Stockport NHS
NHS Foundation Trust

BOARD OF DIRECTORS

PUBLIC MEETING

30 NOVEMBER 2017

Your Health. Our Priority.

Board of Directors Meeting - 30 November 2017

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Stockport NHS
NHS Foundation Trust

November 2017

Dear Colleague

You are invited to a meeting of the Board of Directors which will be held on **Thursday 30 November 2017 at 1.15pm in Lecture Theatre A, Pinewood House, Stepping Hill Hospital.**

An agenda for the meeting is detailed below.

Yours sincerely

ADRIAN BELTON
CHAIR

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AGENDA ITEM	TIME
1. Apologies for Absence.	1.15pm – 1.20pm
2. Opening Remarks by the Chair.	"
3. Declaration of Amendments to the Register of Interests.	"
4. Patient Story	1.20pm – 1.45pm
5. **OPENING MATTERS:**	
5.1 To approve the minutes of the previous meeting of the Board of Directors held on 27 October 2017 (attached).	1.45pm – 1.50pm
5.2 Report of the Chair (attached).	1.50pm – 1.55pm
5.3 Report of the Chief Executive (attached).	1.55pm – 2.00pm
5.4 Key Issues Reports from Assurance Committees: 5.4.1 Audit Committee (attached and Mr J Sandford to report) 5.4.2 Quality Assurance Committee (attached and Dr M Cheshire to report) 5.4.3 Finance & Performance Committee (attached and Mr M Sugden to report) 5.4.4 People Performance Committee (attached and Ms A Smith to report)	2.00pm – 2.20pm
6. **ASSURANCE AND GOVERNANCE:**	
6.1 Performance Report (Report of Chief Operating Officer attached).	2.20pm – 2.40pm

AGENDA ITEM	TIME
6.2 Review of Integrated Performance Report (Report of Director of Support Service attached)	2.40pm – 3.00pm
6.3 Maintaining Safe Staffing Levels (Report of Director of Nursing & Quality attached).	3.00pm – 3.05pm
6.4 Quality Improvement (Presentation from the Director of Nursing & Quality)	3.05pm – 3.30pm
6.5 Financial Recovery Plan (Report of Director of Finance attached)	3.30pm – 3.55pm
6.6 Terms of Reference Report (Report of Director of Corporate Affairs attached).	3.55pm – 4.00pm
7 **CLOSING MATTERS:**	
7.1 Date of next meeting: • Wednesday, 31 January 2018, 1.30pm, in Lecture Theatre B, Pinewood House, Stepping Hill Hospital.	4.00pm

STOCKPORT NHS FOUNDATION TRUST

Minutes of a meeting of the Board of Directors held in public on Friday 27 October 2017 1.15pm in Lecture Theatre A, Pinewood House, Stepping Hill Hospital

Present:

Mr A Belton	Chair
Mrs C Anderson	Non-Executive Director
Mrs C Barber-Brown	Non-Executive Director
Dr M Cheshire	Non-Executive Director
Mr J Sandford	Non-Executive Director
Ms A Smith	Non-Executive Director
Mr M Sugden	Non-Executive Director
Mrs A Barnes	Chief Executive
Mrs A Lynch	Director of Nursing & Quality
Mr H Mullen	Director of Support Services
Mr F Patel	Director of Finance
Mrs J Shaw	Director of Workforce & OD
Ms S Toal	Chief Operating Officer

In attendance:

Dr G Burrows	Deputy Medical Director
Mrs S Curtis	Membership Services Manager
Mrs H Thomson	Interim Chief Executive (Designate)
Mr K Spencer	Interim Provider Director
Ms J Bennett	Patient
Ms C Dent	Matron for Surgery
Mrs E Rogers	Matron for Patient Experience

243/17 Apologies for Absence

Apologies for absence had been received from Mr P Buckingham and Dr C Wasson.

244/17 Declaration of Amendments to the Register of Interests

Mrs C Anderson advised that she had been appointed as a Director of John Paul II Multi-Academy Trust.

245/17 Patient Story

The Board of Directors welcomed Ms J Bennett (patient), Mrs E Rogers (Matron for Patient Experience) and Ms C Dent (Matron for Surgery) to the meeting. The Chair reminded the Board that the purpose of patient stories was to bring the patient's voice to the Board providing real and personal examples of the issues within the Trust's quality and safety agendas. Ms J Bennett advised the Board that she had suffered a fractured neck of femur in May 2017 and had subsequently been admitted to Ward M4. She provided an overview of her experience on the ward which had been

adversely affected by noise at night due to a considerable number of dementia patients on the ward. She praised the nurses who had cared for her but noted the ward had been significantly short staffed. Ms J Bennett commented that the combination of the issues and the consequent lack of sleep had had an adverse impact on her recovery.

Ms C Dent advised that following feedback received from Ms J Bennett, a number of mitigating actions had been implemented. She briefed the Board of these actions which included a review of workforce; increased staffing and leadership; work regarding noise at night and the introduction of a bay tagging system which ensured that the most vulnerable patients were always under staff supervision. Ms C Dent advised that additional training had also been implemented to ensure that all staff was compliant in areas such as the Mental Capacity Act (MCA) and Depravation of Liberty Standards (DoLS).

In response to a question from Dr M Cheshire, Ms J Bennett commented that her length of stay may have been a day or two shorter had her recovery not been hindered by the issues raised. In response to a question from Mr J Sanford, Ms C Dent noted that she had visited Ms J Bennett at her bedside but acknowledged that more could have been done regarding earlier implementation of mitigating actions. The Director of Nursing & Quality advised that Ward M4 would be piloted in the Ward Accreditation Scheme which would be useful as an early warning tool. In response to a question from the Chief Executive, Mrs E Rogers noted that her involvement in patient stories was to ensure that patient voices were heard and that patients had the best possible experience at the hospital. She provided an overview of the work in this area, which included conversations with patients, sharing best practice, triangulating the information with surveys and identifying themes. Mrs E Rogers advised that she worked closely with Business Groups to ensure implementation of lessons learned.

The Board of Directors thanked Ms J Bennett, Mrs E Rogers and Ms C Dent for attending the meeting and sharing the powerful story.

The Board of Directors:

- Received and noted the Patient Story.

246/17 Minutes of the previous meeting

The minutes of the previous meeting held on 28 September 2017 were agreed as a true and accurate record of proceedings. The action log was reviewed and annotated accordingly.

247/17 Report of the Chair

The Chair presented a report which included information with regard to notable events, matters concerning the development of the Board, Chair engagements, any significant regulatory developments that the Chair had been involved in and a forward look to significant events or possible developments. He referred to s2.3 of the report and wished to thank everyone involved for the successful formal opening of the Medical & Surgical Centre on 26 October 2017 which had been performed by the HRH Duchess of Gloucester. The Chair noted that one of the outcomes from the Board

Development Day held on 26 October 2017 had been a request to allocate more time for Board development going forward with perhaps a slight decrease in the number of formal meetings.

The Chair then referred to s5.1 of the report and noted that the most recent Enhanced Oversight meeting with NHS Improvement (NHSI) had been held on 19 October 2017 and had been attended by the Deputy Chair, Chief Executive and the Director of Finance. The Chief Executive briefed the Board on the content and outcomes of the meeting and noted an expectation for the Trust to have an improved control of the current year's challenges by the November meeting and future years' challenges by the December meeting. Mr M Sugden advised that with regard to the Financial Recovery Plan, NHSI had requested demonstration regarding "grip" on the plan by the Finance & Performance Committee meeting on 15 November 2017. The Director of Finance agreed to provide a summary regarding progress in this area to Mr M Sugden in advance of that meeting.

The Board of Directors:

- Received and noted the Report of the Chair.

248/17 Report of the Chief Executive

The Chief Executive presented a report which provided an update regarding the Alliance Provider Board. She advised that the first formal meeting of the Alliance Provider Board had taken place on 10 October 2017 and noted that the Director of Support Services had been the Trust's representative at the meeting. The Board noted that the key issues discussed at the meeting had been outlined in s2.2 of the report. In response to a question from Mr M Sugden, the Interim Provider Director advised that the aspiration was for the Independent Chair of the Alliance Provider Board to be a General Practitioner and that the appointment would need to be endorsed by all four provider partners.

Mr J Sandford, Mr M Sugden, Mrs C Barber-Brown and Mrs C Anderson referred to the delays in the implementation of Neighbourhoods and queried the associated financial implications to the Trust. The Interim Provider Director advised that he would update the Board regarding Stockport Together benefits realisation at the meeting on 30 November 2017. The Director of Finance provided an overview of associated contract implications for next year but confirmed that the delay would not adversely affect the availability of transformation funding. The Chief Executive queried the level of detail the Board would wish to receive regarding the work of the Alliance Provider Board. Mr J Sandford suggested that it would be helpful to review the report from the Interim Provider Director at the November meeting and then establish if further supplementary information was required.

The Chief Executive then referred to the mock CQC Inspection which had been held on 24 October 2017. She wished to thank all the mock inspectors and the medical wards involved in the process and noted that the inspectors had commended the openness and transparency of the day. The Chief Executive advised that the outcomes would be fed back to the medical wards and that any areas for improvement would be actioned and areas of best practice cascaded to other wards.

The Chief Executive was delighted to announce that the Trust's Stroke Unit had been officially ranked as the best in England. She advised that a report from the Sentinel Stroke National Audit Programme (SSNAP) had rated the Trust's Stroke Unit as the first in the country out of a total of 224 stroke centres. The Board wished to congratulate everyone involved for this exceptional achievement, with a specific mention made to the Chief Operating Officer and the Deputy Chief Operating Officer. In response to a question from the Chair, the Chief Executive advised that the ratings were published annually.

The Board of Directors:

- Received and noted the Report of the Chief Executive.

249/17 Key Issues Reports

Finance & Performance Committee

Mr M Sugden briefed the Board on matters considered at a meeting of the Finance & Performance Committee held on 18 October 2017. He reported that the Committee had noted the Trust's improved cash position and that access to a working capital facility would now not be required until January 2018 as opposed to December 2017 reported last month. Mr M Sugden advised that the Committee had noted a deteriorating performance against the A&E 4-hour standard and non-achievement of the RTT standard in September 2017. Mr M Sugden advised that the Committee had noted a reduced level of agency expenditure for a third consecutive month. He commented that whilst this further reduction had reduced the risk of non-compliance with the overall 2017/18 agency ceiling, the risk to achievement of the further 10% reduction in medical agency usage still remained. Mr M Sugden advised that a further contributory factor to reduced expenditure was anticipated to result from planned service reviews and noted that the Committee had considered a report detailing the methodology for the reviews which were scheduled to commence in November 2017.

Mr M Sugden advised that the Committee had also considered a report on the 2017/18 Cost Improvement Programme (CIP) and had noted a gap of circa £2.1 against the £15m target for the year. He advised that the Committee was only able to report low assurance on delivery of the 2017/18 CIP. Mr M Sugden reported that the main focus of the meeting had been on a Financial Recovery Plan and he briefed the Board on a series of measures included in the plan document which were aimed to achieve the Trust's financial plan for 2017/18. Mr M Sugden advised that the Committee had endorsed the proposed measures but had noted the level of risk associated with full delivery of the additional efficiencies. Due to the consequent risk associated with delivery of the financial position, the Committee had requested that the Executive Team identify additional schemes to provide an appropriate level of contingency.

Mr M Sugden advised the Board that the Committee had then considered reports on benefits of the EPR project together with a summary of current progress. He advised that the Committee had noted the Non-Executive Director oversight arrangements established for this key project and received positive assurance from the relevant Non-Executive Directors regarding the plans to achieve benefits from Roll Out 1. With regard to progress, Mr M Sugden referred to the decision taken to postpone Roll Out 1

implementation and advised that the Committee had noted continuing work across all project work streams to ensure readiness for a revised implementation date.

People Performance Committee

Ms A Smith briefed the Board on matters considered at a meeting of the People Performance Committee held on 19 October 2017. She advised that the Committee had approved an updated Recruitment & Retention Strategy but had requested further detail regarding the Trust's current and target positions with regard to key objectives of the Strategy. Ms A Smith reported that the Committee had considered a refreshed Workforce Plan and that Committee members had been requested to provide further comments on the structure of the Plan in advance of approving the final Plan at the Committee meeting in November 2017. Ms A Smith also advised that the Committee had requested a staff story on the role of Allied Health Professionals at a future Committee meeting to provide further information regarding this important role.

Ms A Smith noted that the Committee had received assurance on the effective implementation of the Internal Communications & Engagement Plan 2017/18 and had reviewed a Quarter 1 Workforce & OD Performance Report. She advised that the Committee would review the Quarter 2 report at the next meeting but that thereafter, the report would be presented annually and that monthly Workforce Flash Reports would be considered at Committee meetings going forward. Ms A Smith advised that the Committee had then considered reports on Training Needs Analysis and Medical Appraisal & Revalidation and had received positive assurance in both of these areas.

Ms A Smith advised that the Committee had been pleased to note that the level of agency expenditure had reduced for a third consecutive month and she wished to thank all staff involved for this achievement, noting the efforts of the Workforce Transformation Manager in particular. In response to a question from Mr J Sandford, the Director of Workforce & OD confirmed that the Trust was IR35 compliant but noted individual issues in this area. Ms A Smith concluded her report by advising the Board that the Committee had received an update following a visit by the Health Education England North West (HEENW) on 21 September 2017. She noted that HEENW had visited the Emergency Department following concerns from their previous visit in September 2016 relating to medical training standards. Ms A Smith advised that a significant amount of work had been done by the Trust's Emergency Department, Acute Medicine and Post-Graduate Medical Centre since the previous visit and was pleased to note that both the General Medical Council and the HEENW had commended the Trust for an improved position.

The Board of Directors:

- Received and noted the Key Issues Reports.

The Deputy Chief Operating Officer joined the meeting.

250/17 Urgent Care Recovery Plan and Winter Preparedness

The Chief Operating Officer, the Deputy Chief Operating Officer and the Interim Provider Director delivered a presentation on Urgent Care Recovery Plan and Winter Preparedness. The presentation covered the following subject areas:

- Urgent Care Recovery Plan and Winter Preparedness
- Urgent Care Recovery Plan – Final Outcome
  - KPI 1: ED performance July to 8 Oct 2017
  - KPI 2: DToCs and MOATS to 19 October 2017
  - KPI 3: DToCs July 2017 to 8 October 2017
- Winter Preparedness – Planning Principles
- Winter Preparedness – Adoption of Best Practice
  - Acute Medical Unit Occupancy
  - Decongested Emergency Department
  - Earlier Discharge
  - Neighbourhood Response
  - Managing Flu and Respiratory patients

In response to questions from Mr J Sandford and Dr M Cheshire, the Chief Operating Officer advised the Board of bed utilisation rates and noted that the Acute Medical Unit beds were critical in ensuring appropriate flow. In response to a question from Mrs C Barber-Brown regarding the proposed Frailty Unit, the Deputy Chief Operating Officer briefed the Board on the strict clinical criteria the Trust would use for frailty scoring and noted that low occupancy rates would be necessary to ensure efficient operation of the Unit. In response to a question from Dr M Cheshire regarding access to the Frailty Unit, the Deputy Chief Operating Officer advised that patients would be streamed to the Unit from the Emergency Department or referred by Neighbourhood Teams, the Crisis Response Team and General Practitioners.

The Interim Chief Executive Designate sought assurance that the waiting time for patients was not merely shifted elsewhere as a result of the proposed changes. The Deputy Chief Operating Officer noted the importance of capturing this metric to provide the necessary assurance. In response to a further question from the Interim Chief Executive Designate, the Deputy Chief Operating Officer briefed the Board on the way in which the changes would be incorporated to become 'business as usual' following the winter period. In response to a question from Mr J Sandford, the Deputy Chief Operating Officer noted that the key to sustainable improvement of the 4-hour A&E position was effective leadership driving the improvement initiatives. He noted that these initiatives included the 3 x weekly "Creating Efficient and Effective Patient Flow in Stockport NHS Foundation Trust" (CEEPFIT) sessions and the 7-Day Stranded patient reviews. In response to a follow up question from Mr J Sandford, the Interim Provider Director advised that funding for these initiatives was included in the Stockport Together business cases.

In response to a question from the Interim Chief Executive Designate, the Deputy Chief Operating Officer advised that senior clinical challenge was key in facilitating timely discharges. In response to a question from Mrs C Anderson, the Deputy Chief Operating Officer commented that continued staff engagement would be facilitated by the process being the whole organisation's responsibility. In response to a question from the Director of Workforce & OD regarding the flu vaccination rate in community, the Deputy Chief Operating Officer noted that this area was led by the Clinical Commissioning Group (CCG) but agreed to establish the current position.

The Deputy Chief Operating Officer left the meeting.

There followed a discussion regarding appropriate governance arrangements to track progress in this area. It was consequently proposed that the Chief Operating Officer would produce a set of key metrics to provide necessary assurance and which would be considered at the Finance & Performance Committee. With regard to the proposed bed reconfiguration plans, the Director of Finance noted the importance of establishing the associated impact on nurse staffing.

The Board of Directors:

- Received and noted the Urgent Care Recovery Plan and Winter Preparedness presentation.

251/17 Trust Performance Report – Month 6

The Chief Operating Officer presented the Performance Report which summarised the Trust's performance against the NHSI Single Oversight Framework for the month of September 2017, including the key risks to delivery. She advised that the report also provided a summary of the key risk areas within the Integrated Performance Report which was attached in full in Annex A. The Chief Operating Officer noted that much of the content had already been covered during consideration of the Committee Key Issues Reports and the Urgent Care Recovery Plan & Winter Preparedness presentation. She advised that there were two areas of non-compliance in month which were the non-achievement of the Accident & Emergency (A&E) 4-hour target and the Referral to Treatment (RTT) 92% incomplete standard.

With regard to the Emergency Department (ED) performance, the Board noted the September position of 79.9% which was below the improvement trajectory of 90%. The Chief Operating Officer advised that RTT performance was below the national standard for the first time in 10 months and noted that the Trust was predicted to achieve compliance regarding the Cancer 62-day target for September 2017 and Quarter 2. The Director of Workforce & OD briefed the Board on workforce performance and advised that the essentials training compliance was 82.7% for September 2017. She noted the detrimental impact of e-learning transition to the overall compliance and advised that a full review of the process had been undertaken. The Director of Workforce & OD noted a £2.12m (1.4%) decrease in bank & agency costs since the previous month and advised that the in-month unadjusted sickness absence figure for September 2017 was 3.76%, a decrease of 0.56% since the previous month.

The Director of Finance noted that the majority of the Finance section had been covered earlier on the agenda during consideration of the Finance & Performance Key Issues Report. He advised that following a decision by the Stockport CCG to reinvest penalties, the financial position in October was anticipated to be slightly better than planned. The Chair commented on the content of the Performance Report and requested that more emphasis be given to forward looking information. Dr M Cheshire referred to the Clinical Correspondence information and suggested a more focused way of reporting performance. He also requested inclusion of improvement outcomes in the report. Mrs C Barber-Brown endorsed Dr M Cheshire's comment and noted the importance of understanding the effect of the various initiatives detailed in the report.

In response to a question from Mrs C Barber-Brown regarding the elective income position, the Chief Operating Officer advised that the Surgical & Critical Care Business Group had been asked to present a recovery plan to the Finance & Performance Committee in November 2017. In response to a question from Dr M Cheshire who queried the process and outcomes of a mid-year contract review with the CCG, the Director of Finance provided assurance that the process had commenced and advised that the associated project plan and governance process would be shared with the Board. Mr J Sandford queried the impact of the significant reduction in the completion of discharge summaries on ED performance and flow. The Chief Operating Officer noted that this issue was two-fold; firstly there were patients who had been discharged home but the discharge summaries had not been completed. Secondly, there was a cohort of patients without discharge summaries and the Chief Operating Officer advised that a process map had been requested to understand key issues in this area.

Mr J Sandford referred to Chart 34 in the Integrated Performance Report and noted his concern with regard to the increasing trend in the ED re-attendance rate. Ms A Smith noted her concern with regard to the increasing trend in pressure ulcers and proposed that this area be explored further at the Quality Assurance Committee. The Chief Operating Officer agreed to review the cumulative pressure ulcer position. The Chair suggested that going forward, Board members contact the appropriate Executive Director colleagues prior to Board meetings to raise any questions or concerns with regard to any aspects of the Integrated Performance Report. The Chief Executive noted that one of the outcomes of the Board Development Day held on 26 October 2017 had been a proposal to refresh the Performance Report to facilitate improved interrogation of the report by Board Assurance Committees. In response to a question from the Chair, the Director of Nursing & Quality advised that it was envisaged that the new format of the report would be available in March 2018.

The Board of Directors:

- Received and noted the contents of the Trust Performance Report
- Noted the position for Month 6 compliance standards
- Noted the future risks to compliance and corresponding actions to mitigate
- Noted the key risk areas from the Integrated Performance Report.

252/17 Maintaining Safe Staffing Levels

The Director of Nursing & Quality presented a report which provided an overview, by exception, of actual versus planned staffing levels for the month of September 2017. She advised that the report also highlighted the percentage of temporary staff utilised, outlined recruitment and retention initiatives to address the shortfall of Registered Nurses and Midwives and included recent Acuity Audit results. The Director of Nursing & Quality briefed the Board on the content of the report and advised that the Acuity Audit results suggested that nine areas showed an under establishment (red rating) of nursing staff, one area reported amber ratings and 16 were green. She advised that average fill rates for Registered Nurses and Midwifes remained above 90% average for both day and night duty. The nine areas reporting suboptimal registered staff levels below 90% were in Child & Family (2 areas), in Surgery & Critical Care (3 areas) and in Integrated Care and Medical wards (4 areas). The Board noted that Medicine &

Integrated Care and Surgery & Critical Care were greatest areas of concern with regard to Registered Nurse vacancies.

The Director of Nursing & Quality briefed the Board on recruitment and retention initiatives and noted that the Trust had been invited to join an NHSI Recruitment & Retention collaborative. She advised that a review of the Safe Staffing Report would be undertaken with a view to enhancing the report content but noted that the format would remain the same. In response to a question from the Chair, she confirmed that the changes would be incorporated in the next Safe Staffing Report in November 2017. The Director of Nursing & Quality referred to the fill rate indicator table included at Appendix 1 of the report and noted that, going forward, further detail would be included to explain the reasons for sub-optimal staffing levels. In response to a question from the Chair, the Director of Nursing & Quality noted that safe staffing was a significant area of concern for the Trust.

The Board of Directors:

- Received and noted the Safe Staffing Report and the measures in place to ensure patient safety.

253/17 MRSA Bacteraemia

The Deputy Medical Director presented a report which provided an overview regarding an incidence of MRSA bacteraemia which had occurred in the Trust in August 2017. She briefed the Board on the content of the report and advised that prior to this incident, the Trust had not had any cases of MRSA bacteraemia in 970 days. The Deputy Medical Director advised that a serious incident investigation had consequently been carried out which had unfortunately identified a number of shortcomings in care. She referred the Board to s4 of the report which outlined the concerns and associated mitigating actions. In response to a question from Mrs C Barber-Brown, the Deputy Medical Director advised that whilst the appropriate procedures had been in place, they had not been followed in a number of occasions.

The Chair advised the Board that a communications plan had been prepared to manage reputational risk to the Trust. In response to questions from Mrs C Anderson and Mrs C Barber-Brown, the Deputy Medical Director and the Director of Nursing & Quality advised that both the ward accreditation system and the CQC actions were hoped to help improve performance with regard to adherence to policies and procedures. In response to a question from Mr J Sandford, regarding the root cause for the failure to follow processes, the Deputy Medical Director noted issues relating to ward leadership and holding to account.

The Board of Directors:

- Received and noted the MRSA Bacteraemia report.

254/17 Corporate Objectives 2017/18

The Chief Executive presented a report which provided an update on progress with regard to the Corporate Objectives for 2017/18 as at the end of Quarter 2. She briefed the Board on the content of the report and noted that a full list of strategic objectives,

corporate objectives for 2017/18, progress updates and RAG ratings had been attached as Appendix 1 to the report. The Chief Executive referred to an earlier decision made by the Board not to include amber in the RAG ratings. With regard to corporate objective ref: C20, Dr M Cheshire noted that the Finance & Performance Committee had not been informed of plans to effectively reorganise the Trust's estate to improve clinical services. The Director of Support Services advised that a Rationalisation Group had been established to oversee work in this area.

Mr J Sandford commented that there was nothing new in the Corporate Objectives that the Board was not already sighted upon. The Chair noted a need for a discussion regarding the way in which the Board would review objectives going forward.

The Board of Directors:

- Received and noted the Corporate Objectives 2017/18 update report.

The Freedom to Speak Up Guardian joined the meeting.

255/17 Freedom to Speak Up Report

The Freedom to Speak Up Guardian presented a report, the purpose of which was to provide the Board with assurance on the effective working of the Trust's Freedom to Speak Up arrangements. He briefed the Board on the content of the report and provided an overview with regard to communications / awareness raising, policy, training, casework & approach, emerging themes & actions, national developments, national Freedom to Speak Up Guardian survey and forward view. The Freedom to Speak Up Guardian noted that Appendix 1 provided a timeline of concerns with Freedom to Speak Up Guardian oversight with levels of escalation and awareness.

With regard to reporting arrangements, he noted that quarterly reports would be produced for the People Performance Committee and that the Board would receive updates every six months. The Freedom to Speak Up Guardian noted that the report provided assurance that the Trust was working in positive collaboration with the Freedom to Speak Up Guardian to meet all National Guardian Office recommendations and improve its culture and processes around raising and dealing with concerns. In response to a question from Mr J Sandford regarding the appropriateness of the organisation's culture, the Freedom to Speak Up Guardian noted positive senior leadership support but that perception by front line staff was variable. In response to a question from Mr M Sugden regarding addressing the themes highlighted in s3.5 of the report, the Freedom to Speak Up Guardian provided an overview of actions in this area, including associated staff training.

In response to a question from the Chair, the Freedom to Speak Up Guardian confirmed that he felt well supported by senior management. He referred to s5.3 of the report and, as an example, noted that he had direct access to the Chief Executive, which was not the case for all guardians. The Board thanked the Freedom to Speak Up Guardian for the report and noted that the next update report would be considered in six months' time.

The Board of Directors:

- Received and noted the Freedom to Speak Up Report.

The Freedom to Speak Up Guardian left the meeting.

256/17 Board Assurance Framework

The Chief Executive presented the Board Assurance Framework (BAF) 2017/18 to the Board of Directors for consideration and approval. She noted that the format of the document, which had been attached at Annex A to the report, had been designed in partnership with Mersey Internal Audit Agency (MIAA) with scope of content and presentation informed by best practice identified by MIAA. The Chief Executive advised that the BAF had been reviewed by the relevant risk owners and updated accordingly and noted the following changes to residual risk scores:

- Risk 1: Delivery of the Trust's Five Year Strategy – 16 to 20
- Risk 4: Inability to maintain and improve compliance with CQC standards – 16 to 20
- Risk 7: Failure to ensure efficient management of the EPR project will mean the inability to realise the benefits expected – 8 to 16.

In response to a question from Mrs C Anderson regarding the risk rating for the A&E 4-hour target compliance (SO3), the Chief Operating Officer acknowledged that the risk rating of 16 appeared too low and would be reviewed. In response to a question from Ms A Smith, the Director of Workforce & OD agreed to review the risk rating of 12 for the workforce risk (SO6) which also appeared to be too low. Mr J Sandford commented that, in general, the BAF provided the necessary assurance against the Trust's key risks. He noted, however, that this was not the case in areas where the Trust was failing to achieve progress or risks were not being managed appropriately in which case the Board would need to be sighted on associated recovery plans in order to gain the necessary assurance. It was subsequently proposed that the Audit Committee would consider this issue further and make any necessary recommendations to the Board.

The Board of Directors:

- Considered and approved the content of the Board Assurance Framework at Annex A but noted that SO3 and SO6 required review.

257/17 Date, time and venue of next meeting

There being no further business, the Chair closed the meeting and advised that the next meeting of the Board of Directors would be held on Thursday, 30 November 2017, at 1.15pm in Lecture Theatre A, Pinewood House.

Post-Meeting Review

Those present reflected on the nature of the meeting and noted the following:

- The format of the Patient Story was commended as it was delivered by a patient and consequent learning was outlined by the nursing staff.

- It was proposed that Assurance Committee Key Issues Reports were taken as read but that time was allowed for associated questions from the Board.

Signed:_____Date:_____

BOARD OF DIRECTORS: ACTION TRACKING LOG

Ref.	Meeting	Minute Ref	Subject	Action	Responsible
9/16	24 Nov 16	340/16	Strategic Risk Register	Mrs J Morris advised that all risks would be transferred to the new Datix system by the end of December 2016 and suggested that once implemented, Ms C Marsland would provide a presentation to the Board with regard to the new system. **Update on 27 Jan 2017** – A presentation would be provided to the Board in April 2017. **Update 27 Apr 17** – The Board noted a delay to implementation of the Datix system and agreed that the presentation would be provided on 29 June 2017. **Update 26 Jun 17** – Mrs J Morris advised that due to the revised Board meeting date, Ms C Marsland had been unable to attend the meeting as she was at an inquest. It was noted that the presentation would be deferred to the July Board meeting. **Update 27 Jul 17** – The Chief Executive advised the Board that the Trust was looking to procure an external trainer to provide training on the new Datix system. It was noted that the presentation to the Board would be arranged as soon as practicable. **Update 28 Sep 17** – The Chief Executive advised the Board that the Trust had procured an external trainer for a 6 month period to provide training on the new Datix system and noted that the Board would receive a presentation on the new system at the October meeting. **Update 27 Oct 17** – The Chief Executive noted her disappointment that due to the unavailability of fit for purpose risk management information, the Board was not able to consider a Strategic Risk Register at the meeting. A number of Board members noted their concern and disappointment with regard to this position. The Director of Nursing & Quality advised that mitigating actions were underway in this area and agreed to provide a status update to the Board prior to the next meeting. In response to a comment from Mr M Sugden, it was agreed to amalgamate the outstanding presentation on the Datix system with a presentation on the Post-Implementation Review of the Surgical &	J Morris (Director of Nursing) A Lynch (Dir of Nursing & Quality) A Lynch (Dir of Nursing & Quality)/ H Mullen (Dir of

				Medical Centre.	Support Services)
13/17	26 Jun 17	170/17	Stockport Together – Outline Business Cases	Board members agreed to receive presentations on key enablers at the Board of Directors meetings in August / September 2017: • Workforce – August • IM&T and Information Governance – September **Update 28 Sep 17** – The Director of Corporate Affairs agreed to liaise with the Director of Support Services and the Director of Workforce & OD with regard to the scheduling of these presentations.	J Shaw (Dir of Workforce & OD) / H Mullen (Dir of Support Services) / P Buckingham (Dir of Corporate Affairs)
15/17	26 Jun 17	173/17	Strategic Risk Register	The Director of Corporate Affairs and Mr J Sandford agreed to review the Audit Committee terms of reference with a view to incorporating risk in its functions and consider content for a risk workshop. **Update 27 Jul 17** – The Director of Corporate Affairs advised that outcomes of the review would be considered at the next Audit Committee meeting on 12 September 2017. **Update 28 Sep 17** – The Director of Corporate Affairs noted that he had met with Mr J Sandford and advised that a revised version of the Audit Committee terms of reference would be considered at the Audit Committee in November, with a view to being presented to the Board of Directors for approval in November 2017. **Update for 30 Nov 17 –** Report included on the agenda. Actin complete.	P Buckingham (Dir of Corporate Affairs) / J Sandford
16/17	27 Jul 17	199/17	CQC Inspection – June 2017	The Chief Executive advised that the Improvement Plan would be considered by the Board of Directors at the meeting on 29 September 2017 but noted that the plan might not be the final version at that stage. **Update 28 Sep 17** – The Chief Executive noted that the Trust was still awaiting the publication of the CQC Reports and it was therefore proposed that the final Consolidated Improvement Plan be considered by the Board at the meeting in November 2017. **Update 27 for Oct 17 –** CQC reports published in October 2017. Progress report to be presented to the Board of Directors by the Director of Nursing & Quality and Medical Director on 30 November 2017	A Barnes (Chief Executive) A Lynch (Dir of Nursing & Quality) / C Wasson (Medical Director)

17/17	28 Sep 17	220/17	Finance & Performance Key Issues Report	Mr M Sugden reported that the Committee had considered the Trust's cash position and had noted the likelihood that the Trust would require additional cash investment in December 2017. He advised that relevant approval documentation would be prepared for consideration by the Board of Directors in November 2017.	F Patel (Director of Finance)
18/17	28 Sep 17	221/17	Trust Performance Report – Month 5	The Interim Provider Director made reference to the increased capability of neighbourhood teams and 7-day working and noted that the Board of Directors would receive a report regarding the Implementation Plan of the Stockport Together Programme at the meeting in October 2017. **Update 27 Oct 17** – The Interim Provider Director noted that following discussions at the most recent Alliance Board, a single report would be prepared for all providers which would be presented to this Board on 30 November 2017. He noted, however, that the Board might benefit from a "walk through" of the report beforehand.	K Spencer (Interim Provider Director)
19/17	28 Sep 17	222/17	CQC Report	In response to a question from the Interim Provider Director, the Interim Director of Nursing advised that the ward accreditation programme would be based on external assessment and it was subsequently proposed that Ms C Sparks, Assistant Director of Nursing, would be invited to deliver a presentation on this topic to a future meeting of the Board of Directors. **Update for 27 Oct 17** – Presentation scheduled to be presented to the Board on 30 November 2017. **Update for 30 Nov 17 –** Superseded by Quality Improvement presentation	A Lynch (Director of Nursing & Quality)
20/17	28 Sep 17	225/17	Draft Alliance Provider Agreement	In response to a question from the Chair, the Interim Provider Director advised that he would provide an update with regard to the risk and gain share agreement at the next Board meeting. **Update 27 Oct 17** – The Interim Provider Director advised that he had written to all Directors of Finance with regard to the risk and gain share agreement and noted that the issue would be discussed at the Locality Finance Meeting on 6 November 2017.	K Spencer (Interim Provider Director)

21/17	27 Oct 17	248/17	Report of the Chief Executive	Mr J Sandford, Mr M Sugden, Mrs C Barber-Brown and Mrs C Anderson referred to the delays in the implementation of Neighbourhoods and queried the associated financial implications to the Trust. The Interim Provider Director advised that he would update the Board regarding Stockport Together benefits realisation at the meeting on 30 November 2017.	K Spencer (Interim Provider Director)
22/17	27 Oct 17	256/17	Board Assurance Framework	Mr J Sandford commented that, in general, the BAF provided the necessary assurance against the Trust's key risks. He noted, however, that this was not the case in areas where the Trust was failing to achieve progress or risks were not being managed appropriately in which case the Board would need to be sighted on associated recovery plans in order to gain the necessary assurance. It was subsequently proposed that the Audit Committee would consider this issue further and make any necessary recommendations to the Board.	Mr J Sandford

Stockport NHS
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	30 November 2017
Subject:	Chair's Report		
Report of:	Chair	**Prepared by:**	Mr P Buckingham

REPORT FOR NOTING

Corporate objective ref:	**Summary of Report** The purpose of this report is to advise the Board of Directors of the Chair's recent and planned activities
Board Assurance Framework ref:	
CQC Registration Standards ref:	N/A
Equality Impact Assessment:	☐ Completed ☐ Not required

Attachments:	Nil

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

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1. PURPOSE OF THE REPORT

1.1 The purpose of this report is to advise the Board of Directors of the Chair's recent and planned activities. As previously, the report provides brief information since the previous Board meeting in relation to:

- Notable events
- Matters concerning the development of the Board itself
- My own engagements and visits on behalf of the Trust
- Any significant regulatory developments that as Chair I have been involved in
- A forward look to significant events or possible developments.

2. NOTABLE EVENTS

2.1 Board members should note that this will be the final Board meeting which will be attended by Mrs A Barnes prior to her retirement on 31 December 2017. I am sure that all Board members will join me in wishing Ann well for her retirement and acknowledge the tremendous service she has provided to the NHS generally, and this Trust in particular, throughout her extensive career with the health service.

3. BOARD DEVELOPMENT

3.1 I have undertaken a series of Non-Executive Director appraisals this month. A number of development themes have emerged from the appraisals which will be incorporated in the wider Board Development programme.

3.2 The Remuneration Committee is scheduled to meet on 30 November 2017 to agree the timetable and process for recruitment of a substantive Chief Executive and we anticipate advertisement of the position in early January 2018. In the meantime, the handover of Chief Executive responsibilities from Mrs A Barnes to Mrs H Thomson is progressing well and Mrs A Barnes will retain the responsibilities of Accounting Officer until her retirement date.

4. CHAIR ENGAGEMENTS

4.1 A summary of the Chair's activities is as follows:

19 October 2017	Visit to Emergency Department, Frailty Unit & Crisis Response Team
26 October 2017	'NED to NED' meeting with Stockport CCG
31 October 2017	Met with Mr P Connellan, retiring Chair of Tameside NHS Foundation Trust
1 November 2017	Attended a meeting of the Clinical Directors' Forum
7-8 November 2017	Attended the NHS Providers Annual Conference

14 November 2017	Met with the Chair & Chief Executive of North West Ambulance Service and completed a tour of the NWAS Manchester Operations Centre
15 November 2017	Attended a NHS Providers dinner with Sir Muir Gray to discuss Population Health
16 November 2017	Met with two Non-Executive Directors; Mr J Greenhough, Stockport CCG, and Mr G page, Equity Housing
16 November 2017	Attended an introductory meeting with newly-elected Governors
22 November 2017	Visited the Trust's Pathology Lab

5. REGULATORY DEVELOPMENTS

5.1 The Trust is currently attending monthly Enhanced Oversight meetings with NHS Improvement representatives which focus on the Trust's plans to address the financial position. The most recent meeting was held on 20 November 2017 and was attended by the Deputy Chair, Chief Executive and Director of Finance.

6. FORWARD LOOK

6.1 A number of events to note during December 2017 are as follows:

- Council of Governors Meeting – 6 December 2017
- Volunteers Christmas Lunch – 12 December 2017
- Chief Executive Retirement Event – 20 December 2017

7. RECOMMENDATIONS

7.1 The Board of Directors is recommended to:

- Receive and note the content of the report.

Stockport NHS
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	30 November 2017
Subject:	Chief Executive's Report		
Report of:	Chief Executive	**Prepared by:**	Mr P Buckingham

REPORT FOR NOTING

Corporate objective ref:	**Summary of Report** The purpose of this report is to advise the Board of Directors of national and local strategic and operational developments which include: • Quarter 2 Locality Assurance Meeting • Updated Single Oversight Framework
Board Assurance Framework ref:	
CQC Registration Standards ref: N/A	
Equality Impact Assessment: ☐ Completed ☐ Not required	

Attachments: Annex A – Updated Single Oversight Frameworkl

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

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1. INTRODUCTION

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

2. QUARTER 2 LOCALITY ASSURANCE MEETING

2.1 The Quarter 2 Locality Assurance Meeting was held on 9 November 2017. The Deputy Chief Executive, Chief Operating Officer, Director of Finance, Medical Director and the Managing Director SNC represented the Trust at the meeting.

2.2 The meeting covered a broad range of issues affecting the Stockport locality, with key areas as follows:

- The local authority pledged to provide financial support where appropriate
- The continuing challenge of performance against the A&E 4-hour standard
- Mr J Rouse agreed to meet with the Director of Nursing & Quality to discuss progress with the CQC action plan and the introduction of a Ward Accreditation Scheme
- The Stockport system was commended for establishing a data sharing agreement between relevant parties
- Discussion on the Trust's current financial position.

2.3 With regard to performance against the A&E standard, there was consideration and discussion on the flow challenge and the need to effectively balance elective and emergency flow whilst mitigating the risk of 52-week breaches. The work undertaken by the system to reduce the number of Delayed Transfer of Care (DTOC) patients was acknowledged and a request was made for the Trust to provide details of the support currently being provided by external stakeholders.

2.4 There was much discussion on the Trust's financial position and there was clear emphasis of the expectation that the Trust will deliver its financial plan for 2017/18. The expectation that measures to address the financial challenge are owned by leaders across all Trust areas was also clearly stated.

3. UPDATED SINGLE OVERSIGHT FRAMEWORK

3.1 Following a period of consultation, NHS Improvement published an updated Single Oversight Framework SOF) on 13 November 2017. The changes in the updated version are summarised as follows:

- Changes to improve the structure and presentation of the document
- Introduction of a separate section outlining the five key themes of the SOF including details of what would trigger consideration of a support need
- Changes to some of the metrics used to assess Providers' performance
- Clarity under each theme that other material concerns arising from intelligence gathered by or provided to NHS Improvement could trigger consideration of a support need

- Making explicit that Providers are expected to notify NHS Improvement of significant actual or prospective changes in performance or risk outside routine monitoring.

3.2 No changes have been made to the underlying framework itself i.e. there are no changes to; the five themes, NHS Improvement's approach to monitoring, how support needs are identified or how Providers are segmented. A copy of the updated Single Oversight Framework is included for reference at Annex A of this report.

4. RECOMMENDATIONS

4.1 The Board of Directors is recommended to:

- Receive and note the content of the report.

NHS Improvement

Single Oversight Framework

Updated November 2017

collaboration trust respect innovation courage

We support providers to give patients safe, high quality, compassionate care within local health systems that are financially sustainable.

Contents

1. Introduction

This document sets out NHS Improvement's approach to overseeing and supporting NHS trusts and NHS foundation trusts under the Single Oversight Framework (SOF). It explains what the SOF is, how it is applied and how it relates to NHS Improvement's duties and strategic priorities.

The document will help providers to understand how NHS Improvement is monitoring their performance; how we identify any support they may need to improve standards and outcomes; and how we co-ordinate agreed support packages where relevant. It summarises the data and metrics we regularly collect and review for all providers, and the specific factors that will trigger more detailed investigation into a trust's performance and support needs.

The document will also be used by NHS Improvement's regional teams to guide their monitoring and assessment of providers and their decisions about the level and nature of support needs a provider may have.

The first version of the SOF was published in September 2016. This version has been updated to improve the structure and presentation of the document, and to clarify certain processes and definitions. These changes are based on feedback and lessons learned from the first year of operating the SOF.

We have also made a small number of changes to the information and metrics we use to assess providers' performance under each theme, and the indicators that trigger consideration of a potential support need. These updates reflect changes in national policy and standards, other regulatory frameworks and the quality of performance data, to ensure that our oversight activities are consistent and aligned. The main changes we have made in this way are set out in Table 1.

Table 1: Summary of changes to indicators and triggers monitored under each theme

Changes	Rationale
Quality of care	
+ Added *Escherichia coli* (*E. coli)* bacteraemia bloodstream infection (BSI) rates to quality indicators	New national commitment to reduce healthcare associated Gram-negative bloodstream infections by 50% by 2021
+ Added Meticillin-sensitive *Staphylococcus aureus* (MSSA) rates to quality indicators	Existing national priority to reduce rates, which are currently rising
- Removed Aggressive cost reduction plans metric from list of quality indicators	No specific metric available to track this.
- Removed Hospital standardised mortality ratio – weekend (Doctor Foster Intelligence) from list of quality indicators for acute providers	Indicator not yet sufficiently developed to inform identification of support needs
- Removed Emergency readmission rates from list of quality indicators for acute providers	No validated national metric available
Finance and use of resources	
+ Added Reference to new Use of Resources (UoR) framework, with explanation of how UoR assessments will be used under the SOF	To ensure consistency across oversight frameworks
Operational performance	
+ Added Dementia assessment and referral standards for acute providers	To maintain focus on existing national priority
+ Added Reduction of inappropriate adult mental health out-of-area placements as standard for mental health providers	New national priority to eliminate inappropriate out-of-area placements by 2021

Changes	Rationale
- Removed Patients requiring acute care who received a gatekeeping assessment as standard for mental health providers	No longer considered a useful indicator of performance. New metric being developed
~ Amended *Data Quality Maturity Index (DQMI)* - Mental Health Services Data Set (MHSDS) Data score replaces previous standards for submitting 'priority' and 'identifier' metrics to MHSDS	Original measure of complete and valid metrics in the monthly Mental Health Services Data Set submissions not supported by NHS Digital.
~ Amended Where relevant, we will use performance against the national standard rather than Sustainability and Transformation Fund (STF) trajectories as the trigger of potential support needs in relation to operational performance standards	Consideration of support needs should be based on absolute performance. Progress against trajectories can be taken into account when confirming whether there is an actual support needs, and what form the support should take.
~ Amended Ambulance response time standards	Updated to reflect the new standards, indicators and measures that have been introduced for ambulance providers through the Ambulance Response Programme
Strategic change	
+ Added We will review the assessment of system-wide leadership in relevant sustainability and transformation partnership (STP) ratings when considering providers' performance under this theme.	To reflect developments in national policy regarding STPs
Leadership and improvement capability	
+ Added Reference to NHS Improvement and CQC's new, fully joint well-led framework and guidance on developmental reviews	To ensure consistency across oversight frameworks

2. NHS Improvement

NHS Improvement is responsible for overseeing NHS foundation trusts, NHS trusts and independent healthcare providers. We support these providers to give patients safe, high quality, compassionate care within local health systems that are financially sustainable.

Our 2020 strategic objectives[1] set out our overarching aims for the trust sector across **five themes**:

Theme	Aim
Quality of care (safe, effective, caring, responsive)	To continuously improve care quality, helping to create the safest, highest quality health and care service
Finance and use of resources	For the provider sector to balance its finances and improve its productivity
Operational performance	To maintain and improve performance against core standards
Strategic change	To ensure every area has a clinically, operationally and financially sustainable pattern of care
Leadership and improvement capability (well-led)	To build provider leadership and improvement capability to deliver sustainable services

By focusing on these five themes, in 2017/18 we aim to:

- help more providers achieve CQC 'good' or 'outstanding' ratings
- reduce the number of providers in special measures for quality
- help the sector achieve aggregate financial balance
- improve provider productivity
- help providers meet NHS Constitution standards, with a particular focus on the aggregate accident and emergency (A&E) standard.

[1] Available at https://improvement.nhs.uk/uploads/documents/NHSI_2020_Objectives_13july.pdf

3. The Single Oversight Framework

The Single Oversight Framework:

- provides one framework for overseeing NHS trusts and NHS foundation trusts
- sets out how we will identify potential support needs, under five themes, as they emerge
- allows us to tailor our support packages to the specific needs of providers in the context of their local health systems, drawing on expertise from across the sector and from other agencies and partner organisations, as well as within NHS Improvement
- is based on the principle of earned autonomy.

The purpose of the Single Oversight Framework is to:

- help NHS Improvement identify where providers[2] may benefit from, or require, improvement support if they are to meet the standards required of them in a safe and sustainable way, and the overall objectives for the sector are to be met
- determine the way we work with each provider to ensure appropriate support is made available.

[2] For the rest of this document and for the purposes of the SOF, we use the term 'provider' to mean NHS trusts and NHS foundation trusts. This framework does not apply to independent sector providers. The *Risk assessment framework for independent sector providers of NHS services* (available at www.gov.uk/government/publications/risk-assessment-framework-independent-sector-providers-of-nhs-services) covers our statutory duty to assess financial risk at those organisations where they provide commissioner-requested services (CRS).

The SOF sets out an oversight process which follows an ongoing cycle of:

- monitoring providers' performance and capability under our five themes
- identifying the scale and nature of providers' support needs
- co-ordinating support activity so that it is targeted where it is most needed.

This cycle is summarised in Figure 1 (see page 10).

The SOF does not:

- give a performance assessment or rating of individual providers in its own right, nor is it intended to predict the ratings given by the Care Quality Commission (CQC)
- set out in detail the improvement support we will offer to providers, as this will be tailored to individual provider needs.

Relationship between the Single Oversight Framework and the statutory obligations of Monitor and the NHS Trust Development Authority

NHS Improvement is the operational name for an organisation that brings together Monitor and the NHS Trust Development Authority (NHS TDA), plus other bodies and teams, with a focus on supporting providers and local health systems to help them improve. NHS Improvement is responsible for overseeing NHS foundation trusts and trusts, as well as independent providers and NHS controlled providers that deliver NHS-funded care.

The SOF replaced Monitor's Risk Assessment Framework and NHS TDA's Accountability Framework in September 2016. It applies equally to both NHS trusts and foundation trusts. As far as possible, we have combined and built on the previous approaches of Monitor and TDA, adapting them to reflect and enable our primary improvement role. All other related policies and statements, unless indicated, remain and should be read in the light of this document.

The SOF works within Monitor's continuing statutory duties and powers with respect to NHS foundation trusts and NHS TDA's with respect to NHS trusts (NHS TDA exercises functions via directions from the Secretary of State).

NHS Improvement must ensure the continuing operation of a licensing regime. The NHS provider licence[3] forms the legal basis for Monitor's oversight of NHS foundation trusts. While NHS trusts are exempt from the requirement to apply for and hold the licence, directions from the Secretary of State require NHS TDA to ensure that NHS trusts comply with conditions equivalent to the licence as it deems appropriate. This includes giving directions to an NHS trust where necessary to ensure compliance.

We aim to treat all providers in comparable circumstances similarly unless there is sound reason not to. We will therefore base our oversight, using the Single Oversight Framework, of all NHS trusts and NHS foundation trusts on the conditions of the NHS provider licence.[4]

[3] www.gov.uk/government/publications/the-nhs-provider-licence

[4] This is mostly likely to entail holding trusts to account against the standards in condition FT4 – the governance condition, but other conditions such as those relating to continuity of services and integrated care could be engaged too. Our scope extends to the entire NHS provider licence. For completeness it should be noted that NHS Improvement has functions and powers in addition to those stemming from the Monitor provider licence in relation to both NHS trusts (through directions from the Secretary of State) and NHS foundation trusts (through statute). The Single Oversight Framework does not cover these additional matters.

Updating the SOF

We intend to align future updates of the SOF with the national planning cycle. The next scheduled refresh will therefore be for 2019/20, and will reflect any changes in planning assumptions introduced for the next funding and contracting period.

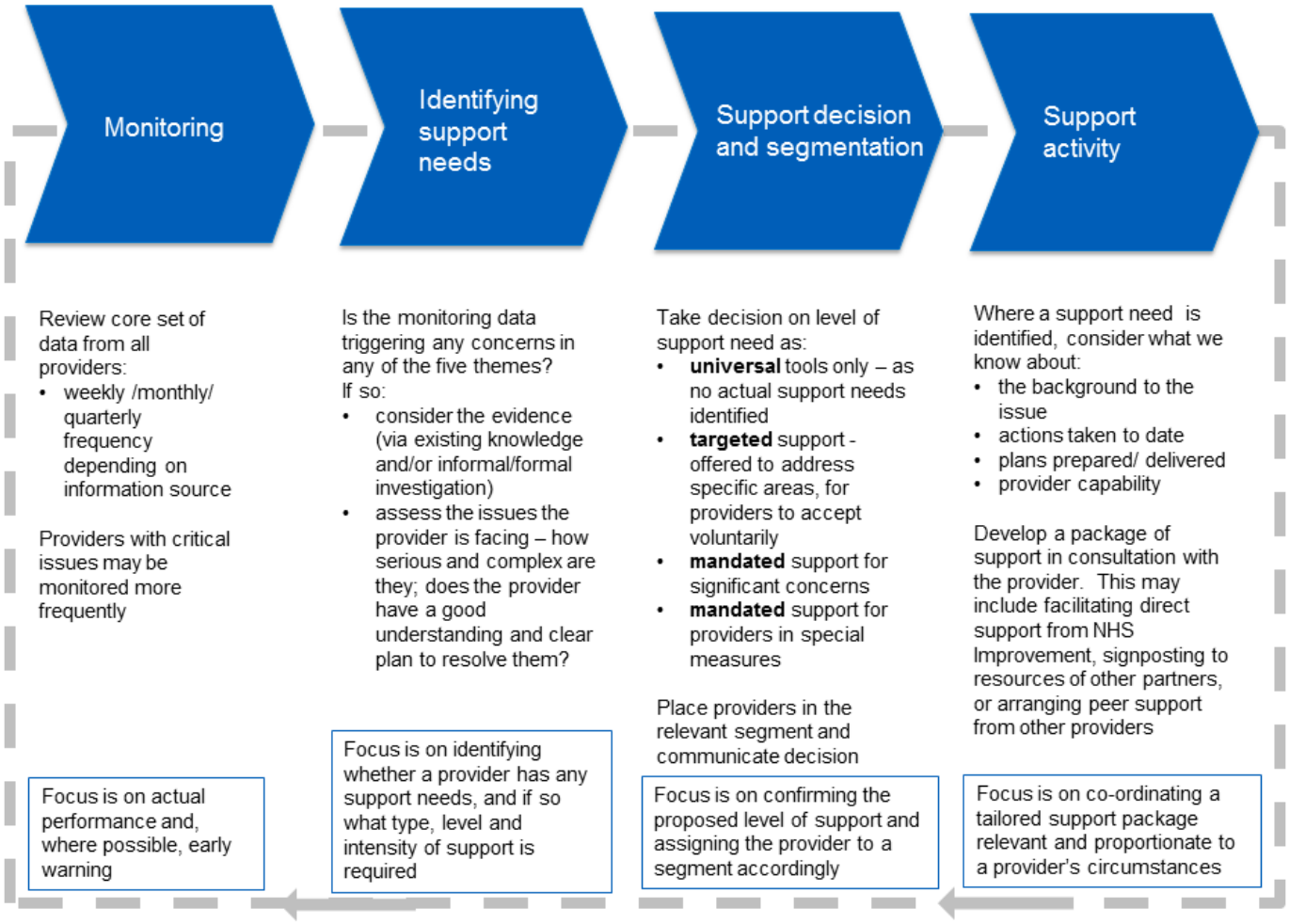
However, we will be flexible in how we carry out our role and implement the SOF. For example, we may need to respond quickly and proactively to unexpected issues in individual providers or sets of providers, to national policy changes, the introduction of new service planning or delivery models or new sector pressures. We may, therefore, adjust the approach set out in this document from time to time, for example:

- add/remove some metrics from our oversight of providers, or change the way we aggregate data
- change the frequency of our data collection
- act sooner than the general threshold set in the framework.

Alignment with national partners

We recognise that the challenges facing the health and care system require a joined-up approach and increased partnership between national bodies. We are committed to working more closely with the Care Quality Commission (CQC), NHS England and other partners at national, regional and local levels to ensure our activities are aligned in the ways outlined below.

Figure 1: NHS Improvement's oversight cycle



Care Quality Commission

CQC sets out what good and outstanding care looks like, as well as identifying where services are inadequate or require improvement. CQC asks five key questions of all care services: are they safe, are they effective, are they caring, are they responsive to people's needs and are they well-led? While our five themes are linked to CQC's key questions, they are not identical. This is because we have a particular role in supporting improvement in performance against the NHS Constitution standards for patients; and because our approach to improvement incorporates the strategic changes within local health systems that will be needed to assure the delivery of high quality services by providers in the longer term.

We work together in the effective discharge of our respective functions, seeking to remove duplication between our organisations and minimise the requirements

placed on trusts. We continue to share data and information on the results of our inspections and oversight, and develop common datasets where possible, and have recently created a new joint appointment of chief digital officer to ensure data consistency across the two organisations.

We are increasingly aligning our operational working, from the way we work together in engaging with individual providers to wider healthcare system oversight. We have worked closely with CQC to develop new well-led and Use of Resources frameworks, and continue to do so as we consider a new combined rating of quality and Use of Resources for acute trusts, to help demonstrate that quality should and can be maintained and improved alongside financial sustainability.

NHS England

As sustainability and transformation partnerships (STPs) take a greater role in planning and leading service development in their regions, it is increasingly important that oversight and support for individual providers take account of wider system objectives and priorities. This is already reflected in the 'strategic change' theme of the SOF, under which providers' engagement with local partners and contribution to addressing system-wide challenges is considered. We are working closely with NHS England to ensure that our oversight of providers is consistent and closely aligned with its oversight of commissioners. We are also working with NHS England to ensure that as providers and commissioners come together in accountable care systems our collective oversight, potentially within a single framework, reflects the one-system working that those organisations aspire to.

The rest of this document outlines our approach to monitoring providers and gathering insights (Section 4) and identifying support needs and segmenting providers (Section 5). We then set out more detail on how we identify and address support needs under each of the five themes in Section 6. Details of the metrics used to monitor and assess performance under each theme are included in the separate appendices.[5]

[5] https://improvement.nhs.uk/resources/single-oversight-framework/

4. Monitoring performance

As part of our oversight of providers, NHS Improvement will monitor and gather insights about providers' performance across the five themes of quality; finance and use of resources; operational performance; strategic change; and leadership and improvement capability.

The information collected and reviewed under the SOF will include annual plans and reports, regular financial and operational information and other exceptional or significant data, including relevant third-party material. We will increasingly adopt a 'measurement for improvement' approach in our monitoring of providers, ensuring data is used not just to make judgements, but to help identify how services and outcomes can be improved.

Depending on the type of information, the collection and review of data may be:

- **in-year**: using monthly, quarterly or lower frequency collections as appropriate; in extreme circumstances (eg where a provider is displaying critical problems, such as in weekly A&E performance) we will consider more frequent information
- **annual:** using annual provider submissions (eg annual plans, annual statements on quality) or other annually published data (eg staff surveys)
- **by exception:** NHS Improvement aims to be as agile as possible in responding to issues identified at providers; where material events occur, or we receive information that triggers our concern outside the regular monitoring cycle, we will take these into account when considering whether there are potential support needs at the provider.

Examples of the type of information considered and the frequency of data collection under the SOF are provided in Figure 2 (see page 14).

The full list of metrics we will use for monitoring providers is set out in appendices 1 to 4. We may revise this list – introducing new metrics, varying the collection frequency or refining data aggregation – as necessary and appropriate.

We seek to ensure that the data collection burden is proportionate. Rather than require providers to make bespoke data submissions, wherever possible we will

use nationally collected and evaluated datasets, in particular for operational performance. We also provide the data collected and used in the SOF transparently to providers through the Model Hospital[6] to aid local analysis and understanding of the underlying data. We are working with the Department of Health, NHS England, CQC and NHS Digital to rationalise the reporting requirements on providers and use a shared dataset across the oversight bodies, which will result in a clear reduction in burdens over time.

Providers are expected to notify NHS Improvement of actual or prospective changes in performance or risks that fall outside the routine SOF monitoring, where these are material to the provider's ability to deliver safe and sustainable services. Such exception reports might include (but are not limited to):

- unplanned significant reductions in income or significant increases in costs
- failure to comply with any formal reporting requirements
- discussions with external auditors that may lead to a qualified audit report
- enforcement notices from other bodies implying potential or actual significant breach of any other requirement for foundation trust authorisation or equivalent, eg:
  - health and safety executive or fire authority notices
  - material issues affecting a provider's reputation
  - adverse reports from overview and scrutiny committees
- transactions that meet the threshold set out in the transactions guidance[7]
- consideration of novel or contentious contracts or risk-sharing arrangements (eg alliance contracts; risk and gain share agreements, etc) with significant implications for a provider's risk profile.

[6] Users from NHS providers and arm's length bodies can register at https://model.nhs.uk
[7] https://improvement.nhs.uk/resources/supporting-nhs-providers-considering-transactions-and-mergers/

Figure 2: Summary of information requirements for monitoring

	In-year	Annual/ less frequently	By exception[1]
Quality of care	In-year quality information to identify any areas for improvement (see Appendix 1)	Annual quality information	Results of CQC inspections CQC warning notices, fines, civil or criminal actions and information on other relevant matters
Finance and use of resources	Monthly returns	Annual operational plans Information relating to Use of Resources (UoR) assessments	One-off financial events (eg sudden drops in income/ increases in costs) Transactions/mergers
Operational performance	Quarterly/monthly/weekly operational performance information (see Appendix 3)		Any sudden and unforeseen factors driving a significant failure to deliver
Strategic change	Delivery of sustainability and transformation plans Progress of any new care models, devolution plans	Sustainability and transformation plans	Any sudden and unforeseen factors driving a significant failure to deliver
Leadership and improvement capability	Third-party information with governance implications[2] Organisational health indicators - staff absenteeism - staff churn - board vacancies	Staff and patient surveys Third-party information with governance implications[2]	Findings of well-led reviews and developmental well-led reviews Third-party information with governance implications[2]

[1]Providers are also expected to notify NHS Improvement of any other material changes in performance or risks that fall outside routine monitoring

[2]eg reports from quality surveillance groups (QSGs), General Medical council, ombudsman, CCGs, Healthwatch England, NHS Digital, auditors, Health and Safety Executive, patient groups, complaints, whistleblowers, medical Royal Colleges

5. Identifying support needs and segmenting the sector

We use the information we collect on provider performance to identify where providers may need support across our five themes.

Under each theme, a defined set of indicators will trigger consideration of a support need. The information used to assess providers under each theme, and the related triggers, are summarised in Section 6.

5.1 Identifying support needs

Where providers are triggering a concern and a potential support need is identified, we will consider the circumstances to understand why the trigger has arisen and whether any actual support need exists. We will use our judgement to assess the seriousness, scale and complexity of the issues a provider is facing, based on information we collect under the SOF, existing relationship knowledge, information from system partners (eg CQC, NHS England, clinical commissioning groups) and evidence from formal or informal investigations.

Practically, we will consider:

- the **extent** to which the provider is triggering a concern in the SOF under one, or more, of the five themes
- **which** of the triggers across the five themes the provider is hitting
- any **associated circumstances** the provider is facing
- the degree to which the provider **understands what is driving the issue**
- the provider's **capability** and the **credibility of plans it has developed** to address the issue
- the extent to which the provider **is delivering against a recovery trajectory**
- whether a provider is in **breach or suspected breach of licence conditions**.

Based on this assessment, we will identify whether a provider has a support need, and if so what **level** of support is required. This might be:

- **universal support:** tools that providers can draw on if they wish to improve specific aspects of performance; their use is voluntary
- **targeted support**: support to help providers with specific areas: eg intensive support teams to help in emergency care or agency spend; programmes of targeted support will be agreed with providers and its use is voluntary
- **mandated support:** where a provider has complex issues, we may implement a mandated series of improvement actions: eg appoint an improvement director, or agree a recovery trajectory and support providers to deliver this. In these serious cases, providers are required to comply with NHS Improvement's actions/expectations. When a trust goes into special measures a mandated support package will be designed to address the issues that directly led to this decision, but also other challenges it is facing. For example, when NHS Improvement receives a recommendation from the CQC Chief Inspector to place a trust in special measures for quality reasons, we will consider the evidence CQC provides us alongside other relevant evidence including trust finances and operational performance. A trust may therefore be subject to mandated support relating to its finances when it has gone into special measures for quality reasons, and vice versa.

Where mandated support is required for a NHS foundation trust we may use the powers we have under the Health and Social Care Act 2012.[8] For NHS trusts we will adopt a similar approach using powers under the National Health Service Act 2006. In particular, we may seek to agree enforcement undertakings with the provider.

[8] See sections 105, 106 and 111 of the Health and Social Care Act 2012.

5.2 Segmentation

Having assessed a provider's support needs, we will allocate them to a support 'segment'. The segment in which a provider is placed is determined by the **level** of support we have decided is appropriate (universal, targeted or mandated). A segmentation decision is not a performance rating, and it does not determine the specifics of the support package in each case.

The relationship between a provider's identified support needs, the type of support made available and segmentation is summarised in Table 2 (see page 18).

Segmentation enables NHS Improvement to take an overview of the level and nature of support required across the provider sector, and to target its support capacity as effectively as possible.

The process of identifying changes in a provider's support needs, and making subsequent segmentation decisions, needs to be as timely and rigorous as possible without becoming over-bureaucratic or complex. It is not a one-off or annual process. We will monitor and engage with providers on an ongoing basis and, where our in-year, annual or exceptional monitoring flags a potential support need we will review the provider's situation. We will consider whether the level of interaction needs to change to monitor the issue and the provider's response to it, and whether we need to change its allocated segment.

We will generally review a provider's support needs and segmentation monthly. For providers in segment 1, although some data will be collected monthly and reviewed as for providers in other segments, we will – in line with the principle of earned autonomy – review the segmentation of the provider only on a quarterly basis, unless there is information giving cause for concern.

Table 2: Support needs and segment descriptions

Description of support needs	Level of support offered	Segment
No actual support needs identified across our five themes. Maximum autonomy and lowest level of oversight appropriate. Expectation that provider will support providers in other segments.	**Universal**	**1 (Maximum autonomy)**
Support needed in one or more of the five themes, but not in breach of licence (or equivalent for NHS trusts) and/or NHS Improvement considers formal action is not needed.	**Universal** **+ Targeted** support as agreed with the provider to address issues identified and help move the provider to Segment 1	**2 (Targeted support)**
The provider has significant support needs and is in actual or suspected breach of the licence (or equivalent for NHS trusts), but is not in special measures.	**Universal** **Targeted** **+ Mandated** support as determined by NHS Improvement to address specific issues and help move the provider to segment 2 or 1	**3 Mandated support)**
The provider is in actual or suspected breach of its licence (or equivalent for NHS trusts) with very serious/complex issues that mean it is in special measures.	**Universal** **Targeted** **+ Mandated** support as determined by NHS Improvement to minimise the time the provider is in special measures	**4 (Special measures)**

5.3 Co-ordinating support activity

Based on their identified support needs and segmentation, NHS Improvement teams will work with providers to determine and co-ordinate an appropriate, tailored support package for each support need identified.

We may identify support needs in more than one theme where there is a shared underlying cause. In these cases, we will not double-count identified support needs and will ensure the support activity is appropriate to the underlying cause.

Depending on the need, the support offered may include directly provided support from NHS Improvement, resources available through other organisations and, increasingly, support facilitated by other parts of the sector.

The support package will be developed by NHS Improvement, facilitating access to relevant support available from within the organisation and from other providers, as well as signposting external resources.

The process of identifying and responding to providers' support needs is an ongoing cycle. The identification of new or different support needs may be triggered by insight derived from NHS Improvement's support activities.

The support available directly from NHS Improvement includes:

- focused service improvement initiatives, such as the maternal and neonatal health safety collaborative[9]
- practical help for providers and health systems to address key improvement priorities, such as the Emergency Care Improvement Programme[10]
- leadership development, coaching and mentoring
- resources to help trusts develop their capability to improve and apply evidence-based improvement methodologies
- dedicated support and development for providers in, or at risk of being in, special measures, including senior leadership capacity and buddying
- resources to help providers improve quality, efficiency and productivity by implementing the recommendations from the Carter review, including the Model Hospital[11] and Getting It Right First Time[12]
- financial recovery support.

Further information about the support available from NHS Improvement is available on our Improvement Hub.[13]

[9] https://improvement.nhs.uk/resources/maternal-and-neonatal-safety-collaborative/
[10] https://improvement.nhs.uk/improvement-offers/ecip/
[11] Users from NHS providers and Arm's Length Bodies can register at https://model.nhs.uk
[12] http://gettingitrightfirsttime.co.uk/
[13] https://improvement.nhs.uk/improvement-hub/

6. The five themes

In this chapter we outline the five themes under which we monitor providers' performance and consider their support needs. We explain what NHS Improvement takes into account in each theme and the metrics we use to track performance across all providers. We also summarise the specific indicators that trigger a more detailed investigation of a provider's situation and its potential support needs.

6.1 Quality of care

Under this theme we assess whether a provider's care is safe, effective, caring and responsive. This will include overseeing delivery of seven-day hospital services across providers to identify where organisations need support in this.

To assess the quality of care theme we will use:

- CQC's most recent ratings
- other relevant information held by CQC such as warning notices, any civil or criminal actions or changes to registration conditions; this is to ensure we use the most up-to-date CQC views of quality and also that we incorporate its views on quality at providers yet to be inspected
- data showing providers' delivery against their agreed commitments regarding the four priority standards for seven-day hospital services; we may, in time, extend this to monitoring other seven-day services standards and metrics where appropriate
- extra in-year quality-related metrics to identify emerging issues and/or scope for improvement at providers (see Appendix 1)
- other evidence indicating that quality of care may be at risk – for example, the introduction of aggressive cost-reduction plans.

Triggers of potential support need regarding quality of care:

- CQC rating of 'inadequate' or 'requires improvement' in overall rating, or against any of the safe, effective, caring or responsive key questions
- CQC warning notices
- any other material concerns identified through, or relevant to, CQC's monitoring process: such as civil or criminal cases raised, or whistleblower information
- concerns arising from trends in our quality indicators (Appendix 1)
- failure to deliver against agreed commitments regarding the four priority standards for seven-day hospital services
- any other material concerns about a provider's quality of care arising from intelligence gathered by or provided to NHS Improvement

6.2 Finance and use of resources

Under this theme we will oversee and support providers in improving financial sustainability, efficiency and value for money. We will consider a provider's compliance with current sector controls such as agency staffing, capital expenditure and financial control total, in line with the approach taken in *Strengthening financial performance and accountability*.[14] We will also consider how efficiently a provider uses its resources more broadly, and how financially sustainable it is over the longer term.

In identifying providers' support needs under this theme we will take into account:

- a monthly finance score
- a use of resources assessment (where available)
- other relevant information on financial performance, operational productivity and whether a provider is making optimal use of its resources.

[14] Published in July 2016 and available at https://improvement.nhs.uk/uploads/documents/Strengthening_financial_performance_and_accountability_in_2016-17_-_Final_2.pdf

Finance score

The monthly finance score is calculated by scoring providers on a scale of 1 (best) to 4 against the following five metrics, and averaging these scores to derive an overall figure:

- capital service capacity
- liquidity
- income and expenditure margin
- distance from financial plan
- agency spend.

A provider's overall figure may be moderated down if it scores 4 on any individual finance metric, has not agreed a control total or is in special measures for financial reasons. Details of the finance score calculations and weighting are set out in Appendix 2.

Use of Resources assessments

From autumn 2017, a new use of resources (UoR) assessment[15] has been introduced. Under this framework, NHS Improvement will periodically undertake UoR assessments of providers. These new assessments will begin with non-specialist acute trusts, due to the greater availability and quality of operational productivity data for these trusts, with the aim of rolling out across the sector when more information is available on productivity in other types of providers. The framework has been developed with CQC, which will publish providers' UoR reports and ratings.

The aim of UoR assessments is to understand how effectively trusts are using their resources to provide high quality, efficient and sustainable care for patients. NHS Improvement will do this by assessing how well trusts are meeting financial controls, how financially sustainable they are, and how efficiently they use their workforce, clinical and operational services to deliver high quality care for patients.

The assessments will focus on delivery and performance at trust level currently and over the previous 12 months through the lens of five key lines of enquiry:

[15] https://improvement.nhs.uk/resources/use-resources-assessment-framework

- Clinical services
- People
- Clinical support services
- Corporate services, procurement, estates and facilities
- Finance.

NHS Improvement will draw on a wide range of evidence that will include:

- a set of initial UoR metrics, which includes the finance metrics from the SOF and productivity metrics available through the Model Hospital[16]
- additional data or information collected by NHS Improvement and shared by the trust
- local intelligence from our day-to-day interactions with the trust
- evidence gathered on a structured onsite assessment.

Following an assessment, NHS Improvement will draft a brief report based on a holistic review of all the evidence gathered, and reach a proposed rating (outstanding; good; requires improvement; inadequate) using the ratings characteristics and limiters outlined in the assessment framework. Following a process of quality assurance, this rating and report will be published by CQC, initially alongside its existing quality ratings.[17]

How Use of Resources assessments will be reflected in the SOF

The findings from the Use of Resources assessment will inform NHS Improvement's considerations of improvement support needs under the SOF.

Until a provider has undergone a UoR assessment, NHS Improvement will use the finance score, alongside other evidence of whether a provider is making optimal use of its resources, to identify potential support needs under this theme.

Once a provider has undergone a UoR assessment and been given a proposed rating, we will use the draft UoR report and proposed rating, alongside the finance score, to inform our consideration of the provider's support needs at that point in time.

[16] Users from NHS providers and arm's length bodies can register at https://model.nhs.uk
[17] We expect combined CQC ratings of Use of Resources and quality to be introduced in 2018, and will jointly consult on this before implementation. We will update the SOF when the new approach is introduced.

Between UoR assessments NHS Improvement will continue to monitor a trust's finances and operational productivity – and associated support needs – using the finance score and productivity metrics, alongside other relevant evidence. We will consider changes in the monthly finance score and other indicators of financial performance and operational productivity in the context of the last UoR assessment when considering support needs.

Triggers of potential support need regarding finance and the use of resources:

- poor levels of overall financial performance, such as a monthly finance score of 4 or 3
- a Use of Resources rating of 'inadequate' or 'requires improvement'
- any other material concerns about a provider's finances or use of resources arising from intelligence gathered by or provided to NHS Improvement

6.3 Operational performance

Under this theme we will track providers' performance against a number of NHS standards, including those in the NHS Constitution as well as A&E waiting times, referral to treatment times, cancer treatment times, mental health treatment times and ambulance response times.

Appendix 3 lists the metrics we will use and how frequently they are collected across acute, mental health, ambulance and community providers.

Triggers of potential support need regarding operational performance:

- failure to meet any operational performance standard for at least two consecutive months
- other factors (eg a significant deterioration in a single month or multiple potential support needs across standards and/or other themes) indicate we need to get involved before two months have elapsed
- any other material concerns about a providers' operational performance arising from intelligence gathered by or provided to NHS Improvement

Where it is identified that a provider has a support need under this theme, one of the issues we will work with providers to understand and address is the efficiency of patient flow through the organisation, in particular local progress in minimising delayed transfers of care (DToC).

6.4 Strategic change

As described in the *Five Year Forward View*, better outcomes for patients will be delivered by sustainable organisations operating as part of successful health economies. Under this theme, we will consider the extent to which providers are working with partners to address local challenges and to improve services for patients in this context.

Working with our own system partners, we will consider providers' contribution to developing, agreeing and delivering the objectives of sustainability and transformation partnerships (STPs). This might include the implementation of new care models, the establishment of accountable care organisations and accountable care systems, and the enactment of devolution agreements.

We will take into account the nature of providers' relationships with local partners, their role in any agreed service transformation plans, and how far these plans have been implemented. We will consider this in the context of the new STP ratings, and their assessment of system-wide leadership. These ratings will be one part of the broad intelligence used by NHS Improvement to understand a provider's

circumstances and to inform our judgement of a provider's performance under this theme.

We have produced draft guidance on how we expect well-led providers to work with partners and collaborate locally to improve the quality and sustainability of services for patients.[18] In this guidance we set out the expectation that providers should:

- engage in local decision-making and build a shared understanding of local challenges and patient needs
- work collaboratively with other local health and care organisations to design and agree solutions
- implement improvements, taking responsibility for their share of local plans to improve the quality and sustainability of care and ensuring their own organisational plans are aligned to these local priorities.

Triggers of potential support need regarding strategic change:

- material concerns about a provider's delivery against the local transformation agenda, including (where relevant) new care models and devolution

6.5 Leadership and improvement capability (well-led)

Under this theme we will assess whether providers have effective boards and governance, demonstrate continuous improvement capability and make effective use of data. We monitor leadership, governance and improvement capability as part of the SOF because there is good evidence that strong leadership and good governance are indicators of organisational success.

[18] Available at www.improvement.nhs.uk/uploads/documents/Guidance_on_good_governance_in_a_LHE_context_final.pdf

In June 2017 we published guidance for providers[19] on our updated framework for leadership and governance developmental reviews. The guidance sets out how providers should carry out developmental reviews of their leadership and governance using the framework as part of their own continuous improvement. These developmental well-led reviews should be carried out by providers every three to five years.

The structure of our framework is wholly shared with CQC, and underpins CQC's regular regulatory assessments of the well-led question. Building on this joint work to develop a shared system view of what good governance and leadership look like, we will continue to work closely with CQC to refine our approach to identifying providers' support needs under this theme.

Effective boards and governance: We will use several information sources to assess provider leadership, including:

- CQC well-led inspections and the outcomes of developmental well-led reviews where these generate material concerns
- information from third parties – eg Healthwatch, MPs, whistleblowers, coroners' reports
- staff/patient surveys
- level of senior executive turnover
- organisational health indicators (see Appendix 4)
- delivering Workforce Race Equality Standards.

Continuous improvement capability: We will consider assessments of learning, improvement and innovation within the well-led reviews undertaken by CQC or in developmental reviews using the well-led framework.

Use of data: Effective use of information is an important element of good governance. Well-led providers should collect, use and, where required, submit robust data. The well-led framework recommends that providers should adopt a measurement-for-improvement approach, using data to identify how improvements can be implemented and sustained, not just to understand current performance. Where we have reason to believe this is not the case, we will consider the degree to which providers need support in this area.

[19] https://improvement.nhs.uk/uploads/documents/Well-led_guidance_June_2017.pdf

Triggers of potential support need regarding leadership and improvement capability:

- CQC ‘inadequate’ or ‘requires improvement’ assessment against ‘well-led’
- Concerns arising from trends in our organisational health indicators (Appendix 4)
- Other material concerns about a provider’s governance, leadership and improvement capability, arising from third-party reports, developmental well-led reviews or other relevant sources

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NHS Improvement

Single Oversight Framework: appendices

Updated November 2017

Introduction

This document sets out the detail of the metrics used to monitor and assess performance under each theme of the Single Oversight Framework.[1] It will help providers understand which metrics NHS Improvement is using to assess their performance, how these metrics are defined and calculated, and the frequency of data publication. We provide a link to the data source where this is publicly available.

We will try to keep the data source links up to date but iff you come across any outdated links, please get in touch with us at NHSI.singleoversightframework@nhs.net.

[1] https://improvement.nhs.uk/resources/single-oversight-framework/

Appendix 1: Quality of care metrics

NHS Improvement will use the indicators below to supplement Care Quality Commission (CQC) information to identify where providers may need support under the quality of care theme.

Measure	Type	Description/Calculation	Data frequency	Source
All providers				
Written complaints – rate	Caring	Count of written complaints/count of whole time equivalent staff	Quarterly	http://content.digital.nhs.uk/catalogue/PUB21536
Staff Friends and Family Test % recommended – care	Caring	Count of those categorised as extremely likely or likely to recommend/count of all responders	Quarterly	www.england.nhs.uk/ourwork/pe/fft/friends-and-family-test-data/
Occurrence of any Never Event	Safe	Count of Never Events in rolling six-month period	Monthly (six-month rolling)	https://improvement.nhs.uk/resources/never-events-data/
Patient Safety Alerts not completed by deadline	Safe	Number of NHS England or NHS Improvement patient safety alerts outstanding in most recent monthly snapshot	Monthly	https://improvement.nhs.uk/resources/data-patient-safety-alert-compliance/
Acute providers				

Mixed-sex accommodation breaches	Caring	Count of number of occasions sexes were mixed on same-sex wards	Monthly	https://www.england.nhs.uk/statistics/statistical-work-areas/mixed-sex-accommodation/msa-data/
Inpatient scores from Friends and Family Test − % positive	Caring	Count of those categorised as extremely likely or likely to recommend/count of all responders	Monthly	www.england.nhs.uk/ourwork/pe/fft/friends-and-family-test-data/
A&E scores from Friends and Family Test − % positive	Caring	Count of those categorised as extremely likely or likely to recommend/count of all responders	Monthly	https://www.england.nhs.uk/ourwork/pe/fft/friends-and-family-test-data/
Maternity scores from Friends and Family Test − % positive	Caring	Count of those categorised as extremely likely or likely to recommend/Count of all responders	Monthly	https://www.england.nhs.uk/ourwork/pe/fft/friends-and-family-test-data/
Emergency c-section rate	Safe	Percentage of births where the mother was admitted as an emergency and had a c-section	Monthly	Admitted patient care Hospital Episode Statistics (HES)
CQC inpatient survey	Organisation-al health	Findings from the CQC survey looking at the experiences of people receiving inpatient services at NHS hospitals	Annual	http://www.cqc.org.uk/publications/surveys/surveys
Venous thromboembolism (VTE) risk assessment	Safe	Number of patients admitted who have a VTE risk assessment/number of patients admitted in most recently published quarter	Quarterly	https://improvement.nhs.uk/resources/vte/
Clostridium difficile (C. difficile) plan: *C.difficile* actual variance from	Safe	Count of trust apportioned *C. difficile* infections in patients aged two years and over compared to the number of	Monthly	Public Health England – data available here C. difficile infection objectives by trust available here:

plan (actual number v plan number)[2]		planned *C. difficile* cases		https://improvement.nhs.uk/resources/clostridium-difficile-infection-objectives/
Clostridium difficile – infection rate	Safe	Rolling 12-month count of trust-apportioned C-difficile infections in patients aged 2 years and over/Rolling 12 Month Average Occupied bed days per 100,000 beds	Monthly (12-month rolling)	Public Health England – data available here
Meticillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia infection rate	Safe	Rolling 12-month count of trust assigned MRSA infections/Rolling 12 month average occupied bed days multiplied by 100,000	Monthly (12-month rolling)	Public Health England – data available here
Meticillin-susceptible Staphylococcus aureus (MSSA) bacteraemias	Safe	Rolling 12-month count of trust-apportioned MSSA infections/rolling 12-month average occupied bed days multiplied by 100,000	Monthly (12-month rolling)	Public Health England – data available here
Escherichia coli (*E. coli)* bacteraemia bloodstream infection (BSI)	Safe	Rolling 12-month count of all *E. coli* infections/rolling 12-month average occupied bed days multiplied by 100,000	Monthly (12-month rolling)	Public Health England – data available here
Hospital Standardised Mortality Ratio	Effective	The ratio of observed deaths that occurred following admission in a	Quarterly	Dr Foster Intelligence (licensed data)

[2] NHS Improvement has access to the Public Health England (PHE) Data Capture System (DCS) through which organisations report their infection data. Infection data is downloaded from the DCS by NHS Improvement before publication to allow timely internal reporting. The agreement with PHE is that NHS Improvement will not share this information outside the organisation. This unpublished data is used in the SOF. The DCS is a live system and there may be slight differences between the data that appears in the SOF and that which is published by PHE on www.gov.uk and https://fingertips.phe.org.uk/ due to the timing of the data extracts.

		provider to a modelled expectation of deaths (multiplied by 100) on the basis of the average England death rates for 56 specific clinical groups given a selected set of patient characteristics for those treated there.		
Summary Hospital-level Mortality Indicator	Effective	The ratio of the actual number of patients who die following hospitalisation at the trust or within 30 days of discharge to the number that would be expected to die on the basis of the average England death rate, given a selected set of patient characteristics for those treated there.	Quarterly	www.digital.nhs.uk/SHMI
Potential under-reporting of patient safety incidents[3]	Safe	Count of reported incidents (no harm, low harm, moderate harm, severe harm, death)/estimated total person bed days for rolling six months shown as rate per 1000 bed days	Monthly (six-month rolling)	https://improvement.nhs.uk/resources/monthly-data-patient-safety-incident-reports/
Community providers				
Community scores from Friends and Family Test – % positive	Caring	Count of those categorised as extremely likely or likely to recommend/Count of all responders	Monthly	www.england.nhs.uk/ourwork/pe/fft/friends-and-family-test-data/

[3] This indicator is valid only at the level of extreme outliers for under-reporting as per CQC Intelligent Monitoring methodology and only in non-specialist acute trusts.

Mental health providers				
CQC community mental health survey	Organisation-al health	Findings from the CQC survey which gathered information from people who received community mental health services	Annual	Data available here: www.cqc.org.uk/publications/surveys/surveys
Mental health scores from Friends and Family Test – % positive	Caring	Count of those categorised as extremely likely or likely to recommend/Count of all responders	Monthly	www.england.nhs.uk/ourwork/pe/fft/friends-and-family-test-data/
Admissions to adult facilities of patients under 16 years old	Safe	Number of children and young persons under 16 who are admitted to adult wards	Monthly	NHS Digital (MHSDS) Reference: MHS24a Further information: http://content.digital.nhs.uk/mhsds
Care programme approach (CPA) follow-up – proportion of discharges from hospital followed up within seven days[4] – Mental Health Services Data Set	Effective	Proportion of discharges from hospital followed up within 7 days	Monthly	NHS England Further information: www.england.nhs.uk/statistics/statistical-work-areas/mental-health-community-teams-activity/
% clients in settled accommodation	Effective	Percentage of people aged 18 to 69 in contact with mental health services in settled accommodation	Monthly	NHS Digital (MHSDS) Reference: AMH15

[4] NHS Improvement is following the development of indicators to measure 48-hour follow-up, in line with evidence, and will consider amending this in a future version of the SOF.

				Further information: http://content.digital.nhs.uk/mhsds
% clients in employment	Effective	Percentage of people aged 18 to 69 period in contact with mental health services in employment	Monthly	NHS Digital (MHSDS) Reference: AMH18 Further information: http://content.digital.nhs.uk/mhsds
Potential under-reporting of patient safety incidents[5]	Safe	Count of reported incidents (no harm, low harm, moderate harm, severe harm, death)/Estimated total person bed days for rolling six months shown as rate per 1000 bed days	Monthly (6-month rolling)	https://improvement.nhs.uk/resources/monthly-data-patient-safety-incident-reports/
Ambulance providers				
Ambulance see-and-treat from Friends and Family Test – % positive	Caring	Count of those categorised as extremely likely or likely to recommend/Count of all responders	Monthly	www.england.nhs.uk/ourwork/pe/fft/friends-and-family-test-data/
Ambulance Clinical Outcomes Return of spontaneous circulation (ROSC) where the arrest was bystander witnessed and the initial rhythm was ventricular fibrillation (VF) or	Effective	Proportion of patients who had resuscitation (advanced or basic life support) begun/continued by ambulance service following out-of-hospital cardiac arrest of presumed cardiac origin, where the arrest was bystander witnessed and the initial rhythm was VF or VT, and who had return of spontaneous circulation on	Monthly	www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/

[5] This indicator is valid only at the level of extreme outliers for under-reporting as per CQC Intelligent Monitoring methodology.

ventricular tachycardia (VT)		arrival at hospital		
Stroke 60 minutes	Effective	Proportion of FAST[6] positive patients (assessed face to face) potentially eligible for stroke thrombolysis within agreed local guidelines arriving at hospitals with a hyperacute stroke centre within 60 minutes of call connecting to the ambulance service	Monthly	www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/
Stroke care	Effective	Proportion of suspected stroke patients assessed face to face who received an appropriate care bundle	Monthly	www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/
ST Segment elevation myocardial infarction (STEMI) 150 minutes	Effective	Proportion of patients with initial diagnosis of 'definite myocardial infarction' for whom primary angioplasty balloon inflation occurs within 150 minutes of call connected to the ambulance service, where first diagnostic electrocardiogram (ECG) is performed by ambulance personnel and patient was directly transferred to a designated Primary Percutaneous Coronary Intervention (PPCI) centre as locally agreed	Monthly	www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/

[6] Act F.A.S.T is a national campaign to raise aware of the signs of stroke and encourage people to dial 999 if they recognise any one of the symptoms.

- Face - has their face fallen to one side? Can they smile?
- Arms - can they raise both arms and keep them there?
- Speech - is their speech slurred?
- Time to call 999 if you see any single of these signs of a stroke

Appendix 2: Finance score

The overall finance score is a mean average of the scores on five individual metrics, which are defined and calculated as set out in Figure 3, except that:

- if a provider scores 4 on any individual finance metric, their overall finance score is at least a 3 – ie cannot be a 1 or 2 – triggering a potential support need
- if a provider has not agreed a control total:
  - where they are planning a deficit their finance score will be at least 3 (ie it will be 3 or 4)
  - where they are planning a surplus their finance score will be at least 2 (ie it will be 2, 3 or 4).

Scores are rounded to the nearest whole number. Where a trust's score is exactly between two whole numbers, it is rounded to the lower whole number (eg both 2.2 and 2.5 are rounded down to 2). This follows Monitor's method in assessing best performance where financial scores were rounded positively, ie towards the 'best' score for trusts.

Figure 3: Finance metrics

Area	Weighting	Metric	Definition	Score			
				1	2	3	4
Financial sustainability	**0.2**	**Capital service capacity**	Degree to which the provider's generated income covers its financial obligations	≥2.5x	<2.5x - ≥1.75x	<1.75 - ≥1.25x	<1.25x
	0.2	**Liquidity (days)**	Days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown	≥0	<0 - ≥(7)	<(7) - ≥(14)	<(14)
Financial efficiency	**0.2**	**Income and expenditure (I&E) margin**	I&E surplus or deficit / total revenue	≥1%	<1- ≥0%	<0 - ≥(1)%	<(1)%
Financial controls	**0.2**	**Distance from financial plan**	Year-to-date actual I&E margin (surplus/deficit) in comparison to Year-to-date plan I&E margin (surplus/ deficit) on a control total basis	≥0%	<0% - ≥(1)	<(1)% - ≥(2)	<(2)%
	0.2	**Agency spend**	Distance from provider's cap	≤0%	>0 - ≤25%	>25 - ≤50%	>50%

Note: brackets indicate negative numbers

Appendix 3: Operational performance metrics

Measure	Description/Calculation	Data frequency	Data source	Standard[7]
Acute and specialist providers[8]				
A&E maximum waiting time of four hours from arrival to admission/transfer/discharge	The percentage of attendances at an A&E department that were discharged, admitted or transferred within four hours of arrival.	Monthly	www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/statistical-work-areasae-waiting-times-and-activityae-attendances-and-emergency-admissions-2016-17/	95%

[7] Minimum % of patients for whom standard must be met.

[8] NHS Improvement is tracking the development of metrics to measure, analyse and improve the following aspects of liaison mental health services in acute hospitals, and may incorporate these in future iterations of this framework:

numbers of presentations at A&E of people of all ages with a mental health condition or dementia and liaison mental health service response times

- numbers of emergency admissions of people of all ages with a mental health condition or dementia
- length of stay for people of all ages admitted with a mental health condition or dementia
- delayed transfers of care for people of all ages with a mental health condition or dementia.

Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate − patients on an incomplete pathway	Count of the number of patients whose clock period is less than 18 weeks during the calendar months of the return/Count of number of patients whose clock has not stopped during the calendar months of the return	Monthly	www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-data-2016-17/#Jan17	92%
All cancers – maximum 62-day wait for first treatment from: a. urgent GP referral for suspected cancer b. NHS cancer screening service referrals	Proportion of patients referred for cancer treatment by: a. their GP who have currently been waiting for less than 62 days for treatment to start b. the NHS screening service who have currently been waiting for less than 62 days for treatment to start	Monthly	Provider-level cancer waiting time data available here: www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/monthly-prov-cwt/201617-monthly-prov-cwt/	a. 85% b. 90%
Maximum 6-week wait for diagnostic procedures	Proportion of patients referred for diagnostic tests who have been waiting for less than six weeks	Monthly	Data available here: www.england.nhs.uk/statistics/statistical-work-areas/diagnostics-waiting-times-and-activity/monthly-diagnostics-waiting-times-and-activity/monthly-diagnostics-data-2016-17/	99%

Dementia assessment and referral: the number and proportion of patients aged 75 and over admitted as an emergency for more than 72 hours: a. who have a diagnosis of dementia or delirium or to whom case finding is applied b. who, if identified as potentially having dementia or delirium, are appropriately assessed and c. where the outcome was positive or inconclusive, are referred on to specialist services	The number and proportion of patients aged 75 and over admitted as an emergency for more than 72 hours: a. who have a diagnosis of dementia or delirium or to whom case finding is applied; b. who, if identified as potentially having dementia or delirium, are appropriately assessed; and, c. where the outcome was positive or inconclusive, are referred on to specialist services.	Quarterly	Data source: NHS England Further information: www.england.nhs.uk/statistics/statistical-work-areas/dementia/dementia-assessment-and-referral-2017-18/	a. 90% b. 90% c. 90%
Ambulance providers[9]				
Category 1 (C1) – Life-threatening calls	The mean average response time across all incidents coded as C1 that received a response on scene = The total response time aggregated across all incidents coded as C1 that received a response on scene in the period /	Monthly	www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/	7 minutes mean response time 15 minutes 90th centile

[9] In 2017, new standards, indicators and measures were introduced for ambulance providers through the Ambulance Response Programme. These replace the previous response time standards and metrics for ambulance providers. We have included the new standards in the SOF but, in line with the national programme, there will be a transition period until April 2018 to allow all providers to implement the new requirements. During this period providers will be expected to demonstrate progress towards full implementation of the new standards, following an agreed plan and trajectory. From April 2018, failure to meet the standards will trigger consideration of a provider's support needs in this area.

	The count of incidents coded as C1 that received a response on scene.			response time
Category 2 (C2) – Emergency calls	The mean average response time across all incidents coded as C2 that received a response on scene = The total response time aggregated across all incidents coded as C2 that received a response on scene in the period / The count of incidents coded as C2 that received a response on scene	Monthly	www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/	18 minutes mean response time 40 minutes 90th centile response time
Category 3 (C3) – Urgent calls	The mean average response time across all incidents coded as C3 that received a response on scene = The total response time aggregated across all incidents coded as C3 that received a response on scene in the period / The count of incidents coded as C3 that received a response on scene.	Monthly	www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/	120 minutes 90th centile response time
Category 4 (C4) – Less urgent calls	The mean average response time across all incidents coded as C4 that received a response on scene = The total response time aggregated across all incidents coded as C4 that received a response on scene in the period / The count of incidents coded as C4 that received a response on scene.	Monthly	https://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/	180 minutes 90th centile response time

Mental health providers[10]				
People with a first episode of psychosis begin treatment with a NICE-recommended care package within two weeks of referral (UNIFY2, moving to Mental Health Services Data Set – MHSDS)[11]	Percentage of people with a first episode of psychosis beginning treatment with a NICE-recommended care package within two weeks of referral	Quarterly (three-month rolling)	www.england.nhs.uk/statistics/statistical-work-areas/eip-waiting-times/	50%

[10] NHS Improvement is tracking the development of metrics to measure, analyse and improve the following areas, and may incorporate these in future iterations of this framework:

- access and waiting times for children and young people with eating disorders to begin NICE-recommended treatment, in line with the Five Year Forward View (5YFV) mental health commitment that, by 2021, 95% of children and young people in need receive treatment within one week for urgent cases, and four weeks for routine cases.
- providers' collection of data on waiting times for:
  - acute mental healthcare (decision to admit to time of admission, decision to home-treat to time of home-treatment start),
  - dementia care, including memory assessment services
- the quality and responsiveness of care provided to people of all ages with urgent and emergency mental health needs, including liaison services and crisis resolution and home treatment teams.
- differential rates of detention under the Mental Health Act for people from black, Asian and minority ethnic (BAME) groups.
- access to individual placement support.
- the implementation of the Prime Minister's Challenge on Dementia 2020.
- young people's experience of transition to adult mental health services.
- data quality of key data items related to 5YFV MH priorities, including data related to referral to treatment waiting times, interventions delivered, outcomes and experience.

[11] This standard applies to anyone with a suspected first episode of psychosis who is aged 14 to 65. People aged over 35 who may historically not have had access to specialist early intervention in psychosis services should not be excluded. Technical guidance is available at: www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/02/tech-cyped-eip.pdf.

Provider boards must be fully assured that RTT data submitted is complete, accurate and in line with published guidance. Both 'strands' of the standard must be delivered:

- performance against the RTT waiting-time element of the standard is being measured via MHSDS and UNIFY2 data submissions.
- performance against The National Institute for Health and Care Excellence concordance element of the standard is to be measured via:
  - a quality assessment and improvement network being hosted by the College Centre for Quality Improvement at the Royal College of Psychiatrists; all providers will be expected to take part in this network and submit self-assessment data, which will be validated and performance-scored on a four-point scale at the end of the year. This assessment will be used to track progress against the trajectory set out in Implementing the Five Year Forward View for Mental Health: www.england.nhs.uk/wp-content/uploads/2016/07/fyfv-mh.pdf
  - submission of intervention and outcomes data using SNOMED-CT codes in line with published guidance. Provider boards must be fully assured that intervention and outcomes data submitted is complete and accurate.

Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas: a. inpatient wards b. early intervention in psychosis services c. community mental health services (people on care programme approach)[12]	The number of patients in the defined audit sample who have both: - a completed assessment for each of the cardio-metabolic parameters with results documented in the patient's electronic care record held by the secondary care provider. - a record of interventions offered where indicated, for patients who are identified as at risk as per the red zone of the Lester Tool.	Annual	a) Internal mental health provider sample submitted to national audit provider for the CQUIN b) Early intervention: Internal mental health provider sample submitted to the Royal College of Psychiatrists CCQI EIP Network	a. 90% b. 90%

Further information can be found in the implementation guidance published by NHS England: www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/04/eip-guidance.pdf

[12] Board declaration but can be cross-checked with results of CQUIN audit (which will be for a sample of patients in each service area). People with psychosis should receive:

- a completed assessment for each of the cardio-metabolic parameters with results documented in the patient's records
- a record of interventions offered where indicated, for patients who are identified as at risk as per the red zone of the Lester Tool.

The cardio-metabolic parameters based on the Lester Tool are:

- smoking status
- lifestyle (including exercise, diet, alcohol and drug use)
- body mass index
- blood pressure
- glucose regulation (HbA1c or fasting glucose or random glucose, as appropriate)
- blood lipids.

Information on the Lester Tool and the recommended key interventions and treatments can be found at: www.england.nhs.uk/2014/06/lester-tool/. This indicator aligns with the national CQUIN scheme for 2017/19: /www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19/

The data is currently collected through an annual audit carried out by the Royal College of Psychiatrists.

			c) Mental health: Internal mental health provider sample submitted to national audit provider for the CQUIN For further information, please see: www.england.nhs.uk/publication/cquin-indicator-specification/	c. 65%
Data Quality Maturity Index (DQMI) – MHSDS dataset score	MHSDS quarterly score in DQMI	Quarterly	Data source: NHS Digital Further information: http://content.digital.nhs.uk/dq	95%[13]

[13] As this is a revised indicator, the initial focus (until April 2018) will be ensuring providers understand their current score and, where the standard is not being reached, have a clear plan for improving data quality. During 2018/19, failure to meet the standard will trigger consideration of a provider's support needs in this area.

Improving Access to Psychological Therapies (IAPT)/talking therapies a. proportion of people completing treatment who move to recovery (from IAPT minimum dataset) b. waiting time to begin treatment (from IAPT minimum dataset) i) within 6 weeks ii) within 18 weeks	a. Percentage of people completing a course of IAPT treatment moving to recovery b. Percentage of people waiting i) six weeks or less from referral to entering a course of talking treatment under Improving Access to Psychological Therapies (IAPT) ii) 18 weeks or less from referral to entering a course of talking treatment under IAPT	a. Quarterly b i. 3-month rolling b ii. 3-month rolling	Source: NHS Digital http://content.digital.nhs.uk/iaptmonthly Further information: /www.england.nhs.uk/mental-health/adults/iapt/service-standards/	a. 50% b i. 75% b ii. 95%

Inappropriate out-of-area placements for adult mental health services.	Total number of bed days patients have spent out of area in last quarter	Monthly	Source:http://content.digital.nhs.uk/oaps Further information: www.gov.uk/government/publications/oaps-in-mental-health-services-for-adults-in-acute-inpatient-care/out-of-area-placements-in-mental-health-services-for-adults-in-acute-inpatient-care	Progress in line with agreed trajectory for elimination of inappropriate adult acute out of area placements no later than 2021[14]
Community providers[15]				
Any relevant mental health or acute metrics above				

[14] The process for agreeing trajectories toward eliminating acute mental health out-of-area placements (OAPs) will be jointly led by the NHS England and NHS Improvement regional teams during October to December 2017. Sustainability and transformation partnership (STP) mental health leads, supported by regional teams, will work with their clinical commissioning groups and mental health providers during this period to develop both STP and provider level baselines and trajectories. Provider boards must be assured by 31 December 2017 that data is being properly and completely submitted every month to the NHS Digital administered Clinical Audit Platform (CAP) collection. The January 2018 submission will be taken as an agreed baseline position.

[15] NHS Improvement is working to develop valid national indicators of performance for community providers. This will be a priority in the next scheduled update of the SOF.

Appendix 4: Organisational health indicators

Measure	Type	Description / calculation	Data frequency	Source
Staff sickness	Organisational health	Level of staff absenteeism through illness in the period Numerator = number of days sickness reporting within the month. Denominator = number of days available within the month	Monthly	NHS Digital maintains staff sickness here: https://digital.nhs.uk/article/6743/Staff-management
Staff turnover	Organisational health	Number of Staff leavers reported within the period /Average of number of Total Employees at end of the month and Total Employees at end of the month for previous 12 month period Numerator = number of leavers within the report period. Denominator = staff in post at the start of the reporting period	Monthly	NHS Digital maintains staff sickness here: https://digital.nhs.uk/article/4304/Workforce

NHS Staff Survey	Organisational health	Staff recommendation of the organisation as a place to work or receive treatment	Annual	Data available here: www.nhsstaffsurveys.com/Page/1006/Latest-Results/2016-Results/
Proportion of temporary staff	Organisational health	Agency staff costs (as defined in measuring performance against the provider's cap) as a proportion of total staff costs. Calculated by dividing total agency spend over total pay bill.	Monthly	Monthly provider return

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Stockport NHS
NHS Foundation Trust

Board of Directors' Key Issues Report

Report Date: 30/11/17		**Report Of:** Audit Committee
Date of last meeting: 14/11/17		**Membership Numbers:** Quorate
1.	Key Issues Highlighted:	The Committee considered an agenda which included the following: ▪ Internal Audit Progress Report ▪ Anti-Fraud Progress Report ▪ External Audit Sector Report ▪ External Audit Plan 2017/18 ▪ Facilities Assurance Report ▪ Audit Recommendations - Assurance Report ▪ Job Planning Assurance Report ▪ IT Service Continuity ▪ General Data Protection Regulation ▪ Clinical Audit Plan - Progress Report ▪ Committee Terms of Reference With regard to matters to bring to the attention of the Board, the Committee considered a Progress Report from Internal Audit which detailed outcomes of audit reviews as follows: ▪ Contracting Review - Significant Assurance ▪ Appraisal Review - Significant Assurance The Committee noted the positive outcomes from both audit reviews but agreed that members would meet with Internal Audit representatives to consider further the scope of the work conducted as part of the Contracting Review. While the review had focused on arrangements with NHS commissioners, the Committee considered that there was merit in broadening the scope to assess the effectiveness of general contracting arrangements. The Trust's Anti-Fraud Specialist (AFS) presented an Anti-Fraud Service report which detailed good progress with work undertaken to date during 2017/18. The Committee noted that there were currently three active anti-fraud referrals and has requested that benchmark data be provided in order to assess comparative performance in this area with similar organisations. Board members should note that NHS Protect was superseded by the NHS Counter Fraud Authority with effect from 1 November 2017. Directly related to work carried out by Internal Audit was a number of assurance reports prepared in response to recommendations arising from audit reviews. The Director of Estates & Facilities presented a report which detailed progress against recommendations arising from a Facilities Review. The Committee noted that good progress had been made and took positive assurance on the effectiveness of

		current arrangements. The Director of IT attended to present a report which detailed progress against recommendations arising from an IT Service Continuity Review. The Committee noted that implementation of a new back-up system had been successfully completed on 6 October 2017 and took positive assurance from progress made against the remainder of recommendations from the review. The Committee also considered reports on Medical Appraisals and Job Planning that had been prepared by the Deputy Medical Director and Medical Director respectively. The Medical Appraisal report provided assurance that appropriate action had been taken to address matters reported to the Committee at its previous meeting on 12 September 2017 relating to outstanding audit recommendations. With regard to Job Planning, the report prepared by the Medical Director followed an audit review that had resulted in an outcome of Significant Assurance. Nonetheless, the Committee had requested a follow-up report to provide assurance on progress towards achievement of a target of 95% completed job plans by 31 December 2017. The Committee noted that, while progress had been made, the position at 31 October 2017 of 58% remains some way from the 95% target. The Committee noted both the focus that this subject is receiving from the Medical Director and Deputy Medical Director and the benefits likely to accrue from enhancement of medical leadership arrangements. However, non-completion of job plans remains a risk area and the Committee recommended that this matter be subject to regular review by the People Performance Committee. The Committee reviewed a further report from the Director of IT which detailed arrangements to ensure compliance with the General Data Protection Regulations (GDPR) which will come into force in the United Kingdom on 25 May 2018. The Committee noted the action plan established to support implementation but recommended a review of current planned milestones and identification of a critical path to ensure the timely completion of key actions. The Committee also recommended that project management arrangements and alignment of project resources be subject to review. The Head of Outcomes joined the meeting to present a report which detailed the system for ensuring the quality of clinical audits. The Committee noted both the risk-based approach to identification of audit subjects and plans to adopt a revised software system to enhance functionality. Finally, the Committee completed a review of its Terms of Reference. Board members will be aware of an action in the Board tracking log that relates to transition to an Audit & Risk Committee. The Committee endorsed this approach, with the Committee having a greater emphasis on the effectiveness of risk systems, and the proposed change was supported by both External and Internal Audit representatives. The Terms of Reference were recommended to the Board for approval and will form a separate agenda item for the meeting on 30 November 2017.
2.	Summary of Assurance	1. Internal Audit Reviews: ▪ Contracting Review - Significant Assurance ▪ Appraisal Review - Significant Assurance 2. Anti-Fraud Services - positive assurance on progress with delivery of the 2017/18 plan. 3. Facilities Assurance Report - positive assurance on progress with addressing audit recommendations. 4. IT Service Continuity - positive assurance on progress with addressing audit recommendations.

		5. Medical Appraisal – positive assurance that outstanding audit recommendations had been addressed. 6. Job Planning – limited assurance on achievement of 95% completion target. Referred to People Performance Committee for monitoring.		
3.	Risks Identified	Risk associated with completion of Job Plans		
4.	Report Compiled by	John Sandford, Chair	Minutes available from:	Company Secretary

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Stockport NHS
NHS Foundation Trust

Board of Directors' Key Issues Report

Report Date: 30/11/17		**Report of:** Quality Assurance Committee
Date of last meeting: 21/11/17		**Membership Numbers:** Quorate
1.	Key Issues Highlighted:	The Committee considered an agenda which included the following: • Quality Governance Committee - Key Issues Reports • Quality Improvement – 'Plan on a Page' • Discharge Summary / Clinical Correspondence • CQC Action & Assurance Plan • Monthly Clinical Governance Report • Infection Prevention Annual Report • Policies for Validation With regard to matters to bring to the attention of the Board, the Committee considered Key Issues Reports from the Quality Governance Committee and noted the range of business being conducted by the Committee. In presenting the report, the Medical Director noted in particular work being undertaken by the Committee in relation to actions to address non-compliance with standards for clinical documentation and work to ensure the timely completion of serious incident investigations. The Committee noted a significant reduction in the number of investigations where the 60 day threshold had been breached. The Committee noted that the Quality Governance Committee had reviewed its Terms of Reference and approved the revised Terms of Reference. However, the Committee was briefed by the Medical Director that revised arrangements to conduct the business presently undertaken by the Quality Governance Committee will be planned and implemented in order to ensure that the full range of business can be conducted efficiently and effectively. The Committee endorsed this approach and acknowledged that the revised Terms of Reference would be time limited. The Director of Nursing & Quality delivered a presentation titled *Quality Improvement, through agreed Quality Measures, within a Quality Governance Framework.* The presentation detailed outline plans for the use and reporting of relevant quality metrics / subject areas through management groups, Board-level committees and, ultimately, the Board of Directors. The Director of Nursing & Quality also described the activities to be undertaken within an overarching Quality Governance Framework. The Committee welcomed the presentation, commended the progress made within a relatively short timescale and noted that the planned developments were supported by Mrs C Griffiths, Improvement Director. While the Committee will receive reports relevant to the next stages of the process at its next meeting in January 2018, a recommendation was made to determine how Board members generally can be sighted on the current position.

		The Committee considered a report on the CQC Assurance & Action Plan which was supplemented by a briefing from Mrs H Kershaw, Deputy Director of Quality, on development of a concise Quality Improvement Plan document for on-going monitoring of compliance with recommendations arising from previous CQC inspections. The Committee acknowledged that, while the previous comprehensive action plan approach had been necessary at a period in time, a revised approach was necessary for on-going monitoring and assurance. The Committee endorsed the template presented by Mrs H Kershaw as a positive and timely development. The Chief Operating Officer delivered a presentation which detailed factors affecting performance in the production of Discharge Summaries and Clinical Correspondence together with actions to address performance. The Committee noted the benefit in the longer term from implementation of the EPR system with regard to Discharge Summaries and the establishment of an administrative 'hub' to improve processes for clinical correspondence. The Committee was assured that there is a low level of risk associated with current performance and has requested an update report for its next meeting in January 2018. The Committee considered a Clinical Governance Report and noted continuing to develop the format of the report to provide a greater emphasis on assurance reporting. No specific risks were identified in the report. The Committee received a briefing from the Deputy Director of Quality on progress with implementation of the Datix risk management system and the Director of Nursing & Quality advised that the system had been successfully used as a live tool at recent meetings of the Risk Management and Quality Governance Committees. The Medical Director also commented positively on the effectiveness of the system from personal experience as a risk owner. However, there remains an issue in the production of hard copy risk registers in a format that facilitates practical review by Committees and other groups and the Committee agreed that resolution of this issue needs to be expedited. Finally. the Committee received and noted the Infection Prevention Annual Report 2016/17 and received a briefing from the Medical Director on the current position relating to recruitment of Microbiology consultants. The Committee noted the potential need to adopt an alternative approach to service delivery should recruitment activity prove unsuccessful. The Committee also validated a revised Patient Access Policy.		
2.	Risks Identified	Production of risk registers.		
3.	Actions to be considered at the *(insert appropriate place for actions to be considered)*	Nil		
4.	Report Compiled by	Mike Cheshire, Chair	Minutes available from:	Company Secretary

Stockport NHS
NHS Foundation Trust

Board of Directors' Key Issues Report

Report Date: 30/11/17		**Report of:** Finance & Performance Committee
Date of last meeting: 15/11/17		**Membership Numbers:** Quorate
1.	Key Issues Highlighted:	The Committee considered an agenda which included the following: ▪ Month 7 Finance Report ▪ Month 7 Operational Performance Report ▪ Month 7 Agency Utilisation Report ▪ Financial Recovery Update ▪ Surgical & Critical Care – Recovery Plan ▪ Bed / Ward Reconfiguration Plan ▪ Service Review Update Report ▪ 2017/18 CIP Report ▪ Draft Operational Plan – Progress Report ▪ Theme 3 & 4 Update Report ▪ Tender Log October 2017 With regard to matters to bring to the attention of the Board, the Committee considered the Month 7 Finance Report and noted a deficit position of £18.4m at 31 October 2017, compared to a planned deficit of £19.6m, which resulted in a favourable variance of £1.1m. The Director of Finance provided an overview of report content and noted in particular a further deterioration in elective income. This matter was considered in detail during review of the Surgical & Critical Care recovery plan. The Committee noted confirmation from Stockport CCG that financial penalties for 2017/18 will be re-invested and welcomed this decision. With regard to Operational Performance, the Committee noted that, while performance against the A&E 4-hour standard in October 2017 had improved with a position of 86.1% for the month, the trajectory position of 90% had not been achieved. The Committee was assured that the RTT position had been recovered in October 2017, with performance of 92%, and noted the actions being taken to address performance in the non-compliant specialties of; ENT, Ophthalmology, Oral Surgery and Rheumatology. Less positive was performance against the Cancer 62-day standard with a position of 81.5% against the 85% standard. The Committee noted the sensitivity of the standard with regard to low patient numbers, 10 patients had breached the standard, and was advised of remedial actions by the Chief Operating Officer who assured the Committee that the position would be recovered in November 2017. The Committee considered a report which detailed performance against the Agency Expenditure Ceiling as at 31 October 2017. Board members should note that, despite reducing monthly levels of expenditure during the period July – September

		2017, a significant increase was experienced in October 2017 with expenditure of £749k against a targeted figure of £476k. The Committee noted factors influencing expenditure, which included short notice medical leavers and corporate services agency cover, and was advised of work being undertaken by the Director of Nursing & Quality to better manage the use of off-framework agency arrangements which incur an additional cost premium. The Director of the Surgical & Critical Care Business Group attended the meeting to present a financial recovery plan. The Committee noted the requirement to improve the Business Group's financial position by circa £700k in order to meet the Trust's overall financial plan. The Committee was assured on actions being taken to monitor and track elective activity and confirmation was provided that Getting it Right First Time (GIRFT) recommendations had been adopted. The Committee concluded that positive assurance had been provided on delivery of the recovery plan but agreed that further assurance was required on the accuracy of activity modelling for 2018/19, having acknowledged the factors such as CCG initiatives to reduce referrals that were influencing in-year activity levels. A main focus of the meeting was on consideration of Bed Reconfiguration plans and progress with the Financial Recovery Plan. With regard to the former, the Committee considered a presentation from the Deputy Chief Operating Officer which detailed a number of options for Phase 1 (2017/18) of a reconfiguration programme. The Committee noted that the options identified had been developed in the context of ensuring patient safety and quality, operational performance and financial sustainability. On conclusion of a detailed discussion, the Committee endorsed the recommended option which was based on the reduction of 35 beds during November / December 2017. While this option will only generate modest savings of circa £175k in-year, the Committee agreed that alternative options to achieve higher cost reductions could not be achieved without a detrimental impact on quality and performance. The Committee considered a report which detailed the Trust's Financial Recovery Plan and was briefed by the Director of Finance on the current position and progress made to date. The Committee noted use of a financial recovery checklist, endorsed by NHS Improvement, which includes an extensive series of measures to control and/or reduce expenditure and acknowledged that the various measures were being assessed by Executive Directors. However, the Committee noted that there remained a gap of circa £2.5m against the financial plan for 2017/18 and that potential mitigating actions identified to date would only reduce the gap by circa £1m. Consequently, the Committee concluded that there is currently a low level of assurance on full delivery of the financial plan for 2017/18 and requested that a report on this subject be presented to the Board of Directors on 30 November 2017. The low level of assurance also applied to delivery of the CIP programme which is an integral part of the overall financial plan. Finally, the Committee considered progress reports on planned Service Reviews and preparation of the Operational Plan 2018/19. With regard to Service Reviews, Board members will note that outputs from the reviews will form a key part of the efficiency programme for 2018/19. Consequently, it is imperative that the reviews are appropriately resourced and completed within planned timescales. The Committee noted a rolling programme to complete reviews in the following areas by week commencing 9 April 2018: ▪ Trauma & Orthopaedics

		▪ General Surgery ▪ Cardiology ▪ Rheumatology ▪ DMOP ▪ Obstetrics Outcomes from the reviews will be reported to the Committee on the completion of each review. The Committee considered a report which detailed progress on preparation of the Operational Plan and noted that national guidance on both requirements and submission dates has yet to be published. The Trust is currently working to have a draft version of the document prepared for Executive consideration on 5 December 2017. The Committee acknowledged the numerous factors leading to uncertainty in the operational and strategic environment and emphasised the need for plans to be formulated on the best intelligence available.		
2.	Summary of Assurance	1. Delivery of 2017/18 financial position – Limited Assurance 2. Delivery of 2017/18 Cost Improvement Programme – Limited Assurance 3. Delivery of the A&E 4-hour standard trajectory – Limited Assurance		
3.	Risks Identified	Delivery of 2017/18 Cost Improvement Programme Delivery of 2017/18 Financial Plan Operational Risk associated with delivery of the A&E 4-hour standard trajectory Delivery of Agency Expenditure Ceiling 2017/18		
4.	Actions to be considered	Financial Recovery Plan report to Board of Directors on 30 November 2017.		
5.	Report Compiled by	Malcolm Sugden, Chair	Minutes available from:	Company Secretary

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Stockport NHS
NHS Foundation Trust

Board of Directors' Key Issues Report

Report Date: 30/11/17		**Report of:** People Performance Committee
Date of last meeting: 23/11/17		**Membership Numbers:** Quorate
1.	Key Issues Highlighted:	The Committee considered an agenda which included the following: • Recruitment & Retention Strategy Implementation Plan • Shared Services Update • Appraisal Report • Guardian of Safe Working Report • HEE NW / GMC Enhanced Monitoring Report • Junior Doctors Contract Implementation • Job Planning • Agency Expenditure • Apprenticeship Scheme Update • Cover for Consultant Absence & Vacancies • Key Issues Reports - JCNC - LNC - Health & Wellbeing Steering Group With regard to matters to bring to the attention of the Board, the Committee considered a report which detailed progress with work being undertaken with Stockport metropolitan Borough Council on options for Shared Services. The Committee noted that an Options Appraisal is currently being undertaken by KPMG LLP with outcomes scheduled to be reported in mid-January 2018. The Committee was assured on the work being undertaken to ensure that staff working in the areas under consideration for Shared Services are being kept informed of developments with information such as Frequently Asked Questions made available on the Trust's intranet. The Committee acknowledged the recruitment and retention risk that could arise from the Shared Service development. The Committee received the Quarter 2 report from the Trust's Guardian of Safe Working and took positive assurance from the improvements made since the previous report. The Committee noted in particular a significant decrease in the number of days taken to close exception reports which had reduced from 70 days in Quarter 1 to 19 days in Quarter 2. The Committee congratulated Dr S Rendell on embedding a greater understanding of relevant requirements amongst colleagues which contributed significantly to the improved performance. The Committee also considered a report presented by Dr D Baxter, Director of Medical Education which detailed requirements arising from a HEENW / GMC Enhanced Monitoring Visit on 21 September 2017. A patient safety concern was identified during the visit and the Committee noted the response provided by the Trust in advance of the deadline date of 17 October 2017. The Committee was assured

		that HEE NW had been satisfied with the Trust's response and associated action plan which will be subject to monthly monitoring by the Committee. A number of 'Other Issues' requirements were identified during the visit and the Trust is required to respond to these requirements by 28 February 2017. The Committee considered reports from the Deputy Medical Director on the subjects of Junior Doctors 2016 Contract Implementation and Job Planning. With regard to the former, the Committee was assured that implementation of the Junior Doctors Contract had been completed. The Committee noted progress made against recommendations arising from a Job Planning Review completed by Internal Audit, which had resulted in an assessment of Significant Assurance. The Committee triangulated this report with discussions at a recent Audit Committee meeting where assurance had been requested on achievement of 95% completion of job plans by 31 December 2017. The Committee was advised by the Head of Medical Workforce of a number of factors that had to be taken into account to provide context for the current completion rate of 58%. The Committee requested that the relevant information be provided in future reports. The Committee considered a report which detailed performance against the Agency Expenditure Ceiling as at 31 October 2017. Board members should note that, despite reducing monthly levels of expenditure during the period July – September 2017, a significant increase was experienced in October 2017 with expenditure of £749k against a targeted figure of £476k. The Committee noted factors influencing expenditure, which included short notice medical leavers and corporate services agency cover, together with a supplementary report which detailed additional remedial actions in response to the Month 7 variance. On a more positive note, the Committee ratified an *Agreement for Consultants covering Absent Colleagues and Vacancies'* and noted the significant amount of work involved in successfully concluding this agreement. The Committee also received a report which detailed a positive outcome of an Appraisal Review completed by Internal Audit which resulted in assessment of Significant Assurance. The report also detailed outcomes of an internal Quality Audit and the Committee noted that the outcomes complemented those of the Internal Audit review. The Committee noted a current compliance rate of 92.8% which is the highest rate across Greater Manchester organisations.		
2.	Summary of Assurance	• Job Planning – Significant Assurance (Internal Audit) • Appraisal Review – Significant Assurance (Internal Audit)		
3.	Risks Identified	• Achievement of the Agency Expenditure Ceiling for 2017/18.		
4.	Report Compiled by	Angela Smith, Chair	Minutes available from:	Company Secretary

Report to:	Board of Directors	**Date:**	30th November 2017
Subject:	Trust Performance Report (reporting period : Month 7 2017/18)		
Report of:	Chief Operating Officer	**Prepared by:**	Joanne Pemrick Head of Performance

REPORT FOR APPROVAL

Corporate objective ref: N/A	In relation to month 7 performance, the following are the main areas of concern for the Boards attention: • ED was non-compliant against the Single Oversight Framework metric and against the 90% trajectory plan. However, performance in October was much improved at 86.1%. • RTT regained compliance with standard in month. • The Cancer 62 day standard is not predicted to achieve for October. • The Trust financial position is favourable to plan to the end of October by £1.1m, but this is still an £19.5m loss equal to £86,000 per day. • In year CIP is £1.2m ahead of the profiled plan to date, a deterioration of £0.8m from last month as the target is now catching up with the savings transacted to date. Recurrent CIP has increased in month to £5.9m (39%), of which theatre productivity represents £2.4m of the total recurrent CIP. • Elective income has deteriorated again in month. Scheduled sessions taking place in certain specialties are being run more efficiently, but fewer lists are going ahead than planned so income is low. • The Trust has now received written agreement from Stockport CCG that financial penalties will be re-invested as part of the Trust Financial Recovery Plan, and this has caused an in month favourable variance of £0.7m. The summary of all the key issues to note are detailed in section 1.1 of the report.
Board Assurance Framework ref: N/A	
CQC Registration Standards ref: N/A	
Equality Impact Assessment: ☐ Completed ☒ Not required	

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

1. Introduction

This report provides a summary of performance against the NHSI Single Oversight Framework for the month of October 2017, including the key issues and risks to delivery. It also provides, in section 4, a summary of the key risk areas from the Trust Integrated Performance Report which is attached in full in Annex A.

1.1 Key issues to note:

Operational Performance

- While ED performance was non-compliant in October 2017 against the Single Oversight Framework metric and the 90% trajectory plan, performance was significantly improved at 86.1%.
- As forecast, RTT compliance was achieved this month.
- At the point of reporting close, the Cancer 62 day standard is not predicted to achieve for October.
- Elective cancelled operations on the day was above the threshold target of 0.85%

Workforce

- Bank and agency costs in month (October 2017) account for 12.3% (£2.18m) of the £17.65m total pay costs. This is an increase of 2.13% from the position reported in September (£1.85m).
- The in-month unadjusted sickness absence figure for October 2017 is 4.15%; an increase of 0.17% compared to the previous month. The increase for coughs and colds by 3% is significant.

Finance

- The Trust financial position is favourable to plan to the end of October by £1.1m, but this is still an £19.5m loss equal to £86,000 per day.
- In year CIP is £1.2m ahead of plan the profiled plan to date, a deterioration of £0.8m from last month as the target is now catching up with the savings transacted to date. Recurrent CIP has increased in month to £5.9m (39%), of which theatre productivity represents £2.4m of the total recurrent CIP.
- Elective income has deteriorated again in month. Scheduled sessions taking place in certain specialties are being run more efficiently, but fewer lists are going ahead than planned so income is low.
- The Trust has now received written agreement from Stockport CCG that financial penalties will be re-invested as part of the Trust Financial Recovery Plan, and this has caused an in month favourable variance of £0.7m.

2. Compliance against Single Oversight Framework

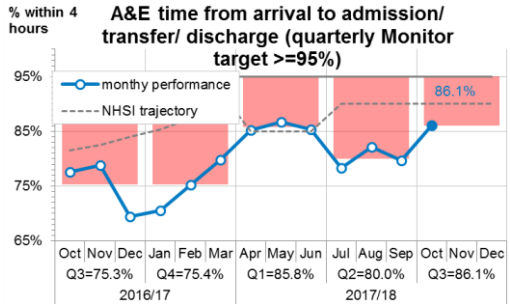
The table below shows performance against the indicators in the Single Oversight Framework that came into effect 1st October 2016. The forecast position for next month is also indicated by a red (non-compliant) or green (compliant) box.

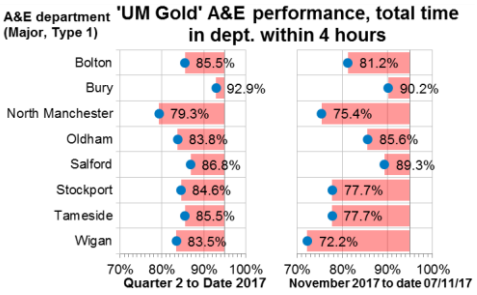
	Standard	Monitoring Period	Nov-16	Dec-16	Q3	Jan-17	Feb-17	Mar-17	Q4	Apr-17	May-17	Jun-17	Q1	Jul-17	Aug-17	Sep-17	Q2	Oct-17	Nov-17 (f/cast)
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate: Patients on an incomplete pathway	92%	Monthly	92.4%	92.1%	92.0%	92.1%	92.5%	92.6%	92.4%	92.5%	93.3%	92.7%	92.8%	92.7%	92.1%	91.7%	92.1%	92.0%	
A&E maximum waiting time of four hours from arrival to admission/ transfer/ discharge:	95%	Monthly	78.9%	69.4%	75.3%	70.5%	75.2%	79.8%	75.4%	85.3%	86.7%	85.3%	85.8%	78.3%	82.1%	79.7%	80.0%	86.1%	
All cancers: Maximum 62-day wait for first treatment from: urgent GP referral for suspected cancer	85%	Monthly	85.1%	89.1%	86.0%	85.4%	87.3%	91.2%	88.1%	91.3%	74.5%	85.0%	83.7%	85.9%	90.7%	85.6%	87.5%	83.2%	
All cancers: maximum 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	n/a	n/a
Maximum 6-week wait for diagnostic procedures	99%	Monthly	99.8%	99.6%	99.7%	99.8%	99.7%	99.8%	99.8%	99.6%	99.8%	99.8%	99.7%	99.4%	99.3%	99.8%	99.5%	99.8%	

3. Month 7 2017/18: Performance against Single Oversight Framework

There are two areas of non-compliance against the regulatory framework in month 7:

i) A&E 4hr target





Performance against the 4hr standard was much improved during October, at 86.1%. However, this was still below the trajectory plan of 90%. At the end of October 2017, we had incurred 13% less breaches of the 4 hour target in the past 12 months than at the same point in October 2016. Performance in October 2017 was approximately 10% higher than October 2016 yet attendances were nearly 4% higher.

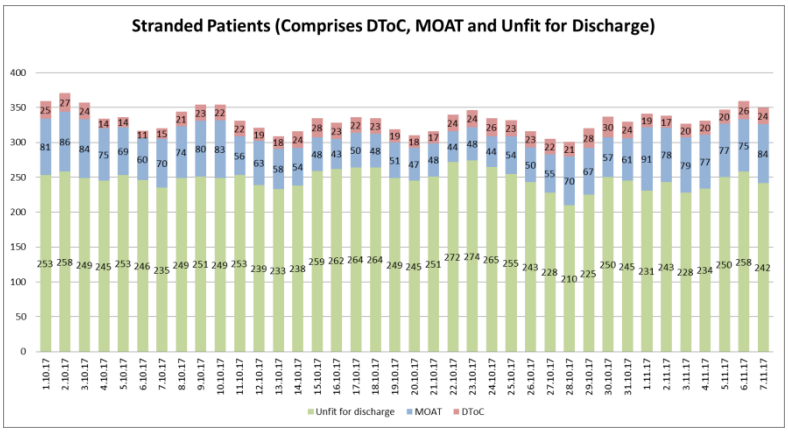
At the time of writing, performance against the 4hr Standard in November is extremely challenged due to a number of factors:

- Variable periods of surge are having a significant effect on our ability to maintain performance and greater attention is required to ensure a "whole hospital response".
- Overnight performance continues to be a key issue due to the shortfall in Consultants in the Emergency Department in the "twilight" shift.
- Our OPEL System response remains acute Trust focused with limited sight of actions being taken across the health economy.
- Despite significant national pressure, we have not closed any of our paediatric bed base and we have taken transfers from other organisations who have done so, thereby adding additional pressure on our services.

In addition to the plans for Winter preparedness, the following actions are being taken to improve short and medium term performance:

- Stranded patient reviews commenced on the 8th November focusing senior attention on those patients staying the longest in the hospital. This is recognised as best practice nationally and will allow the teams from Medicine & Clinical Support and Surgery, GI and Critical Care to identify the key themes and blockages in patient flow across their bed base.
- "CEEPFIT" meetings 3 times per week with the Clinical teams from across Medicine and Surgery to focus on early discharge and expediting patient flow across the system. This working is starting to have a tangible effect with early discharges increasing from the Medicine wards through effective MDT working and clinical leadership.
- The continued refinement of the OPEL escalation process and ensuring the Stockport System response is fit for purpose, has clear roles and responsibilities for all stakeholder groups and is providing the required resilience to meet the challenge of the approaching Winter months.

- A review of the Emergency Department Medical rota to provide two consultants every evening (from 1pm – 9pm) in order to meet the demands of the twice daily surges.
- The project to implement the Frailty Unit continues with a view to increasing capacity at the front end to provide the necessary capacity to ensure flow across the hospital each day.
- The focus on the reduction of DTOCs to 10 by December and MOATs through further development of Discharge to Assess pathways continues with close working between system partners.



ii) Cancer 62 day standard

The latest position for the month of October is 83.2% with a total of 10 patients breaching the 62 day standard.

7 patients were late referrals to other providers for treatment (i.e. past day 42 of their pathway). Of those 7 patients, the issues arising were:

- 3 cross-tumour group pathways,
- Delays in diagnostics, more notably;
    - Lymph node biopsy
    - PET scan - increasing waits being experienced for PET scans across GM
    - Histology reporting
- Patients requiring repeat tests,
- Patients requiring extended support, including a patient with acute learning difficulties.

Actions being undertaken to improve current performance include:

- A new Lymph node biopsy pathway has been presented by the Clinical Cancer Lead to the Cancer Quality and Service Improvement Committee which will reduce the wait to test. Adherence to this new pathway is being monitored through the Committee.
- The performance of the Upper GI pathway has been identified as a key risk. As a result, the SLA with Manchester Foundation Trust is being reviewed with a view to agreeing the earlier transfer of patients, where possible.
- The Colorectal "straight to test" model has been agreed by the Clinical team and is in the process of implementation.

Future risks to compliance against the new Single Oversight Framework

Future risks to compliance with the new framework are:

- ED
    - Recruitment and retention of medical and nursing staff to ensure 24/7 resilience.

- Speed and pace required to deliver cultural change associated with large scale transformation across the Stockport System.
- Sustained increase in demand over the winter period.

- RTT
  - Redirection of Clinical resource away from elective activity to support the urgent care pathway, will affect the ability to maintain RTT performance over the winter period.

4. Key Risks/hotspots from the Integrated Performance Report

4.1 Quality

- **Discharge Summary**

The Trust is failing to make any further progress with publishing HCRs within the 48hr timeframe. Furthermore, these issues may be compounded as there is a commissioner request to move to a 24hr standard from next April.

It is acknowledged that several factors are contributing to poor performance;

- Lack of real time admission and discharge (ADT) on PAS.
  The discharge summary will not be published, even if completed, if the patient has not been discharged on the PAS system. This is mainly an issue across services where administrative support is not present such as out of hours or at the weekend.

- Outlying patients prior to discharge.
  It is reliant on the staff from the ward the patient was transferred from to action the discharge.

- Junior doctor gaps
  This function is heavily reliant on the junior doctor workforce. Gaps in rotas and subsequent reliance on locum medical staff of all grades affects completion rates, most notably in high throughput and assessment areas eg CDU, ACU etc…

Actions being undertaken to improve current performance include:

- Generation of a report 24hrs post discharge to highlight outstanding HCRs and prompt completion.
- The work being led through the CEEPFIT sessions to drive discharges earlier in the day will ensure that we are minimizing the numbers of patients discharged out of hours.
- IT solutions to mitigate out of hours administrative function being investigated.

- **Clinical Correspondence**

The percentage of correspondence typed within 7 days fluctuates between 60%-70% each month, which is adrift from the 95% target.

The specialties with the longest waits presently are Cardiology, Chest and DMOP.
There are currently acute staffing gaps within the Medicine and Clinical Support Business Group which is hampering progress with reducing these waits which will be further exacerbated next month as planned sickness and resignations take effect. Similarly, the WC&D Business Group will have a 50% deficit in secretarial staff from next month due to similar issues.

Actions

- The short to medium term solution is reliant on moving to a clinical correspondence typing hub in order to increase efficiencies and resilience within associated resource. The project group plan for this to take place on December 4th 2017.
- Flexible use of peripatetic typists across the Medicine and Clinical Support Business Group
- The ultimate solution is to transfer to a voice recognition process which is planned in for phase 2 of EPR implementation.

- **Patient Experience**
  Overall in October, the trust scored 92% extremely likely or likely to recommend. The ED score improved to 88.9%. Feedback from patients attending ED continued to cite long waiting times, although many positive comments were received regarding staff providing excellent care under pressure.

4.2 Performance

- **Cancelled operations on the day (Non-clinical reasons)**
  There were 45 cancelled operations on the day for non-clinical reasons in October.

  The specialty with the highest number of cancellations was Orthopaedics with 18 cases cancelled (8 due to lack of theatre time, 5 due to urgent cases taking priority and 4 due to no bed availability).

  Overall, the most common reason for cancellation was lack of theatre time (13 cases), followed by no bed availability (7 cases) and urgent cases taking priority (7 cases).

- **Outpatient Waiting Lists:**
  At the end of October, Ophthalmology, Chest and Gastroenterology were on track against their revised forecast positions. Cardiology was behind plan which was mainly due to a loss of clinical sessions following the appointment of a substantive consultant and the release of a Locum, whose job plan was predominantly clinical sessions. Unfortunately due to a recent resignation, another Consultant gap will occur from December and it is anticipated that this will be filled by a locum.

4.3 Finance

- **CIP**
  To the end of October £5.8m of CIP has been actioned towards the year-to date target of £4.6, so is £1.2m ahead of plan. £9.5m (63%) of the £15.0m annual saving has been achieved. Recurrent CIP has increased in month to £5.9m (39%), of which theatre productivity represents £2.4m of the total recurrent CIP. This remains as a risk as although efficiency has improved in some specialties, the overall volume of lists required to meet the plan is not being delivered.

  Overall delivery of full year CIP savings of £15.0m is required to achieve the planned deficit of £27.4m but at present recurrent delivery is low. **This is a significant concern as it does not support the Trust's drive to return to financial balance in the medium term, as a further £15m of recurrent CIP is required in 2018/19, in addition to delivery of the full £15m recurrently in 2017/18.**

- **Financial sustainability**
  The Trust's Use of Resources (UOR) score under the Single Oversight Framework is a 3, classified by NHSI as triggering significant concerns. The Trust's operational plan for 2017/18 predicted a score of 3 for October 2017 and our actual performance is in line with this.

For the Trust's overall score to improve to a 2 the planned financial deficit would need to improve by £24.7m to a deficit of £2.7m (within 1% of planned operating income).

- **Agency Ceiling**
  Agency costs to date are £7.8m, which represents 6% of total pay costs. This is in excess of the profiled NHSI agency ceiling to date by £1.3m.

  Agency costs for medical staffing are £5.6m to October 2017, which is 72% of all agency costs and highlights that the Medicine and Integrated Care business groups' reliance on agency medical staff is a key driver for breaching the NHSI ceiling to date.

  NHSI's national team are now providing targeted support to the Trust, focusing on the highest cost agency staff and working to reduce this premium rate cost.

- **Elective Income**
  Elective income has deteriorated again in month by £0.2m, and is £1.9m behind plan after the target has been increased for CIP. Compared to forecast the Surgery business group's recovery plan is 28 cases ahead, but the recovery trajectory does not bring income in line with plan.

  Inpatient income is currently behind plan by £1.4m, and day case activity is £0.5m adverse. The Trust has spent £1.3m on waiting list initiatives and £0.9m on out-sourcing in seven months, but this is not solely on elective work and includes out-sourced radiology reporting.

  Elective activity continues to the main contributor to this deficit year, with activity 1,359 spells below planned levels. Both day case and inpatient activity is below plan by 855 and 504 spells respectively. As a result, the overall elective income is £1.9m adverse to plan.

  The focus this month has centered on recovery plans and close monitoring of actions required to ensure delivery. The Surgery Business group has undertaken a detailed review of expected elective activity until the end of the financial year and the forecast year-end recovery plan is dependent on delivering this level of activity. A weekly recovery plan meeting tracks progress in each specialty and alongside this progress is also tracked at the weekly Patient Tracking List (PTL) meeting and the 6-4-2 theatre scheduling meeting. During October, the business group overachieved against the forecast activity for the month by 28 spells. This close scrutiny will continue over the remainder of the financial year.

4.4 Workforce

- **Essentials training**
  The essentials training compliance is 86.7% for October 17; up 3% on September 2017. The improvement being attributed to a focused effort by the e-learning specialist, underpinned by improved data validation.

  A new Statutory and Mandatory training matrix was launched on 8th November, supported by new e-learning packages; which is receiving positive feedback. It is expected that the upturn in performance will continue in response to the improved training experience.

- **Appraisals**
  The Trust's total appraisal compliance for October 2017 is 92.7%. The learning and development team has been focusing on data validation and is supporting the business groups to develop and implement improvement action plans. Areas achieving less than 90% compliance will be the target for additional focused support. It is anticipated that the improvement in performance will continue and the aim to meet target by December met.

- **Efficiency**
  Bank & Agency costs

Bank and agency costs in month (October 2017) account for 12.3% (£2.18m) of the £17.65m total pay costs. This is an increase of 2.13% from the position last month (£1.85m).

Bank and agency spend across the Medicine &CS Business Group, which is still carrying a high number of medical and nursing vacancies, increased from £0.75m in September 2017 to £0.84m in October 2017, and continues to have the highest spend on bank and agency equating to 24.05% of the Trust overall bank and agency spend and 4.74% of the Trust total pay bill.

- **Sickness Absence**
  The in-month unadjusted sickness absence figure for October 2017 is 4.15%; an increase of 0.17% compared to the previous month. The sickness rate for comparison in September 2016 was also 4.15%. The top three reasons for absence in October 2017 are: Stress at 33.7% (a 1.28% decrease from September 2017), Back Problems and Other Musculoskeletal Problems including injury/fracture at 22.8% (a 2.29% decrease from September 2017), and Coughs/Colds/Influenza and Asthma at 10.43% (compared to 3.01% in September). The increase for coughs and colds by 3% is significant.

5. Recommendations

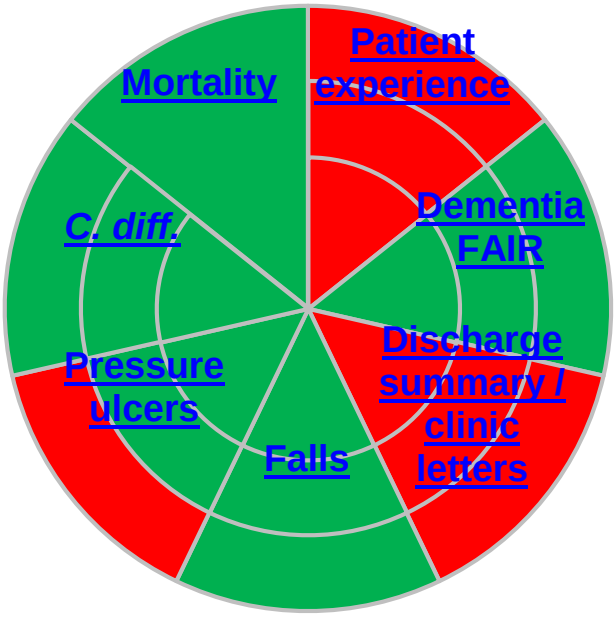
The Board is asked to:

- Note the current position for month 7 compliance against standards.
- Note the future risks to compliance and corresponding actions to mitigate.
- Note the key risks areas from the Integrated Performance Report.

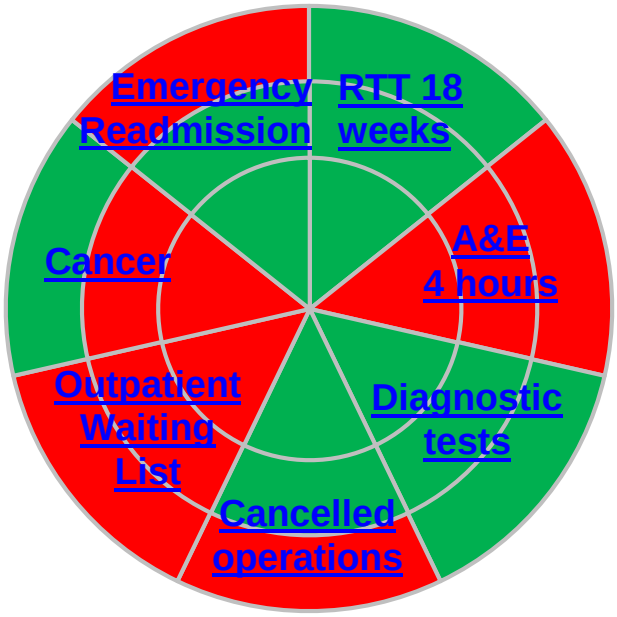
Integrated Performance Report October 2017

Stockport NHS Foundation Trust

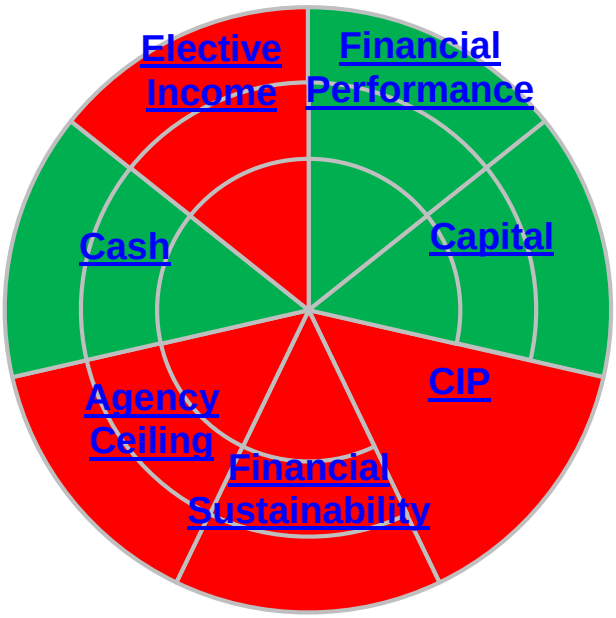
1. Quality



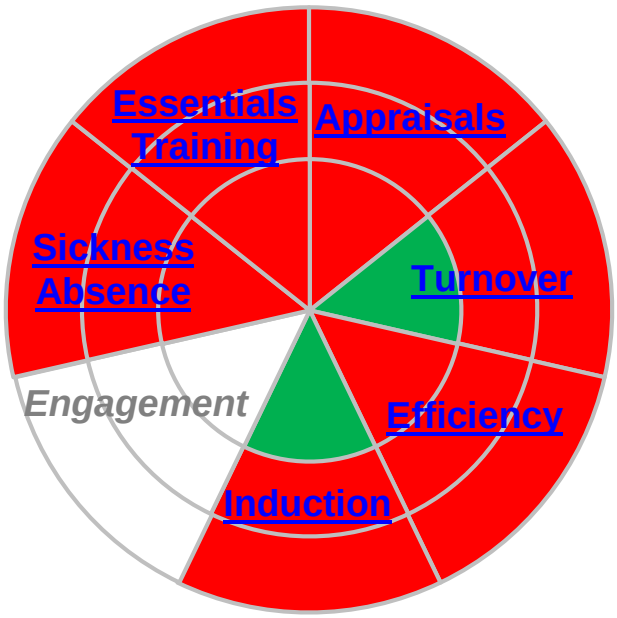
2. Performance



3. Finance



4. Workforce



Key to wheels:

Outer ring; Year-to-date performance. Middle ring, latest quarter. Inner ring, latest month. Mortality is assessed on the latest 12 months, CIP (Cost Improvement Programme) on the year-to-date.

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Integrated Performance Report

Changes to this month's report October 2017:

- This month information on progress with the flu vaccination programme has been included. This can be seen in charts 92-94.

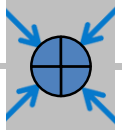
Key to indicators:

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



Patient Experience

In the month of October we had a total of 4620 responses for the Friends and Family test and 92% of patients stated that they were extremely likely or likely to recommend the Trust.

Results broken down:

AREA	Response rate March	Variance on previous month (RR)	% extremely likely / likely to recommend March	Variance on previous month (% Rec)
ED inc children's ED	20%	same	89%	+2%
Inpatients	32%	-3%	95%	same
Maternity (Birth)	44%	-7%	99%	+2%
Outpatients	33%	+2%	91%	+1%
Daycase	32%	-2	92%	-3%
Community	27%	+1	90%	+1%

Maternity all stages: response rate = 31%, change from last month +5%

Maternity all stages: % extremely likely / likely to recommend 97%, this is an increase of 1% from September.

Feedback Themes (acute):

ED (adult) Positive comments received related to professional, knowledgeable staff who provide excellent care even when under pressure. There were also many positive comments relating the excellent service that is provided to patients. Negative comments continue to be related to long waiting times.

Inpatients (adults) Positive comments continue to be related to kind, caring and friendly staff who deliver an efficient service. Negative comments continue to relate to poor communication and lack of staff.

Maternity All comments received were positive and related to the fantastic care and service delivered by caring and knowledgeable staff.

Paediatrics (inpatients) All comments received were extremely positive relating to professional, caring staff who provide family centered care.

Daycase: Positive comments related to professional, knowledgeable staff who deliver fantastic care. Negative comments related to long waits and poor communication.

Outpatients: Positive comments continue to relate to

Chart 1

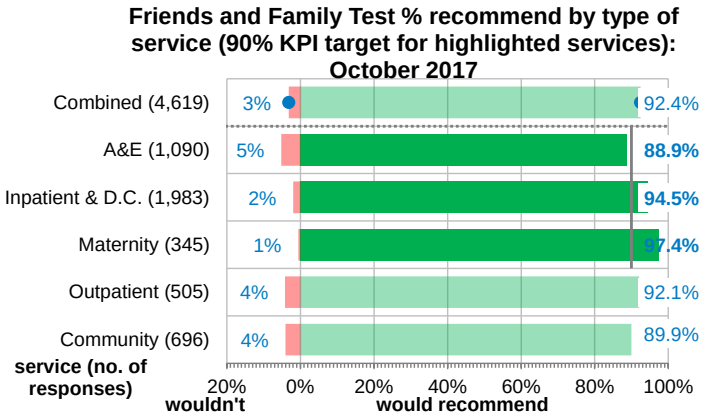


Chart 2

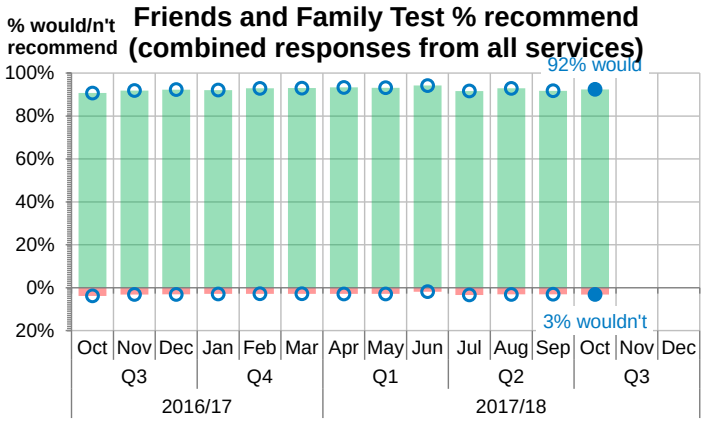


Chart 3

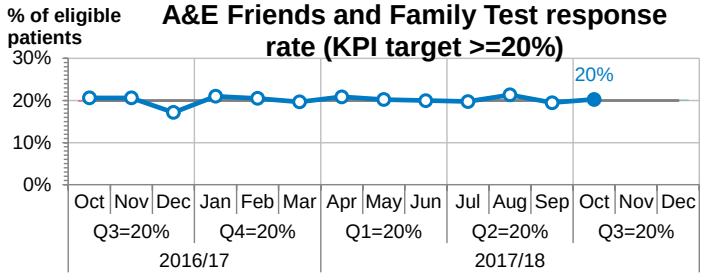
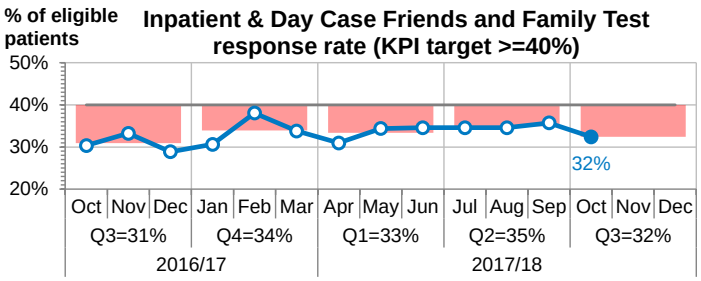


Chart 4



extremely friendly and helpful staff who make patients feel at ease and who have a smile on their face. There were also positive comments related to the clean environment. Negative comments continue to relate to waiting times.

IPad Inpatient Surveys

In October 222 inpatient iPad surveys were undertaken, which is a decrease of 21 compared to the number completed in September.

All wards have log in access to review / undertake iPad surveys and this continues to be encouraged.

All results can be seen via the trust Corporate Information System (CIS) and continue to be sent to wards on a monthly basis in more detail as a report. Using a RAG rating system the results via CIS are presented in a format which enables an overall trust wide view of where performance is good and where targeted focus is required.

Overall, the trust scored 86% positive responses in October which is a decrease of 1% from September.

Results in October have shown improvements where patients feel there were enough nurses on duty with an increase of 2%, where patients feel nurses talk in front of them as if they were not there with an increase of 5%, where patients have been bothered by noise at night from other patients with an increase of 4% and a 6% increase in relation to the temperature of the hospital foods.

Less positively results have deteriorated significantly where patients did not receive assistance with eating and drinking or opening sachets and cutting up food. Results also show a deterioration where patients feel after receiving pain relief they haven't been asked if it was effective with a decrease of 9%, adequate choice of food with a decrease of 8%, completion of a property form with a decrease of 8% and a 3% decrease where patients feel they had been given enough privacy when discussing their condition.

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Dementia

Chart 5

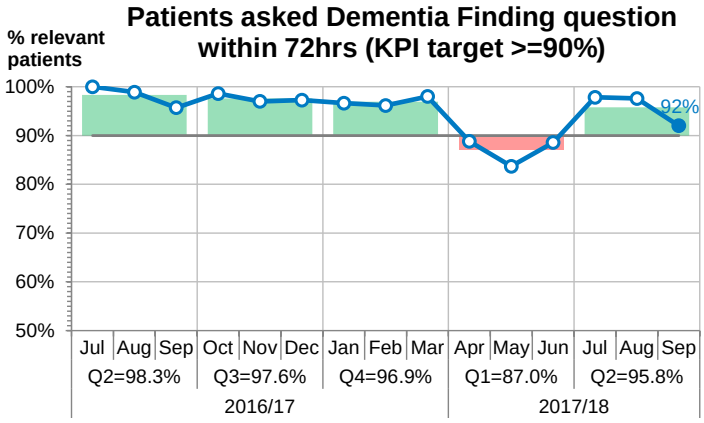


Chart 6

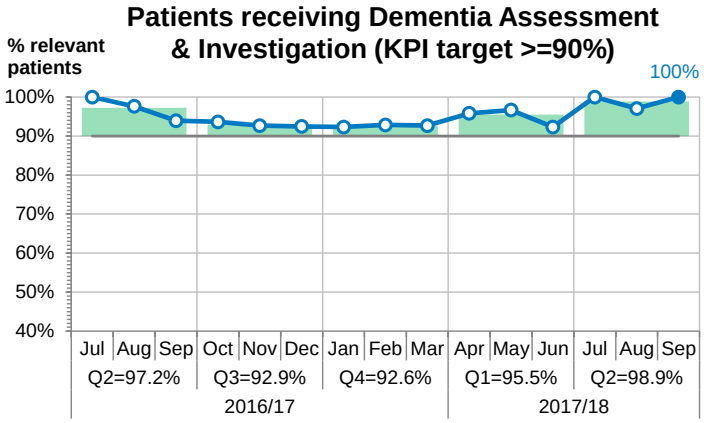
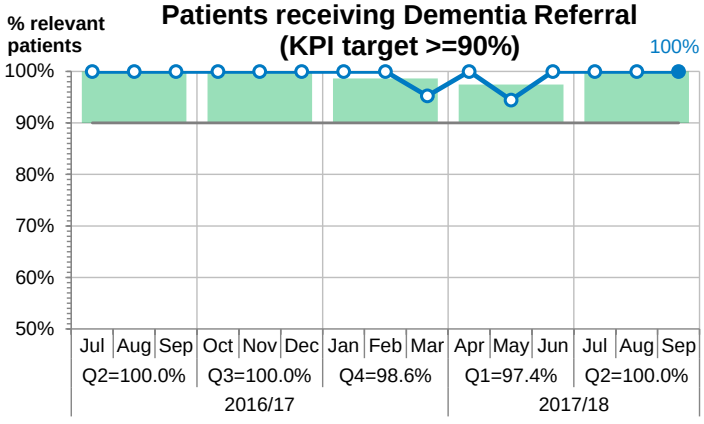


Chart 7



Charts 5 to 7 show performance against the dementia standards.

Compliance against the standard has been achieved for September.

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Discharge Summary

Chart 8

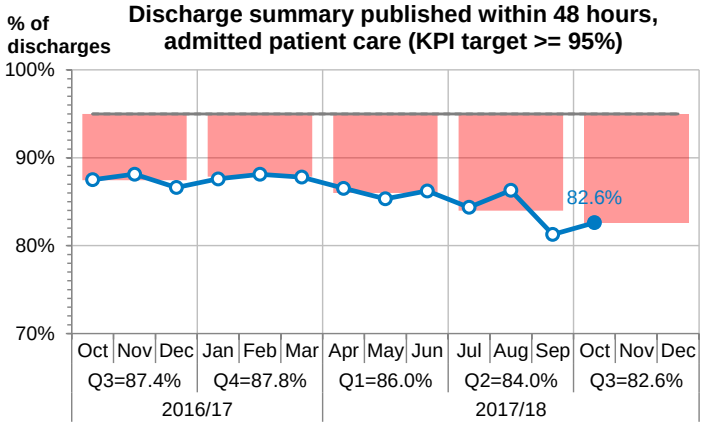

Chart 8 shows compliance with discharge summary completion within 48hrs.

The percentage of discharge summaries published within 48 hours was 82.6% in October.

Lack of real time admission and discharge (ADT) on PAS and gaps in the junior doctor workforce are the main contributors to the continuing under achievement of the standard.

Actions being undertaken to improve current performance include:

- Generation of a report 24hrs post discharge to highlight outstanding HCRs and prompt completion.
- The work being led through the CEEPFIT sessions to drive discharges earlier in the day will ensure that we are minimizing the numbers of patients discharged out of hours.
- IT solutions to mitigate out of hours administrative function being investigated.

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Clinical correspondence (typing backlog)

Chart 9

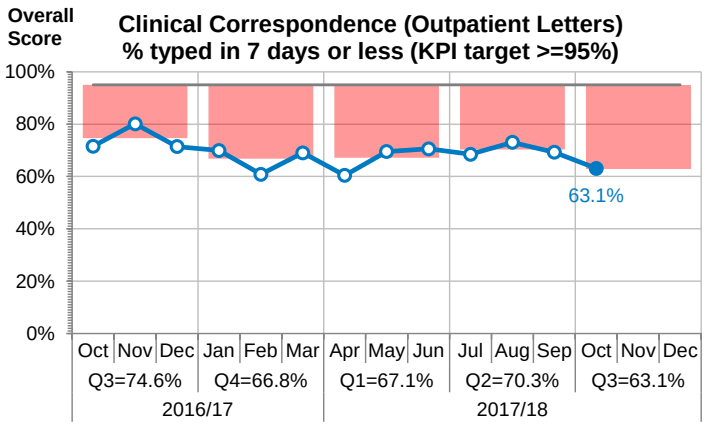

Chart 9 shows the performance against the clinical correspondence standard of 95% of Outpatient letters to be typed within 7 days.

The specialties with the longest waits presently are Cardiology, Chest and DMOP. There are currently acute staffing gaps within the Medicine and Clinical Support Business Group which is hampering progress with reducing these waits which will be further exacerbated next month as planned sickness and resignations take effect. The Women, Children & Diagnostics Business Group will have a 50% deficit in secretarial staff from next month which will further impact on performance.

Actions being taken to mitigate and improve performance are:

- Moving to a clinical correspondence typing hub in order to increase efficiencies and resilience. The project group plan for this to take place on December 4th 2017.
- Flexible use of peripatetic typists across the Medicine and Clinical Support Business Group
- A longer term solution is to transfer to a voice recognition process which is planned in for phase 2 of EPR implementation.

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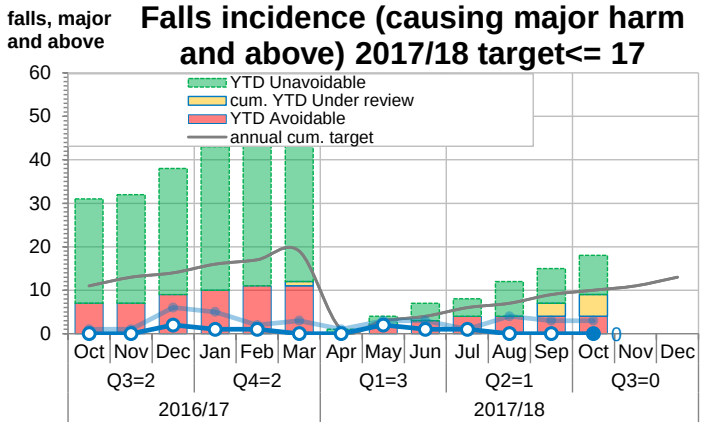
Falls 16

Chart 10



This year's target is 17 or below avoidable falls. In October **3** falls were reported. To date there has been **4** avoidable falls.

Work continues to identify patients at risk of falls and ensure the falls bundle is implemented.

Falls training has been reviewed and formal training commenced for HCA's and for staff attending clinical induction.

The Trust has commenced "Bay tagging" on M4 and A10 where the nursing staff tag someone on to the bay when they want to leave ensuring someone is present on the bay at all times. Initial results have shown a decrease in falls and this project will roll out to other wards within the next 2 months

Pressure Ulcers 16

Chart 11

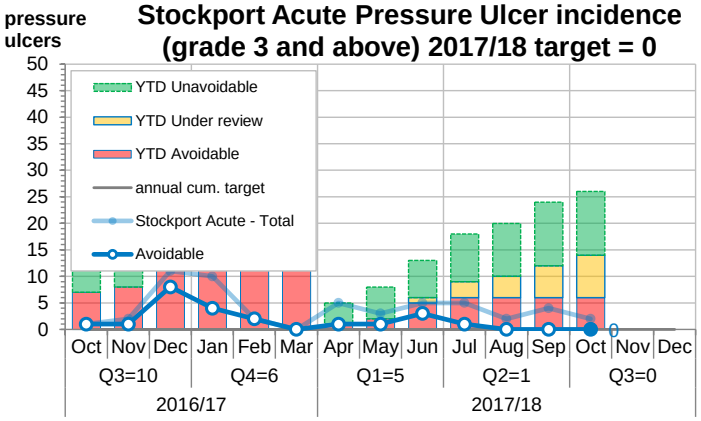
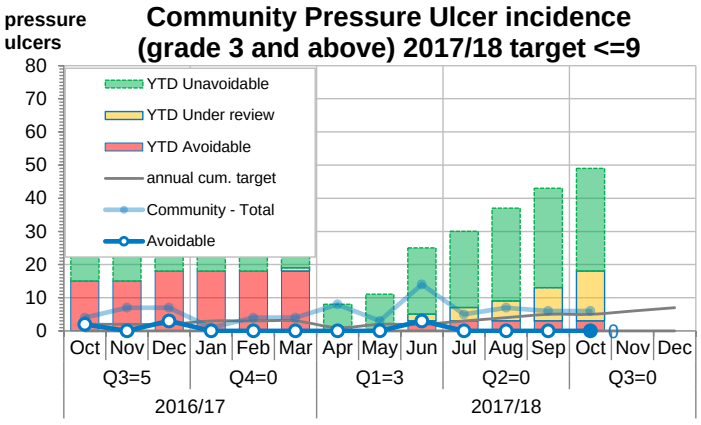


Chart 12



The stretch target for Stockport Acute services is zero tolerance of avoidable pressure ulcers grade 3 and 4 by the end of 2017/18. In October, there have been 2, category 3 and above pressure ulcers reported in the hospital, both are currently under review, so avoidable/unavoidable status remains to be determined. Therefore for this month, the total avoidable pressure ulcers for this financial year remains at 6.

The stretch target for Stockport Community is a 50% reduction in grade 3 and 4 avoidable pressure ulcers by the end of 2017/18. The target is 9 avoidable pressure ulcers for the year. In October there have been 6 new grade 3 or 4 pressure ulcers reported, 5 of which are still under review, and one has been deemed unavoidable. There have been a total of 3 confirmed avoidable pressure ulcers this year in community; however a number of incident investigations remain to be confirmed.

The numbers of pressure ulcers in the Acute setting have reduced over the last three months, whilst total numbers in the community remain static. The community pressure ulcer reporting flow chart has been revised and is to be reissued.

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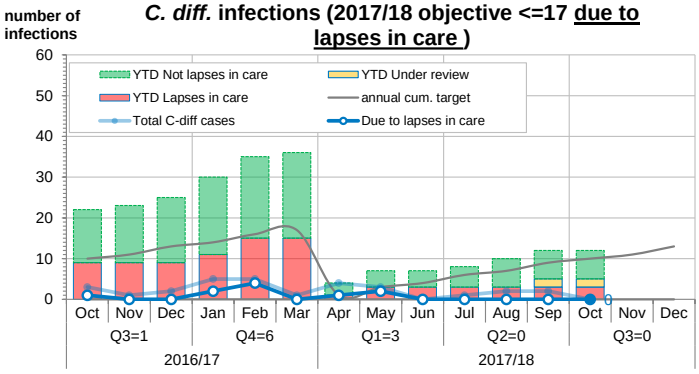
Clostridium difficile (C. diff.) infections

Chart 13



There has been zero cases of Clostridium difficile in October, the total number YTD is 12. Of these 12 cases 10 have been reviewed with the other 2 cases still under review.

We have been advised by the CCG that 7 cases reviewed by them do not have significant lapses in care and do not reach the threshold for reporting; however 3 cases do have significant lapses in care and do reach the threshold for reporting. Therefore 7 cases would not count towards the trajectory of 17 significant lapses in care but 3 cases will.

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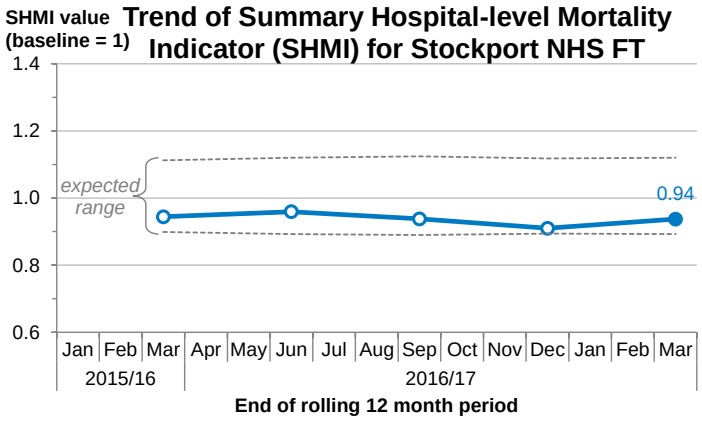
Mortality

Summary Hospital-level Mortality Indicator (SHMI)

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

Chart 14



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

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

Chart 15

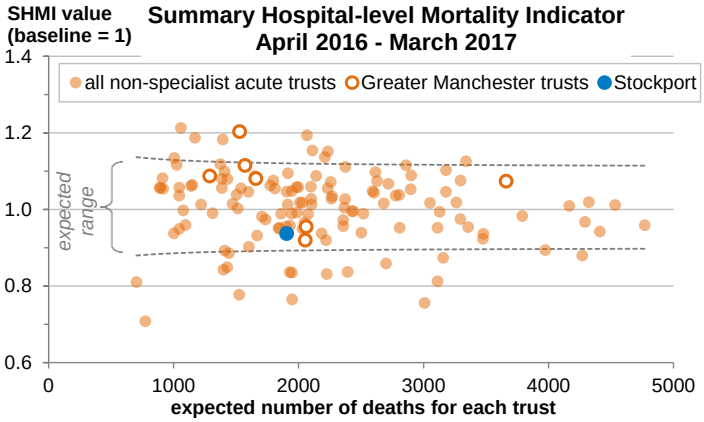
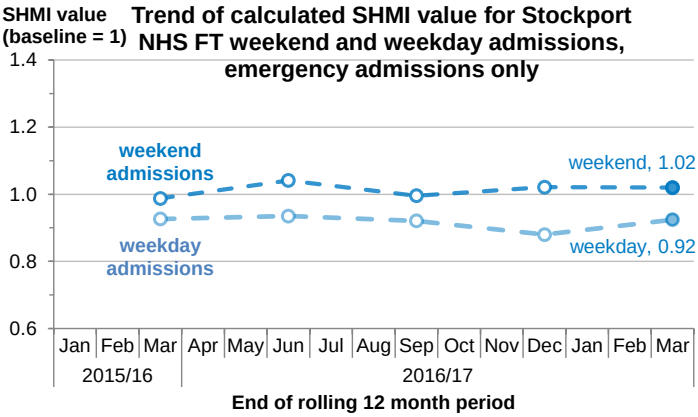


Chart 16



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Risk Adjusted Mortality Index (RAMI)

The main differences in calculation from SHMI are: RAMI only includes in-hospital deaths; it excludes patients admitted as emergencies with a zero length of stay discharged alive, and patients coded with receiving palliative care; the estimates of risk used to work out the number of expected deaths are calculated once per year ("rebasing"), data is shown here using latest 2016 benchmarks; RAMI includes data from the whole patient spell rather than just the first two admitting consultant episodes.

Data source: CHKS

Chart 17

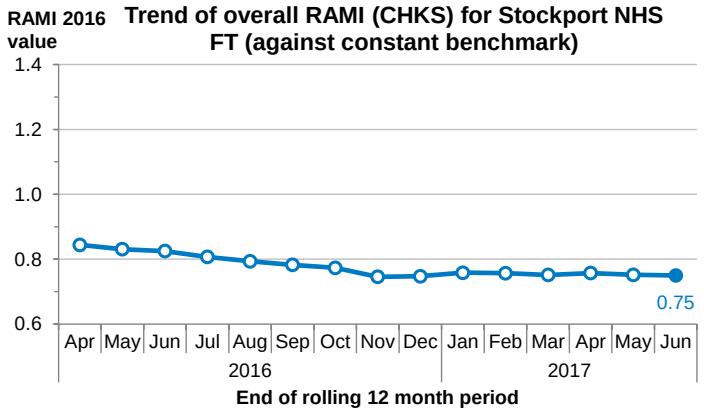


Chart 18

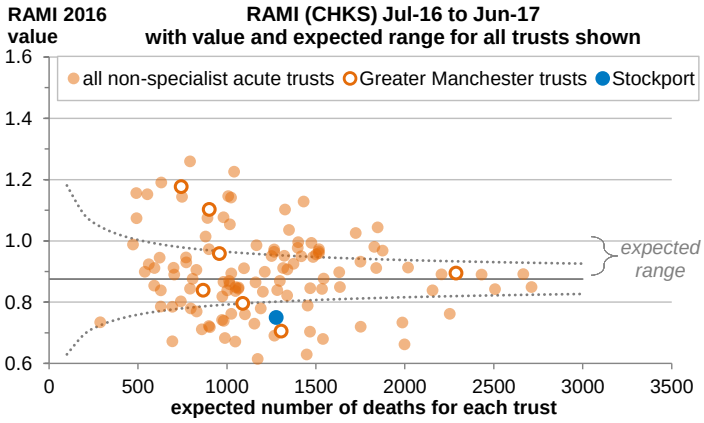
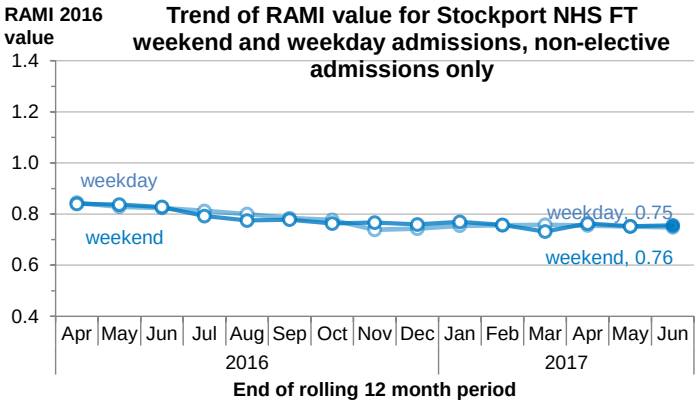


Chart 19



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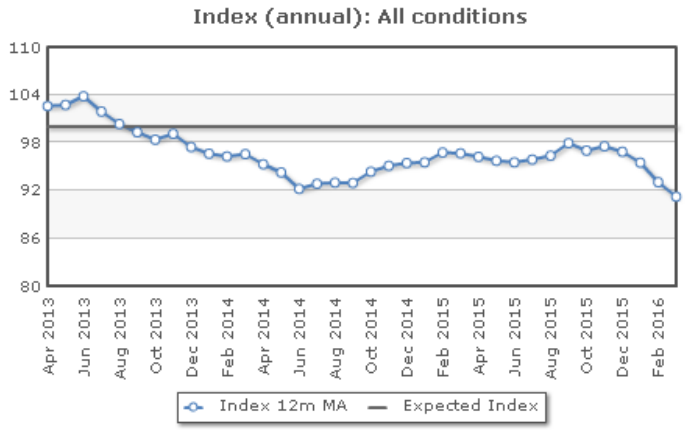
Hospital Standardised Mortality Data (HMSR)

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

Data source: CHKS (using Dr Foster Intelligence methodology)

Chart 20



Referral to Treatment (RTT) waiting times

Chart 21

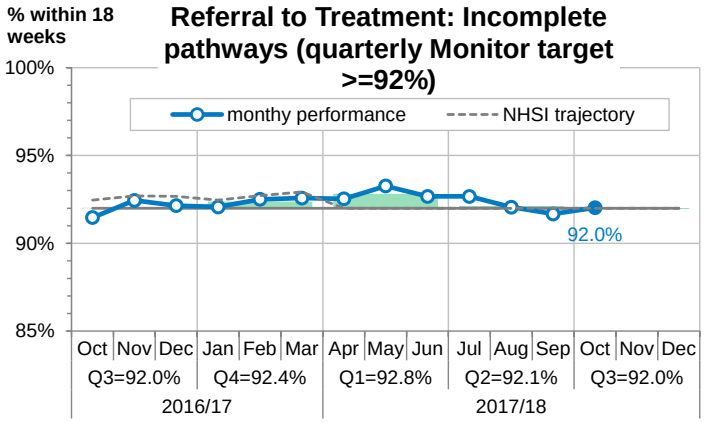


Chart 22

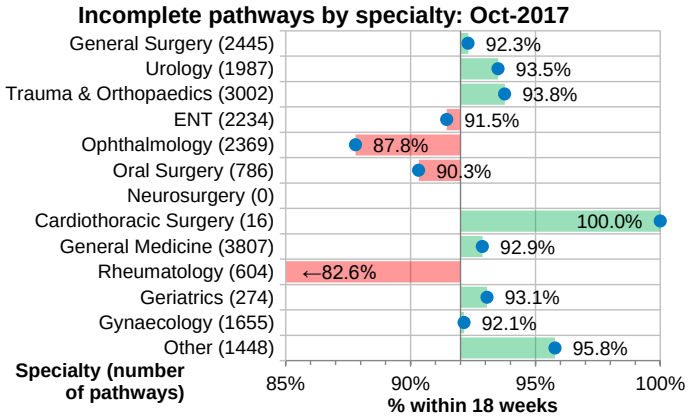


Chart 23

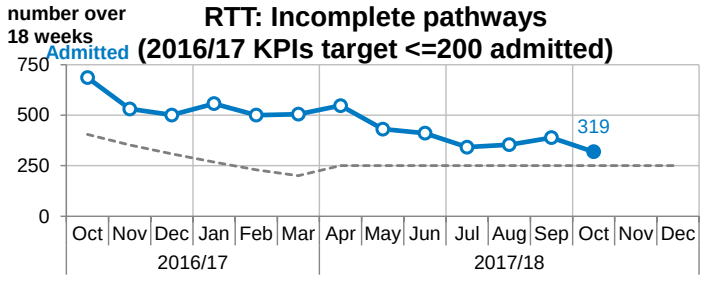


Chart 24

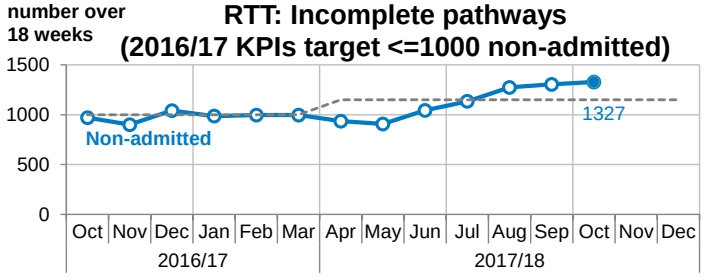


Chart 21 shows performance against the RTT Incomplete standard.

The Trust has achieved the RTT standard in October achieving 92.03%.

4 services failed the standard at specialty level in October; Rheumatology, Ophthalmology, ENT and Oral Surgery. The main contributing factors are workforce issues related to Outpatient nurse staffing and the ability to secure anaesthetic cover for theatre lists.

Actions planned to address performance in the 4 specialties include:

- Additional weekend Oral surgery theatre lists throughout November and December
- Engaging a locum consultant to undertake additional Outpatient sessions (Oral surgery)
- Exploring option of additional weekend lists (ENT)
- Exploring outsourcing options for oculoplastic ophthalmology cases
- Skill mix review (ophthalmology)
- Switching some follow-up capacity to new from December (Rheumatology)

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

The admitted backlog decreased from 385 to 319 at month end.

The non-admitted backlog has risen to 1327, mainly due to pressures within the Ophthalmology and Rheumatology services.

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Accident & Emergency, Urgent Care & Flow

Chart 25

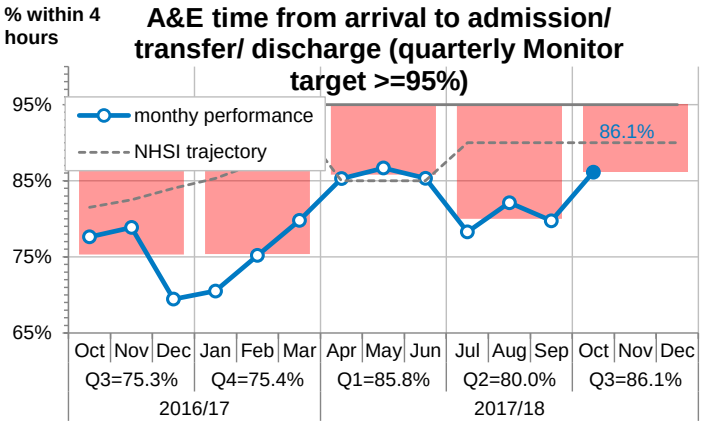


Chart 26

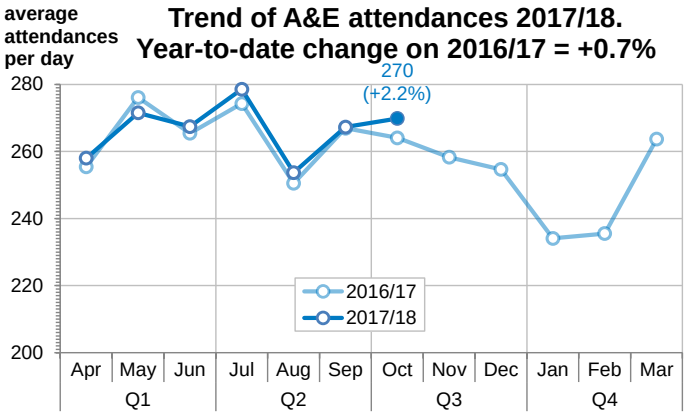
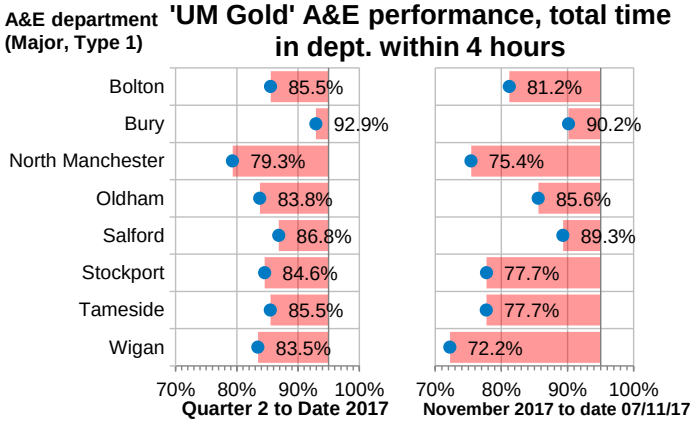


Chart 27



Source: Greater Manchester Academic Health Science Network.

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

Performance in October was 86.1%, which is below the improvement trajectory of 90% but is a significant improvement on the previous 3 months.

At the end of October 2017, we had incurred 13% less breaches of the 4 hour target in the past 12 months than at the same point in October 2016. Performance in October 2017 was approximately 10% higher than October 2016 yet attendances were nearly 4% higher.

In addition to the plans for Winter preparedness, the following actions are being taken to improve short and medium term performance:

- Stranded patient reviews commenced on the 8th November focusing senior attention on those patients staying the longest in the hospital
- A review of the Emergency Department Medical rota to provide two consultants every evening (from 1pm – 9pm) in order to meet the demands of the twice daily surges.
- The project to implement the Frailty Unit continues with a view to increasing capacity at the front end to provide the necessary capacity to ensure flow across the hospital every day.
- The focus on the reduction of Delayed Transfers Of Care to 10 by December and Medically Optimised Awaiting Transfer through further development of Discharge to Assess pathways continues with close working between system partners.

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Chart 28

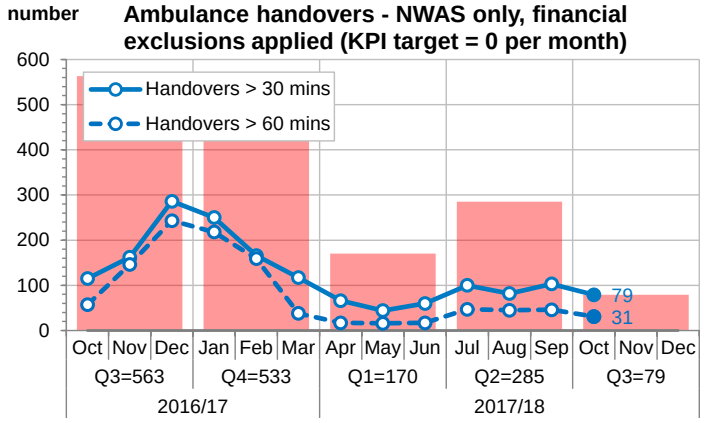


Chart 29

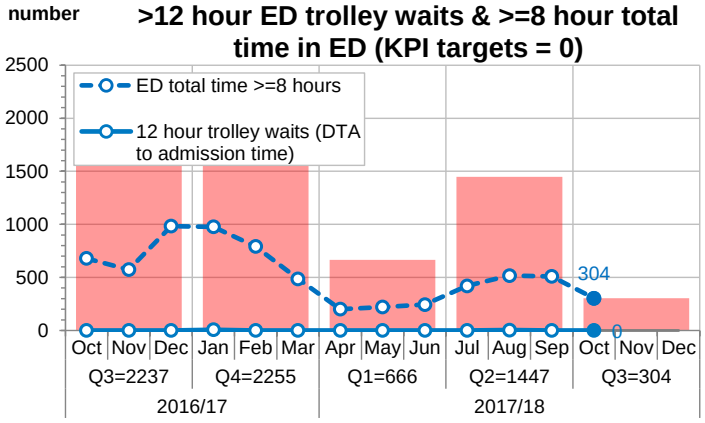


Chart 30

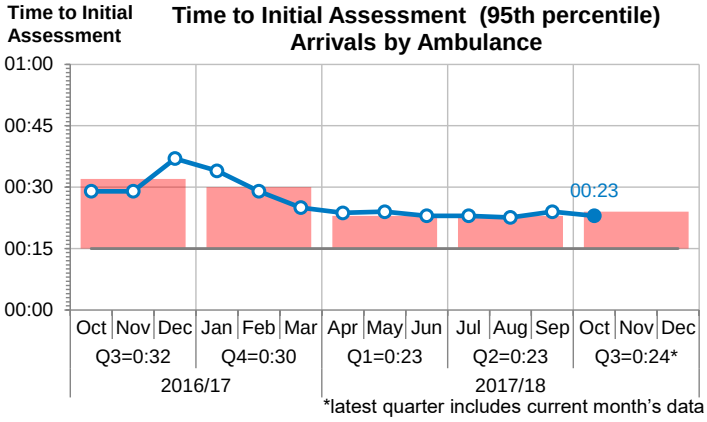


Chart 31

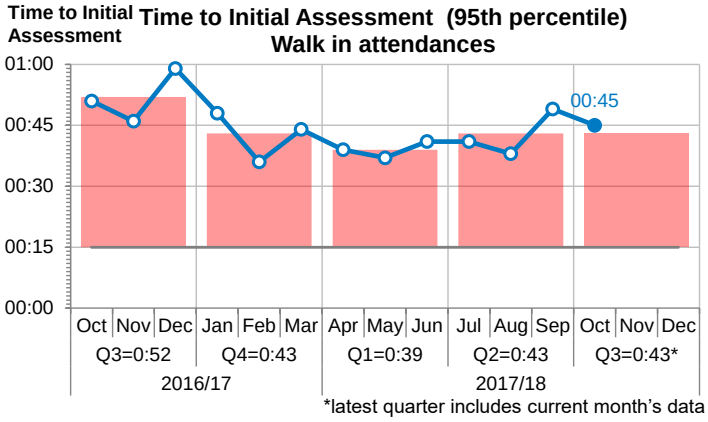


Chart 32

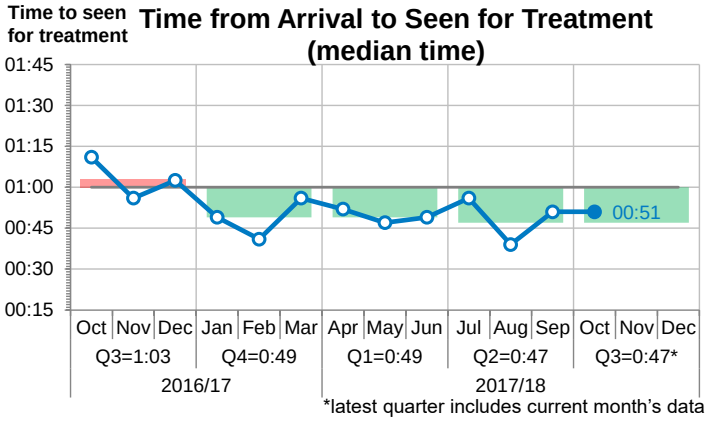


Chart 33

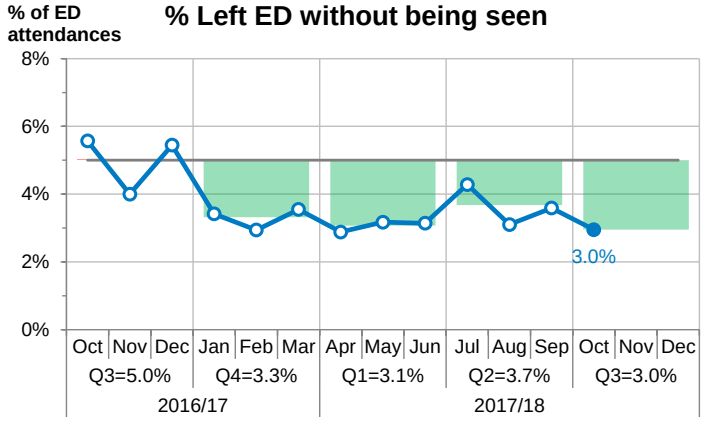


Chart 34

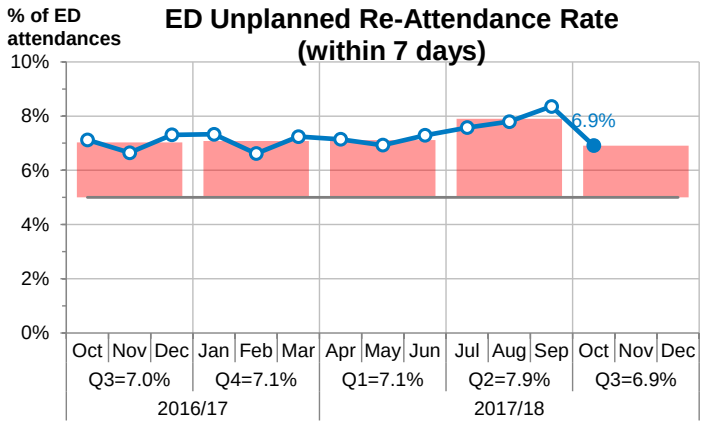
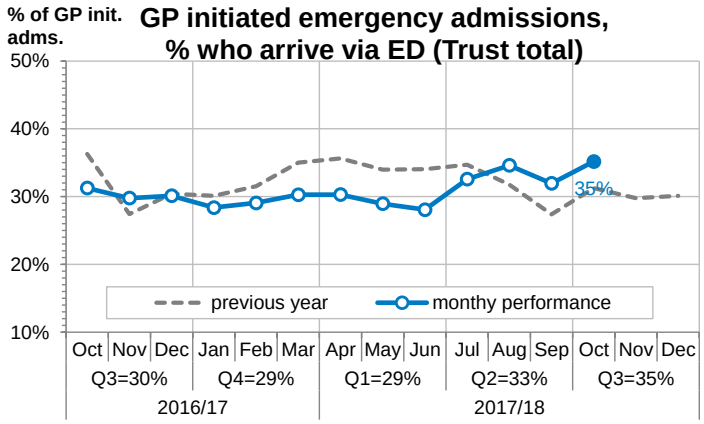


Chart 35



The following charts (35 to 43) are the high level KPIs to measure progress realized through the implementation of the Urgent care 90 day plan.

Chart 36

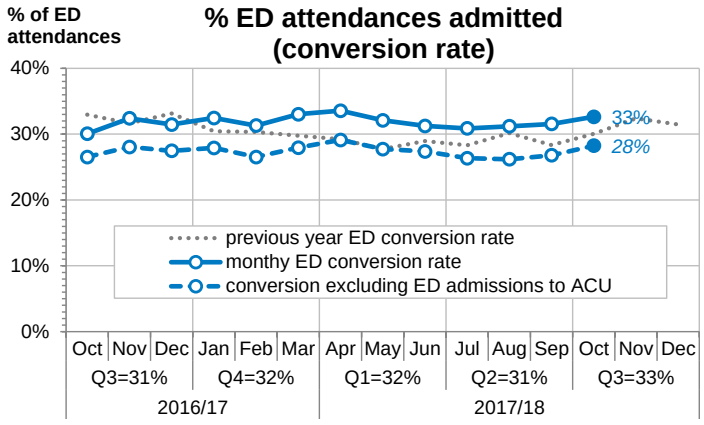


Chart 37

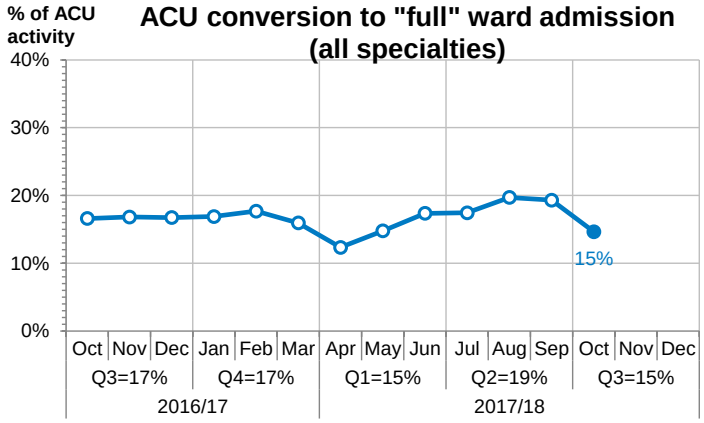


Chart 38

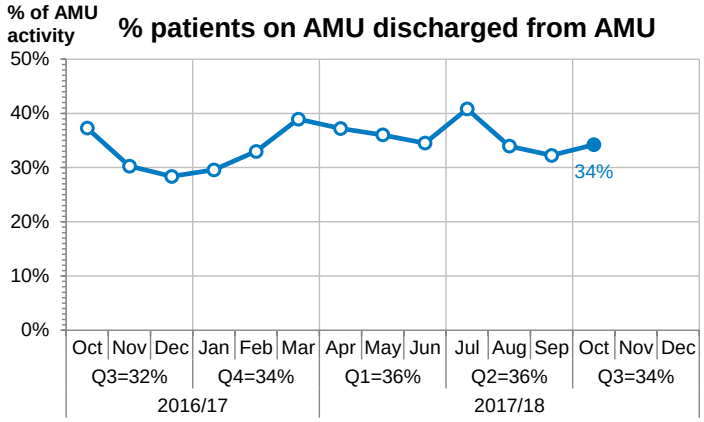


Chart 39

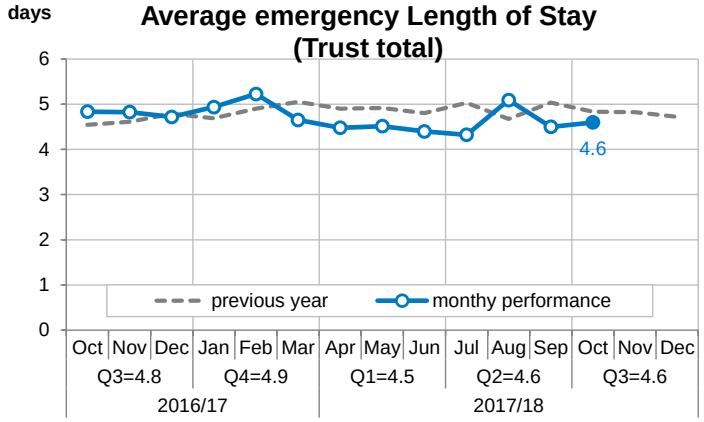
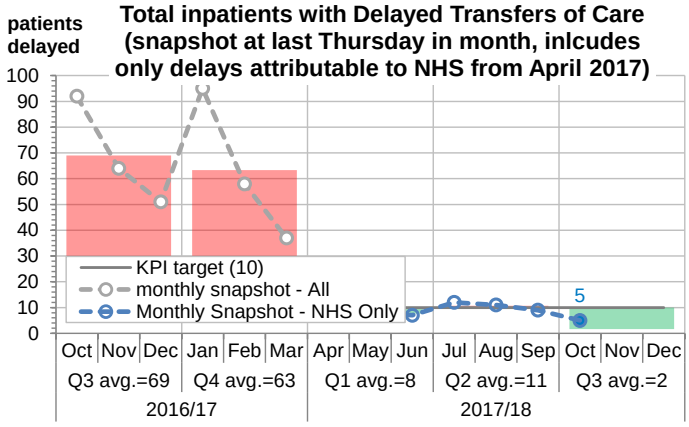


Chart 40



SAFER - is intended to improve the patient journey by ensuring an efficient pathway from admission to discharge by delivering timely appropriate care at the right time in the right place.

Key metrics have been agreed to measure SAFER performance which includes discharges before 12md and 16:30hrs as shown in chart 33 and 34. All wards are invited to attend monthly performance meetings to report compliance against these key metrics and actions plans developed as appropriate.

Chart 41

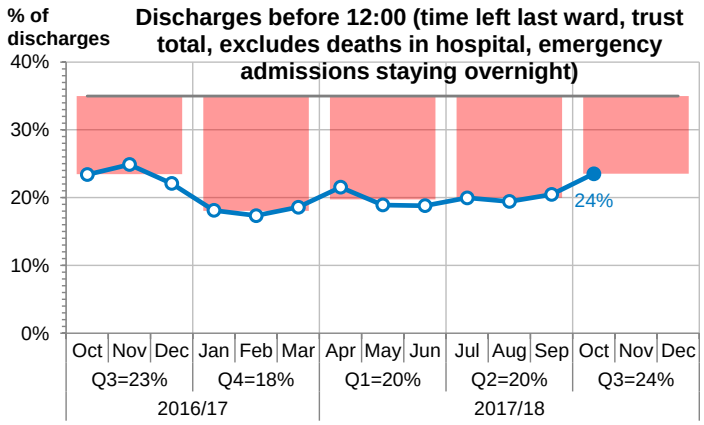
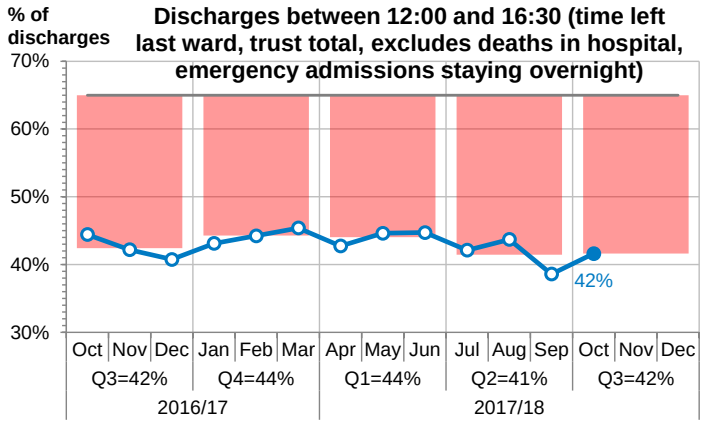
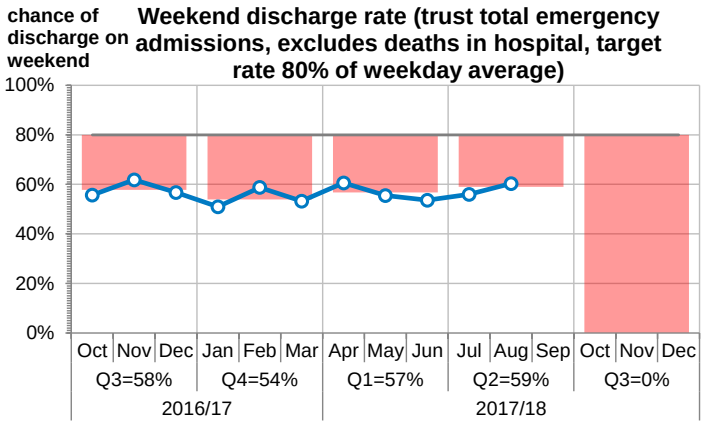


Chart 42



Identifying patients for discharge at the weekend is just as important as weekday discharges to continue flow and create capacity. An action plan has been developed to strengthen roles and responsibilities' of the on call team at weekend in order to ensure robust plans are in place and adhered to.

Chart 43



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Diagnostic tests (6 week wait) 16

Chart 44

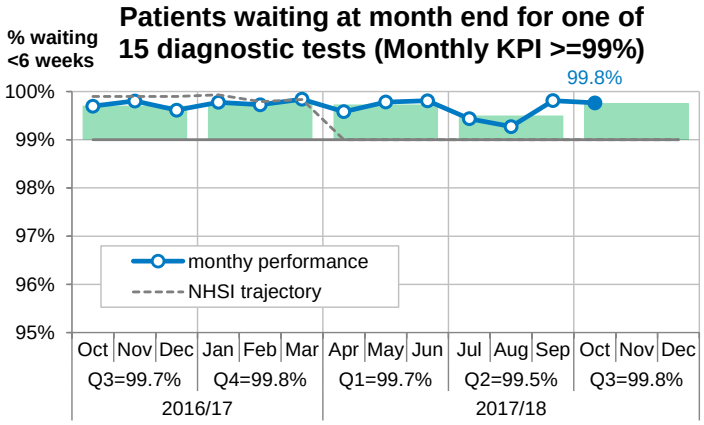

Chart 44 shows performance against the diagnostic standard.

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Cancelled Operations 20

Chart 45

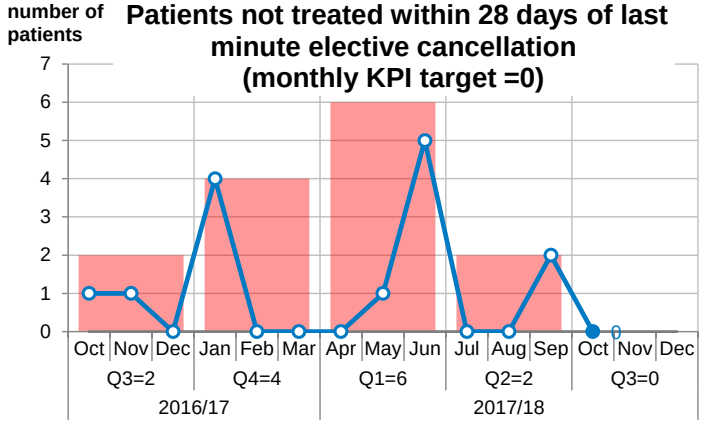

Chart 45 shows 0 breaches of standard in month.

Chart 46

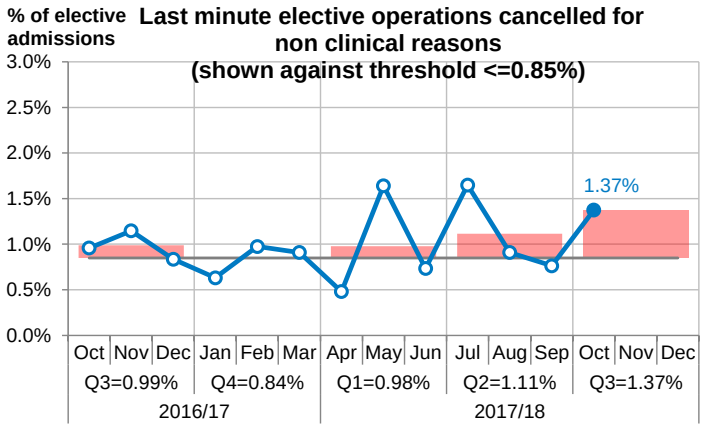

Chart 46 shows performance for last minute elective operations for non-clinical reasons.

In October 45 cancellations were reported on the day for non-clinical reasons.

The specialty with the highest number of cancellations was Orthopaedics with 18 cases cancelled (8 due to lack of theatre time, 5 due to urgent cases taking priority and 4 due to no bed availability).

Overall, the most common reason for cancellation was lack of theatre time (13 cases), followed by no bed availability (7 cases) and urgent cases taking priority (7 cases).

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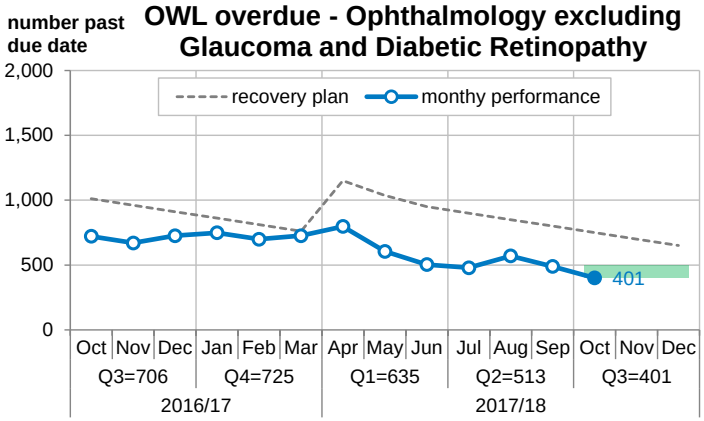
Outpatient Waiting List (OWL) 20

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

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

Chart 47 Ophthalmology OWLs past due date

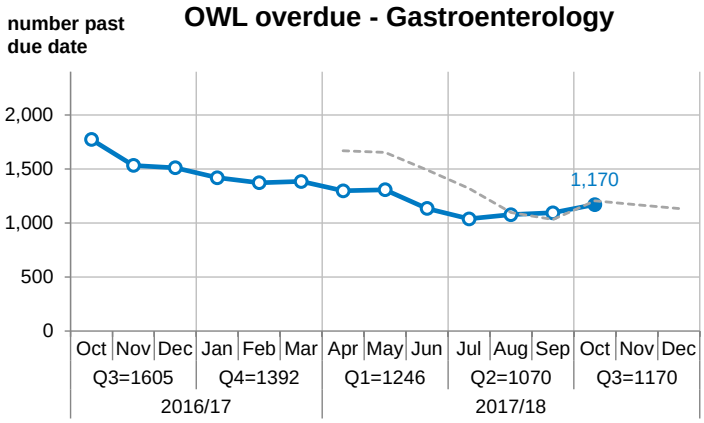


Ophthalmology

Chart 47 shows the number of Ophthalmology patients on the Outpatient waiting list beyond their due date.

Ophthalmology remains ahead of its recovery trajectory. A new Glaucoma practitioner commenced in October providing further clinic capacity.

Chart 48 Gastroenterology OWLs past due date

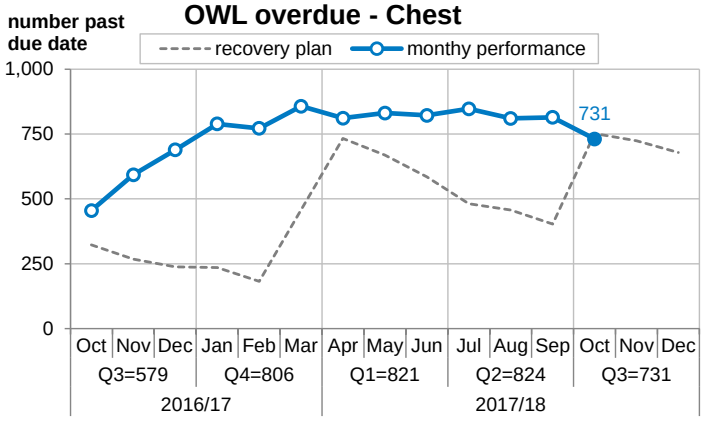


Gastroenterology

Chart 48 shows the number of Gastroenterology patients on the Outpatient waiting list beyond their due date.

Gastroenterology remains on recovery trajectory. A Senior Clinical Fellow commenced in October providing additional clinic capacity.

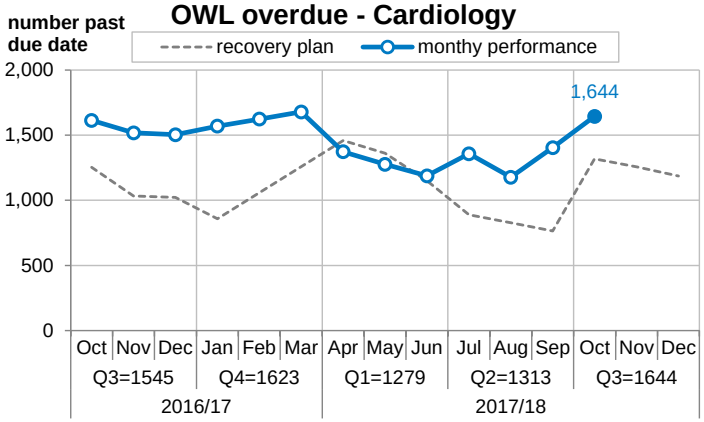
Chart 49 Respiratory Medicine OWLs past due date



Respiratory Medicine

The revised trajectory is being met. 2 substantive Consultant posts were not able to be recruited to in August due to candidates withdrawing their applications. The Trust is engaging with partner Organisations to create a more attractive joint post arrangement in order to secure a robust workforce model.

Chart 50 Cardiology OWLs past due date



Cardiology

Cardiology was adverse to trajectory in October mainly due to a loss of clinical sessions following the appointment of a substantive consultant and the release of a Locum, whose job plan was predominantly clinical sessions. Unfortunately due to a recent resignation, another Consultant gap will occur from December and it is anticipated that this will be filled by a locum.

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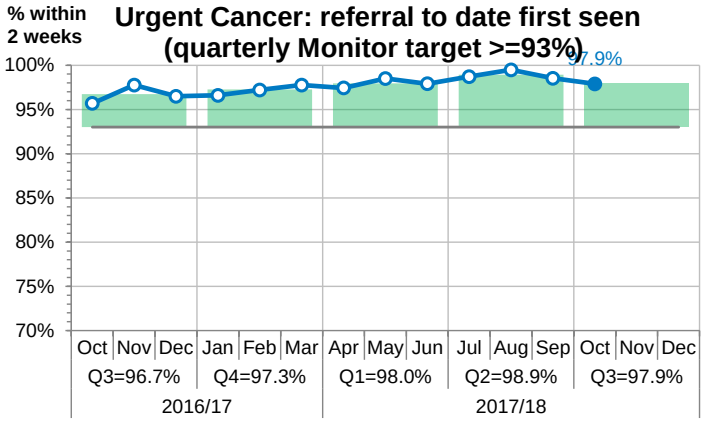
Cancer waiting times M 16

Chart 51



Compliance with the urgent referral standard continues.

Chart 52

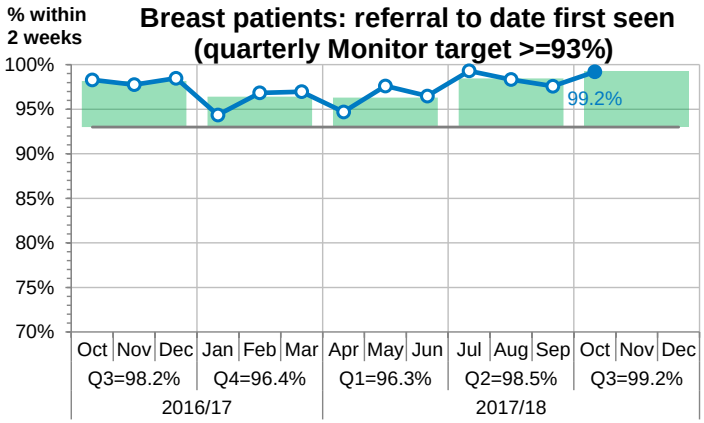


Chart 53

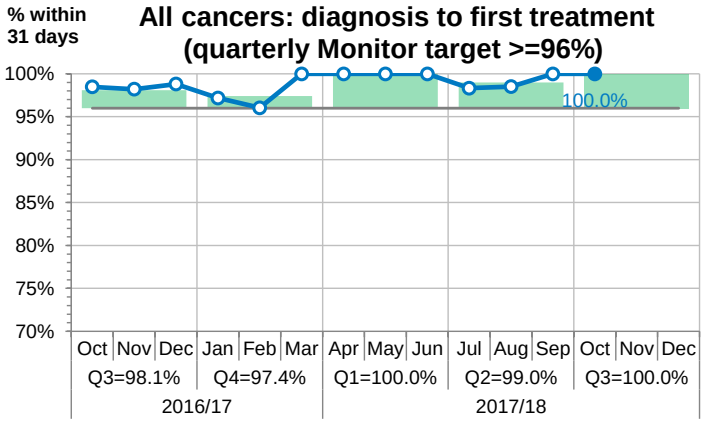


Chart 54

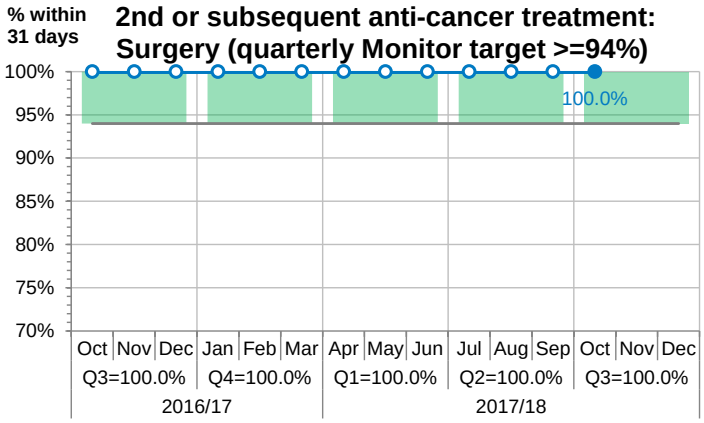


Chart 55

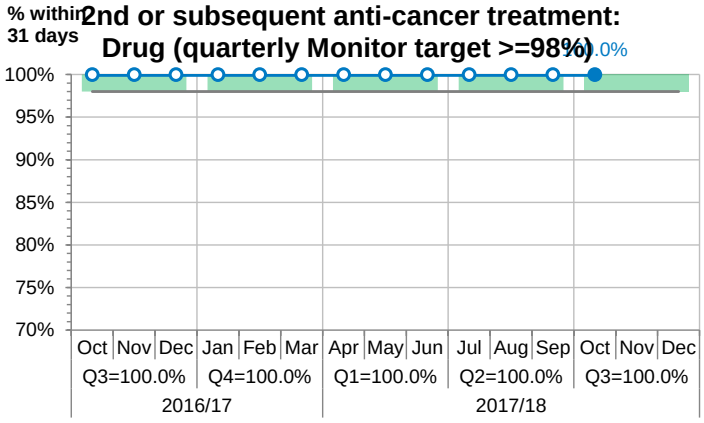


Chart 56

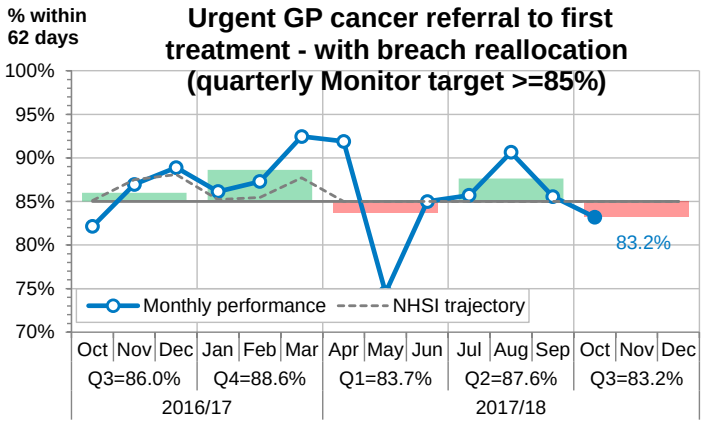


Chart 56 shows performance against the 62 day cancer standard.

The latest position for the month of October is 82.8%.

The performance of the Upper GI pathway has been identified as an area of concern and the SLA with Central Manchester FT is being reviewed with a view to agreeing the earlier transfer of patients, where possible.

A 'straight to test' model for suspected Colorectal cancers is being implemented

Chart 57 GP referral to first treatment with breach reallocation, by tumour group.

Tumour Group (Oct-17 data)	Number of breaches / cases	Performance (85% target)	Monthly trend
Upper GI	3 / 8	63%	
Colorectal	2 / 8.5	76%	
Haematology	2 / 5	60%	
Gynaecology	2 / 4	50%	
Urology	1 / 19	95%	
Breast	0 / 10.5	100%	
Head & Neck	0 / 1.5	100%	
Lung	0 / 1.5	100%	

Chart 57 shows performance against the 62 day standard by tumour group.

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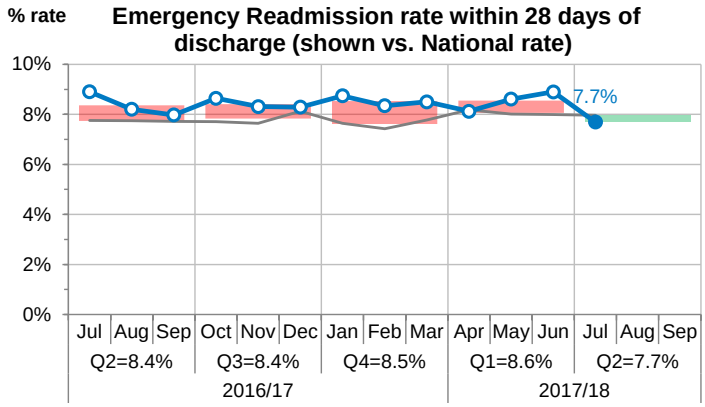
Emergency Readmissions

Chart 58



Data source: CHKS / Health and Social Care Information Centre

Chart 58 shows the Emergency Readmission rate within 28 days of discharge.

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Financial Performance

Chart 59

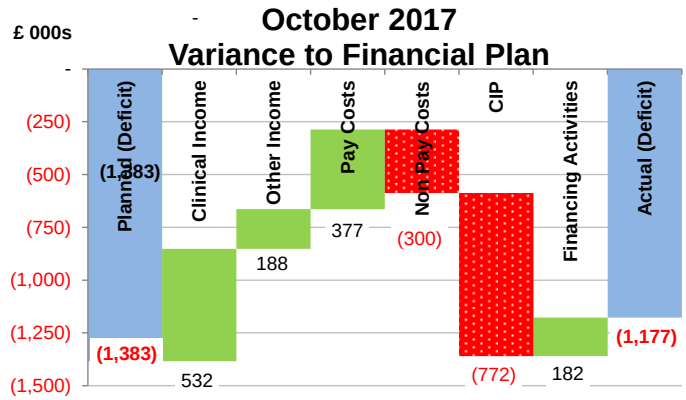


Chart 60

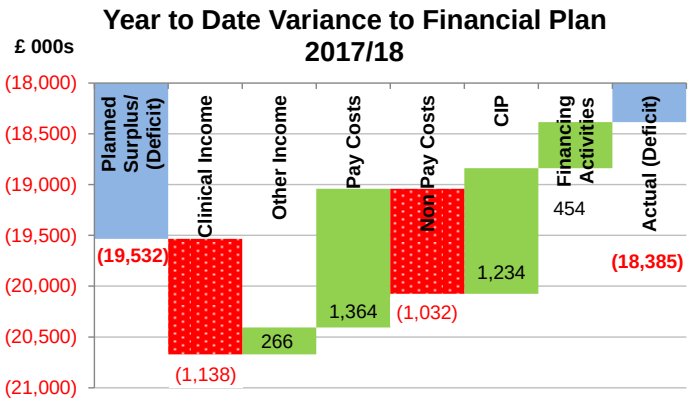
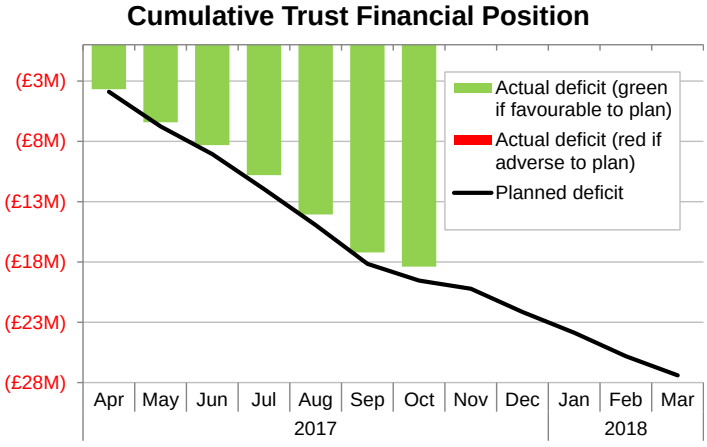


Chart 61



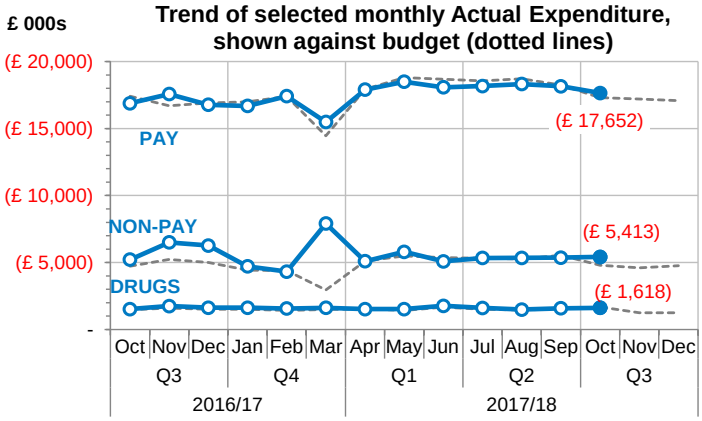
In the seven months so far this financial year the Trust has lost £18.4m. The planned deficit was £19.6m so this is £1.1m favourable to plan. The average loss per day is £86,000 to the end of October.

The overall variance from plan to date continues to be driven by:

- In-year CIP ahead of the profiled plan to date (£1.2m favourable), a deterioration of £0.8m from last month as the target is now catching up with the savings transacted to date.
- Extra Sustainability and Transformation Fund (STF) received in relation to 2016/17 (£0.4m favourable)
- Whilst elective theatre lists are delivering activity more efficiently, the overall clinical income performance is behind plan excluding CIP and STF above (£1.0m adverse).
- As the capital plan remains behind plan, the costs linked to capital financing are a saving to the Trust (£0.5m favourable).

CIP is £1.2m ahead of plan; £4.6m (31%) was expected by this stage in the year when £5.8m (39%) has been transacted. £9.5m (63%) of the £15.0m annual saving has been achieved. As anticipated, the favourable CIP variance has deteriorated in month as the expected profile of savings increases significantly for the second half of the year. **Recurrent CIP has increased in month to £5.9m (39%), of which theatre productivity represents £2.4m of the total recurrent CIP.** This remains as a risk as although efficiency has improved in some specialties, the overall volume of lists required to meet the plan is not being delivered and this impacts on the medium term financial plans of the Trust.

Chart 62



Pay budgets are underspent to date excluding CIP by £1.4m, as the Trust level of vacancies remains high. Agency expenditure to date is £7.8m, but the agency cost is offset by vacancies not covered mainly in the non-clinical areas of the Trust. Bank and agency costs including NHS Professionals, internal locums and waiting list initiative payments total £15.7m and represent 12% of overall pay expenditure.

Non-pay is overspent by £1.0m excluding CIP, which includes £0.9m of out-sourcing costs for surgical specialties and outsourced radiology reporting. The areas where outsourcing is used is part of efficiency CIP plans and therefore has a double impact as CIP is not being delivered. In radiology this is linked to shortfalls in recruitment.

The Trust has now received written agreement from Stockport CCG that financial penalties for failure to deliver national access targets will be re-invested as part of the recovery plan in 2017/18, so sanctions from the lead commissioner have been excluded from the financial position. This has caused an in month favourable variance of £0.7m, so there is no adverse variance from plan for penalties to date.

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Capital Programme

Chart 63

Description	Plan 2017/18 Year	Month 7 - YTD October 2017/18 Plan	Actual	Variance	Full Year Forecast Forecast	Variance
	£'000	£'000	£'000	£'000	£'000	£'000
Healthier Together Schemes						
ED Resus Expansion	2,400	1,725	109	1,616	304	2,096
Ward Refurbishments	1,200	330	52	278	60	1,140
Endoscopy Building	250	250	-	250	15	235
Equipment - Critical Care & IT	280	280	-	280	-	280
	4,130	2,585	161	2,424	379	3,751
Internally Funded Schemes						
Equipment						
Endoscopy	250	250	-	250	250	-
Diagnostics	1,139	409	537	(128)	1,672	(533)
Surgery and Critical Care	848	552	487	65	887	(39)
Other Medical Equipment	812	363	105	258	515	297
Estates and Facilities Equipment	610	415	36	379	256	354
	3,659	1,989	1,165	824	3,580	79
Information Management & Technology						
Wireless Network	650	487	102	385	123	527
Hardware for Electronic Patient Records (EPR)	380	315	177	138	245	135
Software for EPR - Interfaces & Voice Recognition	590	217	9	208	275	315
Other Hardware	910	729	345	384	975	(65)
Other Software	120	-	30	(30)	201	(81)
Aspen House Server Room		-	1	(1)	59	(59)
	2,650	1,748	664	1,084	1,878	772
Estates						
Backlog Maintenance	335	160	115	45	407	(72)
Non Backlog Maintenance	500	280	460	(180)	1,239	(739)
Other Projects	863	430	96	334	95	768
	1,698	870	671	199	1,742	(44)
Revenue to Capital	-	-	70	(70)	174	(174)
Capital Expenditure Plan (excluding finance leases)	**12,137**	**7,192**	**2,731**	**4,461**	**7,753**	**4,384**
Specific Finance Leases						
Acute EPR - Intersystems - Capital repayments	1,422	1,006	1,006	0	1,724	(302)
Community EPR - EMIS- Capital repayments	68	40	40	(0)	68	-
Pathology - Point of Care Testing				-	15	(15)
	1,490	1,046	1,046	0	1,807	(317)
Capital Expenditure Plan (incl. finance leases)	**13,627**	**8,238**	**3,776**	**4,462**	**9,560**	**4,067**

Capital costs of £3.8m have been incurred to date against a plan of £8.2m and so is £4.5m behind plan. This is due to a delay in the commencement of schemes linked to Healthier Together of £2.4m and planned spend for 2017/18 being brought forward at the end of 2016/17 mainly in IT which is £1.1m behind plan. Internal equipment purchases are also behind plan by £0.8m.

The full funding of Healthier Together schemes is crucial to the delivery of the capital programme but is reliant on external parties and their approval processes and are currently being validated at a detailed level by the Greater Manchester Devolution Team (GM Devo). The process has taken much longer than envisaged as Central Government approvals were delayed. The Trust is presently waiting for GM clearances to commence work once funding is confirmed.

The capital forecast has now been updated to include the expected delay in Healthier Together spend, and shows a forecast underspend of £4.1m at the year end. When confirmation of funding is received the lead time for project commencement and the project time plan for these major capital investments means that they will be unlikely to start in this financial year.

Cost Improvement Programme 20 M

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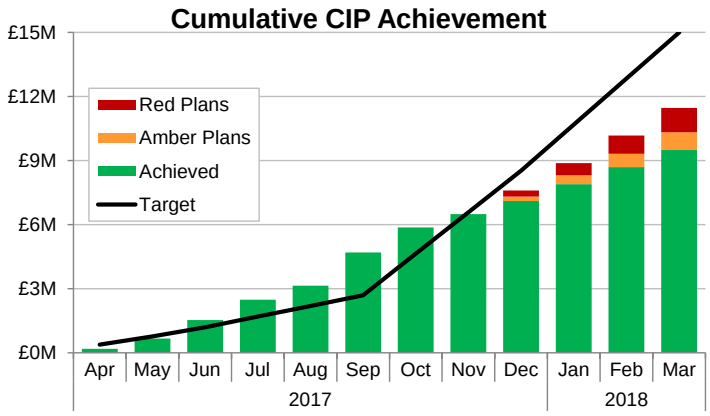
Chart 64



To the end of October £5.8m of CIP has been actioned towards the year-to date target of £4.6, so is £1.2m ahead of plan. £9.5m (63%) of the £15.0m annual saving has been achieved. Recurrent CIP has increased in month to £5.9m (39%), of which theatre productivity represents £2.4m of the total recurrent CIP. This remains as a risk as although efficiency has improved in some specialties, the overall volume of lists required to meet the plan is not being delivered.

Overall delivery of full year CIP savings of £15.0m is required to achieve the planned deficit of £27.4m but at present recurrent delivery is low. **This is a significant concern as it does not support the Trust's drive to return to financial balance in the medium term, as a further £15m of recurrent CIP is required in 2018/19, in addition to delivery of the full £15m recurrently in 2017/18.**

Financial Use of Resources Rating

Chart 65

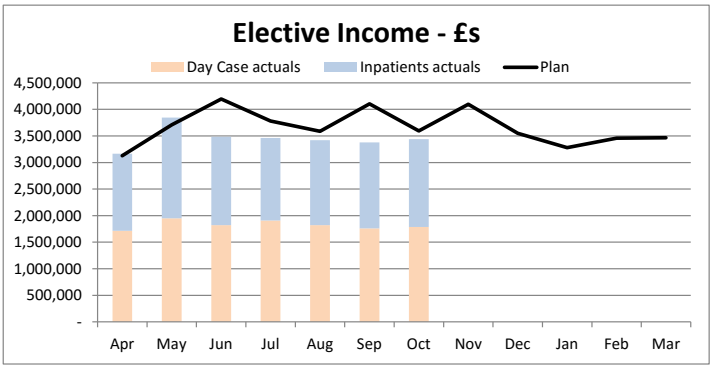
Finance & Use of Resources Metrics		Rating	Trigger Override	Excellent 1	2	3	Poor 4	Weight	Weighted score
Financial sustainability	Capital service cover	4	Yes	2.50	1.75	1.25	< 1.25	20%	0.8
Financial sustainability	Liquidity (days)	3	No	0	-7	-14	< -14	20%	0.4
Financial efficiency	I&E margin (%)	4	Yes	1.0%	0.0%	-1.0%	<-1.0%	20%	0.8
Financial controls	Distance from financial plan (%)	1	No	0.0%	-1.0%	-2.0%	<-2.0%	20%	0.2
Financial controls	Agency spend	2	No	< 0%	0%	25%	50%	20%	0.4
Finance Use of Resource Metric (UOR) - Calculated									**3**
OVERRIDE TRIGGERED?			Yes						Yes
Finance Use of Resource Metric (UOR) - Final Reportable									**3**

The Trust's Use of Resources (UOR) score under the Single Oversight Framework is a 3, classified by NHSI as triggering significant concerns. The Trust's operational plan for 2017/18 predicted a score of 3 for October 2017 and our actual performance is in line with this.

For the Trust's overall score to improve to a 2 the planned financial deficit would need to improve by £24.7m to a deficit of £2.7m (within 1% of planned operating income).

Elective Income vs. Plan

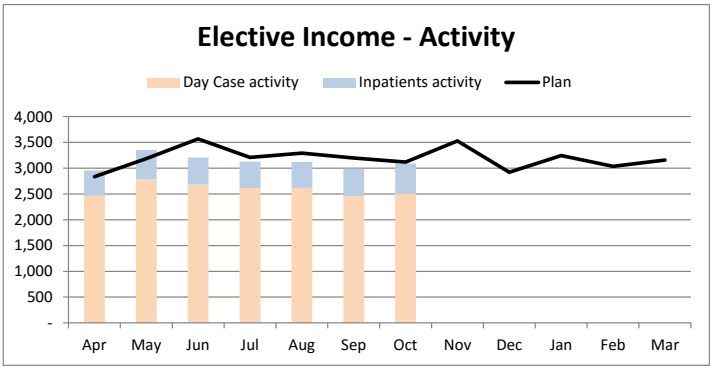
Chart 66



Elective income has deteriorated again in month by £0.2m, and is £1.9m behind plan after the target has been increased for CIP. Compared to forecast the Surgery business group's recovery plan is 28 cases ahead, but the recovery trajectory does not bring income in line with plan.

Inpatient income is currently behind plan by £1.4m, and day case activity is £0.5m adverse. The Trust has spent £1.3m on waiting list initiatives and £0.9m on out-sourcing in seven months, but this is not solely on elective work and includes out-sourced radiology reporting.

Chart 67

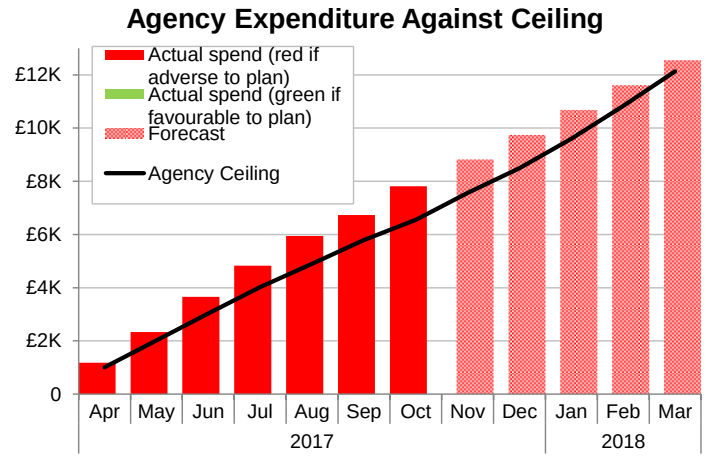


Elective activity continues to the main contributor to this deficit year, with activity 1,359 spells below planned levels. Both day case and inpatient activity is below plan by 855 and 504 spells respectively. As a result, the overall elective income is £1.9m adverse to plan.

The focus this month has centred on recovery plans and close monitoring of actions required to ensure delivery. The Surgery business group have undertaken a detailed review of expected elective activity until the end of the financial year and the forecast year-end recovery plan is dependent on delivering this level of activity. A weekly recovery plan meeting tracks progress in each specialty and alongside this progress is also tracked at the weekly Patient Tracking List (PTL) meeting and the 6-4-2 theatre scheduling meeting. During October, the business group overachieved against the forecast activity for the month by 28 spells. This close scrutiny will continue over the remainder of the financial year.

Agency Ceiling

Chart 68



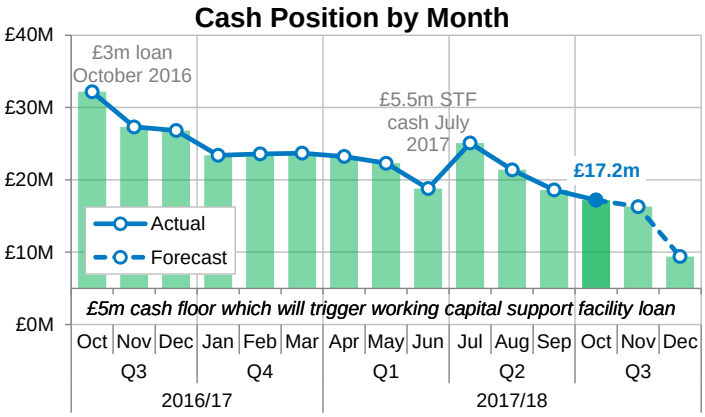
Agency costs to date are £7.8m, which represents 6% of total pay costs. This is in excess of the profiled NHSI agency ceiling to date by £1.3m.

Agency costs for medical staffing are £5.6m to October 2017, which is 72% of all agency costs and highlights that the Medicine and Integrated Care business groups' reliance on agency medical staff is a key driver for breaching the NHSI ceiling to date.

NHSI's national team are now providing targeted support to the Trust, focusing on the highest cost agency staff and working to reduce this premium rate cost.

Cash

Chart 69

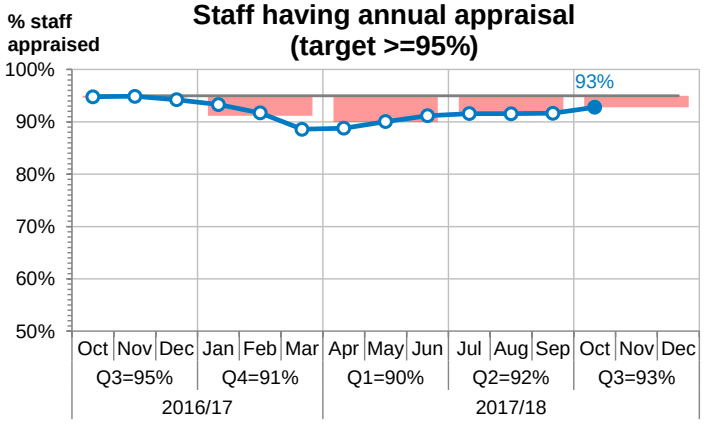


Cash in the bank on 31st October 2017 was £17.2m, which is £1.4m less than last month and £12m better than planned. Receipt of STF relating to 2016/17 is £6.2m higher than included in the agreed plan for this year, so is a key driver for the higher than expected cash balance. In addition the capital programme is £4.5m behind plan.

The cash position is carefully managed and the requirement for a working capital support facility loan will fall into Q4. This is contingent on delivery of the Trust recovery plan including CIP and business group spend improvements, and the Trust's ability to contain the potential winter pressures ahead.

Workforce Appraisals

Chart 70

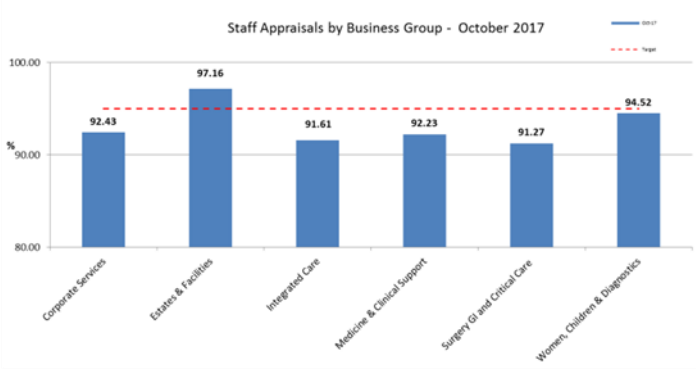


The Trust's total appraisal compliance for October 2017 is 92.78%.

The learning & development team has a particular focus on data validation processes which has resulted in a 1% increase in a five day period; it is therefore anticipated that the continuing focus and support for business groups will continue with this trajectory and achieve the aim of 95% by December.

The learning & development team have supported business groups with the development and implementation of action plans to improve performance; an improvement which has been demonstrated month on month.

Chart 71



The future area of increased support will be on areas 90% and below, to ensure that action plans are in place and support has been identified to deliver an improved position.

Chart 72

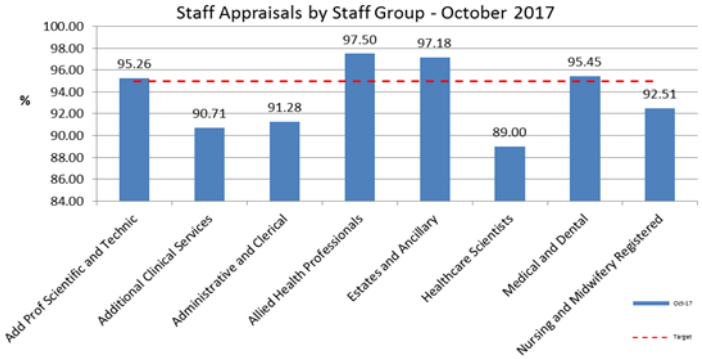
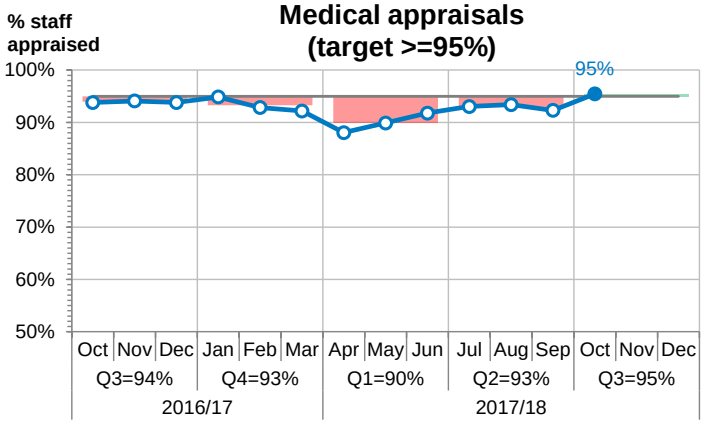


Chart 73



The medical appraisal rate for October 2017 is 95.45%, an increase of 3.14% from September 2017 (92.31%) and above the Trust target of 95%.

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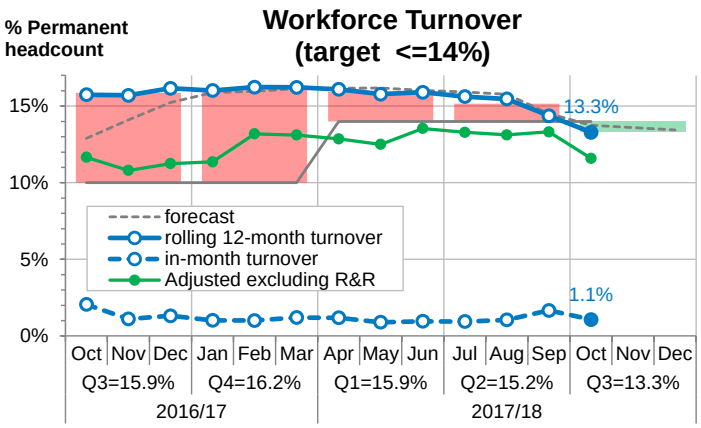
Workforce Turnover

Chart 74



The Trust's turnover figure is reported and compared nationally as an unadjusted figure, meaning that the data includes retire and return employees and TUPE transfers out of the organisation. The Trust target of 13.94% is based on the national average turnover rate for medium size Foundation Trusts in 2016/17.

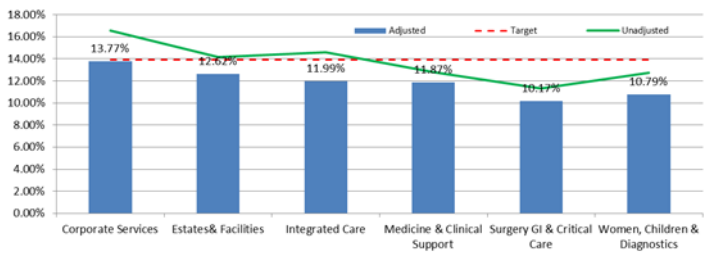
The rolling 12-month permanent headcount unadjusted turnover figure at the end of October 2017 is 13.29%. For comparison the turnover rate in October 2016 was 15.74%.

The adjusted rolling 12 month permanent headcount turnover figure in the period November 2016 to October 2017 is 11.59%. This is a decrease of 1.73% compared to the September 2017 figure of 13.32%. The top three leaving reasons are: Relocation 2.30%, Retirement 2.22% and Promotion 1.69%.

Corporate Services has the highest turnover rate at 16.54%, but the adjusted turnover brings this figure down to 13.77%. The three highest leaving reasons in Corporate Services are: Retirement at 3.39% and Promotion at 3.18%; and Work Life Balance at 2.33%. Work to understand the work life balance issue is underway and appropriate action to address any development areas identified.

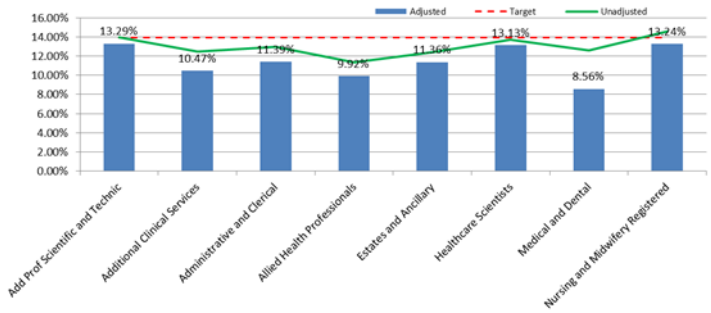
Of the adjusted permanent headcount leavers from November 2016 to October 2017; 38.52% have no further employment linked to retirement (44%) and work life balance/dependents (19%), and 31.64% have moved to other NHS organisations of which 26% are within Greater Manchester.

Chart 75



The Registered Nursing & Midwifery adjusted turnover has seen a decrease from the previous month, which takes them below the Trust target. This is also an improved position (1.54% reduction) in comparison to the same time last year.

Chart 76



Workforce Efficiency

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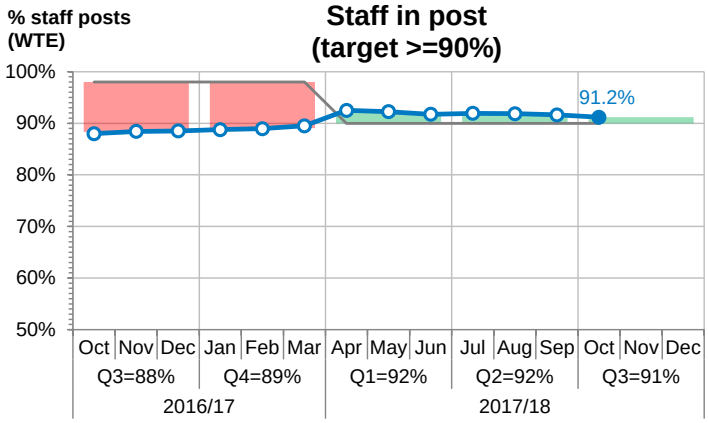
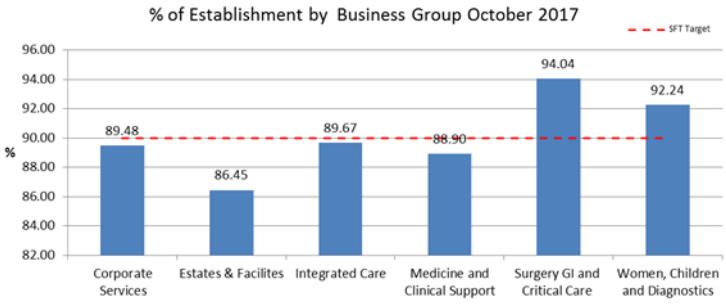
Chart 77



The Trust staff in post figure for October 2017 is 91.16% of the establishment, which is a decrease of 0.46% from 91.62% in September 2017.

Corporate Services, Estates & Facilities, Medicine & Clinical Support, and Integrated Care all fall below the '90% Staff In Post target'. Estates & Facilities have the highest percentage vacancy rate at 13.55% (52.80 FTE vacancies). Further analysis is being undertaken to understand the reason for this. There are 36 posts within E&F at various stages of the recruitment process.

Chart 78



Registered Nursing and Midwifery have the highest number of vacancies at 178.67 FTE, (a decrease from 207.65 FTE in September 2017), equating to 11.14% of the establishment for that staff group. Add Prof Scientific and Technical staff is slightly over established at 103.8% attributed to Surgical, GI and Critical Care Business Group.

Chart 79

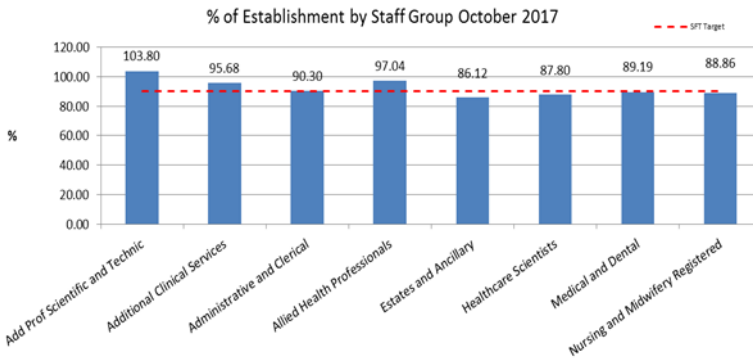


Chart 80

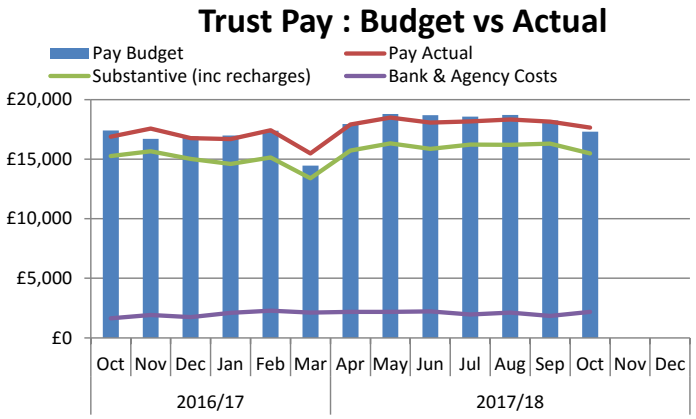


Chart 81

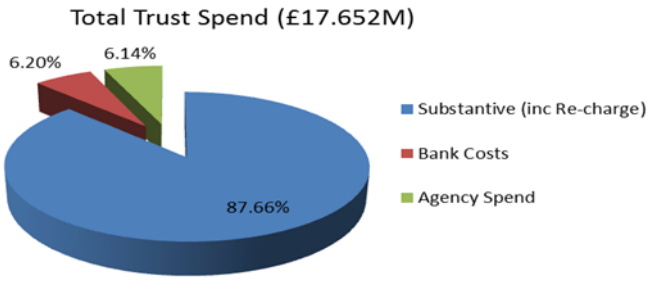


Chart 82

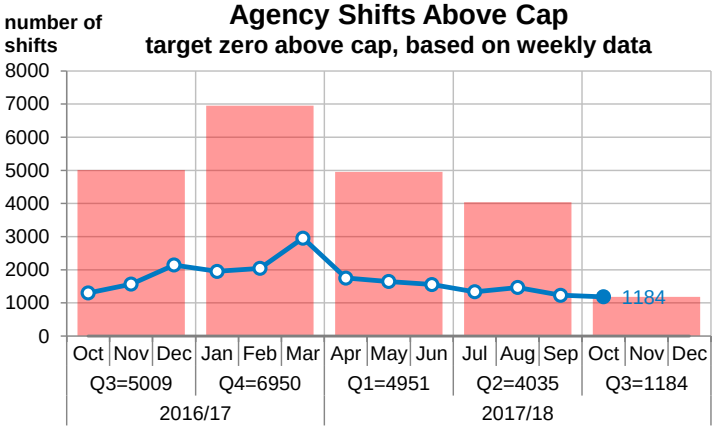
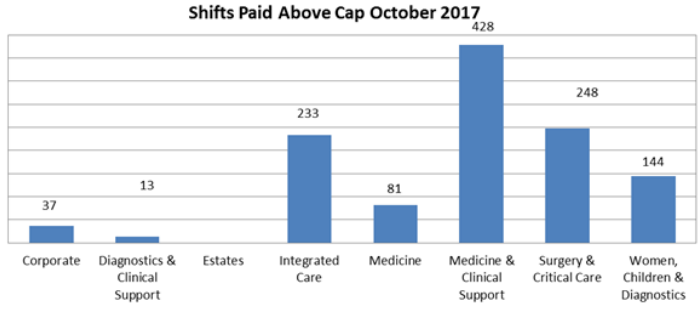


Chart 83



The total pay spend in October 2017 was £15.474M, excluding bank and agency spend (details overleaf). This is a decrease of £836K compared to September 2017.

Total spend, including bank and agency, equates to £17.652M, which is £345K over the total pay budget for the month.

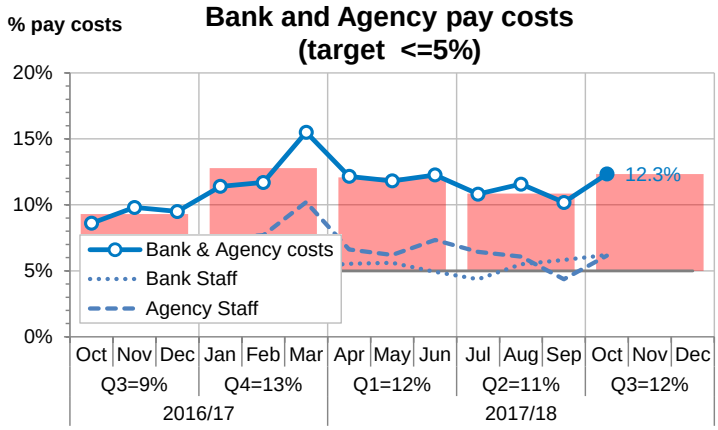
The total spend on bank staff in October 2017 was £1.09M, which is 6.20% of the total pay spend. Agency spend was 6.14% of total pay expenditure, a figure of £1.08M.

There were a total of 1,184 agency shifts paid above cap in the 4 week period from 2nd to 29th October. This is a decrease of 48 shifts compared to the previous month's figures. There was a reduction in NHSP and medical shifts of 25 and 8 respectively. Over the last 6 months, the weekly average number of shifts above cap has reduced from 411 to 296 and reflects the significant amount of work that has been undertaken in this area.

The number of shifts worked via a non-framework agency has also reduced considerably to on average 2 shifts per week. Use of non-framework agencies is strictly governed and by exception only.

Recruitment to the medical bank continues and the advert will be regularly refreshed to attract new workers. Work has also begun on ways to reduce the highest paid agency workers, following discussions with NHSI.

Chart 84



Bank and agency costs in month (October 2017) account for 12.34% (£2.18M) of the £17.65M total pay costs. This is an increase of 2.13% from the position reported in September (£1.85M).

The Medicine & CS Business Group bank and agency spend has increased from £0.75M in September 2017 to £0.84M in October 2017, and continues to have the highest spend on bank and agency equating to 24.05% of the Trust overall bank and agency spend and 4.74% of the Trust total pay bill. This relates to a high number of vacancies within Medical and Nursing.

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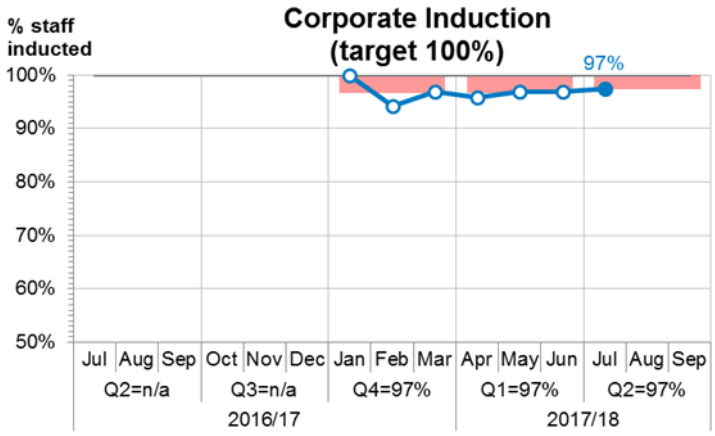
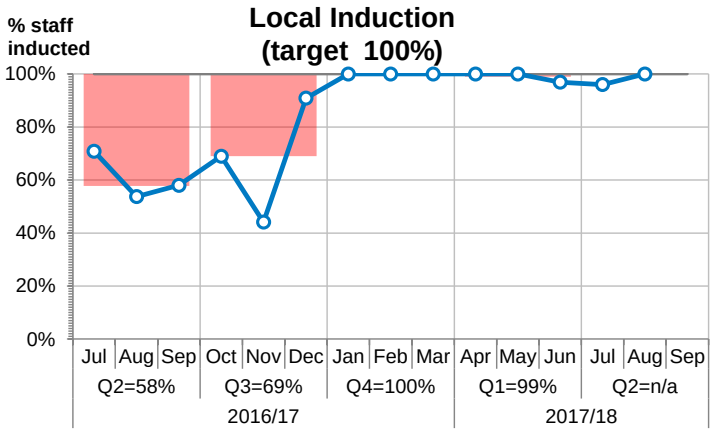
Workforce Induction

Chart 85



Due to technical issues, data for Corporate welcome and local induction is not available for October at the time of writing.

Chart 86



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Staff Engagement

To be developed

Sickness Absence

Chart 86

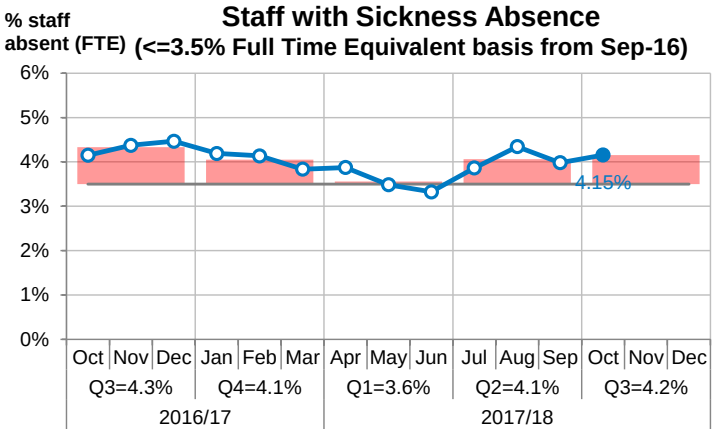


Chart 87

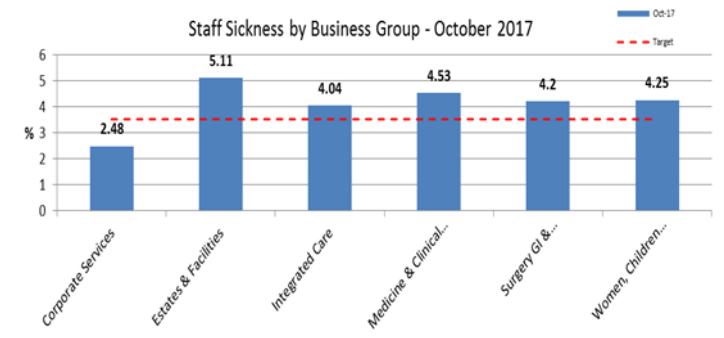
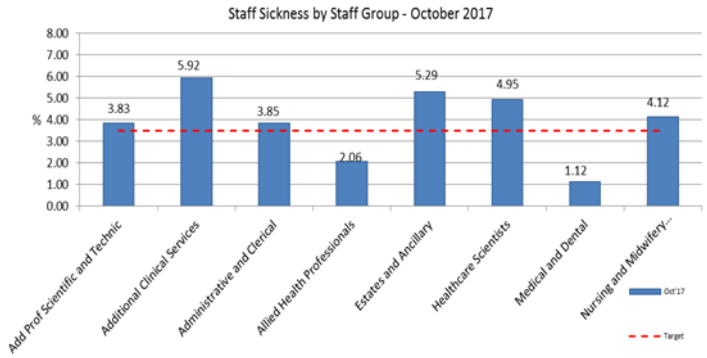


Chart 88



The in-month unadjusted sickness absence figure for October 2017 is 4.15%; an increase of 0.17% compared to the previous month. The sickness rate for comparison in October 2016 was also 4.15%.

The unadjusted cost of sickness absence in October 2017 is £444,429, up £39,602 from the adjusted figure of £404,827 in September 2017. This does not include the cost to cover the sickness absence.

Whilst the top three reasons for absence in October 2017 have remained the same as previous months; Stress at 33.7% (a 1.28% decrease from September 2017), Musculoskeletal Problems including injury/fracture at 22.8% (a 2.29% decrease from September 2017), and cough/ cold/ influenza/ asthma at 10.43% (a 3.01% increase compared to September 2017). The increase for coughs and colds by 3% is significant.

All Business Groups are above the 3.5% target in October 2017 with the exception of Corporate Services. Women, Children & Families has seen the highest increase of 0.41% from the previous month followed by Integrated Care and Medicine &CS, both with an increase of 0.26% on the previous month. The 12-month rolling sickness percentage for the period November 2016 to October 2017 is 4.0%.

The unadjusted short term sickness for November 2016 to October 2017 is 1.35%, which is an increase of 0.21% on the adjusted short term sickness figure reported last month. The long term sickness for November 2016 to October 2017 is 2.64% which is a decrease of 0.18%on the adjusted long term sickness figure reported last month.

Estates and Facilities Business Group has the highest sickness rate at 5.11% (1.61% above the 3.5% target) in October 2017. The two highest reasons given are musculoskeletal/back/injury problems at 1.77% and stress at 0.96%. Sickness is being managed in line with the Attendance Management Policy. There are monthly meetings with E&F managers to discuss the KPIs compliance and action plans to achieve improved positions.

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Essentials Training

Chart 89

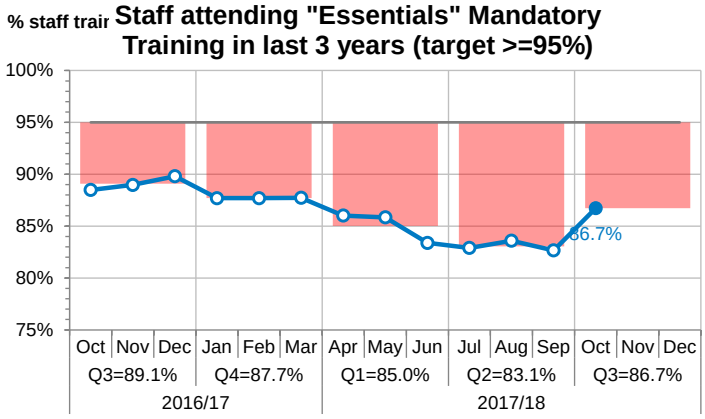
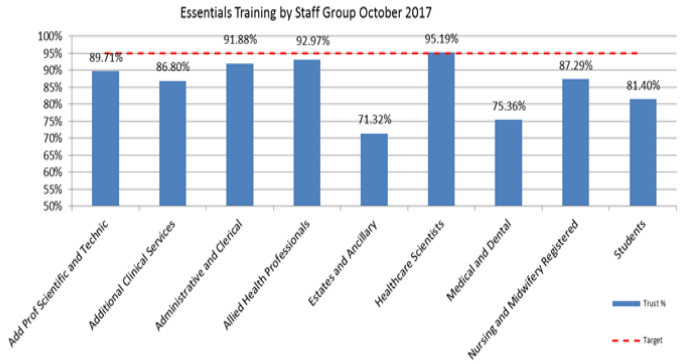


Chart 86

Chart 87



The essentials training compliance is 86.74% for October 17 a significantly improved position from September, which is attributed to a focused effort by the e-learning specialist which has been underpinned by improved data validation.

It is expected that this upturn in performance will continue towards the achievement of this target and further improvements will be seen as a result of the refreshed training matrix. The Statutory and Mandatory training matrix was launched on 8th November supported by new e-learning packages; which is receiving positive feedback.

The training report had been amended to reflect the statutory and mandatory topics for all staff. Going forward the report will be called statutory and mandatory as opposed to essentials

The essential to role matrix is out for consultation and will be launched by the end of November.

E-learning clinics continue and are offered on a weekly basis and week day telephone support is available.

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Flu Campaign

Chart 92

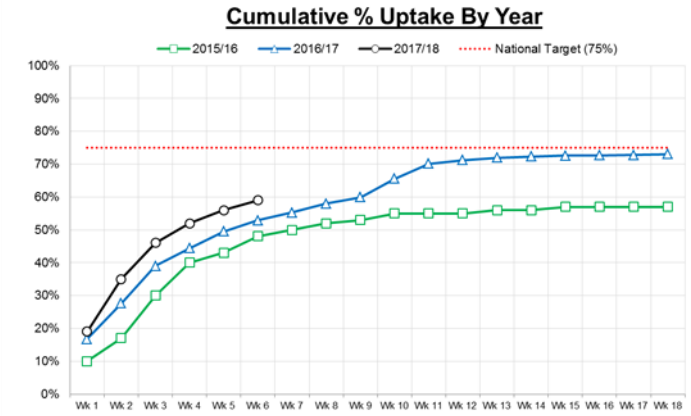


Chart 93

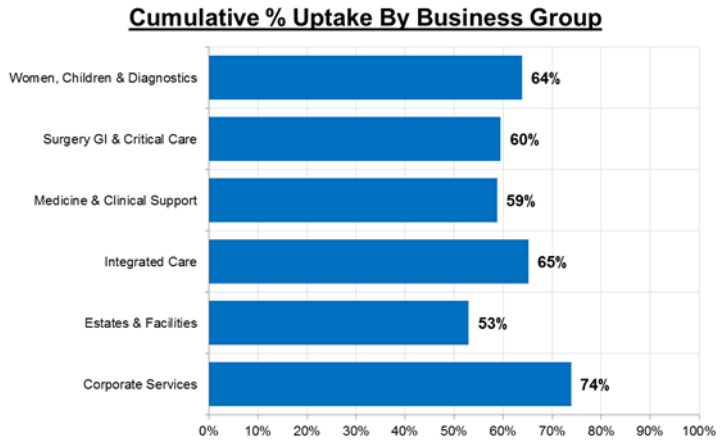
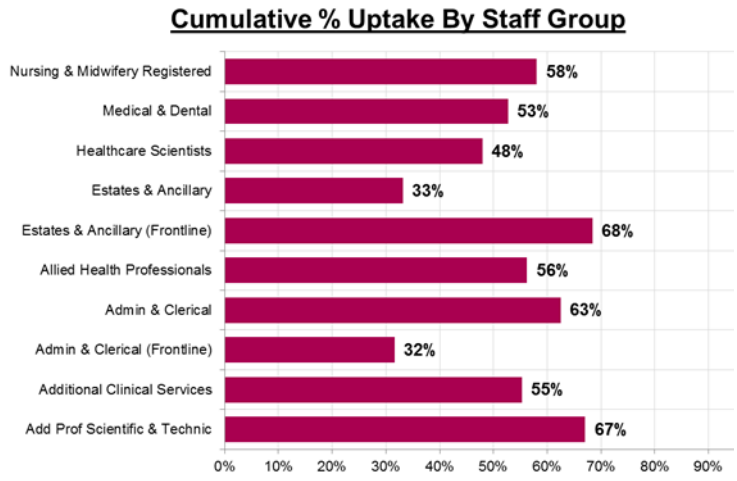


Chart 94



These figures are based on flu forms returned by the link nurses and data entered in the relevant flu week by Occupational Health.

As at week 6 ending 12th November 2017, 59% of the Trust staff have received the flu vaccine, which is 16% short of the Trust overall target. This equates to a further 785 staff requiring the flu vaccination.

Integrated Performance Report
Financial Table

Stockport NHS
NHS Foundation Trust

Income and Expenditure Statement	Trust Annual Plan	Year to Date		
		Plan	Actual	Variance
	£k	£k	£k	£k
INCOME				
Elective	43,531	25,856	23,964	(1,891)
Non Elective	80,046	45,633	45,991	358
Outpatient	31,591	18,473	18,504	32
A&E	13,048	7,671	7,640	(30)
Community Services	28,509	18,693	18,818	125
Non-tariff income	54,584	31,392	31,676	284
Clinical Income from Patient Care Activities	**251,309**	**147,718**	**146,594**	**(1,124)**
Private Patients	55	32	122	90
Other Non-NHS Clinical Income	917	535	431	(104)
Other Clinical Income	**972**	**567**	**553**	**(14)**
Research & Development	485	283	268	(15)
Education and Training	6,957	4,111	4,221	110
Stockport Pharmaceuticals/RQC	5,462	3,204	3,173	(31)
Other income	13,638	8,703	9,881	1,178
Other Income	**26,543**	**16,302**	**17,544**	**1,243**
TOTAL INCOME	**278,824**	**164,586**	**164,691**	**105**
EXPENDITURE				
Pay Costs	(213,982)	(128,247)	(126,766)	1,481
Drugs	(17,062)	(10,817)	(11,126)	(309)
Clinical Supplies & services	(21,633)	(13,211)	(13,208)	3
Other Non Pay Costs	(38,490)	(23,657)	(24,243)	(586)
TOTAL COSTS	**(291,166)**	**(175,931)**	**(175,343)**	**589**
EBITDA	**(12,342)**	**(11,345)**	**(10,652)**	**693**
Depreciation	(9,982)	(5,427)	(5,015)	412
Interest Receivable	63	36	27	(9)
Interest Payable	(1,003)	(514)	(510)	4
Other Non-Operating Expenses	-	-	-	-
Fixed Asset Impairment Reversal	-	-	-	-
Unwinding of Discount	(30)	-	-	-
Profit/(Loss) on disposal of fixed assets	-	-	3	3
Donations of cash for PPE	-	-	-	-
PDC Dividend	(4,105)	(2,282)	(2,238)	44
RETAINED SURPLUS / (DEFICIT) FOR PERIOD	**(27,400)**	**(19,532)**	**(18,385)**	**1,147**

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Stockport NHS
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	30 November 2017
Subject:	Integrated Performance Report - Review		
Report of:	Director of Support Services	**Prepared by:**	Director of Support Services

REPORT FOR APPROVAL

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

Summary of Report

At the Board Away day in October I gave a presentation on Benchmarking, Data Quality and Managing Data.
One of the actions agreed during the discussion that followed was that there would be a review of the current Integrated Performance report.
I have attached a paper which sets out the current position and the plan to have a revised IPR in place in shadow form for the January meeting.
The plan would be to use the new report from April 2018.

The Board is asked to agree to the actions and timelines set out in the paper.

Attachments:
Appendix 1: Trust IPR Indicators
Appendix 2: IPR & Quality Metrics – Reported to boards

This subject has previously been reported to:

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

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1. Current IPR

1.1 The current Trust Integrated Performance Report (IPR) is produced for the Trust Board meeting on a monthly basis. The format is based on four sections;

- Quality
- Performance
- Finance
- Workforce

1.2 The data is presented as a mix of graphical representation and tables. The commentary varies between a descriptive analysis of the current position and limited description of actions (many indicators have no actions identified). A summary sheet includes a RAG rating by indicator and section.

2. Key Issues

2.1 In the last three CQC inspections undertaken between 2016-2017 concerns were identified relating to quality and safety governance. In addition the NHSI report relating to Board oversight and governance; The NHS Improvement Investigative and Proposed Regulatory Approach, 25th August 2017, highlighted significant weaknesses. The Trust is also undertaking a self-assessment against the Well Led Framework which will identify governance and reporting gaps and priorities.

2.2 A high level review of the current IPR (see appendix 1) indicates that;

- It does not include a number of essential KPIs for Quality and Safety
- The rationale for current KPIs is not clear and does not reflect the Standard Operating Framework (SOF) or CQC domains
- There is significant variation in the presentation and analysis of KPIs and many lack forward actions

2.3 As a result the presentation and interpretation of the Trust's position in relation to delivering mandatory requirements and the Trust objectives is compromised. The Trust therefore needs to review effectiveness of its current Governance Framework and reporting to support improvement and assurance. This includes the IPR together with the information reviewed at subcommittee and Business Group level, ensuring there is consistency with;

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

3. Best Practice Examples

3.1 A number of IPRs used by other acute Trusts have been reviewed in terms of the metrics and presentation of the data (see appendix 2). The common features of IPRs developed by Trusts which are improving and achieving 'Good' or above in CQC reviews are;

- Use of visual aids and heat maps to identify trends and issues
- Use of both % and values to ensure the scale of improvement can be identified
- Targets or benchmarks are identified with stretch performance improvement (benchmarks)
- Trends are identified as well as in month changes (variance)
- KPIs are aligned to CQC domains and KLOES
- Actions are identified and clear (not too much descriptive narrative)
- There are clear rules (e.g. exception reports, recovery plans)
- There is consistency with subcommittee reporting and therefore ability to 'deep dive' in subcommittees where additional assurance is required

4. Interdependency

4.1 Any work on the development of the IPR needs to be undertaken in conjunction with a structured plan to develop a range of governance and assurance arrangements including the following;

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

5. IPR Development Process

5.1 The process to develop the IPR will include the following stages;

- A review of the KPIs reported to Board and Subcommittees confirming which needs to sees the KPIs and the level of detail required for Board assurance (reference to IPRs used by other Trusts see Appendix 2)
- A review of how the KPIs and performance is presented in the IPR with reference to best practice
- The Standard Operating Procedures (SOP) for producing the IPR will include Executive ownership of KPIs ensuring the narrative includes an appropriate level of

analysis and description of mitigating actions (such as escalation and/or recovery plan). The Executive team reviews the IPR prior to deadline for Board Paper submissions to ensure all sections are completed to the required standard.

- The IPR development includes the overarching dashboard/summary which will identify key risks and issues for Board review
- Subcommittee dashboards (People and Performance, Finance and Performance, Quality and Assurance) are linked to the IPR triangulating information supporting the IPR across the Trust Business Group and corporate functions
- Business Group performance reviews and dashboards (consistency re content and process)
- The Operating Plan objectives and key programmes have indicators which can be reviewed quarterly at Board (in conjunction with the BAF) and in the Business Group performance reviews

5.2 The priority will be to establish the Quality and Safety section first linked to the review of the Quality and Safety Governance framework and structure currently being undertaken by the Director of Nursing and Medical Director.

5.3 The development of the IPR will need to be supported by the Board and Business Group Development sessions(led by Executives) to ensure all users are familiar with the interpretation of the information and are able to contribute to the discussion and challenge thereby improving assurance.

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Appendix 1

Trust IPR Indicators

IPR Information	Presentation	Target or Benchmark	Trend	Compliance Risk	Action Response
Patient Experience	4 charts 1 table Actual numbers and %	KPI target overall and for ED, IP and maternity	Variance on previous month 13 month data	Narrative re comments and improvement/ deterioration	None identified
Dementia Assessment	3 charts and standards	KPI for each standard	13 month data	Compliant	None identified
Discharge Summary	1 Chart	KPI 95%	13 month data	Non-compliant	Review at performance meetings
Clinical Correspondence	1 chart and 1 table Actual numbers and %	KPI 95%	13 month data	Comment re deterioration Non-compliant	None identified
Falls	1 chart (5 data sets)	KPI <17	13 month data	Risk of non-compliance based on YTD	Falls Collaborative Group
Pressure Ulcers	2 charts -acute and community (6 data sets)	Acute KPI zero Community KPI 50% reduction	13 month data	Risk of non-compliance based on YTD	Heel task and finish group
C.diff	1 chart (6 data sets)	KPI <17	13 month data	Risk of non-compliance based on YTD	None identified
Mortality	SHMI (3 charts) RAMI (3 charts) HMSR (1 chart)	National benchmark/ Index	13 month data	Weekend mortality	7 Day services action plan
RTT	4 charts (Trust and specialty)	KPI 92%	13 month data	Specialty level risks identified and backlog	None identified
ED/Urgent Care/ Flow	21 Charts Performance Attendances Breaches DTOC	KPI 95% Improvement trajectory 90%	12 month data (some relate to March)	Non-compliant (more risk at night)	Staffing (night) Senior presence on each shift Recruitment Discharge model SMBC Improved Better Care Fund SAFER/ECIP Support

Appendix 1

IPR Information	Presentation	Target or Benchmark	Trend	Compliance Risk	Action Response
Diagnostic Test	1 chart	6 weeks	13 month data	Compliant (1 month deterioration)	None identified
Cancelled Operations	2 Charts	KPI zero for 28 days	13 month data	Increase in cancellations	None identified
Outpatient Waiting List (Follow-Up)	4 Charts			4 specialties non-compliant	QUAC review Consultant recruitment
Cancer Waiting Times	7 Charts	KPIs for 2 weeks, 31 days and 62 days	13 month data	Compliant Breaches identified (% and number)	
Readmissions	1 Chart	Compared to national rate	15 month data	None identified	None identified
Finance variance to plan	4 Charts Month YTD Cumulative Expenditure (compared to budget)	Planned deficit £12.0m	Current year	Income 0.9m behind plan CIP £0.8m ahead of plan (back end pressure) Pay underspent Non-pay overspent	None identified
Capital Programme	1 Chart	YTD against plan (£7.0m)	Current year	Delays due to Healthier together programme	None identified
CIP	1 Chart	Target £15.0m (recurrent)	Current year	Exceeding plan but risks identified	None identified
Use of Resources	1 Table	Target 2 (SOF)	Current year	Significant concerns (3)	None identified
Elective Income	2 Charts (Income & activity)	Plan identified (month)	Current year	Deterioration plus WLI costs & outsourcing	Increase utilisation, efficiency and throughput
Agency costs	1 Chart	NHSI Ceiling	12 month data	Exceeding YTD target by £0.9m	Deep dive in medical specialties & recruitment
Cash	1 Chart	Planned profile	15 month data	Receipt of STF improved position	Delivery of CIP Capital underspend
Workforce Appraisal	4 Charts Trust CBUs Staff Group Medical	KPI 95%	15 Month data and current month	Non compliant (92.7%)	None Identified

Appendix 1

Workforce Turnover	3 charts Trust CBU Staff group	KPI 14%	15 month data	Non compliant	None identified
Workforce Efficiency	8 Charts Establishments; Trust CBU Staff Group Pay Agency cost Agency shifts Shifts above cap Bank & agency costs	KPI 90% staff in post KPI 5% bank and agency costs	15 Month data Current month	Variance by staff group and CBU identified	Recruitment
Workforce Induction	2 Charts Corporate Local	KPI 100% for both	13/14 month data	Corporate non-compliant	None identified
Sickness Absence	3 Charts % staff absent CBU Staff group	KPI 3.5%	15 month data	Non compliant	None identified
Essentials Training	3 Charts Trust CBU Staff group	KPI 95%		Non compliant	

Appendix 2

IPR & Quality Metrics – Reported to Boards

Metric	Trust A	Trust B	Trust C	Trust D
ED	**x**	**x**	**x**	x
RTT	**x**	**x**	**x**	x
Cancer	**x**	**x**	**x**	x
OP (DNAs)	**x**			x (backlog)
Cancelled Ops	**x**	**x**	**x**	x
FFT	**x**	**x**	**x**	x
Complaints	**x**	**x**	**x**	x
Compliments			**x**	x
Ombudsman	**x**			**x**
RIDDOR	**x**			
Agency	**x**	**x**	**x**	**x**
Absence	**x**	**x**	**x**	**x**
Appraisal	**x**	**x**	**x**	**x**
Staff survey	**x**			**x**
SNAP	**x**			**x**
Mandatory training	**x**	**x**	**x**	**x**
HAS	**x**	**x**	**x**	**x**
CQUIN	**x**	**x**	**x**	**x**
DTOC various		**x**		**x**
Diagnostic wait		**x**	**x**	**x**
LOS		**x**		**x**
Turnover/vacancy		**x**	**x**	**x**
Mortality various	**x**	**x**	**x**	**x**
IPC various	**x**	**x**	**x**	**x**
Safer staffing	**x**	**x**	**x**	
Safety thermometer	**x**	**x**		**x**
Incidents			**x**	**x**
VTE assessment	**x**	**x**		**x**
Safe medicines	**x**			
Nutrition	**x**		**x**	
30 readmissions	**x**		**x**	**x**
Safer surgery	**x**			
SIs/STEIS	**x**	**x**		**x**
Duty of Candour	**x**			**x**
Never Events	**x**		**x**	**x**
Regulation 28	**x**			**X**
Trolley waits	**x**	**x**	**x**	**x**
Emergency C section	**x**			**x**
Pain Management			**x**	**x**

Stockport NHS
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	30 November 2017
Subject:	Safe Staffing report		
Report of:	Director of Nursing and Quality	**Prepared by:**	Corporate Lead Nurse Workforce

REPORT FOR INFORMATION

Corporate objective ref:	-----	Summary of Report This report provides an overview of Registered Nurse (RN) Registered Midwife (RM) and staffing levels for the month of October 2017. Key points of note are as follows; RN and RM staffing vacancies across the Trust equates to 195 whole time equivalents. Average fill rates for Registered staff ,including Registered Nurse (RN) and Registered Midwives (RM) and care staff remains above 90% for both day and night duty 6 medical wards , 3 surgical wards, 2 areas in child and family and one area in integrated care report below 90% registered staff in month . Temporary staff, both agency and NHS professionals, have been utilised in the clinical areas to support safe staffing levels. Recruitment initiatives are not providing sufficient recruits to address the underlying vacancy rates. The levels recruited are supporting the monthly turnover only. The Board of Directors is asked to note the contents of this report.
Board Assurance Framework ref:	-----	
CQC Registration Standards ref:	Safe staffing	
Equality Impact Assessment:	☐ Completed ☐ Not required	

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

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1.0 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 October 2017.
Work-streams to support safe staffing continue, with a monthly Safe staffing group chaired by the Director of Nursing and Quality.
The Board of Directors is asked to note the contents of this report.

2.0 BACKGROUND

2.1 NHS England is not currently RAG (Red, Amber and 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.
9 areas in month report below 90% RN or RN fill rate. The unify data entry provides the percentage per area and narrates the reasons behind the figures but in brief they are :
Child and Family -Neonates – long term sick, Birth center 9.85 WTE vacancies.
Surgery,Critical Care and Gastroenterology-D1 vacancies , care staff increased , M4 beds closed to support safe staffing . C6 beds closed to support safe staffing.
Medical wards- B2 and C2 now merged onto A10 to support safe staffing, A11 function changed now a rehabilitation ward and care staff increased, B4 and B6 vacancies .

October 2017	DAY	NIGHT
RN/RM Average Fill Rate	91.2%	94.6
Care Staff Average Fill Rate	105.9%	114.2%

3.0 CURRENT SITUATION

3.1 **RN/ RM vacancies.(This includes all Registered RN RM staff band 5 upwards)**
Medicine and clinical support report 68.66 RN vacancies
Corporate Services report 16.65 RN vacancies
Integrated Care reports 57.61 RN vacancies
Surgery Gastro and Critical care report 39.50 RN vacancies
Women Children and Diagnostics report 16.28 RN/RM vacancies

3.2

Temporary Staffing

Temporary staffing has been broken down into business groups to enable the board to have clarity as regards percentages utilized. In previous months there has been a focus on the Emergency Department temporary staffing. In month this is 19% at RN grade.

Business Group	**RN**	**CARE STAFF**
Medicine and Clinical support	20%	17%
Child & Family and Diagnostics	3%	3%
Surgical & Critical Care and Gastro	13%	13%
Integrated Care	12%	16%

3.3

Recruitment

Local recruitment campaigns continue with monthly weekend recruitment open days for theatre practitioners and RNs. Event bright, Facebook, Instagram and text campaigns are also ongoing. Skype interviews are undertaken as a minimum twice monthly to encourage applications. NHS jobs adverts are placed continuously on a rolling basis.

3.4 **Retention**

The Trust joined cohort 2 of the NHSi retention support program in October 2017. A 90 day plan is being developed with support from NHSi which will be submitted early February 2018. NHSi will undertake a site visit in November 2017 to support and guide the Trust develop a plan which will cover 4 key areas, with the aim to reduce turnover and improve retention within 12 months.

The workforce lead nurse attended NHSi retention masterclass in November to assist with developing a nursing retention plan .This has now been initially drafted with support from a team including HR, nursing, finance and the transformation team. This needs input from key stakeholders and therefore will be presented to the Director of Nursing and Quality initially , then the Associate Nurse Directors for the business groups , then to the senior management team 23rd November and then a final plan will be submitted for consideration by the Executive Team end of November 2017.

The lead nurse for workforce also presented to the CCG in November 2017, issues relating to recruitment and retention plans and safe staffing initiatives at the Trust.

4.0 Care hours per patient day (CHPPD)

4:1 October 2107 report also includes information relating to care hours per patient day (CHPPD). This is the staffing metric advised by the Carter review which aims to allow comparison between organisations to a greater extent than previously, whilst noting that location specific services (specialty centres for example) will influence the final measure.

The CHPPD calculates the total amount of Nursing (RN and Care staff) available during a month, and divides this by the number of patients present on the in-patient areas at midnight. This gives an overall average for the daily care hours available per patient (all nursing and midwifery staff). During the Carter pilot stages, 25 trusts were included and their results showed CHPPD range from 6.3 to 15.48 CHPPD and a median of 9.13. For October 2107, our report shows an average CHPPD of 8.1

5.0 RISK & ASSURANCE

5.1 Safe staffing levels have been challenged by the levels of RN and RM vacancies at band 5. A reliance on temporary staffing has been required in the medical and surgery and critical care business groups to support wards and departments safe staffing

6.0 CONCLUSION

6.1 Staffing levels have been maintained above an overall average of 90% with a number of areas reporting less than 90% staffing levels at RN/ RM , supported by temporary workers and non-registered care staff .

7.0 RECOMMENDATIONS

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

Appendix A– Unify entry

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

Org: RWJ - Stockport NHS Foundation Trust
Period: October_2017-18

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: Registered midwives/nurses		Day: Care Staff		Night: Registered midwives/nurses		Night: Care Staff		Day		Night		Care Hours Per Patient Per Day (CHPPD)				Head of Nursing Comment
Site code	Hospital Site name		Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	Neonatal Unit	420 - PAEDIATRICS		2325	1950	0	0	1627.5	1239	0	0	83.9%	n/a	76.1%	n/a	200	15.9	0.0	15.9	The activity on the unit has been matched by the staffing levels meaning that we have maintained safe staffing for the demand on the service. We are fully recruited but have some issues around long term sickness within the team.
RWJ09	STEPPING HILL HOSPITAL - RWJ09	Tree House	420 - PAEDIATRICS		3255	2977.5	465	465	2170	1881.5	0	0	91.5%	100.0%	86.7%	n/a	587	8.3	0.8	9.1	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	Jasmine Ward	502 - GYNAECOLOGY		930	922	465	465	620	620	0	10	99.1%	100.0%	100.0%	n/a	208	7.4	2.3	9.7	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	Birth Centre	560- MIDWIFE LED CARE	501 - OBSTETRICS	1860	1612.5	465	465	1240	1150	310	300	86.7%	100.0%	92.7%	96.8%	41	67.4	18.7	86.0	Staffing deficit in all maternity areas caused by 9.85 Registered Midwife vacancies and short term sickness. Situation monitored on a daily basis and staff redeployed as appropriate.
RWJ09	STEPPING HILL HOSPITAL - RWJ09	Delivery Suite	501 - OBSTETRICS		2790	2617.5	465	450	1860	1732.5	310	290	93.8%	96.8%	93.1%	93.5%	203	21.4	3.6	25.1	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	Maternity 2	501 - OBSTETRICS	560- MIDWIFE LED CARE	1627.5	1552.5	930	930	620	610	310	310	95.4%	100.0%	98.4%	100.0%	472	4.6	2.6	7.2	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	ICU & HDU	192 - CRITICAL CARE MEDICINE		4650	4542	775	751	4092	4081	0	0	97.7%	96.9%	99.7%	n/a	263	32.8	2.9	35.6	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	Short Stay Surgical Unit	100 - GENERAL SURGERY	101 - UROLOGY	2064.5	1997.5	802.5	740.5	880	863	682	682	96.8%	92.3%	98.1%	100.0%	628	4.6	2.3	6.8	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	C6	101 - UROLOGY	100 - GENERAL SURGERY	1395	1179	1395	1371	682	682	682	791	84.5%	98.3%	100.0%	116.0%	616	3.0	3.5	6.5	Registered Nurse staffing on day duty has been sub-optimal. 2 Registered Nurses on duty at all times with Matrons reviewing daily to ensure safety. Due to staffing concerns beds have now been closed to support the vacancies on the ward. Beds closed 31.10.17. Increased Care staff on night to support acuity of patients
RWJ09	STEPPING HILL HOSPITAL - RWJ09	D1	110 - TRAUMA & ORTHOPAEDICS		1627.5	1342.5	1395	1401	682	682	682	880	82.5%	100.4%	100.0%	129.0%	653	3.1	3.5	6.6	Additonal Care Staff have been used at night to support dependency and acuity on the ward. Vacancies have been recruited to however some are still awaiting start dates
RWJ09	STEPPING HILL HOSPITAL - RWJ09	D2	110 - TRAUMA & ORTHOPAEDICS		1395	1257	1162.5	1107.5	682	682	682	671	90.1%	95.3%	100.0%	98.4%	434	4.5	4.1	8.6	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	D4	110 - TRAUMA & ORTHOPAEDICS		942	906	1002	1056	682	682	495	616	96.2%	105.4%	100.0%	124.4%	423	3.8	4.0	7.7	Additonal Care staff shifts have been used at night to support dependency and acuity.
RWJ09	STEPPING HILL HOSPITAL - RWJ09	D6	100 - GENERAL SURGERY		1395	1335	1162.5	1150.5	682	682	682	726	95.7%	99.0%	100.0%	106.5%	692	2.9	2.7	5.6	Additonal care staff shifts have been used at night to support dependency and acuity.
RWJ09	STEPPING HILL HOSPITAL - RWJ09	M4	110 - TRAUMA & ORTHOPAEDICS		1560	1177.5	1674	2050.25	682	572	1023	1531.25	75.5%	122.5%	83.9%	149.7%	628	2.8	5.7	8.5	The staffing figures behind this calcultaion need to be updated to reflect changes made to the ward establishment; current safe staffing compliance is better than this report would indicate.
RWJ09	STEPPING HILL HOSPITAL - RWJ09	SAU	100 - GENERAL SURGERY	101 - UROLOGY	1627.5	1620	1116	1098	868	819	682	661	99.5%	98.4%	94.4%	96.9%	398	6.1	4.4	10.5	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	A1	300 - GENERAL MEDICINE		1395	1305	1209	1201.5	1023	1001	682	715	93.5%	99.4%	97.8%	104.8%	828	2.8	2.3	5.1	Additonal care staff shifts have been used at night to support dependency and acuity.
RWJ09	STEPPING HILL HOSPITAL - RWJ09	A3	320 - CARDIOLOGY		1423	1357	976.5	961.5	1023	836	682	682	95.4%	98.5%	81.7%	100.0%	736	3.0	2.2	5.2	Slight reduction of Registered Nurse on night duty. Never less than 2 Registered Nurses on duty, ward is monitored by Matron and safety is maintained.
RWJ09	STEPPING HILL HOSPITAL - RWJ09	A10	430 - GERIATRIC MEDICINE		1581	1297	1627.5	1567.5	682	682	682	682	82.0%	96.3%	100.0%	100.0%	570	3.5	3.9	7.4	Ward changed function fom the 10th October. Wards B2 and C2 were merged onto A10 which is now hyper-acute stroke.Staffing levels are stroke specific. Slight reduction in Registered Nurse day shifts due to vacancies, ward is monitored by Matron and safety is maintained.
RWJ09	STEPPING HILL HOSPITAL - RWJ09	A11	430 - GERIATRIC MEDICINE		1906.5	1534.5	1441.5	1441.5	682	319	682	1023					872				Ward changed function from the 11th September 2017 and is now a rehabilitation ward. Suboptimal day and night staffing due to vacancies, additional care support workers to support patient care. Ward is monitored by Matron for safety.Never less than 2 Registered Nurses on duty.
RWJ09	STEPPING HILL HOSPITAL - RWJ09	A12	300 - GENERAL MEDICINE		744	624	372	402	682	682	372	432	83.9%	108.1%	100.0%	116.1%	791	1.7	1.1	2.7	Slight reduction in day time Registered Nurses , additional care support workers are supporting patient care. Never less than 2 Registered Nurse per shift and safety is maintained.
RWJ09	STEPPING HILL HOSPITAL - RWJ09	AMU	300 - GENERAL MEDICINE		4092	3462	3348	3594	3720	3368	3069	3355	84.6%	107.3%	90.5%	109.3%	1455	4.7	4.8	9.5	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	B2	430 - GERIATRIC MEDICINE		1674	1674	837	837	1364	1364	682	682	100.0%	100.0%	100.0%	100.0%	125	24.3	12.2	36.5	Ward merged with C2 onto A10 from the 10th October
RWJ09	STEPPING HILL HOSPITAL - RWJ09	B4	300 - GENERAL MEDICINE		1209	765	604.5	895.5	682	682	682	682	63.3%	148.1%	100.0%	100.0%	491	2.9	3.2	6.2	Suboptimal Registered Nurse on day shifts with additional care support workers to support patient care, ward is never less than 2 Registered Nurse and patient safety is maintained.
RWJ09	STEPPING HILL HOSPITAL - RWJ09	B5	300 - GENERAL MEDICINE		837	827.5	837	913.5	682	682	682	759	98.9%	109.1%	100.0%	111.3%	434	3.5	3.9	7.3	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	B6	300 - GENERAL MEDICINE		1209	1054.5	1069.5	1350.5	682	682	682	924	87.2%	126.3%	100.0%	135.5%	663	2.6	3.4	6.0	Suboptimal Registered Nurse on day shifts with additional care support workers to support patient care, ward is never less than 2 Registered Nurse and patient safety is maintained.
RWJ09	THE MEADOWS - RWJ88	Bluebell Ward	318- INTERMEDIATE CARE		1209	1209	2077	1964.5	682	682	682	674.5	100.0%	94.6%	100.0%	98.9%	687	2.8	3.8	6.6	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	C2	430 - GERIATRIC MEDICINE		1284	1284	744	744	682	682	682	682	100.0%	100.0%	100.0%	100.0%	131	15.0	10.9	25.9	Ward merged with B2 onto ward A10 from the 10th October
RWJ09	STEPPING HILL HOSPITAL - RWJ09	C4	300 - GENERAL MEDICINE		1209	954	604.5	934.5	682	682	682	704	78.9%	154.6%	100.0%	103.2%	470	3.5	3.5	7.0	Suboptimal Registered Nurses on day shifts with additional care support workers to support patient care, ward is never less than 2 Registered Nurse and patient safety is maintained.
RWJ09	STEPPING HILL HOSPITAL - RWJ09	Coronary Care Unit	320 - CARDIOLOGY		837	943.5	465	513.75	682	781	341	352	112.7%	110.5%	114.5%	103.2%	156	11.1	5.5	16.6	Ward currently has a planned overestablishment
RWJ03	STEPPING HILL HOSPITAL - RWJ09	Clinical Decisions Unit	300 - GENERAL MEDICINE		372	372	372	372	341	341	341	341	100.0%	100.0%	100.0%	100.0%	139	5.1	5.1	10.3	
RWJ09	CHERRY TREE HOSPITAL - RWJ03	Devonshire Centre for Neuro-Rehabilitation	314 - REHABILITATION		1069.5	1024.5	1999.5	2329.5	682	682	682	1023	95.8%	116.5%	100.0%	150.0%	558	3.1	6.0	9.1	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	E1	430 - GERIATRIC MEDICINE		1945.5	1690.5	2309.5	2212	1023	968	1364	1353	86.9%	95.8%	94.6%	99.2%	958	2.8	3.7	6.5	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	E2	430 - GERIATRIC MEDICINE		2278.5	2263.5	1581	1993	1023	1001	1023	1364	99.3%	126.1%	97.8%	133.3%	1056				
RWJ09	STEPPING HILL HOSPITAL - RWJ09	E3	430 - GERIATRIC MEDICINE		2278.5	2265	1581	1909.5	1023	1034	1023	1639	99.4%	120.8%	101.1%	160.2%	1041	3.2	3.4	6.6	
RWJ09	STEPPING HILL HOSPITAL - RWJ09	Short Stay Olders People's Unit	430 - GERIATRIC MEDICINE		1162.5	1057.5	790.5	730.5	682	671	682	659	91.0%	92.4%	98.4%	96.6%	636	2.7	2.2	4.9	
		Total			59160	53952.5	38121	40368.5	36793.5	34800	22939	26195.75	91.2%	105.9%	94.6%	114.2%	19243	4.6	3.5	8.1	

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Stockport NHS
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	30 November 2017
Subject:	Financial Recovery Plan		
Report of:	Director of Finance	**Prepared by:**	Deputy Director of Finance

REPORT FOR APPROVAL

Corporate objective ref:	C12, C13
Board Assurance Framework ref:	S05
CQC Registration Standards ref:	-----
Equality Impact Assessment:	☐ Completed ☒ Not required

Summary of Report

Following the construction and publication of the Trust's Financial Recovery Plan to address the £9.7m shortfall in 2017-18, this paper provides an update on the next steps following the Finance and Performance Meeting and the Enhanced Oversight Meeting with NHSI.

At this stage, the gap / risk of the actions described in October's Financial recovery plan is £2.3m. However, there are plans to recover £0.5m of penalties from non-Stockport CCGs and utilise the CQUIN reserve.

The Board of Directors are asked to:

a) Review and challenge the contents of this paper; and
b) Note the current level of assurance on the delivery of 2017-18 financial plan;
c) Request further updates on the development of the medium term financial strategy.

Attachments:	Annex A – NHSI Financial Recovery Checklist Annex B – NHSI Locum and Agency Checklist Annex C – November NHSI Enhanced Oversight Meeting

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

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1. INTRODUCTION

1.1 Stockport NHSFT (the Trust) submitted a two year Operational Plan in December 2016, which planned for a financial deficit of £27.4m in 2017-18. The Trust did not accept the Sustainability and Transformation Fund of £7.6m to deliver a deficit of £4.4m however the Trust received £0.4m in relation to 2016-17 and therefore the revised planned deficit is £27.0m

1.2 The expectation from NHSI is that Trust will meet the financial plan of a deficit of £27.4m and will need to be supported in the delivery of the plan and therefore have placed the Trust in Enhanced Financial Oversight consisting of monthly meetings with the regulator.

1.3 Following the publication of September 2017 financial performance, the Trust forecasted a financial deficit of £36.7m, which is a shortfall of £9.7m. This took into account a significant expected shortfall on CIP delivery and a worsening of the income and expenditure position for the business groups.

1.4 At the Executive Team Meeting on 16th October 2017 and subsequent Finance and Performance Committee on the 18th October 2017, the Trust agreed a financial recovery plan to deliver a number of actions to retrieve the deteriorating performance and continue to deliver the plan. The recovery plan was split into 5 action areas which covered:

1. Review of planning assumptions
2. Delivery of existing amber and red CIP schemes
3. Reinvestment of contract penalties
4. Improvement of business group forecast positions
5. Focussed stretch of CIP

1.5 There was not sufficient assurance given at the Finance and Performance Committee that the actions contained within the plan could deliver the £9.7m. The Executive Team were asked to review the actions and look at additional schemes to aim to deliver above the £9.7m plan.

2. FINANCIAL RECOVERY PLAN - ACTIONS UPDATE

2.1 Since the agreement of the Financial Recovery Plan, the Finance and Operational Teams have been working on the actions that were agreed and updates for each of the five actions are summarised below:

Action 1: Planning assumptions - £2.3m (Delivered)

Action 2: Delivery of amber and red CIP schemes - £2.3m

Since the Finance and Performance Committee, the Trust held the scheduled Financial Improvement Group on 30th October 2017. It was re-affirmed at the meeting that delivery of the amber and red schemes was tasked to each Accountable Executive Officer (AEO) of the CIP Themes. It was also confirmed that the non-complex CIP documentation in relation to the schemes would be progressed and finalized in line with the QIA process for action by the end

of November 2017.

Due to the speed with which the Financial recovery Plan was developed, it has come to light that there are certain elements of the amber and red schemes that are either:

a) already included in the Business Group Forecasts and therefore need to be transferred into Business Group Improvement target; or
b) cost avoidance schemes rather reducing the financial shortfall.

The revised target for this action is now £2.0m and the expected level of delivery is currently £1.87m.

Action 3: Contract penalties £1.6m (Delivered)

Action 4: Improvement to business group positions - £1.7m

Following the agreement of the Financial Recovery Plan, the Director and Deputy Director of Finance met with Operational colleagues to disseminate the Plan and set the respective targets for improvement.

In the past two weeks, Executive Directors have met with each Business group as part of the bi-monthly Performance Review meetings. At each meeting, Business Group Financial Recovery plans were discussed and challenged. The current position is as follows:

	£'m
Improvement Required (inc £0.3m Action 2)	**2.0**
Business Group Recovery Actions:	
Medicine and Clinical Support	0.4
Surgery and Critical Care	0.6
Integrated Care	0.2
Estates and Facilities	0.2
Total Recovery Actions	**1.4**
Gap	**(0.6)**

Action 5: Targeted CIP improvement £1.8m

This action was split into three areas

(a) Bed utilisation - £1.2m
(b) Outpatient utilization - £0.1m
(c) Medical Agency & Locum reduction - £0.5m

The original bed capacity calculation was based on closing two full wards from November 2017 onwards. The Finance and Performance Committee considered the bed reconfiguration presentation at the November meeting. The proposal was the closure of 35 beds with a savings £175k compared to the £1.2m that was originally planned.

With the uncertainty of winter demand and the Trust's approach to address the surges in activity, it is highly unlikely that any of the three projects within this action will deliver any significant financial benefit in 2017-2018 and therefore the prudent approach is not to

forecast the delivery in the recovery.

The risk assessed gap for this action is therefore £1.6m.

The summary gap / risk of the actions described in October's Financial recovery plan is £2.3m as summarised in the table below

	Original Target £'m	Revised Target £'m	Latest Recovery £'m	Shortfall / Risk £'m
Action 1 – Planning Assumptions	2.3	2.3	2.3	0.0
Action 2 – Red and Amber Schemes	2.3	2.0	1.9	(0.1)
Action 3 – Penalties	1.6	1.6	1.6	0.0
Action 4 – Business Group Improvement	1.7	2.0	1.4	(0.6)
Action 5a – Bed Utilisation	1.2	1.2	0.2	(1.0)
Action 5b – Outpatients Utilisation	0.1	0.1	0.0	(0.1)
Action 5c – Locum and Agency Reduction	0.5	0.5	0.0	(0.5)
Total	**9.7**	**9.7**	**7.2**	**(2.3)**

3. FURTHER ACTIONS AND UPDATES

3.1 NHSI Financial Recover Checklist

At the Executive Team meeting on 31st October 2017, colleagues agreed to review, and where appropriate, action recommendation from NHSI's Financial Recovery Checklist. As the Trust has already been through the Financial Improvement Programme, a number of items may have already been delivered however it is an important exercise to evidence that the grip and control has not slipped. The latest position on the Financial Recovery Checklist is provided in Annex A.

3.2 NHSI Agency and Locum Usage Checklist

The Trust continues to be one of the worst performing Trusts in the country for medical agency and locum usage and therefore to provide assurance on the sign-off process, the Executive Team is reviewing NHSIs Agency and Locum Usage Checklist provided in Annex B with a view to resubmitting it to NHSI.

3.3 CQUIN Risk Reserve

As part of the national contracting rules for 2017-18, the Trust should have created a risk reserve of £1.1m representing 0.5% of the 2.5% CQUIN available for the Trust. In practice however, the Trust along with the majority of NHS providers across the country assumed the receipt of the whole 2.5% in the delivery of their respective control total and plans. This has become an issue between NHS Improvement and NHS England, and both providers and commissioners are awaiting a national solution.

As part of the forecasting process in October, the Trust created the risk reserve of £1.1m however guidance being received from both the local and national regulator is to continue to

report the assumption that the Trust receives the CQUIN and it improves the overall financial performance.

3.4 **Non-Stockport CCG Penalty Re-investment**

The Trust continues to communicate, with the support of GM and Stockport CCG, with other commissioners to ensure that the penalties invoked remain with the Trust to meet the financial pressures of urgent care and the CQC actions. It is estimated if agreed, the total benefit could be £0.5m

3.5 **Winter Planning**

The Trust has been asked by NHSI to submit the financial impact of the winter planning and the increased level of capacity required to address any surges in activity over the period. As described in the October Financial Recovery Plan, the Trust does not have any contingency for investment into winter escalation in either monetary or resource terms. The Trust has however submitted the size of the financial gap due to the Trust unable to close capacity over the period.

3.6 If the further actions and updates are delivered then the overall shortfall reduces to

	£'m
Current shortfall	(2.3)
0.5% CQUIN Risk Reserve	1.1
Non-Stockport CCG Penalties	0.5
Revised Shortfall	**(0.7)**

4. NHSI ENHANCED OVERSIGHT MEETING (NOVEMBER)

4.1 Representatives from the Trust met with representatives from NHSI to provide an update to the 2017-18 Financial Recovery Plan. The Trust prepared an analysis for discussion which is provided in Annex C.

The main focus of the meeting centred on 5 key items:

a) The drivers of the deficit and the Trust being an outlier nationally on certain specialties. (The descriptions of the drivers of the deficit on page 3 manifests themselves in the Specialty Level profitability on Page 4);

b) There was considerable challenge on the 2017-18 Bed Reconfiguration plan summarised on Page 8;

c) Based on information that NHSI have access to and the current gap on the Business Group Recovery plans, NHSI challenged the Trust on the level of grip and control in operational areas;

d) NHSI requested further information on the current contract performance that included analysis of the PbR versus Block performance **(Director of Finance)**;

e) With regard to 2018-19, they were not surprised by the range of the gap summarised on page 11 however they wanted to better understand how the Board of Directors intend to address such a big gap next year and whether a 3-4 year plan is being developed to ensure overall sustainability.

4.2 The Trust agreed the following actions:

i. A high level breakdown of the top 5 specialties categorised into the main drivers such as agency staff, length of stay, outpatient activity etc. We therefore agreed that we will ensure the Service Reviews that are currently being developed should focus on the top 5 immediately including the disaggregation of General Medicine into Sub-Specialties **(Chief Operating Officer)**;

ii. NHSI want to see much more pace in the development and delivery of the bed reconfiguration / reduction programme as the Trust still has significant opportunities in Length of Stay (LOS). Alongside the current staffing and recruitment issues, it would be a mutual benefit to finance and quality **(Chief Operating Officer)**;

iii. NHSI wanted to see evidence of better grip and control of:
   a. Use of agency **(Director of Workforce & OD)**; and
   b. The overall Business Group Financial Performance including the closure of their respective recovery gaps **(Director of Finance)**;

iv. With regard to 2018-19:
   c. they would like to see the main bridging items diagrammatically presented **(Director of Finance)**; and
   d. a summarised work-up of the key projects as a result of the work on the service reviews **(Chief Operating Officer)**.

4.3 NHSI have requested that these items are provided and discussed at the next Enhanced Oversight Meeting scheduled for 13th December 2017.

5. CONCLUSION

5.1 The Trust continues to face a significant shortfall and risk in the delivery of the 2017-18 financial plan. Even if the Trust utilises the £1.1m CQUIN risk reserve, the Trust is only able to give a low level of assurance on the overall delivery of the plan in this quarter.

5.2 The Executive Team will continue to develop and pursue further actions through the attached checklists however these will be non-recurrent in nature and coupled with the low level of recurrent delivery of CIP in 2017-18. The financial outlook for 2018-19 remains extremely challenging and therefore crucially, the Trust needs to develop the medium term plan and strategy.

6. RECOMMENDATIONS

6.1 The Board of Directors are asked to:

a) Review and challenge the contents of this paper; and
b) Note the current level of assurance on the delivery of 2017-18 financial plan;
c) Request further updates on the development of the medium term financial strategy.

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Not Started
In Progress
Delivered
N / A

Stockport NHS
NHS Foundation Trust

ANNEX A - NHSI FINANCIAL RECOVERY CHECKLIST

ID	Area	Proposal	Executive Lead	Current Status	Evidence / Update
1A	**GOVERNANCE**	Set up a recovery committee with Chief Executive Officer leadership	CEO	Delivered	Finance Improvement Group (FIG) is an established group to manage delivery of CIP. The CEO is Chair and all ACOs and SROs attend. This is the correct group to manage the financial recovery delivery. Frequency needs to be discussed between the CEO and DoF – options include, moving to fortnightly from monthly or having a virtual "meeting" mid month with a flash report on progress and escalation virtually as necessary? FIG meetings have agenda, papers and minutes. Financial flash reports produced fortnightly for Executive Team meetings supplement this FIG recovery delivery. A review of the content to ensure CIP is covered sufficiently should be made by the DoF.
1B	**GOVERNANCE**	Set up a Tactical Savings Group with Executive leadership	AEO	Delivered	Tactical savings are explored and delivered through each CIP Theme Steering Group. Any Trust wide savings or technical in nature are explored and delivered by the Technical CIP Theme
1C	**GOVERNANCE**	Ensure Procurement Group in place and working effectively	DoN & Q	In Progress	The Director of Nursing and Quality will assume the chairmanship of the Procurement Steering Group and evolve it into a clinical commodities group to ensure ownership and reduced variation across the Trust.
1D	**GOVERNANCE**	Ensure Drugs and Therapeutics committee in place and working effectively.	MD	Not Started	A review will be undertaken as part of the Governance Structure
1E	**GOVERNANCE**	Ensure organisation understands that a focus on improving finances is necessary and communicate progress regularly	COO	In Progress	Financial position is reported monthly at Team Brief. In most weeks it is also referenced in the CEO weekly update to ensure focus on priority of financial position. Engagement events with Medical Leadership and Executive Team, and Senior Clinical/ Medical and operational managers to promote need to focus on Urgent Care, Quality and Financial recovery Communications team are accessing a video produced By Wigan, Wrightington and Leigh (WWL) on CIP delivery, for consideration by DoF. Contact made with both WWL and Bolton regarding comms for CIP, as proposed by GM NHSI.
2A	**PLANNING**	The Trust's overarching Financial Recovery Plan demonstrates that the trust moves from its current position to achievement of the Control Total in the current financial year	Trust Board	In Progress	In agreeing to the 2017-18 Financial Recovery Plan, the Trust is aiming to deliver the in-year Plan. The F&P Committee along with NHSI's Enhanced Oversight Meeting, challenge to scale and pace of the plan.
2B	**PLANNING**	Trust has considered difficult decisions within its control and/or influence that it can/will take to deliver savings	Trust Board	Not Started	
2C	**PLANNING**	Trust can show a clear understanding of expected bed changes over the plan as a result of CIPs AND Can usefully include WTE bridging that identifies agency, bank, vacancies, CIP impact.	COO	In Progress	Bed Reconfiguration Presentation. Further analysis of bed reconfiguration relating to i) internal process and flow efficiencies and ii) Stockport Together and Healthier Together impact for 18/19 to be presented 5th December

ID	Area	Proposal	Executive Lead	Current Status	Evidence / Update
2D	**PLANNING**	Trust demonstrates a clear understanding of how productivity savings will be achieved/sustained through Winter operational pressures	COO	In Progress	Winter Plan including reduced reliance on Beds Dec- Feb. Ring Fenced elective ortho beds
2E	**PLANNING**	Trust demonstrates a clear understanding of how operational productivity schemes (e.g. LoS, theatre, outpatient) schemes will result in financial benefit	COO	In Progress	Improving our Efficiency Steering Group/GIRFT analysis and implementation of change/Service Review Process; initially looking at top 5 loss making specialities
2F	**PLANNING**	The plan includes milestones for delivery of financial recovery	COO	In Progress	Summary of Recovery Plans for each Business Group
2G	**PLANNING**	The Trust can show a clear understanding of current WTE/headcount and end of year and plan expected WTE/headcount post savings with monthly expected phasing.	DoW & OD	In Progress	Establishment reconcilliation process, workforce tracker. Operational plan submission. Subject to revised operational planning round, business plan development and strategy refresh refined information will be available.
2H	**PLANNING**	The recovery plan is supported with directorate level plans	COO	In Progress	Business Group Recovery Plans detail responsible officer and timeframes
3A	**CIP GOVERNANCE**	Trust has a strong CIP development and reporting methodology and a clear CIP maturity tracking approach	DoF	Delivered	A new process for Service Reviews is being implemented which will form the basis of the 18/19 CIP programme. The first 5 areas have been identified and work has commenced. CIP reporting is via Finance Improvement Group (FIG) on a monthly basis with progress reports from each Theme. Additionally, reports on CIP progress are received monthly at Finance and Performance Committee and fortnightly at Executive Team meetings. A CIP tracker is maintained and updated. This details, for all schemes, the delivery of CIP against agreed targets with RAG status for each scheme: Red : Ideas agreed to progress and estimated finances calculated Amber: Approved and signed off by all parties at steering group, submitted to PMO and approved - awaiting QIA Green : QIA approved - budget removed or date agreed for removal
3B	**CIP GOVERNANCE**	Trust plan clearly demonstrates a good understanding of the critical pathway for CIP plans and any interactions between themes/schemes	DoF	In Progress	For each scheme, standard project documentation is generated and approved. There is a section on dependencies within this documentation where both enabling and dependent schemes are defined. All project documentation is held by the PMO and a Dependency Register is being generated.
3C	**CIP GOVERNANCE**	The plan includes profiled risk assessment of monthly CIP forecast delivery and mitigations	DoF	Delivered	A CIP tracker is maintained and updated. This details, for all schemes, the delivery of CIP against agreed targets with RAG status for each scheme. Risk and Assurance are reported via the Finance and Performance Committee on a monthly basis
3D	**CIP GOVERNANCE**	Recurrent, non-recurrent savings are clearly set out along with the full year effect with these split between income and costs	DoF	Delivered	The CIP Tracker breaks down the CIP savings into recurrent and non-recurrent, split between Income, Pay and Non-Pay
3E	**CIP GOVERNANCE**	Monthly phasing of CIP delivery is clearly laid out	DoF	Delivered	For each scheme, the monthly phasing of CIP delivery is defined within the standard project documentation
3F	**CIP GOVERNANCE**	Trust is able to demonstrate monthly phasing of savings across themes, divisions, and income/cost categories	DoF	Delivered	For each scheme, the monthly phasing of CIP delivery is defined within the standard project documentation
3G	**CIP GOVERNANCE**	Trust demonstrates it is effectively managing risk of back ended CIPs (i.e. 60% in H2 or more) by tracking relevant leading indicator KPIs	DoF	Delivered	On some schemes, where appropriate -e.g. Theatres Efficiency with indicator KPIs based on the work undertaken with FourEyes
4A	**INCOME**	Ensure no income is lost from cancellation of elective activity in support of winter resilience initiative over Christmas period.	COO	In Progress	Ring fenced Surgical Beds and medical beds convert to general beds. In reach to wards and ED at no cost.

ID	Area	Proposal	Executive Lead	Current Status	Evidence / Update
4B	**INCOME**	Ensure all income is recovered from third parties e.g. use of estate/joint appointments etc.	DoSS	In Progress	
4C	**INCOME**	Review ICR income bad debt provision rate recommended by Department of Health (DH) against trust's own experience and agree a reduced write-off with auditors if it is supported by evidence.	DoF	Delivered	The Trust regularly reviews bad debt provision and wrote off circa £180k of bad debt in 16/17 accounts and through the Cash Action Group actively monitors aged debt. There is little scope at the present time to change the current arrangement.
4D	**INCOME**	Review deferred income, particularly Research and Development to ascertain whether old balances comply with accounting guidance for deferral or should be written back to income and expenditure.	DoF	Delivered	The Trust has limited R&D income and does make necessary adjustments each year in the statement of accounts
4E	**INCOME**	Review partially completed spells methodology to see whether this can be extended to other areas to ensure full and proper income accounting for activity delivered e.g. critical care/non PbR activity.	DoF	In Progress	The Trust continually reviews the partial spell calculation at the end of each Financial Year to take on board Critical Care areas. Historically, the partial spell adjustment was predixated on an agreement with the Commissioners. This assessment can on the last day of the financial year.
4F	**INCOME**	Work with Information and Coding departments to ensure that clinical pathway changes have not had unforeseen impacts on income recovery	DoN & Q	Not Started	
4G	**INCOME**	Ensure the process for income recovery from overseas patients is robust	DoN & Q	In Progress	The Trust has been audited twice on the systems and processes for identifying and charging for overseas patients. The Diretor of Nursing and Quality will review
4H	**INCOME**	Ensure the process for recovering income for private patients is robust	DoF	N / A	The Trust has very little Private Patient activity and income
4I	**INCOME**	Ensure all trading activity income covers costs and makes a contribution e.g. crèche, catering, printing, accommodation, car parking	DoSS	In Progress	
4J	**INCOME**	Use charitable funds where possible and appropriate	DoF	Delivered	The Director of Finance actively encourages the Business Group to make applications to the Charitable Funds Committee for major items of capital spend. The Committee also makes a nominal grant to all clinical areas to spend on non-specific items too. In 16/17, the Trust deploed £849k to provide new medical equipment to a range of wards
4K	**INCOME**	Ensure any SLAs with higher education institutions cover costs and ensure optimal use of education awards and research funds.	DoW & OD	Delivered	Service Level Agreements
5A	**PAY**	Freeze all non-clinical posts except where this would genuinely impact on income recovery, cost reduction, clinical effectiveness or materially affect patient safety or experience	DoW & OD	Not Started	ECP Terms of Reference. Review of terms of reference to be completed in November 2017, with revised actions to commence from 1st December 2017.
5B	**PAY**	Review clinical vacancies to see whether appointments could be deferred or taken out of establishment without detriment to patient safety, with appropriate quality impact assessment and board involvement	DoW & OD	Not Started	ECP Terms of Reference. Review of terms of reference to be completed in November 2017, with revised actions to commence from 1st December 2017.
5C	**PAY**	Stop all waiting list initiative payments where the cost of the activity exceeds the income	COO	Not Started	

ID	Area	Proposal	Executive Lead	Current Status	Evidence / Update
5D	**PAY**	Temporarily redirect 50% plus specialist nurses into vacant ward nursing posts to reduce use of agency	DoN & Q	In Progress	The Director of Nusing and Quality will dicuss this items with Associate Heads of Nursing and Business Group Directors
5E	**PAY**	Slow Health Visitor recruitment and accept ratio impact	DoN & Q	Not Started	Awaiting discussion with the Director of Women, Children and Diagnostics
5F	**PAY**	Implement ban on agency Health Care Assistants as should be able to recruit/cover vacancies.	DoN & Q	Delivered	The Director of Nursing and Quality will confirm the delivery of this item
5G	**PAY**	a) No non-medical agency cover for short-term sickness of less than three days and cover from existing staff b) No nursing agency cover for short-term sickness of less than three days and cover from existing staff c) No AHP agency cover for short-term sickness of less than three days and cover from existing staff d) No admin & clerical agency cover for short-term sickness of less than three days and cover from existing staff e) No estates & facilities agency cover for short-term sickness of less than three days and cover from existing staff	DoW & OD	a - c Not Started d & e delivered	ECP Terms of Reference. Review of terms of reference to be completed in November 2017, with revised actions to commence from 1st December 2017.
5Hi	**PAY**	Ensure full compliance with rostering policy (Nursing)	DoN & Q	Not Started	Review of the e-rostering compliance policy required
5Hii	**PAY**	Ensure full compliance with rostering policy (Medical)	MD	Not Started	This acton will be reviewed following the sign-off the medical job plans
5Hiil	**PAY**	Ensure full compliance with rostering policy (Non-Medical)	DoSS	In Progress	
5I	**PAY**	Review specialling policy and senior sign off of all 1:1 specialling requests	DoN & Q	Not Started	Review of the enhanced care policy required
5Ji	**PAY**	Ensure no off-framework agency usage (Nursing & Midwifery)	DoN & Q	In Progress	Nurse staffing Escalation policy agreed by ET on 14-11-17
5Jii	**PAY**	Ensure no off-framework agency usage (Medical)	MD	Not Started	Will be reviewed as part of the Medical and Locum Agency checklist
5K	**PAY**	Enable staff to buy additional annual leave where no agency cover would be necessary	DoW & OD	Delivered	Purchase of Additional Annual Leave Scheme SOP
5L	**PAY**	Review methodology for annual leave accrual – particularly where generated from e-rostering systems	DoF	Delivered	As part of the 2016/17 Financial Improvement Programme and the Annual Accounts, a review was undertaken on the methodology of annual leave accrual. A stocktake is being undertaken by Director of Workforce and OD.
5M	**PAY**	Recruit new posts on 35 hours where possible	DoW & OD	Not Started	ECP Terms of Reference. Review of terms of reference to be completed in November 2017, with revised actions to commence from 1st December 2017.
5N	**PAY**	Stop non clinical overtime	DoW & OD	Not Started	ECP Terms of Reference. Review of terms of reference to be completed in November 2017, with revised actions to commence from 1st December 2017.
5O	**PAY**	Ensure that policies that restrict the carry forward of annual leave are adhered to, and encourage staff to take their full annual leave entitlement: this will factor into the holiday pay accrual at year end.	COO	In Progress	Awaiting output from Annual Leave audit. Clearly articulated to the organisation

ID	Area	Proposal	Executive Lead	Current Status	Evidence / Update
5P	**PAY**	Rigorous application of referral pathways returning patients to General Practitioner's	COO	In Progress	To clearly define and describe the expectation and process
5Q	**PAY**	Defer implementation of service developments which have cost implication	CEO	Delivered	Business Cases go through a governance route of the Senior Management Team (SMT) before going for approval to the Executive Team or a Board level assurance committee or Board of Directors. Chairs of SMT and Business Group Performance meetings have been asked to inform the meetings, at the start, that there will be no favourable response to business cases which are not as a minimum break even, or preferably provide a saving, for at least the remainder of the financial year and probably beyond.
5R	**PAY**	close unfunded escalation beds	COO	Delivered	Bed reconfiguration paper - no unfunded beds open. Community Unit closed without event
6A	**NON-PAY**	Tighten procedures for reviewing non-discretionary non-pay spend.	DoCA	In Progress	Consideration is being given to whether to impose a moratarium on non-contractual non-pay spend with any requirements subject to approval by the Director of Finance / Deputy Director of Finance.
6B	**NON-PAY**	Stop non-pay spend which is very discretionary, such as hospitality	DoCA	Delivered	Given the relatively modest sums involved, and the likely downsides of significantly reducing expenditure, at present, this area should not be pursued as a contributor to the Financial Recovery Plan. However, there is currently no clear policy in place that sets out when hospitality is appropriate and the DoCA will work with respective groups to address the gap.
6C	**NON-PAY**	Use no win/no fee VAT consultants to review VAT recovery	DoF	Delivered	The Trust has awarded the tender for the provision of VAT expertise and the expenditure is reviewed periodically.
6D	**NON-PAY**	Use no win/no fee rating consultants to review potential rebates for business rates	DoF	In Progress	A review is under way with the Director of Estates and the District valuer.
6E	**NON-PAY**	Review mobile phone distribution and cancel all unused mobile phones	DoSS	In Progress	
6F	**NON-PAY**	Review policy on taxis and patient transport and ensure rigorous controls are in place.	DoSS	In Progress	
6I	**NON-PAY**	Ensure best practice is in place regarding choice and use of drugs: medicines optimisation plans should be in place and delivered	DoF	Delivered	The Trust uses the Greater Manchester Medicine Management Group (GMMMG) formulary which is based on best practice. The Trust has a savings tracker I use to review savings which is based on devomanc CIP plans and contract opportunities. The Trust has a medicines optimisation strategy against which our progress has been recently reviewed, however this is not a specific CIP project.
6J	**NON-PAY**	Review Private Finance Initiative (PFI) payments and whether penalties are appropriate.	DoF	N / A	
6K	**NON-PAY**	Review methodology for splitting PFI unitary payment to ascertain whether there should be a lower charge to income and expenditure and a higher charge to balance sheet. Note DH model is not mandatory.	DoF	N / A	
6L	**NON-PAY**	Review all accruals and creditors and write back to income and expenditure where appropriate	DoF	In Progress	
6M	**NON-PAY**	Review asset lives to ensure they remain appropriate given future constraints on the Department's capital budget.	DoF	Delivered	The Trust has undertaken the review of asset lives in the previous year alongside which we undertook the MEAV project. This action will be re-reviewed as part of the Annual Accounts process
6N	**NON-PAY**	Review staff subsidies (catering, parking etc.)	DoSS	In Progress	

ID	Area	Proposal	Executive Lead	Current Status	Evidence / Update
6P	**NON-PAY**	Ensure year end stock is fully accounted for and has not been wrongly charged to operating expenses and that your accounting policy for inventory accounting does not charge items to expenditure before they are used	DoF	Delivered	This action was undertaken as part of the 2016/17 Annual Accounts closedown and will be re-reviewed as part of the 2017/18 Annual Accounts process
6Q	**NON-PAY**	Ensure bad debt provisions are appropriate and not overstated. In particular if a receivable is impaired, ensure that this is as a result of a past 'loss event(s)' as defined in International Accounting Standard 39 (2011).	DoF	Delivered	This action was undertaken as part of the 2016/17 Annual Accounts closedown and will be re-reviewed as part of the 2017/18 Annual Accounts process
6R	**NON-PAY**	Ensure leased car annual charges are treated as prepayments where they cover the year end	DoF	N / A	
7A	**CASH**	Establish 13 week cash flow process	DoF	Delivered	13 week cash flow reported to Board each month and to Cash Action Group
7B	**CASH**	No payments without purchase orders	DoF	In Progress	No Purchase Order No Pay Policy drawn up by Procurement and awaiting final approval
7C	**CASH**	Ensure accounts receivable processes are fit for purpose	DoF	In Progress	Internal Debt Reduction Group introduced to review long standing debts. Monthly ongoing debt collection. Cash Action Group reporting on accounts receivables issues
7D	**CASH**	Minimise stock levels to ensure cash not tied up in stock	DoF	In Progress	Expansion of the materials management team in 1718 to include theatres.
7E	**CASH**	Examine whether creditor payments could be stretched beyond current creditor days by agreement without adversely impacting supplier relations	DoF	Delivered	Letter sent to all suppliers in June 16 to extend terms o 60 days. Terms negotiated with Procurement where suppliers cannot agree to 60 days
7F	**CASH**	Stop maintenance contracts payments in advance	DoF	Not Started	
7G	**CASH**	Review capital expenditure to stop or defer	DoSS	In Progress	

ANNEX B - NHSI LOCUM / AGENCY CHECKLIST

	Self-certification checklist Please discuss this in your board meeting	Yes - please specify steps taken	No. We will put this in place - please list actions
	Governance and accountability		
1	Our trust chief executive has a strong grip on agency spending and the support of the agency executive lead, the nursing director, medical director, finance director and HR director in reducing agency spending.		
2	Reducing nursing agency spending is formally included as an objective for the nursing director and reducing medical agency spending is formally included as an objective for the medical director.		
3	The agency executive lead, the medical director and nursing director meet at least monthly to discuss harmonising workforce management and agency procurement processes to reduce agency spending.		
4	We are not engaging in any workarounds to the agency rules.		
	High quality timely data		
5	We know what our biggest challenges are and receive regular (eg monthly) data on: - which divisions/service lines spend most on agency staff or engage with the most agency staff - who our highest cost and longest serving agency individuals are - what the biggest causes of agency spend are (eg vacancy, sickness) and how this differs across service lines.		
	Clear process for approving agency use		
6	The trust has a centralised agency staff booking team for booking all agency staff. Individual service lines and administrators are not booking agency staff.		
7	There is a standard agency staff request process that is well understood by all staff. This process requires requestors and approvers to certify that they have considered all alternatives to using agency staff.		
8	There is a clearly defined approvals process with only senior staff approving agency staff requests. The nursing and medical directors personally approve the most expensive clinical shifts.		
	Actions to reducing demand for agency staffing		
9	There are tough plans in place for tackling unacceptable spending; eg exceptional over-reliance on agency staffing services radiology, very high spending on on-call staff.		
10	There is a functional staff bank for all clinical staff and endeavour to promote bank working and bank fill through weekly payment, auto-enrolment, simplifying bank shift alerts and request process.		
11	All service lines do rostering at least 6 weeks in advance on a rolling basis for all staff. The majority of service lines and staff groups are supported by eRostering.		
12	There is a clear process for filling vacancies with a time to recruit (from when post is needed to when it is filled) of less than 21 days.		
13	The board and executives adequately support staff members in designing innovative solutions to workforce challenges, including redesigning roles to better sustain services and recruiting differently.		
14	The board takes an active involvement in workforce planning and is confident that planning is clinically led, conducted in teams and based on solid data on demand and commissioning intentions.		
	Working with your local health economy		
15	The board and executives have a good understanding of which service lines are fragile and currently being sustained by agency staffing.		
16	The trust has regular (eg monthly) executive-level conversations with neighbouring trusts to tackle agency spend together.		

Signed by [Date]

Trust Chair: [Signature]

Trust Chief Executive: [Signature]

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Stockport NHS
NHS Foundation Trust

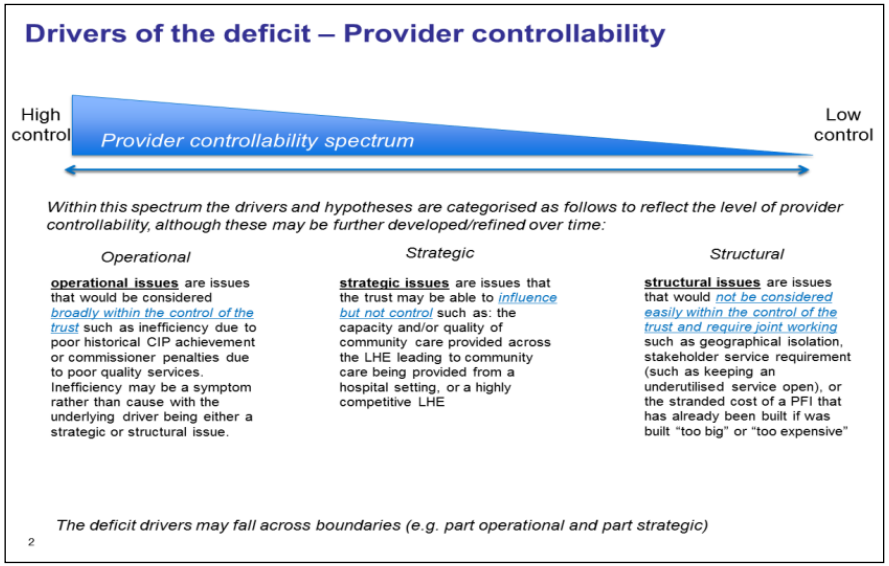
AGENDA

Meeting Title:	Enhanced Oversight Meeting
Time:	9.00am – 10.00am
Date:	20th November 2017
Venue:	Calder, 5th floor, 3 Piccadilly Place, M1 3BN

Agenda No.	Item Description	Objectives/Desired Outcomes	Page
1.	Apologies & Introductions		
2.	Drivers of the deficit	Provide a summary of the make-up of the deficit and provide a breakdown of the 2017/18 deficit	2
3.	2017/18 recovery plan	a) Re-cast the position to reflect M7 and the actions that have now been implemented – such as additional CIP delivery, agreement with CCGs and divisional recovery plans. b) Show the impact of recovery actions by month. c) Quantify the residual gap and actions to close this gap. d) Summarise assumptions that have been made regarding winter on the current projections.	7
4.	High level bridge for 2018/19	Present: a) Opening 18/19 position. b) Cost pressures c) FYE of 17/18 CIPs d) Identified 18/19 CIPs e) Closing 18/19 position as currently stands	11
5.	Date of next meeting	Wednesday 13th December at 4pm	

Drivers of the Deficit – Historical Information

	2013/14	2014/15	2015/16	2016/17	2017/18 Forecast
Financial Position					
Operational Plan	**(4.0)**	**(4.9)**	**(13.1)**	**(6.0)**	**(27.4)**
Income	293.8	302.2	307.1	302.6	282.6
Expenditure	(281.4)	(290.1)	(307.4)	(293.1)	(295.5)
EBITDA	12.4	12.1	(0.3)	9.5	(13.0)
Financing activities	(11.5)	(8.4)	(12.7)	(15.8)	(14.0)
Reported position	**1.0**	**3.7**	**(12.9)**	**(6.3)**	**(27.0)**
Variance	**5.0**	**8.6**	**0.2**	**(0.3)**	**0.4**
Add back non-recurrent items:					
Technical adjustments		(3.8)	(0.9)	(2.1)	
Balance sheet support			(1.7)		
STF				(11.4)	(0.4)
Consultancy (FIP)				2.5	
GMH&SCP Support				(3.5)	
Non-Recurrent CIP	(2.2)	(6.9)	(2.7)	(6.6)	
Normalised position	**(1.2)**	**(7.0)**	**(18.2)**	**(27.4)**	**(27.4)**
Agency					
Registered Nurses	(0.6)	(1.3)	(3.2)	(2.8)	(2.5)
Scientific, Therapeutic and Technical	(1.4)	(0.9)	(1.2)	(0.8)	(0.9)
Support to clinical staff	(0.2)	(0.3)	(0.2)	(0.2)	(0.1)
Consultants	(3.3)	(2.4)	(4.8)	(3.4)	(2.7)
Career/Staff Grades	(1.4)	(4.0)	(6.2)	(5.6)	(6.0)
Trainee Grades	(0.0)	(0.0)	(0.0)	-	
Non Medical - Non-Clinical Staff	(1.8)	(3.2)	(2.5)	(0.8)	(0.2)
Total Agency Spend	**(8.6)**	**(12.0)**	**(18.2)**	**(13.5)**	**(12.6)**
% of total pay costs	**4%**	**6%**	**8%**	**7%**	**6%**
Capital					
Replacement	4.5	3.0	1.9	2.4	4.9
Development	4.6	6.5	14.4	7.6	4.6
Total Capital Spend	**9.1**	**9.5**	**16.3**	**10.0**	**9.6**
less depreciation	(7.4)	(7.8)	(8.9)	(8.8)	(8.9)
Investment above depreciation	**1.7**	**1.7**	**7.4**	**1.2**	**0.7**
Cash					
Year end cash balance	**46.6**	**44.6**	**31.4**	**23.7**	**5.0**



Cost pressures	£'m
Agency medical staffing based on out-turn	4.6
Delivering elective capacity with minimal contribution from outsourcing	1.1
Delivering additional diagnostic capacity at premium rates including endoscopy	1.3
Nurse and medical recruitment support	1.0
Nurse specialling in Medicine	0.8
Community consumable contracts	0.2
Theatre agency nursing	0.4
CIP - non recurrently delivery - where balance sheet or other non-recurrent means has met shortfall	5.6
Total	**15.0**

Service investments	£'m
Investment in nursing for safe staffing following Francis & Berwick reports	1.2
Additional investment in ED - medical	1.3
Additional CQC investment in ED nursing	1.4
Electronic Patient Record	3.0
D Block	1.0
Urology robot	0.3
Transformation Team / Exec Team / Management structure	1.5
Total	**9.7**

Contract changes	£m
Transfer of Community Services to Tameside, after incorporating into Stockport Community and therefore loss of contribution	2.4
Loss of contracts for sexual health for Stockport (contribution)	0.3
Loss of contract for wheelchairs for Tameside (contribution)	0.4
SMBC expectations on contribution to health visitor contracts	0.3
Total	**3.4**

Grand Total	**28.1**

Drivers of the Deficit – Service Line Reports

No	Specialty	2014/15	2015/16	2016/17 excl STF	Movement 2014/15 to 2016/17
1	Care of Elderly	(538)	(4,528)	(5,029)	(4,491)
2	General Medicine	(4,686)	(326)	(4,707)	(21)
3	Obstetrics	(3,898)	(2,780)	(4,211)	(313)
4	T&O	(1,270)	(2,087)	(3,616)	(2,346)
5	General Surgery	(1,463)	(1,668)	(2,091)	(628)
6	ED	(606)	(1,195)	(1,377)	(771)
7	Endoscopy	657	(274)	(479)	(1,136)
8	Cardiology cath lab	153	(44)	(398)	(551)
9	Paeds & Swanbourne	713	(265)	(221)	(934)
10	Community	5,679	4,996	(181)	(5,860)
11	Gynae	594	(726)	(118)	(712)
12	Pathology	1,004	369	155	(849)
	Total extract of specialties	**(3,661)**	**(8,528)**	**(22,273)**	**(18,612)**
	The above table shows an extract of specialties that either				
	(a) Make the largest loss				
	(b) Show the largest deterioration in position over the past two years				
	Or are a combination of both				

General Medicine

Expenditure	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
Expenditure on General Medicine	2015/16	£37.23m	£21.65m	£22.40m			No trendline available
Expenditure on General Medicine as a % of total trust clinical expenditure	2015/16	13.8%	8.1%	7.3%			No trendline available

Cost per FTE	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
Average cost per medical FTE	2015/16	£112.11k	£70,680	£66,393			No trendline available
Average cost per consultant FTE	2015/16	£157.88k	£141.45k	£138.84k			No trendline available

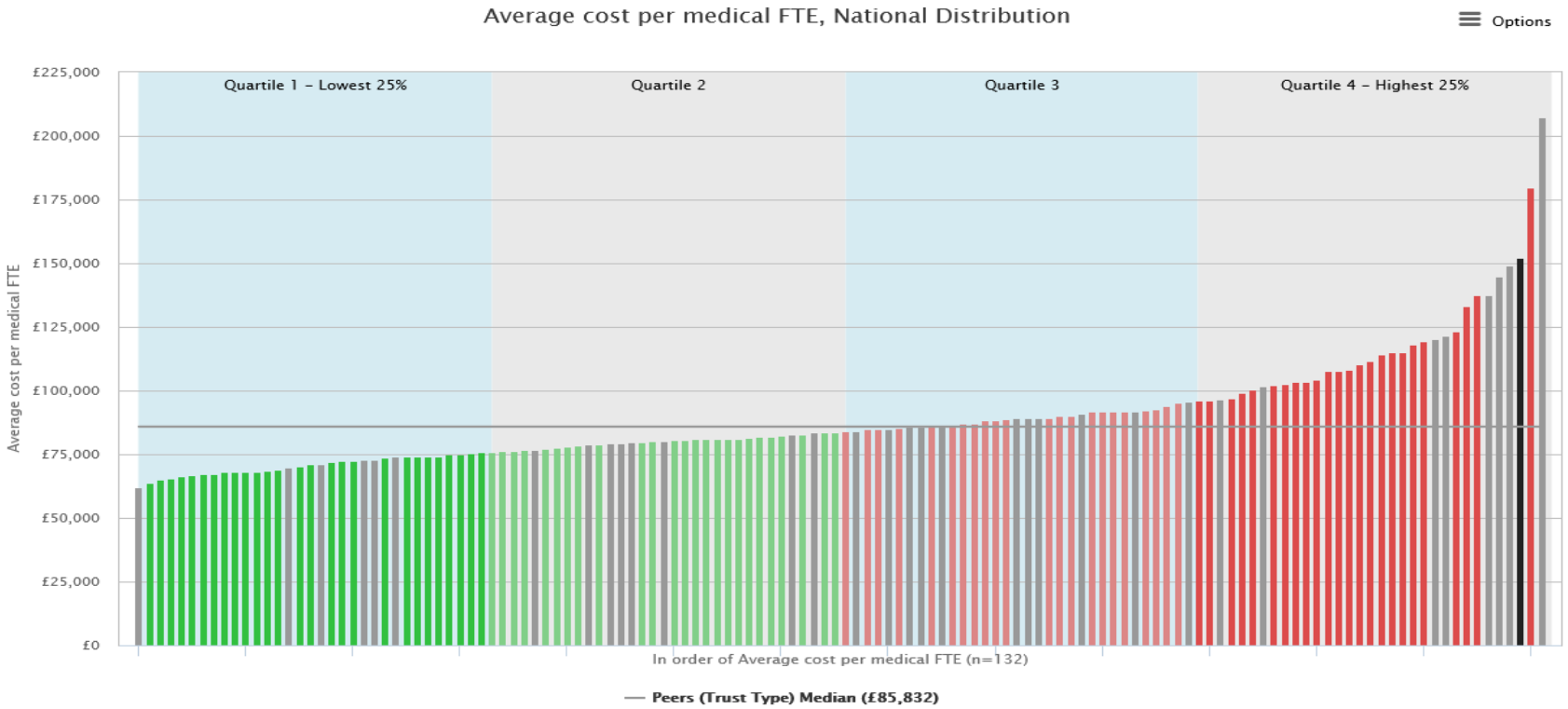
Trauma and Orthopaedics

Expenditure	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
Expenditure on Orthopaedic and Spinal Surgery	2015/16	£30.41m	£24.89m	£26.88m			No trendline available
Expenditure on Orthopaedic and Spinal Surgery as a % of total trust clinical exp...	2015/16	11.3%	9.4%	9.1%			No trendline available

Cost per FTE	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
Average cost per medical FTE	2015/16	£119.36k	£98,971	£99,222			No trendline available
Average cost per consultant FTE	2015/16	£143.18k	£138.64k	£139.64k			No trendline available
Average cost per nurse FTE	2015/16	£33,756	£31,798	£31,869			No trendline available
Average cost per qualified nurse FTE	2015/16	£39,358	£38,305	£38,289			No trendline available

Care of the Elderly

Expenditure	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
Expenditure on Geriatric Medicine	2015/16	£24.11m	£13.62m	£13.22m			No trendline available
Expenditure on Geriatric Medicine as a % of total trust clinical expenditure	2015/16	8.9%	5.3%	3.9%			No trendline available



Cost per FTE	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
Average cost per medical FTE	2015/16	£152.08k	£85,832	£83,690			No trendline available

Month 7 Performance

I&E Position	Budget £m	Actual £m	Variance £m
Income	164.6	164.7	0.1 f
Expenditure	(175.9)	(175.3)	0.6 f
EBITDA	(11.3)	(10.7)	0.7 f
EBITDA margin %	*(7%)*	*(6%)*	*0%*
Financing activities	(8.2)	(7.7)	0.5 f
RETAINED SURPLUS / (DEFICIT)	(19.5)	(18.4)	1.1 f

Key Points:

1. CIP performance is ahead of the profiled plan to date by £1.2m (better than plan). This is a deterioration of £0.8m from last month;
2. Extra STF received relating to 2016-17 of £0.4m (better than plan);
3. Written agreement from Stockport CCG that penalties will not be invoked causing in month improvement of £0.7m but not an overall variance to the plan;
4. Continued underperformance of elective activity due to reduced theatre lists of £0.0m (worse than plan);
5. Saving on financing costs due to delayed / deferred capital expenditure of £0.5m (better than plan).

2017-18 Financial Recovery

Action	Description	Value £'m	Confidence
1	Review of all available resources	2.3	High
2	Drive the deliverable amber and red schemes	2.4	Medium-High
3	Agree re-investment of contract penalties	1.6	Medium-High
4	Improve Business Group Forecasts	1.7	Medium-Low
5	Improve the CIP performance	1.8	Low
Total value of improvements		**9.7**	

2017-18 Financial Recovery Update

Action 1: Planning assumptions - £2.3m (Delivered)
Action 2: Delivery of amber and red CIP schemes - £2.3m (Change in plan with £130k gap)
Action 3: Contract penalties £1.6m (Stockport CCG Delivered)
Action 4: Improvement to business group positions - £1.7m (Change in plan with £600k gap)
Action 5: Targeted CIP improvement £1.8m (See below)

2017-18 Bed Reconfiguration

Considered at the Finance and Performance Committee in November

Action	Bed Numbers
Moving the Spinal Unit from Ward D4 to Ward B3 to continue the development of the "Emergency Village"	-2
Establishing a TWOC Clinic in the Annex on Ward C6 Four Eyes data identified this opportunity	-6
Moving the Diabetes/ General Medicine service from Ward A11 to Ward A12	-2
Moving the Acute Rehabilitation service from Ward A10 to Ward A11.	0
Consolidating the HASU on B2 and the Stroke Rehab ward on C2 onto Ward A10	-5
Close Ward B5 allowing the change of purpose of Ward A11.	-14
Moving the Short Stay for Older People Ward from B3 to Ward D4 to continue the development of the "Emergency Village"	-6
	-35

	Part Year Estimated Budget Savings 17/18	Full Year Effect of Savings
Ward B3 to Ward D4	-	-
Integrated Care		
B2/C2 into A10	29,300	70,500
A11 Rehab to DMOP	-	-
B5 Closure	118,133	354,400
Medicine & Clinical Support	**147,433**	**424,900**
C6 Annex Closure	27,300	82,000
Ward D4 to Ward B3	-	-
Surgery GI & Critical Care	**27,300**	**82,000**
Total:	**174,733**	**506,900**

17/18 Bed Reduction Target:	**1,200,000**
17/18 Variance subtotal:	**1,025,267**

The part year savings of Phase 1 of the Bed Reconfiguration Plan mean there is still a significant gap against the target set for bed reduction in the Recovery Plan.

2017-18 Outpatient Utilisation – Not forecasted to deliver

2017-18 locum and Agency Reduction – Not forecasted to deliver

- Nursing Agency SBAR escalation agreed at Executive Team Meeting;
- Further development required for medical locum and agency usage.

2017-18 Financial Recovery Update

	Original Target £'m	Revised Target £'m	Latest Recovery £'m	Shortfall / Risk £'m
Action 1 – Planning Assumptions	2.3	2.3	2.3	0.0
Action 2 – Red and Amber Schemes	2.3	2.0	1.9	(0.1)
Action 3 – Penalties	1.6	1.6	1.6	0.0
Action 4 – Business Group Improvement	1.7	2.0	1.4	(0.6)
Action 5a – Bed Utilisation	1.2	1.2	0.0	(1.2)
Action 5b – Outpatients Utilisation	0.1	0.1	0.0	(0.1)
Action 5c – Locum and Agency Reduction	0.5	0.5	0.0	(0.5)
Total	**9.7**	**9.7**	**7.2**	**(2.5)**

Further Actions

- NHSI Financial Recovery Checklist (Board of Directors – November)
- NHSI Locum and Agency Checklist (Board of Directors – November)
- Pursue other Commissioners for Penalty re-investment (Opportunity £0.8m)
- CQUIN – 0.5% Risk Reserve (£1.1m)

Recovery Profile

YEAR TO DATE £m	Sep-17 (Q2)	Oct-17	Nov-17	Dec-17 (Q3)	Jan-18	Feb-18	Mar-18 (Q4)
Forecast Reported Last Month (October M06)							
Plan	(18.1)	(19.5)	(20.2)	(22.2)	(23.9)	(25.8)	(27.4)
Forecast	(17.2)	(19.8)	(22.4)	(26.5)	(29.4)	(33.4)	(36.7)
Variance	0.9	(0.2)	(2.2)	(4.3)	(5.5)	(7.5)	(9.3)
Adjustment for STF	(0.4)	(0.4)	(0.4)	(0.4)	(0.4)	(0.4)	(0.4)
Forecast Gap reported October	**0.6**	**(0.6)**	**(2.6)**	**(4.7)**	**(5.9)**	**(7.9)**	**(9.7)**
Recovery Plan Actions Achieved							
Action 1 - Review of all available resources	-	0.2	0.5	0.8	1.1	1.6	2.3
Action 2 - Drive in delivery of red and amber schemes	-	0.6	0.7	0.8	0.9	0.9	1.0
Action 3 - Agreed re-investment of contract penalties	-	0.7	0.8	1.0	1.2	1.4	1.6
Sub-Total	-	1.6	2.0	2.6	3.2	3.9	4.9
Recovery Plan Actions Update							
Action 2 - Drive in delivery of red and amber schemes	-	-	0.1	0.3	0.4	0.6	0.8
Action 4 - Business Group Improvement	-	-	0.3	0.6	0.8	1.1	1.4
Sub-Total	-	-	0.4	0.9	1.2	1.7	2.2
Revised Forecast Gap	**0.6**	**1.0**	**(0.1)**	**(1.2)**	**(1.5)**	**(2.3)**	**(2.5)**

2018-19 High Level Impact Assessment

Original Operational Plan assumed recurrent delivery of £15m cost improvement in 2017-18 and therefore deliver a further £15m in 2018-19 and plan £24.4m deficit.

Key issues for Consideration:

1. Level of non-recurrent CIP in 2017-18
2. Contract Pressures:
    a. CQUIN and Penalties
    b. Eastern Cheshire Stroke Service
    c. Stockport Together Impact
3. Healthier Together Impact
4. Continued increase in CQC and CNST Costs
5. Junior Doctor Lead employer costs
6. Continued investment in EPR
7. Financing Costs for working capital loans

Overall the shortfall against the original operational plan ranges between between £5m to £10m pressure over and above the required £15m

Key Actions:

1. Operational grip and control
2. Deliver the Service Review at pace using Model Hospital, GIRFT, CHKS etc
3. More focussed contract discussions with Stockport CCG , Stockport MBC and Eastern Cheshire CCG
4. Continued review of length of stay and bed configuration
5. More ambitous plans to partner and federate specialites across a wider footprint in preparation of Theme 3

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Stockport NHS
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	30 November 2017
Subject:	Committee Terms of Reference – Periodic Review		
Report of:	Director of Corporate Affairs	**Prepared by:**	P Buckingham

REPORT FOR APPROVAL

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

Attachments:	Annex A – Draft Audit & Risk Committee Terms of Reference

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

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1. INTRODUCTION

1.1 The purpose of this report is to present the Terms of Reference for the Audit Committee following periodic review.

2. BACKGROUND

2.1 The Terms of Reference for the Audit Committee were last reviewed and approved by the Board of Directors on 24 November 2016 and are therefore due for annual review. In addition, in June 2017 during Board consideration of the Strategic Risk Register, a request was made that the Chair of the Audit Committee give consideration to a change of emphasis for the Committee with a view to a greater focus on obtaining assurance on the effectiveness of risk management systems.

3. CURRENT SITUATION

3.1 The Audit Committee completed a review of its Terms of Reference during a meeting held on 14 November 2017 and considered the matter requested by the Board. The Committee noted that the current Terms of Reference included functions relating to risk management but agreed that this should be made more explicit. It was also agreed that the title of the Committee should be revised to Audit & Risk Committee. Amendments to the current Terms of Reference were proposed and are identified by use of bold red font in the document included for reference at Annex A of the report.

3.2 The Committee recommended the revised Terms of Reference to the Board of Directors for approval and Board members are requested to note that the aim to achieve greater focus on risk systems was endorsed by Internal Audit and External Audit representatives present at the meeting on 14 November 2017. If approved by the Board, the Chair of the Committee and the Director of Corporate Affairs will work closely with the Director of Nursing & Quality to determine the nature and frequency of risk-related reporting to the Committee.

4. RECOMMENDATIONS

4.1 The Board of Directors is recommended to:

- Approve the draft Terms of Reference for the Audit & Risk Committee included at Annex A to this report.

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Stockport NHS
NHS Foundation Trust

AUDIT & RISK COMMITTEE

DRAFT TERMS OF REFERENCE

1. Authority

1.1 The Audit **& Risk** Committee is constituted as a standing committee of the Foundation Trust's Board of Directors. Its constitution and terms of reference shall be as set out below, subject to amendment at future Board of Directors meetings. The Audit **& Risk** Committee shall not have executive powers in addition to those delegated in these terms of reference.

1.2 The Audit **& Risk** Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Audit **& Risk** Committee.

1.3 The Audit **& Risk** Committee is authorised by the Board of Directors to obtain outside legal or other independent professional advice. The Committee is authorised by the Board of Directors to request the attendance of individuals and authorities from outside the Foundation Trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions.

2. Purpose

2.1 The Audit **& Risk** Committee has primary responsibility for monitoring and reviewing financial and other risks and associated controls, corporate governance and financial assurance.

2.2 The Board of Directors is responsible for ensuring effective financial decision-making, management**, risk management** and internal control including:

- Management of the Foundation Trust's activities in accordance with statute and regulations;
- The establishment and maintenance of a system of internal control to give reasonable assurance that assets are safeguarded, waste or inefficiency avoided and reliable financial information produced, and that value for money is continuously sought;
- **The establishment and maintenance of a Risk Management Framework that identifies risks to the Trust's activities and plans and mitigates those risks in accordance with the Trust's identified risk appetite.**

2.3 The Audit **& Risk** Committee shall provide the Board of Directors with a means of independent and objective review of financial and corporate governance, assurance processes **(including the Board Assurance Framework)** and risk management across the whole of the Foundation Trust's activities (clinical and non-clinical) both generally and in support of the annual governance statement. In addition the Audit **& Risk** Committee shall:

- Provide assurance of independence for external and internal audit;
- Ensure that appropriate standards are set and compliance with them is monitored in all areas that fall within the remit of the Audit **& Risk** Committee; and
- Monitor corporate governance (e.g. compliance with terms of the licence, constitution, codes of conduct, standing orders, standing financial instructions, maintenance of registers of interests).
- **Provide advice and / or assurance to the Accounting Officer as and when required**

3. Membership

3.1 The Committee shall be composed of four independent non-executive directors, at least one of whom should have recent and relevant financial experience.

3.2 Quorum - No business shall be transacted unless at least two independent non-executive directors are present.

4. Attendance

4.1 Only members of the Audit **& Risk** Committee have the right to attend meetings, but the Director of Finance and Head of Internal Audit of the Foundation Trust shall normally be invited to attend meetings. **Similarly the Director of Nursing & Quality as the Executive responsible for the risk management system will normally be invited to attend the meeting, together with the Head of Risk Management.**

4.2 A representative of the external auditors will normally be invited to attend meetings of the Audit **& Risk** Committee.

4.3 Foundation Trust directors and/or staff shall be invited to attend those meetings in which the Audit **& Risk** Committee will consider areas of risk or operation that are their responsibility.

4.4 The Foundation Trust Chair shall not be a member of the Committee but may be invited to attend meetings of the Audit **& Risk** Committee as required. **The Chair of the Committee will meet annually with the Foundation Trust Chair.**

4.5 A representative of the local anti-fraud service may be invited to attend meetings of the Audit **& Risk** Committee.

4.6 The Chief Executive should be invited **to attend each meeting but must attend** at least annually to discuss with the Committee the process for the assurance that supports the Annual Governance Statement.

4.7 The Company Secretary shall be the secretary to the Audit **& Risk** Committee and will provide administrative support and advice. The duties of the Company Secretary in this regard include but are not limited to:

- Agreement of the agenda with the Chair of the Audit **& Risk** Committee and attendees together with the collation of connected papers;
- Taking the minutes and keeping a record of matters arising and issues to be carried forward;
- Advising the Audit **& Risk** Committee as appropriate

5. Frequency of meetings

5.1 Meetings shall be held at least five times per year, with additional meetings where necessary.

5.2 The external auditor and internal auditor shall be afforded the opportunity at least once per year to meet with the Audit **& Risk** Committee without executive directors present.

5.3 The Audit **& Risk** Committee will agree a forward work programme for each year.

6. Duties

6.1 Internal control and risk management

6.1.1 To ensure the provision and maintenance of an effective system of risk identification and associated controls, reporting and governance.

6.1.2 To maintain an oversight of the Foundation Trust's general risk management structures, **(Board) Assurance Frameworks,** processes and responsibilities, including the production and issue of any risk and control-related disclosure statements.

6.1.3 To review processes to ensure appropriate information flows to the Audit **& Risk** Committee from executive management and other Board committees in relation to the Trust's overall internal control and risk management position.

6.1.4 To review the adequacy of the policies and procedures in respect of all Anti-Fraud services work.

6.1.5 To review the adequacy of the Foundation Trust's arrangements by which Foundation Trust staff may, in confidence, raise concerns about possible improprieties in matters of financial reporting and control and related matters or any other matters of concern.

6.1.6 To review the adequacy of policies and procedures for ensuring compliance with relevant regulatory, legal and conduct requirements.

6.2 Internal audit

6.2.1 To review and approve the internal audit strategy and programme, ensuring that it is consistent with the needs of the organisation.

6.2.2 To oversee on an on-going basis the effective operation of internal audit in respect of:

- Adequate resourcing;
- Its co-ordination with external audit;
- Meeting relevant internal audit standards;
- Providing adequate independence assurances;
- Having appropriate standing within the Foundation Trust; and
- Meeting the internal audit needs of the Foundation Trust.

6.2.3 To consider the findings of internal audit investigations and management's response and their implications and monitor progress on the implementation of recommendations.

6.2.4 To evaluate performance of the internal audit service against relevant key performance indicators on an annual basis.

6.2.5 To oversee the conduct of a market testing exercise for the appointment of an internal auditor at least once every five years and, based on the outcome, make a recommendation to the Board of Directors for award of contract.

6.3 External audit

6.3.1 To make a recommendation to the Council of Governors in respect of the appointment, re-appointment and removal of an external auditor and related fees as applicable. To the extent that the recommendation is not adopted by the Council of Governors, this shall be included in the Annual Report, along with the reasons that the recommendation was not adopted.

6.3.2 To discuss with the external auditor, before the audit commences, the nature

and scope of the audit, and ensure co-ordination, as appropriate, with other external auditors in the local health economy.

6.3.3 To assess the external auditor's work and fees each year and based on this assessment, to make the recommendation in 6.3.1 to the Council of Governors with respect to the re-appointment or removal of the auditor. This assessment should include the review and monitoring of the external auditor's independence and objectivity and effectiveness of the audit process in light of relevant professional and regulatory standards.

6.3.4 To oversee the conduct of a market testing exercise for the appointment of an external auditor at least once every five years and, based on the outcome, make a recommendation to the Council of Governors with respect to the appointment of the auditor.

6.3.5 To review external audit reports, including the annual audit letter, together with the management response, and to monitor progress on the implementation of recommendations.

6.3.6 To develop and implement a policy on the engagement of the external auditor to supply non-audit services.

6.3.7 To consider the provision of the external audit service, the cost of the audit and any questions of resignation and dismissal of the auditors.

6.4 Annual accounts review

6.4.1 To review the annual accounts, before they are presented to the Board of Directors, in order to determine their completeness, objectivity, integrity and accuracy. This review will cover but is not limited to:

- The meaning and significance of the figures, notes and significant changes;
- Areas where judgment has been exercised;
- Adherence to accounting policies and practices;
- Explanation of estimates or provisions having material effect;
- The schedule of losses and special payments;
- Any unadjusted statements; and
- Any reservations and disagreements between the external auditors and management which have not been satisfactorily resolved.

6.4.2 To review the Annual Report (including the Annual Quality Report) and Annual Governance Statement before they are submitted to the Board of

Directors to determine completeness, objectivity, integrity and accuracy.

6.4.3 To review all accounting and reporting systems for reporting to the Board of Directors, including in respect of budgetary control.

6.5 Standing orders, standing financial instructions and standards of business conduct

6.5.1 To review on behalf of the Board of Directors the operation of, and proposed changes to, the standing orders and standing financial instructions, the constitution, codes of conduct and standards of business conduct; including maintenance of registers.

6.5.2 To examine the circumstances of any significant departure from the requirements of any of the foregoing, and whether those departures relate to a failing, an overruling or a suspension.

6.5.3 To review the scheme of delegation.

6.6 Other

6.6.1 To examine any other matter referred to the Audit **& Risk** Committee by the Board of Directors and to initiate investigation as determined by the Audit **& Risk** Committee.

6.6.2 To review each year the accounting policies of the Foundation Trust and make appropriate recommendations to the Board of Directors.

6.6.3 To consider the outcomes of significant reviews carried out by other bodies which include but are not limited to regulators and inspectors within the health and social care sector and professional bodies with responsibilities that relate to staff performance and functions.

6.6.4 To review and monitor the Trust's Clinical Audit programme through the consideration of six-monthly progress updates.

7. Reporting

7.1 The minutes of Audit **& Risk** Committee meetings shall be formally recorded by the Company Secretary and a Key Issues Report submitted to the Board of Directors. The Chair of the Committee shall draw to the attention of the Board of Directors any issues that require disclosure to the Board of Directors or requires executive action.

7.2 The Audit **& Risk** Committee will report annually to the Board of Directors in respect of the fulfilment of its functions in connection with these terms of reference. Such report shall include but not be limited to functions undertaken in connection with the Annual Governance Statement; the assurance framework; the effectiveness of

risk management within the Foundation Trust; the integration of and adherence to governance arrangements; and any pertinent matters in respect of which the Audit **& Risk** Committee has been engaged.

7.3 The Foundation Trust's annual report shall include a section describing the work of the Audit **& Risk** Committee in discharging its responsibilities.

8. Review

8.1 The terms of reference of the Audit **& Risk** Committee shall be reviewed by the Board of Directors at least annually.

9. Required frequency of attendance by members

9.1 Members of the Audit **& Risk** Committee must attend at least three meetings of the Audit **& Risk** Committee each financial year and should aim to attend all scheduled meetings.

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