41 | 28 | 38 | 36 | 37 | 36 |
| **STAFF PLEDGE 4: To engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services.** | | | | | | | | |
| KF6. % reporting good communication between senior management and staff | 33 | 29 | 29 | 23 | 29 | 34 | 33 | 35 |
| KF7. % able to contribute towards improvements at work | 83 | 63 | 67 | 80 | 58 | 76 | 69 | 80 |
| **ADDITIONAL THEME: Equality and diversity** | | | | | | | | |
| * *KF20. % experiencing discrimination at work in last 12 mths* | 6 | 9 | 4 | 6 | 9 | 11 | 11 | 9 |
| KF21. % believing the organisation provides equal opportunities for career progression / promotion | 87 | 86 | 85 | 91 | 85 | 81 | 93 | 89 |
| **ADDITIONAL THEME: Errors and incidents** | | | | | | | | |
| * *KF28. % witnessing potentially harmful errors, near misses or incidents in last mth* | 43 | 26 | 17 | 26 | 13 | 42 | 50 | 38 |
| KF29. % reporting errors, near misses or incidents witnessed in the last mth | 89 | 80 | 86 | 91 | 75 | 100 | 93 | 93 |
| KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents | 3.74 | 3.78 | 3.65 | 3.73 | 3.71 | 3.71 | 3.69 | 3.76 |
| KF31. Staff confidence and security in reporting unsafe clinical practice | 3.67 | 3.69 | 3.56 | 3.68 | 3.51 | 3.49 | 3.68 | 3.76 |
| **ADDITIONAL THEME: Patient experience measures** | | | | | | | | |
| KF32. Effective use of patient / service user feedback | 3.63 | 3.75 | 3.70 | 3.66 | 3.50 | 3.96 | 3.95 | 3.76 |
| **Overall staff engagement** | 3.90 | 3.81 | 3.75 | 3.77 | 3.80 | 3.84 | 3.87 | 3.89 |
| **Number of respondents** | 66 | 227 | 651 | 223 | 110 | 38 | 94 | 447 |

Please note that the staff groups classification was provided by Stockport NHS Foundation Trust

## Table 6.4: Key Findings for different work groups

| | Full time / part time[a] | |
|---|---|---|
| | Full time | Part time |
| **STAFF PLEDGE 1: To provide all staff with clear roles, responsibilities and rewarding jobs.** | | |
| KF1. Staff recommendation of the organisation as a place to work or receive treatment | 3.80 | 3.75 |
| KF2. Staff satisfaction with the quality of work and patient care they are able to deliver | 3.92 | 3.84 |
| KF3. % agreeing that their role makes a difference to patients / service users | 91 | 86 |
| KF4. Staff motivation at work | 3.89 | 3.85 |
| KF5. Recognition and value of staff by managers and the organisation | 3.48 | 3.42 |
| KF8. Staff satisfaction with level of responsibility and involvement | 3.94 | 3.87 |
| KF9. Effective team working | 3.81 | 3.74 |
| KF14. Staff satisfaction with resourcing and support | 3.31 | 3.31 |
| **STAFF PLEDGE 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.** | | |
| KF10. Support from immediate managers | 3.78 | 3.76 |
| KF11. % appraised in last 12 mths | 77 | 79 |
| KF12. Quality of appraisals | 3.13 | 2.86 |
| KF13. Quality of non-mandatory training, learning or development | 4.06 | 3.96 |
| **STAFF PLEDGE 3: To provide support and opportunities for staff to maintain their health, well-being and safety.** | | |
| **Health and well-being** | | |
| KF15. % of staff satisfied with the opportunities for flexible working patterns | 46 | 58 |
| * *KF16. % working extra hours* | 72 | 61 |
| * *KF17. % suffering work related stress in last 12 mths* | 39 | 28 |
| * *KF18. % feeling pressure in last 3 mths to attend work when feeling unwell* | 57 | 53 |
| KF19. Org and mgmt interest in and action on health / wellbeing | 3.59 | 3.59 |
| **Number of respondents** | 1355 | 469 |

[a] Full time is defined as staff contracted to work 30 hours or more a week

## Table 6.4: Key Findings for different work groups (cont)

| | Full time / part time[a] | |
|---|---|---|
| | Full time | Part time |
| **Violence and harassment** | | |
| * *KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths* | 11 | 8 |
| * *KF23. % experiencing physical violence from staff in last 12 mths* | 1 | 2 |
| KF24. % reporting most recent experience of violence | 52 | 41 |
| * *KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths* | 22 | 19 |
| * *KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths* | 22 | 18 |
| KF27. % reporting most recent experience of harassment, bullying or abuse | 40 | 29 |
| **STAFF PLEDGE 4: To engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services.** | | |
| KF6. % reporting good communication between senior management and staff | 32 | 24 |
| KF7. % able to contribute towards improvements at work | 73 | 67 |
| **ADDITIONAL THEME: Equality and diversity** | | |
| * *KF20. % experiencing discrimination at work in last 12 mths* | 7 | 5 |
| KF21. % believing the organisation provides equal opportunities for career progression / promotion | 86 | 91 |
| **ADDITIONAL THEME: Errors and incidents** | | |
| * *KF28. % witnessing potentially harmful errors, near misses or incidents in last mth* | 29 | 22 |
| KF29. % reporting errors, near misses or incidents witnessed in the last mth | 89 | 91 |
| KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents | 3.72 | 3.68 |
| KF31. Staff confidence and security in reporting unsafe clinical practice | 3.66 | 3.59 |
| **ADDITIONAL THEME: Patient experience measures** | | |
| KF32. Effective use of patient / service user feedback | 3.77 | 3.62 |
| **Overall staff engagement** | 3.83 | 3.74 |
| **Number of respondents** | 1355 | 469 |

[a] Full time is defined as staff contracted to work 30 hours or more a week

## 7. Key Findings by demographic groups

Tables 7.1 and 7.2 show the Key Findings at Stockport NHS Foundation Trust broken down by different demographic groups: age group, gender, disability and ethnic background.

Technical notes:

- As in previous years, there are two types of Key Finding:
    - percentage scores, i.e. percentage of staff giving a particular response to one, or a series of, survey questions
    - scale summary scores, calculated by converting staff responses to particular questions into scores. For each of these scale summary scores, the minimum score is always 1 and the maximum score is 5
- For most of the Key Findings presented in tables 7.1 and 7.2, the higher the score the better. However, there are some Key Findings for which a high score would represent a negative result. For these Key Findings, marked with an asterisk and shown in italics, the lower the score the better.
- Care should be taken not to over interpret the findings if scores differ slightly. For example, if for 'KF11. % appraised in the last 12 months' staff in Group A score 45%, and staff in Group B score 40%, it may appear that a higher proportion of staff in Group A have had appraisals than staff in Group B. However, because of small numbers in these sub-groups, it is probably not statistically significant. A more sensible interpretation would be that, on average, similar proportions of staff in Group A and B have had appraisals.
- Please note that, unlike the overall trust scores, data in this section are not weighted.
- Please also note that all percentage scores are shown to the nearest 1%. This means scores of less than 0.5% are displayed as 0%.
- In order to preserve anonymity of individual staff, a score is replaced with a dash if the demographic group in question contributed fewer than 11 responses to that score.

## Table 7.1: Key Findings for different age groups

| | Age group | | | |
|---|---|---|---|---|
| | Age 16-30 | Age 31-40 | Age 41-50 | Age 51+ |
| **STAFF PLEDGE 1: To provide all staff with clear roles, responsibilities and rewarding jobs.** | | | | |
| KF1. Staff recommendation of the organisation as a place to work or receive treatment | 4.01 | 3.86 | 3.72 | 3.74 |
| KF2. Staff satisfaction with the quality of work and patient care they are able to deliver | 3.99 | 3.85 | 3.86 | 3.93 |
| KF3. % agreeing that their role makes a difference to patients / service users | 88 | 91 | 89 | 91 |
| KF4. Staff motivation at work | 3.86 | 3.86 | 3.89 | 3.91 |
| KF5. Recognition and value of staff by managers and the organisation | 3.61 | 3.48 | 3.41 | 3.45 |
| KF8. Staff satisfaction with level of responsibility and involvement | 3.94 | 3.91 | 3.92 | 3.93 |
| KF9. Effective team working | 3.89 | 3.82 | 3.79 | 3.76 |
| KF14. Staff satisfaction with resourcing and support | 3.52 | 3.30 | 3.25 | 3.30 |
| **STAFF PLEDGE 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.** | | | | |
| KF10. Support from immediate managers | 3.93 | 3.78 | 3.72 | 3.77 |
| KF11. % appraised in last 12 mths | 65 | 78 | 78 | 81 |
| KF12. Quality of appraisals | 3.44 | 3.16 | 3.06 | 2.93 |
| KF13. Quality of non-mandatory training, learning or development | 4.15 | 4.07 | 4.05 | 3.98 |
| **STAFF PLEDGE 3: To provide support and opportunities for staff to maintain their health, well-being and safety.** | | | | |
| **Health and well-being** | | | | |
| KF15. % of staff satisfied with the opportunities for flexible working patterns | 51 | 55 | 49 | 46 |
| * *KF16. % working extra hours* | 63 | 71 | 74 | 68 |
| * *KF17. % suffering work related stress in last 12 mths* | 23 | 37 | 37 | 39 |
| * *KF18. % feeling pressure in last 3 mths to attend work when feeling unwell* | 54 | 60 | 54 | 56 |
| KF19. Org and mgmt interest in and action on health / wellbeing | 3.80 | 3.55 | 3.54 | 3.59 |
| **Number of respondents** | 244 | 348 | 528 | 698 |

## Table 7.1: Key Findings for different age groups (cont)

| | Age group | | | |
|---|---|---|---|---|
| | Age 16-30 | Age 31-40 | Age 41-50 | Age 51+ |
| **Violence and harassment** | | | | |
| * *KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths* | 16 | 12 | 10 | 8 |
| * *KF23. % experiencing physical violence from staff in last 12 mths* | 1 | 2 | 2 | 1 |
| KF24. % reporting most recent experience of violence | 47 | 53 | 47 | 50 |
| * *KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths* | 19 | 18 | 23 | 22 |
| * *KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths* | 17 | 22 | 23 | 20 |
| KF27. % reporting most recent experience of harassment, bullying or abuse | 44 | 33 | 38 | 39 |
| **STAFF PLEDGE 4: To engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services.** | | | | |
| KF6. % reporting good communication between senior management and staff | 34 | 31 | 28 | 30 |
| KF7. % able to contribute towards improvements at work | 71 | 73 | 72 | 72 |
| **ADDITIONAL THEME: Equality and diversity** | | | | |
| * *KF20. % experiencing discrimination at work in last 12 mths* | 7 | 9 | 7 | 5 |
| KF21. % believing the organisation provides equal opportunities for career progression / promotion | 94 | 89 | 89 | 84 |
| **ADDITIONAL THEME: Errors and incidents** | | | | |
| * *KF28. % witnessing potentially harmful errors, near misses or incidents in last mth* | 32 | 28 | 29 | 23 |
| KF29. % reporting errors, near misses or incidents witnessed in the last mth | 83 | 85 | 93 | 92 |
| KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents | 3.83 | 3.74 | 3.71 | 3.68 |
| KF31. Staff confidence and security in reporting unsafe clinical practice | 3.82 | 3.69 | 3.65 | 3.56 |
| **ADDITIONAL THEME: Patient experience measures** | | | | |
| KF32. Effective use of patient / service user feedback | 3.73 | 3.77 | 3.67 | 3.77 |
| **Overall staff engagement** | 3.87 | 3.82 | 3.79 | 3.80 |
| **Number of respondents** | 244 | 348 | 528 | 698 |

## Table 7.2: Key Findings for other demographic groups

| | Gender | | Disability | | Ethnic background | |
|---|---|---|---|---|---|---|
| | Men | Women | Disabled | Not disabled | White | Black and minority ethnic |
| **STAFF PLEDGE 1: To provide all staff with clear roles, responsibilities and rewarding jobs.** | | | | | | |
| KF1. Staff recommendation of the organisation as a place to work or receive treatment | 3.83 | 3.78 | 3.69 | 3.81 | 3.78 | 3.99 |
| KF2. Staff satisfaction with the quality of work and patient care they are able to deliver | 3.91 | 3.91 | 3.97 | 3.89 | 3.90 | 3.99 |
| KF3. % agreeing that their role makes a difference to patients / service users | 87 | 90 | 91 | 90 | 90 | 83 |
| KF4. Staff motivation at work | 3.78 | 3.90 | 3.76 | 3.90 | 3.87 | 4.11 |
| KF5. Recognition and value of staff by managers and the organisation | 3.49 | 3.47 | 3.25 | 3.50 | 3.47 | 3.47 |
| KF8. Staff satisfaction with level of responsibility and involvement | 3.94 | 3.92 | 3.76 | 3.95 | 3.93 | 3.90 |
| KF9. Effective team working | 3.71 | 3.81 | 3.58 | 3.83 | 3.80 | 3.85 |
| KF14. Staff satisfaction with resourcing and support | 3.33 | 3.31 | 3.22 | 3.33 | 3.31 | 3.40 |
| **STAFF PLEDGE 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.** | | | | | | |
| KF10. Support from immediate managers | 3.71 | 3.79 | 3.55 | 3.81 | 3.79 | 3.71 |
| KF11. % appraised in last 12 mths | 71 | 78 | 73 | 78 | 77 | 82 |
| KF12. Quality of appraisals | 3.09 | 3.07 | 2.69 | 3.12 | 3.04 | 3.49 |
| KF13. Quality of non-mandatory training, learning or development | 3.98 | 4.05 | 4.01 | 4.05 | 4.03 | 4.16 |
| **STAFF PLEDGE 3: To provide support and opportunities for staff to maintain their health, well-being and safety.** | | | | | | |
| **Health and well-being** | | | | | | |
| KF15. % of staff satisfied with the opportunities for flexible working patterns | 47 | 50 | 47 | 50 | 49 | 52 |
| * *KF16. % working extra hours* | 77 | 68 | 73 | 69 | 70 | 68 |
| * *KF17. % suffering work related stress in last 12 mths* | 34 | 37 | 54 | 33 | 36 | 32 |
| * *KF18. % feeling pressure in last 3 mths to attend work when feeling unwell* | 50 | 57 | 74 | 53 | 56 | 48 |
| KF19. Org and mgmt interest in and action on health / wellbeing | 3.60 | 3.59 | 3.47 | 3.62 | 3.59 | 3.69 |
| **Number of respondents** | 302 | 1474 | 214 | 1573 | 1676 | 136 |

## Table 7.2: Key Findings for other demographic groups (cont)

| | Gender | | Disability | | Ethnic background | |
|---|---|---|---|---|---|---|
| | Men | Women | Disabled | Not disabled | White | Black and minority ethnic |
| **Violence and harassment** | | | | | | |
| * *KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths* | 11 | 10 | 8 | 11 | 10 | 10 |
| * *KF23. % experiencing physical violence from staff in last 12 mths* | 2 | 1 | 1 | 1 | 1 | 4 |
| KF24. % reporting most recent experience of violence | 47 | 50 | 68 | 47 | 50 | 50 |
| * *KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths* | 15 | 22 | 23 | 21 | 21 | 23 |
| * *KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths* | 22 | 21 | 29 | 19 | 20 | 27 |
| KF27. % reporting most recent experience of harassment, bullying or abuse | 34 | 39 | 38 | 38 | 38 | 43 |
| **STAFF PLEDGE 4: To engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services.** | | | | | | |
| KF6. % reporting good communication between senior management and staff | 31 | 30 | 25 | 31 | 30 | 42 |
| KF7. % able to contribute towards improvements at work | 71 | 72 | 60 | 74 | 72 | 64 |
| **ADDITIONAL THEME: Equality and diversity** | | | | | | |
| * *KF20. % experiencing discrimination at work in last 12 mths* | 11 | 6 | 12 | 6 | 5 | 26 |
| KF21. % believing the organisation provides equal opportunities for career progression / promotion | 84 | 88 | 76 | 89 | 88 | 78 |
| **ADDITIONAL THEME: Errors and incidents** | | | | | | |
| * *KF28. % witnessing potentially harmful errors, near misses or incidents in last mth* | 32 | 26 | 32 | 26 | 27 | 26 |
| KF29. % reporting errors, near misses or incidents witnessed in the last mth | 89 | 89 | 82 | 91 | 89 | 94 |
| KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents | 3.68 | 3.73 | 3.57 | 3.74 | 3.71 | 3.80 |
| KF31. Staff confidence and security in reporting unsafe clinical practice | 3.57 | 3.66 | 3.50 | 3.67 | 3.65 | 3.68 |
| **ADDITIONAL THEME: Patient experience measures** | | | | | | |
| KF32. Effective use of patient / service user feedback | 3.67 | 3.74 | 3.57 | 3.76 | 3.73 | 3.85 |
| **Overall staff engagement** | 3.79 | 3.81 | 3.64 | 3.84 | 3.80 | 3.92 |
| **Number of respondents** | 302 | 1474 | 214 | 1573 | 1676 | 136 |

## 8. Work and demographic profile of the survey respondents

The occupational group of the staff survey respondents is shown in table 8.1, other work characteristics are shown in table 8.2, and demographic characteristics are shown in table 8.3.

### Table 8.1: Occupational group of respondents

| Occupational group | Number questionnaires returned | Percentage of survey respondents |
|---|---|---|
| ***Allied Health Professionals*** | | |
| Occupational Therapy | 45 | 3% |
| Physiotherapy | 79 | 4% |
| Radiography | 29 | 2% |
| Clinical Psychology | 4 | 0% |
| Psychotherapy | 2 | 0% |
| Other qualified Allied Health Professionals | 103 | 6% |
| Support to Allied Health Professionals | 36 | 2% |
| ***Scientific and Technical / Healthcare Scientists*** | | |
| Pharmacy | 51 | 3% |
| Other qualified Scientific and Technical / Healthcare Scientists | 37 | 2% |
| Support to Scientific and Technical / Healthcare Scientists | 15 | 1% |
| ***Medical and Dental*** | | |
| Medical / Dental - Consultant | 71 | 4% |
| Medical / Dental - In Training | 7 | 0% |
| Medical / Dental - Other | 16 | 1% |
| ***Operational ambulance staff*** | | |
| Emergency care assistant | 1 | 0% |
| ***Nurses, Midwives and Nursing Assistants*** | | |
| Registered Nurses - Adult / General | 250 | 14% |
| Registered Nurses - Mental Health | 2 | 0% |
| Registered Nurses - Learning Disabilities | 9 | 1% |
| Registered Nurses - Children | 34 | 2% |
| Midwives | 26 | 1% |
| Health Visitors | 43 | 2% |
| Registered Nurses - District / Community | 65 | 4% |
| Other Registered Nurses | 28 | 2% |
| Nursing auxiliary / Nursing assistant / Healthcare assistant | 111 | 6% |
| ***Social Care Staff*** | | |
| Social care support staff | 1 | 0% |
| ***Other groups*** | | |
| Public Health / Health Improvement | 7 | 0% |
| Admin and Clerical | 384 | 22% |
| Central Functions / Corporate Services | 101 | 6% |
| Maintenance / Ancillary | 98 | 6% |
| General Management | 53 | 3% |
| Other | 65 | 4% |
| Did not specify | 83 | |

## Table 8.2: Work characteristics of respondents

| | Number questionnaires returned | Percentage of survey respondents |
|---|---|---|
| ***Full time / part time*** | | |
| Full time | 1355 | 74% |
| Part time | 469 | 26% |
| Did not specify | 32 | |
| ***Length of time in organisation*** | | |
| Less than a year | 165 | 9% |
| Between 1 to 2 years | 185 | 10% |
| Between 3 to 5 years | 226 | 12% |
| Between 6 to 10 years | 429 | 24% |
| Between 11 to 15 years | 336 | 18% |
| Over 15 years | 481 | 26% |
| Did not specify | 34 | |

Sums of percentages may add up to more than 100% due to rounding, and do not include 'did not specify' responses

## Table 8.3: Demographic characteristics of respondents

| | Number questionnaires returned | Percentage of survey respondents |
|---|---|---|
| ***Age group*** | | |
| Between 16 and 30 | 244 | 13% |
| Between 31 and 40 | 348 | 19% |
| Between 41 and 50 | 528 | 29% |
| 51 and over | 698 | 38% |
| Did not specify | 38 | |
| ***Gender*** | | |
| Male | 302 | 17% |
| Female | 1474 | 83% |
| Did not specify | 80 | |
| ***Ethnic background*** | | |
| White | 1676 | 92% |
| Black and minority ethnic | 136 | 8% |
| Did not specify | 44 | |
| ***Disability*** | | |
| Disabled | 214 | 12% |
| Not disabled | 1573 | 88% |
| Did not specify | 69 | |

Sums of percentages may add up to more than 100% due to rounding, and do not include 'did not specify' responses

## Appendix 1

## Key Findings for Stockport NHS Foundation Trust benchmarked against other combined acute and community trusts

Technical notes:

- The first column in table A1 shows the trust's scores for each of the Key Findings. The same data are displayed in section 3 and 4 of this report.
- The second column in table A1 shows the 95% confidence intervals around the trust's scores for each of the Key Findings.
- The third column in table A1 shows the average (median) score for each of the Key Findings for combined acute and community trusts. The same data are displayed in section 3 and 4 of this report.
- The fourth and fifth columns in table A1 show the thresholds for below and above average scores for each of the Key Findings for combined acute and community trusts. The data are used to describe comparisons with other trusts as displayed in section 3 and 4 of this report.
- The sixth column in table A1 shows the lowest score attained for each of the Key Findings by an combined acute and community trust.
- The seventh column in table A1 shows the highest score attained for each of the Key Findings by an combined acute and community trust.
- For most of the Key Findings presented in table A1, the higher the score the better. However, there are some Key Findings for which a high score would represent a negative score. For these Key Findings, marked with an asterisk and shown in italics, the lower the score the better.
- Please note that the data presented in table A1 are rounded to the nearest whole number for percentage scores and to two decimal places for scale summary scores.

## Table A1: Key Findings for Stockport NHS Foundation Trust benchmarked against other combined acute and community trusts

| | Your trust | | National scores for combined acute and community trusts | | | | |
|---|---|---|---|---|---|---|---|
| | Trust score | 95% Confidence Interval | Median score | Threshold for below average | Threshold for above average | Lowest score attained | Highest score attained |
| Response rate | 34 | - | 41 | 34 | 45 | 19 | 59 |
| **STAFF PLEDGE 1: To provide all staff with clear roles, responsibilities and rewarding jobs.** | | | | | | | |
| KF1. Staff recommendation of the organisation as a place to work or receive treatment | 3.80 | [3.76, 3.84] | 3.71 | 3.65 | 3.80 | 3.22 | 4.22 |
| KF2. Staff satisfaction with the quality of work and patient care they are able to deliver | 3.90 | [3.85, 3.95] | 3.94 | 3.91 | 3.96 | 3.68 | 4.15 |
| KF3. % agreeing that their role makes a difference to patients / service users | 90 | [89, 92] | 91 | 89 | 91 | 86 | 95 |
| KF4. Staff motivation at work | 3.90 | [3.86, 3.93] | 3.92 | 3.89 | 4.00 | 3.76 | 4.11 |
| KF5. Recognition and value of staff by managers and the organisation | 3.47 | [3.43, 3.51] | 3.42 | 3.39 | 3.47 | 3.17 | 3.63 |
| KF8. Staff satisfaction with level of responsibility and involvement | 3.94 | [3.91, 3.97] | 3.93 | 3.89 | 3.94 | 3.77 | 4.03 |
| KF9. Effective team working | 3.80 | [3.77, 3.84] | 3.77 | 3.74 | 3.79 | 3.60 | 3.92 |
| KF14. Staff satisfaction with resourcing and support | 3.30 | [3.27, 3.34] | 3.30 | 3.25 | 3.33 | 3.11 | 3.50 |
| **STAFF PLEDGE 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.** | | | | | | | |
| KF10. Support from immediate managers | 3.78 | [3.73, 3.82] | 3.72 | 3.70 | 3.76 | 3.53 | 3.88 |
| KF11. % appraised in last 12 mths | 78 | [76, 80] | 86 | 82 | 88 | 70 | 94 |
| KF12. Quality of appraisals | 3.09 | [3.02, 3.16] | 3.03 | 2.97 | 3.10 | 2.82 | 3.37 |
| KF13. Quality of non-mandatory training, learning or development | 4.06 | [4.02, 4.09] | 4.04 | 4.00 | 4.08 | 3.88 | 4.15 |
| **STAFF PLEDGE 3: To provide support and opportunities for staff to maintain their health, well-being and safety.** | | | | | | | |
| **Health and well-being** | | | | | | | |
| KF15. % of staff satisfied with the opportunities for flexible working patterns | 49 | [47, 51] | 50 | 48 | 51 | 41 | 59 |
| * *KF16. % working extra hours* | 71 | [69, 73] | 72 | 70 | 74 | 65 | 79 |
| * *KF17. % suffering work related stress in last 12 mths* | 36 | [34, 39] | 36 | 34 | 38 | 24 | 43 |
| * *KF18. % feeling pressure in last 3 mths to attend work when feeling unwell* | 55 | [53, 58] | 58 | 57 | 61 | 51 | 71 |
| KF19. Org and mgmt interest in and action on health / wellbeing | 3.59 | [3.54, 3.63] | 3.59 | 3.54 | 3.63 | 3.31 | 3.76 |

## Table A1: Key Findings for Stockport NHS Foundation Trust benchmarked against other combined acute and community trusts (cont)

| | Your trust | | National scores for combined acute and community trusts | | | | |
|---|---|---|---|---|---|---|---|
| | Trust score | 95% Confidence Interval | Median score | Threshold for below average | Threshold for above average | Lowest score attained | Highest score attained |
| **Violence and harassment** | | | | | | | |
| * *KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths* | 11 | [10, 13] | 14 | 12 | 14 | 8 | 20 |
| * *KF23. % experiencing physical violence from staff in last 12 mths* | 1 | [1, 2] | 2 | 2 | 2 | 0 | 5 |
| KF24. % reporting most recent experience of violence | 50 | [43, 57] | 52 | 50 | 56 | 41 | 80 |
| * *KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths* | 22 | [20, 24] | 27 | 26 | 29 | 20 | 35 |
| * *KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths* | 21 | [19, 23] | 24 | 22 | 25 | 17 | 37 |
| KF27. % reporting most recent experience of harassment, bullying or abuse | 38 | [34, 42] | 38 | 35 | 40 | 15 | 51 |
| **STAFF PLEDGE 4: To engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services.** | | | | | | | |
| KF6. % reporting good communication between senior management and staff | 31 | [29, 33] | 30 | 28 | 31 | 19 | 42 |
| KF7. % able to contribute towards improvements at work | 72 | [70, 74] | 71 | 69 | 72 | 61 | 77 |
| **ADDITIONAL THEME: Equality and diversity** | | | | | | | |
| * *KF20. % experiencing discrimination at work in last 12 mths* | 7 | [6, 8] | 10 | 8 | 11 | 5 | 21 |
| KF21. % believing the organisation provides equal opportunities for career progression / promotion | 88 | [86, 90] | 87 | 85 | 89 | 70 | 94 |
| **ADDITIONAL THEME: Errors and incidents** | | | | | | | |
| * *KF28. % witnessing potentially harmful errors, near misses or incidents in last mth* | 29 | [27, 31] | 29 | 28 | 30 | 20 | 37 |
| KF29. % reporting errors, near misses or incidents witnessed in the last mth | 90 | [87, 93] | 90 | 88 | 92 | 82 | 94 |
| KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents | 3.72 | [3.69, 3.76] | 3.71 | 3.65 | 3.74 | 3.41 | 3.92 |
| KF31. Staff confidence and security in reporting unsafe clinical practice | 3.65 | [3.61, 3.70] | 3.64 | 3.59 | 3.67 | 3.31 | 3.81 |
| **ADDITIONAL THEME: Patient experience measures** | | | | | | | |
| KF32. Effective use of patient / service user feedback | 3.75 | [3.70, 3.80] | 3.65 | 3.61 | 3.71 | 3.41 | 3.98 |

## Appendix 2

## Changes to the Key Findings since the 2013 and 2014 staff surveys

Technical notes:

- For most of the Key Findings presented in tables A2.1 and A2.2, the higher the score the better. However, there are some Key Findings for which a high score would represent a negative result. For these Key Findings, marked with an asterisk and shown in italics, the lower the score the better.

- It is likely that we would see some small change simply due to sample differences between the two years. The final column of the tables shows whether the change in your trust is statistically significant or not. If a change is not significant, then there is no evidence of a real change in the trust score.

- Please note that the trust scores and change scores presented in tables A2.1 and A2.2 are rounded to the nearest whole number for percentage scores and to two decimal places for scale summary scores.

- All percentage scores are shown to the nearest 1%. This means scores of less than 0.5% are displayed as 0%.

- In certain cases a dash (-) appears in Table A2.1 or A2.2. This is either because the Key Finding was not calculated in previous years, or there have been changes in how the Key Finding has been calculated this year.

To enable comparison between years, scores from 2014 and 2013 have been re-calculated and re-weighted using the 2015 formulae, so may appear slightly different from figures in previous feedback reports. More details about these changes can be found in the document ***Making sense of your staff survey data***, which can be downloaded from www.nhsstaffsurveys.com.

## Table A2.1: Changes in the Key Findings for Stockport NHS Foundation Trust since 2014 survey

| | Stockport NHS Foundation Trust | | | |
|---|---|---|---|---|
| | **2015 score** | **2014 score** | **Change** | **Statistically significant?** |
| Response rate | 34 | 29 | 5 | - |
| **STAFF PLEDGE 1: To provide all staff with clear roles, responsibilities and rewarding jobs.** | | | | |
| KF1. Staff recommendation of the organisation as a place to work or receive treatment | 3.80 | 3.69 | 0.11 | No |
| KF2. Staff satisfaction with the quality of work and patient care they are able to deliver | 3.90 | - | - | -- |
| KF3. % agreeing that their role makes a difference to patients / service users | 90 | - | - | -- |
| KF4. Staff motivation at work | 3.90 | 3.88 | 0.02 | No |
| KF5. Recognition and value of staff by managers and the organisation | 3.47 | - | - | -- |
| KF8. Staff satisfaction with level of responsibility and involvement | 3.94 | 3.93 | 0.01 | No |
| KF9. Effective team working | 3.80 | - | - | -- |
| KF14. Staff satisfaction with resourcing and support | 3.30 | - | - | -- |
| **STAFF PLEDGE 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.** | | | | |
| KF10. Support from immediate managers | 3.78 | 3.81 | -0.03 | No |
| KF11. % appraised in last 12 mths | 78 | 89 | -12 | Yes |
| KF12. Quality of appraisals | 3.09 | - | - | -- |
| KF13. Quality of non-mandatory training, learning or development | 4.06 | - | - | -- |
| **STAFF PLEDGE 3: To provide support and opportunities for staff to maintain their health, well-being and safety.** | | | | |
| **Health and well-being** | | | | |
| KF15. % of staff satisfied with the opportunities for flexible working patterns | 49 | - | - | -- |
| * *KF16. % working extra hours* | 71 | 73 | -2 | No |
| * *KF17. % suffering work related stress in last 12 mths* | 36 | 37 | 0 | No |
| * *KF18. % feeling pressure in last 3 mths to attend work when feeling unwell* | 55 | 54 | 1 | No |
| KF19. Org and mgmt interest in and action on health / wellbeing | 3.59 | - | - | -- |

## Table A2.1: Changes in the Key Findings for Stockport NHS Foundation Trust since 2014 survey (cont)

| | Stockport NHS Foundation Trust | | | |
|---|---|---|---|---|
| | **2015 score** | **2014 score** | **Change** | **Statistically significant?** |
| **Violence and harassment** | | | | |
| * *KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths* | 11 | 12 | -1 | No |
| * *KF23. % experiencing physical violence from staff in last 12 mths* | 1 | 2 | -1 | No |
| KF24. % reporting most recent experience of violence | 50 | 68 | -18 | No |
| * *KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths* | 22 | 25 | -3 | No |
| * *KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths* | 21 | 21 | -1 | No |
| KF27. % reporting most recent experience of harassment, bullying or abuse | 38 | 43 | -5 | No |
| **STAFF PLEDGE 4: To engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services.** | | | | |
| KF6. % reporting good communication between senior management and staff | 31 | 27 | 4 | No |
| KF7. % able to contribute towards improvements at work | 72 | 67 | 5 | No |
| **ADDITIONAL THEME: Equality and diversity** | | | | |
| * *KF20. % experiencing discrimination at work in last 12 mths* | 7 | 7 | 0 | No |
| KF21. % believing the organisation provides equal opportunities for career progression / promotion | 88 | 92 | -4 | No |
| **ADDITIONAL THEME: Errors and incidents** | | | | |
| * *KF28. % witnessing potentially harmful errors, near misses or incidents in last mth* | 29 | 33 | -4 | No |
| KF29. % reporting errors, near misses or incidents witnessed in the last mth | 90 | 88 | 2 | No |
| KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents | 3.72 | - | - | -- |
| KF31. Staff confidence and security in reporting unsafe clinical practice | 3.65 | 3.71 | -0.05 | No |
| **ADDITIONAL THEME: Patient experience measures** | | | | |
| KF32. Effective use of patient / service user feedback | 3.75 | 3.69 | 0.06 | No |

## Table A2.2: Changes in the Key Findings for Stockport NHS Foundation Trust since 2013 survey

| | Stockport NHS Foundation Trust | | | |
|---|---|---|---|---|
| | **2015 score** | **2013 score** | **Change** | **Statistically significant?** |
| Response rate | 34 | 54 | -19 | - |
| **STAFF PLEDGE 1: To provide all staff with clear roles, responsibilities and rewarding jobs.** | | | | |
| KF1. Staff recommendation of the organisation as a place to work or receive treatment | 3.80 | 3.84 | -0.04 | No |
| KF2. Staff satisfaction with the quality of work and patient care they are able to deliver | 3.90 | - | - | -- |
| KF3. % agreeing that their role makes a difference to patients / service users | 90 | - | - | -- |
| KF4. Staff motivation at work | 3.90 | 3.98 | -0.08 | No |
| KF5. Recognition and value of staff by managers and the organisation | 3.47 | - | - | -- |
| KF8. Staff satisfaction with level of responsibility and involvement | 3.94 | 3.94 | 0.00 | No |
| KF9. Effective team working | 3.80 | - | - | -- |
| KF14. Staff satisfaction with resourcing and support | 3.30 | - | - | -- |
| **STAFF PLEDGE 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.** | | | | |
| KF10. Support from immediate managers | 3.78 | 3.74 | 0.04 | No |
| KF11. % appraised in last 12 mths | 78 | 85 | -7 | Yes |
| KF12. Quality of appraisals | 3.09 | - | - | -- |
| KF13. Quality of non-mandatory training, learning or development | 4.06 | - | - | -- |
| **STAFF PLEDGE 3: To provide support and opportunities for staff to maintain their health, well-being and safety.** | | | | |
| **Health and well-being** | | | | |
| KF15. % of staff satisfied with the opportunities for flexible working patterns | 49 | - | - | -- |
| * *KF16. % working extra hours* | 71 | 69 | 2 | No |
| * *KF17. % suffering work related stress in last 12 mths* | 36 | 34 | 2 | No |
| * *KF18. % feeling pressure in last 3 mths to attend work when feeling unwell* | 55 | 64 | -8 | Yes |
| KF19. Org and mgmt interest in and action on health / wellbeing | 3.59 | - | - | -- |

## Table A2.2: Changes in the Key Findings for Stockport NHS Foundation Trust since 2013 survey (cont)

| | Stockport NHS Foundation Trust | | | |
|---|---|---|---|---|
| | **2015 score** | **2013 score** | **Change** | **Statistically significant?** |
| **Violence and harassment** | | | | |
| * *KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths* | 11 | 12 | -1 | No |
| * *KF23. % experiencing physical violence from staff in last 12 mths* | 1 | 2 | -1 | No |
| KF24. % reporting most recent experience of violence | 50 | 50 | 0 | No |
| * *KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths* | 22 | 22 | 0 | No |
| * *KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths* | 21 | 17 | 4 | No |
| KF27. % reporting most recent experience of harassment, bullying or abuse | 38 | 44 | -6 | No |
| **STAFF PLEDGE 4: To engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services.** | | | | |
| KF6. % reporting good communication between senior management and staff | 31 | 38 | -7 | Yes |
| KF7. % able to contribute towards improvements at work | 72 | 71 | 2 | No |
| **ADDITIONAL THEME: Equality and diversity** | | | | |
| * *KF20. % experiencing discrimination at work in last 12 mths* | 7 | 8 | -1 | No |
| KF21. % believing the organisation provides equal opportunities for career progression / promotion | 88 | 92 | -4 | Yes |
| **ADDITIONAL THEME: Errors and incidents** | | | | |
| * *KF28. % witnessing potentially harmful errors, near misses or incidents in last mth* | 29 | 29 | 0 | No |
| KF29. % reporting errors, near misses or incidents witnessed in the last mth | 90 | 97 | -7 | Yes |
| KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents | 3.72 | - | - | -- |
| KF31. Staff confidence and security in reporting unsafe clinical practice | 3.65 | - | - | -- |
| **ADDITIONAL THEME: Patient experience measures** | | | | |
| KF32. Effective use of patient / service user feedback | 3.75 | - | - | -- |

## Appendix 3

## Data tables: 2015 Key Findings and the responses to all survey questions

For each of the 32 Key Findings (Table A3.1) and each individual survey question in the core version of the questionnaire (Table A3.2), this appendix presents your trust's 2015 survey response, the average (median) 2015 response for combined acute and community trusts, and your trust's 2014 survey response (where applicable).

In Table A3.1, the question numbers used to calculate the 32 Key Findings are also listed in the first column.

In Table A3.2, the responses to the survey questions are presented in the order that they appear within the core version of the 2015 questionnaire.

Technical notes:

- In certain cases a dash (-) appears in the 'Your Trust in 2014' column in Tables A3.1 or A3.2. This is because of changes to the format of survey questions or the calculation of the Key Findings so comparisons with the 2014 score are not possible.

- In certain cases a dash (-) appears in Tables A3.1 or A3.2. This is in order to preserve anonymity of individual staff, where there were fewer than 11 responses to a survey question or Key Finding.

- Please note that the figures reported in tables A3.1 and A3.2 are un-weighted, and, as a consequence there may be some slight differences between these figures and the figures reported in sections 3 and 4 and Appendix 2 of this report, which are weighted according to the occupational group profile of a typical combined acute and community trust.

- More details about the calculation of Key Findings and the weighting of data can be found in the document ***Making sense of your staff survey data***, which can be downloaded from: www.nhsstaffsurveys.com

## Table A3.1: Key Findings for Stockport NHS Foundation Trust benchmarked against other combined acute and community trusts

| | Question number(s) | Your Trust in 2015 | Average (median) for combined acute and community trusts | Your Trust in 2014 |
|---|---|---|---|---|
| **STAFF PLEDGE 1: To provide all staff with clear roles, responsibilities and rewarding jobs.** | | | | |
| KF1. Staff recommendation of the organisation as a place to work or receive treatment | Q21a, 21c-d | 3.79 | 3.71 | 3.67 |
| KF2. Staff satisfaction with the quality of work and patient care they are able to deliver | Q3c, 6a, 6c | 3.90 | 3.92 | - |
| KF3. % agreeing that their role makes a difference to patients / service users | Q6b | 90 | 90 | - |
| KF4. Staff motivation at work | Q2a-c | 3.88 | 3.93 | 3.86 |
| KF5. Recognition and value of staff by managers and the organisation | Q5a, 5f, 7g | 3.46 | 3.43 | - |
| KF8. Staff satisfaction with level of responsibility and involvement | Q3a, 3b, 4c, 5d, 5e | 3.92 | 3.91 | 3.91 |
| KF9. Effective team working | Q4h-j | 3.80 | 3.78 | - |
| KF14. Staff satisfaction with resourcing and support | Q4e-g, 5c | 3.31 | 3.30 | - |
| **STAFF PLEDGE 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.** | | | | |
| KF10. Support from immediate managers | Q5b, 7a-e | 3.78 | 3.71 | 3.80 |
| KF11. % appraised in last 12 mths | Q20a | 77 | 86 | 89 |
| KF12. Quality of appraisals | Q20b-d | 3.07 | 3.02 | - |
| KF13. Quality of non-mandatory training, learning or development | Q18b-d | 4.04 | 4.04 | - |
| **STAFF PLEDGE 3: To provide support and opportunities for staff to maintain their health, well-being and safety.** | | | | |
| **Health and well-being** | | | | |
| KF15. % of staff satisfied with the opportunities for flexible working patterns | Q5h | 49 | 49 | - |
| * *KF16. % working extra hours* | Q10b-c | 70 | 72 | 70 |
| * *KF17. % suffering work related stress in last 12 mths* | Q9c | 36 | 36 | 36 |
| * *KF18. % feeling pressure in last 3 mths to attend work when feeling unwell* | Q9d-g | 56 | 58 | 55 |
| KF19. Org and mgmt interest in and action on health / wellbeing | Q7f, 9a | 3.59 | 3.59 | - |

## Table A3.1: Key Findings for Stockport NHS Foundation Trust benchmarked against other combined acute and community trusts (cont)

| | Question number(s) | Your Trust in 2015 | Average (median) for combined acute and community trusts | Your Trust in 2014 |
|---|---|---|---|---|
| **Violence and harassment** | | | | |
| * *KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths* | Q14a | 10 | 14 | 11 |
| * *KF23. % experiencing physical violence from staff in last 12 mths* | Q14b-c | 1 | 2 | 2 |
| KF24. % reporting most recent experience of violence | Q14d | 50 | 52 | 67 |
| * *KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths* | Q15a | 21 | 27 | 24 |
| * *KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths* | Q15b-c | 21 | 24 | 21 |
| KF27. % reporting most recent experience of harassment, bullying or abuse | Q15d | 38 | 38 | 45 |
| **STAFF PLEDGE 4: To engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services.** | | | | |
| KF6. % reporting good communication between senior management and staff | Q8a-d | 30 | 30 | 26 |
| KF7. % able to contribute towards improvements at work | Q4a-b, 4d | 72 | 71 | 67 |
| **ADDITIONAL THEME: Equality and diversity** | | | | |
| * *KF20. % experiencing discrimination at work in last 12 mths* | Q17a-b | 7 | 10 | 7 |
| KF21. % believing the organisation provides equal opportunities for career progression / promotion | Q16 | 87 | 87 | 92 |
| **ADDITIONAL THEME: Errors and incidents** | | | | |
| * *KF28. % witnessing potentially harmful errors, near misses or incidents in last mth* | Q11a-b | 27 | 29 | 31 |
| KF29. % reporting errors, near misses or incidents witnessed in the last mth | Q11c | 89 | 89 | 88 |
| KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents | Q12a-d | 3.71 | 3.71 | - |
| KF31. Staff confidence and security in reporting unsafe clinical practice | Q13b-c | 3.64 | 3.65 | 3.68 |
| **ADDITIONAL THEME: Patient experience measures** | | | | |
| KF32. Effective use of patient / service user feedback | Q21b, 22b-c | 3.74 | 3.66 | 3.68 |

## Table A3.2: Survey questions benchmarked against other combined acute and community trusts

| | | Your Trust in 2015 | Average (median) for combined acute and community trusts | Your Trust in 2014 |
|---|---|---|---|---|
| | **Contact with patients** | | | |
| Q1 | % saying they have face-to-face contact with patients / service users as part of their job | 78 | 85 | 77 |
| | **Staff motivation at work** | | | |
| | % saying often or always to the following statements: | | | |
| Q2a | "I look forward to going to work" | 57 | 59 | 50 |
| Q2b | "I am enthusiastic about my job" | 66 | 75 | 68 |
| Q2c | "Time passes quickly when I am working" | 81 | 79 | 76 |
| | **Job design** | | | |
| | % agreeing / strongly agreeing with the following statements: | | | |
| Q3a | "I always know what my work responsibilities are" | 87 | 88 | 87 |
| Q3b | "I am trusted to do my job" | 92 | 92 | 93 |
| Q3c | "I am able to do my job to a standard I am personally pleased with" | 79 | 80 | 77 |
| | **Opportunities to develop potential at work** | | | |
| | % agreeing / strongly agreeing with the following statements: | | | |
| Q4a | "There are frequent opportunities for me to show initiative in my role" | 72 | 73 | 65 |
| Q4b | "I am able to make suggestions to improve the work of my team / department" | 77 | 75 | 74 |
| Q4c | "I am involved in deciding on changes introduced that affect my work area / team / department" | 55 | 53 | 55 |
| Q4d | "I am able to make improvements happen in my area of work" | 58 | 56 | 59 |
| Q4e | "I am able to meet all the conflicting demands on my time at work" | 44 | 43 | - |
| Q4f | "I have adequate materials, supplies and equipment to do my work" | 54 | 54 | 48 |
| Q4g | "There are enough staff at this organisation for me to do my job properly" | 28 | 29 | 29 |
| Q4h | "The team I work in has a set of shared objectives" | 75 | 72 | - |
| Q4i | "The team I work in often meets to discuss the team's effectiveness" | 61 | 61 | - |
| Q4j | "Team members have to communicate closely with each other to achieve the team's objectives" | 78 | 78 | - |
| | **Staff job satisfaction** | | | |
| | % satisfied or very satisfied with the following aspects of their job: | | | |
| Q5a | "The recognition I get for good work" | 52 | 51 | 48 |
| Q5b | "The support I get from my immediate manager" | 68 | 67 | 67 |
| Q5c | "The support I get from my work colleagues" | 84 | 81 | 80 |
| Q5d | "The amount of responsibility I am given" | 75 | 75 | 75 |
| Q5e | "The opportunities I have to use my skills" | 73 | 72 | 74 |
| Q5f | "The extent to which my organisation values my work" | 42 | 42 | 40 |
| Q5g | "My level of pay" | 36 | 37 | 31 |
| Q5h | "The opportunities for flexible working patterns" | 49 | 49 | - |

| | | Your Trust in 2015 | Average (median) for combined acute and community trusts | Your Trust in 2014 |
|---|---|---|---|---|
| | **Contribution to patient care** | | | |
| | % agreeing / strongly agreeing with the following statements: | | | |
| Q6a | "I am satisfied with the quality of care I give to patients / service users" | 80 | 82 | - |
| Q6b | "I feel that my role makes a difference to patients / service users" | 90 | 90 | - |
| Q6c | "I am able to deliver the patient care I aspire to" | 65 | 67 | - |
| | **Your managers** | | | |
| | % agreeing / strongly agreeing with the following statements: | | | |
| Q7a | "My immediate manager encourages those who work for her/him to work as a team" | 73 | 73 | 69 |
| Q7b | "My immediate manager can be counted on to help me with a difficult task at work" | 71 | 70 | 71 |
| Q7c | "My immediate manager gives me clear feedback on my work" | 60 | 59 | 63 |
| Q7d | "My immediate manager asks for my opinion before making decisions that affect my work" | 54 | 53 | 53 |
| Q7e | "My immediate manager is supportive in a personal crisis" | 77 | 74 | 76 |
| Q7f | "My immediate manager takes a positive interest in my health and well-being" | 68 | 65 | - |
| Q7g | "My immediate manager values my work" | 72 | 71 | - |
| Q8a | "I know who the senior managers are here" | 82 | 82 | 78 |
| Q8b | "Communication between senior management and staff is effective" | 39 | 38 | 33 |
| Q8c | "Senior managers here try to involve staff in important decisions" | 31 | 30 | 24 |
| Q8d | "Senior managers act on staff feedback" | 29 | 28 | 23 |
| | **Health and well-being** | | | |
| Q9a | % saying their organisation definitely takes positive action on health and well-being | 27 | 29 | - |
| Q9b | % saying they have have experienced musculoskeletal problems (MSK) in the last 12 months as a result of work activities | 23 | 25 | - |
| Q9c | % saying they have have felt unwell in the last 12 months as a result of work related stress | 36 | 36 | 36 |
| Q9d | % saying in the last three months they had gone to work despite not feeling well enough to perform their duties | 59 | 62 | 62 |
| | If attended work despite not feeling well enough (YES to Q9d), % saying they... | | | |
| Q9e | ...had felt pressure from their manager to come to work | 27 | 28 | 28 |
| Q9f | ...had felt pressure from their colleagues to come to work | 18 | 21 | 24 |
| Q9g | ...had put themselves under pressure to come to work | 92 | 92 | 89 |
| | **Working hours** | | | |
| Q10a | % working part time (up to 29 hours a week) | 26 | 24 | 27 |
| Q10b | % working additional PAID hours | 27 | 31 | 30 |
| Q10c | % working additional UNPAID hours | 59 | 60 | 58 |
| | **Witnessing and reporting errors, near misses and incidents** | | | |
| Q11a | % witnessing errors, near misses or incidents in the last month that could have hurt staff | 15 | 16 | 17 |

| | | Your Trust in 2015 | Average (median) for combined acute and community trusts | Your Trust in 2014 |
|---|---|---|---|---|
| Q11b | % witnessing errors, near misses or incidents in the last month that could have hurt patients / service users | 22 | 25 | 28 |
| Q11c | If they witnessed an error, near miss or incident that could have hurt staff or patients / service users (YES to Q11a or YES to Q11b), % saying the last time this happened, either they or a colleague had reported it | 94 | 95 | 92 |
| | **Fairness and effectiveness of procedures for reporting errors, near misses or incidents** | | | |
| | % agreeing / strongly agreeing with the following statements: | | | |
| Q12a | "My organisation treats staff who are involved in an error, near miss or incident fairly" | 53 | 52 | - |
| Q12b | "My organisation encourages us to report errors, near misses or incidents" | 90 | 87 | - |
| Q12c | "When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again" | 68 | 68 | - |
| Q12d | "We are given feedback about changes made in response to reported errors, near misses and incidents" | 51 | 52 | - |
| | **Raising concerns about unsafe clinical practice** | | | |
| Q13a | % saying if they were concerned about unsafe clinical practice they would know how to report it | 93 | 94 | 91 |
| | % agreeing / strongly agreeing with the following statements: | | | |
| Q13b | "I would feel secure raising concerns about unsafe clinical practice" | 67 | 69 | 71 |
| Q13c | "I am confident that the organisation would address my concern" | 57 | 56 | 59 |
| | **Experiencing and reporting physical violence at work** | | | |
| | % experiencing physical violence at work from patients / service users, their relatives or other members of the public in last 12 months... | | | |
| Q14a | Never | 90 | 86 | 89 |
| Q14a | 1 to 2 times | 6 | 9 | 5 |
| Q14a | 3 to 5 times | 2 | 3 | 3 |
| Q14a | 6 to 10 times | 1 | 1 | 0 |
| Q14a | More than 10 times | 1 | 1 | 2 |
| | % experiencing physical violence at work from managers in last 12 months... | | | |
| Q14b | Never | 100 | 99 | - |
| Q14b | 1 to 2 times | 0 | 0 | - |
| Q14b | 3 to 5 times | 0 | 0 | - |
| Q14b | 6 to 10 times | 0 | 0 | - |
| Q14b | More than 10 times | 0 | 0 | - |
| | % experiencing physical violence at work from other colleagues in last 12 months... | | | |
| Q14c | Never | 99 | 98 | - |
| Q14c | 1 to 2 times | 1 | 1 | - |
| Q14c | 3 to 5 times | 0 | 0 | - |
| Q14c | 6 to 10 times | 0 | 0 | - |
| Q14c | More than 10 times | 0 | 0 | - |
| Q14d | (If YES to Q14a, Q14b or Q14c) % saying the last time they experienced an incident of physical violence, either they or a colleague had reported it | 64 | 66 | 82 |

| | | Your Trust in 2015 | Average (median) for combined acute and community trusts | Your Trust in 2014 |
|---|---|---|---|---|
| | **Experiencing and reporting harassment, bullying and abuse at work** | | | |
| | % experiencing harassment, bullying or abuse at work from patients / service users, their relatives or other members of the public in last 12 months... | | | |
| Q15a | Never | 79 | 73 | 76 |
| Q15a | 1 to 2 times | 14 | 17 | 12 |
| Q15a | 3 to 5 times | 4 | 6 | 6 |
| Q15a | 6 to 10 times | 1 | 2 | 1 |
| Q15a | More than 10 times | 2 | 2 | 5 |
| | % experiencing harassment, bullying or abuse at work from managers in last 12 months... | | | |
| Q15b | Never | 90 | 87 | - |
| Q15b | 1 to 2 times | 7 | 9 | - |
| Q15b | 3 to 5 times | 2 | 2 | - |
| Q15b | 6 to 10 times | 0 | 1 | - |
| Q15b | More than 10 times | 1 | 1 | - |
| | % experiencing physical violence at work from other colleagues in last 12 months... | | | |
| Q15c | Never | 86 | 82 | - |
| Q15c | 1 to 2 times | 10 | 13 | - |
| Q15c | 3 to 5 times | 3 | 3 | - |
| Q15c | 6 to 10 times | 1 | 1 | - |
| Q15c | More than 10 times | 1 | 1 | - |
| Q15d | (If YES to Q15a, Q15b or Q15c) % saying the last time they experienced an incident of harassment, bullying or abuse, either they or a colleague had reported it | 44 | 44 | 51 |
| | **Equal opportunities** | | | |
| Q16 | % saying the organisation acts fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age | 87 | 87 | 92 |
| | **Discrimination** | | | |
| Q17a | % saying they had experienced discrimination from patients / service users, their relatives or other members of the public in the last 12 months | 3 | 4 | 5 |
| Q17b | % saying they had experienced discrimination from their manager / team leader or other colleagues in the last 12 months | 4 | 7 | 4 |
| | % saying they had experienced discrimination on the grounds of: | | | |
| Q17c | Ethnic background | 2 | 3 | 2 |
| Q17c | Gender | 1 | 2 | 1 |
| Q17c | Religion | 0 | 0 | 0 |
| Q17c | Sexual orientation | 0 | 0 | 0 |
| Q17c | Disability | 0 | 1 | 0 |
| Q17c | Age | 1 | 2 | 1 |
| Q17c | Other reason(s) | 3 | 3 | 3 |
| | **Job-relevant training, learning and development** | | | |
| Q18a | % having received non-mandatory training, learning or development in the last 12 months | 72 | 73 | - |

| | | Your Trust in 2015 | Average (median) for combined acute and community trusts | Your Trust in 2014 |
|---|---|---|---|---|
| | % who had received training, learning and development in the last 12 months (YES to Q18a) agreeing / strongly agreeing with the following statements: | | | |
| Q18b | "It has helped me to do my job more effectively" | 84 | 83 | - |
| Q18c | "It has helped me stay up-to-date with professional requirements" | 86 | 87 | - |
| Q18d | "It has helped me to deliver a better patient / service user experience" | 80 | 82 | - |
| Q19 | % who had received mandatory training in the last 12 months | 85 | 97 | - |
| | **Appraisals** | | | |
| Q20a | % saying they had received an appraisal or performance development review in the last 12 months | 77 | 86 | 89 |
| | If (YES to Q20a) had received an appraisal or performance development review in the last 12 months: | | | |
| Q20b | % saying their appraisal or development review definitely helped them to improve how they do their job | 19 | 19 | - |
| Q20c | % saying their appraisal or development review definitely helped them agree clear objectives for their work | 33 | 32 | - |
| Q20d | % saying their appraisal or development review definitely made them feel their work was valued by the organisation | 30 | 27 | - |
| Q20e | % saying the values of their organisation were definitely discussed as part of the appraisal | 37 | 29 | - |
| Q20f | % saying their appraisal or development review had identified training, learning or development needs | 66 | 69 | 65 |
| | If (YES to Q20a) had received an appraisal or performance development review AND (YES to Q20f) training, learning or development needs identified as part of their appraisal or development review: | | | |
| Q20g | % saying their manager definitely supported them to receive training, learning or development | 56 | 52 | - |
| | **Your organisation** | | | |
| | % agreeing / strongly agreeing with the following statements: | | | |
| Q21a | "Care of patients / service users is my organisation's top priority" | 76 | 73 | 69 |
| Q21b | "My organisation acts on concerns raised by patients / service users" | 73 | 72 | 71 |
| Q21c | "I would recommend my organisation as a place to work" | 61 | 58 | 56 |
| Q21d | "If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation" | 73 | 67 | 65 |
| | **Patient / service user experience measures** | | | |
| | % saying 'Yes' | | | |
| Q22a | "Is patient / service user experience feedback collected within your directorate / department?" | 90 | 91 | 92 |
| | If patient / service user feedback collected (YES to Q22a), % agreeing or strongly agreeing with the following statements: | | | |
| Q22b | "I receive regular updates on patient / service user experience feedback in my directorate / department" | 62 | 58 | 62 |
| Q22c | "Feedback from patients / service users is used to make informed decisions within my directorate / department" | 60 | 54 | 59 |
| | **BACKGROUND DETAILS** | | | |
| | Gender | | | |
| Q23a | Male | 17 | 19 | 18 |
| Q23a | Female | 83 | 81 | 82 |

| | | Your Trust in 2015 | Average (median) for combined acute and community trusts | Your Trust in 2014 |
|---|---|---|---|---|
| | Age group | | | |
| Q23b | Between 16 and 30 | 13 | 15 | 9 |
| Q23b | Between 31 and 40 | 19 | 20 | 17 |
| Q23b | Between 41 and 50 | 29 | 28 | 26 |
| Q23b | 51 and over | 38 | 38 | 49 |
| | Ethnic background | | | |
| Q24 | White | 92 | 90 | 94 |
| Q24 | Mixed | 1 | 1 | 0 |
| Q24 | Asian / Asian British | 4 | 5 | 4 |
| Q24 | Black / Black British | 1 | 1 | 1 |
| Q24 | Chinese | 0 | 0 | 0 |
| Q24 | Other | 1 | 1 | 0 |
| | Sexuality | | | |
| Q25 | Heterosexual (straight) | 92 | 92 | 89 |
| Q25 | Gay Man | 1 | 1 | 1 |
| Q25 | Gay Woman (lesbian) | 1 | 1 | 2 |
| Q25 | Bisexual | 0 | 0 | 0 |
| Q25 | Other | 0 | 0 | 0 |
| Q25 | Preferred not to say | 6 | 6 | 7 |
| | Religion | | | |
| Q26 | No religion | 31 | 29 | 25 |
| Q26 | Christian | 59 | 58 | 66 |
| Q26 | Buddhist | 0 | 0 | 1 |
| Q26 | Hindu | 1 | 1 | 0 |
| Q26 | Jewish | 0 | 0 | 0 |
| Q26 | Muslim | 2 | 2 | 1 |
| Q26 | Sikh | 0 | 0 | 0 |
| Q26 | Other | 2 | 1 | 0 |
| Q26 | Preferred not to say | 5 | 5 | 6 |
| | Disability | | | |
| Q27a | % saying they have a long-standing illness, health problem or disability | 12 | 17 | 16 |
| Q27b | If long-standing disability (YES to Q27a and if adjustments felt necessary), % saying their employer has made adequate adjustment(s) to enable them to carry out their work | 81 | 73 | 59 |
| | Length of time at the organisation (or its predecessors) | | | |
| Q28 | Less than 1 year | 9 | 8 | 5 |
| Q28 | 1 to 2 years | 10 | 12 | 8 |
| Q28 | 3 to 5 years | 12 | 14 | 12 |
| Q28 | 6 to 10 years | 24 | 20 | 23 |
| Q28 | 11 to 15 years | 18 | 17 | 19 |
| Q28 | More than 15 years | 26 | 28 | 32 |

| | | Your Trust in 2015 | Average (median) for combined acute and community trusts | Your Trust in 2014 |
|---|---|---|---|---|
| | Occupational group | | | |
| Q29 | Registered Nurses and Midwives | 26 | 29 | 25 |
| Q29 | Nursing or Healthcare Assistants | 6 | 7 | 4 |
| Q29 | Medical and Dental | 5 | 8 | 5 |
| Q29 | Allied Health Professionals | 17 | 15 | 16 |
| Q29 | Scientific and Technical / Healthcare Scientists | 6 | 7 | 7 |
| Q29 | Social Care staff | 0 | 0 | 0 |
| Q29 | Emergency Care Practitioner | 0 | 0 | 0 |
| Q29 | Paramedic | 0 | 0 | 0 |
| Q29 | Emergency Care Assistant | 0 | 0 | 0 |
| Q29 | Ambulance Technician | 0 | 0 | 0 |
| Q29 | Ambulance Control Staff | 0 | 0 | 0 |
| Q29 | Patient Transport Service | 0 | 0 | 0 |
| Q29 | Public Health / Health Improvement | 0 | 0 | 1 |
| Q29 | Commissioning staff | 0 | 0 | 0 |
| Q29 | Admin and Clerical | 22 | 15 | 20 |
| Q29 | Central Functions / Corporate Services | 6 | 6 | 5 |
| Q29 | Maintenance / Ancillary | 6 | 4 | 7 |
| Q29 | General Management | 3 | 2 | 5 |
| Q29 | Other | 4 | 3 | 7 |
| | Team working | | | |
| Q30a | % working in a team | 95 | 96 | - |
| | (If YES to Q30a): Number of core members in their team | | | |
| Q30b | 2-5 | 26 | 22 | - |
| Q30b | 6-9 | 24 | 21 | - |
| Q30b | 10-15 | 18 | 19 | - |
| Q30b | More than 15 | 33 | 37 | - |

## Appendix 4

## Other NHS staff survey 2015 documentation

This report is one of several ways in which we present the results of the 2015 national NHS staff survey:

1) A separate summary report of the main 2015 survey results for Stockport NHS Foundation Trust can be downloaded from: www.nhsstaffsurveys.com. The summary report is a shorter version of this feedback report, which may be useful for wider circulation within the trust.

2) A national briefing document, describing the national Key Findings from the 2015 survey and making comparisons with previous years, will be available from www.nhsstaffsurveys.com in March 2015.

3) The document ***Making sense of your staff survey data***, which can be downloaded from www.nhsstaffsurveys.com. This includes details about the calculation of Key Findings and the data weighting method used.

4) A series of detailed spreadsheets are available on request from www.nhsstaffsurveys.com. In these detailed spreadsheets you can find:
    - responses of staff in your trust to every core survey question
    - responses in every trust in England
    - the average responses for each major trust type (e.g. all acute trusts, all ambulance trusts)
    - the average trust responses within each strategic health authority
    - the average responses for each major occupational and demographic group within the major trust types

This page has been left blank

Stockport NHS
NHS Foundation Trust

| | | | |
|---|---|---|---|
| **Report to:** | Board of Directors | **Date:** | 31st March 2016 |
| **Subject:** | Annual Budget Approval for 2016/17 | | |
| **Report of:** | Director of Finance | **Prepared by:** | Deputy Director of Finance |

# REPORT FOR APPROVAL

| | |
|---|---|
| **Corporate objective ref:** ----- | **Summary of Report**<br>To request approval of 2016/17 financial plan including planned cost improvements and capital expenditure.<br><br>To highlight the declarations which need to be submitted as part of the financial templates with the final submission, due on the 11th April 2016.<br><br>The Board are asked to approve for 2016/17<br>• Opening Annual Budgets<br>• CIP plan<br>• Capital Programme |
| **Board Assurance Framework ref:** ----- | |
| **CQC Registration Standards ref:** ----- | |
| **Equality Impact Assessment:** ☐ Completed ☐ Not required | |

| | |
|---|---|
| **Attachments:** | Appendix A – NHS Improvement declarations as part of operational plan submission |

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

**- THIS PAGE IS INTENTIONALLY BLANK -**

## 1. INTRODUCTION

1.1 The Trust is required to submit a one year operational plan for 2016/17 on the 11th April 2016. This plan is then operationalised into budgets for 2016/17, a Cost Improvement Programme (CIP) plan and a capital programme and these need to be approved by the Board.

1.2 The Trust Board has separately been presented with the operational plan for 2016/17 and this paper reads directly across to the narrative and financial analysis within this report.

## 2. BACKGROUND

2.1 The Trust has prepared its one year operational plan in accordance with the planning guidance set out in "Delivering the forward view: NHS Planning Guidance 2016/17 to 2020/21". The timetable for this is set out in Table 1 as follows:

Table 1

| Timetable | Date |
|---|---|
| Publication of planning guidance | 21st December 2015 |
| Publication of 2016/17 indicative prices | 22nd December 2015 |
| Issue technical annexes to planning guidance | January 2016 |
| First submission of full draft 16/17 Operational Plan | 8 February 2016 |
| Boards of providers and commissioners approve budgets and final plans | By 31 March 2016 |
| Submission of final 16/17 Operational Plans, aligned with contracts | 11th April 2016 |

2.2 The Annual Plan 2016/17 is presented under International Financial Reporting Standards.

## 3. CURRENT SITUATION

### 2016/17 Operational Plan – Draft plan

3.1 The Trust has experienced a financially challenging year in 2015/16 and is forecast to have a deficit of £13.3m. The levels of CIP needed to deliver financial security on a recurrent basis have not been achieved in year and this has a significant impact into 2016/17.

3.2 In order to address the deficit within the NHS, the planning guidance is based not only on providing a one year operational plan but also on producing a five year Sustainability & Transformation Plan. This looks at the wider economy within a health and social care sector to deliver system financial balance by 2020/21.

3.3 As part of the planning guidance, NHS Improvement has introduced a Sustainability & Transformation Fund (STF) for 2016/17 which is to support Trusts in reducing their deficit positions. The Trust received an offer of £8.4m from this fund but with the conditions that the Trust:

- Achieve a financial control total of a break-even position

- Achieve a performance trajectory on national targets e.g. A&E 4 hour
- Achieve a reduction in agency costs within a control total of £12.1m for 2016/17

3.4 The Board in private session in January 2016 considered the offer of the STF for 2016/17 and the risks associated with this. This was accepted by the Board and the draft operational plan was submitted on the 8th February 2016.

3.5 At the time of the draft submission of the operational plan, in order to deliver a break-even financial position the Trust must deliver a Cost Improvement Programme (CIP) of £28m. Table 2 gives a reconciliation between the forecast deficit of £13.3m to the funding requirement for 2016/17:

| Description | Operational Plan £m |
|---|---|
| 2015/16 forecast deficit | (13.3) |
| Non-recurrent CIP | (9.2) |
| Non-recurrent balance sheet support | (1.7) |
| Tameside & Glossop Divestment | (2.3) |
| 2015/16 normalised performance | (26.5) |
| Tariff 2016/17 – inflator | 3.3 |
| Pay uplift (include pay award, employers cost increases & pension change impact) | (6.6) |
| Non pay uplift (contractual obligations) | (0.9) |
| CNST uplift | (0.8) |
| Total national mandates | (5.0) |
| EPR | (1.8) |
| Other developments including nurse recruitment | (2.4) |
| Loan repayments / Public Dividend Capital | (0.7) |
| Total agreed developments | (4.9) |
| TOTAL DEFICIT BEFORE COST IMPROVEMENT PROGRAMME | (36.4) |
| CIP plan requirement | 28.0 |
| Sustainability & Transformation Fund | 8.4 |
| PLANNED SURPLUS / (DEFICIT) FOR 2016/17 | 0 |

**Explanations of key components of the Operational Plan**

3.6 In "normalising" the financial position from 2015/16, non-recurrent items need to be removed and this year these have included the non-recurrent achievement of CIP, the release of unutilised provisions from the balance sheet and a shortfall in the contribution which the Tameside & Glossop Community services made to the Trust which is no longer available after transfer to Tameside Foundation Trust.

3.7 The draft tariff for 2016/17 recognises inflation rather than the deflation seen in previous financial years and based on the predicted out-turn activity position for 2015/16 results in an increase of £3.3m. The final tariff is due before the 31st March 2016 but is not predicted to change.

3.8 However whilst the tariff recognises inflation, the actual costs to the Trust of the increase in pay is £6.6m. This includes a 1% pay award which has recently been confirmed in the last

week as well as an estimate for medical pay award, which including the negotiation of the junior doctors contract is not finalised. Also included is the removal of an earnings rebate for Employer's National Insurance contribution and this has increased costs by £4.1m.

3.9 The Trust is obliged to pay an increase in CNST premiums, which is the Trust's clinical negligence scheme. This will increase by £0.8m in 2016/17. The Trust also has a number of other contractually obligation inflationary increases which total £0.9m.

3.10 The Trust has a number of other developments which it is has approved during 2015/16 which have a financial impact in 2016/17 and these include the Electronic Patient Record (EPR), international recruitment for doctors and nurses, investment in Consultants for Paediatrics and General Surgery and the opening of the Surgical Centre in October 2016.

3.11 The Trust took out an additional loan from the Independent Trust Financing Facility (ITFF) in January 2016 and the repayments of this and the impact of additional depreciation and public dividend capital (PDC) for all areas is an additional £0.7m.

**Updates from NHS Improvement on the draft plan and changes since the draft submission**

3.12 Due to the sensitivity of operational plans in 2016/17 and the level of deficits, NHS Improvement reviewed the plans of a significant number of Foundation Trust in order to gain assurance on the processes followed and the deliverability of the plans submitted. The Trust received a full day visit on Friday 4th March 2016.

3.13 Confirmation was received by the Trust on the 8th March 2016 that due to the donated asset income that was considered non-recurrent in 2015/16, that the "control total" offer for the STF would be revised to give the Trust an allowed deficit of £1m in 2016/17.

3.14 The Trust is in the process of finalising additional financial support from Stockport CCG and Stockport MBC, conditional upon the Trust delivering a £20m CIP and therefore receiving the £8.4m STF. It is expected that this will not be finalised by the date of the Board meeting on the 31st March 2016 and therefore approval will need to be delegated to the Finance & Investment Committee on the 8th April 2016 to approve the operational plan before submission on the 11th April 2016.

**2016/17 Operational Plan – Revised position as at 23rd March 2016**

3.15 The summary operational plan as at the 23rd March 2016 can be summarised in Table 3

**Table 3**

| Description | Operational Plan £m |
|---|---|
| Original deficit 2016/17 | (36.4) |
| Sustainability & Transformation Fund (STF) | 8.4 |
| Reduction due to donated assets adjustment to control total | 1.0 |
| Additional financial support from Stockport partners | 5.0 |
| Technical financial support – linked to balance sheet | 2.0 |
| **Revised CIP requirement for 2016/17** | **20.0** |

3.16 The initial opening budgets for 2016/17 can be shown in Table 4. The left table is shown without CIP and the right table is shown after the CIP plan.

**Table 4**

| UNDERLYING POSITION EXCLUDING CRP | Trust Annual Plan 2016/17 £k |
|---|---|
| **INCOME** | |
| Total Income at Full Tariff | 159,415 |
| Clinical Income - NHS | 242,416 |
| Non NHS Clinical Income | 1,027 |
| Other Income | 37,393 |
| **TOTAL INCOME** | **280,835** |
| **EXPENDITURE** | |
| Pay Costs | (212,687) |
| Non-Pay Costs | (74,340) |
| **TOTAL COSTS** | **(287,027)** |
| **EBITDA** | **(6,192)** |
| Financing Costs | (14,762) |
| **RETAINED SURPLUS / (DEFICIT) FOR PERIOD** | **(20,954)** |

| INITIAL 2016/17 OPENING BUDGETS | Trust Annual Plan 2016/17 £k |
|---|---|
| **INCOME** | |
| Total Income at Full Tariff | 159,415 |
| Clinical Income - NHS | 242,416 |
| Non NHS Clinical Income | 1,027 |
| Other Income | 39,510 |
| **TOTAL INCOME** | **282,953** |
| **EXPENDITURE** | |
| Pay Costs | (199,357) |
| Non-Pay Costs | (69,787) |
| **TOTAL COSTS** | **(269,144)** |
| **EBITDA** | **13,808** |
| Financing Costs | (14,762) |
| **RETAINED SURPLUS / (DEFICIT) FOR PERIOD** | **(954)** |

3.17 The Financial Sustainability Risk Rating (FSRR) which is generated from the operational plan can be shown in Table 5:

**Table 5**

| Financial Sustainability Risk Rating | 2015/16 Out-turn | 2016/17 Plan |
|---|---|---|
| Capital Service Capacity rating | 1 | 3 |
| Liquidity rating | 4 | 4 |
| I&E Margin rating | 1 | 3 |
| I&E Margin Variance rating | 3 | 3 |
| Financial Sustainability Risk Rating before overrides | 2 | 3 |
| 1 Rating Trigger for FSRR | Trigger | No Trigger |
| **Overall Financial Sustainability Risk Rating** | **2** | **3** |
| Cash (£m) | 29.7 | 25.0 |

3.18 A reconciliation of the cash position from forecast out-turn for 2015/16 to closing cash balance in 2016/17 is shown in Table 6:

**Table 6**

| Annual Plan Cashflow Summary | **2016/17 £m** |
|---|---|
| Opening Cash at 1st April 2016 | 29.7 |
| Income | 278.8 |
| Expenditure | (264.0) |
| **EBITDA** | **14.8** |
| Financing | (8.7) |
| Non Operating Expenses | (0.7) |
| Capital Programme 2016/17 | (10.0) |
| **Closing Cash at 31st March 2017** | **25.0** |

**Cost Improvement Programme**

3.19 The Cost Improvement Programme total requirement for 2016/17is £20m.

3.20 Under the lead of the Chief Operating Officer and the Director of Strategy, the Strategic Planning Team have developed a series of transformational schemes linked to the "Strategic Staircase", which along with a residual element of business as usual schemes will deliver the CIP 2016/17. At this stage £17.5m of CIP has been identified / allocated.

3.21 A revised governance structure for CIP reporting has been agreed and will commence in April 2016.

**Capital Programme**

3.22 The draft 2016/17 capital programme is summarised in Table 7.

**Table 7**

| CAPITAL | Trust Annual Plan 2016/17 £k |
|---|---|
| **Surgical Centre** | 5,000 |
| Building | 3,740 |
| Furniture & Fittings | 600 |
| Medical Equipment (partly donated) | 660 |
| | |
| **Electronic Patient Record (EPR)** | 1,673 |
| Purchased Software | 598 |
| Estate enabling works | 55 |
| Software finance lease | 1,020 |
| | |
| Medical Ward Refurbishments | 250 |
| Medical Equipment | 1,339 |
| Facilities Equipment | 135 |
| IT Hardware | 504 |
| IT Software | 299 |
| Estates - Backlog Maintenance | 125 |
| Estates - Other | 710 |
| **Total Capital Plan** | **10,035** |

This investment is funded by

| **Funded by:** | |
|---|---|
| Depreciation 2016/17 | 9,094 |
| Legacy and Donations | 540 |
| Cash reserve | 401 |
| **Total Funding** | **10,035** |

3.23 The capital programme is challenging for the coming year and prioritisation will have to be made on a number of schemes in order to deliver within the overall total.

## 4. DOWNSIDE SCENARIO MODELLING

4.1 Delivering a financial plan with a CIP requirement of 7.5% is a challenge to the organisation. One of the key risks for the Trust is the availability of cash in order to meet its operating requirements. In order to assess the risk of the key variables, which are delivery of the CIP plan and the receipt of the STF, Table 8 shows the impact of these risks:

**Table 8**

| Description | CIP delivery | Surplus / (Deficit) £m | Y/End cash position £m | FSRR |
|---|---|---|---|---|
| Draft operational plan 2016/17 | 20.0 | (1.0) | 25 | 3 |
| Scenario 1: Achieve 100% CIP<br>Fail to secure STF £8.4m<br>Non receipt of £5m locality support | 20.0 | (14.4) | 11.6 | 1 |
| Scenario 2 : Achieve 75% of CIP plan<br>Fail to secure STF £8.4m<br>Non receipt of £5m locality support | 15.0 | (19.4) | 6.6 | 1 |
| Scenario 3: Achieve 50% of CIP plan<br>Fail to secure STF £8.4m<br>Non receipt of £5m locality support | 10.0 | (24.4) | 1.6 | 1 |

4.2 The table above does not include a possible loan drawdown of £3m in the financial year; however it does demonstrate the need to deliver planned CIP and secure operational performance in order to receive the STF.

4.3 A formal Going Concern paper is scheduled to be presented to the Audit Committee on the 17th May 2016 and this will demonstrate that based on the modelling undertaken as part of setting the 2016/17 operational plan and the formulation of a 14-month cash flow, that the Trust still be considered a going concern. However given the sensitivity of the operational plan it is recommended that this be brought forward to the Board meeting in April 2016.

4.4 In the event that the Trust only delivers a £10m CIP and therefore the cash balances falls below £5m, the Trust will have to consider a number of mitigations:

- Reducing capital expenditure
- Request distress financing

## 5. DECLARATIONS

5.1 There are 5 declarations that are required as part of NHS Improvement's assurance process on submission of the operational plan. The declaration summary is attached as Appendix A.

5.2 The first declaration is the Continuity of Services (Condition 7) – Availability of Resources, requires the Board to declare that they have the required resources available to it in order to fulfil its obligations. The answer is either yes, no or yes with noted conditions. The

Board need to discuss the risks to the financial position for the Trust and agree a response.

5.3 The second declaration is whether or not the Trust requires interim or planned term support from the Department of Health. It is not expected that in 2016/17 that this will be required by the Trust as the Trust expects to still have working capital available, albeit on a reducing balance. The Trust will continue to carefully manage its cash position so that if this support is required that notification is made as early as possible.

5.4 The third declaration is the statement of factors taken into account in deciding the answer to the first declaration and therefore depends upon the agreed Trust response.

5.5 The fourth declaration is that there has been a senior management review of the templates completed and that any warning flags have been adequately explained. This review will be undertaken by the Director and Deputy Director of Finance.

5.6 The final declaration is that the operational plan for 2016/17 meets or exceeds the financial control total (£1.0m deficit) for 2016/17 and that the Board agrees to the conditions associated with the STF. These conditions relate to the financial delivery within the control total, agreed performance trajectory and compliance with the agency control total.

5.7 The Board are asked to consider the declarations and make initial decisions on them. They will also need to be reviewed at the Finance & Investment Committee on the 6th April 2016 in there is material changes to the figures.

## 6. RECOMMENDATIONS

6.1 The Board of Directors is asked to:

(a) Approve the plans presented as the initial opening budgets for 2016/17
(b) Approve the level of CIP target of £20m within the financial plan for 2016/17
(c) Approve the Capital Programme for 2016/17

6.2 The Board is asked to consider the responses to the declarations as part of the operational plan template submission.

6.3 The Board is asked to:

(a) Delegate authority to the Finance & Investment Committee on the 6th April 2016 to approve any amendments to this plan
(b) Delegate authority to the Finance & Investment Committee on the 6th April 2016 to approve the final declarations to be submitted.
(c) Consider an earlier consideration of the Going Concern paper for 2016/17 at April 2016 Board.

Appendix A

## Self Certification

**1 Continuity of services condition 7 - Availability of Resources**

EITHER:

**1a** After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.

OR

**1b** After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box in section 3, below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.

OR

**1c** In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.

**2 Declaration of interim and/or planned term support requirements**

The trust forecasts a requirement for Department of Health (DH) interim support or planned term support for the year ending 31 March 2017

Note: If interim support is forecast in the plan period, but was not required in the preceding year, the trust should contact its relationship team by 31 January 2016, and before including any amounts in their plan (unless the DH has already approved the interim support funding). Further information regarding the requirements for trusts forecasting a need for DH funding support can be found in the template guidance.

DH Support Not Required

**3 Statement of main factors taken into account in making the above declaration**

In making the above declaration, the main factors which have been taken into account, as stated in section 1b above, by the Board of Directors are as follows:

**4 Declaration of review of submitted data**

The board is satisfied that adequate governance measures are in place to ensure the accuract of data entered in this planning template.

We would expect that the template's validation checks are reviewed by senior management to ensure that there are no errors arising prior to submission and that any relevant flags within the template are adequately explained.

**5 Control Total and Sustainability & Transformation Fund Allocation**

The Board has submitted a final operational plan for 2016/17 that meets or exceeds the required financial control total for 2016/17 and the Board agrees to the conditions associated with the Sustainability and Transformation fund

**In signing to the right, the board is confirming that:**

**To the best of its knowledge, using its own processes and having assessed against Monitor's Risk Assessment Framework, the financial projections and other supporting material included in the completed Annual Plan Review Financial Template represent a true and fair view, are internally consistent with the operational and, where relevant, strategic commentaries, and are based on assumptions which the board believes to be credible.**

**Approved by:**

**Signature**

**Name**

**Capacity**

**Date**

**Signature**

**Name**

**Capacity**

**Date**

This page has been left blank

Stockport NHS
NHS Foundation Trust

| | | | |
|---|---|---|---|
| **Report to:** | Board of Directors | **Date:** | 31 March 2016 |
| **Subject:** | Full Operational Plan (FOP) Monitor submission | | |
| **Report of:** | James Sumner, Chief Operating Officer | **Prepared by:** | Andrea Gaukroger, Director of Strategy & Planning |

# REPORT FOR APPROVAL

| | |
|---|---|
| **Corporate objective ref:** Annual Requirement | **Summary of Report**<br><br>This report requests the Board of Directors to approve the Final Full Operational Plan 2016/17.<br><br>Submission of this plan to Monitor (which becomes part of NHS Improvement from 1 April 2016), is due by midday, 11 April 2016.<br><br>The Board of Directors are requested to;<br>• Approve the content of the Full Operational Plan 2016/17 prior to its submission to Monitor<br>• Note that in due course this version will be published on websites belonging to Monitor/NHS Improvement and the Trust |
| **Board Assurance Framework ref:** ----- | |
| **CQC Registration Standards ref:** ----- | |
| **Equality Impact Assessment:** ☒ Completed ☐ Not required | |

**Attachments:** Annex A – Final Operational Plan 2016/17

| | |
|---|---|
| **This subject has previously been reported to:** | ☐ Board of Directors<br>☐ Council of Governors<br>☐ Audit Committee<br>☒ Executive Team<br>☐ Quality Assurance Committee<br>☐ FI Committee<br>☐ Workforce & OD Committee<br>☒ SDC Committee<br>☐ Charitable Funds Committee<br>☐ Nominations Committee<br>☐ Remuneration Committee<br>☐ Joint Negotiating Council<br>☐ Other |

**- THIS PAGE IS INTENTIONALLY BLANK -**

## 1. INTRODUCTION

1.1 This report presents to the Board of Directors the public version of our Final Operational Plan 2016/17. Submission of this plan to Monitor (which becomes part of NHS Improvement from 1 April 2016), alongside a private version, is due by midday, 11 April 2016.

## 2. BACKGROUND

2.1 For the 2016/17 Monitor annual planning submission, the Trust is required to submit two Final Operational Plan narratives for 2016/17;

- A one year operational plan; a detailed response to a set of key considerations set out in *'Delivering the Forward View: NHS Shared Planning Guidance 2016/17'*; and
- A separate version of the final plan narrative, in a format suitable for external publication.

Both documents are required to be presented in a structure outlined by Monitor in their planning guidance.

## 3. CURRENT SITUATION

The attached public version of the Full Operational Plan, developed with Communications, will be submitted to Monitor on 11 April 2016.

## 4. RECOMMENDATIONS

The Board of Directors are requested to;

- Approve the content of the Public Full Operational Plan 2016/17 prior to its submission to Monitor
- Note that in due course this version will be published on websites belonging to Monitor/NHS Improvement and the Trust

**Andrea Gaukroger**
**Director of Strategy and Planning**

**Andrew Bailey**
**Head of Planning**

This page has been left blank

Stockport NHS
NHS Foundation Trust

# OPERATIONAL PLAN 2016/17

Your Health. Our Priority.



www.stockport.nhs.uk

# CONTENTS

# Operational Plan for 2016/17

## 1 INTRODUCTION

In our 2015/16 operational plan, the refreshed Trust strategy 2015-20 was described in detail. Our Board of Directors continues to be committed to our strategy, underpinned by our four strategic priorities;

- Quality
- Partnership
- Integration; and
- Efficiency

The strategy was communicated to stakeholders as a five year strategic plan.

During 2015/16 our Board supported the short and longer term delivery of the strategy through the reallocation of existing resources and investment in new resources, as identified in year one of the five year strategic plan.

We are required by NHS Improvement to update our annual operational plan for 2016/17. This must be based on key considerations, outlined by NHS Improvement, that we are required to address.

This document outlines what is happening externally to our Trust and what impact this has had internally. It provides an overview of our plans for activity, quality, workforce and finance. We also cover our new sustainability and transformation plans that will be submitted later in the year by the Stockport locality and what that means for us. Finally, we provide an overview of membership and elections to our council of governors.

### 1.1 External to our Trust

We continue to be involved in both regional and local strategic partnerships within health and social care. At a regional level, we are currently engaged in two strategic work programmes;

- The first is the South East Sector Partnership; a collaboration of acute providers for the South East of Greater Manchester to deliver the Healthier Together single service approach for emergency or planned high risk abdominal surgery; and
- The second is the significant Greater Manchester Devolution Strategic Plan; which aims to deliver an ambitious collective approach for better health and social care across Greater Manchester

The GM strategic plan *'Taking Charge of Our Health and Social Care'* endorsed by all 37 GM organisations is built upon 10 locality and provider plans. It outlines the vision for GM over the next five years. We believe that the four key areas of Greater Manchester focus are aligned to our Trust strategy and the Stockport locality plan, particularly in view of reduced length of stay and our multidisciplinary neighbourhood team approach to reform.

Locally, within the Stockport locality the multi-specialty community provider (MCP) Vanguard new model of care is being accelerated (under the banner of Stockport Together). This is led by the chief officers for health and social care in Stockport to implement an ambitious redesign of services within the Borough.

In Tameside and Glossop (T&G) community health services are being transferred from our trust into a T&G integrated care organisation from 1st April 2016. This was in line with our strategic plan and aligned to recommendations for the T&G integrated care organisation.

Other potential developments in the external landscape include emerging changes from the Derbyshire and East Cheshire health and social care economy.

All of these local and regional strategic changes gathered pace in 2015/16 and have increased in their potential to substantially affect our position in 2016/17 and therefore our strategic plans.

### 1.2 Internal to our Trust

During 2015/16 we have continued to build upon change that started in 2014/15, in order to be in the best position to deliver our strategic plan. Examples of this include:

- Delivered year 1 of strategy, invested in strategy and planning capability, as well as innovation resources
- Maintained a monthly focus on strategic issues at the Board meeting
- Held Board development sessions on enabling change, strengthening governance and understanding in areas such as the board assurance framework and risk appetite, as well as advancing the standardisation of sub-committees
- Appointed two non-executive directors with expertise in workforce and commercial activities
- Continued to strengthen the internal medical, clinical and managerial capacity and capability across the Trust, in order to become more resilient. This continues into 2016/17
- Improved our performance management accountability framework
- Invested in cultural assessment and development work with staff groups; and
- Adapted building plans for our new surgical centre, due to open 2016/17, to accommodate the Healthier Together decision to appoint us as one of four 'specialist' centres in Greater Manchester for emergency or planned high risk abdominal surgery

Artist's impression of our surgical centre due to open 2016/17

# 2 ACTIVITY PLANNING

In line with NHS Improvement guidance to take an integrated whole system approach, we are working closely with Stockport Clinical Commissioning Group to assess the level of growth and decline in activity. This is through looking at historic trends before assessing the impact of local health and social care economy wide developments.

### 2.1 Delivery of urgent care

Our Trust experienced issues similar to the majority of other hospitals nationally in that we did not achieve the A&E four-hour wait target for 2015/16, therefore we have invested in a number of resources including:

- A revised front end model
- Reconfiguration of the acute assessment unit; and
- 24 hour bed management and discharge co-ordinators

Addressing ongoing issues remains a high priority focus, in collaboration with the systems resilience group.

### 2.2 Achievement and recovery of national targets

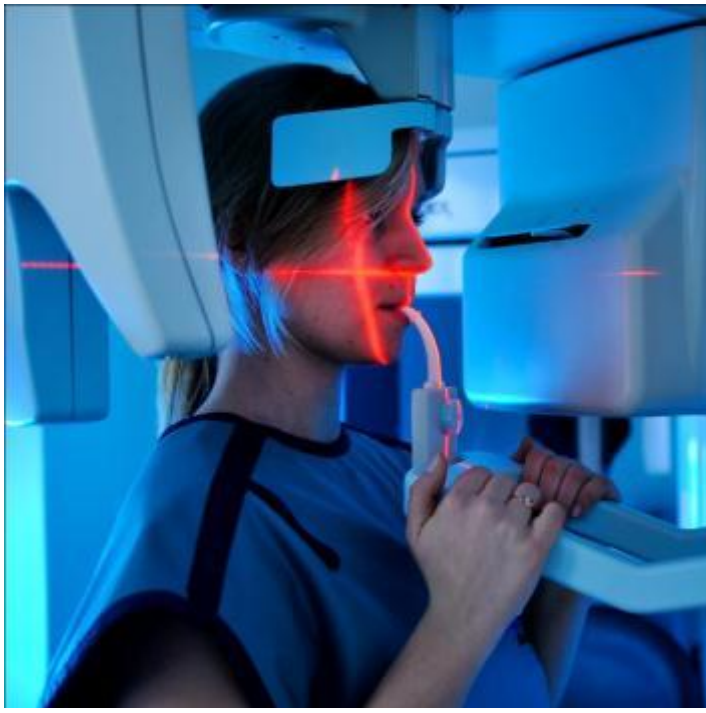
Referral to treatment and cancer targets were met in 2015/16. The resilient solution for A&E performance is for the Stockport Together Health & Social Care partnership programme to be fully implemented. Some of this work is about identifying and implementing long-term solutions, therefore our priorities for 2016/17 are based upon projects within our strategic work streams. These include:

- Improvements in length of stay
- Resilient staffing levels
- Improving discharge processes and reducing delays; and
- Diagnostic delays

We continue to make best use of our capacity to ensure continued performance against these standards in 2016/17.

### 2.3 Elective capacity

Our new flagship surgical centre is due to open in October 2016. This will include four new operating theatres to replace older facilities to help manage the growth seen in urology, general surgery and ENT (ear, nose and throat) over the past two years. This will also accommodate predicted growth under the Healthier Together programme.



### 2.4 Diagnostic capacity (imaging)

We have strengthened our diagnostic capacity in MR scanning and a new second permanent scanner was installed in February 2016. A replacement CT scanner was installed in March 2016 which will also bring more up-to-date technology and provide resilience to the services that CT scanning supports.

# 3 QUALITY PLANNING

We have set out our quality priorities, and associated approach to quality improvement, in our quality strategy. We aim to become one of the safest trusts in the NHS providing safe, high-quality care and achieving a good Care Quality Commission (CQC) rating. There are currently no outstanding quality concerns from the CQC.

### 3.1 Quality improvement

Good progress was made during 2015/16; these are reflected in the table below including our objectives for 2016/17. The priorities for 2016/17 will build on this work, with three key areas going forward being;

- Management of sepsis
- Reduction of avoidable serious falls; and
- Infection prevention

We will also be participating in the annual publication of avoidable deaths.

Our approach to introducing an organisation-wide improvement methodology was developed further during 2015/16 with the launch of our refreshed Trust strategy. Supporting our strategy is our innovation programme. Implementation of our strategy, supported by innovation, will be underpinned by a culture of strong leadership and clinical engagement. This is supported by the executive leads for quality improvement; the medical director and director of nursing and midwifery, as well as a focus on the well-led elements of the CQC framework. These elements include;

- Having an inspiring vision
- Clear lines of accountability and governance
- An open, transparent and innovative culture; and
- Strong staff and patient engagement

All of which have been further developed as a result of our new strategy.

***Progress against our quality improvement objectives***

| Project | Objectives 2015-16 | Achievements | Objectives 2016-17 |
|---|---|---|---|
| **Reduce mortality:** Sepsis | Establish the systems and processes to achieve compliance with sepsis guidelines | 1. Sepsis delivery group established<br>2. Sepsis pathway in emergency department established<br>3. Screening process at triage now in place<br>4. Interface developed between IT systems in emergency department and acute medical unit | To achieve full compliance with sepsis guidelines |
| **Reduce mortality:** Weekend mortality | Reduce Trust mortality weekend metrics | 1. Gap analysis of current Trust position against 7 day audit toolkit<br>2. Implementation of appropriate actions now within Stockport Together programme | To make significant progress in achieving 7-day working to improve weekend mortality |
| **Provide harm free care**: Pressure Ulcers | To ensure that the incidence of avoidable grade 3 and 4 pressure ulcers is reduced:<br>Acute: zero<br>Community: 12 | 1. Year to date incidence for Acute 3, Community 5<br>2. Database developed for accurate reporting<br>3. Pressure ulcer summit held November 2015<br>4. Updated guidelines implemented (NICE compliant)<br>5. PURIS project to establish whole health economy working<br>6. Annual mattress audit completed<br>7. Whole health economy equipment now standardised for discharged patients | To continue to work towards achieving zero incidence for acute, and <=10 for community of avoidable grade 3 and 4 pressure ulcers |
| **Provide harm free care:** Falls | To ensure that the incidence of avoidable serious falls is <=10 | 1. Year to date incidence 14<br>2. Database developed; awaiting Datix upgrade<br>3. Adopted 'stop, look and listen' approach following a fall<br>4. Use of a 'pictorial assessment prompt card' for patients<br>5. Review of ward environments ongoing (see dementia project) | To continue to work towards achieving <=10 avoidable serious falls |

| | | | |
|---|---|---|---|
| | | 6. Continued training on falls care bundle<br>7. Falls risk assessment transferring to hand-held electronic tool<br>8. Whole health economy working to avoid admissions and educate patients/carers | |
| **Provide harm free care:** VTE | Reduce by 50% hospital acquired venous thromboembolism (VTE) from 2014/15 baseline | 1. Year to date 2015/16 reduction of 10% achieved<br>2. Year to date compliance for root cause analysis (RCA) of VTE patients within 30 days of discharge 55% (target of 65%)<br>3. Continued to implement 'lessons learnt' | To continue to work towards a 50% reduction by implementing lessons from VTE RCAs |
| **Provide harm free care:** Medication errors | To work towards reducing medication incidents which cause harm by at least 50% from the 2014/15 baseline | 1. Year to date 2015/16 reduction of 30% achieved<br>2. Emphasis on promoting and standardising medication error reporting, associated investigation and audit across the Trust<br>3. Initial focus on reducing prescribing and administration errors relating to critical medicines (antibiotics, anticoagulants, anti-Parkinsonian drugs, insulin and controlled drugs)<br>4. Continued to engage with staff who prescribe and administer medicines to raise awareness of errors, review their training and promote lessons learned via the safe medicines practice group | To continue with all measures designed to reduce medication incidents which cause harm |
| **Provide harm free care:** Healthcare associated infections (HCAI) | To achieve the following targets:<br>a) Zero MRSA bacteraemias<br>b) Clostridium difficile – <=17 cases due to lapses in care<br>c) Compliance with VAP (ventilator associated pneumonia) care bundle<br>d) Reduced device related bacteraemias<br>e) Reduced catheter urinary tract infections (UTI) | 1. ANTT process reviewed; to be launched in April 2016<br>2. Catheter UTI group to reconvene February 2016<br>3. E-Learning package for all new prescribing staff on antibiotic stewardship<br>4. Review of products used for environmental cleaning<br>5. Compliant with regionally approved VAP bundle<br>6. Compliant with CRB SI bundle<br>7. All hospital C. diff. cases subject to serious incident investigation to identify lessons in care<br>8. All community acquired C. diff. cases (with hospital admission in last 3 months) subject to review by infection prevention Team<br>9. Continuing development of IC net system<br>10. Reviewed utilisation of side rooms and process for access<br>11. Alert systems for HCAIs now on Advantis system | To achieve both local and national HCAI targets |
| **Provide harm free care:** Diabetes | To review diabetes care to ensure safe and effective care for all patients with diabetes in hospital | 1. Additional diabetes specialist consultants and specialist nurses<br>2. Development of trust wide training need analysis regarding diabetes training; E-learning module on insulin management for medical and nursing staff<br>3. Identification of link nurses for diabetes and development of training to disseminate to staff in 'tool box' training<br>4. Specific focused training for wards involved in serious incidents<br>5. Community insulin administration guidelines reviewed<br>6. Development of the Trust diabetes microsite for staff<br>7. 'Think Insulin' campaign re-launched across the trust, with a link to the 'Think Glucose' campaign on the diabetes microsite<br>8. Clearer prescribing process for emergency department patients with diabetes | To embed the changes made during 2015-16 and achieve zero incidence of diabetes related serious incidents |
| **Provide reliable care:** Care bundles | Achieve full compliance with the Advancing Quality evidence-based care bundles for COPD, sepsis, AKI, ARLD and diabetes | 1. Achieved compliance with COPD and sepsis care bundles<br>2. Compliance with the AKI bundle has improved; shortfall is mainly around patient information leaflets<br>3. The ARLD care bundle has been implemented well with the exception of one measure and progress is being made<br>4. The diabetes care bundle is currently being reviewed by AQUA | To continue to embed evidence-based care bundles to achieve full compliance |
| **Provide reliable care:** Early warning score | Reduction in the numbers of cardiac arrests on wards from 2014/15 baseline | 1. Year to date 2015/16 30% reduction achieved<br>2. 'Patientrack' successfully introduced in medicine, surgery and maternity to record observations electronically<br>3. Continued to progress alerting functionality<br>4. Inpatient observation policy reviewed<br>5. Further progress on compliance with NICE Guidance<br>6. Continued to undertake RCA for all cardiac arrests<br>7. Observation training reviewed and in the clinical skills strategy | To continue to build on progress made during 2015-16 to further reduce cardiac arrests on wards |
| **Reduce hospital readmissions** | Reduction of 30-day hospital readmission rates for non-elective patients | 1. Key issues identified from audit intelligence<br>2. Significant progress made on COPD pathway, coding for early pregnancy unit pathway and readmissions following surgery (part of Trust innovation programme) | To build on the COPD pathway work through Stockport Together to improve further patient pathways |

| | | | |
|---|---|---|---|
| **Capturing and learning from patient and family feedback** | To continue to build capacity and opportunity to enable patients and their families to provide feedback on their care, resulting in learning and improvement | 1. Strengthened compliance with Friends and Family Test<br>2. Introduced 'Patient Voices' for emergency department attenders<br>3. Real-time feedback available to staff<br>4. IPad questions reviewed to reflect themes and trends<br>5. Quarterly report highlights changes to practice<br>6. Continued to work in partnership with local Healthwatch<br>7. Review of Trust's local 'user groups'; further work with AQUA<br>8. Process agreed for ensuring issues raised from patient feedback are included in training programmes as appropriate | To continue to build on progress made during 2015-16 to enable continued improvements based on feedback |
| **Providing care with dignity and compassion** | To utilise every opportunity to improve patients' experience of compassionate dignified care | **1.** All patient and family feedback monitored monthly and action taken on identified themes; quarterly reporting<br>**2.** Annual PLACE action plan implemented and 'mini' PLACE assessments undertaken throughout the year<br>**3.** Values based behaviours introduced through appraisals | To further develop all opportunities to improve patients' experience of compassionate dignified care |
| **Improve care for patients with dementia** | To review and re-launch the dementia strategy using whole health economy stakeholder engagement | 1. Dementia strategy reviewed, incorporating the outcomes of a stakeholder event held in August 2015; strategy launched October 2015<br>2. Signed up to national 'John's Campaign' to enable open visiting for carers; carers' passport and reduced parking charges<br>3. Environmental group introduced memory boxes, music therapy and therapeutic equipment across all inpatient wards and emergency department; dementia-friendly flooring on corridors<br>4. Therapeutic observation policy in development<br>5. Foundation of Nursing Studies £5000 grant for nurse specialing pilot | To continue to deliver the dementia strategy, including the introduction of a 'dementia ward' |
| **Complaints management and Duty of candour** | To continue to improve the complaints process based on patient and family feedback, and take account of any changing national guidance. | 1. Template for complaints responses improved from feedback<br>2. Continued with complaints training; effectiveness monitored<br>3. Continue to develop 'themes' in quarterly reports<br>4. Gap analysis against 'my expectations'<br>5. Action plan completion for all complaints (formal) to be rolled out as mandatory from February 2016 | To review management of complaints against NHS England 'A Quality Framework for Complaints' (2015) and PHSO 'Breaking down the Barriers'(2015) for further improvement, particularly for older people |

Quality and safety are improved through the year, not only as we work towards our strategic objectives, but also as a result of learning from other organisations. During 2015/16, executive and non-executive members of the Board participated in the 'Making Safety Visible' programme, run by Haelo/Greater Manchester Academic Health Science Network and sponsored by the Health Foundation. This centred on the 'framework for measuring and monitoring safety' and we have now used this to look at reducing emergency readmissions, with a particular focus on our local chronic obstructive pulmonary disease (COPD) patient pathway.

### 3.2 Seven day services

Our approach to seven day services has focused on reducing weekend mortality rates. Our plans for 2016/17, led by the medical director, are to consider the four Keogh standards directly linked with weekend mortality and to explore making progress in a financially challenged health economy.

# 4 WORKFORCE PLANNING

Workforce plans are fully aligned to our strategic direction and the wider health and social care economy. We have started to use the workforce repository and planning tool developed by GE Healthcare to better inform our workforce planning ability. External and internal strategic developments will fully incorporate the staffing plans across health and social care providers at locality level.

The workforce will be increasingly employed across traditional health and social care boundaries to deliver more integrated services. New roles are being considered to create a sustainable new model that enables person-centred care such as; generic health and social care roles, health coaches, care navigators and community based specialists.

We work closely with Health Education North West to ensure that the workforce supply and demand issues and challenges are effectively articulated through the planning process. This is in order to confirm the appropriate commission of further education places and role development.

We continue to successfully recruit international registered nurses, which has significantly reduced the vacancy rate for this staff group. Our plan for 2016/17 is to recruit 60 non EU registered nurses and a further 40 EU registered nurses. We will continue to run our own local recruitment campaigns.

'Hard to recruit' groups will be given priority when running targeted international and/or national recruitment campaigns. We also continue to look at alternative roles to medical staffing such as enhanced and advanced practitioners.

The workforce plan and workforce risks are regularly considered within our governance and assurance structure.

A number of initiatives we are undertaking in 2016/17 include:

- Develop the Trust as a socially inclusive employer
- Engage with academic institutions
- Maintain links with Jobcentre Plus
- Promote return to practice (nurses, health visitors and advanced nurse practitioners)
- Enable healthcare assistant secondment to nursing/ midwifery degrees
- Sponsor foundation degrees (substantive healthcare Assistants who are sponsored to complete foundation degrees)
- Explore new nursing associate roles
- Promote a career path to develop student district nurses and health visitors; and
- Continue to offer work experience

# 5 FINANCIAL PLANNING

## 5.1 Financial Performance

We faced an extremely challenging financial environment in 2015/16. The summary financial performance is summarised in the table below:

***Financial performance summary 2015/16***

| | Plan £m | Actual £m | Variance £m |
|---|---|---|---|
| Income | 301.1 | 305.0 | 3.9 |
| Expenditure | (300.9) | (305.1) | (4.2) |
| EBITDA | 0.2 | 0.0 | (0.2) |
| Non-Operating expenditure | (13.3) | (13.3) | 0.0 |
| Surplus / (Deficit) | (13.1) | (13.3) | (0.2) |
| Year end cash balance | 29.7 | 29.7 | 0.0 |
| CIP | 11.8 | 11.8 | |
| Capital Expenditure | 16.2 | 16.2 | |
| FSR rating | 2.0 | 2.0 | |

## 5.2 Financial Plans

Our financial plans for 2016/17 are summarised in the table below:

***Financial planning summary 2016/17***

| | £m |
|---|---|
| **2015-16 Forecast Out-turn Surplus / (Deficit)** | **(13.3)** |
| Non-recurrent CIP & balance sheet support | (10.9) |
| Tameside & Glossop Community Service divestment | (2.3) |
| National income and cost inflation | (5.0) |
| EPR development | (1.8) |
| Other cost pressures / developments inc. international recruitment | (3.1) |
| **Total business group forecast** | **(36.4)** |
| 2016/17 CIP requirement | 20.0 |
| Support from Stockport Partners | 5.0 |
| Technical improvement | 2.0 |
| **2016-17 Gross Forecast Surplus / (Deficit)** | **(9.4)** |
| Sustainability & Transformation Fund [STF] | 8.4 |
| **2016/17 Net Forecast Surplus / (Deficit)** | **(1.0)** |

## 5.3 Efficiency savings for 2016/17

In 2015/16 we achieved our ambitions for year one of the five year strategic plan. We have developed our savings plan for 2016/17, which incorporates recommendations from Lord Carter of Coles' review with regard to operational productivity.

### 5.4 Capital planning

The key capital investment programmes for this year are aligned to the 5 year strategic plan which was refreshed in 2015/16. Highlights of these developments are described below:

- **New surgical centre**

The Board approved a revised business case that proposed a change to the original design of the surgical centre in August 2015. This was in response to the decision by the Greater Manchester committees in common in July 2015 (upheld by judicial review in January 2016) that Stockport NHS Foundation Trust would be one of the four 'specialist' sites for emergency or planned high risk abdominal surgery in the Healthier Together reconfiguration.

The revised development will provide four new operating theatres and 120 new beds, enabling us to demolish part of the old infrastructure on the Stepping Hill site.

- **Endoscopy**

We have identified, in line with the national picture, the increased demand in 2016/17 to 2019/20 for endoscopy services. Our current service capacity is limited by poor estate. Plans are underway to develop land onsite to house endoscopy. This will allow old estate to be demolished.

- **Hospital Electronic Patient Record (EPR) and Community EPR**

We will commence implementation of a fully integrated patient administration system and an electronic patient record (EPR) in 2016. This is strategically important and a necessary investment in our future ability to deliver high quality care, enabled by a seamless, single patient record. We are introducing a community EPR system to support out of hospital care.

***Capital Programme 2016/17***

| | £m |
|---|---|
| **Property & Estates Schemes** | |
| Surgical Centre | 5,000 |
| Medical Ward Refurbishments | 250 |
| Estates - Backlog Maintenance | 125 |
| Estates - Other | 710 |
| | 6,085 |
| **Equipment Schemes** | |
| Plant and Equipment Other | 135 |
| Medical Equipment | 1,339 |
| | 1,474 |
| **I M & T Projects** | |
| EPR Finance Lease AUC | 1,020 |
| EPR Internal Capital | 653 |
| Other IM &T | 803 |
| | 2,476 |
| **Capital Programme 1617** | **10,035** |

# 6 SUSTAINABILITY AND TRANSFORMATION PLANS (STP)

As described in the introduction, we are very active in both regional and local health and social care system reform. For example, our chief executive is the Chair of the Greater Manchester NHS Provider Trust Federation Board, while our Chairman is the Chair of the Greater Manchester Trust Chair's Group. The refresh of our Trust strategy in 2015/16 aligned our strategy with the regional Greater Manchester devolution strategic plan, as well as the Stockport locality plan.

### 6.1 Regional Plans

The '*Five Year Forward View'* identified the vision for the future of the health system. Our position aligns with the triple aims of the Greater Manchester strategic plan: improved population health, quality of care and cost control, matched by triple integration of removing the boundaries between mental and physical health, primary and specialist services, health and social care. The Greater Manchester strategic plan '*Taking Charge of our Health and Social Care*', to which we have contributed, outlines the vision for the region over the next five years and beyond. It focuses on four key areas:

- A fundamental change in the way people and our communities take charge of, and responsibility for, their own health and wellbeing
- A focus on local care, and local care organisations, where doctors, nurses and other health professionals come together with social care professionals in co–located teams, in increasingly community based settings
- Hospitals across Greater Manchester working together to make sure expertise and experience can be shared widely; and
- Other changes, which will make sure standards are consistently high across Greater Manchester, and will generate significant financial efficiencies. For example, sharing back office functions across organisations, making best use of the public sector estate, investing in new technology and embedding research and innovation

### 6.2 Locality Plans

The health and social care organisations in Stockport see the next five years as a challenging but pivotal period. There is a strong desire to transform the way in which health and social care is delivered and to achieve improved outcomes as part of the Stockport Together plan.

We play a key role in the ongoing development of the Vanguard multi-specialty community provider (MCP) organisation. Stockport Together was selected as one of 15 areas nationwide to test the MCP model. Our work will inform the national agenda and learning around the reliability of the model. Locally, there has been high level endorsement of the partnership work.

The partner organisations within Stockport Together are our Trust, Stockport Clinical Commissioning Group, Stockport Metropolitan Borough Council, Pennine Care Foundation Trust and the GP Federation Viaduct. The Providers are working closely to develop a provider board for 2016/17.

The expected outcomes from Stockport Together are; healthier people, quality services and a sustainable system.

# 7 MEMBERSHIP AND ELECTIONS

The Council of Governors membership is achieved through an election cycle which results in a proportion of Council seats being subject to election on an annual basis. Any unscheduled vacancies that arise are also included in the annual elections. Elections during 2015/16 were held in the following constituencies:

- Community Staff - 1 staff governor
- Other Staff - 3 staff governors
- Tame Valley & Werneth - 4 public governors
- High Peak & Dales and Tameside & Glossop - 3 public governors
- Outer Region - 1 public governor
- Heatons & Victoria (vacancy) - 1 public governor

The elections took place between July and October 2015. All seats were filled with the exception of the community staff for which no nominations were received. Elections in the Tame Valley & Werneth, Outer Region and Heatons & Victoria constituencies were uncontested.

Elections are scheduled to be held in the following constituencies during 2016/17:

- Bramhall & Cheadle – 4 public governors
- Marple & Stepping Hill – 4 public governors

Our aim is to ensure that the elections in each of these constituencies are contested through a programme of awareness raising, publicity on the opportunities for members to become governors and prospective governor workshops.

We run a programme of events, on an annual basis, which provide governors with the opportunity to engage with both members and the public. This includes a series of health talk and tour and 'Members Week' which coincides with the Annual Members' Meeting. Governors are also able to engage through participation in member recruitment activities. Training and development has tended to be provided in-house, although governors do have the opportunity to participate in North West governor forum events.

# 8 CONCLUSION

This plan sets out the work we intend to deliver in 2016/17, whilst supporting the delivery of our five year strategic plan within the context of a new Greater Manchester and Stockport locality health and social care system.

This page has been left blank

Stockport NHS
NHS Foundation Trust

# Board of Directors' Key Issues Report

| | | |
|---|---|---|
| **Report Date:** 31/03/16 | | **Report of:** Workforce & Organisational Development Committee |
| **Date of last meeting:** 29/02/16 | | **Membership Numbers:** Quorate<br>Apologies from: David Baxter, Judith Morris. |
| 1. | Key Issues Highlighted: | The Committee considered an agenda which included the following:<br><br>• Staff Voice – Staff Story, "A successful Approach to Apprenticeships"<br>• Recruitment and Retention Strategy – Implementation Plan<br>• Leadership Strategy<br>• Draft Talent Management Strategy<br>• Workforce Plan Update<br>• Staff Survey Update Presentation<br>• Quarterly Workforce Report<br>• Workforce & OD Performance Targets 2016/17<br>• Apprenticeship Scheme Update<br>• Nursing Revalidation Update<br>• Consent agenda:<br>- MARS Report<br>- Critical Incident Report for Medical Trainees<br>- Industrial Action Assurance Report<br>- Corporate Risk Register<br>- Value Based Recruitment Update<br>- Occupational Health – SEQOHS Accreditation<br>- Policies for Validation<br>• Key Issues Reports from Reporting Groups<br><br>With regard to matters to bring to the attention of the Board, the Committee received a presentation from Jackie Cartwright (Business Manager, Estates & Facilities) and Mark Worrall (Contracts & Purchasing Manager) about the Trust's Apprenticeship Programme and was pleased to hear about Mr Worrall's first-hand experience of progressing through the programme, having initially started as an Apprentice at the Trust. The Committee also received a report which outlined the planned changes to the National Apprenticeship Scheme from April 2017. Specific reference was made to new apprenticeship standards and the introduction of an apprenticeship levy. The Committee approved a series of 'next steps' actions to facilitate a detailed review of the implications of the planned changes.<br><br>With regard to development of supporting strategies, the Committee considered a Recruitment & Retention Strategy Implementation Plan following the Board's approval of the Strategy at its meeting on 25 February 2016. The Implementation |

| | | |
|---|---|---|
| | | Plan would be regularly monitored by the Committee to ensure the implementation of the Strategy and the achievement of the required actions. The Committee also considered a final draft of the Leadership Strategy which it recommended for approval by the Board of Directors at its meeting on 31 March 2016. In addition, the Committee considered an early draft of a Talent Management Strategy and was invited to provide feedback on its content.<br><br>The Committee considered a report which provided an outline Workforce Plan, describing the anticipated internal and external drivers affecting the Trust's workforce over the next five years. The Committee noted that the document would be updated regularly to ensure that the Trust had a full understanding of its workforce while making strategic decisions. The Committee subsequently approved the Workforce Plan and endorsed a number of actions.<br><br>The Committee received a further presentation from the Head of Organisational Development & Learning on the outcomes of the 2015 Staff Survey which incorporated national figures that had been unavailable at the time of the Committee's previous meeting. The Committee approved a series of 'next steps' actions relating to multi-disciplinary analysis of outcomes and the cascade of Directorate specific results to Business Groups.<br><br>The Committee reviewed a Quarterly Performance Report which detailed performance against key workforce metrics during Quarter 3. The Committee noted deterioration from the position at Quarter 2 with metrics related to turnover (increase of 0.10%) and sickness absence (increase of 0.05%). Reference was made to an improved position with regard to metrics related to vacancy & establishment, bank & agency spend, appraisals and essentials training but the Committee noted that these were all still red-rated as at Quarter 2. The Committee considered the varying levels of compliance with regard to local induction and would continue to monitor this area in future meetings.<br><br>The Committee considered the current Workforce Key Performance Indicators (KPIs) and reviewed the proposed KPIs for 2016/17 which remained the same for Appraisal & PDR Compliance (95%) and Essential (Mandatory) Training Compliance (95%). The Committee considered the following proposed changes:<br><br>• Sickness Absence – target increased from 4% to 4.5%. It was noted that this was based on analysis of the last six years' performance and average year end position and the anticipated increase resulting from a review of medical staff absence.<br>• Turnover – removal of the 10% target. It was noted that turnover would be monitored against the North West national average and other benchmarking data to ensure that any adverse activity was identified.<br>• Inclusion of reporting on the following CCG contractual targets:<br>- Safeguarding Adults & Children Level 2 Training – Target 85%<br>- Mental Capacity Act & Deprivation of Liberties – Target 85%<br><br>The Committee subsequently approved the above Workforce KPIs for 2016/17 with effect from 1 April 2016.<br><br>The Committee received Key Issues Reports from the various Groups which report to the Committee. The Committee also considered a Nursing Revalidation Update Report and endorsed a recommendation for the management of non-compliance. Finally, the Committee noted the following items which had been included on a |

| | | | | |
|---|---|---|---|---|
| | | Consent Agenda and validated the necessary policy and procedure documents:<br><br>• MARS Report<br>• Critical Incident Report for Medical Trainees<br>• Industrial Action Assurance Report<br>• Corporate Risk Register<br>• Value Based Recruitment Update<br>• Occupational Health – SEQOHS Accreditation<br>• Recruitment & Selection Policy & Procedure<br>• Car Parking Policy<br>• Professional Registration Standard Operating Procedure | | |
| 2. | Risks Identified | Delivery of key performance indicators for 2016/17 | | |
| 3. | Actions to be considered at the *(insert appropriate place for actions to be considered)* | Nil | | |
| 4. | Report Compiled by | Carol Prowse, Chair | Minutes available from: | Company Secretary |

This page has been left blank

Stockport NHS
NHS Foundation Trust

# Board of Directors' Key Issues Report

| | | |
|---|---|---|
| **Report Date:** 31/03/16 | | **Report Of:** Audit Committee |
| **Date of last meeting:** 01/03/16 | | **Membership Numbers:** Quorate |
| 1. | Key Issues Highlighted: | The Committee considered an agenda which included the following:<br><br>▪ Internal Audit Progress Report<br>▪ Internal Audit Follow-Up Report<br>▪ Internal Audit Plan 2016/17<br>▪ Anti-Fraud Plan 2016/17<br>▪ External Audit Plan 2016/17<br>▪ Referral to Treatment (RTT) Audit Report<br>▪ Effectiveness of Risk Management Systems<br>▪ Accounting Policies<br>▪ Key Issues for Annual Accounts & Annual Report 2015/16<br>▪ Losses & Special Payments 2015/16<br>▪ Waiver Analysis Report<br>▪ Costing Process for Reference Cost Submission<br>▪ Code of Governance - Compliance Report<br>▪ Committee Work Plan 2016/17<br>▪ Integration with Other Committees<br><br>With regard to matters to bring to the attention of the Board, the Committee considered a progress report from Internal Audit which detailed outcomes as follows for audit work completed since the last meeting in November 2015:<br><br>▪ Monitoring Nursing Staffing Levels Review - Significant Assurance<br>▪ Payroll Review - Significant Assurance<br>▪ Surgical & Medical Block Review - High Assurance<br>▪ Catering Review - Significant Assurance<br><br>Board members are requested to note the positive outcomes from each of the above reviews and, in particular, should note the High Assurance assessment for the Surgical & Medical Block Review. The report considered by the Committee detailed numerous areas of best practice which were identified by auditors and there were no recommendations arising from the review. The Committee noted similarly positive performance relating to implementation of audit recommendations with no outstanding recommendations being detailed in the Internal Audit Follow-Up Report.<br><br>The Committee considered and approved the risk-based Internal Audit Plan for 2016/17 and endorsed the intention to complete audit reviews on the Cost |

| | | |
|---|---|---|
| | | Improvement Programme and Discharge Planning during Quarter 1 of 2016/17. The Committee also considered and approved the Anti-Fraud Plan for 2016/17 and noted work to review the content of Codes of Conduct in anticipation of a thematic review by NHS Protect during 2016/17. The Plan also includes proactive reviews of Waiting List Activity and the Consultant Job Planning process.<br><br>The Committee considered a report from External Audit which detailed the plan for the 2015/16 audit. The Committee discussed and noted the significant risks which will be areas for focus during the audit. These risks were:<br><br>▪ Recognition of NHS Revenue<br>▪ Property Revaluations<br>▪ Management Override of Controls<br><br>The Committee also considered the scope of work associated with the Value for Money conclusion and was assured that the significant risk around Going Concern would be covered by audit work in this area. The Committee noted audit requirements relating to the Quality Report which will include testing of indicators for; Reduction of Avoidable Falls, 4-hour A&E target and 18 week RTT. Board members will recall that the latter was also tested during the 2014/15 audit and resulted in a qualified opinion. As a result, the Committee has been regularly monitoring management actions to improve data quality in this area and considered the latest progress report on this subject during the meeting. There is an expectation that that the outcome of testing during the 2015/16 audit will be much improved.<br><br>Other audit-related items considered by the Committee were reports on Accounting Policies and Key Issues for consideration in preparation of the Annual Accounts and Annual Report. The Committee approved the recommendations in both reports. The Committee noted a Losses & Special Payments Report, which detailed a significant decrease in the value of losses in comparison with the previous year, and noted a periodic report relating to instances of Waivers of Standing Orders. With regard to the latter the Committee noted the positive effect of management action which had resulted in a significant reduction in the number of Waivers from September 2015. The Committee approved the Costing Process to support the Reference Costs Submission and noted that external assurance on the robustness of the Trust's systems in this area would be provided by an independent audit which is being conducted as part of a national audit programme on Reference Costs.<br><br>Finally, the Committee considered a report on the Effectiveness of Risk Management Systems and noted that a working group will be established to review risk reporting including the High profile Report, Annual Safety Report and Strategic / Corporate Risk Registers. The Committee endorsed this as a positive development. The Committee reviewed and approved the outcomes of a 6-monthly assessment of compliance with the Foundation Trust Code of Governance and is able to report positive assurance on current compliance levels. Board members should note that periodic review by the Committee will support Board approval of relevant compliance statements as part of the 2015/16 Annual Report. The Committee also approved its forward work plan for 2016/17 and is content that the areas covered will facilitate discharge of functions set out in the Committee's Terms of Reference. The meeting concluded with a discussion on Integration with Other Committees and it was noted that current composition ensures a good degree of |

| | | | | |
|---|---|---|---|---|
| | | 'cross over' with membership of the Assurance Committees. The insight provided by this cross over will be supplemented by Committee consideration of the minutes of other Committee meetings as a standing agenda item. | | |
| 2. | Risks Identified | Nil | | |
| 3. | Actions to be considered at the *(insert appropriate place for actions to be considered)* | Nil | | |
| 4. | Report Compiled by | John Sandford, Chair | Minutes available from: | Company Secretary |

This page has been left blank

Stockport NHS
NHS Foundation Trust

# Board of Directors' Key Issues Report

| | | |
|---|---|---|
| **Report Date:** 31/03/16 | | **Report of:** Finance & Investment Committee |
| **Date of last meeting:** 02/03/16 | | **Membership Numbers:** Quorate |
| 1. | Key Issues Highlighted: | The Committee considered an agenda which included the following:<br><br>▪ Pharmacy Shop Report<br>▪ Month 10 Financial Report<br>▪ Financial Position 2016/17<br>▪ Capital Report<br>▪ Surgical Centre Progress Report<br>▪ Governance Framework<br>▪ CIP Executive Group - Key Issues Report<br>▪ Health Informatics Steering Board - Key Issues Report<br>▪ PLICS System - Front End Demonstration<br>▪ Surgical Centre Progress Report<br><br>With regard to matters to bring to the attention of the Board, the primary focus of the meeting was on financial planning for 2016/17. The Committee considered reports from the Director of Finance and the Chief Operating Officer which related to the 'bridge' from 2015/16 financial outcomes to the planned financial position for 2016/17 and cost improvement planning respectively. The Committee was assured that the Trust remains on target to achieve the planned deficit of £13.3m for 2015/16 and noted measures being taken to deliver the year-end control total. The Committee also noted the benefit of enhanced Executive scrutiny through the CIP Executive Group in relation to delivery of Business Group control totals.<br><br>However, while the Committee was assured on the level of effort and focus being applied to financial modelling for 2016/17, it was noted that there remained a number of elements which were subject to confirmation and clarification such as; the contract agreement for 2016/17 and resolution of a significant residual pressure resulting from the divestment of Tameside & Glossop Community Services. The Committee emphasised the importance of achieving relevant clarifications in order to finalise the financial elements of the Operational Plan 2016/17 in advance of the Board meeting on 31 March 2016. The Committee also noted the importance of continued negotiations with partners to identify local health economy solutions to mitigate financial risks.<br><br>Board members should note that the level of cost improvement required in 2016/17 is certain to be extremely challenging with the likely need to identify efficiencies over and above those planned to be derived from the Strategic Staircase / Innovation Programmes. The report presented by the Chief Operating Officer |

| | | | | |
|---|---|---|---|---|
| | | detailed efficiencies identified to date with a value of circa £14m, with the majority of efficiencies phased to commence delivery from October 2016 onwards. The Committee endorsed the work completed to date, but emphasised the need to assess opportunities for earlier delivery where possible together with identification of additional efficiency schemes.<br><br>The Committee received a progress report on Pharmacy Shop operations from Mr M Taylor, Non-Executive Chairman. The Committee noted that the Pharmacy Shop is now well-established, is providing a good quality service for both patients and staff and that there are plans to further enhance the services provided. The Committee was advised of recent difficulties relating to the availability of financial management information but was provided with assurance by the Director of Finance on plans to address these difficulties.<br><br>The Committee considered a report on Capital Expenditure from the Director of Estates & Facilities and was assured that expenditure at Month 10 remained within Monitor's tolerance level of 15%. It is expected that this position will be maintained through to 31 March 2016. The Director of Estates & Facilities also presented a report detailing progress with development of the new Surgical Centre and the Committee was assured that there are no significant concerns associated with the build programme. The Committee also noted a report which detailed a refreshed governance framework for reporting of assurance and monitoring delivery of the Operational Plan. Finally, the Committee noted Key Issues Reports from the CIP Executive Group and Health Informatics Steering Board and members received a demonstration from the Chief Financial Analyst of a new 'front-end' model for the Patient-Level Information Costing System (PLICS). | | |
| 2. | Risks Identified | Financial position 2016/17<br>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:** | 31 March 2016 |
| **Subject:** | Proposed Amendments to the Trust's Constitution | | |
| **Report of:** | Company Secretary | **Prepared by:** | P Buckingham |

# REPORT FOR APPROVAL

| | | |
|---|---|---|
| **Corporate objective ref:** | N/A | **Summary of Report**<br>*Identify key facts, risks and implications associated with the report content.*<br><br>The purpose of this report is to present proposed amendments to the Trust's Constitution to the Board of Directors for approval. |
| **Board Assurance Framework ref:** | N/A | |
| **CQC Registration Standards ref:** | N/A | |
| **Equality Impact Assessment:** | ☐ Completed<br>X Not required | |

| | |
|---|---|
| **Attachments:** | Appendix 1 – Proposed Amendment: Staff Governors<br>Appendix 2 – Proposed Amendment: Senior Independent Director<br>Appendix 3 – Proposed Amendment: Model Election Rules |

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

**- THIS PAGE IS INTENTIONALLY BLANK -**

## 1. INTRODUCTION

1.1 The purpose of this report is to present proposed amendments to the Trust's Constitution to the Board of Directors for approval.

## 2. BACKGROUND

2.1 The current version of the Constitution was approved by the Council of Governors on 8 July 2014. Since this time, revised Model Election Rules have been published, which have yet to be incorporated in the Constitution, and matters arising in recent months have identified the need for amendments to particular sections of the Constitution.

## 3. CURRENT SITUATION

3.1 The proposed amendments, and the rationale for the amendments, are summarised below.

3.2 Staff Governors

At the Governance Committee meeting held on 18 January 2016, the Committee considered arrangements relating to a separate class of Staff Governor for Community Staff in view of the impending transfer of the Tameside & Glossop element of the Community Services Business Group. The Committee agreed that there should be just one class for the Staff Constituency which would be represented by a total of four Staff Governors. This change would necessitate amendments to Section 8, Annex 2 and Annex 3 of the Constitution. The proposed amendments are included for reference at Appendix 1 to this report.

3.3 Senior Independent Director

A recent meeting of the Nominations Committee considered appointments for the positions of Deputy Chair and Senior Independent Director and, in both cases, made appropriate recommendations to the Council of Governors. However, during consideration of this matter it was noted that Section 27 of the Constitution as currently drafted grants the Council of Governors a level of authority in respect of the Senior Independent Director appointment which is inconsistent with the Foundation Trust Code of Governance.

3.4 Code provision A.4.1 states that *In consultation with the Council of Governors, the Board should appoint one of the independent Non-Executive Directors to be the Senior Independent Director etc.* Section 27 of the Constitution states that any appointment of a Senior Independent Director shall require the approval of the Council of Governors. This is a clear inconsistency and the Nominations Committee agreed that the Constitution should be amended. A proposed amendment is included for reference at Appendix 2 to this report.

3.5 Model Election Rules

Board members should note that there is no requirement for the incorporation of revised Model Election Rules to be formally approved by the Council of Governors in accordance with Section 13 of the Constitution. However, this section itself needs to be amended and presentation as part of a 'package' of amendments will serve to bring the revised rules to the attention of both the Council of Governors and the Board of Directors. The proposed

amendment to Section 13 and a copy of the revised Model Election Rules are included for reference at Appendix 3.

3.6 Board members are requested to note that the revised rules provide for the option of using electronic voting systems for elections to the Council of Governors. It should be noted that, while the rules provide the option for use of such systems, use is not mandatory and is a matter for individual trusts to determine.

3.7 The proposed amendments were considered by the Governance Committee on 21 March 2016 and a recommendation was made to the Council of Governors for approval. Assuming that the proposed amendments are approved by the Board, a report seeking final approval will be presented at the Council of Governors meeting on 13 April 2016.

## 4. LEGAL IMPLICATIONS

4.1 There are no direct legal implications arising from the subject of this report. The arrangements for approval of proposed amendments i.e. approval by both the Board of Directors and Council of Governors are compliant with paragraph 44 of the Trust's Constitution.

## 5. RECOMMENDATIONS

5.1 The Board of Directors is recommended to:

- Approve the proposed amendments to the Trust's Constitution as detailed at Appendices 1-3 of the report.

## 8. Staff Constituency

**8.1** An individual who is employed by the Trust under a contract of employment with the Trust may become or continue as a member of the Trust provided:

**8.1.1** He/she is employed by the Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or

**8.1.2** He/she has been continuously employed by the Trust under a contract of employment for at least 12 months.

**8.2** Individuals who exercise functions for the purposes of the Trust under a contract of employment with a body other than the Trust may become or continue as members of the staff constituency provided such individuals have exercised these functions continuously for a period of at least 12 months. For the avoidance of doubt, this does not include those who assist or provide services to the Trust on a voluntary basis.

**8.3** Those individuals who are eligible for membership of the Trust by reason of the previous provisions are referred to collectively as the Staff Constituency.

**8.4** The Staff Constituency shall be divided into ~~two~~ descriptions of individuals who are eligible for membership of the Staff Constituency, each description of individuals being specified within Annex 2 and being referred to as a class within the Staff Constituency.

**8.5** The minimum number of members in each class of the Staff Constituency is specified in Annex 2.

## ANNEX 2 – THE STAFF CONSTITUENCY

There ***is one*** ~~are two~~ staff class~~es~~:

~~1) Community staff; and~~ 1) Staff - All individuals who satisfy the criteria for membership of the Staff Constituency in accordance with paragraphs 8.1 – 8.2 of the Constitution.

~~2) Other staff.~~

The minimum number of members of each class of the Staff Constituency is to be 16.

## ANNEX 3 – COMPOSITION OF COUNCIL OF GOVERNORS

The Council of Governors of the Trust is to comprise:

1. twenty Public Governors, from the following public constituencies:
   - 1.1 Bramhall and Cheadle – four Public Governors;
   - 1.2 Tame Valley and Werneth – four Public Governors;
   - 1.3 the Heatons and Victoria – four Public Governors;
   - 1.4 Marple and Stepping Hill – four Public Governors;
   - 1.5 High Peak and Dales and Tameside and Glossop – three Public Governors (two representing High Peak and Dales and one representing Tameside and Glossop); and
   - 1.6 Outer region – one Public Governor.

2. four Staff Governors from the following classes:
   - ~~2.1 Community Staff – one Staff Governor; and~~ Staff - All individuals who satisfy the criteria for membership of the Staff Constituency in accordance with paragraphs 8.1 – 8.2 of the Constitution.
   - ~~2.2 Other Staff – three Staff Governors.~~

3. One Local Authority Governor to be appointed by Stockport Metropolitan Borough Council.

4. Two Governors appointed by Anchorpoint.

5. One Governor appointed by Stockport College of Education – one Partnership Governor.

## 27. Board of Directors – appointment of deputy chairman and Senior Independent Director

**27.1** The Council of Governors shall appoint one of the non-executive Directors to be the Deputy Chairman of the Board of Directors. If the Chairman is unable to discharge their office as Chairman of the Trust, the Deputy Chairman of the Board of Directors shall be acting Chairman of the Trust.

**27.2** The Board of Directors may appoint a non-executive Director as a Senior Independent Director. The Senior Independent Director may be the Deputy Chairman.

~~**27.3**~~ Any appointment of a Senior Independent Director pursuant to the preceding paragraph ***shall be made following consultation with the Council of Governors.*** ~~shall require the approval of the Council of Governors.~~

## 13. Council of Governors – election of governors

**13.1** Elections for elected members of the Council of Governors shall be conducted in accordance with the Model Election Rules on a Single Transferable Vote basis.

~~**13.2** The Model Election Rules as published from time to time by the Department of Health form part of this constitution. The Model Election Rules current at the date of the Trust's authorisation are attached at Annex 4.~~ ***Elections shall be carried out in accordance with the Model Election Rules as published from time to time by NHS Providers. The Model Election Rules current at the date of this Constitution being approved are set out in Annex 4.***

**13.3** A subsequent variation of the Model Election Rules by ***NHS Providers*** ~~the Department of Health~~ shall not constitute a variation of the terms of this constitution for the purposes of paragraph **Error! Reference source not found.** of the constitution (amendment of the constitution).

**13.4** An election, if contested, shall be by secret ballot.

# MODEL ELECTION RULES 2014

*Procedure for receipt of envelopes, internet votes, telephone vote and text message votes*



**PART 6: COUNTING THE VOTES**



**PART 7: FINAL PROCEEDINGS IN CONTESTED AND UNCONTESTED ELECTIONS**



**PART 8: DISPOSAL OF DOCUMENTS**

**PART 9: DEATH OF A CANDIDATE DURING A CONTESTED ELECTION**



**PART 10: ELECTION EXPENSES AND PUBLICITY**

*Expenses*



*Publicity*



**PART 11: QUESTIONING ELECTIONS AND IRREGULARITIES**



**PART 12: MISCELLANEOUS**

## 1. Interpretation

1.1 In these rules, unless the context otherwise requires:

"*2006 Act*" means the National Health Service Act 2006;

"*corporation*" means the public benefit corporation subject to this constitution;

"*council of governors*" means the council of governors of the corporation;

"*declaration of identity*" has the meaning set out in rule 21.1;

"*election*" means an election by a constituency, or by a class within a constituency, to fill a vacancy among one or more posts on the council of governors;

"*e-voting*" means voting using either the internet, telephone or text message;

"*e-voting information*" has the meaning set out in rule 24.2;

"*ID declaration form*" has the meaning set out in Rule 21.1; "internet voting record" has the meaning set out in rule 26.4(d);

"*internet voting system*" means such computer hardware and software, data other equipment and services as may be provided by the returning officer for the purpose of enabling voters to cast their votes using the internet;

"*lead governor*" means the governor nominated by the corporation to fulfil the role described in Appendix B to The NHS Foundation Trust Code of Governance (Monitor, December 2013) or any later version of such code.

"*list of eligible voters*" means the list referred to in rule 22.1, containing the information in rule 22.2;

"*method of polling*" means a method of casting a vote in a poll, which may be by post, internet, text message or telephone;

"*Monitor*" means the corporate body known as Monitor as provided by section 61 of the 2012 Act;

"*numerical voting code*" has the meaning set out in rule 64.2(b)

"*polling website*" has the meaning set out in rule 26.1;

"*postal voting information*" has the meaning set out in rule 24.1;

"*telephone short code"* means a short telephone number used for the purposes of submitting a vote by text message;

"*telephone voting facility*" has the meaning set out in rule 26.2;

"*telephone voting record*" has the meaning set out in rule 26.5 (d);

"*text message voting facility*" has the meaning set out in rule 26.3;

"*text voting record*" has the meaning set out in rule 26.6 (d);

"*the telephone voting system*" means such telephone voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by telephone;

"*the text message voting system*" means such text messaging voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by text message;

"*voter ID number*" means a unique, randomly generated numeric identifier allocated to each voter by the Returning Officer for the purpose of e-voting,

"*voting information*" means postal voting information and/or e-voting information

1.2 Other expressions used in these rules and in Schedule 7 to the NHS Act 2006 have the same meaning in these rules as in that Schedule.

## 2. Timetable

2.1 The proceedings at an election shall be conducted in accordance with the following timetable:

| Proceeding | Time |
|---|---|
| Publication of notice of election | Not later than the fortieth day before the day of the close of the poll. |
| Final day for delivery of nomination forms to returning officer | Not later than the twenty eighth day before the day of the close of the poll. |
| Publication of statement of nominated candidates | Not later than the twenty seventh day before the day of the close of the poll. |
| Final day for delivery of notices of withdrawals by candidates from election | Not later than twenty fifth day before the day of the close of the poll. |
| Notice of the poll | Not later than the fifteenth day before the day of the close of the poll. |
| Close of the poll | By 5.00pm on the final day of the election. |

## 3. Computation of time

3.1 In computing any period of time for the purposes of the timetable:

(a) a Saturday or Sunday;

(b) Christmas day, Good Friday, or a bank holiday, or

(c) a day appointed for public thanksgiving or mourning,

shall be disregarded, and any such day shall not be treated as a day for the purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

3.2 In this rule, “bank holiday” means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales.

## 4. Returning Officer

4.1 Subject to rule 69, the returning officer for an election is to be appointed by the corporation.

4.2 Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

## 5. Staff

5.1 Subject to rule 69, the returning officer may appoint and pay such staff, including such technical advisers, as he or she considers necessary for the purposes of the election.

## 6. Expenditure

6.1 The corporation is to pay the returning officer:

(a) any expenses incurred by that officer in the exercise of his or her functions under these rules,

(b) such remuneration and other expenses as the corporation may determine.

## 7. Duty of co-operation

7.1 The corporation is to co-operate with the returning officer in the exercise of his or her functions under these rules.

## 8. Notice of election

8.1 The returning officer is to publish a notice of the election stating:

(a) the constituency, or class within a constituency, for which the election is being held,

(b) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(c) the details of any nomination committee that has been established by the corporation,

(d) the address and times at which nomination forms may be obtained;

(e) the address for return of nomination forms (including, where the return of nomination forms in an electronic format will be permitted, the e-mail address for such return) and the date and time by which they must be received by the returning officer,

(f) the date and time by which any notice of withdrawal must be received by the returning officer

(g) the contact details of the returning officer

(h) the date and time of the close of the poll in the event of a contest.

## 9. Nomination of candidates

9.1 Subject to rule 9.2, each candidate must nominate themselves on a single nomination form.

9.2 The returning officer:

(a) is to supply any member of the corporation with a nomination form, and

(b) is to prepare a nomination form for signature at the request of any member of the corporation,

but it is not necessary for a nomination to be on a form supplied by the returning officer and a nomination can, subject to rule 13, be in an electronic format.

## 10. Candidate's particulars

10.1 The nomination form must state the candidate's:

(a) full name,

(b) contact address in full (which should be a postal address although an e-mail address may also be provided for the purposes of electronic communication), and

(c) constituency, or class within a constituency, of which the candidate is a member.

**11. Declaration of interests**

11.1 The nomination form must state:

(a) any financial interest that the candidate has in the corporation, and

(b) whether the candidate is a member of a political party, and if so, which party,

and if the candidate has no such interests, the paper must include a statement to that effect.

**12. Declaration of eligibility**

12.1 The nomination form must include a declaration made by the candidate:

(a) that he or she is not prevented from being a member of the council of governors by paragraph 8 of Schedule 7 of the 2006 Act or by any provision of the constitution; and,

(b) for a member of the public or patient constituency, of the particulars of his or her qualification to vote as a member of that constituency, or class within that constituency, for which the election is being held.

**13. Signature of candidate**

13.1 The nomination form must be signed and dated by the candidate, in a manner prescribed by the returning officer, indicating that:

(a) they wish to stand as a candidate,

(b) their declaration of interests as required under rule 11, is true and correct, and

(c) their declaration of eligibility, as required under rule 12, is true and correct.

13.2 Where the return of nomination forms in an electronic format is permitted, the returning officer shall specify the particular signature formalities (if any) that will need to be complied with by the candidate.

**14. Decisions as to the validity of nomination**

14.1 Where a nomination form is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election unless and until the returning officer:

(a) decides that the candidate is not eligible to stand,

(b) decides that the nomination form is invalid,

(c) receives satisfactory proof that the candidate has died, or

(d) receives a written request by the candidate of their withdrawal from candidacy.

14.2 The returning officer is entitled to decide that a nomination form is invalid only on one of the following grounds:

(a) that the paper is not received on or before the final time and date for return of nomination forms, as specified in the notice of the election,

(b) that the paper does not contain the candidate's particulars, as required by rule 10;

(c) that the paper does not contain a declaration of the interests of the candidate, as required by rule 11,

(d) that the paper does not include a declaration of eligibility as required by rule 12, or

(e) that the paper is not signed and dated by the candidate, if required by rule 13.

14.3 The returning officer is to examine each nomination form as soon as is practicable after he or she has received it, and decide whether the candidate has been validly nominated.

14.4 Where the returning officer decides that a nomination is invalid, the returning officer must endorse this on the nomination form, stating the reasons for their decision.

14.5 The returning officer is to send notice of the decision as to whether a nomination is valid or invalid to the candidate at the contact address given in the candidate's nomination form. If an e-mail address has been given in the candidate's nomination form (in addition to the candidate's postal address), the returning officer may send notice of the decision to that address.

**15. Publication of statement of candidates**

15.1 The returning officer is to prepare and publish a statement showing the candidates who are standing for election.

15.2 The statement must show:

(a) the name, contact address (which shall be the candidate's postal address), and constituency or class within a constituency of each candidate standing, and

(b) the declared interests of each candidate standing,

as given in their nomination form.

15.3 The statement must list the candidates standing for election in alphabetical order by surname.

15.4 The returning officer must send a copy of the statement of candidates and copies of the nomination forms to the corporation as soon as is practicable after publishing the statement.

**16. Inspection of statement of nominated candidates and nomination forms**

16.1 The corporation is to make the statement of the candidates and the nomination forms supplied by the returning officer under rule 15.4 available for inspection by

members of the corporation free of charge at all reasonable times.

16.2 If a member of the corporation requests a copy or extract of the statement of candidates or their nomination forms, the corporation is to provide that member with the copy or extract free of charge.

## 17. Withdrawal of candidates

17.1 A candidate may withdraw from election on or before the date and time for withdrawal by candidates, by providing to the returning officer a written notice of withdrawal which is signed by the candidate and attested by a witness.

## 18. Method of election

18.1 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is greater than the number of members to be elected to the council of governors, a poll is to be taken in accordance with Parts 5 and 6 of these rules.

18.2 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of members to be elected to the council of governors, those candidates are to be declared elected in accordance with Part 7 of these rules.

18.3 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is less than the number of members to be elected to be council of governors, then:

(a) the candidates who remain validly nominated are to be declared elected in accordance with Part 7 of these rules, and

(b) the returning officer is to order a new election to fill any vacancy which remains unfilled, on a day appointed by him or her in consultation with the corporation.

**19. Poll to be taken by ballot**

19.1 The votes at the poll must be given by secret ballot.

19.2 The votes are to be counted and the result of the poll determined in accordance with Part 6 of these rules.

19.3 The corporation may decide that voters within a constituency or class within a constituency, may, subject to rule 19.4, cast their votes at the poll using such different methods of polling in any combination as the corporation may determine.

19.4 The corporation may decide that voters within a constituency or class within a constituency for whom an e-mail address is included in the list of eligible voters may only cast their votes at the poll using an e-voting method of polling.

19.5 Before the corporation decides, in accordance with rule 19.3 that one or more e-voting methods of polling will be made available for the purposes of the poll, the corporation must satisfy itself that:

(a) if internet voting is to be a method of polling, the internet voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate internet voting record in respect of any voter who casts his or her vote using the internet voting system;

(b) if telephone voting to be a method of polling, the telephone voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate telephone voting record in respect of any voter who casts his or her vote using the telephone voting system;

(c) if text message voting is to be a method of polling, the text message voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate text voting record in respect of any voter who casts his or her vote using the text message voting system.

**20. The ballot paper**

20.1 The ballot of each voter (other than a voter who casts his or her ballot by an e-voting method of polling) is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.

20.2 Every ballot paper must specify:

(a) the name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) instructions on how to vote by all available methods of polling, including the relevant voter's voter ID number if one or more e-voting methods of polling are available,

(f) if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll, and

(g) the contact details of the returning officer.

20.3 Each ballot paper must have a unique identifier.

20.4 Each ballot paper must have features incorporated into it to prevent it from being reproduced.

**21. The declaration of identity (public and patient constituencies)**

21.1 The corporation shall require each voter who participates in an election for a public or patient constituency to make a declaration confirming:

(a) that the voter is the person:

(i) to whom the ballot paper was addressed, and/or

(ii) to whom the voter ID number contained within the e-voting information was allocated,

(b) that he or she has not marked or returned any other voting information in the election, and

(c) the particulars of his or her qualification to vote as a member of the constituency or class within the constituency for which the election is being held,

("declaration of identity")

and the corporation shall make such arrangements as it considers appropriate to facilitate the making and the return of a declaration of identity by each voter, whether by the completion of a paper form ("ID declaration form") or the use of an electronic method.

21.2 The voter must be required to return his or her declaration of identity with his or her ballot.

21.3 The voting information shall caution the voter that if the declaration of identity is not duly returned or is returned without having been made correctly, any vote cast by the voter may be declared invalid.

*Action to be taken before the poll*

**22. List of eligible voters**

22.1 The corporation is to provide the returning officer with a list of the members of the constituency or class within a constituency for which the election is being held who are eligible to vote by virtue of rule 27 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

22.2 The list is to include, for each member:

(a) a postal address; and,

(b) the member's e-mail address, if this has been provided

to which his or her voting information may, subject to rule 22.3, be sent.

22.3 The corporation may decide that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list.

**23. Notice of poll**

23.1 The returning officer is to publish a notice of the poll stating:

(a) the name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the council of governors to be elected from that constituency, or class with that constituency,

(d) the names, contact addresses, and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) that the ballot papers for the election are to be issued and returned, if appropriate, by post,

(f) the methods of polling by which votes may be cast at the election by voters in a constituency or class within a constituency, as determined by the corporation in accordance with rule 19.3,

(g) the address for return of the ballot papers,

(h) the uniform resource locator (url) where, if internet voting is a method of polling, the polling website is located;

(i) the telephone number where, if telephone voting is a method of polling, the telephone voting facility is located,

(j) the telephone number or telephone short code where, if text message voting is a method of polling, the text message voting facility is located,

(k) the date and time of the close of the poll,

(l) the address and final dates for applications for replacement voting information, and

(m) the contact details of the returning officer.

**24. Issue of voting information by returning officer**

24.1 Subject to rule 24.3, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by post to each member of the corporation named in the list of eligible voters:

(a) a ballot paper and ballot paper envelope,

(b) the ID declaration form (if required),

(c) information about each candidate standing for election, pursuant to rule 61 of these rules, and

(d) a covering envelope;

("postal voting information").

24.2 Subject to rules 24.3 and 24.4, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by e-mail and/ or by post to each member of the corporation named in the list of eligible voters whom the corporation determines in accordance with rule 19.3 and/ or rule 19.4 may cast his or her vote by an e-voting method of polling:

(a) instructions on how to vote and how to make a declaration of identity (if required),

(b) the voter's voter ID number,

(c) information about each candidate standing for election, pursuant to rule 64 of these rules, or details of where this information is readily available on the internet or available in such other formats as the Returning Officer thinks appropriate, (d) contact details of the returning officer,

("e-voting information").

24.3 The corporation may determine that any member of the corporation shall:

(a) only be sent postal voting information; or

(b) only be sent e-voting information; or

(c) be sent both postal voting information and e-voting information;

for the purposes of the poll.

24.4 If the corporation determines, in accordance with rule 22.3, that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list, then the returning officer shall only send that information by e-mail.

24.5 The voting information is to be sent to the postal address and/ or e-mail address for each member, as specified in the list of eligible voters.

**25. Ballot paper envelope and covering envelope**

25.1 The ballot paper envelope must have clear instructions to the voter printed on it, instructing the voter to seal the ballot paper inside the envelope once the ballot paper has been marked.

25.2 The covering envelope is to have:

(a) the address for return of the ballot paper printed on it, and

(b) pre-paid postage for return to that address.

25.3 There should be clear instructions, either printed on the covering envelope or elsewhere, instructing the voter to seal the following documents inside the covering envelope and return it to the returning officer –

(a) the completed ID declaration form if required, and

(b) the ballot paper envelope, with the ballot paper sealed inside it.

**26. E-voting systems**

26.1 If internet voting is a method of polling for the relevant election then the returning officer must provide a website for the purpose of voting over the internet (in these rules referred to as "the polling website").

26.2 If telephone voting is a method of polling for the relevant election then the returning officer must provide an automated telephone system for the purpose of voting by the use of a touch-tone telephone (in these rules referred to as “the telephone voting facility”).

26.3 If text message voting is a method of polling for the relevant election then the returning officer must provide an automated text messaging system for the purpose of voting by text message (in these rules referred to as “the text message voting facility”).

26.4 The returning officer shall ensure that the polling website and internet voting system provided will:

(a) require a voter to:

(i) enter his or her voter ID number; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

in order to be able to cast his or her vote;

(b) specify:

(i) the name of the corporation,

(ii) the constituency, or class within a constituency, for which the election is being held,

(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(iv) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(v) instructions on how to vote and how to make a declaration of identity,

(vi) the date and time of the close of the poll, and

(vii) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("internet voting record") that is stored in the internet voting system in respect of each vote cast by a voter using the internet that comprises of-

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(iii) the candidate or candidates for whom the voter has voted; and

(iv) the date and time of the voter's vote,

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this; and

(f) prevent any voter from voting after the close of poll.

26.5 The returning officer shall ensure that the telephone voting facility and telephone voting system provided will:

(a) require a voter to

(i) enter his or her voter ID number in order to be able to cast his or her vote; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

(b) specify:

(i) the name of the corporation,

(ii) the constituency, or class within a constituency, for which the election is being held,

(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(iv) instructions on how to vote and how to make a declaration of identity,

(v) the date and time of the close of the poll, and

(vi) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("telephone voting record") that is stored in the telephone voting system in respect of each vote cast by a voter using the telephone that comprises of:

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(iii) the candidate or candidates for whom the voter has voted; and

(iv) the date and time of the voter's vote

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(f) prevent any voter from voting after the close of poll.

26.6 The returning officer shall ensure that the text message voting facility and text messaging voting system provided will:

(a) require a voter to:

(i) provide his or her voter ID number; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

in order to be able to cast his or her vote;

(b) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("text voting record") that is stored in the text messaging voting system in respect of each vote cast by a voter by text message that comprises of:

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(ii) the candidate or candidates for whom the voter has voted; and

(iii) the date and time of the voter's vote

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(f) prevent any voter from voting after the close of poll.

*The poll*

**27. Eligibility to vote**

27.1 An individual who becomes a member of the corporation on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

**28. Voting by persons who require assistance**

28.1 The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.

28.2 Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as he or she considers necessary to enable that voter to vote.

**29. Spoilt ballot papers and spoilt text message votes**

29.1 If a voter has dealt with his or her ballot paper in such a manner that it cannot be accepted as a ballot paper (referred to as a "spoilt ballot paper"), that voter may apply to the returning officer for a replacement ballot paper.

29.2 On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if he or she can obtain it.

29.3 The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless he or she:

(a) is satisfied as to the voter's identity; and

(b) has ensured that the completed ID declaration form, if required, has not been returned.

29.4 After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter in a list ("the list of spoilt ballot papers"):

(a) the name of the voter, and

(b) the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it), and

(c) the details of the unique identifier of the replacement ballot paper.

29.5 If a voter has dealt with his or her text message vote in such a manner that it cannot be accepted as a vote (referred to as a "spoilt text message vote"), that voter may apply to the returning officer for a replacement voter ID number.

29.6 On receiving an application, the returning officer is to obtain the details of the voter ID number on the spoilt text message vote, if he or she can obtain it.

29.7 The returning officer may not issue a replacement voter ID number in respect of a spoilt text message vote unless he or she is satisfied as to the voter's identity.

29.8 After issuing a replacement voter ID number in respect of a spoilt text message vote, the returning officer shall enter in a list ("the list of spoilt text message votes"):

(a) the name of the voter, and

(b) the details of the voter ID number on the spoilt text message vote (if that officer was able to obtain it), and

(c) the details of the replacement voter ID number issued to the voter.

**30. Lost voting information**

30.1 Where a voter has not received his or her voting information by the tenth day before the close of the poll, that voter may apply to the returning officer for replacement voting information.

30.2 The returning officer may not issue replacement voting information in respect of lost voting information unless he or she:

(a) is satisfied as to the voter's identity,

(b) has no reason to doubt that the voter did not receive the original voting information,

(c) has ensured that no declaration of identity, if required, has been returned.

30.3 After issuing replacement voting information in respect of lost voting information, the returning officer shall enter in a list ("the list of lost ballot documents"):

(a) the name of the voter

(b) the details of the unique identifier of the replacement ballot paper, if applicable, and

(c) the voter ID number of the voter.

**31. Issue of replacement voting information**

31.1 If a person applies for replacement voting information under rule 29 or 30 and a declaration of identity has already been received by the returning officer in the name of that voter, the returning officer may not issue replacement voting information unless, in addition to the requirements imposed by rule 29.3 or 30.2, he or she is also satisfied that that person has not already voted in the election, notwithstanding the fact that a declaration of identity if required has already been received by the returning officer in the name of that voter.

31.2 After issuing replacement voting information under this rule, the returning officer shall enter in a list ("the list of tendered voting information"):

(a) the name of the voter,

(b) the unique identifier of any replacement ballot paper issued under this rule;

(c) the voter ID number of the voter.

**32. ID declaration form for replacement ballot papers (public and patient constituencies)**

32.1 In respect of an election for a public or patient constituency an ID declaration form must be issued with each replacement ballot paper requiring the voter to make a declaration of identity.

*Polling by internet, telephone or text*

**33. Procedure for remote voting by internet**

33.1 To cast his or her vote using the internet, a voter will need to gain access to the polling website by keying in the url of the polling website provided in the voting information.

33.2 When prompted to do so, the voter will need to enter his or her voter ID number.

33.3 If the internet voting system authenticates the voter ID number, the system will give the voter access to the polling website for the election in which the voter is eligible to vote.

33.4 To cast his or her vote, the voter will need to key in a mark on the screen opposite the particulars of the candidate or candidates for whom he or she wishes to cast his or her vote.

33.5 The voter will not be able to access the internet voting system for an election once his or her vote at that election has been cast.

**34. Voting procedure for remote voting by telephone**

34.1 To cast his or her vote by telephone, the voter will need to gain access to the telephone voting facility by calling the designated telephone number provided in the voter information using a telephone with a touch-tone keypad.

34.2 When prompted to do so, the voter will need to enter his or her voter ID number using the keypad.

34.3 If the telephone voting facility authenticates the voter ID number, the voter will be prompted to vote in the election.

34.4 When prompted to do so the voter may then cast his or her vote by keying in the numerical voting code of the candidate or candidates, for whom he or she wishes to vote.

34.5 The voter will not be able to access the telephone voting facility for an election once his or her vote at that election has been cast.

**35. Voting procedure for remote voting by text message**

35.1 To cast his or her vote by text message the voter will need to gain access to the text message voting facility by sending a text message to the designated telephone number or telephone short code provided in the voter information.

35.2 The text message sent by the voter must contain his or her voter ID number and the numerical voting code for the candidate or candidates, for whom he or she wishes to vote.

35.3 The text message sent by the voter will need to be structured in accordance with the instructions on how to vote contained in the voter information, otherwise the vote will not be cast.

*Procedure for receipt of envelopes, internet votes, telephone votes and text message votes*

**36. Receipt of voting documents**

36.1 Where the returning officer receives:

(a) a covering envelope, or

(b) any other envelope containing an ID declaration form if required, a ballot

paper envelope, or a ballot paper,

before the close of the poll, that officer is to open it as soon as is practicable; and rules 37 and 38 are to apply.

36.2 The returning officer may open any covering envelope or any ballot paper envelope for the purposes of rules 37 and 38, but must make arrangements to ensure that no person obtains or communicates information as to:

(a) the candidate for whom a voter has voted, or

(b) the unique identifier on a ballot paper.

36.3 The returning officer must make arrangements to ensure the safety and security of the ballot papers and other documents.

**37. Validity of votes**

37.1 A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied that it has been received by the returning officer before the close of the poll, with an ID declaration form if required that has been correctly completed, signed and dated.

37.2 Where the returning officer is satisfied that rule 37.1 has been fulfilled, he or she is to:

(a) put the ID declaration form if required in a separate packet, and

(b) put the ballot paper aside for counting after the close of the poll.

37.3 Where the returning officer is not satisfied that rule 37.1 has been fulfilled, he or she is to:

(a) mark the ballot paper “disqualified”,

(b) if there is an ID declaration form accompanying the ballot paper, mark it “disqualified” and attach it to the ballot paper,

(c) record the unique identifier on the ballot paper in a list of disqualified documents (the “list of disqualified documents”); and

(d) place the document or documents in a separate packet.

37.4 An internet, telephone or text message vote shall not be taken to be duly returned unless the returning officer is satisfied that the internet voting record, telephone voting record or text voting record (as applicable) has been received by the returning officer before the close of the poll, with a declaration of identity if required that has been correctly made.

37.5 Where the returning officer is satisfied that rule 37.4 has been fulfilled, he or she is to put the internet voting record, telephone voting record or text voting record (as applicable) aside for counting after the close of the poll.

37.6 Where the returning officer is not satisfied that rule 37.4 has been fulfilled, he or she is to:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) "disqualified",

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents; and

(c) place the document or documents in a separate packet.

**38. Declaration of identity but no ballot paper (public and patient constituency)[1]**

38.1 Where the returning officer receives an ID declaration form if required but no ballot paper, the returning officer is to:

(a) mark the ID declaration form "disqualified",

(b) record the name of the voter in the list of disqualified documents, indicating that a declaration of identity was received from the voter without a ballot paper, and

(c) place the ID declaration form in a separate packet.

**39. De-duplication of votes**

39.1 Where different methods of polling are being used in an election, the returning officer shall examine all votes cast to ascertain if a voter ID number has been used more than once to cast a vote in the election.

39.2 If the returning officer ascertains that a voter ID number has been used more than once to cast a vote in the election he or she shall:

(a) only accept as duly returned the first vote received that was cast using the relevant voter ID number; and

(b) mark as "disqualified" all other votes that were cast using the relevant voter ID number

39.3 Where a ballot paper is disqualified under this rule the returning officer shall:

(a) mark the ballot paper "disqualified",

(b) if there is an ID declaration form accompanying the ballot paper, mark it "disqualified" and attach it to the ballot paper,

(c) record the unique identifier and the voter ID number on the ballot paper in the list of disqualified documents;

(d) place the document or documents in a separate packet; and

(e) disregard the ballot paper when counting the votes in accordance with these rules.

39.4 Where an internet voting record, telephone voting record or text voting record is disqualified under this rule the returning officer shall:

(a) mark the internet voting record, telephone voting record or text voting record

[1] It should not be possible, technically, to make a declaration of identity electronically without also submitting a vote.

(as applicable) “disqualified”,

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents;

(c) place the internet voting record, telephone voting record or text voting record (as applicable) in a separate packet, and

(d) disregard the internet voting record, telephone voting record or text voting record (as applicable) when counting the votes in accordance with these rules.

**40. Sealing of packets**

40.1 As soon as is possible after the close of the poll and after the completion of the procedure under rules 37 and 38, the returning officer is to seal the packets containing:

(a) the disqualified documents, together with the list of disqualified documents inside it,

(b) the ID declaration forms, if required,

(c) the list of spoilt ballot papers and the list of spoilt text message votes,

(d) the list of lost ballot documents,

(e) the list of eligible voters, and

(f) the list of tendered voting information

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

**STV41. Interpretation of Part 6**

STV41.1 In Part 6 of these rules:

"*ballot document*" means a ballot paper, internet voting record, telephone voting record or text voting record.

"*continuing candidate*" means any candidate not deemed to be elected, and not excluded,

"*count*" means all the operations involved in counting of the first preferences recorded for candidates, the transfer of the surpluses of elected candidates, and the transfer of the votes of the excluded candidates,

"*deemed to be elected*" means deemed to be elected for the purposes of counting of votes but without prejudice to the declaration of the result of the poll,

"*mark*" means a figure, an identifiable written word, or a mark such as "X",

"*non-transferable vote*" means a ballot document:

(a) on which no second or subsequent preference is recorded for a continuing candidate,

or

(b) which is excluded by the returning officer under rule STV49,

"*preference*" as used in the following contexts has the meaning assigned below:

(a) "first preference" means the figure "1" or any mark or word which clearly indicates a first (or only) preference,

(b) "next available preference" means a preference which is the second, or as the case may be, subsequent preference recorded in consecutive order for a continuing candidate (any candidate who is deemed to be elected or is excluded thereby being ignored); and

(c) in this context, a "second preference" is shown by the figure "2" or any mark or word which clearly indicates a second preference, and a third preference by the figure "3" or any mark or word which clearly indicates a third preference, and so on,

"*quota*" means the number calculated in accordance with rule STV46,

"*surplus*" means the number of votes by which the total number of votes for any candidate (whether first preference or transferred votes, or a combination of both) exceeds the quota; but references in these rules to the transfer of the surplus means the transfer (at a transfer value) of all transferable ballot documents from the candidate who has the surplus,

"*stage of the count*" means:

(a) the determination of the first preference vote of each candidate,
(b) the transfer of a surplus of a candidate deemed to be elected, or
(c) the exclusion of one or more candidates at any given time,

"*transferable vote*" means a ballot document on which, following a first preference, a second or subsequent preference is recorded in consecutive numerical order for a continuing candidate,

"*transferred vote*" means a vote derived from a ballot document on which a second or subsequent preference is recorded for the candidate to whom that ballot document has been transferred, and

"*transfer value*" means the value of a transferred vote calculated in accordance with rules STV47.4 or STV47.7.

**42. Arrangements for counting of the votes**

42.1 The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

42.2 The returning officer may make arrangements for any votes to be counted using vote counting software where:

(a) the board of directors and the council of governors of the corporation have approved:

(i) the use of such software for the purpose of counting votes in the relevant election, and

(ii) a policy governing the use of such software, and

(b) the corporation and the returning officer are satisfied that the use of such software will produce an accurate result.

**43. The count**

43.1 The returning officer is to:

(a) count and record the number of:

(iii) ballot papers that have been returned; and

(iv) the number of internet voting records, telephone voting records and/or text voting records that have been created, and

(b) count the votes according to the provisions in this Part of the rules and/or the provisions of any policy approved pursuant to rule 42.2(ii) where vote counting software is being used.

43.2 The returning officer, while counting and recording the number of ballot papers, internet voting records, telephone voting records and/or text voting records and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper or the voter

ID number on an internet voting record, telephone voting record or text voting record.

43.3 The returning officer is to proceed continuously with counting the votes as far as is practicable.

**STV44. Rejected ballot papers and rejected text voting records**

STV44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the ballot paper shall not be rejected by reason only of carrying the words "one", "two", "three" and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.2 The returning officer is to endorse the word "rejected" on any ballot paper which under this rule is not to be counted.

STV44.3 Any text voting record:

(a) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate,

(b) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(c) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the text voting record shall not be rejected by reason only of carrying the words "one", "two", "three" and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.4 The returning officer is to endorse the word "rejected" on any text voting record which under this rule is not to be counted.

STV44.5 The returning officer is to draw up a statement showing the number of ballot papers rejected by him or her under each of the subparagraphs (a) to (d) of rule STV44.1 and the number of text voting records rejected by him or her under each of the sub-paragraphs (a) to (c) of rule STV44.3.

**FPP44. Rejected ballot papers and rejected text voting records**

FPP44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which votes are given for more candidates than the voter is entitled to vote,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.2 and FPP44.3, be rejected and not counted.

FPP44.2 Where the voter is entitled to vote for more than one candidate, a ballot paper is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP44.3 A ballot paper on which a vote is marked:

(a) elsewhere than in the proper place,

(b) otherwise than by means of a clear mark,

(c) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the paper is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.4 The returning officer is to:

(a) endorse the word “rejected” on any ballot paper which under this rule is not to be counted, and

(b) in the case of a ballot paper on which any vote is counted under rules FPP44.2 and FPP 44.3, endorse the words “rejected in part” on the ballot paper and indicate which vote or votes have been counted.

FPP44.5 The returning officer is to draw up a statement showing the number of rejected ballot papers under the following headings:

(a) does not bear proper features that have been incorporated into the ballot paper,

(b) voting for more candidates than the voter is entitled to,

(c) writing or mark by which voter could be identified, and

(d) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of ballot papers rejected in part.

FPP44.6 Any text voting record:

(a) on which votes are given for more candidates than the voter is entitled to vote,

(b) on which anything is written or marked by which the voter can be identified except the voter ID number, or

(c) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.7 and FPP44.8, be rejected and not counted.

FPP44.7 Where the voter is entitled to vote for more than one candidate, a text voting record is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP448 A text voting record on which a vote is marked:

(a) otherwise than by means of a clear mark,

(b) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the text voting record is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.9 The returning officer is to:

(a) endorse the word “rejected” on any text voting record which under this rule is not to be counted, and

(b) in the case of a text voting record on which any vote is counted under rules FPP44.7 and FPP 44.8, endorse the words “rejected in part” on the text voting record and indicate which vote or votes have been counted.

FPP44.10 The returning officer is to draw up a statement showing the number of rejected text voting records under the following headings:

(a) voting for more candidates than the voter is entitled to,

(b) writing or mark by which voter could be identified, and

(c) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of text voting records rejected in part.

**STV45. First stage**

STV45.1 The returning officer is to sort the ballot documents into parcels according to the candidates for whom the first preference votes are given.

STV45.2 The returning officer is to then count the number of first preference votes given on ballot documents for each candidate, and is to record those numbers.

STV45.3 The returning officer is to also ascertain and record the number of valid ballot documents.

**STV46. The quota**

STV46.1 The returning officer is to divide the number of valid ballot documents by a number exceeding by one the number of members to be elected.

STV46.2 The result, increased by one, of the division under rule STV46.1 (any fraction being disregarded) shall be the number of votes sufficient to secure the election of a candidate (in these rules referred to as “the quota”).

STV46.3 At any stage of the count a candidate whose total votes equals or exceeds the quota shall be deemed to be elected, except that any election where there is only one vacancy a candidate shall not be deemed to be elected until the procedure set out in rules STV47.1 to STV47.3 has been complied with.

**STV47. Transfer of votes**

STV47.1 Where the number of first preference votes for any candidate exceeds the quota, the returning officer is to sort all the ballot documents on which first preference votes are given for that candidate into sub- parcels so that they are grouped:

(a) according to next available preference given on those ballot documents for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.2 The returning officer is to count the number of ballot documents in each parcel referred to in rule STV47.1.

STV47.3 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.1(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.4 The vote on each ballot document transferred under rule STV47.3 shall be at a value (“the transfer value”) which:

(a) reduces the value of each vote transferred so that the total value of all such votes does not exceed the surplus, and

(b) is calculated by dividing the surplus of the candidate from whom the votes are being transferred by the total number of the ballot documents on which those votes are given, the calculation being made to two decimal places (ignoring the remainder if any).

STV47.5 Where at the end of any stage of the count involving the transfer of ballot documents, the number of votes for any candidate exceeds the quota, the returning officer is to sort the ballot documents in the sub-parcel of transferred votes which was last received by that candidate into separate sub-parcels so that they are grouped:

(a) according to the next available preference given on those ballot documents for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.6 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.5(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.7 The vote on each ballot document transferred under rule STV47.6 shall be at:

(a) a transfer value calculated as set out in rule STV47.4(b), or

(b) at the value at which that vote was received by the candidate from whom it is now being transferred,

whichever is the less.

STV47.8 Each transfer of a surplus constitutes a stage in the count.

STV47.9 Subject to rule STV47.10, the returning officer shall proceed to transfer transferable ballot documents until no candidate who is deemed to be elected has a surplus or all the vacancies have been filled.

STV47.10 Transferable ballot documents shall not be liable to be transferred where any surplus or surpluses which, at a particular stage of the count, have not already been transferred, are:

(a) less than the difference between the total vote then credited to the continuing candidate with the lowest recorded vote and the vote of the candidate with the next lowest recorded vote, or

(b) less than the difference between the total votes of the two or more continuing candidates, credited at that stage of the count with the lowest recorded total numbers of votes and the candidate next above such candidates.

STV47.11 This rule does not apply at an election where there is only one vacancy.

**STV48. Supplementary provisions on transfer**

STV48.1 If, at any stage of the count, two or more candidates have surpluses, the transferable ballot documents of the candidate with the highest surplus shall be transferred first, and if:

(a) The surpluses determined in respect of two or more candidates are equal, the transferable ballot documents of the candidate who had the highest recorded vote at the earliest preceding stage at which they had unequal votes shall be transferred first, and

(b) the votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between those candidates by lot, and the transferable ballot documents of the candidate on whom the lot falls shall be transferred first.

STV48.2 The returning officer shall, on each transfer of transferable ballot documents under rule STV47:

(a) record the total value of the votes transferred to each candidate,

(b) add that value to the previous total of votes recorded for each candidate and record the new total,

(c) record as non-transferable votes the difference between the surplus and the total transfer value of the transferred votes and add that difference to the previously recorded total of non-transferable votes, and

(d) compare:

(i) the total number of votes then recorded for all of the candidates, together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

STV48.3 All ballot documents transferred under rule STV47 or STV49 shall be clearly marked, either individually or as a sub-parcel, so as to indicate the transfer value recorded at that time to each vote on that ballot document or, as the case may be, all the ballot documents in that sub-parcel.

STV48.4 Where a ballot document is so marked that it is unclear to the returning officer at any stage of the count under rule STV47 or STV49 for which candidate the next preference is recorded, the returning officer shall treat any vote on that ballot document as a non-transferable vote; and votes on a ballot document shall be so treated where, for example, the names of two or more candidates (whether continuing candidates or not) are so marked that, in the opinion of the returning officer, the same order of preference is indicated or the numerical sequence is broken.

**STV49. Exclusion of candidates**

STV49.1 If:

(a) all transferable ballot documents which under the provisions of rule STV47 (including that rule as applied by rule STV49.11) and this rule are required to be transferred, have been transferred, and

(b) subject to rule STV50, one or more vacancies remain to be filled,

the returning officer shall exclude from the election at that stage the candidate with the then lowest vote (or, where rule STV49.12 applies, the candidates with the then lowest votes).

STV9.2 The returning officer shall sort all the ballot documents on which first preference votes are given for the candidate or candidates excluded under rule STV49.1 into two sub-parcels so that they are grouped as:

(a) ballot documents on which a next available preference is given, and

(b) ballot documents on which no such preference is given (thereby including ballot documents on which preferences are given only for candidates who are deemed to be elected or are excluded).

STV49.3 The returning officer shall, in accordance with this rule and rule STV48, transfer each sub-parcel of ballot documents referred to in rule STV49.2 to the candidate for whom the next available preference is given on those ballot documents.

STV49.4 The exclusion of a candidate, or of two or more candidates together, constitutes a further stage of the count.

STV49.5 If, subject to rule STV50, one or more vacancies still remain to be filled, the returning officer shall then sort the transferable ballot documents, if any, which had been transferred to any candidate excluded under rule STV49.1 into sub- parcels according to their transfer value.

STV49.6 The returning officer shall transfer those ballot documents in the sub-parcel of transferable ballot documents with the highest transfer value to the continuing candidates in accordance with the next available preferences given on those ballot documents (thereby passing over candidates who are deemed to be elected or are excluded).

STV49.7 The vote on each transferable ballot document transferred under rule STV49.6 shall be at the value at which that vote was received by the candidate excluded under rule STV49.1.

STV9.8 Any ballot documents on which no next available preferences have been expressed shall be set aside as non-transferable votes.

STV49.9 After the returning officer has completed the transfer of the ballot documents in the sub-parcel of ballot documents with the highest transfer value he or she shall proceed to transfer in the same way the sub-parcel of ballot documents with the next highest value and so on until he has dealt with each sub-parcel of a candidate excluded under rule STV49.1.

STV49.10 The returning officer shall after each stage of the count completed under this rule:

(a) record:

(i) the total value of votes, or

(ii) the total transfer value of votes transferred to each candidate,

(b) add that total to the previous total of votes recorded for each candidate and record the new total,

(c) record the value of non-transferable votes and add that value to the previous non-transferable votes total, and

(d) compare:

(i) the total number of votes then recorded for each candidate together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

STV49.11 If after a transfer of votes under any provision of this rule, a candidate has a surplus, that surplus shall be dealt with in accordance with rules STV47.5 to STV47.10 and rule STV48.

STV49.12 Where the total of the votes of the two or more lowest candidates, together with any surpluses not transferred, is less than the number of votes credited to the next lowest candidate, the returning officer shall in one operation exclude such two or more candidates.

STV49.13 If when a candidate has to be excluded under this rule, two or more candidates each have the same number of votes and are lowest:

(a) regard shall be had to the total number of votes credited to those candidates at the earliest stage of the count at which they had an unequal number of votes and the candidate with the lowest number of votes at that stage shall be excluded, and

(b) where the number of votes credited to those candidates was equal at all stages, the returning officer shall decide between the candidates by lot and the candidate on whom the lot falls shall be excluded.

**STV50. Filling of last vacancies**

STV50.1 Where the number of continuing candidates is equal to the number of vacancies remaining unfilled the continuing candidates shall thereupon be deemed to be elected.

STV50.2 Where only one vacancy remains unfilled and the votes of any one continuing candidate are equal to or greater than the total of votes credited to other continuing candidates together with any surplus not transferred, the candidate shall thereupon be deemed to be elected.

STV50.3 Where the last vacancies can be filled under this rule, no further transfer of votes shall be made.

**STV51. Order of election of candidates**

STV51.1 The order in which candidates whose votes equal or exceed the quota are deemed to be elected shall be the order in which their respective surpluses were transferred, or would have been transferred but for rule STV47.10.

STV51.2 A candidate credited with a number of votes equal to, and not greater than, the quota shall, for the purposes of this rule, be regarded as having had the smallest surplus at the stage of the count at which he obtained the quota.

STV51.3 Where the surpluses of two or more candidates are equal and are not required to be transferred, regard shall be had to the total number of votes credited to such candidates at the earliest stage of the count at which they had an unequal number of votes and the surplus of the candidate who had the greatest number of votes at that stage shall be deemed to be the largest.

STV51.4 Where the number of votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between them by lot and the candidate on whom the lot falls shall be deemed to have been elected first.

**FPP51. Equality of votes**

FPP51.1 Where, after the counting of votes is completed, an equality of votes is found to exist between any candidates and the addition of a vote would entitle any of those candidates to be declared elected, the returning officer is to decide between those candidates by a lot, and proceed as if the candidate on whom the lot falls had received an additional vote.

**FPP52. Declaration of result for contested elections**

FPP52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidate or candidates whom more votes have been given than for the other candidates, up to the number of vacancies to be filled on the council of governors from the constituency, or class within a constituency, for which the election is being held to be elected,

(b) give notice of the name of each candidate who he or she has declared elected:

(i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the chairman of the NHS Trust, or

(ii) in any other case, to the chairman of the corporation; and

(c) give public notice of the name of each candidate whom he or she has declared elected.

FPP52.2 The returning officer is to make:

(a) the total number of votes given for each candidate (whether elected or not), and

(b) the number of rejected ballot papers under each of the headings in rule FPP44.5,

(c) the number of rejected text voting records under each of the headings in rule FPP44.10,

available on request.

**STV52. Declaration of result for contested elections**

STV52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidates who are deemed to be elected under Part 6 of these rules as elected,

(b) give notice of the name of each candidate who he or she has declared elected –

(i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the chairman of the NHS Trust, or

(ii) in any other case, to the chairman of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

STV52.2 The returning officer is to make:

(a) the number of first preference votes for each candidate whether elected or not,

(b) any transfer of votes,

(c) the total number of votes for each candidate at each stage of the count at which such transfer took place,

(d) the order in which the successful candidates were elected, and

(e) the number of rejected ballot papers under each of the headings in rule STV44.1,

(f) the number of rejected text voting records under each of the headings in rule STV44.3,

available on request.

**53. Declaration of result for uncontested elections**

53.1 In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election:

(a) declare the candidate or candidates remaining validly nominated to be elected,

(b) give notice of the name of each candidate who he or she has declared elected to the chairman of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

**54. Sealing up of documents relating to the poll**

54.1 On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets:

(a) the counted ballot papers, internet voting records, telephone voting records and text voting records,

(b) the ballot papers and text voting records endorsed with “rejected in part”,

(c) the rejected ballot papers and text voting records, and

(d) the statement of rejected ballot papers and the statement of rejected text voting records,

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

54.2 The returning officer must not open the sealed packets of:

(a) the disqualified documents, with the list of disqualified documents inside it,

(b) the list of spoilt ballot papers and the list of spoilt text message votes,

(c) the list of lost ballot documents, and

(d) the list of eligible voters,

or access the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage.

54.3 The returning officer must endorse on each packet a description of:

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the election relates.

**55. Delivery of documents**

55.1 Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 56, the returning officer is to forward them to the chair of the corporation.

**56. Forwarding of documents received after close of the poll**

56.1 Where:

(a) any voting documents are received by the returning officer after the close of

the poll, or

(b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent, or

(c) any applications for replacement voting information are made too late to enable new voting information to be issued,

the returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the chairman of the corporation.

**57. Retention and public inspection of documents**

57.1 The corporation is to retain the documents relating to an election that are forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the board of directors of the corporation, cause them to be destroyed.

57.2 With the exception of the documents listed in rule 58.1, the documents relating to an election that are held by the corporation shall be available for inspection by members of the public at all reasonable times.

57.3 A person may request a copy or extract from the documents relating to an election that are held by the corporation, and the corporation is to provide it, and may impose a reasonable charge for doing so.

**58. Application for inspection of certain documents relating to an election**

58.1 The corporation may not allow:

(a) the inspection of, or the opening of any sealed packet containing –

(i) any rejected ballot papers, including ballot papers rejected in part,

(ii) any rejected text voting records, including text voting records rejected in part,

(iii) any disqualified documents, or the list of disqualified documents,

(iv) any counted ballot papers, internet voting records, telephone voting records or text voting records, or

(v) the list of eligible voters, or

(b) access to or the inspection of the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage,

by any person without the consent of the board of directors of the corporation.

58.2 A person may apply to the board of directors of the corporation to inspect any of the documents listed in rule 58.1, and the board of directors of the corporation may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

58.3 The board of directors of the corporation's consent may be on any terms or

conditions that it thinks necessary, including conditions as to –

(a) persons,

(b) time,

(c) place and mode of inspection,

(d) production or opening,

and the corporation must only make the documents available for inspection in accordance with those terms and conditions.

58.4 On an application to inspect any of the documents listed in rule 58.1 the board of directors of the corporation must:

(a) in giving its consent, and

(b) in making the documents available for inspection

ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established –

(i) that his or her vote was given, and

(ii) that Monitor has declared that the vote was invalid.

**FPP59. Countermand or abandonment of poll on death of candidate**

FPP59.1 If at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) countermand notice of the poll, or, if voting information has been issued, direct that the poll be abandoned within that constituency or class, and

(b) order a new election, on a date to be appointed by him or her in consultation with the corporation, within the period of 40 days, computed in accordance with rule 3 of these rules, beginning with the day that the poll was countermanded or abandoned.

FPP59.2 Where a new election is ordered under rule FPP59.1, no fresh nomination is necessary for any candidate who was validly nominated for the election where the poll was countermanded or abandoned but further candidates shall be invited for that constituency or class.

FPP59.3 Where a poll is abandoned under rule FPP59.1(a), rules FPP59.4 to FPP59.7 are to apply.

FPP59.4 The returning officer shall not take any step or further step to open envelopes or deal with their contents in accordance with rules 38 and 39, and is to make up separate sealed packets in accordance with rule 40.

FPP59.5 The returning officer is to:

(a) count and record the number of ballot papers, internet voting records, telephone voting records and text voting records that have been received,

(b) seal up the ballot papers, internet voting records, telephone voting records and text voting records into packets, along with the records of the number of ballot papers, internet voting records, telephone voting records and text voting records and

ensure that complete electronic copies of the internet voting records telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

FPP59.6 The returning officer is to endorse on each packet a description of:

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the election relates.

FPP59.7 Once the documents relating to the poll have been sealed up and endorsed

pursuant to rules FPP59.4 to FPP59.6, the returning officer is to deliver them to the chairman of the corporation, and rules 57 and 58 are to apply.

**STV59. Countermand or abandonment of poll on death of candidate**

STV59.1 If, at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) publish a notice stating that the candidate has died, and

(b) proceed with the counting of the votes as if that candidate had been excluded from the count so that –

(i) ballot documents which only have a first preference recorded for the candidate that has died, and no preferences for any other candidates, are not to be counted, and

(ii) ballot documents which have preferences recorded for other candidates are to be counted according to the consecutive order of those preferences, passing over preferences marked for the candidate who has died.

STV59.2 The ballot documents which have preferences recorded for the candidate who has died are to be sealed with the other counted ballot documents pursuant to rule 54.1(a).

*Election expenses*

**60. Election expenses**

60.1 Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application made to Monitor under Part 11 of these rules.

**61. Expenses and payments by candidates**

61.1 A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to:

(a) personal expenses,

(b) travelling expenses, and expenses incurred while living away from home, and

(c) expenses for stationery, postage, telephone, internet(or any similar means of communication) and other petty expenses, to a limit of £100.

**62. Election expenses incurred by other persons**

62.1 No person may:

(a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise, or

(b) give a candidate or his or her family any money or property (whether as a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

62.2 Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 63 and 64.

*Publicity*

**63. Publicity about election by the corporation**

63.1 The corporation may:

(a) compile and distribute such information about the candidates, and

(b) organise and hold such meetings to enable the candidates to speak and respond to questions,

as it considers necessary.

63.2 Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 64, must be:

(a) objective, balanced and fair,

(b) equivalent in size and content for all candidates,

(c) compiled and distributed in consultation with all of the candidates standing for election, and

(d) must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more other candidates.

63.3 Where the corporation proposes to hold a meeting to enable the candidates to speak, the corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

**64. Information about candidates for inclusion with voting information**

64.1 The corporation must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 24 of these rules.

64.2 The information must consist of:

(a) a statement submitted by the candidate of no more than 250 words,

(b) if voting by telephone or text message is a method of polling for the election, the numerical voting code allocated by the returning officer to each candidate, for the purpose of recording votes using the telephone voting facility or the text message voting facility ("numerical voting code"), and

(c) a photograph of the candidate.

**65. Meaning of "for the purposes of an election"**

65.1 In this Part, the phrase "for the purposes of an election" means with a view to, or otherwise in connection with, promoting or procuring a candidate's election, including the prejudicing of another candidate's electoral prospects; and the phrase "for the purposes of a candidate's election" is to be construed accordingly.

65.2 The provision by any individual of his or her own services voluntarily, on his or her own time, and free of charge is not to be considered an expense for the purposes of this Part.

## 66. Application to question an election

66.1 An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to Monitor for the purpose of seeking a referral to the independent election arbitration panel ( IEAP).

66.2 An application may only be made once the outcome of the election has been declared by the returning officer.

66.3 An application may only be made to Monitor by:

(a) a person who voted at the election or who claimed to have had the right to vote, or

(b) a candidate, or a person claiming to have had a right to be elected at the election.

66.4 The application must:

(a) describe the alleged breach of the rules or electoral irregularity, and

(b) be in such a form as the independent panel may require.

66.5 The application must be presented in writing within 21 days of the declaration of the result of the election. Monitor will refer the application to the independent election arbitration panel appointed by Monitor.

66.6 If the independent election arbitration panel requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

66.7 Monitor shall delegate the determination of an application to a person or panel of persons to be nominated for the purpose.

66.8 The determination by the IEAP shall be binding on and shall be given effect by the corporation, the applicant and the members of the constituency (or class within a constituency) including all the candidates for the election to which the application relates.

66.9 The IEAP may prescribe rules of procedure for the determination of an application including costs.

**67. Secrecy**

67.1 The following persons:

(a) the returning officer,

(b) the returning officer's staff,

must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to:

(i) the name of any member of the corporation who has or has not been given voting information or who has or has not voted,

(ii) the unique identifier on any ballot paper,

(iii) the voter ID number allocated to any voter,

(iv) the candidate(s) for whom any member has voted.

67.2 No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter or the voter ID number allocated to a voter.

67.3 The returning officer is to make such arrangements as he or she thinks fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

**68. Prohibition of disclosure of vote**

68.1 No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom he or she has voted.

**69. Disqualification**

69.1 A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is:

(a) a member of the corporation,

(b) an employee of the corporation,

(c) a director of the corporation, or

(d) employed by or on behalf of a person who has been nominated for election.

**70. Delay in postal service through industrial action or unforeseen event**

70.1 If industrial action, or some other unforeseen event, results in a delay in:

(a) the delivery of the documents in rule 24, or

(b) the return of the ballot papers,

the returning officer may extend the time between the publication of the notice of the poll and the close of the poll by such period as he or she considers appropriate.

This page has been left blank

Stockport NHS
NHS Foundation Trust

| | | | |
|---|---|---|---|
| **Report to:** | Board of Directors | **Date:** | 31 March 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<br>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:

- Tameside & Glossop Community Services
- Greater Manchester Devolution
- Monitor / NHS Improvement Communications

**Attachments:** Nil.

**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 |

**- THIS PAGE IS INTENTIONALLY BLANK -**

## 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. TAMESIDE & GLOSSOP COMMUNITY SERVICES

2.1 Board members will be aware that Tameside and Glossop Community Services will transfer to Tameside Hospital NHS Foundation Trust on 1 April 2016. This will enable the formation of an integrated care organisation, where the health and social care providers of Tameside will work together for the local population. This approach is in line with the regional and national picture, where NHS services are being reorganised for closer collaboration between hospital, community and social care in order to provide more joined up care for patients.

2.2 Tameside and Glossop Community Services originally transferred to Stockport NHS Foundation Trust on the 1 April 2011 and we can be extremely proud of what the services have achieved over the last 5 years, and will continue to achieve as part of the new integrated care organisation. As Chief Executive, I am proud of the commitment and professionalism which staff have shown during the transitional period with staff continuing to provide excellent patient care. Tameside and Glossop Community Services has a highly skilled, motivated and committed workforce who have always put the patient at the heart of care delivery. I would like to take this opportunity to thank staff for their hard work and wish them all the very best for the future.

## 3. GREATER MANCHESTER DEVOLUTION

3.1 From 1 April 2016, Greater Manchester will take control of £6 billion of public funding for health and social care as devolution officially begins. For the last 12 months the region has been preparing to become the first region in the country to achieve devolution through the transfer of certain powers and responsibilities from national government. A total of 37 different health and social care organisations have been working together in 'shadow form' and have agreed a five year strategic plan.

3.2 The strategic plan promotes a *'Taking charge'* theme and sets out plans to improve health and wellbeing of the 2.8 million people of Greater Manchester. It also looks at how the region can work towards closing the predicted £2 billion shortfall in health and social care funding by 2021, through transformation initiatives and working together more efficiently and effectively. Ten locality plans, including the Stockport Together Vanguard locality plan, form part of the five year strategic plan and our Trust strategy is completely aligned to these plans.

3.3 The Chief Executive sits on the programme board for Greater Manchester devolution and is also chair of the Greater Manchester NHS Provider Federation, comprising Chief Executives from all of the NHS provider Trust organisations, which links in to the programme board. A Chief Officer for Greater Manchester health and social care devolution is being appointed. Also, as part of the devolution deal, a Mayor will be elected by the public in 2017 and will lead the Greater Manchester Combined Authority, representing the 10 GM local

authorities.

## 4. MONITOR / NHS IMPROVEMENT COMMUNICATIONS

4.1 As reported at the last Board meeting, members of the Executive Team attended a workshop in London on 1 March 2016 which was facilitated by NHS Improvement. Also in attendance were representatives from 29 other Provider trusts that are struggling to meet the 4-hour A&E standard. This was a useful event, which included presentations from a number of trusts that had recovered from being in a similar position, and provided opportunities to consider initiatives which may assist development of the Trust's plans.

4.2 The Trust has committed to participating in a follow-up workshop which will be held in June 2016 and, in the meantime, a similar event specifically for Provider trusts in Greater Manchester will be held towards the end of April 2016.

## 5. PUBLICATIONS

5.1 Could I draw the attention of the Board of Directors to the following items from issues 70-73 of the NHS England 'Informed' publication.

- **Maternity review sets bold plan for safer, more personal service**

  Maternity services in England must become safer, more personalised, kinder, professional and more family-friendly. That's the vision of the National Maternity Review, which today publishes its recommendations for how services should change over the next five years. The NHS England commissioned review – led by independent experts and chaired by Baroness Julia Cumberlege – sets out wide-ranging proposals designed to make care safer and give women greater control and more choices.

- **New Sustainability and Transformation Plan letter published**

  The national bodies have written to local health and care systems to set out the next steps on developing multi-year, place-based Sustainability and Transformation Plans (STPs): a key part of the NHS planning guidance for 16/17- 20/21. The letter explains more about the STP process; outlines support that will be available; and provides a timeline for local systems. STPs will show how local services will evolve and become sustainable over the next five years.

- **NHS England announces plan to support ten healthy new towns**

  NHS England Chief Executive, Simon Stevens has announced plans to create ten NHS-supported 'healthy new towns' across the country, covering more than 76,000 new homes with potential capacity for approximately 170,000 residents. Simon Stevens has named the sites that form the Healthy New Town programme, supported by Public Health England. The NHS will help shape the way these new sites develop, so as to test creative solutions for the health and care challenges of the 21st century, including obesity, dementia and community cohesion.

- **New initiative aims to imprmove maternity services through patient feedback**

  Maternity services have been invited to bid for money from a new Challenge Fund

aimed at finding innovative ways to use patient feedback to improve services. The #MatExp Fund aims to explore innovative ways to make better use of patient insight to deliver improved services. The initiative aligns with the National Maternity Review, which has published wide-ranging proposals designed to make care safer and give women greater control and more choices. The closing date for applications is 11 March.

- **Register now for Expo 2016**

  Registration is now open for Health and Care Innovation Expo 2016, which will be held on 7 and 8 September 2016 at Manchester Central. Complimentary ticket codes are being distributed to those eligible, while a discounted early-bird rate is now available - you can register now. Expo will host an inspiring list of speakers, with many more to be confirmed over the next few months. The unique pop-up university will return, with more than 100 expert-led workshops running throughout the two days. To discuss ways in which your team can contribute to Expo 2016, please contact england.expo@nhs.net

- **NHS England launches national programme to combat antibiotic over usage**

  NHS England has launched the world's largest healthcare incentive scheme for hospitals, family doctors and other health service providers to prevent the growing problem of antibiotic resistance. The new programme, which goes live in April 2016, will offer hospitals incentive funding worth up to £150 million to support expert pharmacists and clinicians review and reduce inappropriate prescribing of antibiotics.

- **New care model vanguards celebrate an inspirational first year**

  New care model vanguards across England have marked one year since the launch of the programme. The 50 vanguards, who are spread across different parts of the country, are redesigning and transforming care for patients, communities and staff. Vanguards are part of the national new care models programme which is playing a key role in the delivery of the Five Year Forward View – the vision for the future of the NHS. Samantha Jones, Director of the New Care Models Programme, reflects on the progress they have made over the last year.

- **New standards for communicating patient diagnostic test results**

  NHS England has developed a new set of standards for the communication of diagnostic test results when a patient is discharged from hospital. The standards, endorsed by the Academy of Royal Colleges, describe acceptable safe practice around how diagnostic test results should be communicated with patients and between secondary care and primary and social care. This is part of a wider national patient safety programme to protect patients from potential harm caused by delays or errors in the communication of information between care providers.

## 6. RECOMMENDATIONS

6.1 The Board of Directors is recommended to:

- Receive and note the content of the report.

This page has been left blank

Stockport NHS
NHS Foundation Trust

| | | | |
|---|---|---|---|
| **Report to:** | Board of Directors | **Date:** | 31st March 2016 |
| **Subject:** | Leadership Strategy | | |
| **Report of:** | Director of Workforce & Organisational Development | **Prepared by:** | Vanessa Trimble |

# REPORT FOR APPROVAL

| | |
|---|---|
| **Corporate objective ref:** | N/A |
| **Board Assurance Framework ref:** | N/A |
| **CQC Registration Standards ref:** | N/A |
| **Equality Impact Assessment:** | ☐ Completed<br>X Not required |

**Summary of Report**

The purpose of the Leadership Strategy is to identify the importance of leadership, why we need great leadership in the Trust and identify what is required by the Trust's leaders on an individual and collective basis. It also describes a leadership culture that supports and draws on the collective leadership capabilities of leaders acting together in groups and across boundaries to implement strategies, support innovation, adapt to change and transformation and lead in times of uncertainty and transition.

The Leadership Strategy was presented to the Workforce and OD Committee on the 29th February 2016 where it was recommended for Board approval.

The Board are requested to approve the strategy (Annex 1).

**Attachments:** Annex 1 – The Leadership Strategy

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

**- THIS PAGE IS INTENTIONALLY BLANK -**

Stockport NHS
NHS Foundation Trust

# Leadership Strategy

# 2016 - 2020

## 1. Introduction

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

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

The Greater Manchester Health and Social Care Strategic Plan will set out how the fastest and biggest improvement in health and wellbeing to the people of Greater Manchester over the next five years will be achieved. The plan is the culmination of many years of conversations between the organisations and public of Greater Manchester and builds on many successful pieces of work to improve health, wellbeing and services. The plan will have three building blocks:

- Ten locality plans
- Big 'transformation initiatives' and other Greater Manchester wide plans
- Plans for how services for the public can work together more efficiently and effectively

Stockport Together is an integration project covering health & social care across the Stockport area. The project includes four clinical programmes; prevention and empowerment, pro-active care, urgent and planned care. Stockport together includes five parts of four organisations; general practice, social care, mental health, acute and community care.

As the model of care evolves, staff may be employed in different types of organisations across traditional health social care and health boundaries to deliver services that meet the increasing complex needs of our patients. The aim is to foster and embed innovative workforce models of care and support, including new ways of working to release efficiencies, the creation of new roles to reduce over-reliance on traditional professions where there are existing recruitment gaps.
Staff will increasingly need to work across organisational, professional and service boundaries. The integration of health and social care will incur role-blurring and result in the development of new generic roles.

In order to meet these challenges and to achieve our vision, we need leadership of the highest calibre if we are to respond successfully to service and financial pressures that are unprecedented. This has significant implications for our leadership community, who will be the enablers to provide the motivation and inspiration to enable us to meet our challenges. As the Dalton Review (2014) points out, "leadership is key to change". Only strong and capable leadership will drive transformational change and will involve us being courageous and taking bold decisions. This is not about more management but better leadership; not just more attention to resources but more focus on how to handle change and uncertainty.

The nature of leadership has changed significantly over the last two decades from:

- Power through hierarchy….. to power through connection
- Mission and vision….. to shared purpose
- Rational argument….. to emotional connection
- Top down innovation….. to grass roots driven creativity
- Transactions….. to relationships.

For leaders to be at their most effective they need confidence in their role. To secure confidence they need competence, skills, expertise, experience and support. This comes from expert development and training as well as on the job learning. Leaders need to have a breadth of behaviours to draw on to exercise their

role in a multi-agency, complex system such as health care. Lack of development tends to result in leaders having a very narrow range of styles to draw on.

Leaders need the right behaviours to build alliances with a wide range of professionals and across organisational boundaries to serve the needs of diverse communities with enduringly complex needs. The success of the NHS over the next decade or so will rely heavily on the behaviours adopted by healthcare leaders at all levels being able to work with leaders in other parts of the public and private system.

Leaders need to be able to engage and empower those working with them, and rely less on old style command and control approaches that inhibit innovation, discretionary effort and a more caring and considerate climate to work that generate both employee engagement and compassion in care.

The King's Fund has recently stressed the importance of moving from the pace-setting, command and control and target-driven approaches which have in some cased delivered achievement of some targets but at a cost to patients and staff. The Commission on Dignity in Care for Older People identified top-down cultures as a cause of poor care: "If senior managers impose a command and control culture that demoralises staff and robs them of authority to make decisions, poor care will follow" (2012).

In light of all the forthcoming changes and the enormous challenges we face as a Trust, it is timely and imperative that we review the role that our leaders will place in the future success of our Trust. The evidence is clear about the impact and importance that leaders and leadership will play in the delivery of continuous high quality care.

As a Trust we now have an opportunity to be as ambitious with our leadership strategy as we are in our vision.

## 2. Purpose of the Leadership Strategy

In order to understand what a leadership strategy is, we first need to understand what we mean by leadership. Leadership begins with individuals in leadership positions, but doesn't end there. The ability of an organisation to accomplish its goals does not depend solely on a single great leader, but by the collective actions of leaders working together to shape and influence organisational culture. It is not simply the number or quality of individual leaders, but it is the strength and impact of the relationships and mutual support within our leadership community. There are three areas that this strategy will focus on; leadership culture, individual leaders and our collective leadership. It is only by paying attention to all three, we will achieve our goals.

The purpose of this strategy is to identify the importance of leadership, to identify what is required by the Trust's leaders on an individual and collective basis. Also, to describe a leadership culture that supports and draws on the collective leadership capabilities of leaders acting together in groups and across boundaries to implement strategies, support innovation, adapt to change and transformation and lead in times of uncertainty and transition.

The aim of the leadership strategy is to create a leadership culture in which staff are fully engaged at all levels, accepting responsibility for outcomes, create opportunities for others to learn and lead, create space for innovation and share best practice supporting a culture of continuous high quality compassionate care. To achieve this requires leadership behaviours and attitudes of the highest order, where leadership is supported and enabled at all levels of the organisation, both individually and collectively. This means developing a leadership culture that supports new ways of sharing power, thinking, being and doing and by working closely with one another to collectively achieve goals and objectives. It means that distribution and allocation of leadership power to wherever expertise, capability and motivation sits within our Trust.

We all need to know what great leadership looks like. Even though not every job will require leadership qualities, some parts of every job will. We should not try to prescribe from any particular discipline. We should aim to develop, recognise and reward appropriately leadership qualities across all of our Trust.

We also need to recognise that we must work with what we have, recognise our limitations and exploit our opportunities. A few simple things would make a huge difference: centralising our external training budget to ring fence monies for leadership development, helping our middle managers to maintain and enhance their confidence and skills and providing all leaders and managers with the appropriate support, development and clear pathways to progression. We need leaders who are connected, with one another and with their teams.

The Leadership Strategy will underpin and support many of our Trust's strategies including; the Trust Strategy, the Nursing Strategy, the Coaching Strategy. It is one of the five key deliverables of the Organisational Development Strategy.

## 3. What Our Leaders can Expect from the Trust

In order to develop a culture where individual leaders can thrive and shine in times of significant organisational change, Stockport NHS Foundation Trust will commit to providing the resources, space and time for our leaders to excel.

We want our leaders to have the space and time to think creatively, challenge assumptions and believe in the art of the possible. We want our leaders to be inspiring, enabling, supportive, energising and to create the culture, environment and behaviours where individuals and teams can flourish. A place where people are clear on what is expected of them, take personal responsibility for their actions and are recognised and valued for providing the very best care and high standards of service delivery.

Whilst the expectations may be high of our leaders, our promise as a Trust is to acknowledge the role leaders play in delivering high quality care and commit to providing a programme of support that will shape the culture and create the conditions where our leaders can succeed.

Our promise to our leaders is that we will:

- Create opportunities, time and space where our leaders can think, challenge assumptions, be courageous, innovative and shape and influence what we do and how we do things in the Trust.
- Commit to provide a range of development opportunities (internal and external) for managers and leaders at all levels of the Trust to enhance skills, abilities, attitudes and confidence; both individually and as leadership communities.
- Acknowledge the challenges of being a leader encouraging supportive, compassionate and collaborative ways of working in our everyday conversation, one to one, meetings and networks
- Support our leaders to enable them to create conditions where individuals and team can give of their best, feel valued, recognised for the great work that they do and supported at all times.

## 4. What We Expect from our Leaders

- To be role models and exemplar's of our Trust's values and behavioural framework.
- To support and enable a culture of continuous high quality care.
- To demonstrate commitment as a collective leadership team to the success of the Trust overall.
- To be curious and creative and to support innovation at all levels, engaging all staff in conversations and in decision-making processes and gaining their support in taking forward innovations.
- To create the conditions where teams are high performing and where all staff can give of their best and feel valued, engaged and supported with clear objectives and priorities.
- To communicate openly, timely and widely for the benefit of all.
- To work collaboratively with all stakeholders with a commitment to improve care.

## 5. What Success Will Look Like

- Continuously improving high quality patient care and increased patient satisfaction as evidenced by our patient feedback, performance measures and achievement of targets.
- Stockport NHS Foundation Trust is a great place to work. A place where people are able to give of their best, fulfil their potential, are engaged and feel valued and supported in the workplace. This will be evidenced by our staff surveys, our retention rates, sickness and absence figures and the increased number of applicants applying for jobs.
- Local, regional and national recognition for excellence in a wide range of service provision, research, leadership, change and transformation and learning and development.

## 6. Next Steps

Next Steps

1. Develop a detailed, ambitious leadership development plan
2. Secure the resources to support the delivery of the leadership development plan
3. Scope external development opportunities
4. Develop the infrastructure to capture data relating to all development activity.
5. Develop a supporting Talent Management Strategy and Succession Plan.

## 7. Conclusion

The key challenge facing all NHS organisations is to nurture cultures that ensure the delivery of continuously improving high quality, safe and compassionate care. Leadership is the most influential factor in shaping organisational culture so ensuring the necessary leadership behaviours, strategies and qualities are developed is fundamental. There is clear evidence of the link between leadership and a range of important outcomes within health services, including patient satisfaction, patient mortality, organisational financial performance, staff well-being, engagement, turnover and absenteeism, and overall quality of care.

As a Trust, we need to acknowledge the significant role our leaders play in the delivery of high quality patient care, staff satisfaction and in shaping our future. In achieve we want to provide the commitment, space, resources, support and development opportunities for our leaders to be able to excel.

This page has been left blank

| | | | |
|---|---|---|---|
| **Report to:** | Board of Directors | **Date:** | 31 March 2016 |
| **Subject:** | Shadow Provider Board – Memorandum of Understanding | | |
| **Report of:** | Chief Operating Officer | **Prepared by:** | Andrea Gaukroger<br>Director of Strategy & Planning |

# REPORT FOR APPROVAL

| | | |
|---|---|---|
| **Corporate objective ref:** | ----- | **Summary of Report**<br><br>This paper presents the memorandum of understanding (MOU) that is made between the Providers working within the Stockport Together Programme. This outlines a convergence of will between the parties and the agreement of a common line of action. It is intended to set out how the parties will work together to form a Shadow Multi-Specialty Community Provider.<br><br>This MOU has been circulated to the Boards of all relevant parties for approval.<br><br>The memorandum of understanding would come into use on 1st April 2016 and will expire on 31st March 2017. |
| **Board Assurance Framework ref:** | ----- | |
| **CQC Registration Standards ref:** | ----- | |
| **Equality Impact Assessment:** | ☐ Completed<br>☒ Not required | |

| | |
|---|---|
| **Attachments:** | Annex A - MOU |

| | | |
|---|---|---|
| **This subject has previously been reported to:** | ☐ Board of Directors<br>☐ Council of Governors<br>☐ Audit Committee<br>☒ Executive Team<br>☐ Quality Assurance Committee<br>☒ FI Committee | ☐ Workforce & OD Committee<br>☒ SDC Committee<br>☐ Charitable Funds Committee<br>☐ Nominations Committee<br>☐ Remuneration Committee<br>☐ Joint Negotiating Council<br>☐ Other |

**- THIS PAGE IS INTENTIONALLY BLANK -**

## 1. BACKGROUND

1.1 The Stockport Together partners continue to work closely together on the design and implementation of new delivery models aimed at achieving both improved services for patients and users at lower cost.

1.2 A particular focus over the past few months has been on the plans for 2016/17, ensuring that all partners are sighted on the difficulties and opportunities faced by each other and how a more collective and integrated approach can be taken to the deployment of health and care resources.

1.3 The partners are committed to a fundamental and wide-ranging programme of change in the way health and social care services are commissioned and delivered across Stockport. This change programme is designed to deliver better outcomes and more sustainable services across the local health and social care economy.

1.4 In order to achieve the ambition, Stockport Together partners have reached a number of agreements, the most notable of which is to adopt an integrated approach to system design and development. 2016/17 will be a transitional year as much detail still has to be agreed, but during this period, it is proposed that health and care commissioning will begin to be carried out as a single function.

1.5 In parallel, the key provider partners intend to form a new, shadow organisation in which the GP Federation (Viaduct Health), Stockport Foundation Trust (acute and community services), Pennine Care and the Local Authority would have an equal stake, and within which the traditional competing priorities will be renegotiated and replaced by a collaborative alliance. This shadow organisation would go on to be a Multi-Specialty Community Provider organisation (MCP).

1.6 The Stockport Together programme will oversee and co-ordinate this transformation and ensure that a single conversation about clinical and professional leadership, value for money and organisational structure takes the place of the traditional, fragmented contract negotiation process going forward.

## 2 THE MEMORANDUM OF UNDERSTANDING (MOU)

2.1 The Shadow Provider Board (a collective of the four providers outlined above) has been meeting since early 2016. In order to demonstrate a commitment to how the providers will work together during the next year it was decided to develop a Memorandum Of Understanding which each of the organisations would sign up to in order to indicate their commitment.

2.2 The MOU outlines how the provider board will act as a shadow MCP during 2016/17, starting to make collective decisions on the deployment of resources and taking an open book approach to investment decisions.

2.3 The MOU has been developed by the Shadow Provider Board and shared with the Executive Teams (or equivalent) of the four provider organisations who have all contributed to its development.

## 3 RECOMMENDATION

3.1 The Board are asked to review the MOU and delegate responsibility to the Chief Executive to sign this on behalf of the Foundation Trust.

ANNEX A

**FINAL VERSION**

**MEMORANDUM OF UNDERSTANDING BETWEEN STOCKPORT TOGETHER PROVIDER MANAGEMENT BOARD PARTNERS FOR THE DEVELOPMENT OF A SHADOW MULTI-SPECIALTY COMMUNITY PROVIDER**

## 1. Status and Purpose of the Memorandum of Understanding

1.1 This memorandum of understanding is made between the organisations set out below to express a convergence of will between the parties and the agreement of a common line of action. It is intended to set out how the parties will work together to form a Shadow Multi-Specialty Community Provider.

1.2 Provider organisations, to be together referred to in this Memorandum of Understanding as ‘’Provider participants’’:

**Stockport NHS Foundation Trust**
**Pennine Care NHS Foundation Trust**
**Stockport Metropolitan Borough Council**
**Viaduct Health**

1.3 The provider participants are together referred to a ‘we’, ‘us’ and ‘our’ as the context requires. ‘Participant’ means any one of Us.

1.4 This memorandum of understanding is supported by a letter of intent from NHS Stockport Clinical Commissioning Group explaining how it will enable, facilitate and support the concept of the Shadow Multi-Specialty Community Provider.

## 2. Term

2.1 This memorandum of understanding will come into force on 1st April 2016 and will expire on 31st March 2017.

## 3. Background

3.1 The Provider Participants are providers of NHS-funded healthcare and social care services to the people who live in Stockport. For the purposes of this agreement this applies to all patients registered with a Stockport GP for health services and all people resident within Stockport for social care services and the public health function.

3.2 This agreement is an integral part of our commitment, as participants in Stockport Together, to promote integrated services that deliver personalised care within an agreed cost base.

The full objectives of the Memorandum of Understanding are set out below.

## 4. Shadow Multi-specialty Community Provider objectives for 2016/17

4.1 The overall aim of the Shadow Multi-specialty Community Provider is to work in collaboration to innovate, improve quality, manage costs across the system and deliver practitioner led solutions. As Provider participants we will work to reduce hospital admissions and attendances and shift provision of care to a neighbourhood based approach. We will also start to instigate conversations with individuals and communities in a move towards being equal partners and having a different relationship with services.

4.2 To deliver this aim the Shadow Multi-specialty Community Provider will develop a work programme with two main objectives:

4.2.1 To support and align with the design entities within the Stockport Together programme and then take the approved business cases through to delivery

4.2.2 To make decisions on and accelerate change around current operational issues using a practitioner led approach

4.3 Some initial pieces of work around these objectives will include:

a. Aligning prescribing and achieving cost savings in medicines management

b. Operationalising a neighbourhood model that is practitioner driven and owned

c. Developing a Cross Provider Operational Winter Plan and put forward joint plans to the Systems Resilience Group

d. Designing and implementing a programme of Rapid Improvement Cycles

e. Designing an integrated leadership structure by end of Q1 to be in place by Q4

f. Developing options for and deciding on the preferred option to establish an MCP and move towards full model for 17/18

g. Working together to flexibly absorb growth across providers

## 5. Shadow Multi-specialty Community Provider purpose and remit

5.1 A Shadow Multi-speciality Community Provider is part of Stockport's Vanguard status; to develop and test out a replicable MCP as part of the New Models of Care set out in the Five Year Forward View. This agreement is formed in the context of Stockport's Locality Plan developed as part of Devolution Manchester.

5.2 Delivering benefits to the people of Stockport is key within this new provider form. The Vision Decision and Draft Design Decision Documents set out the detail of the benefits which will be delivered through Stockport Together and the Shadow Multi-specialty Community Provider. The high level benefits to people include;

- Healthy life expectancy in the most deprived areas improves so that mortality rates are 15% lower in five years
- The healthy life expectancy across Stockport to be at or above the national average
- To narrow the gap in life expectancy across the borough from 11 years to 9 years
- Individuals to have more healthy years as well as longer lives
- To reduce the years of life lost amenable to health care
- Reduction in mortality from preventable causes
- Individuals to have increased quality of life
- Fewer people in Stockport making risky or unhealthy lifestyles choices
- More people in Stockport making active and positive choices to improve their health and wellbeing Increased identification of people with needs
- Demonstrable system which is geared to enable self-care (optimise, maintain and sustain)
- More community capacity and increased empowerment
- More individuals to be self managing effectively
- Improved experience of joined up/ integrated working (staff and individuals)
- Improved experience of care
- Reduced emergency attendance/admissions for people on a Planned/Proactive Care pathway
- Reduction in A&E attendances and non-elective admissions
- Reduced reliance on ‘acute’-based Planned Care
- Reduction in out-patients and elective treatment
- To be 'best in class' for long-term condition outcomes

5.3 Provider Participants will work closely together to ensure that the services provided within the Shadow Multi-speciality Community Provider are person centred and the organisational blockers that may have previously prevented this from happening are removed.

5.4 We have agreed to form a Shadow Multi-specialty Community Provider to progress the work of Stockport Together and start to work together to establish and improve a financial, governance and contractual framework for the delivery of integrated health and social care in Stockport. Within the parameters of the Provider Management Board we will take decisions to accelerate change in the system and take a problem solving approach to

issues. Provider participants will work together to recommend collective solutions to the Design Authority.

5.5 This Memorandum of Understanding sets out the key terms we have agreed with each other. Our remit is to work across all age ranges from age 18+ utilising our collective provider expenditure. One element of this remit is our commitment is to the over 65 age group and the agreed outcomes and indicators for the services contained within the Section 75 Partnership Agreement for the creation of a pooled fund and integrated commissioning arrangements for Health and Social Care Services in Stockport.

## 6. Shadow Multi-specialty Community Provider principles

### *6.1 Our commitment to working together*

6.1.1 We recognise that the successful development of the MCP in shadow form will require strong relationships and the creation of an environment of trust, collaboration and innovation.

6.1.2 All provider participants recognise the importance of good formal and informal working relations with shared responsibility, while respecting differences, building trust and mutual respect, openness and honesty.

6.1.3 We will make decisions on the basis of our shared values and common purpose; delivering improved population health and care through our Shadow Multi-Specialty Community Provider and its alignment to the Stockport Locality Plan and our Vanguard status.

6.1.4 We will work collaboratively with the Integrated Commissioning Board to provide them with assurance around planned changes, system outcomes, delivery, quality and safety. All provider participants will work together to provide innovative and integrated solutions which meet the needs of the population of Stockport.

### *6.2 Our commitment to our services and our staff*

6.2.1 Each of us will perform our respective obligations under our individual contracts with our commissioners. We acknowledge that the overall quality of our services will be determined by our collective performance and we will work together to discuss how we optimise this performance and share risk and rewards.

6.2.2 The staff working within the Shadow Multi-specialty Community Provider will retain their employment with their existing employer under their existing terms and conditions. The policies and procedures from each organisation continue to apply.

6.2.3 Our approach will be to deliver a practitioner led model with all practitioners having an equitable voice in developments. General practice will lead the clinical direction within the neighbourhoods via Viaduct Health.

6.2.4 Over the life of the Shadow MCP we will start to alter the provision of services based on the most effective use of staff, premises and resources and agree a full MCP form for 2017/18.

## 7. Shadow Multi-specialty Community Provider governance

7.1 We must communicate with each other and all relevant staff in a clear, direct and timely manner to optimise the ability for each of us, the Provider Management Board and Provider Senior Leadership Team to make effective and timely decisions to achieve the shadow MCP objectives.

7.2 We agree to be bound by the actions and decisions of the Provider Management Board carried out in accordance with this agreement. The Provider Management Board is constituted of:

**Director of People, Stockport MBC**
**Director of Adult Social Care, Stockport MBC**
**Chief Operating Officer/Deputy Chief Executive, Stockport NHS Foundation Trust**
**Medical Director, Pennine Care NHS Foundation Trust**
**Chief Officer, Viaduct Health**

7.3 The Terms of reference for the Provider Management Board are as follows;

- Leads the development of MCP – Form, governance, establishment as a legal entity
- Manages the delivery of a scoped and costed provider model
- Manages the governance, planning, design, resource deployment to deliver an agreed Provider Form
- Makes recommendations to the Exec Board on the Provider Form
- Co-designs the models of care programmes in collaboration with Partner organisations; the Commissioning Board and the Enablers to ensure there is system wide consensus:
- Collates recommendations to the Design Entities and Exec Board on the scope, scale and detail of the design
- Maintains clinical and professional ownership of the models of care
- Provides subject matter expertise

- Coordinates the capacity and capability to design and deliver the models of care programmes
- Coordinates time-limited activities (programme and project) to design models of care to the point of implementation
- Utilises business intelligence and analysis for process capture; and quantification and process change quantification.
- Leads the implementation of the new services, tracking detailed performance and delivery of KPIs and benefits.

7.4 The Provider Management Board is the group responsible for directing and leading the Shadow MCP

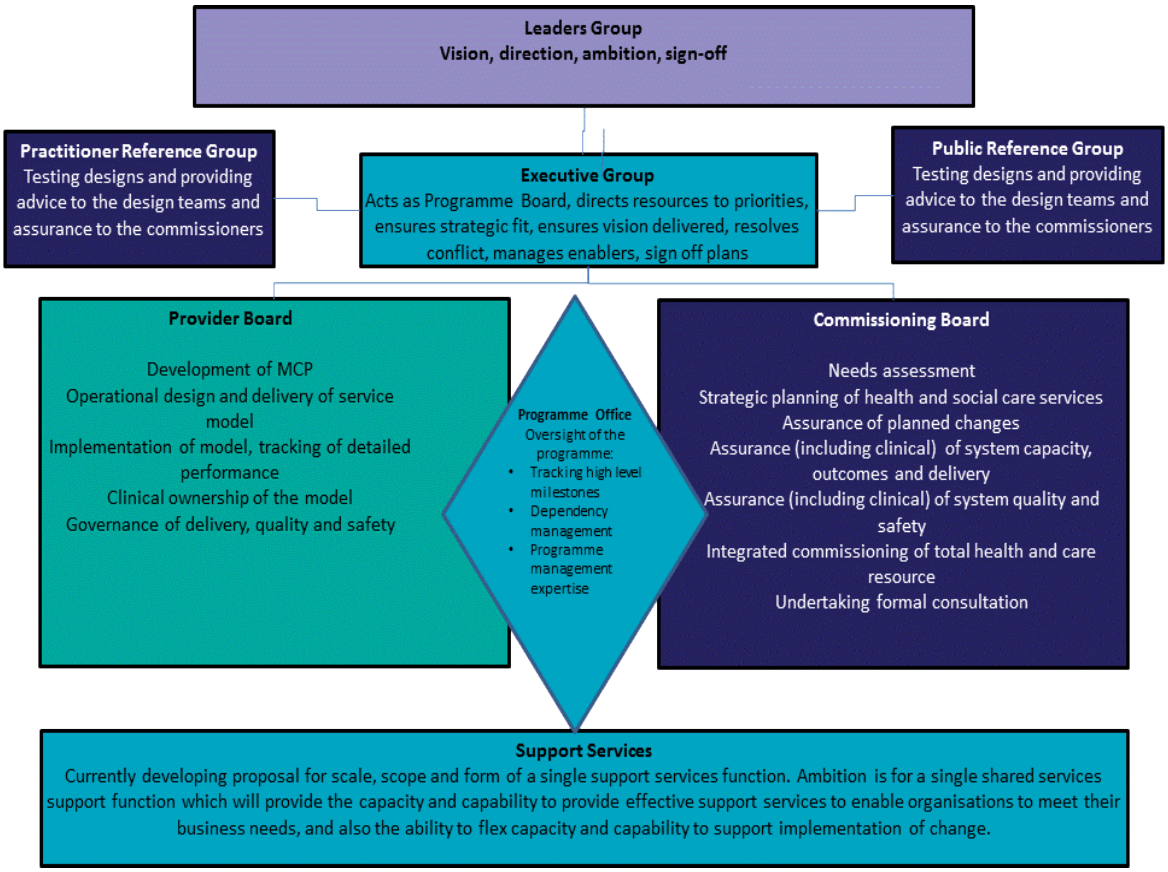
7.5 The Provider Senior Leadership Team is responsible for the implementation of the MCP model going forward and implementation of operational governance.

7.6 Members of the Provider Management Board are responsible for describing the decisions and scenarios in which they have the delegated authority to make a decision on behalf of their organisation and the decisions which they will require the agreement of their organisation's governing body (e.g. Board of Directors, Council Executive).

7.7 The Provider Management Board will be responsible for:

- The development of the full Multi-specialty Community Provider for 2017/18
- Operational design and delivery of the service model
- Implementation of the model, tracking of detailed performance
- Clinical ownership of the model
- Governance of delivery, quality and safety

7.8 In Q1 of 2016/17 the Provider Management Board will develop and agree a new leadership structure which will be in place before 31st March 2017.




## 8. Risk management

### 8.1 Service risk management

8.1.1 All provider participants covered by this agreement recognise that they remain accountable for the management of risks within their services in 2016/17 but will work together to identify and resolve risks together.

8.1.2 It is acknowledged that by starting to integrate services into a Shadow Multi-Specialty Community Provider form there is an inherent risk of dis-integrating some services from other services that they may have been integrated with previously. All provider participants commit to working together to understand and mitigate these risks.

### 8.2 Financial risk management

8.2.1 During the course of this agreement the partner organisations intend to:

a) Agree a process for sharing and mitigating financial risks in the system that avoids destabilising individual organisations

b) Agree a process for gain share for benefits that are not modelled as part of the Stockport Together design process
c) Develop a process of how to manage financial accountability and sustainability as the organisations move to a full Multi-Specialty Community Provider
d) Plan a collaborative response to operational system financial pressures in 2016/17
e) Work with commissioners to develop a plan for financial sustainability from 2017/18

## 9. Services in scope for this agreement

9.1 Provider participants have put forward a number of services to be considered 'in scope' and 'in view' of the Shadow Multi-specialty Community Provider. In scope are the services which will be directly affected and transformed via the Shadow Multi-specialty Community Provider in 2016/17 and in view services are those which will be impacted on as a result of changes agreed via the Shadow Multi-specialty Community Provider. Provider participants will ensure that the interface between the in scope and in view services is carefully managed.

9.2 For 2016/17, services 'in scope' consist of:

- Adult community nursing services
- Some adult specialist nursing services
- Adult community therapy services
- Adult social care services
- Intermediate tier services across both health and social care
- Older people's community mental health services

9.3 For 2016/17, services 'in view' consist of:

- Outpatient services
- Diagnostics
- Emergency Department
- Acute Medicine
- Frail Elderly Medicine
- Medicines Optimisation
- Primary Care Development

9.4 These services are detailed in appendix A and appendix B. Services not listed in appendix A and appendix B are considered 'out of scope' for the Shadow Multi-specialty Community Provider in 2016/17. Services for children and young people are considered out of the scope of this agreement in 2016/17.

9.5 Further work will be undertaken in year to agree the scope for services to be included in a full Multi-specialty Community Provider from 2017/18.

## 10. Key performance indicators

10.1 The provider participants in this Memorandum of Understanding remain responsible for delivering their statutory obligations and their own key performance indicators as defined by their own organisation, commissioners and regulatory bodies. All participants are committed, however, to work together to achieve these key performance indicators on a system basis.

10.2 During Q1 of 2016/17 the Provider Participants will sign off a performance and assurance framework for the current year and commence work to develop a future framework for a full Multi-specialty Community Provider.

## 11. Agreement and authorisation

On behalf of our constituent organisations we agree to the terms of this Memorandum of Understanding:

| **Signature** | | **Date** |
|---|---|---|
| | For and behalf of Stockport Metropolitan Borough Council | |
| | For and behalf of Stockport NHS Foundation Trust | |
| | For and behalf of Pennine Care NHS Foundation Trust | |
| | For and behalf of Viaduct Health | |

This page has been left blank