NHS
Stockport
NHS Foundation Trust

BOARD OF DIRECTORS

PUBLIC MEETING

31 OCTOBER 2018

Your Health. Our Priority.

Board of Directors - 31 October 2018

This page has been left blank

NHS Stockport NHS Foundation Trust

Board of Directors Meeting
Wednesday, 31 October 2018

Held at 9.00am in Lecture Theatre A, Pinewood House, Stepping Hill Hospital

AGENDA

Time			Enc	Presenting
0900	**1.**	Apologies for absence		
	2.	Declaration of Interests		
	3.	Opening Remarks by the Chair		
0905	**4.**	Patient Story – Fractured Neck of Femur		**D Johnson**
	5.	**OPENING MATTERS**		
0925	5.1	Minutes of Previous Meeting: 27 September 2018	✓	**A Belton**
0930	5.2	Chair's Report	✓	**A Belton**
0935	5.3	Chief Executive's Report	✓	**H Thomson**
0940	5.4	Key Issues Reports from Assurance Committees • Quality Committee • Finance & Performance Committee • People Performance Committee	✓	**Committee Chairs**
	6.	**PERFORMANCE**		
0955	6.1	Performance Report	✓	**H Mullen**
1015	6.2	Winter Plan 2018/19	✓	**J Wood**
1030	6.3	Stockport Neighbourhood Care (Presentation)		**S Toal**
1045	6.4	Corporate Objectives – Quarter 2 Progress	✓	**H Mullen**
	7.	**FINANCE & QUALITY**		
1050	7.1	Freedom to Speak Up Report	✓	**P Gordon**
1100	7.2	Freedom to Speak Up – Self Review	✓	**P Buckingham**
	8.	**STRATEGY & GOVERNANCE**		
1115	8.1	Planning Framework & Operational Plan 2019/20	✓	**H Mullen**
1130	8.2	Trust Risk Register	✓	**A Lynch**
1145	8.3	Board Assurance Framework	✓	**A Lynch**
	9.	**CONSENT AGENDA**		
	9.1	• Health Care Worker Flu Vaccination • Emergency Preparedness Resilience & Response Report		

10. DATE, TIME & VENUE OF NEXT MEETING

10.1 Thursday, 29 November 2018, 9.30am in Lecture Theatre A, Pinewood House, Stepping Hill Hospital.

STOCKPORT NHS FOUNDATION TRUST

Minutes of a meeting of the Board of Directors held in public
on Thursday, 27 September 2018
9.30am in Lecture Theatre A, Pinewood House, Stepping Hill Hospital

Present:

Mr A Belton	Chair
Mrs C Barber-Brown	Non-Executive Director
Dr M Cheshire	Non-Executive Director
Mr D Hopewell	Non-Executive Director
Ms A Smith	Non-Executive Director
Mr M Sugden	Non-Executive Director
Ms H Brearley	Interim Director of Workforce & OD
Mr P Buckingham	Director of Corporate Affairs
Ms A Lynch	Chief Nurse & Director of Quality Governance
Mr H Mullen	Director of Support Services
Mr F Patel	Director of Finance
Mrs H Thomson	Interim Chief Executive
Ms S Toal	Chief Operating Officer
Dr C Wasson	Medical Director
Ms J Wood	Urgent and Emergency Care Improvement Director

In attendance:

Mrs S Curtis	Membership Services Manager
Mrs H Howard	Deputy Chief Nurse
Mrs E Rogers	Matron for Patient Experience & Quality Improvement
Mr J Killeen	Director of Estates & Facilities
Mr M Reed	Key Projects Manager, Estates

211/18 Apologies for Absence

An apology for absence had been received from Mrs C Anderson.

The Chair welcomed Board members and observers to the meeting.

212/18 Declaration of Interests

There were no interests declared.

Mrs H Howard and Mrs E Rogers joined the meeting.

213/18 Patient Story

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. The Chief Nurse delivered a presentation regarding a 96-year old lady who had suffered a fall whilst a patient at a hospital and

who's quality of life had deteriorated following the fall and consequent surgery. The presentation, entitled "Rosemary's Story", covered the following subject headings:

- Rosemary's story
- Ongoing concerns…
- What did we do…
- Learning into action…
- Context within Trust Quality Strategy

The Board was advised of lessons learnt and improvements made following Rosemary's experiences. The Chief Nurse circulated laminated leaf symbols to Board members and advised that the Trust had introduced a new initiative whereby the leaf symbol would be displayed on a badge on any patient who was considered to be a falls risk. The Chief Nurse advised the Board that next month's Patient Story would be about enhanced recovery pathway. In response to a question from Ms A Smith, who commented on the letter Rosemary's family had received and the criteria for formal patient safety investigations, the Chief Nurse confirmed that the process had since changed. In response to a question from Dr M Cheshire, the Deputy Chief Nurse advised that, as part of intentional rounding, checks would be made to ensure that patients had the essential items they required, such as glasses and fully operational hearing aids.

The Medical Director noted that the story illustrated the importance of genuinely listening to and learning from complaints as they provided rich information. The Director of Finance commended the reduction in the number of falls. He noted, however, that one of the learning points from the recent Use of Resources assessment was that the Trust did not publicise the reduction of bed days enough. The Chief Nurse acknowledged this comment and briefed the Board on ongoing work in this area which was led by the Deputy Chief Nurse. The Interim Director of Workforce commented that the story touched upon a number of different elements of the Quality Strategy. She also noted the importance of having an engaged workforce and good retention rates which, in turn, enabled staff to provide good quality care. The Chair noted that he, along with the Medical Director and Chief Nurse, had attended a quality improvement event in London on 26 September 2018 where reference had been made to engagement with people and the importance of language used. He wished to thank the Chief Nurse, the Deputy Chief Nurse and the Matron for Patient Experience & Quality Improvement for the presentation and the associated quality improvement work.

The Board of Directors:

- Received and noted the Patient Story.

(14 minutes)

Mrs H Howard and Mrs E Rogers left the meeting.

214/18 Minutes of the previous meeting

The minutes of the previous meeting held on 30 August 2018 were agreed as a true and accurate record of proceedings subject to an amendment to the final sentence of

minute number 208/18 'Trust Performance Report'. The Chief Nurse noted that a review of Strategic Executive Information System (StEIS) reported incidents had already been undertaken. The action log was reviewed and annotated accordingly.

(2 minutes)

215/18 Chair's Report

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 acknowledged the immense pressure all colleagues had been under in recent weeks and wished to thank everyone on behalf of the Board.

The Chair then referred the Board to the Board of Directors Role Description included at Annex A of the report. He noted that a review completed by the Director of Corporate Affairs had suggested that no amendments to the document were required and that, consequently, the Board was recommended to re-adopt the Role Description as presented. The Board of Directors subsequently approved the recommendation. In response to a question from the Chair, who queried whether the Board of Directors Role Description included appropriate emphasis on culture, the Interim Director of Workforce suggested that this subject could be considered during the Board development day on 26 October 2018.

The Board of Directors:

- Noted the Report of the Chair and adopted the Board of Directors Role Description.

(2 minutes)

216/18 Report of the Chief Executive

The Interim Chief Executive provided a verbal update with regard to national and local strategic and operational developments. She briefed the Board on the ongoing CQC inspection process, including the Use of Resources Assessment on 6 September 2018 and the unannounced core service inspection during week commencing 10 September 2018. The Interim Chief Executive advised that the planned CQC Well Led inspection would take place between 2-4 October 2018. She wished to thank all staff for their efforts during these inspections.

The Interim Chief Executive then briefed the Board on the Stockport Improvement Board held on 25 September 2018 and advised that Mr J Rouse, Chief Officer of the Greater Manchester Health & Social Care Partnership, had been encouraged regarding progress with the Trust's Quality agenda as well as Stockport Neighbourhood Care developments. The Interim Chief Executive was then pleased to report the following achievements: the Trust's Pathology department's reaccreditation with an ISO national standard; the Trust's Stroke Unit being rated the best in the country for the second year running; and the Trust's Finance Department being awarded a Level 3 rating, the

highest level of accreditation, by the Finance Skills Development Network. The Board of Directors wished to congratulate all involved for these fantastic achievements.

Mr M Sugden commended the processes in place in the Stroke Unit, including the measurement of metrics and audit assessments, which were embedded as 'business as usual'. He noted that other areas of the Trust could take positive learning from the Stroke Unit. The Interim Chief Executive acknowledged these comments and also noted the strong medical leadership in the Unit.

The Board of Directors:

- Received and noted the verbal Report of the Chief Executive.

(5 minutes)

217/18 Key Issues Reports

Quality Committee

Dr M Cheshire presented a Key Issues Report which detailed matters considered at a meeting of the Quality Committee held on 18 September 2018, noting that the Committee had considered a particularly full agenda. He briefed the Board on the content of the report and made particular reference to the 'Assurance' section of the report. Dr M Cheshire advised that the Committee had considered a report on the outcomes of analysis of Maternity dashboard indicators to determine whether there was a direct correlation between the rate of emergency caesarean sections and an increase in the number of diverts and formal complaints during the period April to July 2018. He noted that the Committee had been assured that no correlation had been identified from the analysis. Dr M Cheshire commented that, subsequent to the Committee meeting, he had sought further clarity from the Chief Nurse regarding the maternity dashboard.

The Chief Nurse then briefed the Board on Maternity related developments and advised that a report on this subject would be presented to the Quality Committee in November 2018. The Chief Nurse also briefed the Board on the preparation of an overarching Safeguarding Review & Action Plan and advised that an associated report would be presented to the Quality Committee in October 2018. In response to a question from the Chair, Dr M Cheshire advised that the Safeguarding Annual Report 2017, which was included on the Board agenda, had been presented to the Quality Committee in August 2018.

(5 minutes)

Finance & Performance Committee

Mr M Sugden presented a Key Issues Report which detailed matters considered at a meeting of the Finance & Performance Committee held on 19 September 2018. He briefed the Board on the content of the report and made reference to the 'Alert' section of the report. Mr M Sugden advised that the Committee had noted preparation of a trajectory for recovery, in conjunction with commissioners, to address the Referral to Treatment (RTT) waiting list size. He reported that the Committee had

requested that a full report on the recovery trajectory be presented at its next meeting on 24 October 2018. He noted that the Committee would also undertake a 'deep dive' on RTT at that meeting.

Mr M Sugden then referred the Board to the 'Assurance' section of the report and advised that the Committee had agreed that the Agency position currently resulted in a moderate level of assurance, in relation to outturn against the agency ceiling for the year, but noted a risk associated with winter pressures. He reported that, on the basis of the Month 5 Finance Report, the Committee was reporting limited assurance on overall delivery of the 2018/19 financial plan. Mr M Sudgen commented that the Committee had noted key risks relating to CIP delivery and elective/day case activity which could impact the full year outturn position. He then advised that, in reviewing the CIP Progress Report, the Committee remained concerned around identification of efficiency schemes to address a gap of circa £4.2m against the £15m target for the year. Mr M Sugden commented that, consequently, the Committee had been agreed that, at present, there remained only limited assurance on delivery of the CIP programme.

Mr M Sugden reported that, following discussion at the Board meeting on 30 August 2018, the Committee had considered a report which provided an update on progress to improve Clinical Correspondence performance. He advised that the Committee had acknowledged the assurance provided that the seven-day target for Clinical Correspondence would be achieved by 1 November 2018. Mr M Sugden advised that the Committee had considered a comprehensive report on the preparation of the Winter Plan 2018/19. He commented that, while the Committee acknowledged the significant efforts invested in preparing the plan, concerns remained regarding clarity on key projects, implementation costs and full agreement amongst system partners on Winter Plan content and prioritisation. Mr M Sugden advised that the Committee was consequently reporting low assurance on the robustness of the plan which would be the subject of a further discussion later on the agenda.

Mr M Sugden then referred the Board to the 'Advise' section of the report and noted that the Committee had recommended the draft Medium Term Financial Strategy to the Board of Directors for approval, while recognising the need for clear implementation plans. The Chair commented that a number of the areas raised in the Key Issues Report would be subject to detailed discussions later on the Board agenda. He was also pleased to hear about the improved Clinical Correspondence position, noting that he had visited the typing hub himself recently.

(4 minutes)

<u>People Performance Committee</u>

Ms A Smith presented a Key Issues Report which detailed matters considered at a meeting of the People Performance Committee held on 20 September 2018. She briefed the Board on the content of the report and made reference to the 'Alert' section of the report. Ms A Smith reported that the Head of Midwifery had presented a report which detailed a number of clinical risks associated with a deficit of 13.85wte between the funded midwifery staffing establishment and the establishment recommended by a Birthrate Plus workforce planning assessment. She noted that the Committee had been advised of action taken to partially reduce the deficit and noted

that a business case seeking to adjust the Midwifery staffing establishment was currently being progressed through the Trust's approval process. In response to a question from Ms A Smith, who queried whether the business case would require Board approval, the Director of Corporate Affairs advised that this would depend on the value of the investment.

In response to a question from Mrs C Barber-Brown, the Chief Nurse confirmed that the Trust was managing the staffing-related clinical risks pending resolution of the Midwifery staffing business case. She then briefed the Board on maternity related issues, including diverts. The Interim Director of Workforce reported that the Committee had then considered whether the Agency Utilisation report should continue to be presented to both the Finance & Performance Committee and the People Performance Committee. She noted that the Committee had recognised the two distinctly different purposes of the report and that it had been suggested that the Finance & Performance Committee should continue to consider the report from a financial impact perspective and the People Performance Committee from a quality impact perspective.

Ms A Smith then referred the Board to the 'Assurance' section of the report and reported that the Committee had taken positive assurance from a report on Medical Appraisal and Revalidation, noting, in particular, a Medical Staff Appraisal rate of 98.73% in 2017/18. She advised that the Committee had been similarly assured by the content of a draft People Strategy which was consequently recommended to the Board of Directors for approval. With regard to the 'Advise' section of the report, Ms A Smith advised that the Committee had reviewed an initial draft of a Nursing, Midwifery & Allied Health Professional Strategy. She commented that the Committee had endorsed both the inclusion of Allied Health Professionals and the presentation of the Strategy. Ms A Smith noted that a final review of the Strategy would be undertaken by the Committee in October 2018, prior to approval by the Board. Ms A Smith concluded her report by advising the Board that the Committee had considered an update report on 2017 Staff Survey Outcomes and noted that this was the subject of a separate item on the Board agenda.

(6 minutes)

<u>Audit Committee</u>

Mr D Hopewell presented a Key Issues Report which detailed matters considered at a meeting of the Audit Committee held on 24 September 2018. He briefed the Board on the content of the report and advised that, in considering the Internal Audit Progress Report, the Committee had noted Moderate Assurance from an Organisational Planning Review and Substantial Assurance from a Critical Application Review. With regard to the Organisational Planning Review, Mr D Hopewell reported that the Committee had been advised of preparation of a comprehensive planning framework. He advised that the intention was that the Planning Framework, together with details of lessons learned from experience in 2017/18, would be presented to the Board of Directors for approval on 31 October 2018.

With regard to the 'Assurance' section of the report, Mr D Hopewell reported that the Committee had taken positive assurance from a report detailing progress against the six priorities set out in the Risk Management Framework. He noted that one of the

associated objectives related to development of a revised Board Assurance Framework, which was also reviewed by the Committee. Mr D Hopewell advised that the Committee had endorsed the revised approach whilst acknowledging that further refinement of content was required. In response to a question from the Chair, Mr D Hopewell advised that objectives relating to the Risk Management Framework were due for completion by 31 March 2019, while noting that both the Risk Management Framework and the Board Assurance Framework would be refreshed on a continual basis. Mr D Hopewell then reported that the Committee had taken positive assurance from the outcomes of a six-monthly review of compliance with the NHS Foundation Trust Code of Governance.

With regard to the 'Advise' section of the report, Mr D Hopewell advised that the Committee had reviewed an Anti-Fraud Progress Report. He commented that the Committee had considered whether referral rates were low in comparison to similar sized organisations. Mr D Hopewell noted that, as a result of the discussion, the Anti-Fraud Specialist had agreed to identify and implement means of further awareness-raising across the organisation. Mr D Hopewell concluded his report by advising the Board that the Committee had met privately to discuss arrangements for the future procurement of both Internal and External audit services with both contracts scheduled to expire in 2019. He advised that the Director of Finance would progress this matter and noted the integral role of the Council of Governors in the appointment of an External Audit service provider.

(2 minutes)

The Board of Directors:

- Received and noted the Committee Key Issues Reports.

218/18 Trust Performance Report – Month 5

The Director of Support Services presented the Trust Performance Report for month 5 and provided a brief overview of content. He reported that the Trust had regained compliance with regard to emergency caesarean section rates and noted an improvement in complaints responses within 45 days. The Chief Nurse then briefed the Board on the Quality indicators in the Performance Report. She provided an overview on pressure ulcer performance, noting an overall improvement in performance. The Chief Nurse advised that performance relating to the Safety Thermometer: Hospital indicator had dipped just below target. She then reported an improved performance with regard to Venous Thromboembolism (VTE) Risk Assessments. The Chief Nurse noted four Duty of Candour breaches in month and commented that the position was expected to improve. She also reported three Clostridium Difficile infections this month, noting a correlation with hand hygiene audits.

The Chief Nurse then made reference to the improved complaints response rate, noting further work that was ongoing to continue the improvement. The Medical Director referred the Board to the Mortality Rates section on page 29 of the report and provided an overview regarding the difference between HSMR and SHMI metrics. He noted that the HSMR rate was a cause for concern but that assurance provided through SHMI outcomes suggested that the mortality alerts were associated with coding practice, particularly in relation to palliative care. The Medical Director advised

the Board that an AQuA quality improvement project was reviewing the Trust's HSMR data to determine that this was the case. In response to a question from the Chair, the Medical Director noted that the Board would receive an update on progress in approximately three months' time.

In response to a question from Mrs C Barber-Brown, regarding delayed transfers of care and the A&E 4-hour performance, the Urgent & Emergency Care Improvement Director briefed the Board on developments in this area, noting that a monthly dashboard would be produced at the end of September 2018 which would provide greater clarity regarding pressure areas and enable improved target setting and accountability. The Chief Operating Officer then briefed the Board on the Performance indicators in the report, noting that the Cancer 62-day performance had remained an area of concern in August 2018. She noted that, while the position had improved in September 2018, the significant increase in cancer referrals was having an adverse effect on performance, particularly in the area of breast services. The Chief Operating Officer briefed the Board on developments in this area, noting that the Regulators had called an urgent meeting on 28 September 2018 to seek support to the Trust from Greater Manchester peers.

The Chief Operating Officer reported that Emergency Department (ED) performance remained challenging, noting the following three areas of concern: overnight breaches, relating to flow and workforce; early discharges; and stranded patients. She briefed the Board on developments in this area and advised that the Improvement Board was undertaking a 'deep dive' into stranded patients. In response to a question from Mr D Hopewell, the Chief Operating Officer provided further clarity with regard to the stranded patient performance. In response to a follow up question from the Chair, the Chief Operating Officer noted that the stranded patient position had not yet impacted upon elective surgery performance. She briefed the Board on issues regarding outliers in Surgery and explained the 'ring fencing' of elective capacity in the Winter Plan. The Chair noted a concern regarding income versus plan with regard to elective activity. The Chief Operating Officer noted an issue regarding lost capacity in certain specialties due to case mix change and workforce issues. The Urgent & Emergency Care Improvement Director briefed the Board on work with the Stockport Clinical Commissioning Group and the system to improve traction in the area of stranded patients.

Dr M Cheshire commented that he had attended a Junior Doctors' Forum the previous week and noted that one of the big issues raised by the ED Doctors was the management of overnight patients by the day staff. The Chief Operating Officer acknowledged these concerns and noted an issue regarding overnight workforce and processes. In response to a further comment from Dr M Cheshire, the Chief Operating Officer agreed that increased senior decision making would help with the flow of patients and noted work in this area in the context of Healthier Together. The Medical Director also briefed the Board on work in this area, noting that the number of senior medical staff had already increased in ED, making the department more attractive from a workforce perspective. In response to a question from Dr M Cheshire, the Urgent & Emergency Care Improvement Director advised the Board of a planned Emergency Department upgrade, noting that the first phase would commence during week commencing 17 December 2018, and the second phase at the end of February 2019. She advised that the plans were on track and that the work would create additional capacity in the department.

In response to a question from Dr M Cheshire, regarding unused capacity in Stockport and balance of responsibility regarding discharge arrangements, the Urgent & Emergency Care Improvement Director noted that this subject matter would be explored further during the consideration of the Winter Plan and the Board workshop later in the afternoon. The Chief Operating Officer also commented that the issue would be considered as part of the deep dive into stranded patients, referred to earlier. The Chief Operating Officer then briefed the Board on the Referral to Treatment (RTT) standard, noting that the Finance & Performance Committee had requested a 'deep dive' to the standard at its next meeting. She noted preparation of a trajectory for recovery, in conjunction with commissioners, to address the RTT waiting list size. The Chief Operating Officer advised that the recovery plan focused on the following four themes: referral/demand management; increased activity; data quality and validation; and discharge thresholds. In response to a question from the Chair, Mr D Hopewell noted that the Audit Committee had also highlighted data quality as an area of concern and advised that the results of an associated audit would be available in a few months' time.

The Director of Finance then briefed the Board on the Finance indicators in the report. He reported that the Trust was slightly ahead of its Financial Plan and provided an overview of issues relating to elective and day case performance. The Director of Finance noted that the major issue relating to the overall financial performance was performance against the Cost Improvement Programme (CIP). He advised that Mr M Brearley, Interim Director of CIP, was undertaking a line by line review of budgets and that a full review of provisions and revisions of contingencies was also underway. The Board noted that this subject would be further considered at the Private Board meeting as it contained commercial in confidence elements.

With regard to the Trust's Cash position, the Director of Finance advised that in September 2018, the Trust had signed an agreement to borrow £2.3m and had requested a further £2.6m in October 2018. He advised that the planned level of borrowing to March 2019 was £24.7m. Mr D Hopewell commented that the Board should not lose sight and take false assurances of being on plan at this stage, noting the seriousness of the financial situation. The Director of Finance acknowledged these comments and noted that the significant financial deficit was incorporated in the Medium Term Financial Strategy. The Interim Director of Workforce then briefed the Board on the Workforce indicators in the report. She briefed the Board on sickness absence performance and associated initiatives and noted that the report included additional information in this area, including comparative data and financial implications.

The Interim Director of Workforce was pleased to report a significant decrease in nursing and midwifery turnover in month. The Chief Nurse referred the Board to the Safe Staffing Report and noted that staffing had been particularly challenging in August 2018, especially in the Emergency Department and the Acute Medical Unit. She briefed the Board on mitigating actions in this area and noted that the Trust was involved in as many collaboratives as possible. The Interim Director of Workforce was pleased to report that the first cohort of nurse associates had finished training and that a number of them had approached the Trust seeking permanent positions. She also wished to recognise the tremendous efforts of staff given the challenges experienced in August 2018. The Chair summarised the discussion and commented that, while the

Performance Report was improving, further focus was required on forward looking assurances to get performance back on track.

The Board of Directors:

- Received and noted the Trust Performance Report for Month 5.

(37 minutes)

219/18 Winter Plan 2018/19 – Update Report

The Urgent & Emergency Care Improvement Director presented a report which provided an update on progress with regard to the system Winter Plan. In response to a question from the Chair, the Urgent & Emergency Care Improvement Director noted that progress had been made since the report had been written regarding funding issues around staffing beds. The Board noted that further detail would be provided at the Board workshop later in the afternoon. The Urgent & Emergency Care Director also briefed the Board on the development of a winter monitoring plan, noting that the subject matter should be considered as part of whole year performance rather than concentrating on a specific winter plan.

In response to a question from the Chair, the Urgent & Emergency Care Director briefed the Board on work with regard to the risk relating to the availability of resources, noting that this area remained a significant risk even if fully funded. She noted good engagement from partners and commented that this subject matter would be further explored later during the Board workshop. Mr M Sugden acknowledged the work relating to the preparation of the Winter Plan but noted his disappointment at the delay in the agreement of the whole health economy Winter Plan. He commented that it was not just about agreeing the plan but also about implementing and resourcing it. Mr M Sugden noted the need to get a commitment from partners to move to an all year round plan going forward. The Urgent & Emergency Care Director acknowledged these comments and noted that the process would require evaluation at the end of the winter period. She advised that progress was being monitored by the Urgent Care Delivery Board.

In response to a question from Dr M Cheshire, the Urgent & Emergency Care Director briefed the Board on associated recruitment plans for the Winter Plan, noting a multi-faceted approach if medical staff recruitment proved unsuccessful. In response to a question from Mrs C Barber-Brown, regarding stranded patients, the Urgent & Emergency Care Director briefed the Board on system-wide work to resolve issues around areas such as packages of care. She advised the Board that a final fully costed Winter Plan, together with a monitoring plan and a system escalation plan, would be presented to the Board of Directors on 31 October 2018.

The Board of Directors:

- Received and noted the Winter Plan Update Report.

(11 minutes)

220/18 Quality Improvement Plan

The Chief Nurse presented a report which provided progress against the seven themes from the Quality Improvement Plan for Quarter 1 2018/19, noting that the report had also been considered by the Executive Management Group and the Quality Committee. She provided an overview on the content of the report and noted significant progress against each of the seven themes. The Chief Nurse advised that four themes were on-track and three off-track but recoverable, noting that it was anticipated that the off-track themes would be rectified in Quarter 2 as far as possible. The Board of Directors commended the paper as an exemplar report.

The Board of Directors:

- Received and noted the Quality Improvement Plan progress report.

(1 minute)

221/18 Liverpool Community Health – Independent Review

The Chief Nurse presented a report which detailed outcomes of a gap analysis against outcomes of the Liverpool Community Health Independent Review, noting that the report had also been considered by the Quality Committee. She briefed the Board on the content of the report and noted the assurance provided that relevant areas were actively monitored by management groups with assurance reports to appropriate Board Committees. In response to a question from Mr M Sugden, the Chief Nurse noted that the Board could take equal levels of assurance from both a hospital and community perspective, noting that the same QIA process was used for both areas.

The Chair commented on the need to ensure a culture of openness was there to support the delivery of the policies. Dr M Cheshire commended the clarity of the report, noting that the report writer, the Deputy Chief Nurse, had received report writing advice from the Director of Corporate Affairs. He commended the support to anyone involved in report writing.

The Board of Directors:

- Received the report and noted positive assurance provided form outcomes of the gap analysis.

(4 minutes)

222/18 Trainee Experience

The Medical Director presented a report which outlined concerns raised by a number of trainee doctors with regard to issues relating to the Trust's 'out of hours' medical provision. He briefed the Board on the content of the report and noted the concerns raised and the resultant actions. The Medical Director commented that the Trust's response to the concerns had been prompt and had led to a considerable improvement in the trainee feedback. He made reference to the forthcoming site visit by Health Education England North West (HEE NW) on 4 October 2018 and the

possibility that some of the concerns raised by the trainees might be reflected in the outcome of the visit. He reiterated, however, that the experience of trainee doctors had improved considerably following the actions taken by the Trust. The Chief Nurse endorsed these comments and noted the positive development of safety huddles.

The Board of Directors:

- Received and noted the report and were assured that the Trust's response had been rapid and proportionate.

(2 minutes)

223/18 People Strategy

The Interim Director of Workforce presented the People Strategy for consideration and approval of the Board. She briefed the Board on the content of the report and advised that the draft strategy had been developed through a wide engagement and consultation process, involving key staff groups, staff representative groups and external advisors. The Interim Director of Workforce advised that the draft strategy had been developed taking account of the Trust's current ambitions and challenges and of the changing system in which it operated. She reported that the People Strategy aligned with the developing Trust Strategy, and would support the successful achievement of the Trust's priorities and strategic objectives.

The Interim Director of Workforce referred the Board to page 3 of the strategy and noted a number of minor changes made to the wording in the 'Values' section following feedback received to ensure a correct tone. She noted that, as a consequence, there was a slight discrepancy with the Trust's values. In response to a comment from the Director of Corporate Affairs, there followed a discussion regarding the values and whether it would be prudent to revise the Trust Strategy, including all supporting strategies, to ensure consistency. In conclusion of the discussion, the Board agreed the wording in the Values section and it was not deemed necessary to amend all other strategies to align with the People Strategy.

The Interim Director of Workforce then briefed the Board on the content of the People Strategy and provided an overview of the following themes: Education & Practice Development; Culture & Engagement; Leadership Development; Resourcing; and High Performing. She thanked colleagues for their feedback which had been useful in the development of the strategy format. The Interim Director of Workforce advised that the five strategic priorities would be delivered through a number of delivery groups with assurance provided via the People Performance Committee. She commented that, following feedback received from Dr M Cheshire, the actions detailed in the People Strategy Map would be colour coded.

Mrs C Barber-Brown made some suggestions regarding the strategy content, including a need to ensure consistency with regard to the description of culture. She also commended the inclusion of the People Strategy Map. In response to a comment from the Chair, regarding future proofing of the strategy and consistency of approach across system partners, the Interim Director of Workforce advised that this could be taken into account during initial review of the strategy document.

The Board of Directors:

- Approved the People Strategy as presented, subject to a number of minor presentational amendments.

(19 minutes)

224/18 Staff Survey 2017 Outcomes – Update Report

The Interim Director of Workforce presented a report which provided an update on progress against actions arising from the 2017 Staff Survey. She briefed the Board on the content of the report and noted that, due to the limited time available between staff surveys, the Trust was taking a broader approach to culture and engagement and had developed a Culture & Engagement Plan (CEP). The Interim Director of Workforce advised that the CEP included actions to address the issues identified in the Staff Survey, as well as Leadership & Development; Equality, Diversity & Inclusion; and Workforce Health & Wellbeing. She reported that delivery against the plan was monitored by the Culture & Engagement Group with assurance provided via the People Performance Committee on a quarterly basis.

The Interim Director of Workforce advised the Board that the Trust was working with NHS Improvement (NHSI) to establish a way in which various pieces of feedback could be gathered in a way that would facilitate thematic analysis. She noted that NHSI would support the Trust in this area and advised the Board of the development of an associated dashboard. The Director of Corporate Affairs noted the closure of actions from the 2017 Staff Survey and reiterated that, going forward, emphasis would be on the Culture & Engagement Plan rather than staff survey actions.

The Board of Directors:

- Received the report and noted the recommendations at s7 of the report.

(5 minutes)

225/18 Medical Appraisal & Revalidation

The Medical Director presented a report prepared for annual review by the Board of Directors on the subject of Medical Appraisal & Revalidation. He briefed the Board on the content of the report and advised that the report had also been considered by the People Performance Committee. The Medical Director noted that good progress had been made with regard to medical appraisal and revalidation and noted, in particular, the positive outcomes identified in the Annual Organisational Audit (AOA) Report. He then provided an overview of the positive outcomes from a Three Way Peer Review as detailed at Appendix 1 to the report. In response to a question from Mr M Sugden, the Medical Director advised that, providing that trusts followed the due processes, there were no consequent legal implications.

The Board of Directors:

- Received and noted the report and approved the report for Chief Executive completion of the compliance statement.

(4 minutes)

226/18 Safeguarding Annual Report 2017/18

The Chief Nurse presented a Safeguarding Children & Adults Annual Report 2017/18. She briefed the Board on the content of the report, noting that the report had also been considered by the Quality Committee and local safeguarding children and adults' boards. The Chief Nurse commented that safeguarding activity was increasing as a consequence of an increased agenda. In response to a question from Mr D Hopewell, the Chief Nurse provided further clarity regarding safeguarding children's training compliance. She also briefed the Board on work to improve the quality of training and the governance systems in place to oversee and monitor training compliance.

The Board of Directors:

- Received and noted the Safeguarding Annual Report.

(5 minutes)

227/18 Trust Strategy

The Director of Support Services presented the Trust Strategy 2018-2022 to the Board of Directors. He advised that the Board was requested to approve the Trust Strategy document for consultation to commence on 1 October 2018. He briefed the Board on the content of the report and noted that the Strategy had been presented to the Executive Management Group and a new Strategy & Planning Group. The Director of Support Services commented that the feedback received, including from Associate Medical Directors and Clinical Directors, had been relatively positive. He also briefed the Board on plans in place for internal and external consultation, including roadshows and involvement of the Council of Governors. The Chair commented that the Board of Directors had spent a considerable time to date considering the draft Strategy.

There followed a discussion during which a number of comments were made and minor amendments were suggested with regard to content, including typographical errors. The Chair commended the Trust Strategy for having clearer articulation about expectation setting and the Trust's journey of improvement. The Director of Support Services acknowledged these comments and noted that the Strategy would need to be adjusted in light of any significant external strategic changes. In response to a question from Mr M Sugden, who queried whether Attain would continue to work with the Trust in this area, the Director of Support Services advised that the Trust had taken a decision to undertake staff consultation in-house and that Attain's services were therefore not required at this stage. In response to a question from the Chair, the Director of Support Services advised that a progress report would be presented to the Board of Directors on 29 November 2018. He noted that a further report would be presented to the Board at the end of the consultation period in January 2019.

The Board of Directors:

- Received the report and approved the Trust Strategy document for consultation to commence on 1 October 2018.

(9 minutes)

Mr J Killeen and Mr M Reed joined the meeting.

228/18 Estates Strategy

The Director of Support Services presented the Estates Strategy to the Board of Directors. He noted that the Board had received a high level presentation on the Estates Strategy on 26 July 2018 and that the Board was now requested to approve the strategy. The Director of Support Services briefed the Board on the main drivers in the strategy, including the age of estate and Stockport Together developments. The Director of Estates & Facilities advised that the draft Estates Strategy had been presented to a number of stakeholder organisations and had been very well received. He noted that the strategy would continue to be a working document and it was agreed that progress reports would be presented to the Board on a 6-monthly basis.

There followed a discussion during which the following points were raised:

- There was a need for the Estates Strategy to respond to the full Trust Strategy and 'tie in' with other supporting strategies such as the Medium Term Financial Strategy
- Community estate was not included in sufficient detail
- S6 would need to be taken into account with Clinical Strategy
- A number of Board members felt that an inclusion of an 'at a glance road map', as used in the People Strategy, would enhance presentation and provide further clarity regarding first stages of delivery of the strategy
- There was a need for clarity regarding monitoring arrangements and funding options
- The Estates Strategy was welcome in light of the significant challenge of delivering 21st century healthcare in a Victorian building
- There was discussion regarding financial achievability of plans versus ambition and ability to prepare bids.

In response to a question from Mrs C Barber-Brown, the Director of Finance confirmed that the Estates Strategy was sufficient to enable the Trust to meet the necessary criteria for a loan. He noted the challenge regarding limited capital resources and briefed the Board on issues and developments in this area. In response to a question from Mr D Hopewell, the Chair advised that s8.4 of the Estates Strategy provided further information regarding backlog maintenance costs. The Chair summarised the discussion and noted that the Board was content to approve the Estates Strategy, noting that it would remain a 'work in progress' document. He also reiterated the earlier suggestion to include an 'at a glance' road map, as used in the People Strategy.

The Board of Directors:

- Approved the Estates Strategy and agreed that progress reports would be presented to the Board on a 6-monthly basis.

(21 minutes)

Mr J Killeen and Mr M Reed left the meeting.

229/18 Medium Term Financial Strategy

The Director of Finance presented a report seeking a recommendation for approval of a draft Medium Term Financial Strategy (MTFS). He advised that the Finance & Performance Committee had recommended the MTFS for Board approval, following consideration of the draft strategy at its meeting on 19 September 2018. The Director of Finance briefed the Board on the content of the report and noted the work of a task and finish group in further developing the Strategy document following initial review by the Board on 26 July 2018. He noted that further consideration would be given to in-year recovery at the Private Board meeting this afternoon. The Director of Finance also acknowledged the comments regarding the inclusion of an 'at a glance road map'.

Mr M Sugden briefed the Board on discussion at the Finance & Performance Committee regarding the MTFS and advised that the Committee had acknowledged the draft strategy as a 'first stage', noting an urgent need to establish the next level of deliverability. The Chair and the Interim Chief Executive commented on the need to be clear on the required content of a strategy versus a delivery plan. There followed a discussion regarding the MTFS and whether the Board believed that the Five-Point improvement plan included the key areas of focus and whether the reduction of the deficit over a five-year period was sufficiently ambitious. A range of views were raised on whether the strategy was deemed fit for purpose and whether the content would satisfy NHS Improvement's expectations. It was also felt that the strategy did not include sufficient information regarding consequences.

In conclusion of the discussion, the Board agreed that the strategy document required further refinement prior to re-presentation to the Board on 31 October 2018. It was noted that the Trust was therefore required to present the MTFS in a draft form to the NHSI Oversight Meeting on 16 October 2018.

The Board of Directors:

- Received and noted the report and agreed that the Medium Term Financial Strategy document required further refinement prior to re-presentation to the Board on 31 October 2018.

(19 minutes)

230/18 Proposed Amendments to Constitution

The Director of Corporate Affairs presented a report seeking a recommendation for approval of proposed amendments to the Trust's Constitution. He briefed the Board on the content of the report and provided an overview of proposals relating to Meeting Attendance Requirements for Governors and Nominations Committee membership. The Director of Corporate Affairs advised that the potential amendments had been considered by both the Governors' Governance & Membership Committee and the Executive Management Group, and that recommendations had been made for approval of both amendments. The Board of Directors consequently approved the proposed amendments and noted that a report for final approval would be presented to the next meeting of the Council of Governors in October 2018.

The Director of Corporate Affairs then referred the Board to s4 of the report and provided an overview of matters relating to a cap on the tenure of Governors. He advised that there was currently no upper limit specified in the Trust's Constitution regarding the overall tenure of Governors which, he noted, was unusual in comparison to the overwhelming majority of NHS Foundation Trusts. The Director of Corporate Affairs advised that the discussion of this matter by the Governance & Membership Committee had been inconclusive and the outcome of the Committee's deliberation was that the matter should be referred to the Council of Governors for consideration. It had been suggested that consideration of this matter by the Council of Governors should be informed by a view from the Board of Directors on the proposed amendment. The Director of Corporate Affairs advised that the subject had also been considered at the Executive Management Group meeting on 18 September 2018 and that the proposal at s4.3 of the report, to include an upper limit for the tenure of Governors, was endorsed on the basis that the approach reflected good governance practice.

There followed a discussion during which the following points were raised:

- There was support for the introduction of a maximum term of office for Governors to bring the Trust in line with other Foundation Trusts and promote good governance
- Similar 'pros and cons' applied with regard to a maximum term of office for Non-Executive Directors, for whom a maximum term was specified
- A maximum term of office was necessary to ensure periodic refresh of the composition of the Council of Governors.

In conclusion, the consensus of the Board of Directors was to support the introduction of a maximum term of office for Governors. The Director of Corporate Affairs thanked the Board members for offering their view which would be provided to the Council of Governors to inform their discussion on the subject.

The Board of Directors:

- Received and noted the report.
- Approved the proposed amendments to the Constitution set out at s3.3 and s3.6 of the report and provided a view on the matter of maximum tenure of Governors.

(6 minutes)

231/18 Trust Risk Register

The Chief Nurse presented the Trust Risk Register and provided an overview of content. She noted that the five top themes related to staffing, performance, finance, regulatory activity and equipment. The Chief Nurse advised that the Trust Risk Register had been considered by the Executive Management Committee as well as the Board Assurance Committees. She noted that training was required to improve the process with regard to the categorisation and scoring of risks.

The Board of Directors:

- Received and noted the Trust Risk Register.

(2 minutes)

232/18 Board Assurance Framework

The Chief Nurse presented the Board Assurance Framework (BAF) for Quarter 1 and briefed the Board on content. She provided an overview of the development of a revised BAF format and used the entry for Strategic Objective 2 to describe the various elements of the Framework content. The Chief Nurse noted that the revised format provided a greater degree of correlation with the associated high level risks for each area.

In response to a question from Mrs C Barber-Brown, the Chief Nurse provided further clarity regarding the assurance ratings and the difference between the 'Adequacy of Assurance' and 'Overall Assessment of Assurance' ratings. In response to a comment made by the Director of Corporate Affairs, regarding a need to balance the content, it was noted that a specific Board session on the BAF was scheduled for November 2018. Board members endorsed the revised format of the BAF while acknowledging that some further refinement was required. In response to a comment from Mrs C Barber-Brown, the Chief Nurse advised that the risks would be aligned with those included in the Trust Strategy.

The Board of Directors:

- Received and noted the Quarter 1 Board Assurance Framework.

(7 minutes)

233/18 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 Wednesday, 31 October 2018, commencing at 9.30am in Lecture Theatre A, Pinewood House.

Signed:_____Date:_____

BOARD OF DIRECTORS: ACTION TRACKING LOG

Ref.	Meeting	Minute Ref	Subject	Action	Responsible
19/18	28 Jun 18	152/18	People Performance Committee Key Issues report	In response to a question from the Chair, the Interim Director of Workforce advised that a draft Workforce Strategy would be available for initial review by the Board in September 2018. **Update 27 Sep 18** – People Strategy on agenda. Action complete.	H Brearley (Interim Director of Workforce)
20/18	28 Jun 18	156/18	Update on 2017 Staff Survey Outcomes	The Interim Director of Workforce agreed to present a progress report to the Board on 27 September 2018. **Update 27 Sep 18** – Report on agenda. Action complete.	H Brearley (Interim Director of Workforce)
21/18	26 Jul 18	179/18	Performance Report	In response to a question from the Chair, it was agreed to schedule a follow-up development session on the use of the revised Performance Report in Autumn 2018. **Update 27 Sep 18** – The Director of Corporate Affairs advised that the session was scheduled for 13 November 2018. Action complete.	Mr P Buckingham (Director of Corporate Affairs)
22/18	26 Jul 18	181/18	Winter Plan – Progress Report	The Urgent & Emergency Care Improvement Director advised that a fully-costed Winter Plan document would be presented to the Board of Directors on 27 September 2018. **Update 27 Sep 18** – The Urgent & Emergency Care Improvement Director advised that a Winter Plan report was included on the agenda but that the presentation of a fully-costed Winter Plan would now take place at the Board meeting on 31 October 2018.	Mrs J Wood (U&EC Improvement Director)
23/18	26 Jul 18	187/18	Draft Estates Strategy	It was agreed that a final draft of the Estates Strategy would be presented to the Board of Directors for approval on 27 September 2018. **Update 27 Sep 18** – Draft Estates Strategy on agenda. Action complete.	Mr H Mullen (Director of Support Services)
24/18	30 Aug 18	206/18	Report of the Chief Executive	The Interim Chief Executive reported that the Secretary of State for Health & Social Care had written to NHS organisations on 23 August 2018 to advise of the Government's preparations for a 'No Deal' Brexit scenario. The Director of Support Services advised that the subject matter would be	Mr H Mullen (Director of Support Services)

				discussed at the Emergency Preparedness, Resilience & Response (EPRR) meeting in September 2018, a meeting which would be attended by Mrs C Anderson. He agreed to circulate any outcomes from the discussion to Board members. **Update 27 Sep 18** – The Director of Support Services confirmed that the outcomes had been circulated to Board members. Action complete.	
25/18	30 Aug 18	208/18	Trust Performance Report – Month 4	In response to a question from Mr D Hopewell, who queried the financial impact of sickness absence to the Trust, the Interim Director of Workforce commented that work was still ongoing to understand these figures but that the information would be available for the Board meeting in September 2018. **Update 27 Sep 18** – The Interim Director of Workforce confirmed that this information was included in the Performance Report. Action complete.	Ms H Brearley (Interim Director of Workforce)
26/18	30 Aug 18	208/18	Trust Performance Report – Month 4	There followed a discussion regarding Clinical Correspondence performance and, in conclusion, the Board requested that a resolution be presented to the Board meeting on 27 September 2018 detailing how the Trust was planning to regain compliance by the end of the Financial Year. **Update 27 Sep 18** – The Director of Corporate Affairs noted that this subject matter had been considered by the Finance & Performance Committee and that Board members were advised of the outcome via the Committee's Key Issues Report. Action complete.	Mr S Goff (Deputy Chief Operating Officer)
27/18	30 Aug 18	209/18	Elective Care Expectations	In response to a question from Mr M Sugden, regarding the sign off process for the Trust's response to Mr I Dalton's letter, the Deputy Chief Operating Officer advised that the Interim Chief Executive would respond to NHSI in writing by the deadline date of 5 September 2018. The Interim Chief Executive agreed to circulate the Trust's response to Board members for information. **Update 27 Sep 18** – The Interim Chief Executive confirmed that the Trust's response had been circulated to Board members. Action complete.	Mrs H Thomson (Interim Chief Executive)
28/18	27 Sep 18	227/18	Trust Strategy	The Director of Support Services advised that a progress report would be	

				presented to the Board of Directors on 29 November 2018 and noted that a further report would be presented to the Board at the end of the consultation period in January 2019.	H Mullen (Director of Support Services)
29/18	27 Sep 18	229/18	Medium Term Financial Strategy	In conclusion of the discussion, the Board agreed that the strategy document required further refinement prior to re-presentation to the Board on 31 October 2018.	F Patel (Director of Finance)

This page has been left blank

NHS
Stockport
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	31 October 2018
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 ☐ Council of Governors ☐ Audit Committee ☐ Executive Team ☐ Quality Committee ☐ F&P Committee ☐ PP Committee ☐ SD Committee ☐ Charitable Funds Committee ☐ Nominations Committee ☐ Remuneration Committee ☐ Joint Negotiating Council ☐ Other

- THIS PAGE IS INTENTIONALLY BLANK -

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 The Care Quality Commission (CQC) completed a Well-Led Review of the Trust from 2-4 October 2018. This followed an unannounced core service inspection carried out during week commencing 10 September 2018 and a Use of Resources Assessment which was undertaken on 6 September 2018. The Well-Led Review concludes the current cycle of CQC inspections and we anticipate that the report will be published at some point in December 2018.

2.2 The Trust continues to experience severe operational pressures, characterised by poor patient flow through the hospital and high levels of 'stranded' patients i.e. those patients who have been in hospital for seven days or longer. This situation has a consequent impact on performance against key standards and, in particular, performance against the A&E 4-hour standard. The operational pressures will feature heavily during consideration of the Integrated Performance Report at the meeting on 31 October 2018.

3. BOARD DEVELOPMENT

3.1 Successful interviews were held for the post of substantive Chief Executive on 1 October 2018 which resulted in the appointment of Mrs Louise Robson who is scheduled to commence employment with the Trust on 7 January 2019. We are currently liaising with Mrs Robson to agree role profiles for the Director of Workforce and Company Secretary positions prior to commencing relevant recruitment processes.

3.2 Board members will participate in a facilitated Board Development day on Friday, 26 October 2018. The day, which is focused on Relationships & Team Building, will be facilitated by Mr C Lewis, CBE and will build upon an initial session held in April 2018.

4. CHAIR ENGAGEMENTS

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

27 September 2018	Joint dinner attended by Leaders and Chairs from Tameside and Stockport Councils and the respective NHS Foundation Trusts

1 October 2018	Chaired a Council of Governors meeting for appointment of a Chief Executive
3 October 2018	Visited the Occupational Health team
3 October 2018	Attended the Pennine Care NHS Foundation Trust Annual General Meeting
4 October 2018	Well-Led Review interview and initial feedback
9-10 October 2018	Attended the NHS Providers Annual Conference in Manchester
9 October 2018	Hosted the Trust's Annual Members' Meeting at Edgeley Park
10 October 2018	Attended a North West Chairs Dinner in Manchester
16 October 2018	Met with Councillor Tom McGee to discuss Health & Wellbeing Board development
16 October 2018	Attended an Enhanced Oversight meeting with NHS Improvement representatives
23 October 2018	Attended a SMBC workshop to agree Health & Wellbeing Board developments
23 October 2018	Visited Ward D2
25 October 2018	Chaired a Council of Governors meeting.
26 October 2018	Board Development day.

5. REGULATORY DEVELOPMENTS

5.1 The Enhanced Oversight meeting with NHS Improvement representatives on 16 October 2018 was challenging, as expected. Further work to develop the Trust's Medium Term Financial Strategy is required and great emphasis was placed on the imperative of both cost improvement programme delivery in-year and the preparation of efficiency plans for 2019/20.

6. FORWARD LOOK

6.1 Meetings referenced above relating to development of the Stockport Health & Wellbeing Board will result in the Trust's active involvement with this reconstituted body, for the first time, in November 2018. Reconstitution of the Health & Wellbeing Board was a priority action resulting from the recent CQC Local System Review.

7. RECOMMENDATIONS

7.1 The Board of Directors is recommended to:

- Receive and note the content of the report.

NHS
Stockport
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	31 October 2018
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: • EU Exit NHS Trust Contract Review
Board Assurance Framework ref:	
CQC Registration Standards ref:	N/A
Equality Impact Assessment:	☐ Completed ☐ Not required

Attachments:	Annex A: Letter from Secretary of State for Health and Social Care dated 12 Oct 18

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

- THIS PAGE IS INTENTIONALLY BLANK -

1. PURPOSE OF THE REPORT

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

2. EU EXIT NHS TRUST CONTRACT REVIEW

2.1 The Secretary of State for Health and Social Care wrote to NHS Chief Executives on 12 October 2018 on the subject of preparations to ensure continuity of supply of goods and services in the event of a 'no deal' exit from the EU. A copy of the correspondence is included for reference at Annex A to this report.

2.2 The letter states that, while a 'no deal' scenario remains unlikely, the Department of Health and Social Care (DHSC) has been asked to put plans in place to ensure continuity of supplies to the NHS. As part of these plans, the DHSC has developed a self-assessment methodology for NHS Trusts to use to identify contracts that may be impacted by EU exit. Trusts are required to complete the self-assessment and provide DHSC with a summary of contracts deemed highly impacted by 30 November 2018. Trusts are also required to appoint a Senior Responsible Officer (SRO) with a direct link to the Board to oversee this activity.

2.3 Board members are requested to note that completion of the self-assessment methodology will be undertaken by the Head of Procurement. The Director of Finance will act as the Senior Responsible Officer for this activity. Outcomes of the self-assessment will be reported to the Board of Directors prior to submission to DHSC.

3. RECOMMENDATIONS

3.1 The Board of Directors is recommended to:

- Receive and note the content of the report.

This page has been left blank

Department of Health & Social Care

From the Rt Hon Matt Hancock MP
Secretary of State for Health and Social Care

39 Victoria Street
London
SW1H 0EU

020 7210 4850

12 October 2018

Dear Chief Executive,

EU Exit NHS Trust Contract Review

I am writing to advise you of a forthcoming communication to your Trust's Head of Procurement. The communication will consist of a pack of materials, setting out what your Trust needs to do to step up preparations to ensure continuity of supply of goods and services in the event of a 'no deal' exit from the EU.

A scenario in which the UK leaves the EU without agreement (a 'no deal' scenario) remains unlikely given the mutual interests of the UK and the EU in securing a negotiated outcome. Following the publication of the UK government's white paper for the future relationship on 12 July 2018, we are working with the EU's negotiating team at pace to agree the terms of our future relationship alongside the Withdrawal Agreement later this year. However, it is our duty as a responsible government to prepare for all eventualities, including 'no deal', until we can be certain of the outcome of those negotiations. I have therefore asked my Department to put plans in place to ensure the continuity of supplies to the NHS.

DHSC has been working closely with Cabinet Office to implement a cross-Government approach to identifying contracts that may be impacted by potential changes to trading relations with the EU, and developing mitigating actions to help ensure that there are suitable arrangements in place at the point of exit.

As part of this activity, DHSC has developed a self-assessment methodology for NHS Trusts to use to identify contracts that may be impacted by EU exit. This methodology has been tested with four Trusts, covering Acute, Mental Health and Ambulance, and was presented and discussed at the recent DHSC Commercial Conferences.

DHSC will be sharing the details of this methodology with Trust Heads of Procurement today. The prompt completion of this methodology is of the upmost importance. I am therefore asking you to appoint a Senior Responsible Officer (SRO) with a direct link to your executive board to oversee this. Please ensure that your staff

Department of Health & Social Care

From the Rt Hon Matt Hancock MP
Secretary of State for Health and Social Care

39 Victoria Street
London
SW1H 0EU

020 7210 4850

prioritise this activity appropriately, and that updates on progress are incorporated into your existing governance arrangements.

Your Trust is asked to provide DHSC with a summary of those contracts deemed highly impacted, along with your Trust's planned mitigating activities, by 30 November 2018. The specific requirements for self-assessment will be set out in the letter to your Trust's Head of Procurement.

It is acknowledged that a number of categories/ suppliers are best engaged with at a national level. Today's DHSC communications will include a list for categories/ suppliers that are being managed by DHSC, such as the supply of medicines. This should reduce the scope of work for your Trust, and therefore the resource requirements within your organisation to complete the exercise.

A copy of this letter has been sent to the Finance Director and Head of Procurement in your Trust.

I would like to personally thank you for your support with this important piece of work, which will safeguard patient care in the unlikely event of a 'no deal' EU exit.

Yours ever,

MATT HANCOCK

NHS
Stockport
NHS Foundation Trust

Board of Directors' Key Issues Report

Report Date: 31/10/18		**Report of:** Quality Committee
Date of last meeting: 23/10/18		**Membership Numbers:** Quorate
1.	**Agenda**	The Committee considered an agenda which included the following: • Quality Metrics • Seven Day Services Report • Learning from Deaths Report • Safe, High Quality Care Improvement Plan • Quarterly Clinical Governance Report • Clinical Audit Report • Key Issues Reports: - Quality Governance Group - Safeguarding Group - Patient Experience Group - Medicines Optimisation Group • Trust Risk Register • Board Assurance Framework
	Alert	• In considering the Learning from Deaths report, the Committee was disappointed with the reported position on evidenced Morbidity & Mortality meetings across a range of specialties. Despite assurance that actual meetings were being held, the Committee made clear its expectation that the process for such meetings must be fully completed, including the upload of documentary evidence to the relevant shared drive.
	Assurance	• The Committee took positive assurance from a Seven Day Services report which detailed outcomes from a national Seven Day Service audit and survey which placed the Trust in the upper quartile for progress against the 4 priority standards. The Committee noted the development of Specialty Business Cases which will clarify resources required to maintain progress and the Committee expects to receive information on any identified gaps through the next quarterly report in January 2019. • The Deputy Medical Director presented a Learning from Deaths report which provided positive assurance on the level of focus and development in this area. The Committee was also advised of plans to incorporate thematic analysis of resultant learning in the quarterly Clinical Governance Report.

		• The Chief Nurse & Director of Quality Governance presented a report which detailed progress against the Safe, High Quality Care Action Plan, The Committee can report positive assurance on progress, with a range of areas embedded into 'business as usual' and with just 2 of the 31 action areas currently assessed as red-rated. The red-rated areas are: o Ensure that patients can access emergency care and treatment in a timely manner (patient flow) o Ensure that records are securely stored (mitigating arrangements in place pending delivery of storage units w/c 29 October 2018)		
	Advise	• From review of the Key Issues Report from the Safeguarding Group, the Committee noted the Group's consideration of a Security Report related to a number of serious incidents. The Committee noted that a conclusion from the report related to inconsistent application of policies and procedures for patients presenting with complex/challenging behaviour. The Chief Nurse briefed the Committee on engagement with the CQC in relation to these matters and provided assurance that an appropriate report and action plan would be presented to the Committee for consideration at the next meeting on 20 November 2018. • The Committee welcomed presentation of a revised Clinical Governance Report which will facilitate better monitoring of trends and themes across a range of areas including; complaints, claims, inquests, serious incidents and learning from deaths reviews. Development of the content of this quarterly report will continue but the Committee acknowledged the revised format as a positive step forward.		
2.	Risks Identified	Nil		
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

NHS Stockport NHS Foundation Trust

Board of Directors' Key Issues Report

Report Date: 31/10/18		**Report of:** Finance & Performance Committee
Date of last meeting: 24/10/18		**Membership Numbers:** Quorate
1.	**Agenda**	The Committee considered an agenda which included the following: • Operational Performance Report • Month 6 Agency Utilisation Report • Month 6 Finance Report • Pharmacy CIP Workstream • CIP Progress Report • RTT Performance – Deep Dive • Planning Framework & Operational Plan 2019/20 • Terms of Reference - Annual Review • EPR Programme Progress Report • Capital Programme Progress Report • Draft Schedule of Published Reference Costs 2017/18 • Financial & Performance Risks • Consent Agenda
	Alert	• The Committee reviewed the Operational Performance Report, which included a Key Issues Report from the Operational Performance Group, and noted a continuing negative position against a range of key standards, particularly in relation to the A&E 4-hour standard. The Committee was briefed on work being undertaken internally to improve patient flow with a focus on reducing overnight breaches in the Emergency Department, increasing discharges earlier in the day and reducing the level of 'stranded' patients. The Committee noted commitment from system partners to assist with both these factors and winter plan initiatives but without a positive impact to date. • In reviewing the Key Issues Report referenced above, the Committee noted a range of operational risks identified at a recent meeting of the Operational Performance Group. The Committee requested assurance that the matters identified had been appropriately risk-assessed and entered on the Trust Risk Register. • The Committee considered a report which detailed outcomes from a 'deep dive' on Referral to Treatment (RTT) performance. The Committee noted that a reduction in waiting list size would have a consequent impact on performance, in the short term, as a result of a reduced denominator and requested forecast

		performance trajectories for the next meeting on 21 November 2018. The Committee was advised by the Chief Operating Officer of the importance of the Stockport Together Outpatients work stream in relation to RTT developments and agreed that the Board should be alerted to current delays in progressing actions by this work stream. The Committee also noted the importance of ensuring that associated internal projects are effectively progressed.		
	Assurance	• The Committee considered the Month 6 Agency Utilisation Report and noted that, while there had been a marginal reduction in the level of expenditure in comparison with the previous month, the level of expenditure exceeded the Agency Ceiling. The Committee noted that the forecast outturn position for the year indicated an overshoot against the ceiling of circa £0.4m. While it was also noted that the forecast is informed by positive progress in recruitment to substantive positions, there remains a risk associated with winter pressures and, therefore, a moderate level of assurance. • On the basis of the Month 6 Finance Report, the Committee is reporting moderate assurance on overall delivery of the 2018/19 financial plan with a deficit position of £19.9m against a plan position of £20.1m as at 30 September 2018. The Committee noted key risks relating to CIP delivery, elective/day case activity and contract penalties which could impact the full year outturn position. The Committee considered the Trust's current borrowing position and noted the potential impact on borrowing levels in the event of non-achievement of the financial plan. The risk associated with non-delivery of the cost improvement programme, in terms of the 2019/20 financial plan was also noted. • The Committee took positive assurance from a presentation delivered by Mr P Buckley, Chief Pharmacist, on the Medicines Management CIP work stream. In addition to in-year delivery, the Committee took assurance on the presentation and development of pipeline schemes for delivery in 2019/20. Unfortunately, this positive assurance was not available for the overall in-year cost improvement programme. The Committee reviewed the CIP Progress Report and noted a shortfall position of £0.03m at 30 September 2018. While only a marginal variance against plan, the level of recurrent savings identified is still some way short of the required level. The Committee acknowledged mitigating actions to enhance the proportion of recurrent savings but agreed that, at present, there remains only limited assurance on delivery of the CIP programme.		
	Advise	• The Committee had been scheduled to complete an annual review of its Terms of Reference and effectiveness. This matter was deferred until the next meeting on 21 November 2018 with outcomes reported to the Board on 29 November 2018.		
2.	Risks Identified	• Delivery of the cost improvement programme • Delivery of the 2018/19 financial plan • Achievement of the national standard for RTT performance.		
3.	Report Compiled by	Malcolm Sugden, Non-Executive Director	Minutes available from:	Company Secretary

This page has been left blank

Board of Directors' Key Issues Report

Report Date: 31/10/18		**Report of:** People Performance Committee
Date of last meeting: 25/10/18		**Membership Numbers:** Quorate
1.	**Agenda**	The Committee considered an agenda which included the following: • Staff Friends & Family Test • Workforce Race Equality Standard Report • Medical Education Update Report • Recruitment & Retention Plan - Update Report • Appraisal Report • Freedom to Speak Up Report • Workforce Flash Report • Agency Utilisation Report • HR Systems Optimisation Programme • Health Care Worker Flu Vaccination Report • Trust Risk Register • Culture & Engagement Group Key Issues Report
	Alert	• Ms S Woolridge, Head of Medical Workforce, delivered a presentation on HR Systems to the Committee. The Committee was advised of action taken to improve and enhance current e-rostering systems as well as ongoing work to enable further roll-outs. With regard to e-rostering, the Committee noted cultural issues as an area of concern and was advised of actions to progress work in this area.
	Assurance	• The Committee took positive assurance from a report presented by the Director of Medical Education and was pleased to note that the Health Education England North West (HEE NW) had recommended to the General Medical Council (GMC) that the Trust be removed from Enhanced Monitoring. • The Committee was also assured by a Workforce Race Equality Standard (WRES) report presented by Ms S Nadeem, Equality, Diversity & Inclusion Manager, noting an improvement in a number of WRES metrics. The Committee also approved an associated WRES action plan. • Ms L Brigg, HR Business Manager, presented an update report on a Recruitment & Retention Strategy Implementation Plan. The Committee noted positive progress made on the various actions within the implementation plan, particularly with regard to apprenticeships.

	Advise	• Ms T Harkin, Head of Learning & OD, presented results of the latest Staff Friends & Family Test to the Committee. The Committee was pleased to note an increase in the response rate compared to this time last year. The Committee was disappointed to note, however, that only 53.29% of staff would recommend the Trust as a place to work, which was a decrease of 5.58% since the previous quarter. As the results had only just been released to the Trust, the Committee was advised that further work would be undertaken to understand the reasons for the reduced score. • The Head of Learning & OD also presented a Performance Appraisal Report and the Committee was disappointed to note a reduction in appraisal compliance. It was noted that the compliance as at 5 October 2018 was 93.33%, which was a reduction of 1.19% compared to September 2018. The Head of Learning & OD briefed the Committee on mitigating actions, including targeted work with under-performing business groups. • The Interim Director of Workforce & OD presented a Health Care Worker Flu Vaccination Report and the Committee recommended the associated self-assessment checklist to the Board of Directors for approval. • The Committee considered the Month 6 Agency Utilisation Report and noted that, while there had been a marginal reduction in the level of expenditure in comparison with the previous month, the level of expenditure exceeded the Agency Ceiling. The Committee noted that the forecast outturn position for the year indicated an overshoot against the ceiling of circa £0.4m. The Committee noted progress with the recruitment of substantive positions and work regarding job-redesign to make hard to fill specialties more attractive.		
2.	Risks Identified			
3.	Actions to be considered at the *(insert appropriate place for actions to be considered)*	Nil		
4.	Report Compiled by	Angela Smith, Chair	Minutes available from:	Company Secretary

Report To:	Trust Board	**Date:**	31 Oct 2018
Subject:	Integrated Performance Report		
Report of:	Deputy Chief Executive	**Prepared by:**	B.I & Performance Teams

REPORT FOR ASSURANCE

Corporate Objective Ref:	SO2, 2a, 2b, 3a, 3b, 5a, 5c, 6a
Board Assurance Framework Ref:	SO2, SO3, SO5, SO6
CQC Registration Standards Ref:	Regulation 10,12,17,18
Equality Impact Assessment:	☑ Completed ☑ Not Required

Summary of Report

The Board is asked to note performance against the reported metrics.

An overview of changes to performance in month can be found on page 4.

From compliant to non-compliant this month:
- Emergency c-Section rate
- Dementia Finding Question

Noteable improvement:
-Diabetes reviews
- Cancer 62 day

Attention is drawn to the newly included 'Key Issues Update' section on page 5, which provides details on the main performance challenges.

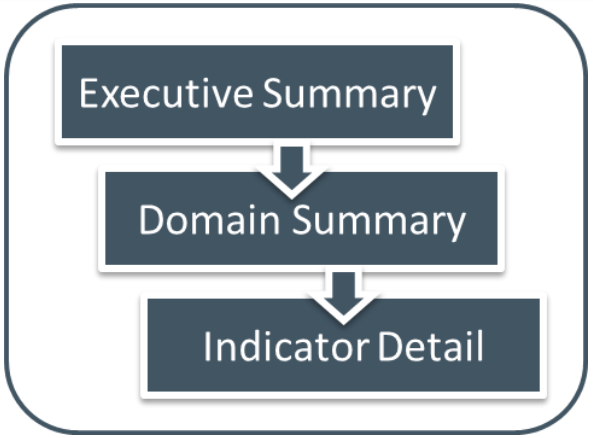
Attachments:

This subject has previously been reported to:

☐ Board of Directors	☐ SD Committee
☐ Council of Governor	☐ Charitable Funds Committee
☐ Audit Committee	☐ Nominations Committee
☐ Executive Team	☐ Remuneration Committee
☐ Quality Committee	☐ Joint Negotiating Council
☐ F&P Committee	☐ Other
☐ PP Committee	

Introduction

The Board report layout consists of three sections:



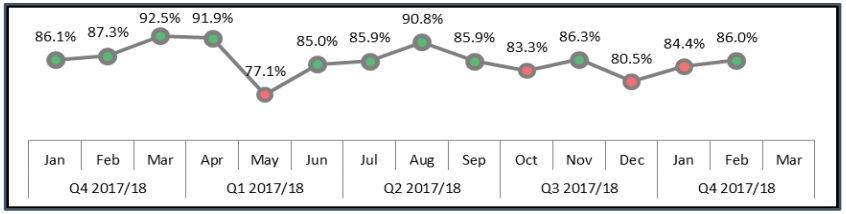
Executive Summary: Provides a high level summary of performance against the Trusts' Key Performance Indicators. The indicators are grouped by the Care Quality themes of Safe, Caring, Responsive, Effective and Efficient. The summary page reflects the Trusts' performance against the Single Oversight Framework indicators as monitored by NHS Improvement.

Domain Summary: Provides a summary of indicator level performance, arranged by Care Quality theme. For each indicator, performance against target is shown at both Trust and Business Group level, where applicable. Page numbers on this level of the report will advise on which page of the report the detailed information for each indicator can be located.

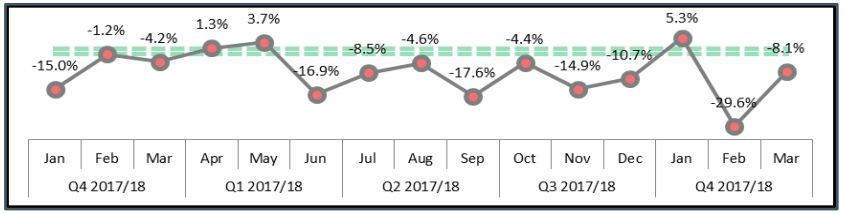
Indicator Detail: Provides detailed information for each indicator. This includes clear descriptions of the indicator, a chart representing the performance trend, and narrative describing the actions that are being undertaken to either maintain or improve performance.

Chart Summary

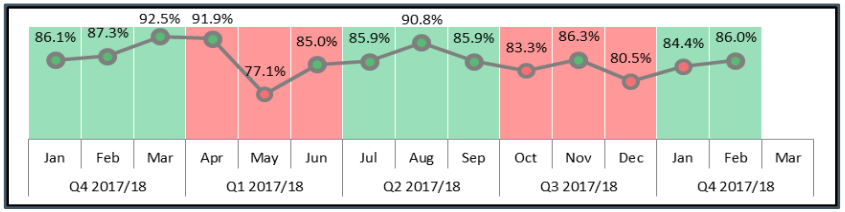
The following chart types are in use throughout the report:



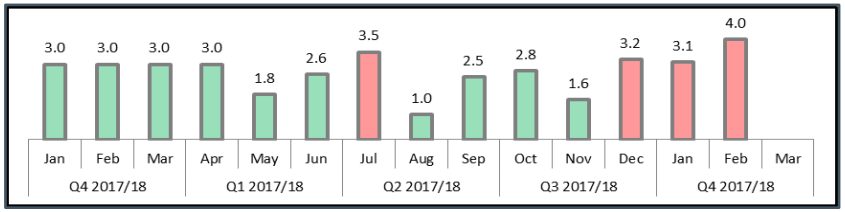
Trends are represented as a line where possible, with each monthly marker coloured to indicate achievement or non-achievement against target.



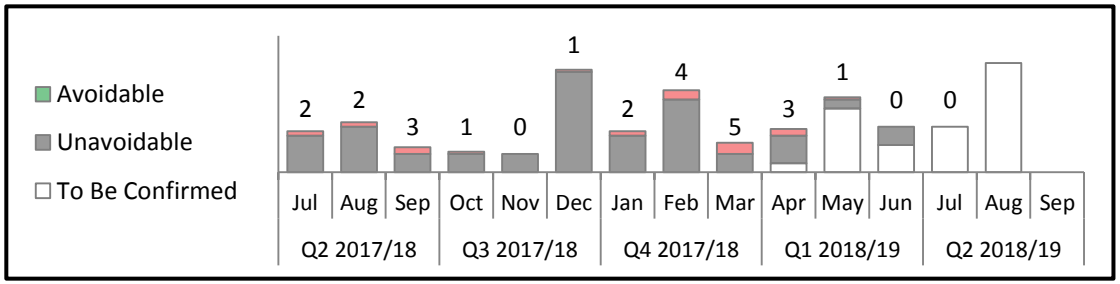
For indicators measured against a target variance, the green dotted lines indicate the target "safe-zone".



Where applicable, quarterly performance is indicated as coloured columns behind the main trend line.



Where a trend line is not as appropriate, column charts are used to display information on indicator counts and totals.



Executive Summary

Stockport NHS Foundation Trust

Key Changes to the indicators in this period are:

From compliant to non-compliant this month:

- Emergency c-Section rate
- Dementia Finding Question

Noteable improvement:

-Diabetes reviews
- Cancer 62 day

Deteriorating position:

-Stranded patients
- A&E 4hr standard
- Elective activity v plan
- RTT: Incomplete pathways
- Appraisal rate (non-medical)
- Agency spend above ceiling

Key Issues Update

Stockport NHS Foundation Trust

Urgent Care – Emergency Department (ED) performance remains challenging. The three main areas of focus are:
- Overnight Breaches. Opening two additional assessment areas for majors and reviewing the nurse practitioner work space. The CCG has also been approached to provide funding to support senior leadership within ED until midnight.
- Early Discharges. Safer metrics now in place and shared weekly with each ward to promote proactive measures. White board rounds to take place on each ward each day.
- Stranded Patients. Ugent Care Improvment Director leading system-wide review

Finance - The Trust has lost of £19.9m in the first half of the financial year, an average loss of £109,000 per day. There is an action plan in place to mitigate the non-delivery of CIP but given the elective income performance, uncertainty of winter demands, risk of additional contract penalties due to operational performance, and risk on Stockport Together, there remains moderate assurance that the operational plan will be delivered.
- I&E. The planned I&E deficit was £20.1m so this is £0.2m favourable to plan. The Trust is reporting moderate assurance delivering this.
- CIP. The Cost Improvement Programme (CIP) is in line with the profiled plan at the end of Q2 with £4.5m of savings transacted. The Trust has identified approximately £11.1m against the £15m target at this stage of the financial year. However, only £4.3m of the identified savings are recurrent against the £15m requirement. Even with potential mitigation the Trust can only provide moderate assurance at this stage on the delivery of the 2018/19 Cost Improvement Programme.

Referral to Treatment Time (RTT) - The focus is waiting list size reduction. Recovery against the 92% standard not anticipated until the end of Q4.
- A joint provider / commissioner focus on reducing the waiting list size, looking at: demand management, activity levels, validation and discharge thresholds is underway.
- CCG implementing GP referral management plan, which is central to meeting the objective
- elective activity recovery plans in development, moderate assurance of recovery for ENT and Urology so far.

Cancer - An improved performance is expected for September with a forecast position of 86.1% against the 85% standard. In year, referrals continue to be 20% higher and new treatment timescales (38 days to refer out for treatment) commenced 1.10.18, both factors may have an adverse impact on performance in the coming months. Capacity issues within the Breast service remain the Trust's biggest area of concern. The CCG has written to neighbouring CCGs informing them that the service is closed to 'out of area referrals' and the Trust is seeking the support of local Trusts in managing patients on the waiting list.

Agency Shifts above cap - Although higher than previous month, compare favourably to the same time period last year.

Domain Summary

NHS Stockport NHS Foundation Trust

Indicator	Exec	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Safe													
C.Diff Infection Rate	CN&DQG	Aug-18		9.01							7.55		15
C.Diff Infection Count (lapses in care)	CN&DQG	Aug-18	<=3 *	0							0		15
MRSA Infection Rate	CN&DQG	Aug-18		0.45							0.81		16
MSSA Infection Rate	CN&DQG	Aug-18		6.76							8.09		16
E.Coli Infection Rate	CN&DQG	Aug-18		15.32							17.36		17
E.Coli Infection Count	CN&DQG	Aug-18	<=15 *	1							9		17
Falls: Total Incidence of Inpatient Falls	CN&DQG	Sep-18	<=689 *	127							674		18
Falls: Causing Moderate Harm and Above	CN&DQG	Sep-18	<=15 *	2							14		18
Pressure Ulcers: Hospital, Avoidable Category 2	CN&DQG	Aug-18	<= 5 *	0							4		19
Pressure Ulcers: Hospital, Avoidable Category 3	CN&DQG	Aug-18	<= 2 *	0							2		19
Pressure Ulcers: Hospital, Avoidable Category 4	CN&DQG	Aug-18	<= 0 *	0							1		20
Pressure Ulcers: Community, Avoidable Category 2	CN&DQG	Aug-18	<= 17 *	0							3		20
Pressure Ulcers: Community, Avoidable Category 3	CN&DQG	Aug-18	<= 4 *	0							3		21

* Target calculated against Cumulative/YTD performance

** YTD figures related to last finanical year

Domain Summary

Indicator	Exec	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Safe													
Pressure Ulcers: Community, Avoidable Category 4	CN&DQG	Aug-18	*<= 1 **	0							0		21
Safety Thermometer: Hospital	CN&DQG	Sep-18	*>= 95%*	96.5%							95.5%		22
Safety Thermometer: Community	CN&DQG	Sep-18	*>= 95%*	97.1%							92.6%		22
Medication Errors: Overall	CN&DQG	Sep-18		74							551		23
Medication Errors: Moderate Harm and Above	CN&DQG	Sep-18	*<= 4%*	4.1%							4.7%		23
VTE Risk Assessment	CN&DQG	Sep-18	*>= 95%*	97.2%							96.8%		24
Clinical Correspondence	COO	Sep-18	*>= 95%*	67.7%							65.5%		24
Flu Vacination Uptake	DoW&OD	Mar-18	*>= 70%*	78.6%									25
Discharge Summaries	MD	Sep-18	*>= 95%*	90.8%							88.6%		25

* Target calculated against Cumulative/YTD performance

** YTD figures related to last finanical year

Domain Summary

NHS Stockport NHS Foundation Trust

Indicator	Exec	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Effective													
Patient Safety Incident Rate	CN&DQG	Sep-18		55.29									26
Emergency C-Section Rate	CN&DQG	Sep-18	<= 15.4%	18.3%							17.9%		26
Never Event: Incidence	CN&DQG	Sep-18	<= 0	0							0		27
Duty of Candour Breaches	CN&DQG	Sep-18		3							16		27
Stranded Patients	COO	Sep-18	<= 35%	57.3%							49.5%		28
Delayed Transfers of Care (DTOC)	COO	Sep-18	<= 3.3%	3.6%							3.1%		28
Medical Optimised Awaiting Transfer (MOAT)	COO	Sep-18	<= 40	94							565		29
Bank & Agency Costs	DoW&OD	Sep-18	<= 5%	12.8%							11.6%		29
Mortality: HSMR	MD	Jul-18	<= 1	1.08									30
Mortality: SHMI	MD	Dec-17	<= 1	0.96									30
Mortality: Deaths in ED or as Inpatient	MD	Sep-18		106							640		31
Mortality: Case Note Reviews	MD	Sep-18		18							196		31
Emergency Readmission Rate	MD	Jul-18	<= 7.9%	8.5%							8.9%		32

* Target calculated against Cumulative/YTD performance

** YTD figures related to last finanical year

Domain Summary

Indicator	Exec	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Caring													
Patient Safety Alerts: Completion	CN&DQG	Sep-18	>= 100%	100.0%							75.0%		32
DSSA (mixed sex)	CN&DQG	Sep-18	<= 0	0							4		33
Complaints Rate	CN&DQG	Sep-18		0.6%							0.8%		33
Complaints: Response Rate 45	CN&DQG	Sep-18	>= 95%	47.4%							28.7%		34
Complaints: Parliamentary & Health Service Ombudsman Cases	CN&DQG	Sep-18		3							9		34
Complaints Closed: Overall	CN&DQG	Sep-18		19							244		35
Complaints Closed: Upheld	CN&DQG	Sep-18		7							67		35
Complaints Closed: Partially Upheld	CN&DQG	Sep-18		8							113		36
Complaints Closed: Not Upheld	CN&DQG	Sep-18		4							64		36
Compliments	CN&DQG	Sep-18		43							136		37
Friends & Family Test: Response Rate	CN&DQG	Aug-18		25.8%							26.5%		37
Friends & Family Test: Inpatient	CN&DQG	Aug-18		93.9%							94.5%		38
Friends & Family Test: A&E	CN&DQG	Aug-18		90.3%							89.7%		38

* Target calculated against Cumulative/YTD performance

** YTD figures related to last finanical year

Domain Summary

Indicator	Exec	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Caring													
Friends & Family Test: Maternity	CN&DQG	Aug-18		96.1%							96.6%		39
Staff Friends & Family Test	CN&DQG	Jun-18		77.0%							77.0%		39
Diabetes Reviews	MD	Sep-18	>= 90%	81.3%							74.5%		40

* Target calculated against Cumulative/YTD performance

** YTD figures related to last finanical year

Domain Summary

Stockport NHS Foundation Trust

Indicator	Exec	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Responsive													
Dementia: Finding Question	CN&DQG	Aug-18	>= 90%	88.1%							96.2%		40
Dementia: Assessment	CN&DQG	Aug-18	>= 90%	100.0%							100.0%		41
Dementia: Referral	CN&DQG	Aug-18	>= 90%	100.0%							100.0%		41
Serious Incidents: STEIS Reportable	CN&DQG	Sep-18		14							102		42
Litigation: Claims	CN&DQG	Sep-18		6							30		42
Litigation: Key Risk Claims Rate	CN&DQG	Sep-18		100.0%							100.0%		43
A&E: 4hr Standard	COO	Sep-18	>= 95%	71.3%							81.1%		43
A&E: 12hr Trolley Wait	COO	Sep-18	<= 0	7							15		44
Cancer: 62 Day Standard	COO	Sep-18	>= 85%	86.1%							80.8%		44
Referral to Treatment: Incomplete Pathways	COO	Sep-18	>= 92%	83.4%							86.2%		45
Referral to Treatment: Incomplete Waiting List Size	COO	Sep-18	<= 22345	25364									45
Diagnostics: 6 Week Standard	COO	Sep-18	>= 99%	99.7%							99.2%		46
Outpatient Activity vs. Plan	COO	Sep-18	+/- 1%	-2.7%							-2.7%		46

* Target calculated against Cumulative/YTD performance

** YTD figures related to last finanical year

Domain Summary

Indicator	Exec	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Responsive													
Elective Activity vs. Plan	COO	Sep-18	+/- 1%	-8.1%							-8.1%		47
Elective Income vs. Plan	COO	Sep-18	+/- 1%	-4.4%							-4.4%		47

* Target calculated against Cumulative/YTD performance

** YTD figures related to last finanical year

Domain Summary

NHS Stockport NHS Foundation Trust

Indicator	Exec	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	M	S	W	YTD	Forecast Risk	Page
Efficient / Well Led													
Financial Efficiency: I&E Margin	DoF	Sep-18	<= 2	4									48
Financial Controls: I&E Position	DoF	Sep-18	<= 1%	-0.9%									48
Cash	DoF	Sep-18	+/- 1%	-75.7%									49
Financial Use of Resources	DoF	Sep-18	<= 3	3									49
CIP Cumulative Achievement	DoF	Sep-18	+/- 1%	-0.6%									50
Capital Expenditure	DoF	Sep-18	+/- 10%	-38.6%									50
Financial Sustainability	DoF	Sep-18	<= 2	4									51
Sickness Absence Rate	DoW&OD	Sep-18	<= 3.5%	4.3%							4.2%		51
Appraisal Rate: Non-medical	DoW&OD	Sep-18	>= 95%	93.3%							94.5%		52
Appraisal Rate: Medical	DoW&OD	Sep-18	>= 95%	96.7%							97.4%		52
Statutory & Mandatory Training	DoW&OD	Sep-18	>= 90%	90.0%							91.1%		53
Workforce Turnover	DoW&OD	Sep-18	<= 13.94%	14.5%									53
Staff in Post	DoW&OD	Sep-18	>= 90%	90.9%							89.9%		54

* Target calculated against Cumulative/YTD performance

** YTD figures related to last finanical year

Domain Summary

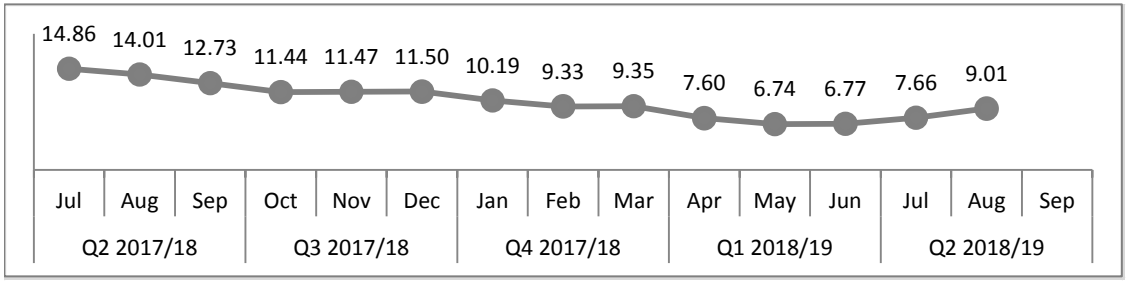
Indicator	Exec	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Efficient / Well Led													
Agency Shifts Above Capped Rates	DoW&OD	Sep-18	<= 0	897							5625		54
Agency Spend: Distance From Ceiling	DoW&OD	Sep-18	<= 3%	16.8%							16.8%		55

* Target calculated against Cumulative/YTD performance

** YTD figures related to last finanical year

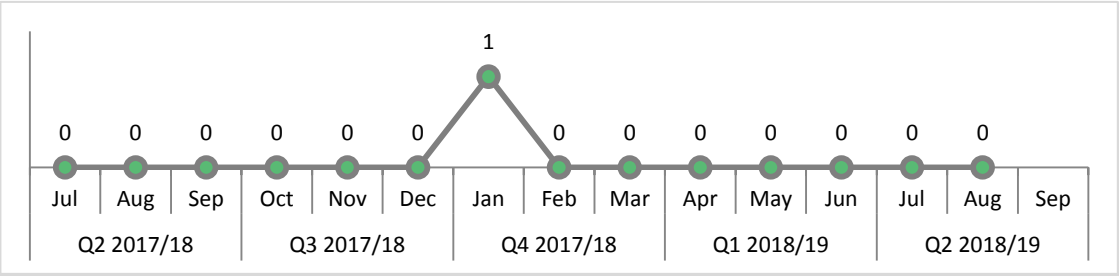
Indicator Detail

Aug-18	C.Diff Infection Rate
9.01	Average number of C.Diff infections for every 100,000 bed days, calculated using a rolling 12 month number of Trust-attributable C.Diff infections compared to the rolling 12 month average number of bed days per 100,000.
Target	The average number of Clostridium difficile infections for every 100,000 bed days, calculated using a rolling 12month number of Trust –attributable Clostridium difficile infections compared to a rolling 12 month average number of bed days per 100,00.



Actions
During August there were five cases of Clostridium difficile - Full investigations currently in progress for all cases - The target rate is monitored through the infection prevention group

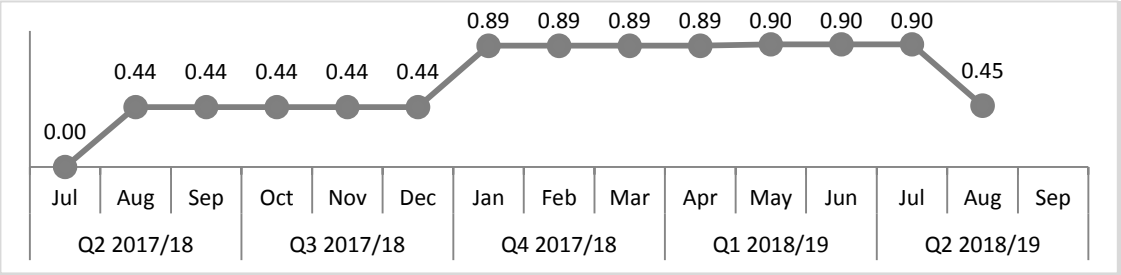
Aug-18	C.Diff Infection Count (lapses in care)
0	Total number of C.Diff infections due to lapses in care.
Target	The target for 2018/19 Clostridium difficile cases is set at 16 lapses in care.
<=3 *	



Actions
All cases identified in August are under investigation. A review of the new NICE draft guidance to combat drug resistant. UTI's with the antibiotic pharmacists and Consultant microbiologist has been undertaken. Awaiting final guidance to be published. Further work will be undertaken with the new site coordinator team around isolation of patients following review and update of the isolation SOP. Following a Clostridium difficile investigation the case will be presented to the harm free care panel.

Indicator Detail

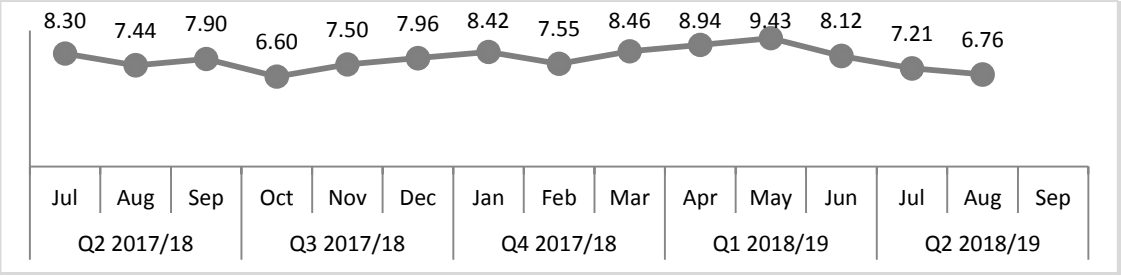
Aug-18	MRSA Infection Rate
0.45	Average number of MRSA infections for every 100,000 bed days, calculated using a rolling 12 month number of Trust-attributable MRSA infections compared to the rolling 12 month average number of bed days per 100,000.
Target	Rolling 12-month count of all MRSA infections as a proportion of the average 12 month rolling occupied bed days per 100, 000 population.



Actions

The MRSA target remains zero for 2018/19, in August there were zero cases of MRSA.
The target is monitored through the infection prevention group.

Aug-18	MSSA Infection Rate
6.76	Average number of MSSA infections for every 100,000 bed days, calculated using a rolling 12 month number of Trust-attributable MSSA infections compared to the rolling 12 month average number of bed days per 100,000.
Target	Rolling 12-month count of all MSSA infections as a proportion of the average 12 month rolling occupied bed days per 100, 000 population.



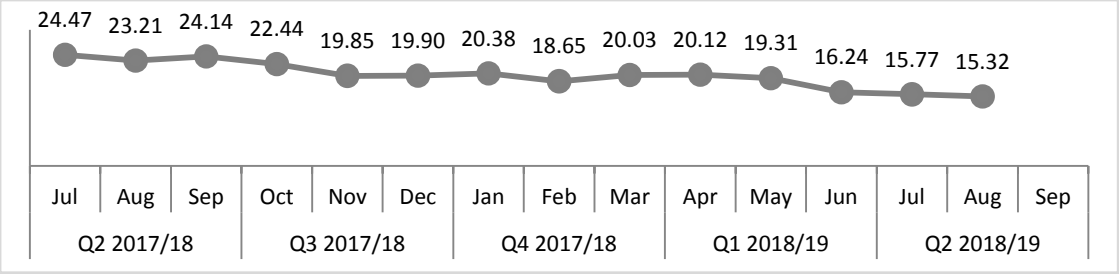
Actions

The MSSA infection rate is monitored as a whole health economy with no target. The figures represented within this report are Trust acquired cases.

This is monitored through the Infection prevention group.

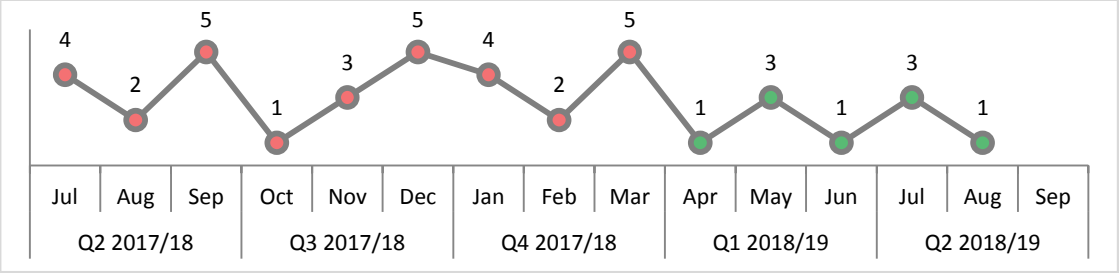
Indicator Detail

Aug-18	E.Coli Infection Rate
15.32	Average number of E.Coli infections for every 100,000 bed days, calculated using a rolling 12 month number of Trust-attributable E.Coli infections compared to the rolling 12 month average number of bed days per 100,000.
Target	Rolling 12-month count of all E. coli infections as a proportion of the average 12 month rolling occupied bed days per 100, 000 population.



Actions
Nationally there is an aim to reduce healthcare associated gram-negative blood stream infections by 50% by March 2021, firstly focusing on E coli infection as one of the largest groups. The figures represented within this report are trust acquired cases. A reduction plan has been developed collaboratively between the Trust, Health protection nurses and CCG. This plan will be monitored through the infection prevention group. Discussions with the clinical director in laboratory medicine in regards to medical investigation of each case underway.

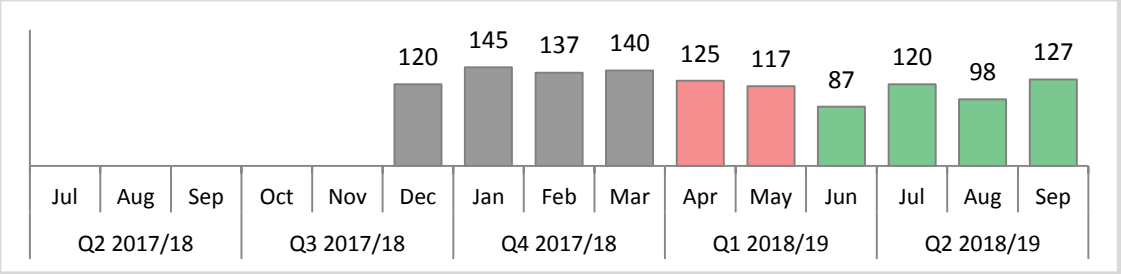
Aug-18	E.Coli Infection Count
1	Total number of E.Coli infections.
Target	The E Coli infection count is monitored as a whole health economy with no target. The figures represented within this report are trust acquired cases
<=15 *	



Actions
This is monitored through the Infection prevention group.

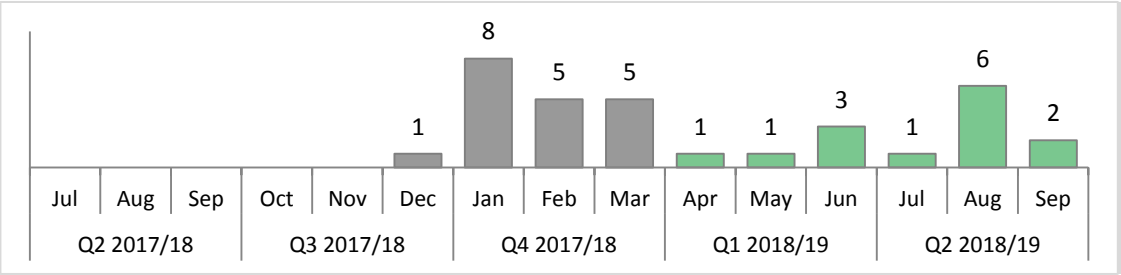
Indicator Detail

Sep-18	Falls: Total Incidence of Inpatient Falls
127	Total number of Inpatient falls
Target	The Trust has a target of reducing all falls by 10% in 2018/19 compared with 2017/18.
<=689 *	



Actions
The reported figures are in line with achieving the target set. A contributory factor to the elevated figure is two patients who have had multiple falls as in patients, both patients have had all appropriate reduction measures put in place but it remains a challenge to stop them falling. The safer mobility collaborative continues to move forward with quality improvement initiatives.

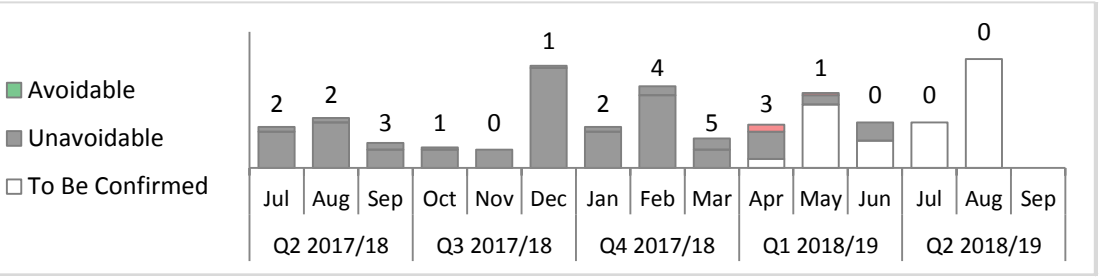
Sep-18	Falls: Causing Moderate Harm and Above
2	Total number of falls causing moderate harm and above.
Target	The Trust has a target of reducing falls causing harm that it moderate or above by 25% in 2018/19 compared with 2017/18
<=15 *	



Actions
There have been two falls this month that have caused moderate harm. Both of these falls are under investigation by the business groups and lessons learned will be shared to all concerned. There is a newly introduced post fall proforma for matrons to complete. This will provide situational and environmental data to support lessons learned and will highlight processes and practice at the time of the fall.

Indicator Detail

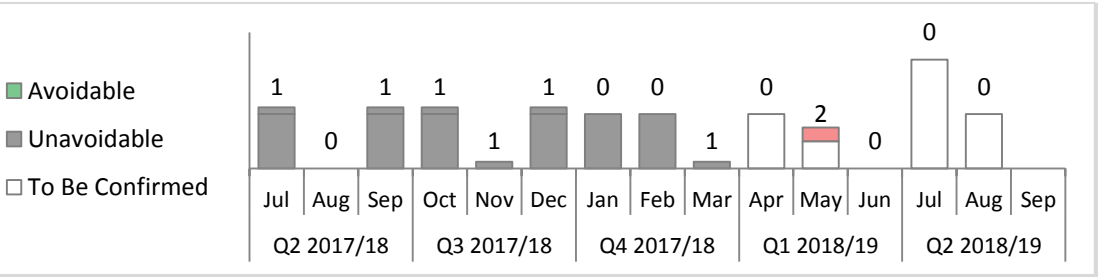
Aug-18	Pressure Ulcers: Hospital, Avoidable Category 2
0	Total number of category 2 pressure ulcers in a hospital setting.
Target	Our aim is to reduce hospital acquired avoidable category 2 pressure ulcers by 50% by the end of March 2019. The figures represented here relate to August. Pressure ulcers are reported as either avoidable (lapses in care were identified), or unavoidable (no lapses in care were identified)
<= 5 *	



Actions

This month there has been a total of 12 category 2 pressure ulcers reported in the hospital
Avoidable = 0, Unavoidable = 0, TBC = 12 . These will be reviewed by the harm free care panel in November
August has seen an increase in the total number of pressure ulcers reported.
A refreshed 3 hour pressure ulcer prevention update session for nursing staff has commenced.
325 staff have now been trained in the Purpose T pressure ulcer risk assessment tool.
A pledge for all staff members to inspect patient's skin for signs of pressure damage where appropriate is now considered as an always event.

Aug-18	Pressure Ulcers: Hospital, Avoidable Category 3
0	Total number of avoidable category 3 pressure ulcers in a hospital setting.
Target	Our aim is to reduce hospital acquired avoidable category 3 pressure ulcers by 50% by the end March 2019. The figures represented here relate to August. Pressure ulcers are reported as either avoidable (lapses in care were identified), or unavoidable (no lapses in care were identified)
<= 2 *	

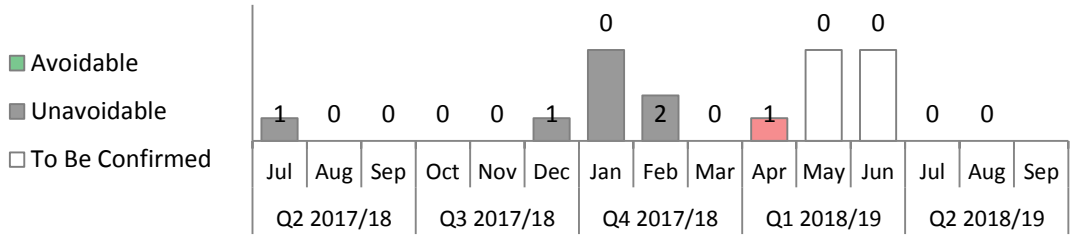


Actions

This month there has been a total of 2 category 3 pressure ulcers reported in the hospital
Avoidable = 0, Unavoidable = 0, TBC = 2. These will be reviewed by the harm free care panel in November
August has seen an increase in the total number of pressure ulcers reported.
A refreshed 3 hour pressure ulcer prevention update session for nursing staff has commenced.
325 staff have now been trained in the Purpose T pressure ulcer risk assessment tool.
A pledge for all staff members to inspect patient's skin for signs of pressure damage where appropriate is now considered as an always event.

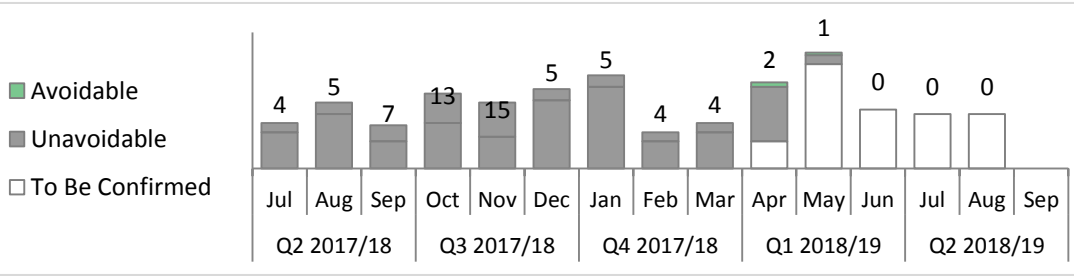
Indicator Detail

Aug-18	Pressure Ulcers: Hospital, Avoidable Category 4
0	Total number of avoidable category 4 pressure ulcers in a hospital setting.
Target	Our aim is to reduce hospital acquired avoidable category 4 pressure ulcers by 50% by the end March 2019. The figures represented here relate to August. Pressure ulcers are reported as either avoidable (lapses in care were identified), or unavoidable (no lapses in care were identified)
<= 0 *	



Actions
This month there have been no category 4 pressure ulcers reported in the Hospital.

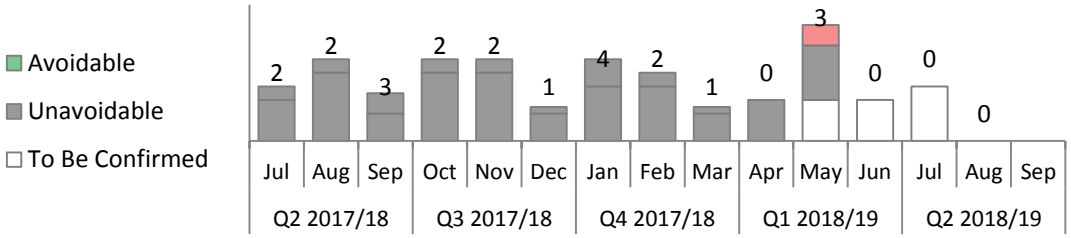
Aug-18	Pressure Ulcers: Community, Avoidable Category 2
0	Total number of avoidable category 2 pressure ulcers in a community setting.
Target	Our aim is to reduce community acquired avoidable category 2 pressure ulcers by 50% by the end March 2019. The figures represented here relate to August. Pressure ulcers are reported as either avoidable (lapses in care were identified), or unavoidable (no lapses in care were identified)
<= 17 *	



Actions
This month there has been a total of 12 category 2 pressure ulcers reported in the community Avoidable = 0, Unavoidable = 0, TBC = 12. These will be reviewed by the harm free care panel in November August has seen an increase in the total number of pressure ulcers reported. A refreshed 3 hour pressure ulcer prevention update session for nursing staff has commenced. 325 staff have now been trained in the Purpose T pressure ulcer risk assessment tool. A pledge for all staff members to inspect patient's skin for signs of pressure damage where appropriate is now considered as an always event.

Indicator Detail

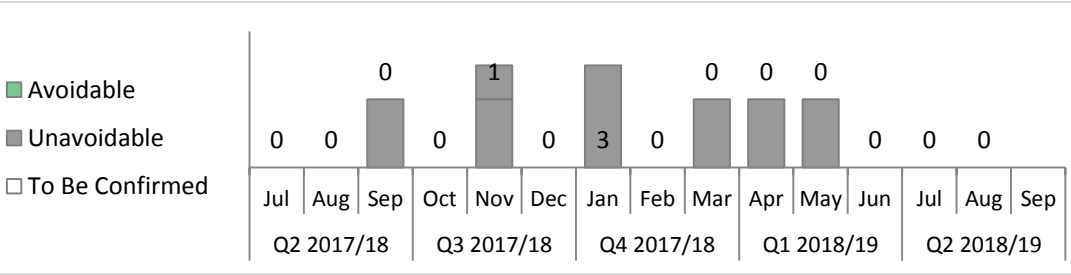
Aug-18	Pressure Ulcers: Community, Avoidable Category 3
0	Total number of avoidable category 3 pressure ulcers in a community setting.
Target	Our aim is to reduce community acquired avoidable category 3 pressure ulcers by 50% by the end March 2019. The figures represented here relate to August. Pressure ulcers are reported as either avoidable (lapses in care were identified), or unavoidable (no lapses in care were identified)
<= 4 *	



Actions

This month there has been a no category 3 pressure ulcers reported in the Community

Aug-18	Pressure Ulcers: Community, Avoidable Category 4
0	Total number of avoidable category 4 pressure ulcers in a community setting.
Target	Our aim is to reduce community acquired avoidable category 4 pressure ulcers by 50% by the end March 2019. The figures represented here relate to August. Pressure ulcers are reported as either avoidable (lapses in care were identified), or unavoidable (no lapses in care were identified)
<= 1 *	

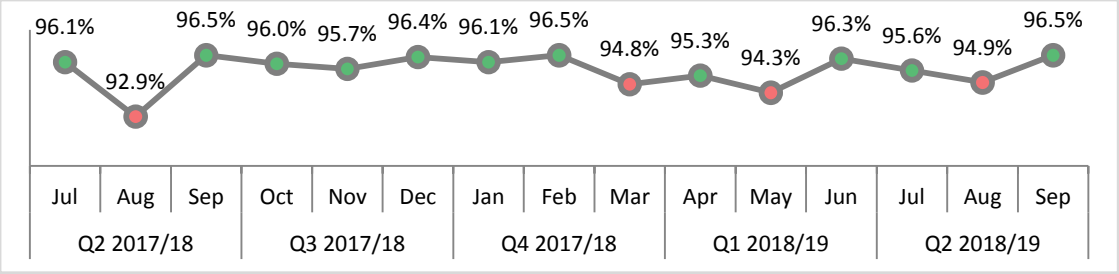


Actions

This month there have been no category 4 pressure ulcers reported in the community.

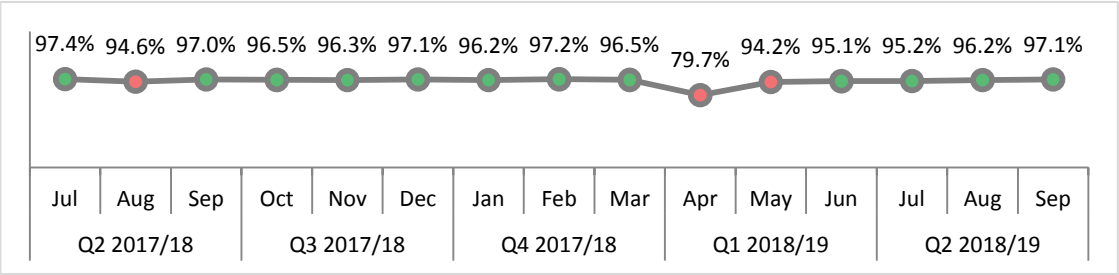
Indicator Detail

Sep-18	Safety Thermometer: Hospital
96.5%	The percentage of patients receiving harm-free care, calculated using a point prevelance sample based on falls, pressure ulcers, UTIs and VTE assessments.
Target	There has been an increased focus on the timeliness and accuracy of data submission and this had led to an improvement of our Safety Thermometer compliance.
>= 95%	



Actions
Below is a summary of actions in progress: Agreement by the Chief Nurse to be included in an AQUA Quality Improvement initiative. New performance report being developed to allow us to identify areas requiring improvement. Validation meetings undertaken weekly to embed the process.

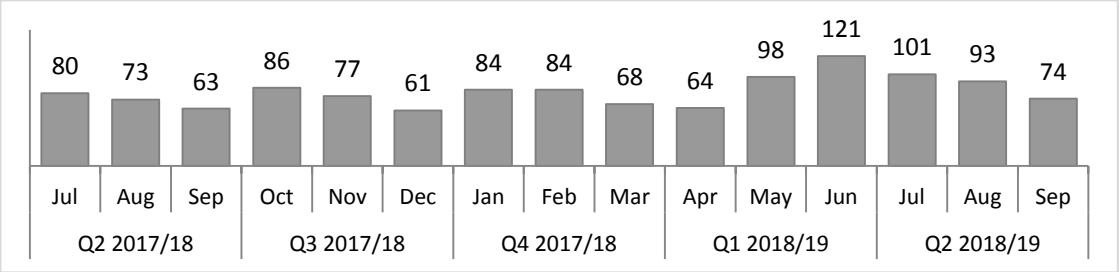
Sep-18	Safety Thermometer: Community
97.1%	The percentage of patients receiving harm-free care, calculated using a point prevelance sample based on falls, pressure ulcers, UTIs and VTE assessments.
Target	The Trust aim is that >95% of patients receive harm free care as monitored by safety thermometer.
>= 95%	



Actions
The target has been achieved in month.

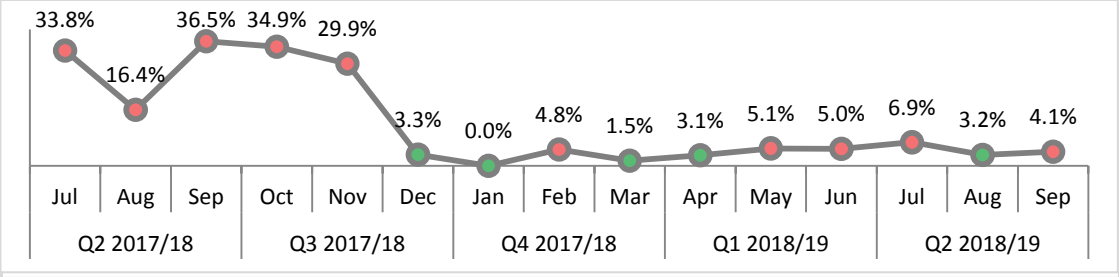
Indicator Detail

Sep-18	Medication Errors: Overall
74	Total number of Medication Errors.
Target	In September 2018 there were 74 medication incidents recorded. This is a reduction for the third month in a row. There were 3 medication errors that resulted in moderate harm or above. 2 of the incidents relate to the same patient.



Actions
All medication incidents are reviewed weekly by a trust executive at the patient safety summit. In September areas highlighted in the patient safety summit update included. - All IV drug and insulin administration MUST be carried out by a registered nurse, midwife or doctor employed by the Trust. - Rates of IV infusions only be adjusted by registered nurses or midwives. - Step by step guide to remind staff of checking all the details carefully in relation to administration of medication by the bed side and to only administer medication to one patient at a time.

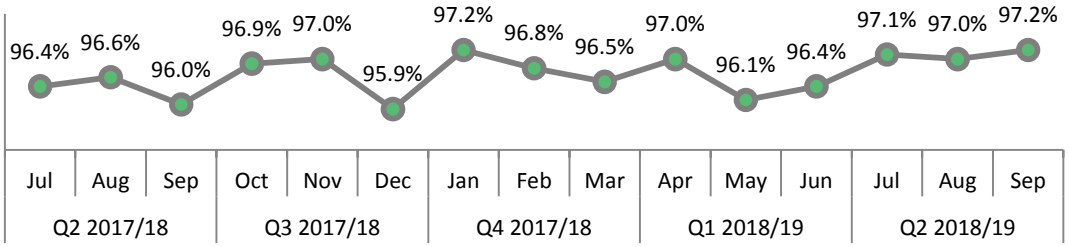
Sep-18	Medication Errors: Moderate Harm and Above
4.1%	The percentage of medication errors causing moderate harm and above.
Target	The number of incidents that have caused moderate harm or above is 3 which is the is the same as last month. Two incidents related to the same patient.
<= 4%	



Actions
Investigations by the business groups are being undertaken into the incidents. The first 6 months of the year saw an average of 4.6% of incidents causing moderate and above harm per 1000 bed days. It has been agreed that at the target is to reach under 4% for Quarter 3 and 4. Further work is being undertaken to align the indicators against those identified in the model hospital.

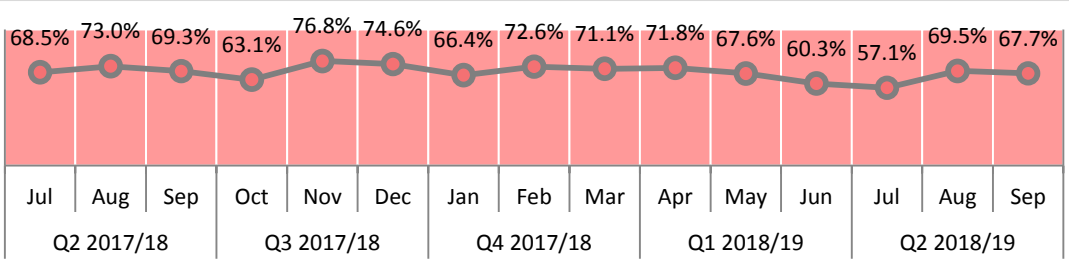
Indicator Detail

Sep-18	VTE Risk Assessment
97.2%	The percentage of eligible admitted patients who have been given a VTE risk assessment.
Target	The target is that >95% of agreed cohorts of patients admitted to the Trust receive an assessment relating to their individual risk of developing a venous thrombo-embolism (VTE).
>= 95%	



Actions
The target has been achieved in month.

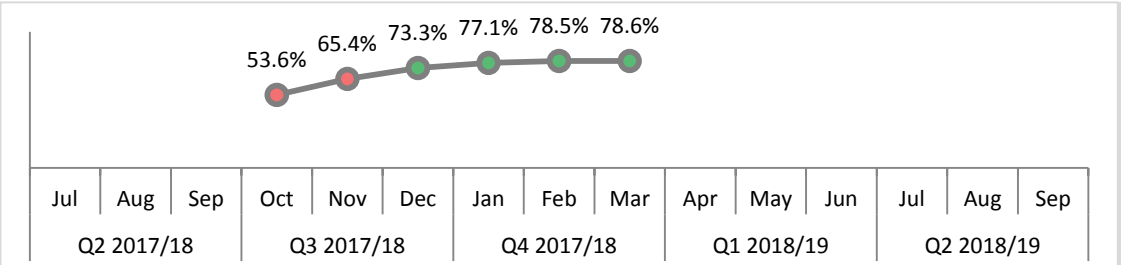
Sep-18	Clinical Correspondence
67.7%	The percentage of clinical correspondence typed within 7 days.
Target	The Trust failed to achieve the standard for clinical correspondence typed within 7 days in month with performance deteriorating slightly in September compared to August.
>= 95%	



Actions
An evaluation of the impact of co-locating staff into the hub at an individual and specialty level is underway to determine developments in phase 2 of the project. Operational and performance management has transferred to the Medicine Business Group management.

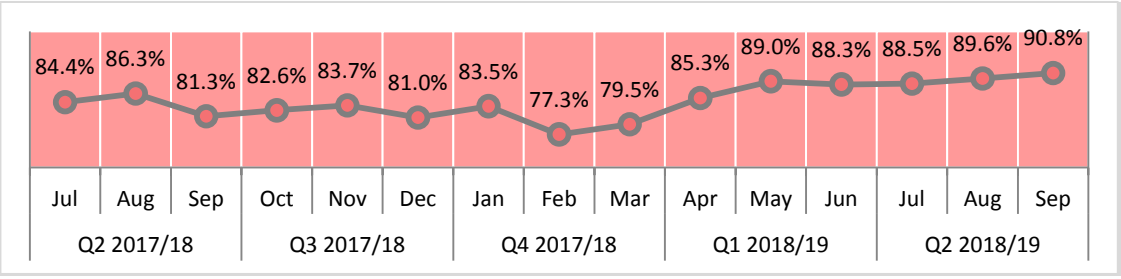
Indicator Detail

Mar-18	Flu Vacination Uptake
78.6%	The percentage of staff receiving the flu vaccination.
Target	33% of staff have been vaccinated in week 2 of the campaign, against a total target of 75% by the end of week 22. (33% of frontline staff have been vaccinated). Corporate Services Business Group has the highest uptake at 53%, with Human Resources at 81%, whilst Integrated Care BG has the lowest uptake at 27%.
>= 70%	



Actions
Add Prof & Technical staff group has the highest percentage uptake at 41%, whilst Additional Clinical Services has the lowest uptake at 25% so far.

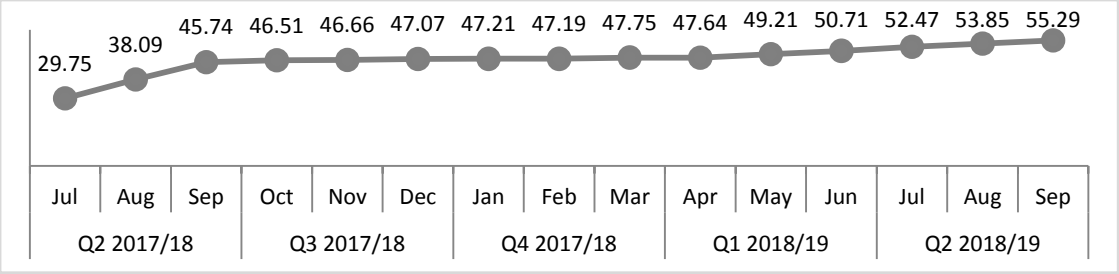
Sep-18	Discharge Summaries
90.8%	The percentage of discharge summaries published within 48hrs of patient discharge.
Target	Performance against target continues to improve, with 3 Business Groups achieving greater than 90%.
>= 95%	Surgery 94.0%, Medicine 92.7%, Womens' 91%, Integrated Care 81.9%



Actions
Sustained improvement continues. Integrated care remain the main outlier. This month, the CCG have agreed to pilot, short stay patients on the clinical decision unit not requiring a full HCR. This will part address their performance.

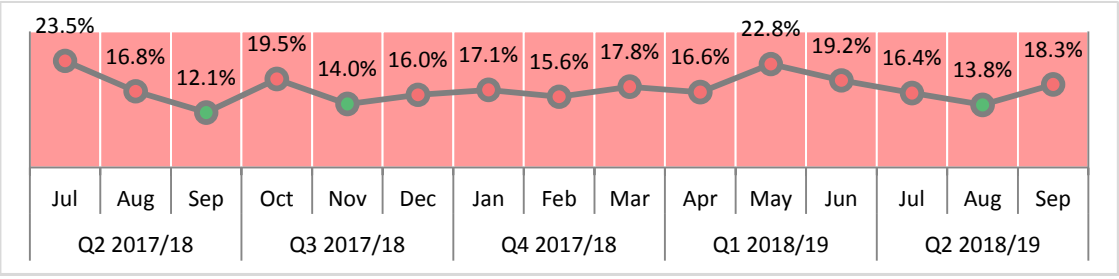
Indicator Detail

Sep-18	Patient Safety Incident Rate
55.29	Average number of patient safety incidents for every 1000 bed days, calculated using a rolling 6 month number of reported patient safety incidents compared to the rolling 6 month average number of bed days per 1000.
Target	The average number of patient safety incidents for every 1000 bed days continues to rise in month, although there has been a slight reduction in the number of patient related incidents reported.



Actions
The way in which staffing incidents are classified has been clarified and they now under staff incidents rather than patient safety incidents. Two sessions a week have been organised in October for reviewers, to give their feedback on the 'Datix' incident form implemented last December. It is also an opportunity to give refresher training on how to review incidents.

Sep-18	Emergency C-Section Rate
18.3%	The percentage of births where the mother was admitted as an emergency and had a c-section.
Target	The emergency caesarean section target is <15.4%
<= 15.4%	

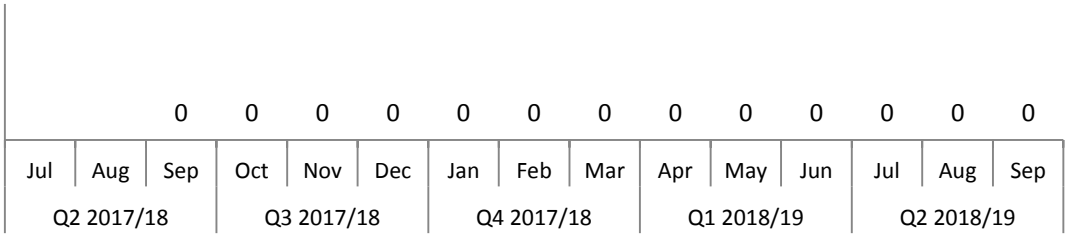


Actions
There were 284 births in September and 52 babies born by emergency caesarean sections.This is monitored via the maternity dashboard within the business group.

Indicator Detail

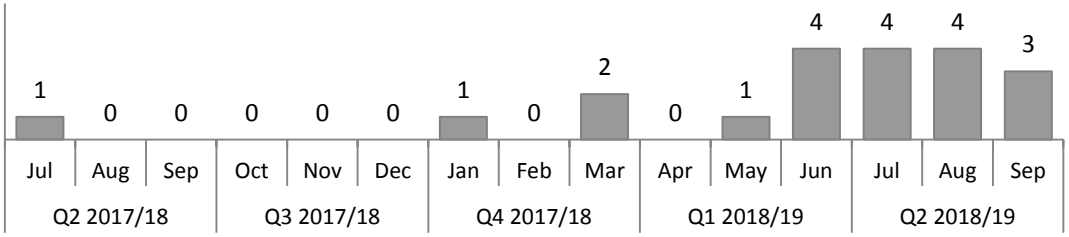
Sep-18	Never Event: Incidence
0	Total number of never events. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
Target	There were no never events recorded in the month of September.
<= 0	

Actions
The last never event reported by the trust was in July 2015. This was an incident of a wrong site interscalene block.



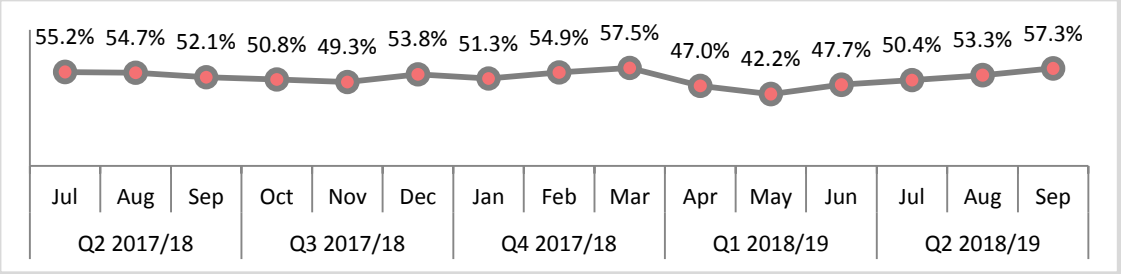
Sep-18	Duty of Candour Breaches
3	Total number of Duty of Candour breaches in month.
Target	In September 2018, out of the 14 incidents that required opening duty of candour, 3 were not completed within the 10 day timeframe. All relate to incidents of patients developing pressure ulcers.

Actions
The new duty of candour and being open policy has been approved and on the trust intranet. Training continues to be delivered to ensure staff are aware of the requirement. Duty of candour compliance is being monitored on a weekly basis. A review is being undertaken regarding timeliness of duty of candour when relating to patients who develop pressure ulcers.



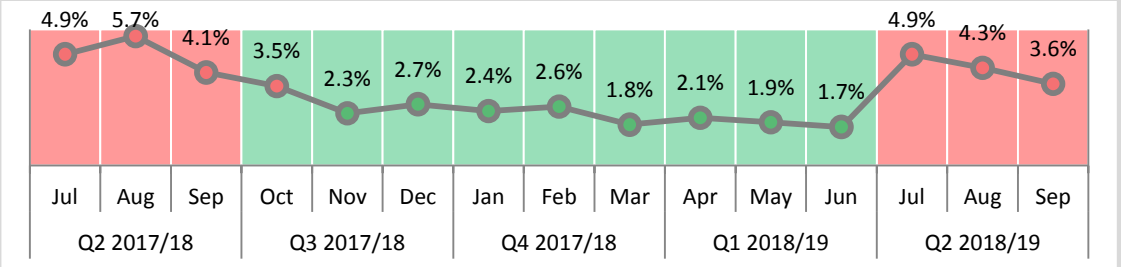
Indicator Detail

Sep-18	Stranded Patients
57.3%	The percentage of patient that have had a length of stay of 7 days or more. This is an average number calculated using daily snapshot data.
Target	The percentage of stranded patients continues to increase, and is adversely impacting on flow and the 4hr ED standard
<= 35%	



Actions
The system recognises the need to respond. The Improvement Board, led by John Rouse, is planning a deep dive into the system-wide issues contributing to our stranded patient numbers. The Urgent Care Improvement Director has been asked to lead the system wide response to the stranded patients. A 4 week task & finish group set up to ensure prospective Consultant cover to white board rounds on every ward, every day. Weekly Safer performance metrics are now being shared with each ward, promoting ownership and proactive improvement measures.

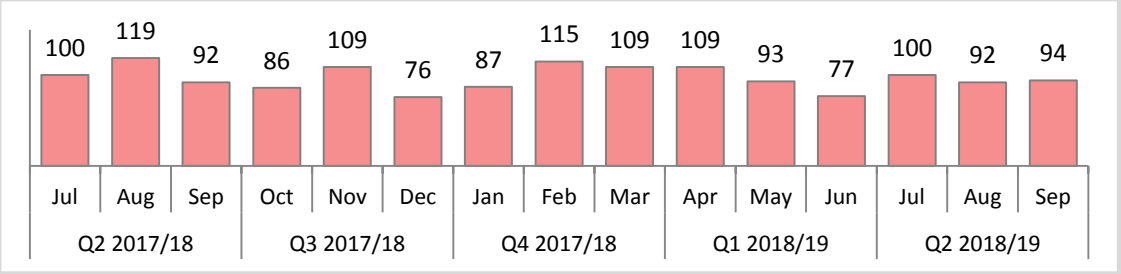
Sep-18	Delayed Transfers of Care (DTOC)
3.6%	The percentage of patients that have remained in their hospital bed beyond their transfer of care date. This is an average number calculated using daily snapshot data.
Target	Whilst it s noted there is an improvement in the DTOC position, there is a corresponding worsening of Medically Optimised patients.
<= 3.3%	



Actions

Indicator Detail

Sep-18	Medical Optimised Awaiting Transfer (MOAT)
94	Total number of patients each day who have been medically optimised. This is an average number calculated using daily snapshot data. 'Medical optimisation' is the point at which care and assessment can safely be continued in a non-acute setting.
Target	The average number of patients medically optimized and awaiting transfer in September increased from August and remains significantly above the target of less than 40.
<= 40	

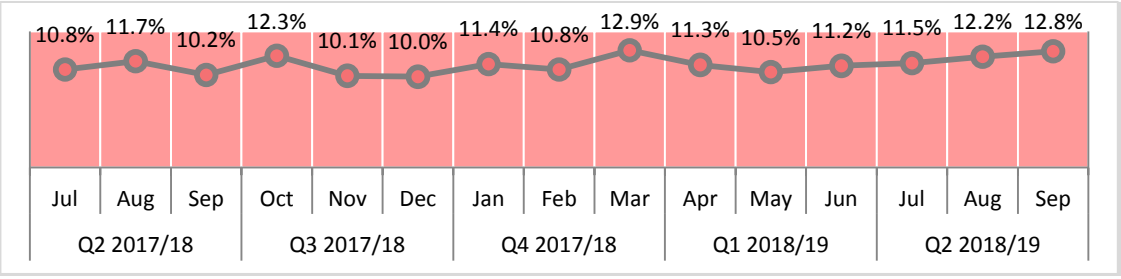


Actions

The Trust continues to work with partner organisations to try to reduce the number of patients remaining in hospital when medically fit to be discharged. Early identification of discharge dates, daily white board rounds and ensuring families are aware of progress towards discharge are key areas of focus.

Actions to address sit within the stranded patient actions.

Sep-18	Bank & Agency Costs
12.8%	The total bank & agency cost as percentage of the total pay costs
Target	Bank and agency costs in September 2018 account for 12.77% (£2.37M) of the £18.55M total pay costs. This is a £77K decrease from the position reported in August 2018 (£2.45M).
<= 5%	



Actions

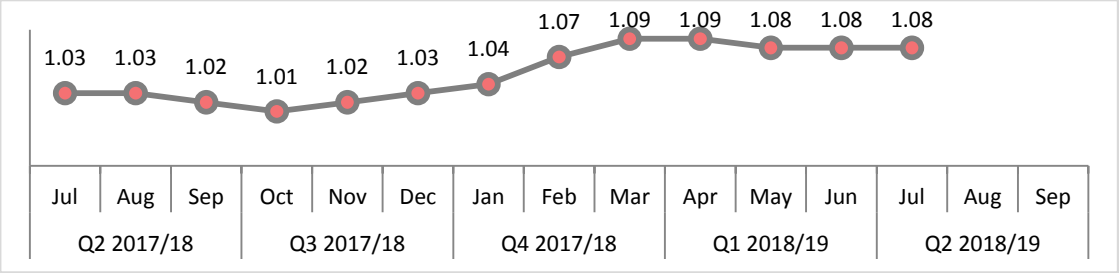
In month 6 the Trust spent £1,029,000 in total, £729,000 on medical agency and £216,000 on non-medical, clinical agency. This is within the forecast presented last month; however, the expenditure exceeds the ceiling. The high spend areas are in the Medicine and Clinical Support business particularly at middle grade and consultant grade.

Actions remain in place to reduce the level of spend and the current forecast for the end of the year is £10.9M, exceeding the agency ceiling of £10,534,000 for 2018/2019.

The Trust will be represented at a recruitment event in November 2018 at the Acute Medicine conference to promote Stockport and aim to recruit acute and general medical doctors in situ at the venue. The recent changes to the price caps in view of the medical and dental pay uplift will be incorporated into the agency approval process.

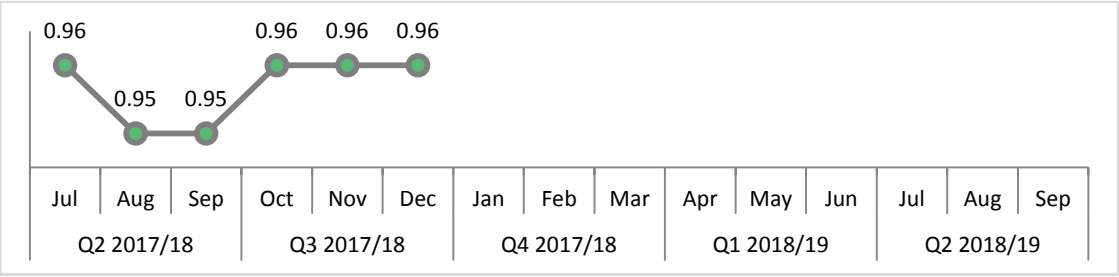
Indicator Detail

Jul-18	Mortality: HSMR
1.08	This is the ratio between the actual number of patients who either die while in hospital compared to the number of patients that would be expected to die based on whether patients are receiving palliative care, and socio-economic deprivation.
Target	HSMR remains unchanged.
<= 1	



Actions
AQUA quality improvement project is reviewing clinical and palliative care coding, as well as clinical documentation, with the goal of better representing clinical practice, and aligning HSMR and SHMI. Board report will be submitted in two months.

Dec-17	Mortality: SHMI
0.96	This is the ratio between the actual number of patients who either die while in hospital or within 30 days of discharge compared to the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated.
Target	Sustained above average performance
<= 1	

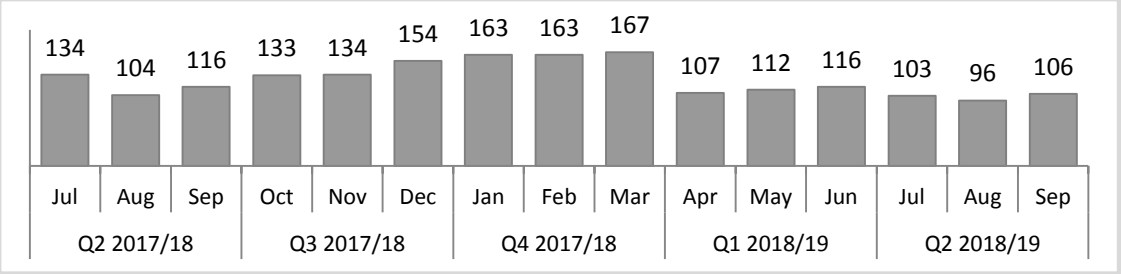


Actions
Review of all outlying mortality indicators if and when they occur.

Indicator Detail

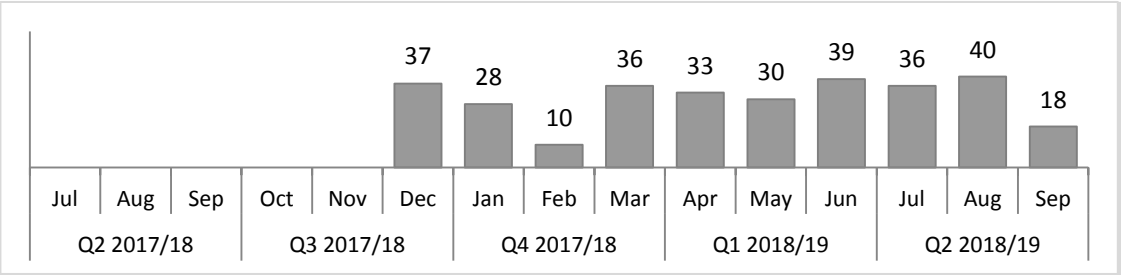
Sep-18	Mortality: Deaths in ED or as Inpatient
106	Total number of patient deaths while patient was in the emergency department or as an inpatient.
Target	The number of deaths in month, continues to follow the trend of 17/18. However the number of deaths per month has been lower for five of the six months.

Actions
We continue to monitor the mortality ratio's relative to peer hospitals.



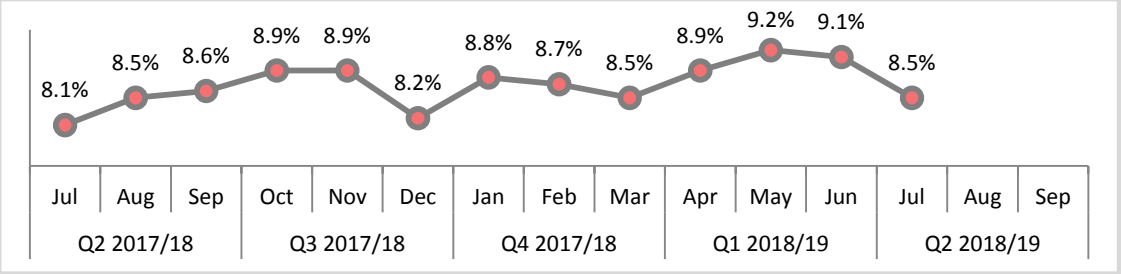
Sep-18	Mortality: Case Note Reviews
18	The total number of case note reviews undertaken of each death in ED or as inpatient
Target	Only 17% of deaths were reviewed this month. The trust target is 30%

Actions
Breakdown by specialty will be reviewed by the medical director and actions taken to improve performance.



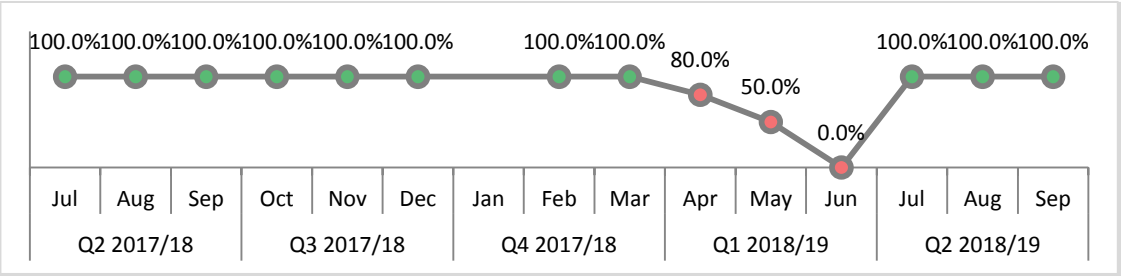
Indicator Detail

Jul-18	Emergency Readmission Rate
8.5%	The percentage of emergency re-admissions within 28 days following an inpatient discharge.
Target	Two months of improved performance. These results align well with the principles of Stockport Together and will serve as a good marker of success of the program.
<= 7.9%	



Actions
None.

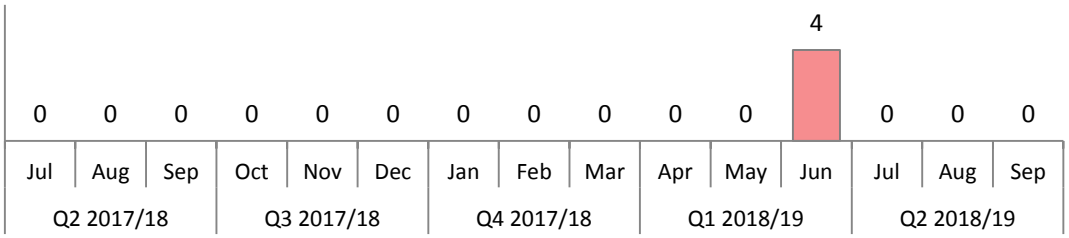
Sep-18	Patient Safety Alerts: Completion
100.0%	The percentage of Patient Safety Alerts that are completed within their due date.
Target	The trust had six alerts issued in the month of September 2018. Three were medical device alerts, one was a drug alert and one was an estates & facilities alert on ligatures. There were two alerts whose deadline for completion was last month; these were closed within the deadline.
>= 100%	



Actions
The Standard Operating Procedure for Alerts and Hazards Management, is going through the process of approval. The system is being refined with all alerts being placed onto the incident reporting system and distributed to areas only if it is relevant to them. An audit of patient safety alerts and their action plans is being undertaken for those alerts issued during the last 3 years.

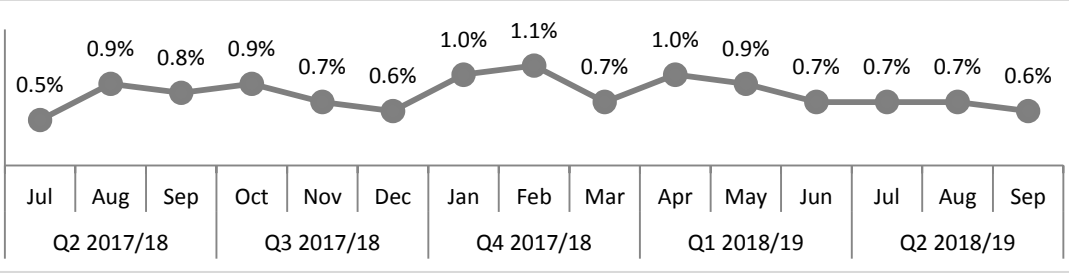
Indicator Detail

Sep-18	DSSA (mixed sex)
0	Total number of occasions sexes were mixed on same sex wards
Target	Total number of occasions sexes were mixed on same sex wards.
<= 0	



Actions
There were no patients affected by a mixed sex breach in the month of September.

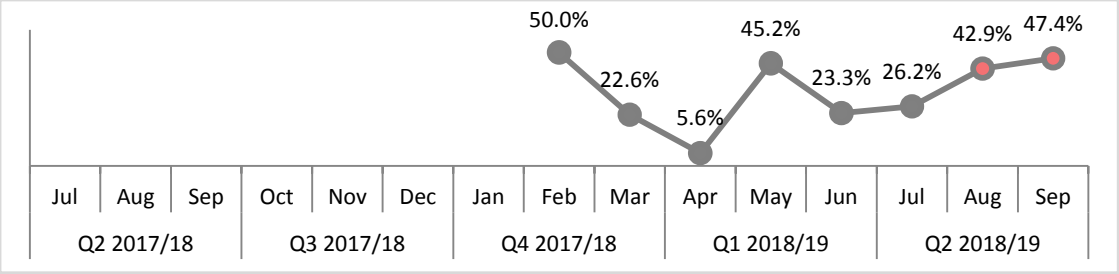
Sep-18	Complaints Rate
0.6%	The total number of formal written complaints received compared with the whole time equivalent staff.
Target	The Trust received 27 new complaints in September 2018: Integrated Care = 8, Medicine & CS = 4, Surgery & CC = 11 and WCDS = 4



Actions
The Trust continues to aim to reduce the number of formal complaints by addressing concerns more robustly at an informal level. This provides a better and quicker outcome for the Trust and the complainant.

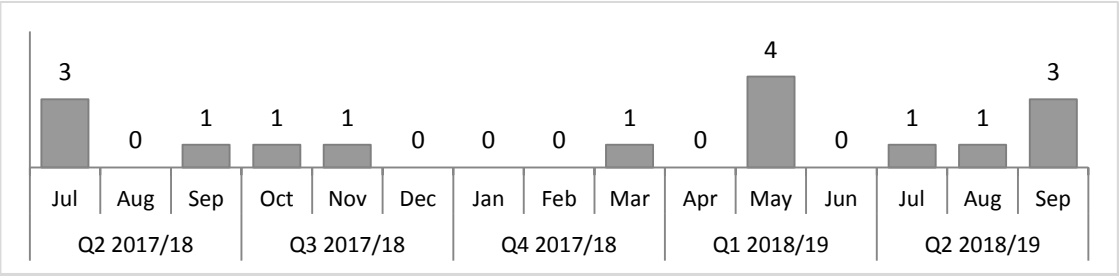
Indicator Detail

Sep-18	Complaints: Response Rate 45
47.4%	The percentage of formal complaints responded to within 45 days.
Target	The overall response for cases that were due out in September that closed in time is 50%. Surgery & CC = 33.3% - Integrated Care = 66.7% - Medicine = 20% Women, Children & DS = 100%
>= 95%	



Actions
The response rate continues to be lower than the Trust is aiming to achieve. Work is still on-going within the business groups to implement the new complaints process. This involves a focus on increased scrutiny and accountability.

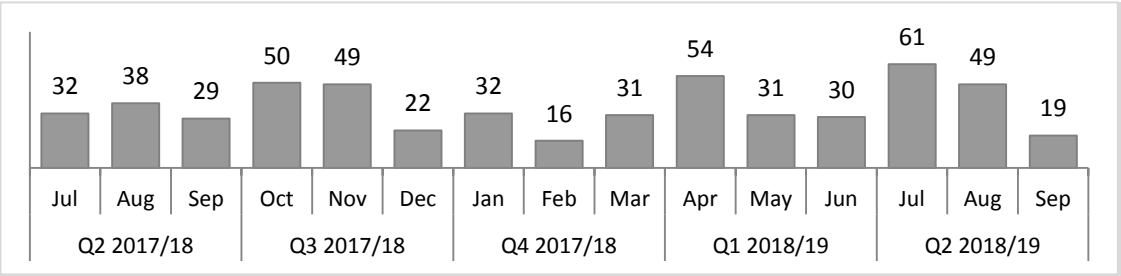
Sep-18	Complaints: Parliamentary & Health Service Ombudsman Cases
3	The total number of open Ombudsman cases.
Target	The Trust received 3 new referrals from the PHSO in September 2018. 2 for medicine and 1 for surgery and critical care.



Actions
All actions arising from the PHSO investigation are shared with the business group. This enables the Trust to learn from the findings to prevent recurrence in future cases.

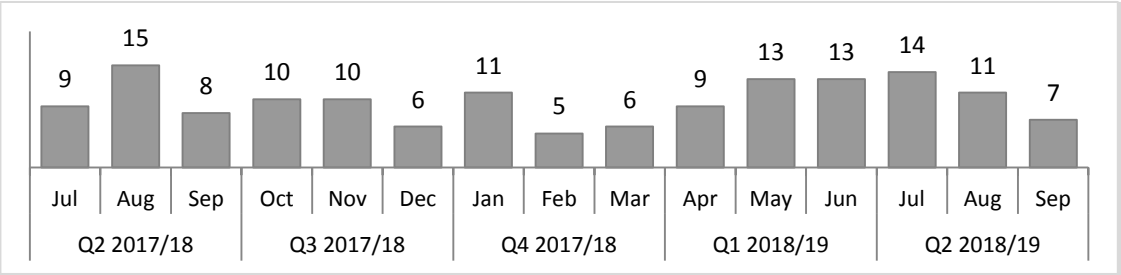
Indicator Detail

Sep-18	Complaints Closed: Overall
19	The total number of formal complaints that have been closed.
Target	In September 2018 19 cases were closed in month (this includes cases that were due out in other months).



Actions
The PCS team continue to cases and their due dates and liaise regularly with the business groups. If we are notified that the response will be delayed the complainant is notified and kept informed as agreed. The chief nurse & director of quality governance continues to receive monthly reports which details when cases are due out and their current position.

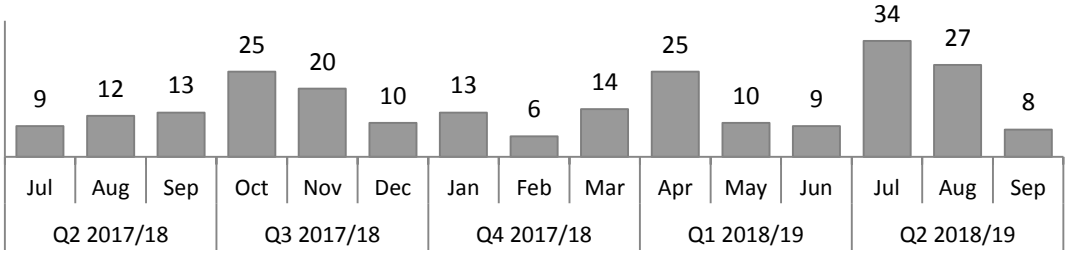
Sep-18	Complaints Closed: Upheld
7	The total number of upheld formal complaints that have been closed.
Target	Of the 19 complaints closed in September 2018, 7 were upheld.



Actions
The Trust continues scrutinise lessons learnt which is always shared with the complainant.

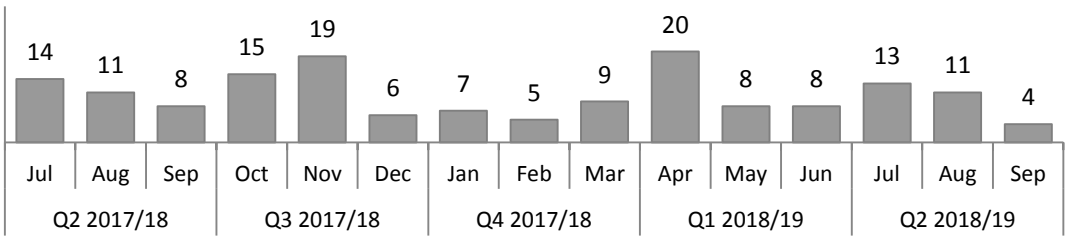
Indicator Detail

Sep-18	Complaints Closed: Partially Upheld
8	The total number of partially upheld formal complaints that have been closed.
Target	Of the 19 complaints closed in September 2018, 8 were partially upheld.



Actions
The Trust continues scrutinise lessons learnt which is always shared with the complainant.

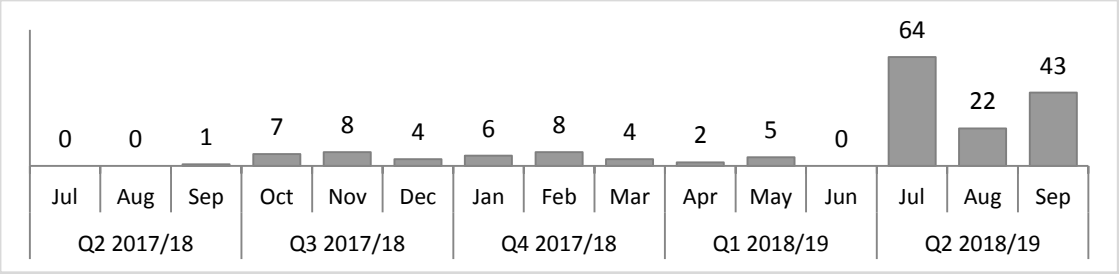
Sep-18	Complaints Closed: Not Upheld
4	The total number of not upheld formal complaints that have been closed.
Target	Of the 19 complaints closed in September 2018, 4 were not upheld.



Actions
All complaints are shared with appropriate staff for self reflection and learning.

Indicator Detail

Sep-18	Compliments
43	Total number of compliments received.
Target	In September 2018 the Patient and Customer Services Department received 15 compliments about the Trust.



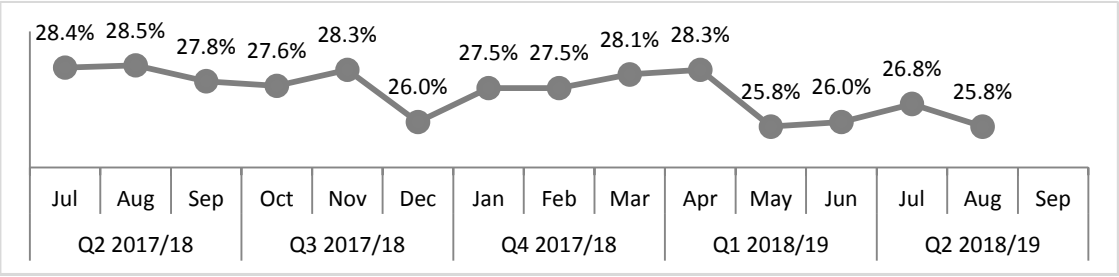
Actions

The matron for patient experience has recently reviewed how the Trust captures compliments and now receives reports, on a monthly basis, from all business groups providing figures and details for compliments received at ward and service level.

When compliments are received, an acknowledgement is sent to the author thanking them for taking the time to write to the Trust with their feedback. The feedback is sent to the relevant business group asking them to share with relevant staff who provided the patient's treatment.

The Trust has recognised that compliments are a valuable tool in learning about our services and is keen to improve how these are processed.

Aug-18	Friends & Family Test: Response Rate
25.8%	The percentage of eligible patients completing an FFT survey.
Target	The overall trust response rate for September 2018 for the Friends and Family test is 25.8%. There is no national indicator for response rate.



Actions

Overall positive comments received related to friendly, caring and compassionate staff who provide excellent care to patients and their families.

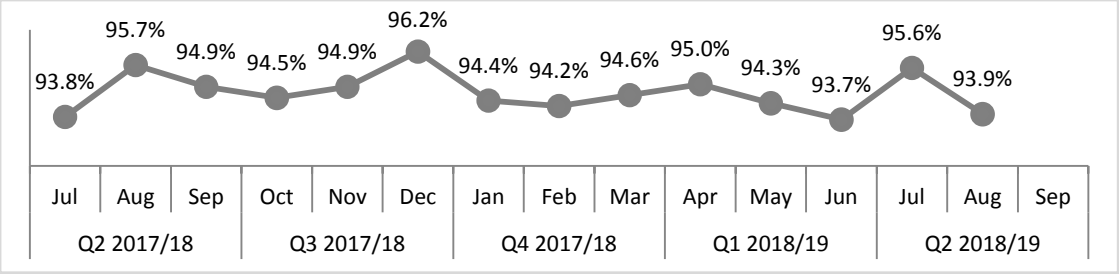
The top themes for negative feedback continue to relate to long waiting times and poor communication.

Although there is no national indicator for response rate business groups, Wards and departments are encouraged to ensure as many patients as possible continue to provide us with feedback to enable us to triangulate this with other patient feedback mechanisms,

The Patient Experience group and the Patient Experience Action group monitor results on a monthly basis.

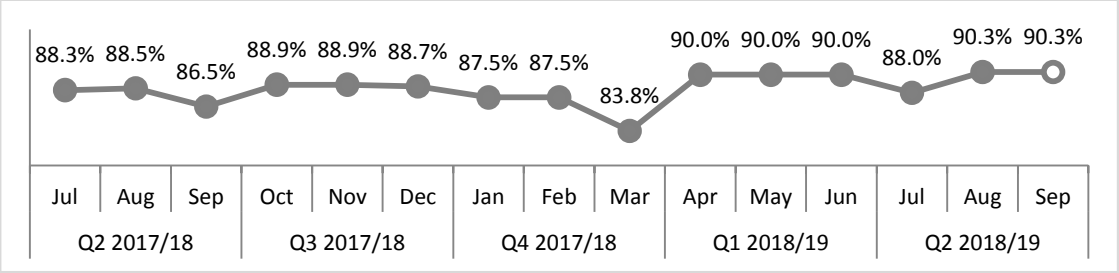
Indicator Detail

Aug-18	Friends & Family Test: Inpatient
93.9%	The percentage of surveyed inpatients who are extremely likey or likely to recommend the Trust for care.
Target	The percentage of surveyed maternity patients who are extremely likely or likely to recommend the Trust for care. There is no national target for the friends and family test.



Actions
Although there is no national indicator for satisfaction rate business groups, Wards and departments are encouraged to ensure as many patients as possible continue to provide us with feedback. Positive themes identified related to compassionate, knowledgeable caring staff who provide excellent care to patients. The Patient Experience group and the Patient Experience Action group monitor results on a monthly basis.

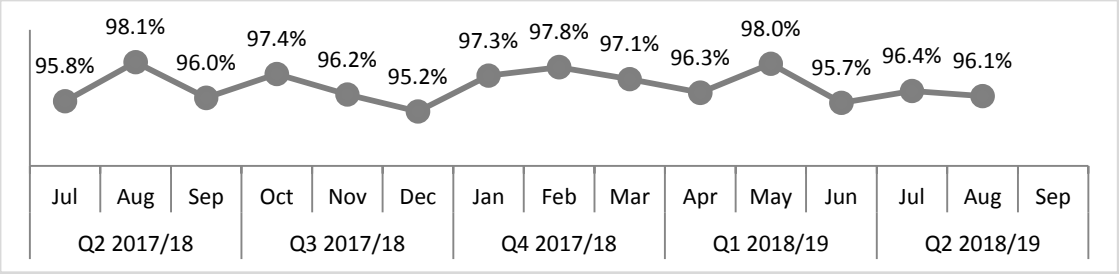
Aug-18	Friends & Family Test: A&E
90.3%	The percentage of surveyed A&E patients who are extremely likey or likely to recommend the Trust for care.
Target	The percentage of surveyed maternity patients who are extremely likely or likely to recommend the Trust for care. There is no national target for the friends and family test.



Actions
Although there is no national indicator for satisfaction rate business groups, Wards and departments are encouraged to ensure as many patients as possible continue to provide us with feedback. Positive comments centred around professional, caring and hardworking staff. The Patient Experience group and the Patient Experience Action group monitor results on a monthly basis.

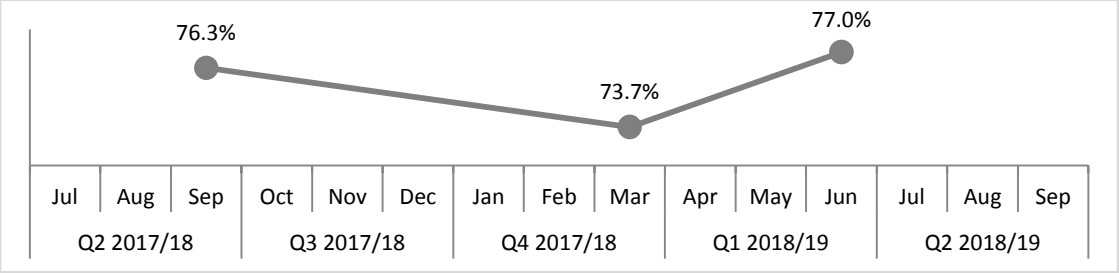
Indicator Detail

Aug-18	Friends & Family Test: Maternity
96.1%	The percentage of surveyed maternity patients who are extremely likey or likely to recommend the Trust for care.
Target	The percentage of surveyed maternity patients who are extremely likely or likely to recommend the Trust for care. There is no national target for the friends and family test.



Actions
Although there is no national indicator for satisfaction rate business groups, Wards and departments are encouraged to ensure as many patients as possible continue to provide us with feedback. Many positive comments related to caring and compassionate staff. There were also positive comments relating to the satisfactory level of patient advice and information given. The Patient Experience group and the Patient Experience Action group monitor results on a monthly basis.

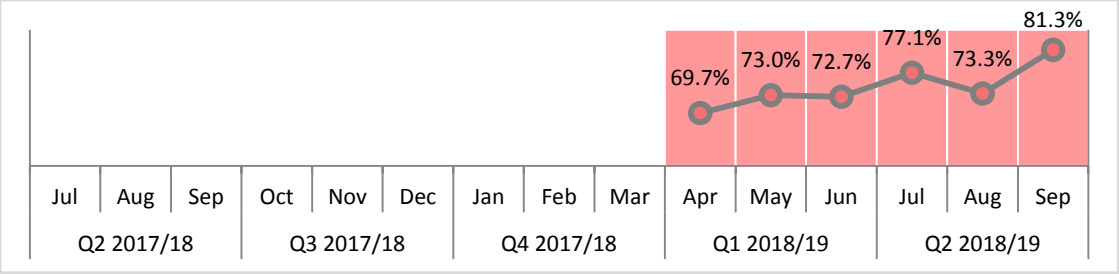
Jun-18	Staff Friends & Family Test
77.0%	The percentage of all surveyed staff who are extremely likely or likely to recommend the Trust for care.
Target	The staff F&F Test is a quarterly survey that provides data on the likelihood that a) staff would recommend their Trust as a place to work and b) as a place to receive care to friends and family. The data we recieve is triangulated with staff survey and pulse survey to support delivery of the Culture and Engagement plan.



Actions
In Qtr.1 2018/19 58.8% of staff indicated that they were likely or extremely likely to recommend the Trust as a place to work. This is 9% higher than the 2017/18 Qtr. 4 survey. There has been a focus on engagement and health and well being which is having a positive impact on resilience and staff experience With regard to recommending the Trust as a place to receive care 77.0% of staff responding to the survey indicated that they were likely or extremely likely to recommend the Trust to friends and family with 3.7% saying that they were unlikely or extremely unlikely to do so.

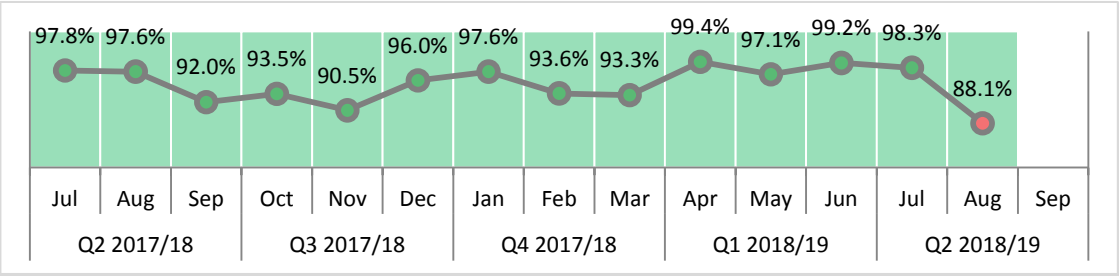
Indicator Detail

Sep-18	Diabetes Reviews
81.3%	The percentage of inpatients with known diabetes, on treatment and with a blood glucose of less than 3mmol/L, that have been reviewed by the diabetes team prior to discharge.
Target	The sustained improvement in performance against this metric continued in month
>= 90%	



Actions
In month performance averaged 81.3% with 3 of the 4 weeks in September achieving 80% or more. The diabetes team continue to prioritise the ward reviews, as evidenced in this performance.

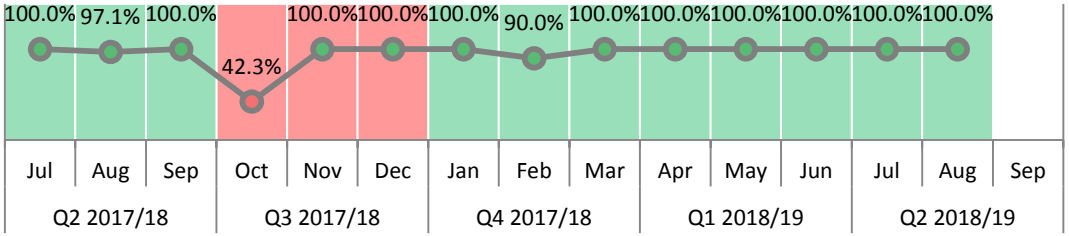
Aug-18	Dementia: Finding Question
88.1%	The percentage of eligible patients who have a diagnosis of dementia or delirium or to whom case finding is applied.
Target	The Trust has a target of above 90% for the finding question within the FAIR process.
>= 90%	



Actions
The target was not achieved this month due to an unexpected change in staff inputting the data resulting in an administrative error.

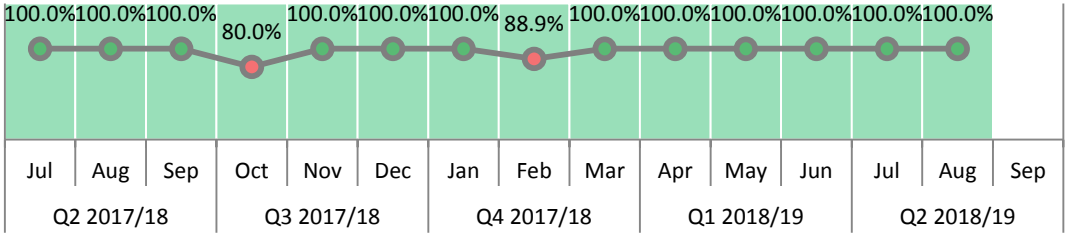
Indicator Detail

Aug-18	Dementia: Assessment
100.0%	The percentage of eligible patients who, if identified as potentially having dementia or delirium, are appropriately assessed.
Target	The target is >90%
>= 90%	



Actions
The target has been achieved in month.

Aug-18	Dementia: Referral
100.0%	The percentage of eligible patients where the outcome was positive or inconclusive, are referred on to specialist services.
Target	The target is >90%.
>= 90%	

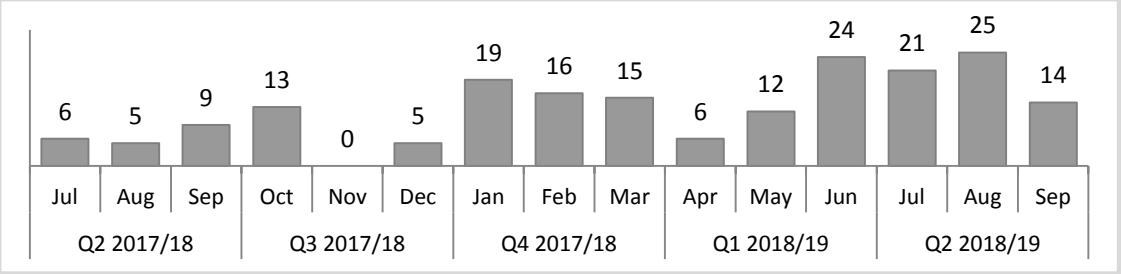


Actions
The target has been achieved in month.

Indicator Detail

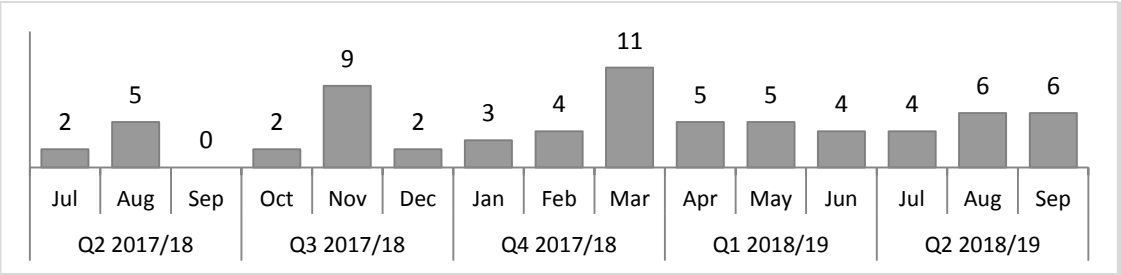
Sep-18	Serious Incidents: STEIS Reportable
14	The total number of STEIS reportable incidents.
Target	There have been 14 incidents reported via StEIS in September 2018. All Serious Incidents have been reviewed by the Chief Nurse & Director of Quality Governance and the Medical Director.

Actions
Investigations are underway in accordance with trust policy. In September there were: 5 cases of stage 3 pressure ulcers 2 cases where patients waited over 12 hours from being clerked in the Emergency Department 2 maternity diverts 1 case of a fall and fracture 1 case of a fall and head injury 1 neonatal death 1 case of a delay in a planned test 1 case of a medication error



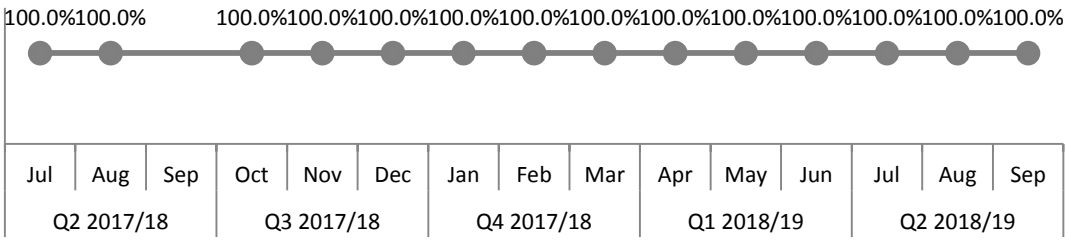
Sep-18	Litigation: Claims
6	Total number of claims opened in month.
Target	In September 2018, the trust received 6 litigation claims. 4 were potential medical negligence claims 2 were potential employment claims

Actions
The process for investigating the claims received has commenced in line with trust policies and procedures.



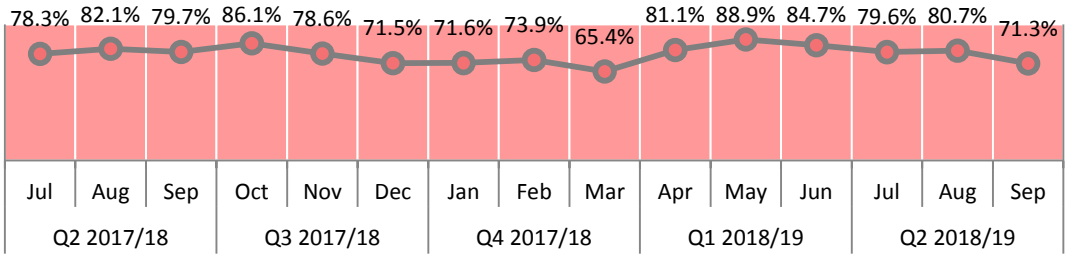
Indicator Detail

Sep-18	Litigation: Key Risk Claims Rate
100.0%	The percentage of claims opened in month that are related to key risk areas.
Target	In September 2018, five claims were closed of which two were unsuccessful against the Trust.



Actions
Key risk claims include those relating to; Obstetrics Slips, trips or falls Failure or delay in treatment failure or delay in diagnosis. Two of the claims that were settled this month relate to a delay in diagnosis and treatment. The third claim to be settled was an employment liability claim.

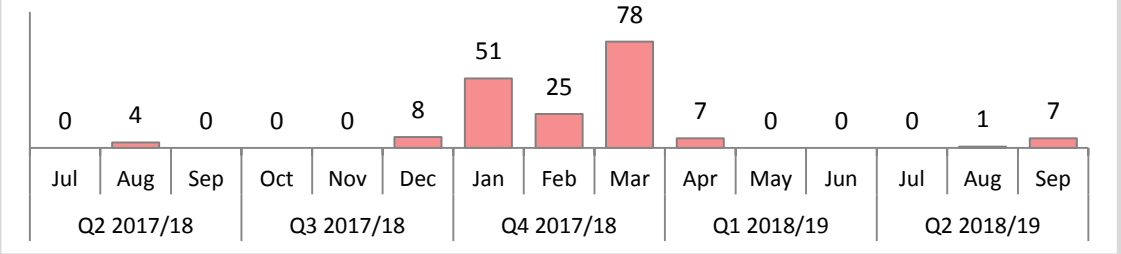
Sep-18	A&E: 4hr Standard
71.3%	The percentage of patients who were admitted, discharged, or leave A&E within 4 hours of their arrival.
Target	Performance in September was particularly poor, at 71.0%, with a clear correlation between the increasing number of stranded patients and deteriorating performance.
>= 95%	



Actions
September was challenging with performance significantly below the 85% improvement trajectory. The Trust continues to maintain a daily focus on patient flow and reducing the number of patients remaining in hospital as follows: Overnight breaches - 2 additional assessment areas for majors being created including a review of nurse practitioner work space - CCG has been approached to fund senior leadership overnight within ED. Early discharge - will be supported by daily board rounds on each ward Stranded patients - System-wide review being led by the Urgent Care Improvement Director

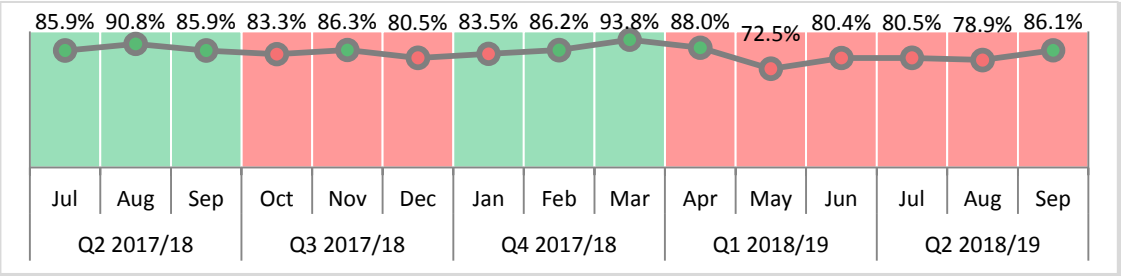
Indicator Detail

Sep-18	A&E: 12hr Trolley Wait
7	Total number of patients whose decision to admit from A&E was over 12 hours from their actual admission.
Target	There were seven 12hr breaches reported in month. Early indications of the root cause analyses suggests no clinical harm to patients.
<= 0	



Actions
The lack of beds first thing in the morning is predominantly the reason for the breaches. The Trust continues to work towards wards identifying 'Golden Patients' for early discharge and on ensuring that TTOs are prepared and transport booked the day before so that the discharge is not delayed until later in the day.

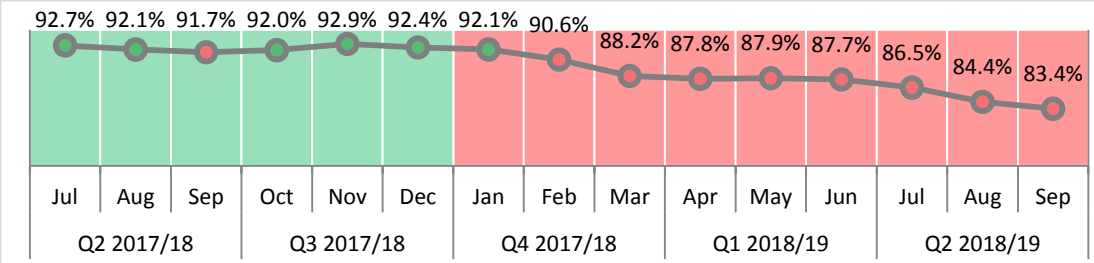
Sep-18	Cancer: 62 Day Standard
86.1%	The percentage of patients on a cancer pathway that have received their first treatment within 62 days of their GP referral.
Target	An improved performance is expected for September with a forecast position of 86.1% against the 85% standard. Referrals continue to be 20% higher than last year at circa 930 per month (from 800). Referrals in August were particularly high at 1015.
>= 85%	



Actions
Following the cancer workshop, the following actions are being taken: - Patient literature review to ensure patients are informed of the urgent nature of their referral to help improve engagement and availability for investigations. - Joint working between Radiology and General Surgery to look at introducing a straight to MR scan model for patients who can be appropriately triaged to this pathway. - Progressing the business case for in-house CPEX provision The safety measures taken to minimise risk to patients on the Breast 2ww pathway should enable a fully compliant service by January 2019. In the interim, there is a risk of increased breaches of the 62 day pathway.

Indicator Detail

Sep-18	Referral to Treatment: Incomplete Pathways
83.4%	The percentage of patients on an open pathway, whose clock period is less than 18 weeks.
Target	As anticipated performance against the standard fell in September. This is a result of the focus on waiting list size reduction and so performance may continue to deteriorate in the short-term before recovery against the 92% is seen.
>= 92%	



Actions

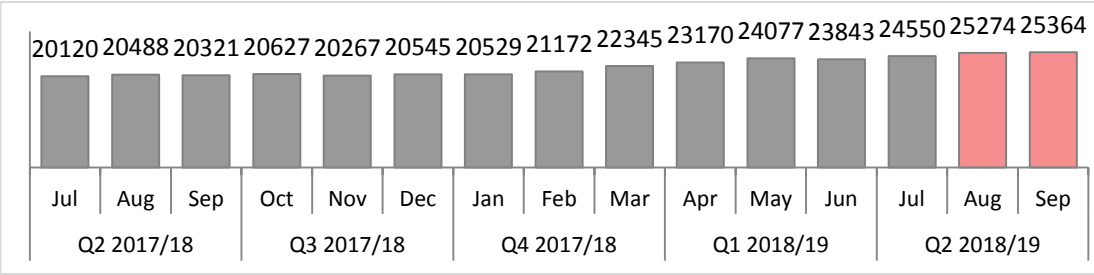
A joint provider / commissioner focus on reducing the waiting list size, looking at:

Data quality / validation checks
- weekly progress tracked via the Elective Performance meeting re validity of pathways
- awareness /update training is being rolled out to staff who administer the elective waiting list to prevent recurrence of data quality issues

Activity
- Plans for maximising elective activity are underway for both the Medicine & Surgical Business Groups

Demand management
- 'Patient Initiated Follow-Up' is being trialled in the Pain service
- CCG led GP referral management

Sep-18	Referral to Treatment: Incomplete Waiting List Size
25364	The total number of patients on an open pathway.
Target	The Trust has met the agreed improvement trajectory for September. However, the overall waiting list has increased slightly in month from 25274 in August '18 to 25364 in September '18, which was compounded by a continued rise in GP referrals.
<= 22345	



Actions

Data quality / validation checks
- weekly progress tracked via the Elective Performance meeting re validity of pathways
- awareness /update training is being rolled out to staff who administer the elective waiting list to prevent recurrence of data quality issues

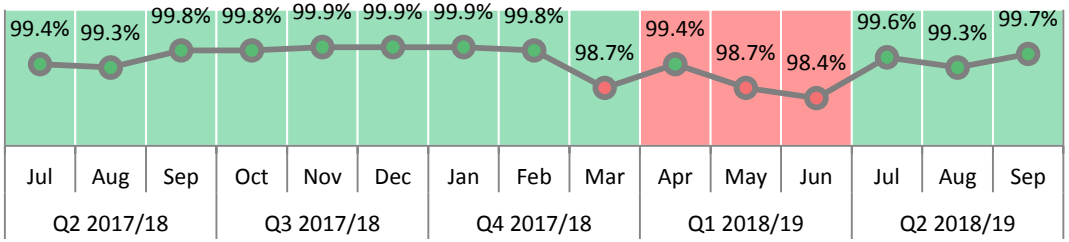
Activity
- Plans for maximising elective activity are underway for both the Medicine & Surgical Business Groups

Demand managment
- 'Patient Initiated Follow-Up' is being trialled in the Pain service

Weekly conference call meetings have been scheduled with Stockport CCG to monitor progress

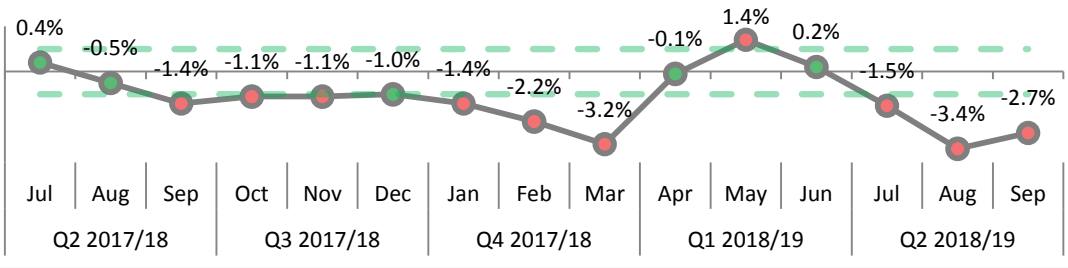
Indicator Detail

Sep-18	Diagnostics: 6 Week Standard
99.7%	The percentage of patients refered for diagnostic tests who have been waiting for less than 6 weeks.
Target	The Trust is forecasting continued compliance with this standard. It should be noted however that: - the CT scanner failed on 3 occasions in month - there is a National supply chain issue of contrast stock affecting MR capacity.
>= 99%	



Actions
Continue to commission additional CT capacity in response, as required. Progress business case / implementation plan for 3rd CT scanner. Note significant risk if this is delayed.

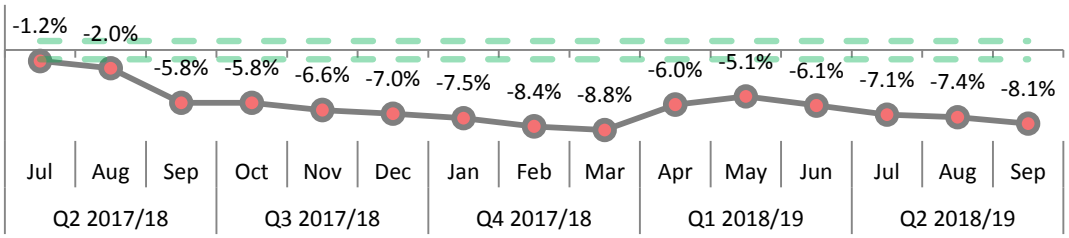
Sep-18	Outpatient Activity vs. Plan
-2.7%	The percentage variance between planned outpatient activity and actual outpatient activity.
Target	The Trust was over-plan for OP attends in month, bringing the cumulative position to -2.7% YTD. The areas of significant variance remain Ophthalmology, Oral Surgery and Chest.
+/- 1%	



Actions
- Successful Recruitment in Ophthalmology will start to address the shortfall. - Contract negotiations are taking place with UHSM regarding the Oral Surgery SLA - Respiratory are recruiting to McMillan funded posts

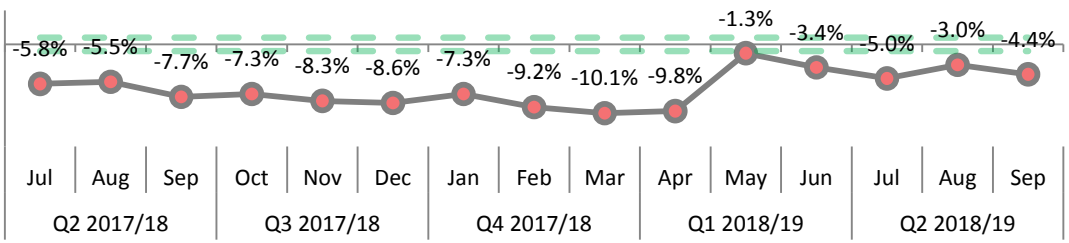
Indicator Detail

Sep-18	Elective Activity vs. Plan
-8.1%	The percentage variance between planned elective activity and actual elective activity.
Target	Elective activity was 300 spells adverse to plan in Month 6. Early indications from specialty level recovery plans suggest recovery by year end. The risk to this is being able to continue operating throughout winter.
+/- 1%	



Actions
Recovery plans are in development for both Medicine and Surgery Business Groups, In particular: - Ophthalmology are finalising plans to outsource elective work until appointed staff commence in post. - additional daycase capacity to be opened on a permanent basis. - Continuing with day-case surgery during the Festive period -Continuing with elective Orthopaedic work throughout the winter period - flexing theatre sessions to allow specialties with longer waiting lists to increase their activity numbers and reduce waiting times

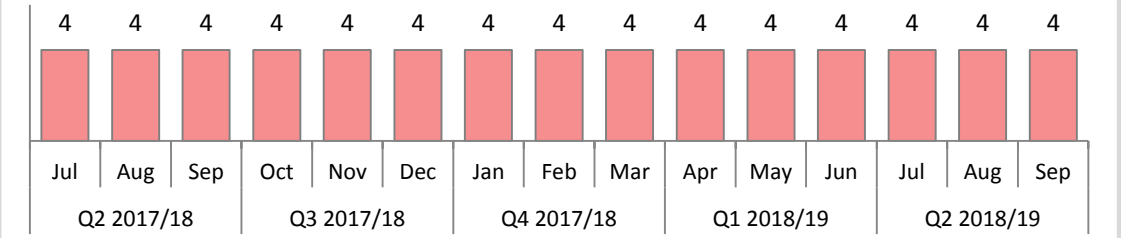
Sep-18	Elective Income vs. Plan
-4.4%	The percentage variance between planned elective income and the actual elective income.
Target	Elective income was significantly behind plan in September, however the year to date position compare quite favourably to month 6 2017/18.
+/- 1%	Adverse activity variance is not directly proportional to income variance in all specialties due to casemix.



Actions
Recovery relates to activity action plans as already described.

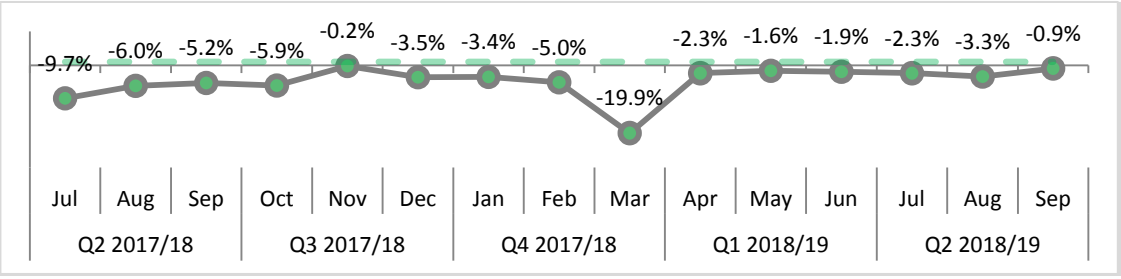
Indicator Detail

Sep-18	Financial Efficiency: I&E Margin
4	A calculated score based on the Income & Expenditure surplus or deficit against total revenue.
Target	The Trust's 2018/19 Operational Plan does not deliver the target of a score of a 2 or better however is forecasting an amber against the delivery of the financial plan. To improve to a 3 the planned deficit would need to improve by circa £30m to a deficit of less than £3m (within 1% of planned operating income).
<= 2	



Actions
The financial outlook for the Trust remains difficult; in the twelve months to 31st March 2019 the Trust is forecasting a loss of £34m (£93,000 per day) even after the achievement of a £15.0m CIP. This is a deterioration of £12m from the £22m loss in 2017/18, where the Trust relied on non-recurrent measures to achieve the year-end position. The Trust's underlying position continues to be monitored by NHSI through the Enhanced Financial Oversight and Use of Resources processes, and is working closely with colleagues to improve the underlying run-rate.

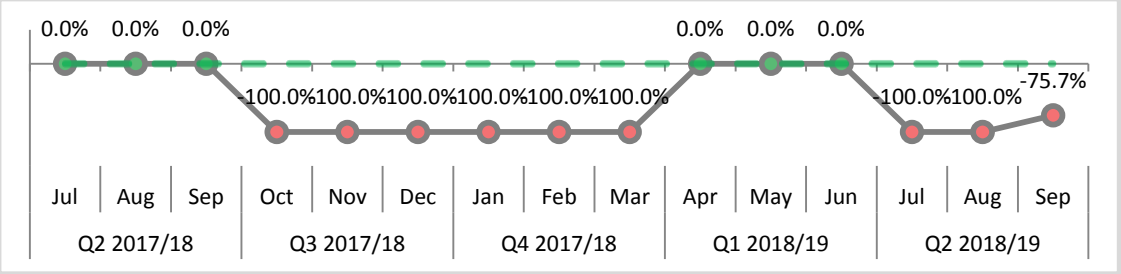
Sep-18	Financial Controls: I&E Position
-0.9%	The percentage variance between planned financial position and the actual financial position.
Target	The Trust has lost of £19.9m in the first half of the financial year, an average loss of £109,000 per day. The planned deficit was £20.1m so this is £0.2m favourable to plan. The Trust is reporting moderate assurance on the delivery of this metric.
<= 1%	



Actions
As the Trust is favourable against the financial plan at this stage of the financial year, the Trust is scoring a 1 (best) under the NHSI use of resources (UoR) metric within the Single Oversight Framework. There are a number of risks which will need to be actively managed to assure the year end financial position, primarily delivery of the cost improvement programme. There is an action plan in place to mitigate the non-delivery of CIP but given the elective income performance, uncertainty over winter demands, risk of additional contract penalties due to operational performance, and risk on Stockport Together, there remains moderate assurance that the operational plan will be delivered at the end of 2018/19.

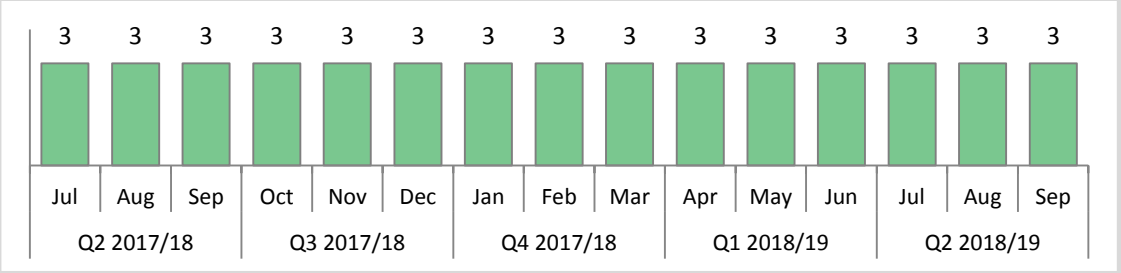
Indicator Detail

Sep-18	Cash
-75.7%	The percentage variance between planned borrowing-to-date and the actual borrowing-to-date.
Target	Cash in the bank on 30th September 2018 was £4.1m. The graph shows that the Trust accessed borrowing for the first time in September 2018. The forward risk is forecasted as a green, as the Trust has applied and received confirmation of revenue support from.
+/- 1%	



Actions
The Trust borrowed £2.3m in September to maintain the minimum required cash balance, and has requested a further £2.6m in October and £5.5m in November. The requirement for a working capital support facility loan is continually being reviewed as part of the 13 week rolling cash flow forecast and the Trust continues to be in dialogue with NHSI's cash and capital team about requirements for cash.

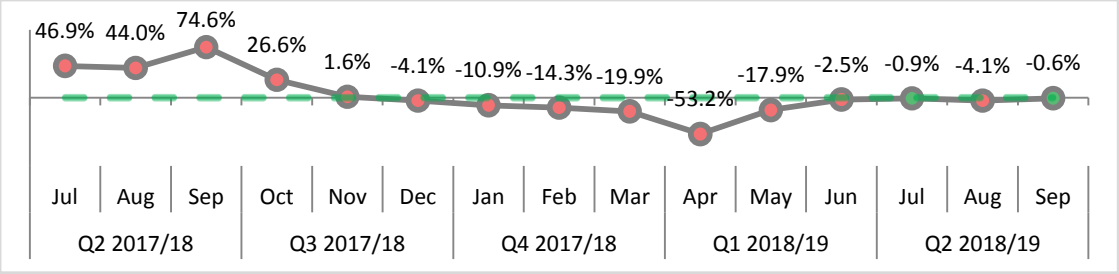
Sep-18	Financial Use of Resources
3	A calculated score based on capital service capacity, liquidity, income & expenditure margin, distance from financial plan, and agency spend.
Target	The Trust's Use of Resources (UOR) score under the Single Oversight Framework is a 3, classified by NHSI as triggering significant concerns.
<= 3	



Actions
For the three metrics on financial sustainability and financial efficiency the Trust scores a 4 (worst). This is not expected to change. The Trust remains in breach of the agency ceiling in month so this score is a 2 (second best).

Indicator Detail

Sep-18	CIP Cumulative Achievement
-0.6%	The percentage variance between planned CIP achievement and the actual CIP achievement.
Target	The Cost Improvement Programme (CIP) is in line with the profiled plan at the end of Q2 with £4.5m of savings transacted. The Trust has identified approximately £11.1m against the £15m target at this stage of the financial year.
+/- 1%	

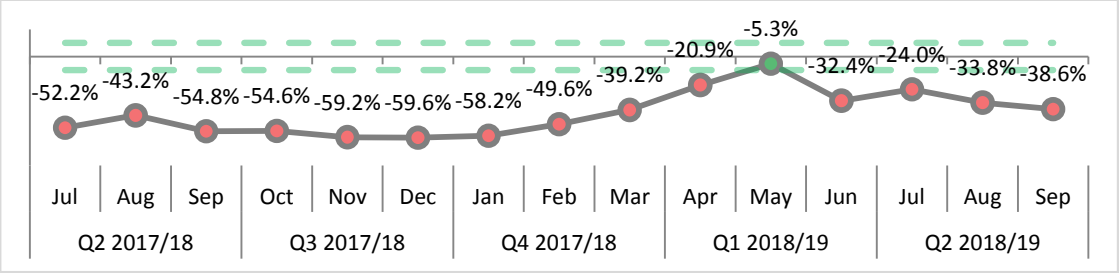


Actions

Recurrent CIP delivery is the most significant risk to the Trust's financial position for 2018/19 and beyond, as it is a key driver for the deterioration in the Trust's underlying financial position and planned £34m deficit in 2018/19. Recurrently only £4.3m of savings have been delivered against the £15m requirement.

Even with potential mitigation the Trust can only provide moderate assurance at this stage on the delivery of the 2018/19 Cost Improvement Programme.

Sep-18	Capital Expenditure
-38.6%	The percentage variance between planned capital expenditure and the actual capital expenditure. Capital expenditure includes such things as buildings and equipment.
Target	Capital costs of £3.6m have been incurred to date against a plan of £5.8m and so is £2.2m behind plan. This relates to internally funded equipment and estates schemes.
+/- 10%	



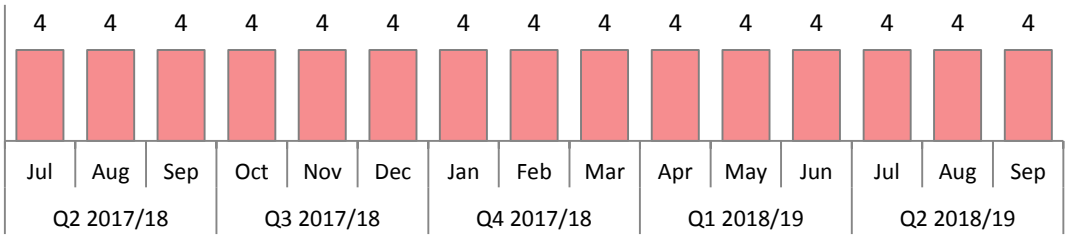
Actions

There is an equipment underspend driven by a reforecast of the gamma camera purchase from August to December, pending implementation discussions with the supplier. Estates maintenance and projects are also behind plan.

The full funding of Healthier Together schemes is fundamental to the delivery of the capital programme, but these are highly unlikely to be incurred in the current financial year, so as a result the Trust's capital plan will show a variance for the Healthier Together schemes later in the year.

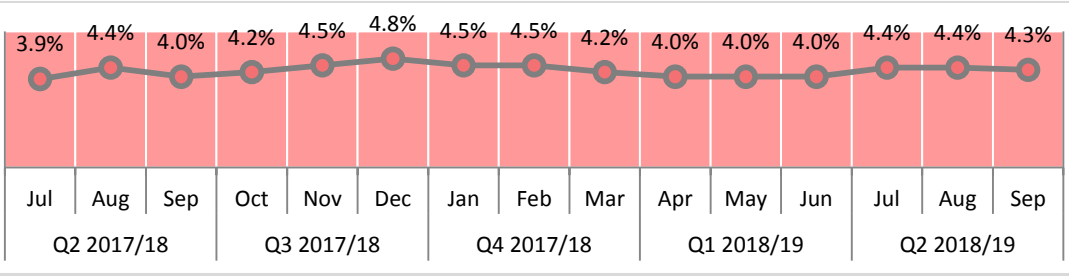
Indicator Detail

Sep-18	Financial Sustainability
4	A calculated score based on the Capital Service Capacity (the degree to which the Trust's generated income covers its financial obligations) and Liquidity in days (the number of days of operating costs held in cash or cash-equivalent).
Target	For the two metrics on financial sustainability the Trust scores a 4 (worst). This is not expected to change.
<= 2	



Actions

Sep-18	Sickness Absence Rate
4.3%	The percentage of staff on sickness absence, based on whole time equivalent.
Target	The in-month unadjusted sickness absence figure for September 2018 is 4.31%; a decrease of 0.11% compared to the adjusted August 2018 figure of 4.42%. The sickness rate for comparison in September 2017 was 3.98%. The 12-month rolling sickness percentage for the period October 2017 to September 2018 is 4.35%.
<= 3.5%	



Actions

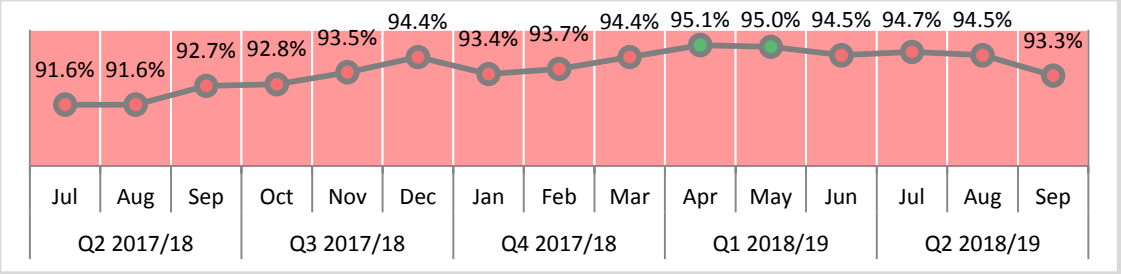
Top 3 reasons for absence are Anxiety/stress/depression, Back/musculoskeletal (including injury/fracture), and gastrointestinal problems. We have proactive wellbeing initiatives in place to support the top 2 reasons.

The unadjusted cost of sickness absence in September 2018 is £449,683; a decrease of £50,318 from the adjusted figure of £500,001 in the previous month.

Proactive support for early returns including phased return and reasonable adjustments is provided by OH. On-going dedicated HR support is provided to assist managers in the management of attendance.

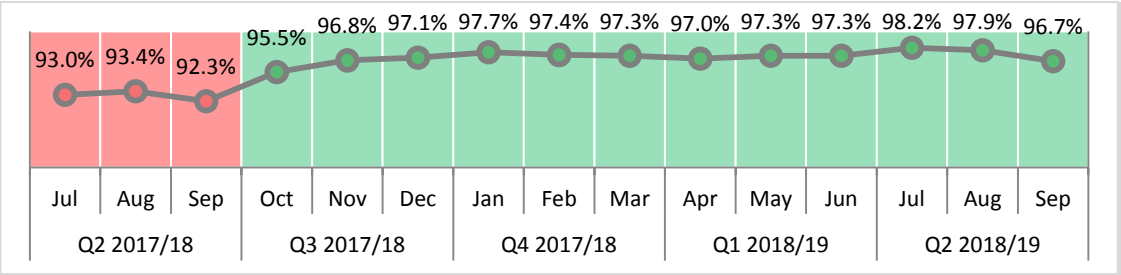
Indicator Detail

Sep-18	Appraisal Rate: Non-medical
93.3%	The percentage of non-medical staff that have been appraised within the last 15 months.
Target	The Trust's total appraisal compliance for September 2018 is 93.33%, a decrease of 1.03% from August and 1.67% below target.
>= 95%	



Actions
The Appraisal documentation is under review to ensure ease of use by staff when conducting an appraisal. Reminders continue to be provided to managers on a monthly basis to support them with the scheduling of appraisals.

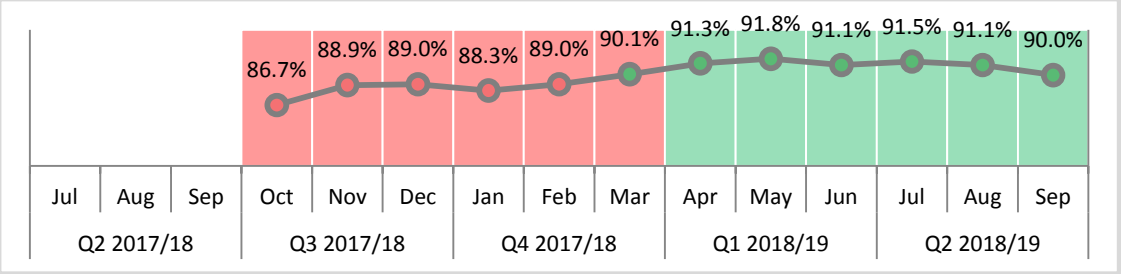
Sep-18	Appraisal Rate: Medical
96.7%	The percentage of medical staff that have been appraised within the last 15 months.
Target	The medical appraisal rate for September 2018 is 96.71%, a marginal decrease from the last month's figure of 97.90%; however remains above the Trust target of 95%.
>= 95%	



Actions

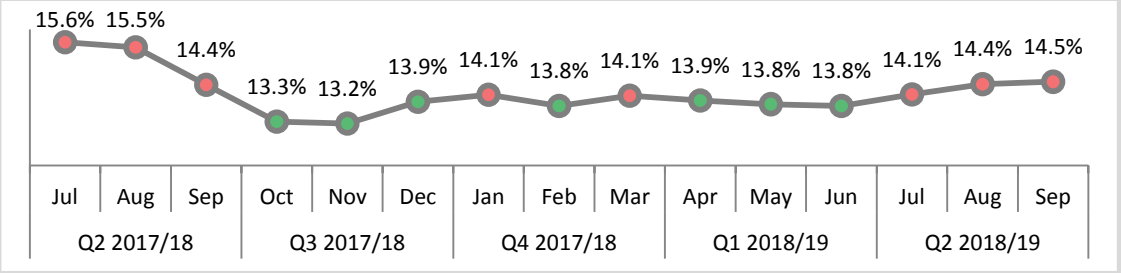
Indicator Detail

Sep-18	Statutory & Mandatory Training
90.0%	The percentage of statutory & mandatory training modules showing as compliant.
Sep-18	Statutory and Mandatory training has again achieved the compliance standard in September 2018 (90.00%).
>= 90%	



Actions
All Business groups continue to receive a monthly report to enable monitoring of staff that are going out of date. Taught sessions being held for low compliance topics eLearning sessions for staff that need assistance with drop in sessions for conflict resolution and end of life care.

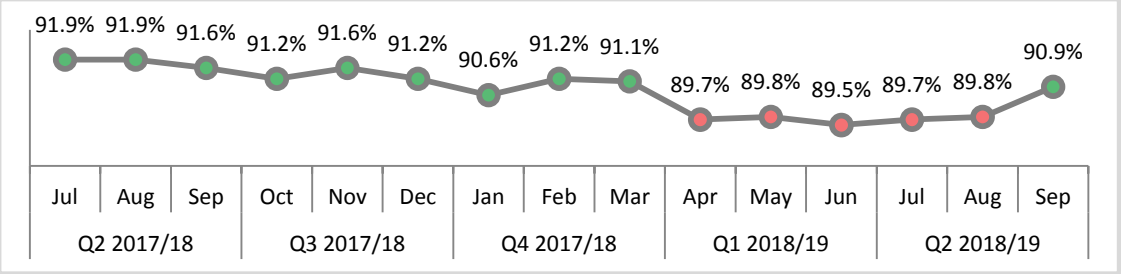
Sep-18	Workforce Turnover
14.5%	The percentage of employees leaving the Trust and being replaced by new employees.
Target	The rolling 12-month permanent headcount unadjusted turnover figure at the end of September 2018 is 14.46%. The rolling 12-month permanent headcount turnover figure for the period to September 2018 when adjusted to remove retire & return and TUPE is 12.97%, which falls below the Trust target.
<= 13.94%	



Actions
Work to address areas of high turnover continues; progressing the actions and interventions as detailed in the recruitment & retention strategy implementation plan and the progression of the NHSI Registered Nursing Recruitment and Retention programme.

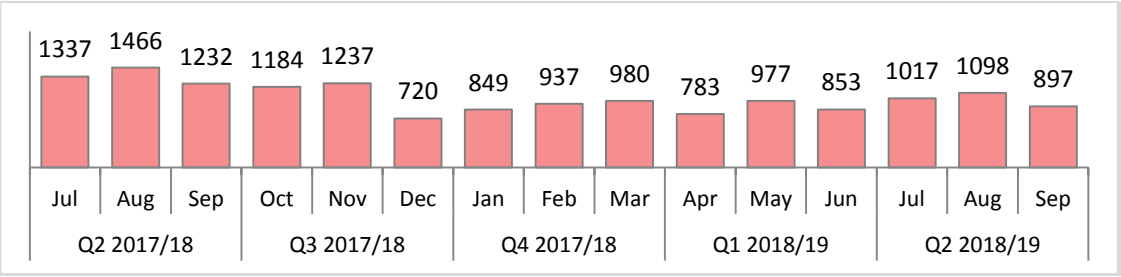
Indicator Detail

Sep-18	Staff in Post
90.9%	The percentage of whole time equivalent staff in post compared with the current establishment.
Target	The Trust staff in post figure for September 2018 is 90.85% of the establishment, which is an increase of 1.09% from 89.76% in August 2018.
>= 90%	



Actions
Work to progress the actions and interventions as detailed in the recruitment & retention strategy implementation plan are on-going.

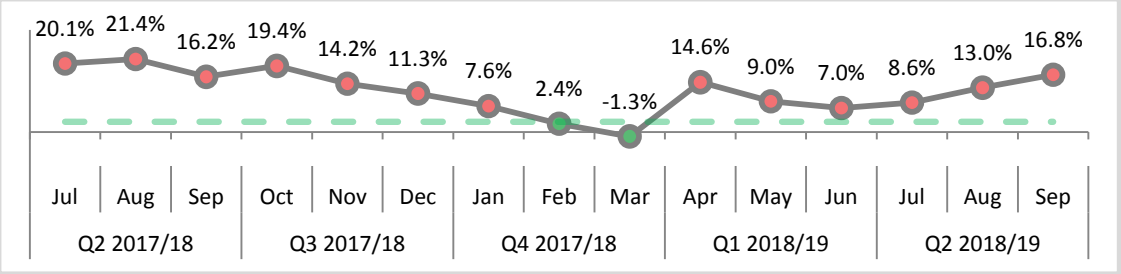
Sep-18	Agency Shifts Above Capped Rates
897	Number of agency shifts above above the provider spend cap.
Target	There were a total of 897 shifts paid above the NHSI cap rate during the 4 week period from 3rd – 30th September. This equates to an average of 224 shifts per week which is an increase of 4 shifts per week compared to August's figures but a reduction of 84 shifts per week compared to September 2017.
<= 0	



Actions
The majority of cap breaches were in Medicine & Clinical Support, with a total of 438 shifts above cap, 421 of which were related to medical staff. The total number of agency shifts worked in this period, including shifts under cap, was 1,593 – an average of 398 per week. The majority of these were medical (785) and nursing (646) shifts. There were a total of 161 shifts paid at or above £100 per hour, which required Chief Executive approval, which is an average of 40 shifts per week. A substantial review of the middle grade rota to support out of hours urgent medical care to include further usage of non-medical roles is underway. Increased challenge and scrutiny of all agency requests at the Establishment Control Panel and performance reviews continues.

Indicator Detail

Sep-18	Agency Spend: Distance From Ceiling
16.8%	The percentage variance between Trusts expenditure on agency and external locums across all staff groups and the cap set by NHSi.
Target	Total spend, including bank and agency, equates to £18.55M, which is £162K under the total pay budget for the month. Total spend on bank staff in September 2018 was £1.34M, which is 7.22% of the total pay spend. Agency spend was 5.55% of total pay expenditure, a figure of £1.03M.
<= 3%	



Actions
Action to address agency spend continues, of note there has been a growth to our medical bank of 30 high cost medical agency locums successfully transferred to the bank to avoid commission costs and the exercise with procurement to implement discounted commission rates from highest supplier agencies is now operational.

Safer Staffing Report

Sep-18	Day				Night				Day		Night		Care Hours Per Patient Per Day (CHPPD)				Safety Thermometer			
	Registered midwives/nurses		Non-registered		Registered midwives/nurses		Non-registered													
Ward Name	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Registered fill rate	Non-registered fill rate	Registered fill rate	Non-registered fill rate	Cumulative number of patients at 23:59 each day	Registered midwives/ nurses	Non-registered	Overall	Pressure Ulcers (new)	Falls with Harm	Catheters & UTIs (new)	New VTEs
AMU	3,960	3,634	3,240	3,270	3,600	3,324	2,970	3,047	91.8%	100.9%	92.3%	102.6%	1678	4.1	3.8	7.9	0	0	0	1
Clinical Decisions Unit	360	360	360	360	330	330	330	330	100.0%	100.0%	100.0%	100.0%	160	4.3	4.3	8.6	0	0	0	0
D4	1,125	990	765	698	660	638	660	660	88.0%	91.2%	96.7%	100.0%	468	3.5	2.9	6.4	0	0	0	0
A3	1,377	1,175	945	900	990	781	660	649	85.3%	95.2%	78.9%	98.3%	689	2.8	2.2	5.1	0	0	0	0
A10	2,700	2,094	1,980	1,914	1,980	1,727	1,320	1,298	77.6%	96.7%	87.2%	98.3%	770	5.0	4.2	9.1	0	0	0	0
A11	1,530	1,203	1,575	1,125	660	517	660	1,056	78.6%	71.4%	78.3%	160.0%	792	2.2	2.8	4.9	1	0	0	0
A12	1,845	1,643	1,395	1,500	660	660	660	935	89.0%	107.5%	100.0%	141.7%	751	3.1	3.2	6.3	0	0	0	1
B4	1,170	710	585	873	660	660	660	636	60.6%	149.2%	100.0%	96.4%	453	3.0	3.3	6.4	0	0	0	0
B6	1,170	713	1,035	968	660	660	660	737	60.9%	93.5%	100.0%	111.7%	636	2.2	2.7	4.8	0	0	0	1
Bluebell Ward	1,170	1,092	2,010	1,782	660	638	660	440	93.3%	88.7%	96.7%	66.7%	661	2.6	3.4	6.0	0	0	0	0
C4	1,170	856	585	886	660	660	660	737	73.1%	151.5%	100.0%	111.7%	492	3.1	3.3	6.4	0	0	1	0
Coronary Care Unit	810	809	450	309	660	660	330	319	99.8%	68.6%	100.0%	96.7%	167	8.8	3.8	12.6	0	0	0	0
Devonshire Centre for Neuro-Rehabilitation	1,035	1,035	1,935	2,181	660	660	660	990	100.0%	112.7%	100.0%	150.0%	504	3.4	6.3	9.7	0	0	0	0
E1	1,875	1,245	2,235	1,838	990	869	1,320	1,320	66.4%	82.2%	87.8%	100.0%	917	2.3	3.4	5.7	0	0	0	0
E2	2,205	2,172	1,530	1,932	990	967	990	1,323	98.5%	126.3%	97.7%	133.6%	985	3.2	3.3	6.5	0	0	0	1
E3	2,205	2,184	1,530	1,614	990	979	990	1,529	99.0%	105.5%	98.9%	154.4%	1035	3.1	3.0	6.1	0	1	0	0

Safer Staffing Report

Sep-18	Day				Night				Day		Night		Care Hours Per Patient Per Day (CHPPD)				Safety Thermometer			
	Registered midwives/nurses		Non-registered		Registered midwives/nurses		Non-registered													
Ward Name	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Registered fill rate	Non-registered fill rate	Registered fill rate	Non-registered fill rate	Cumulative number of patients at 23:59 each day	Registered midwives/ nurses	Non-registered	Overall	Pressure Ulcers (new)	Falls with Harm	Catheters & UTIs (new)	New VTEs
A1	1,395	1,289	1,170	1,079	990	847	990	957	92.4%	92.2%	85.6%	96.7%	760	2.8	2.7	5.5	1	0	0	0
B3	810	830	945	999	660	665	462	671	102.5%	105.7%	100.7%	145.2%	459	3.3	3.6	6.9	0	0	0	0
C6	810	798	945	945	660	660	660	825	98.5%	100.0%	100.0%	125.0%	513	2.8	3.5	6.3	0	0	0	0
D1	1,530	997	1,305	1,353	660	660	990	1,012	65.2%	103.7%	100.0%	102.2%	693	2.4	3.4	5.8	0	0	0	0
D2	1,088	870	945	660	660	473	550	480	80.0%	69.8%	71.7%	87.3%	567	2.4	2.0	4.4	0	0	0	0
D6	1,170	1,068	1,170	1,092	660	606	660	638	91.3%	93.3%	91.8%	96.7%	629	2.7	2.8	5.4	1	0	0	0
M4	1,500	1,254	1,620	1,508	660	649	990	939	83.6%	93.1%	98.3%	94.8%	345	5.5	7.1	12.6	0	0	0	0
SAU	1,755	1,593	945	801	990	825	660	605	90.8%	84.8%	83.3%	91.6%	413	5.9	3.4	9.3	0	0	0	0
Short Stay Surgical Unit	1,752	1,530	732	545	836	790	550	516	87.3%	74.5%	94.5%	93.8%	650	3.6	1.6	5.2	0	0	0	0
ICU & HDU	4,320	4,182	750	726	3,990	3,882	0	0	96.8%	96.8%	97.3%	na	282	28.6	2.6	31.2	0	0	0	0
Birth Centre	900	713	450	435	600	550	300	300	79.2%	96.7%	91.7%	100.0%	20	63.1	36.8	99.9				
Delivery Suite	2,700	2,475	450	420	1,800	1,740	300	280	91.7%	93.3%	96.7%	93.3%	216	19.5	3.2	22.8				
Maternity 2	1,575	1,560	900	885	600	600	300	230	99.0%	98.3%	100.0%	76.7%	542	4.0	2.1	6.0				
Jasmine Ward	900	900	450	450	600	600	0	0	100.0%	100.0%	100.0%	na	209	7.2	2.2	9.3	0	0	0	0
Neonatal Unit	2,250	1,890	0	0	1,575	1,260	0	0	84.0%	na	80.0%	na	273	11.5	0.0	11.5	0	0	0	0
Tree House	2,700	2,438	450	450	1,800	1,613	0	0	90.3%	100.0%	89.6%	na	574	7.1	0.8	7.8	0	0	0	0
	52,862	46,296	35,382	34,495	33,551	31,149	21,602	23,459	87.6%	97.5%	92.8%	108.6%	18303	4.2	3.2	7.4	3	1	1	4

Safer Staffing Report

BOARD PAPERS – Quality, Safety & Experience Section : September 2018			
DESCRIPTION	**AGGREGATE POSITION**	**TREND**	**PERFORMANCE AGAINST PREVIOUS MONTH**
Registered Nurses monthly expected hours by shift versus actual monthly hours per shift. Day time shifts only.	87.6% of expected Registered Nurse hours were achieved for day shifts. Any Registered Nurse numbers that fall below 85% are required to have a business group review & an update of actions provided to the Chief Nurse & Director of Quality & Deputy Chief Nurse.	September 87.6% August 88.1% July 89.1%	The lowest RN staffing levels during the day were on Ward B4 at 60.6%. This has been supported by an increase in non-registered staff to 149.2%. . There are never less than 2 RN on duty. The plan going forward is to revise the establishment to have 2 RNs & 1 Registered Associate Nurse or Assistant Practitioner (band 4) on day duty. The acuity audit undertaken summer 2018 indicates that the actual staffing versus acuity was 14.41% above required, which supporting an establishment review.
Registered Nurses monthly expected hours by shift versus actual monthly hours per shift. Night time shifts only.	92.8% of expected Registered Nurse hours were achieved for night shifts.	September 92.8% August 93.6% July 94.3%	The lowest night staffing levels are reported on D2at 71.7% which relates to the ward move and budget re-alignment. This has now been rectified to accurately reflect the patient cohort and dependency. The Associate Nurse Director confirms D2 been safely staffed.
Non-registered staff monthly expected hours by shift versus actual monthly hours per shift. Day time shifts only.	97.5% of expected Non-registered hours were achieved for day shifts.	September 97.5% August 98.2% July 99.7%	The lowest non registered staffing levels for day duty are the coronary care unit at 68.6%. Ward A3 cardiology which is co- located supports this unit. Recruitment is ongoing with interviews 20/10/18. Close supervision and support provided by the Matrons and business group to assure safe staffing.
Non-registered staff monthly expected hours by shift versus actual monthly hours per shift. Night time shifts only.	108.6% of expected Non-registered hours were achieved for night shifts. For areas with over 100% staffing levels for non-registered staff this is reviewed & is predominately due to wards requiring 1:2:1 specials for patients following a risk assessment or to support Registered Nurses staffing numbers when there are unfilled RN shifts.	September 108.6% August 106.2% July 108.8%	The lowest levels of non-registered staffing at 66.7% are on Bluebell ward. Recruitment is ongoing with interviews booked 22/10/18. Close monitoring and support provided by the business group and Matron to assure safe staffing.

Report to:	Board of Directors	**Date:**	31st October 2018
Subject:	Winter Plan Update		
Report of:	Improvement Director (UEC)	**Prepared by:**	Jayne Wood

REPORT FOR APPROVAL

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

Summary of Report

This paper presents an update on the system winter plan.

The Board are asked to:

- Note that agreement has been reached by the system on a model winter plan
- Note the winter bed capacity requirements and progress in delivery
- Note the specific schemes from SFT and system partners agreed and progress in delivery
- Note the financial gap regarding the system winter plan and the proposed way forward to manage/ mitigate this

Attachments:	Annex 1 – Winter Plan Annex 2 – Financial Analysis

This subject has previously been reported to:	☐ Board of Directors ☐ Council of Governors ☐ Audit Committee ☐ Executive Team ☐ Quality Committee ☐ Finance & Performance Committee	☐ People Performance Committee ☐ Charitable Funds Committee ☐ Exec Management Group ☐ Remuneration Committee ☐ Joint Negotiating Council ☐ Other

THIS PAGE IS INTENTIONALLY BLANK

1. EXECUTIVE SUMMARY

The Trust's Winter Plan 2018/19 has been developed as part of a wider Local Health Economy (LHE) plan to identify capacity and interventions to address anticipated increase in emergency activity.

The Winter Plan for 2018/19 (Annex 1) has a significant focus on increasing acute inpatient capacity to meet expected emergency demand but also on maximising ambulatory pathways, reducing bed occupancy levels and optimizing neighbourhood deflection/management schemes. The system is also in the process of implementing the Urgent and Emergency Care Delivery Plan, supported by the North East Commissioning Support Unit (NECs). The advice and input of North East Commissioning Support (NECs) has been sought to strengthen our system winter plan and escalation response. It is intended that the UEC Improvement programme and business as usual work in tandem with the winter plan to assist us in meeting the national requirements of reducing the numbers of stranded patients, reducing Delayed Transfers of Care (DTOCs), maximising patient streaming in ED and enabling early discharge.

The impact of the proposed schemes once agreed will be tracked internally and monitored formally via the Urgent and Emergency Care Delivery Board (UECDB). The process to finalise the plan has included an initial system-wide workshop, system Commissioner and Provider Group meetings followed last week by a joint Commissioner/Provider meeting. The outcome is that agreement has been reached on a "model winter plan" with schemes requiring funding agreed.

2. MODEL PLAN SCHEMES REQUIRING FUNDING AGREEMENT

In coming to agreement on the model plan Commissioners and Providers have ensured that SFT has plans in place to try and open the prerequisite number of beds aligned to the 18/19 Operational Plan, together with a range of supporting schemes which will address the major drivers of performance in ED, AMU, flow through the wards and promote rapid and timely discharge. Agreement was also reached to ensure that there is additional resilience in primary care on weekdays and at weekends supported through Viaduct and Mastercall, planned investment in deflection schemes and also support from SMBC in terms of additional beds, packages of care, facilitation of discharge and access to care homes. These schemes are detailed in Annexe 2.

As well as funded schemes there are a number of SNC programmes and other funded developments that are optimised or currently being optimised or hours of operation being extended that will help to support attendance and admission avoidance, flow and facilitation of discharge (Annexes 1 and 2).

However, as detailed above the indicative financial impact and cost of proposed schemes exceeds the winter funding identified by approximately £2million (Summary page annex 2).

Within the last week an announcement was made that £1.283 million was awarded to SMBC for winter. With this in mind work underway includes:

- For each provider to review the costs within the model and adjust downwards, for example where the initial operational period was assumed to be October to March.
- For each provider to review the schemes in terms of our ability to deliver/recruit/ operationalize
- For leadership teams supported by finance leaders to identify additional resource or partial resource. This will include a review of the potential deployment of SMBC winter allocation.

3. PROGRESS TO DATE

A task and finish groups has been established for beds and specific schemes and are meeting weekly. A clear project plan (annex A) has been produced to monitor progress.

i. ESCALATION WARDS/ADDITIONAL BEDS

To date, the plan is to open the following:

- Annex's on A1 and C6 which will result in 13 beds
- To flip B3 from Surgery to Medicine which will result in 16 beds
- B2 and B5 to be winter escalation wards which will result in 31 beds.

A12 is to permanently move to C3. Therefore B2 and B5 will have to absorb some of C3 (A12) bed base. Therefore B2 and B5 will have 26 beds allocated to Winter and the remaining 6 beds will be absorbed.

Jasmine Assessment Unit have created an additional 4 bed spaces to support day case surgery in daytime hours.

The opening of the Trauma Assessment Unit (TAU) is dependent on the completion of the ED reconfiguration which is planned to be finalised by mid-January 2019. The current proposal is 4 trolleys and 2 chairs however this proposes a risk of reducing current trauma capacity. However the preferred option is 8 trolleys. This is still yet to be confirmed.

With the Bluebell Scheme there is hoped to be a net gain of 10 beds.

There are also 4 Nursing/Residential Beds at Plane Tree Court, 3 Nursing Beds at Newlands, 5 Step down beds at Clifford Court and 5 additional at Saffron.

A risk assessment of the ability to open beds and further detail is provided in Annexe 1 pages 11 and 12.

ii. ESTATES UPDATE

B2, B5 and C3 require Estates work for them to be fit for purpose. Work commenced on 10th October to replace the floor due to overall poor condition. This is due to be completed on Friday 2nd November. General Maintenance is required for B5; this is to be completed by 2nd November.

Significant refurbishment is required for C3, this has commenced with the initial strip out and demolishing. Plans for refurbishment are currently being designed, specified and quantified to advise on projected outturn cost. Completion of this project is 21st December 2018.

iii. WORKFORCE UPDATE

Nursing staff recruitment is planned for ward cover by late Nov/Dec to staff escalation wards. There is a risk with the ability to recruit with SFT already having 160 RN vacancies not recruited too.

An agreed Cost code is required to carry out NHSP block bookings.

Agreement has been reached from the task and finish group that 3 Medical Teams are required to cover various areas for Winter. Medicine and Clinical Support Business Group is to assess this.

iv. WINTER SCHEMES

The task and finish group has been extended to also focus on other winter schemes, such as additional recruitment, therapies and pharmacy. The Key members of this group are all Business Group Directors, pharmacy, radiology and therapy representatives. Progress is being made to fill the required roles.

4. KEY RISKS

- The availability of resources within the Trust and from partners to fund the desired schemes
- The availability of national funding – and if available the ability to utilise it effectively with a short lead time
- Maintaining support from system wide stakeholders to deliver actions for admission avoidance and timely discharges of medically fit patients.
- Financial risk of incurring additional expenditure above the funding identified.
- Securing sufficient staff numbers to provide adequate levels of acute care in all of the additional capacity areas within the Trust.

5. RECOMMENDATIONS

The Board is asked to:

- Note that agreement has been reached by the system on a model winter plan
- Note the winter bed capacity requirements and progress in delivery
- Note the specific schemes from SFT and system partners agreed and progress in their delivery
- Note the financial gap regarding the system winter plan and the proposed way forward to manage/ mitigate this

STOCKPORT WHOLE SYSTEM WINTER PLAN 2018/19

Responsibility:	Urgent and Emergency Care Delivery Board (UECDB)
Effective Date:	1st October to 31st March 2019
Review Date:	April 2019
Reviewing/Endorsing Committee	Urgent and Emergency Care Delivery Board
Date Ratified by Stockport Urgent and Emergency Care Delivery Board	September 2018
Version Number	1

WINTER PLAN DEVELOPMENT PROCESS

Names of those involved in framework development

Name	Designation	Email
Jayne Wood	Improvement Director – Urgent and Emergency Care	jayne.wood@stockport.nhs.uk
Kate Gascoyne	Assistant Business Manager, Strategy & Planning	katie.gascoyne@stockport.nhs.uk

Names of those consulted in the development of the plan

Name	Designation	Email
Helen Thomson	Chief Executive, SFT	helen.thomson@stockport.nhs.uk
Colin Wasson	Medical Director, SFT	colin.wasson@stockport.nhs.uk
Sue Toal	Chief Operating Officer, SFT	sue.toal@stockport.nhs.uk
Alison Lynch	Chief Nurse & Director of Quality Governance, SFT	alison.lynch@stockport.nhs.uk
Hilary Brearley	Director of Workforce and OD, SFT	hilary.brearley@stockport.nhs.uk
Hugh Mullen	Deputy CEO/Director of Support Services	hugh.mullen@stockport.nhs.uk
Feroz Patel	Director of Finance	feroz.patel@stockport.nhs.uk
Kay Wiss	Deputy Director of Finance	kay.wiss@stockport.nhs.uk
Karl Bonnici	Associate Medical Director	karl.bonnici@stockport.nhs.uk
Dawn Forrest	Delivery Director, SFT	dawn.forrest@stockport.nhs.uk
Simon Goff	Deputy COO, SFT	simon.goff@stockport.nhs.uk
Helen O'Brien	Communication Manager, SFT	Helen.obrien@stockport.nhs.uk
Jen Harrop	Associate Director Urgent Care, SFT	jennifer.harrop@stockport.nhs.uk
Margaret Malkin	Business Group Director, Integrated Care, SFT	margaretmalkin@nhs.net
Nadine Armitage	Business Group Director, Medicine & Clinical Support, SFT	nadine.armitage@stockport.nhs.uk
Karen Hatchell	Business Group Director, Surgery GI & Critical Care, SFT	karen.hatchell@stockport.nhs.uk
Claire Woodford	Business Group Director, Women, Children & Diagnostics	claire.woodford@stockport.nhs.uk
Jaweeda Idoo	Chair Viaduct	jaweeda.idoo@nhs.net
Liz Elliott	Medical Director, Viaduct	elizabeth.elliott2@nhs.net

Diane Jones	Director of Service Reform, Stockport Clinical Commissioning Group	dianejones3@nhs.net
Gillian Miller	Associate Director of Commissioning, Stockport CCG	gillian.miller2@nhs.net
Simon Woodworth	Acting Medical Director, Stockport CCG	simon.woodworth@nhs.net
Roger Roberts	Director for general Practice Development	roger.roberts@nhs.net
Francis Dreniw	Sector Manager, Greater Manchester Area, North West Ambulance Service NHS Trust	francis.dreniw@nwas.nhs.uk
Laureen Donnan	Deputy Chief Executive, Stockport Metropolitan Borough Council	laureen.donnan@stockport.gov.uk
Sarah Ferguson	Interim SNC Programme Director, Stockport Neighbourhood Care	sarah.ferguson@stockport.gov.uk
Vince Fraga	Head of Market Development, Quality and Commissioning	Vince.Fraga@stockport.go.uk
Mark Fitton	Director of Adult Social Services	Mark.Fitton@stockport.gov.uk
Michael Rooney	Medical Director, Mastercall	Michael.rooney1@nhs.net
Kathy Hern	Director of Nursing, Mastercall	kathyhern@nhs.net
Tim Davison	Chief Strategy and Transformation Officer, Mastercall	tdavison@nhs.net
Josie Kershaw	Associate Director Mental Health and Specialised Service Support, Pennine Care	Josie.kershaw@nhs.net

Board Approval

Committee/Group	Date	Status

CONTENTS

1. EXECUTIVE SUMMARY

The Winter Plan 2018/19 is being developed as part of a wider Local Health Economy (LHE) plan to identify capacity and interventions to address the anticipated increase in emergency activity.

The Winter Plan for 2018/19 has a significant focus on increasing acute inpatient capacity to meet expected emergency demand but also on maximising ambulatory pathways, reducing bed occupancy levels and optimizing neighbourhood deflection/management schemes. The system is also in the process of implementing the Urgent and Emergency Care Delivery Plan, supported by the North East Commissioning Support Unit (NECs) which is a major part of addressing the required performance improvement. The advice and input of North East Commissioning Support (NECs) has also been sought to strengthen our system winter plan and escalation response. It is intended that the UEC Improvement programme and business as usual work in tandem with the winter plan to assist us in meeting the locally agreed trajectory for performance for 2018/19 (85%) and aspiring to each the national standard of 95% as well as national requirements of reducing the numbers of stranded patients, reducing Delayed Transfers of Care (DTOCs), maximising ED streaming and enabling early discharge. In line with national guidance, the additional funding available to CCGs in 2018/19 will be utilised the Stockport system to fund and plan in a way that improves ED performance. The plan will be approved by UECDB. The impact of the proposed winter schemes once agreed will be tracked internally and the performance against agreed metrics monitored formally via the Urgent and Emergency Care Delivery Board (UECDB).

This document outlines the following:

- Current schemes that will support the delivery of services throughout the year and over winter
- Areas/services that are commissioned and funded but are not yet optimized and will become so before or during the winter period e.g. Stockport Neighbourhood Care (SNC) schemes
- New additional schemes that Commissioners and the Trust have agreed to fund (subject to available resources)

2. INTRODUCTION AND BACKGROUND

The ED national standard for delivery of the 4-hour target is 95%. However, Stockport FT has agreed with NHSI a trajectory of 85% for the 2018/19 financial year. The current position however is that performance is well below the agreed trajectory at 71.7% for the quarter to date and 80.0% for the year to date. This is against in the context of an ED department that was designed to see 60,000 patients each year but which actually sees between 90,000 and 95,000 patients each year, also the fact that a number of the SNC schemes, as outlined above, are not fully optimised and that unlike other Health Economies, there is no walk-in Centre in Stockport. Therefore significant improvements are required to reach the required and agreed ED standard. Due to the significant differential between actual and required performance it is clear that implementation of winter schemes will only play a small part in delivering the improvements required. It is therefore imperative that the ED Improvement Plan, which the Health Economy is working on, supported by North East Sector Commissioning Support (NECs), delivers the required performance improvements.

In line with national guidance, the additional funding available to CCGs in 2018/19 will be utilised the Stockport system to fund and plan in a way that improves ED performance. Over the next 2 weeks the final plan will be agreed within the funding envelope available. The available winter funding available from the CCG consists of £717,000 from SRG 18/19, £183,000 from SRG 17/18 which has been pre-allocated to fund the GP Intensivist team. There is also an allocation of £250,000 from Healthier Together which is being released in line with the required outputs to fund additional consultant staffing in ED. The Trust has also identified £600,000 of winter resilience monies. Finally the Health Economy is to receive an allocation from national monies for social care of £1.238 million to reduce Delayed Transfer of Care (DTOC). This funding could be used to support home care packages to help patients get out of hospital more quickly, reablement packages which support workers to help patients carry out everyday tasks and regain mobility and confidence and finally, home adaptations, including new facilities for personal care, such as adapting a shower room if a patient has limited movement.

Following a number of meetings and review of Commissioners and Providers separately, a model winter plan has been agreed. This contains a scheme which is in line with the operational plan create additional bed capacity by opening additional escalation beds within the Trust and within the community and specific Trust schemes to assist flow in ED, AMU and through the medical wards. Importantly schemes that will increase resilience in primary care on weekdays and weekends have also been agreed as well as a flexible resource to in-reach from primary care into the Trust at times of escalation. However, the cost of these schemes is circa £2 million in excess of the funding available. The next steps are that each provider:

- Reviews and reduce the costs within the model to reflect the costs from the point of mobilization
- review the schism in terms of ability to recruit/operationalize
- for leadership teams supported by finance to identify additional or particle resource and its application to schemes

The specific winter schemes will be supported by the Stockport Neighbourhood Care (SNC) schemes already funded through transformation monies, a number of which have been optimized or will be optimized over the next few weeks as well as schemes funded by the CCG.
Operationally and for winter preparedness, the key factors affecting urgent care flow are predominantly:

General

- Effective system-wide escalation and response
- Planning for peaks in demand
- Staffing/workforce planning
- Appropriate phasing of the elective programme

Stay Well

- Effective management of influenza and respiratory conditions across the system
- Effective management of frail patients

Home First

- Effective deflection schemes
- Rapid neighbourhood response
- Effective management of the deteriorating patient
- Step up services and availability of packages or care and wrap around services to prevent admission
- Effective care home off to prevent admission

In hospital

- Effective ED streaming 7/7 to enable a decongested Emergency Department and minimise admissions
- Optimise Acute Medical unit (AMU) and ward bed occupancy
- Performance against key GM and national targets – e.g. early discharges, stranded patients, length of stay, overnight performance in ED and majors
- Sufficient bed capacity to admit those patients who require it – Trust, Community and Mental Health

Discharge and Recovery

- Effective support by the ITT and SMBC for complex discharges
- Sufficient packages of care and short term placements
- Effective care home offer which supports discharge 7 days a week
- Effective step down services with optimising access, also placements and IV's
- Maximise use of the Discharge Lounge

For the Stockport system this winter there are 4 documents being produced:

A **system winter plan** which is being co-produced by Stockport FT, Stockport CCG, SMBC, Pennine Care and Viaduct, Mastercall and NWAS which identifies measures that will take place across the Trust to improve patient flow and ensure optimal patient care within the Trust; these include both internal and health economy wide initiatives.

- including schemes defined under 4 areas:
- the "stay well" philosophy
- Home first – encompassing deflection and management of patients out of hospital
- In hospital – which includes the "front door" and also patient flow within the hospital
- Discharge and Recovery

The winter plan is supported by:

- A **monitoring document** which will contain expected impact on ED performance with associated measureable metrics so that performance can be tracked operationally through the Improving UEC Programme and through UECDB and after winter a robust evaluation can be undertaken to enable lessons learned and inform plans for future years.
- A **detailed bank holiday plan** which will cover the two weeks around Christmas and New Year to enable a collaborative approach to re-start the system between Christmas and New Year and after New Year.
- A **system OPEL escalation plan with supporting action cards for each partner**

3. HOW HAS WINTER PLANNING AND PREPAREDNESS CHANGED FROM 2017/18

Planning was started earlier this year and the plan has been developed collectively with full engagement of all system partners. This has proved to be extremely challenging in terms of the complexity of the Health Economy, overlap between commissioned services, overlap between proposed schemes, the current position of the SNC Programme and the absence of central winter monies at the time of writing.

There are a number of developments that have taken place and opportunities that have arisen during 18/19 that will help to maintain performance during winter for example, the improvement work that has been undertaken by the new Delivery Director and the Improvement Plan supported by North East Commissioning (NECs).

Standards have also been agreed internally within the Trust on 22nd August. These standards and other key metrics will be assessed on an ongoing basis through the comprehensive governance systems in place across the Stockport system by individual Providers and Commissioners as well as the Stockport Neighbourhood Care Programme Board and ultimately the Urgent and Emergency Care Delivery Board.

A detailed System Christmas and New year Bank Holiday Plan covering the two weeks around the Christmas and New Year period is being produced to ensure a collaborative approach to "Home for Christmas", delivery of ongoing performance and a system re-start between Christmas and New Year and after New Year. The plan format and content has been tested over the August Bank Holiday with "a perfect 3 days". This will be modified for Christmas and New Year from lessons learned.

A new system escalation document is being produced which contains the agreed OPEL triggers at all levels for the Trust as well as revised action cards for system partners to enable an effective response at all levels. A Table Top exercise to test the triggers and response and is planned to ensure all stakeholders are confident in its application, that actions are specific and enable de-escalation as rapidly as possible.

In terms of opportunities, the ED reconfiguration and streaming capital scheme commenced on plan on 13th August. On completion of the main scheme before Christmas some additional clinical cubicles will be available in ED. The department will also be able to introduce enhanced streaming in an Urgent Treatment Centre (UTC) model which will increase the number of patients seen as ambulatory ill. On completion of the second phase at the end of February an additional 4 majors cubicles will be created. This scheme will also free-up the space occupied by the current CDU. This will have 2 key benefits as it will enable the creation of a TAU (Trauma Assessment Unit) during January 2019, subject to staffing. Move of orthopaedic patients to TDU will also free up space in the new CDU created by the scheme and hence will also contribute to a decongested ED. Finally, an additional £367k of capital has been obtained, following a bidding process from national funds to support ED and flow through the hospital.

Based on the experience of 2017/18 in terms of bed occupancy, the requirement for emergency admissions and the fact that on most days up to 30 patients were requiring beds first thing every morning with the resultant effect that overcrowding has on 4-hour performance, a proportionate amount of beds will be opened within the Trust and escalation areas staffed, subject to the availability of nursing, medical and AHP teams to cover the beds. A task and finish group has been established and the process to enable this has commenced. This plan reconciles to the operational plan submitted to NHSI. An internal contingency plan is also being developed if the above plans do not enable SFT to cope with additional demand. This includes consideration of cancellation of elective work (and the

associated consequences) and use of additional short term bed capacity. If however, pressure becomes extreme consideration would also need to be given to cancellation of training, non-urgent meetings, annual leave, non-emergency surgical work and outpatient work. This will be balanced with the associated risks and consequences.

4. WINTER PLAN

i. Additional Schemes to be Funded to Support Winter

Stay Well Schemes

1. Influenza vaccine for Care Home Staff

Over the last few years Stockport has been the second best in the country for vaccination of staff, patients and the public. The benefits of good coverage in terms of vaccination are well documented. However care home staff has always been a difficult group of people to reach. As part of the SNC programme a GP has now been allocated to each Care Home. As such it should now be possible to offer the vaccine to care home staff delivered on site with the support of district nursing, GPs and Public Health.

Home First Schemes

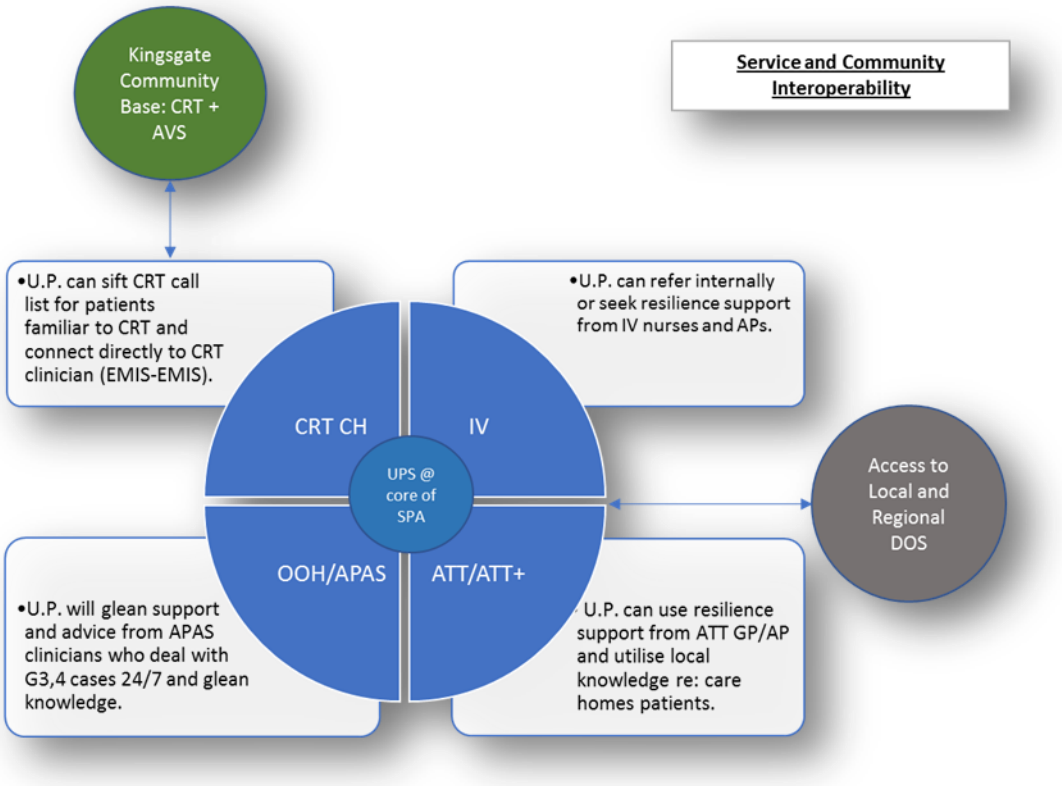
2. Additional IV Therapy Capacity (4 additional slots per day 7 days a week)

By allowing Step-ups from Primary Care or Step-downs from the FT, additional IV slots alleviate pressure by way of admissions avoidance (step-ups) or free of bed capacity in the FT (-owns). Mastercall IV Leads will attend physical ward rounds to assess patient suitability for step down slots.

This service enables FT admission avoidance potential increased by way of community IV step-ups and FT bed capacity to be released by facilitating step-down discharge to community IV. Patients also receive care closer to home and have a reduced chance of hospital acquired infection etc. This service can be operationalised within 48 hours and has the potential to average 20 step downs per month.

3. Reduction in Conveyance of Green Category 3 and 4 Ambulances

This is an integrated response between Mastercall and NWAS (111,999) and is essentially an admission avoidance or alternative to transfer to ED scheme. There is further integration wherein there are appropriate handoffs to the Crisis Response Team (CRT) and the Acute Visiting Service (AVS) for example:



This winter pilot will automate a pre-approved dataset directly to Mastercall and enable their direct intervention. Historically low volumes have been sent to Mastercall It is hoped that this will increase the opportunity to reduce ambulance dispatch and deflect patients away from ED – potentially to enable review of up to 35 cases a day with up to 10 ambulance conveyances per day prevented.

4. Weekend Support to Care Homes

The Pathfinder Tool enables NWAS to work with Mastercall to provide an 'Alternative To Transfer (ATT) service". Care Home staff will only refer patients eliciting "amber" or lower outcomes for GP Referral and follow normal procedures otherwise.

Whilst this is integrated admission avoidance with NWAS, Mastercall will also deflect as a downgrade to AVS or refer to CRT where appropriate.

ATT(+) is already maximised. Additionality is to deliver training and engagement to care homes who are low referrers to ATT but high referrers to ED and then to 'hear and treat' and 'see and treat' these cases. By engaging with five care homes last winter, chosen on account of their disproportionate utilization of 999, Stockport ATT has seen an additional 369 referrals (Nov-Dec '17) of which translates to 142.49hrs of pure additional clinical activity (excluding downtime and operational aspects). By *relatively weighting* the remaining care homes and using the actual additional referral activity (Nov-Dec) as a fixed point, demand prediction states a further monthly increase of 495 referrals equating to 191 additional hrs of *pure* clinical time should engagement be expanded *to all the remaining homes (to deliver training on the Pathfinder pathway/referral process).*

5. Increased Primary Care Resilience of 7-day Hubs

Offering face-to-face appointments for extra primary care capacity in the mornings followed by additional support for home visits requests and where possible the ability to deploy within SFT to support Ambulatory Ill (AI) and ED at times of OPEL escalation 3/4. In addition this investment would support increase in extended hours face-face appointments and where needed over the winter period a flip from routine to urgent and the additional indemnity funding required for GPs to enable them to do this. This should also support the frail elderly in the community.

A business case to support hospital discharge and a reduction in stranded patients with linkages to discharging ECM patients with additional support and identifying patient for ECM was submitted to the CCG. This has been funded for a 6-week pilot which, if successful could be extended over the winter period.

6. Increased Mastercall capacity to manage higher acuity and volume of home visits during winter

This scheme is integrated with NWAS' own response to manage a higher acuity of patients requiring home visits over the winter period. It should facilitate a deflection metric of 88% as standard for ATT where the context is pure admissions avoidance. Similarly for OOH and APAS visiting the capacity to visit facilitates a safe handover from NWAS (111,999 (to Mastercall which avoids conveyance or advice to attend ED. The scheme is further integrated with external and internal onwards referral in much the same way as the Urgent Practitioner pathway below (substitute UP for OOH/ATT/APAS visiting clinician). The scheme delivers FT Admission avoidance increased by increasing capacity of out of hospital visiting workforce for Urgent conditions, NWAS ambulance pre-dispatch freed up by passing UCD DX cases to Mastercall Hub (APAS), NWAS ambulances post-dispatch freed up by passing increased volumes of ATT/Pathfinder cases to Mastercall Hub (ATT). Patients treated out of hospital and closer to home (reduced risk of hospital acquired infection).

7. Additional Packages of Care

This scheme is to enable the purchase additional packages of care for patients to prevent them coming into hospital and also for those patients who require them to facilitate discharge.

In-hospital Schemes

1. Additional Bed Capacity and Bed Flow Equivalent Schemes

There are 2 key factors in terms of having sufficient bed capacity available to manage winter – the ability to open a proportionate amount of additional beds and the reduction in the number of stranded patients. Table 1 below shows the summary of bed based schemes within the winter plan and the confidence at this stage that the Trust will be able to open the beds or that the scheme will deliver the equivalent bed numbers through improved patient flow. These schemes will work in tandem with the programme to reduce stranded patients.

Table 1. Planned Additional bed capacity 17/18 and 18/19 comparison

	Stranded patients	G&A Beds	G&A Beds	ED	Flow (Bed equivalent)	Variation in total bed equivalent
2017/18 (Feb 18)	384	Core	695	26	0	
		Escalation beds	29		0	
		EL flip			16	
		Out of Hospital (Int Tier)			15	
		Total	**724**	**26**	**31**	
		Total Bed Equivalent		**781**		
2018/19 Revised Winter bed plan	260-300 (320 as at 2/10/18)	Core	695			
		LOS	-3		3	
		Escalation beds				
		Escalation beds	17			
		Escalation beds	12			
		Escalation beds	15			
		EL flip			16	
		Bluebell			10	
		Stroke			2	
		Out of Hospital (Int Tier)			19	
		Total	**736**	**0**	**50**	
		Total Bed Equivalent		**786**		

The confidence levels relating to opening of the beds is RAG rated above. Escalation beds n=17 are shown as green as there is a degree of confidence that the escalation areas on A1 and C6 will be able to be opened as el as the 4 day case beds on Jasmine. In terms of the other beds (n=12 in amber) the opening of 8 places in the Trauma Assessment Unit will open subject to staffing once the Ed reconfiguration works are complete. The remaining 4 open as a result of transferring 14 beds from A12 9a 26-bedded ward) to C3 (14 beds) and opening 12 beds on B2 (a 16 bedded ward). Therefore the remaining 4 beds on B2 should be able to be opened subject to staffing. The final 15 beds (marked as red) would require the opening of B5 (15 bedded ward) and are high risk as we are unlikely to be able to staff these. Planned estates work to ensure the wards to be opened are at the required standard will be complete by November 1st. Although not shown on the schedule it is planned to keep B6 open for winter. This ward was due to close for CIP following LOS reductions but this has not been able to be progressed.

In addition there are a number of bed schemes that will contribute to reducing bed occupancy. As part of phasing elective activity Surgery Business Group are working up a plan to temporarily re-designate Ward B3 (16 beds) from a surgical to a medical ward during January and February 2019. This scheme was employed last year and creates additional medical beds from current bed stock. This scheme is rated green and will take place. Equally the Early Supported Discharge for stroke patients will contribute 2 beds in terms of LOS reductions. The out of hospital beds include 5 Step down beds at Clifford Court, 4 Nursing/Residential Beds at Plane Tree Court, 3 Nursing Beds at Newlands and 5 mental health beds at Saffron. Finally, there is also the potential to change Bluebell ward to a Transfer (Discharge) to Assess Unit and improvement flow with the potential to general the equivalent of up to 10 beds.

In additional to opening more beds and gaining capacity through flow changes there is a key imperative to reduce the number of stranded patients as this has the potential to release the equivalent of up to 45 beds if the system meets its targets. Table 2 shows the impact of the 18/19 bed plan on ED performance and again strongly supports a focus to reduce stranded patient numbers to target as rapidly as possible.

Table 2. Predicted Impact of 18/19 Bed plan on ED 4-hour performance

Predicted impact of the 1819 bed plan on A&E 4 hour performance, at various stranded patient thresholds (17/18 baseline)					
Stranded threshold	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
<260	87.9%	82.6%	86.1%	87.9%	81.8%
<300	83.4%	78.1%	82.6%	84.4%	78.3%
<330	78.4%	73.1%	76.6%	78.4%	72.3%
<360	76.4%	71.1%	74.6%	76.4%	70.3%
Winter 17/18 Baseline A&E 4hr performance	78.4%	71.1%	71.6%	73.4%	65.3%

Table 3 shows the relationship between ED performance, bed occupancy and the numbers of stranded patients. This indicates that the required trajectory of 85% can be achieved provided that stranded patient numbers are ideally below 260 but no higher than 300 and bed occupancy is ideally 88%-90% but not greater than 92%. It is also interesting to note that when stranded patients are in the order of 350 which has been the case over the last few weeks that the system becomes chaotic and performance drops rapidly. This again supports a detailed focus on reducing stranded patient numbers.

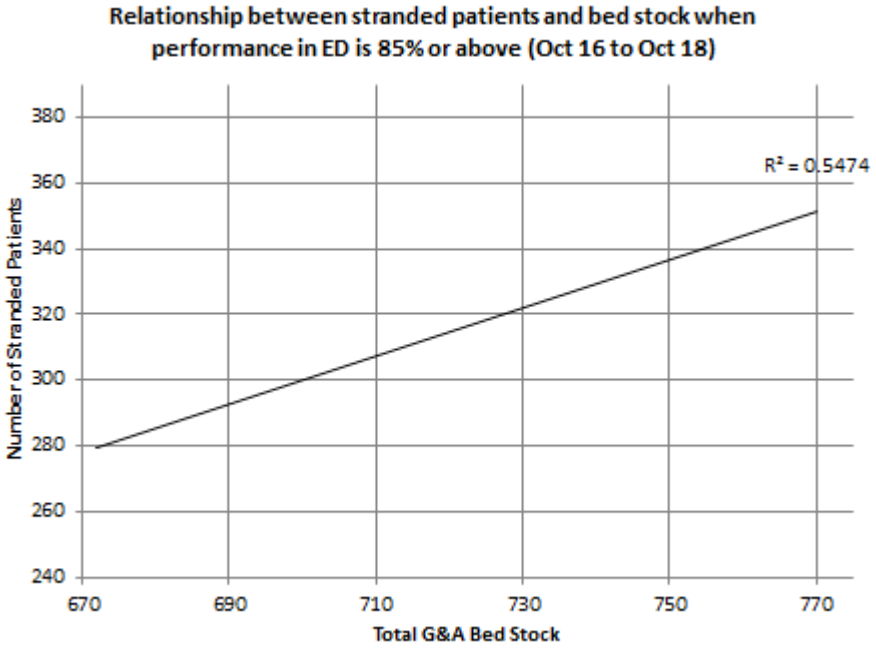
Table 3. ED performance, bed occupancy and stranded patients (Oct 17 to Oct 18 actual)

G&A bed stock	Stranded Patients				
	260	**300**	**330**	**360**	**>360**
695	89.0	86.5	77.1	75.8	
710		83.1	80.2	75.2	64.8
725		74.9	78.4	72.5	67.3
740		86.5	82.2	75.7	73.9
>740		83.4	83.2	80.1	74.7
Grand Total	**89.0**	**86.1**	**80.0**	**78.0**	**73.3**

Bed occupancy	Stranded Patients				
	260	**300**	**330**	**360**	**>360**
88%	89.0	87.1	82.0	80.4	77.0
90%		85.9	81.2	79.0	72.1
92%		88.9	79.4	78.7	76.0
>92%		81.0	77.3	75.5	71.8
Grand Total	**89.0**	**86.1**	**80.0**	**78.0**	**73.3**

Table 4 shows the relationship between stranded patients and bed stock when performance in ED is 85% or above over the last 2 years. This shows that if stranded patient numbers are reduced there is a bed opportunity factor to be gained. This further supports our focus to reduce numbers of stranded patients, especially in the light of the challenges we are facing to recruit the additional nurses required to open escalation beds over winter.

Table 4.



2. Enhanced Patient Streaming in ED

The ED streaming service aims to make care more efficient and take pressure away from emergency departments by having a primary healthcare professional "stream" patients coming through hospital doors, who can then deflect them to primary healthcare or an emergency department.

GP streaming service commenced in November 2017 in SFT. This service is based within the Urgent Care footprint, patients are streamed from triage to Ambulatory Ill, and there the patient will see a GP or ANP. In December 2018, this service will be transferred to the front of the emergency department, where patients will be deflected back to primary care or streamed to the correct. **There will be a clinical navigator and a band 4 administrative support. An additional Band 3 has been funded to assist with outstanding actions** and to support RATs. This will avoid non-admitted breaches.

This will enable swift management and assistance to patients who are being streamed to other areas of the hospital away from ED or to services outside of the hospital. This service is planned to be available 7 days a week 8:00-22:00.

The benefits of this will be decongestion of the Emergency department waiting room, assistance for patients who are in the process of being streamed and reduction in workload through standard major's triage.

3. Additional Staff to Support ED and AMU

From December 2018 there will be additional ED Senior decision making capacity; this is so demand can be met in peak times from 4pm-midnight. This will allow the increased referrals to medicine should be clerked as soon as possible to ensure safety and speed of on-going care pending specialty review wither in ED or Acute medical Unit. This will be supported by **an extra junior doctor to work in ED clerking referred patients to medicine 9-5 and an additional ED senior decision maker (Consultant or Registrar) working a twilight 6pm-2am.**

Ensuring early decision making for patients as soon as they are referred is critical, this has an impact in reducing length of stay and identifying early requirements for patients discharge and **so an additional Physician Of the Day (POD)** will ensure additional senior review of medical patients who are awaiting a bed. Finally, extra support will be provided by **a consultant 9-5pm at weekends and an additional consultant 9-5pm Monday to Friday from December.**

Due to the anticipated increase in medical referrals, additional resource will be required in AMU during peak attendance hours. This will give assistance to the on call teams to ensure medical clerking occurs in a timely manner. **This will be an additional SHO or ANP to cover 6pm-2am every weekend.**

In terms of AHP and pharmacist support, **additional ED Physio will be implemented to extend FRESH hours to 12 hours a day, additional pharmacists to support ED, AMU and the wards on weekdays and weekends, AMU OT cover over 7 days.**

Enhanced access to diagnostics will also be available by an **increase in radiologist hours on site at weekends from 6-12 hours.**

In-reach of geriatricians into ED will enable streamlined pathways from ED to frailty unit and will enable potential deflections to community services from ED avoiding admissions.

Prospective cover to enable full in-reach to AMU to include cardiology and respiratory will be put in place to support clinical plans, speciality pull of patients to wards and the potential to put alternative arrangements in place to manage patients and/or facilitate potential early discharge from AMU.

4. Additional Staffing Resource to Support Wards

1. Transfer Team and Transfer Unit Opening on Saturdays

A transfer team is to be appointed from slippage in budgets to support nursing teams by enabling rapid movement of patients.

The Transfer Unit (Discharge Lounge) will be opened on Saturday to ensure early morning flow to free up beds for patients requiring admission.

2. **Consultants Working at Weekends**

To increase weekend discharges and reduce length of stay, **2 consultants will be available on Saturday and Sunday for 1PA plus junior support each day for each consultant**

3. **Additional Resource in ITT**

In order to support the escalation wards **additional resource for ITT** will enable cover to be provided to facilitate complex discharges from those areas

4. **Shadow Managerial Rota to Manage Escalation**

To support managers call at times of particular pressure throughout winter a shadow rota with an additional manager will be developed and implemented

Discharge and Recovery

1. **Additional Social Workers**

An additional **ED social worker to support FRESH** will be appointed to enable packages of care and alternative arrangements to be made to support patients at home or another onward destination

Eight additional Social workers have already been funded by SMBC to cover the winter period.

2. **GP Support to Stranded Rounds**

The CCG have funded a 6 week pilot for GPs to visit selected wards to undertake **stranded rounds** with the internal teams in order to facilitate discharge. If successful it is hoped to extend this throughout the main winter period.

ii. Commissioned Services that are Funded and will Support Winter

A range of services have been commissioned, funded and will be embedded by winter to support the system throughout the year that also contribute to improving the performance of the system and the care of patients throughout periods when demand is likely to be higher such as winter. These schemes are outlined below:

Stay Well

- NHS 111 online
- Neighbourhood Social Care 7-day working
- Neighbourhood access to Active Recovery and the Crisis Response Team
- Immunisation for influenza programme

- Social Prescribing
- Navigation and signposting of individuals to relevant services
- Social inclusion support to people with serious mental illness

Home First

- The SAFER approach across the bed base
- Community-based IV service
- Five additional step up beds on Saffron Ward to support people with dementia and delirium to be managed by the Crisis Response Team
- Acute Home Visiting

In-hospital

- 24 hour Mental Health Liaison Service providing all age support across wards and ED
- STEM service from 5 to 7 nights per week
- Purchase of increased mortuary capacity

Discharge and Recovery

- Integrated Transfer Team in place to upstream discharge
- Hospital step-down for people awaiting a package of care to active recovery team as a transition from hospital to home

iii. Services that Require Further Optimisation

Within the commissioned, funded services elements, there are a series of services that need to be optimised before they will provide the full anticipated benefits. These are described below:

Home First

- Crisis response service including mental health elements
- 7 day neighbourhood hubs
- Improvements to length of stay in the intermediate care home and bed base

In-Hospital

- Discharge lounge (Monday to Friday)
- STEM move from 5 to a 7 day service
- Early supported discharge - fractured neck of femur pathway
- Early supported discharge for stroke patients

Discharge and Recovery

- Patient Choice and Home of Choice policies
- Care Home Trusted Assessor being piloted in 26 Care Homes
- Discharge to assess pathway

5. Wider System Preparation

i. WINTER COMMUNICATIONS PLAN

a) Proactive Communications

A proactive communications plan is being developed locally to encourage the public to use ED responsibly, to promote self-care and other NHS services and to 'save' ED for the acute and life-threatening injuries. The aim of the plan is to help reduce attendances at ED for minor injuries and illnesses that could have been treated elsewhere by signposting patients to alternative services using the Directory of Services (DOS) which is currently being finalised by the CCG. In addition the SFT communications team will support, contribute to and promote the GM Winter communications plan which focuses on the preventative message of 'staying well' and only accessing A&E in emergencies.

b) Reactive Communications

In line with the 'Operational pressures escalation levels framework (OPEL Framework), SFT communications team will work closely with the communications teams of the local acute providers the CCG and GM ensure external and public facing communications are clear and consistent. The aim of the external communications will be to;

- Communicate operational pressures and actions taken to reassure patients and public
- Portray an accurate picture of operational pressures to the staff and public, with the aim to reduce the amount of queries received
- Inform the public accurately of the pressures on the services in the local area and advise on any actions or response required of them

The messages will be delivered via local media, social media, and websites and via staff and GP practices.

ii. MANAGING INFLUENZA AND RESPIRATORY PATIENTS

Influenza is a key factor in the NHS winter pressures planning and plays a key factor in the local plan, particularly increasing the 'at risk' group up-take and intensifying usage by practices of the excellent support from community nursing teams. It also impacts on both those who fall ill and the NHS services that provide direct care, as well as the wider health and a social care system that supports people in at-risk groups.

Influenza occurs every winter in the UK. Seasonal influenza immunisation is one of the measures that helps to reduce illness in the community and unplanned hospital admissions, and therefore pressure on health services generally and ED in particular. The local annual immunisation programme is a critical element of the system-wide approach for delivering robust and resilient health and care services throughout the year, helping to reduce unplanned hospital admissions and pressure on ED.

In 2018/19, those eligible for flu vaccination are:

- people aged 65 and over,

- people aged under 65 with specific clinical conditions,
- all pregnant women, all two and three year-olds,
- healthcare workers with direct patient contact,
- carers and children in reception class and school years 1, 2, 3 and 4

The GM key deliverables are influenza immunisation uptake - Patients aged 65 and above - 85%, aged under 6 months to under 65 in an at risk group - 65%, all pregnant women - 65%, eligible children aged 2 and 3 years - 65%, Schools programme, reception to year group 4 - 65%, health and social care workers - 85%. An influenza vaccination programme will be delivered as in previous years as this has been very successful and has nationally been one of the most successful in the country. Consideration is also being given to point of care testing for influenza; however the cost effectiveness and the governance arrangements surrounding such a service have yet to be resolved.

iii. INFECTION CONTROL

Providers within the system are expected to have, and are responsible for, individual plans around the management, containment and avoidance of infectious diseases such as norovirus and gastroenteritis and the impact of infectious diseases closing beds which are monitored daily by the CCG. Acute, Community and Mental Health Providers have infection prevention and control teams in place to manage outbreaks of infectious illness. They are expected to manage outbreak within their premises as per their outbreak management plan to include system-wide outbreak meetings with membership from Bedfordshire Clinical Commissioning Group, Public Health England (PHE) and Public Health (Local Authority). Public Health England provide daily weekday outbreak reports covering the care homes in Stockport. Care homes are expected to inform PHE of any outbreak in their premises and then follow PHE advice on the management of the outbreak. Any outbreaks (i.e. Norovirus) are reported via Public Health England and are included on the daily weekday System Resilience Reports.

iv. NWAS

As part of their preparations for winter NWAS are again looking at how they can work with the wider health system in managing patient flow and providing the most appropriate care for patients. They are working with their Commissioners to ensure they have good access to acute GP visiting schemes and other alternatives in the community to which their crews can make timely and appropriate referrals. They will also be working with our crews to ensure they can use these alternative pathways with confidence and have the clinical supervision available to support this process.

As in previous years, NWAS will be increasing capacity in their Emergency Operations Centres (999) including additional call takers and clinicians who will focus on supporting staff and managing calls over the phone (hear and treat), to ensure that they deflect as much activity away from Emergency Departments as possible, where it is safe and appropriate to do so. They will also be increasing their capacity within the 111 service to ensure they provide a robust service during what will be a busy period where there will be rising demand.

The Patient Transport Service which deals with some of the most vulnerable patients, as well as caring for these patients, will be providing information on health education and signposting to services to help

them stay well over winter. NWAS are also looking at how they can support hospital discharges in order to assist the Trust with patient flow.

One of the biggest challenges is the release of crews when they bring patients to Emergency Departments. The Trust will be working in partnership to deliver the 30 minute ambulance turnaround times with a zero tolerance approach according to the GM Ambulance Turnaround Policy.

6. SYSTEM RESILIENCE AND ESCALATION PLANS

Stockport NHS Foundation Trust has an OPEL framework in place which is based on the NHSE Operational Pressures Escalation Levels (OPEL) Framework (Oct 2016). To support the framework Stockport has a set of OPEL Triggers in place which form part of a system plan which sets out the procedures across the Stockport system to manage variations in demand across the health and social care system. This plan provides a coordinated approach to the management of pressures across the whole Health and Social Care system, where local escalation triggers have already been applied and yet the pressure on capacity and the need to mitigate against the possibility of compromising patient care require additional support from other service providers. This plan is designed for managers and clinicians involved in managing capacity and patient flow at times of excess demand. The triggers have been refined over recent weeks and are now signed off. The system plan is nearing completion. There will be a Table Top exercise on 210th September with system partners to test the plan and action cards for the Trust and system partners. From this exercise final adjustments to the cards will be made prior to training across the Health Economy which is inked to an open invitation to partners for their senior managers to attend bed meetings and meet the teams with the Trust.

7. SENIOR MANAGERS AND EXECUTIVES ON-CALL

Under the civil contingency act 2004 all providers are required to ensure they have in place robust on call arrangements. SFT has a senior manager on call and an Executive Director on call. At weekends and at times of escalation these individuals are on site at the hospital based in the control room. Meetings are held at regular intervals during the day internally and senior system partners are engaged as needed according to the level of escalation. On call arrangements are also in place for all system partners. Winter communications tests will be scheduled to assure on call processes are in place and robust. The CCG will continue to monitor system-wide capacity challenges and performance across the Stockport Health and Social Care system. Managers have the autonomy to provide strategic direction in managing and progressing performance and capacity issues, in addition to providing an escalation route.

8. STOCKPORT NHS FOUNDATION SITREP REPORTING

During the winter, Health and Social Care systems are expected to report by exception on a daily basis to NHSE according to the level of OPEL escalation. Contact with NHSE will be initiated and maintained as required from the Trust through the Site Co-ordination team following engagement with partners. Regional teams in NHSE and NHSI will be aware of rising system pressure, providing additional support as deemed appropriate and agreed locally, and will be actively involved in conversations with the system.

9. COLD & SEVERE WEATHER ALERTS

Adverse weather forecasts are available from the Met office via the National Severe Weather Warning Service and the Environment Agency provide Flood Alerts. It is the responsibility of the Emergency Preparedness Resilience and Response (EPRR) leads in each organisation to ensure that these alerts / warnings are made available to appropriate personnel within their organisation and that appropriate plans are initiated.

10. BUSINESS CONTINUITY PLANS

All NHS organisations are required to have robust business continuity plans in place in order to maintain their services to the public and patients and as part of their contractual arrangements as a provider of NHS funded care. Each plan provides details for business continuity incidents, critical incidents and major incidents along with Major Incident Response and responses to severe weather.

11. MAJOR INCIDENT RESPONSE

From an NHS perspective, any occurrence that presents serious threat to the health of the community, disruption to the service or causes (or is likely to cause) such numbers or types of casualties as to require special arrangements to be implemented by hospitals, ambulance trusts or primary care organisations.

In a wider context as demonstrated by recent events on both London and Manchester , a severe event or situation, with a range of significant impacts, which requires special arrangements to be implemented by one or more emergency responder organization, would necessitate a multi-agency major incident response. Partners will at this point work collaboratively to support and help resolve the major incident, in a supportive and inclusive approach.

This page has been left blank

Stockport Locality Winter Plan 2018/19 ANNEX 2

SUMMARY OF SYSTEM RESPONSE

Provider	Identified by Provider £000s	Funding Request £000s	Change in Bed Numbers
VIADUCT HEALTH (GP FEDERATION)	-	343	-
MASTERCALL HEALTHCARE	-	346	-
STOCKPORT MB COUNCIL (SMBC)	320	275	19
STOCKPORT NHS FT (SFT)	297	3,551	62
Additional Beds at Stepping Hill Hospital (SHH)	*9*	*2,259*	*62*
Specific schemes	*288*	*1,187*	-
Neighbourhood schemes	-	*105*	-
OTHER PROVIDERS	-	250	10
RREDUCE ESCALATION BEDS TO NHSI PLAN		(306)	(8)
GRAND TOTAL WINTER PLAN	**617**	**4,459**	**83**

Hospital beds schemes	2,259
All other schemes	2,200
	4,459

FUNDING IDENTIFIED

2018/19 SRG allocation	*717*
Healthier Together	*250*
Community Integrated Stroke	*552*
Stockport CCG	1,519
iBCF	210
Assume IBCF	90
SMBC (iBCF)	300
Sub-Total Comissioner Allocation	1,819
Stockport NHS FT (planning assumption)	600
TOTAL FUNDING IDENTIFIED	**2,419**
SHORTFALL	**(2,040)**
? SMBC - ADULT CARE WINTER ALLOCATION ?	1,283
REVISED SHORTFALL	**(757)**

Stockport Locality Winter Plan 2018/19
VIADUCT HEALTH (GP FEDERATION)

Scheme	Identified by Provider £000s	Funding Request £000s
Social Prescribing: Evidence base that this reduces ED activity by 24% and admissions by 5%. Investment to support further rollout to support the development of Health Champions at practice level. Funded by Stockport Together, low priority in Winter Plan. £253k	-	-
7 Day Hubs: · Flip appointments at peak times from Urgent to Routine	-	116
Clinical Triage and Acute Home Visiting: · Extend operating hours for visiting GP · Clinical triage to support surges in General Practice demand · Additional face to face appointments to underpin the triage model · Clinical advice to the Crisis Response Team Baseline service being optimised, should be in place for winter but unsure if extension is feasible £218k.	-	-
Care Navigation PODs: Appropriate signposting of individuals to relevant service using West Wakefield model	-	-
Extensivist / HIT Team: Team to provide support for frail/complex patients and those with advance progressive disease in the form of hot clinics, clinical support to primary care and INTs, facilitate early discharge (could provide some step up/down bed clinical input) *** Team make up: 1. Community geriatrician 2. Frailty Team (GP/Paramedic)	-	-
Pharmacy team to support discharge and care home pressures Prioritise resource to focus on care home medication reviews and practice medication reviews to ensure that all patients have required medications through the holiday period. Focus on rescue packs for COPD patients and asthma patients.	-	-
Take home and tuck up: Support for patients in initial 24/48 hours following discharge. Operates from 10pm to 1am M to F and 7pm to 7am w/e and sees patients safely taken home by a non-emergency ambulance which is booked by an on duty nurse. Links within community asset and 3rd sector. Providers have identified as not a priority so not proceeding. £128k	-	-
GP support to stranded ward rounds £21k approved, £77k subject to proof of concept/ results - NB Provider to be confirmed.	-	77
Flexible GP resource - Provider and scheme to be defined	-	150
Sub-Total VIADUCT HEALTH (GP FEDERATION)	**-**	**343**

*** 2017/18 SRG allocation

Stockport Locality Winter Plan 2018/19

MASTERCALL HEALTHCARE

Scheme	Identified by Provider £000s	Funding Request £000s
Sat Sun: 0800-2400 Resilience (1GP/Driver) - ATT/OOH/APAS contract. Not prioritised by providers, £156k	-	-
Additional On call 'pot' to cover surges. Not prioritised by providers, £114k	-	-
Additional IV slots x4/day (7days/week).	-	41
Winter CRP testing service. Not prioritised by providers, £13k	-	-
Winter D Dimer testing Not prioritised by providers, £3k	-	-
ATT Plus:Options proposed Option 1. £401k Option 2. £255k Option 3. £177k Option 4. £120k Weekend support to Care Homes - need Care Home offer	-	120
UCP (Cat 3 & 4) Winter scheme Review of service provision, validation of data required £199k	-	100
Capacity to manage higher acuity/volume of home visits during winter	-	85
Sub-Total MASTERCALL HEALTHCARE	**-**	**346**

Stockport Locality Winter Plan 2018/19

STOCKPORT MB COUNCIL (SMBC)

Scheme	Identified by Provider £000s	Funding Request £000s	Change in Bed Numbers
Social Care input to Enhanced Case Management. 600 high risk patients proactively managed.	-	-	
Social Care element of Neighbourhoods working over a seven day period. Already funded in baseline.	-	-	
Continuation of improvements to Length of Stay in Intermediate Care home and bed base. Continue to implement the SAFER approach across the bed base. Challenge to further investment noting evaluation of current progress. £40k	-	-	
Care Home Trusted Assessor in place across 20 Care Homes (pilot approach)	-	-	
Further roll out of the Red Bag scheme	-	-	
Increased capacity for bed based interim placements within the private care sector (explore the viability and impact of 15 beds) 5 beds Clifford Court contracted at risk. 10 beds being progressed at risk *	-	180	19
Re-commissioning of Home Care packages across the borough	-	-	
Weekend admission into care homes - incentivisation.	-	-	
Increased number of packages of care *	-	75	
Trusted Assessor and Transfer to Assess pathways embedded - additional OT £40k	-	-	
Additional Social Workers recruited and in place across the Neighbourhoods and ITT	320	-	
Create 2 a Hospital step down team for people waiting a POC to ART, as a transition from hospital to home	-	-	
Active Recovery N'hood teams to link to CRT to support preventing admissions. Single point of access triage team for streamlining the allocation of cases	-	-	
Influenza Service to care homes - provider potentially GPs linked with care homes	-	20	
Sub-Total STOCKPORT MB COUNCIL (SMBC)	**320**	**275**	**19**

* Funding from Improved Better Care Fund (iBCF)

Stockport Locality Winter Plan 2018/19

STOCKPORT NHS FT (SFT)

NHS Stockport NHS Foundation Trust

Scheme	Identified by Provider £000s	Funding Request £000s	Change in Bed Numbers
Additional and Retained Beds at Stepping Hill Hospital (SHH)			
Retain Bed Capacity - Retain 21 beds on Ward B6 to March ISSUE: Impact on planned ward closure for CIP £0.5m		-	-
Additional Bed Capacity - Open escalation areas 6 beds A1 and 7 beds C6 December to March (17 weeks). Nursing input only, no medical.		431	13
Additional Bed Capacity - Open second additional ward 19 beds on Ward B5 and B2. Following move of A12 (currently 26 beds) to C3 (permanent endocrinology ward of 12 or 15 beds), B2 (beds 16) and B5 (beds 15) - surplus 11 or 14 beds from A12, plus additional winter capacity from December to March (17 weeks)		727	19
Additional Bed Capacity - Flip 16 surgical beds to medical beds on B3 from 19th December		184	16
Trauma Assessment Unit (TAU) - additional 8 spaces (not necessarily all beds) and continued use of chairs in CDU waiting room 8am to midnight January to March. Wholly dependent on completion front end of ED build to release space.		115	8
Jasmine business case to create 4 additional bed spaces to flexibly use to support day case surgery, daytime hours only.	9		4
Change the use and equip Bluebell as a Transfer to Assess Unit to improve flow – possible up to 10 beds advantage including below (SFT Therapies)		250	-
Change the use and equip Bluebell as a Transfer to Assess Unit to improve flow (CCG CHC)		-	-
E1/A10 – Community Integrated Services – ESD (see Neighbourhood Plan)		552	2
Implement #NOF ESD		-	-
Specific Schemes			
Extra ED Acute med consultant at weekends 9-5pm (Nov-Mar) and weekdays (Dec-Mar)		156	
Extra AMU SHO/ANP at weekends 6pm to 2am		30	
Extra Medical SHO/ANP and Senior Decision Maker in ED 6-2am 7 days a week from Dec to March		242	
ED consultant 10pm to midnight **		65	
Extra ED consultant and middle grade 7/7 6pm to 2am **		173	
Extra ED consultant 2-10pm at weekends		67	
ED streaming clinical navigator role 7/7 12 hours		128	
ED streaming and deflection – Band 4 support		28	
ED treatment stream and outstanding actions – Band 3	19		
ED Physio (FRESH) extend to 12 hour days. Not supported by CCG or other providers £26k		26	
ED Social Worker – to support FRESH SMBC and CCG to confirm		25	
Additional pharmacist deployed in ED, AMU and/or discharge by control room weekdays/weekends. Not supported by CCG or other provider £86k		86	
AMU Therapy (Physio) - weekend cover Not supported by CCG or other provider £12k		-	
AMU OT - 7 day cover Not supported by CCG or other provider £43k		43	
Transfer team	114		
Mortuary capacity – mobile store	50		
Access to diagnostics at weekend – Radiologist case to increase from 6 to 12 hours at weekend	89		
Additional consultants at weekend – 3 Hr PA (Sat and Sun) Each consultant supported by FY2 (Weekend cold consultant at WLI rates plus JCF on internal bank)		46	
Consultant of the week in DMOP		57	
In reach into AMU – cardiology and respiratory		14	
Geriatrician at front door (links with frailty)	8		

Shadow rota for escalation (managerial)	8		
Neighbourhood Schemes			
Transfer Unit Weekend opening		26	
Crisis Response Team Expansion (to increase overall capacity) Not fully optimised so not supported by providers £111k		-	
SFT to employ HCA by Trust to support delivery of packages of care – to support Active Recovery and other schemes – may cause issues with move of current staff at SMBC Not supported by CCG or other providers £40k		-	
Active Recovery - additional therapy and nurse capacity Not yet optimised, not supported by CCG or other providers £160k		-	
ITT support to escalation wards. Business case required £79k		79	
Sub-Total STOCKPORT NHS FT (SFT)	**297**	**3,551**	**62**

** Stockport Together funding £250k

Stockport Locality Winter Plan 2018/19

OTHER PROVIDERS

Scheme	Identified by Provider £000s	Funding Request £000s	Change in Bed Numbers
Pennine Care: 24 hours Mental Health liaison Service to whole hospital		-	-
Pennine Care: Mental health Crisis Pathway		-	-
Pennine Care: 5 additional Saffron beds at Meadows		-	-
CCG: Bluebell CHC Procurement		250	10
NWAS: NHS 111 online		-	-
Sub-Total OTHER PROVIDERS	**-**	**250**	**10**

This page has been left blank

Report to:	Board of Directors	**Date:**	31 October 2018
Subject:	Corporate Objectives: 2018/19 – Q2 Update		
Report of:	Chief Executive	**Prepared by:**	Assistant Business Manager, Strategy and Planning

REPORT FOR NOTING

Corporate objective ref:	Master
Board Assurance Framework ref:	N/A
CQC Registration Standards ref:	N/A
Equality Impact Assessment:	☐ Completed

Summary of Report

To provide the Trust Board with an update on progress of the corporate objectives for 2018/19 as at the end of Quarter two.

Appendix One provides the full list of the strategic objectives and corporate objectives for 2018/19 along with progress and RAG rating.

Recommendations:

- Discuss and agree the position to date.

Attachments: Appendix One– Objectives Update Q2 2018/19

This subject has previously been reported to:

☐ Board of Directors	☐ Workforce & OD Committee
☐ Council of Governors	☐ BaSF Committee
☐ Audit Committee	☐ Charitable Funds Committee
☐ Executive Team	☐ Nominations Committee
☐ Quality Assurance Committee	☐ Remuneration Committee
☐ FSI Committee	☐ Joint Negotiating Council
	☐ Other

- THIS PAGE IS INTENTIONALLY BLANK –

1. INTRODUCTION

1.1 The purpose of this report is to show progress against the strategic and corporate objectives for 2018/19 at the end of quarter two.

2. BACKGROUND

2.1 Appendix two shows the agreed trust objectives for 2018/19. Each objective has an accountable executive director.

2.3 The achievement of these objectives is an in-year measure of delivery towards the Trust strategy and narrative is provided against the progress of each objective.

Objectives are shown as follows:

- Green – on track to achieve
- Red – not on track to achieve

3 CURRENT SITUATION

3.1 Objectives for the this year focus on:

- The implementation of the Trusts refreshed strategy by following the NHSI annual planning cycle and developing comprehensive delivery and business plans
- Delivering outstanding quality and patient experience with the support of an effective quality governance framework
- Striving to achieve financial stability by ensuring compliance with the NHS improvement oversight framework
- Full and effective partnership in local strategic programme (Stockport Neighbourhood care, Healthier Together and Theme 3 and 4 programmes)
- Securing full compliance with the requirements of the NHS Provider Licence (non-financial) through fit for purpose governance arrangements
- Developing and maintaining an engaged workforce with the right skills, motivation and leadership through targeted development programmes and workforce strategy
- Creating an environment that maximises the use of resources to improve efficiency, patient experience and clinical quality

3.2 Progress for Quarter two is demonstrated in appendix one for each objective. Objectives currently not on track to be achieved are:

- Corporate Objective 3b
  To maintain compliance with, and aspire to achieve incremental improvements against, the NHS Improvement Single Oversight Framework Financial Performance Metrics, whilst safeguarding the quality of our services.
- Corporate Objective 4a
  i. To implement the new integrated service solution model of care working with our key partners
  ii. To realise the financial and non-financial benefits of the Stockport together business cases
  iii. To review SNC's systems, processes and governance in order to align to business as usual activities, where appropriate
- Corporate Objective 5b
  The Trust will maintain the 18 week RTT standards and achieve compliance with the cancer standards in order to improve access to care by 30 September 2018
- Corporate Objective 5c
  The Trust will comply with its trajectory for improvement against the 4hr A&E target, with actions identified in the Stockport System Urgent Care Plan
- Corporate Objective 7a
  To implement an Acute EPR in line with the programme timescales to improve efficiency of systems and technology resulting in a positive impact on patient experience

4. RECOMMENDATIONS

4.1 The Trust Board is recommended to:

- Note progress for the quarter two and to discuss any variations from plan.

NHS Stockport NHS Foundation Trust

Board of Directors
Trust Strategic and Corporate Objectives
1 April 2018 to 31 March 2019

		Key for progress	Forecasted to achieve					
			Not forecasted to achieve					
	Strategic (longer term) and Corporate (annual) Objectives that will be monitored quarterly in 2018/19 are;	**Executive Director accountable**	**Assurance obtained from subcommittee:**	**Progress**				**Narrative on progress**
				Q1	**Q2**	**Q3**	**Q4**	
Strategic Objective 1	**To achieve full implementation and delivery of the Trust's Refreshed Strategy 2018/22**	**Chief Executive**						
Corporate Objective 1a	To develop a comprehensive, integrated delivery/business plan in order to achieve realisation of the Strategy	Director of Support Services	Finance and Performance Committee					**Q2 Update -** The draft Trust Strategy was agreed at Trust board at the end of September 2018. The Trust strategy will go through a consultation period of three months, starting the 1st October 2018.
Corporate Objective 1b	To lead the annual operational planning cycle in line with NHSI guidance	Director of Support Services	Finance and Performance Committee					**Q2 Update -** The comprehensive planning framework is to be completed by 31st October 2018
Strategic Objective 2	**To deliver outstanding clinical quality and patient experience**	**Chief Executive**						
Corporate Objective 2a	To aspire to the delivery of 'outstanding' clinical quality, safety and experience, which is equitable, person centred and supported by an effective quality governance framework and Quality and Safety Improvement Strategy	Chief Nurse and Director of Quality Governance / Medical Director	Quality Committee					**Q2 Update** - A 6 month review has been undertaken on the Quality Governance Framework as well as the Risk Management Framework - work is planned to ensure alignment to all governance frameworks and the Board Assurance Framework. The Quality Improvement Plan has been presented at the Board of Directors during Q2 - the Q2 report is planned for approval in October (Q3). Good progress has been made across all the quality improvement indicators. The Trust has chosen nine quality indicators to progress throughout 2018/19 - these nine quality indicators form the Quality Strategy alongside safety collaborative, quality initiatives and national and local CQUINs.
Corporate Objective 2b	To drive continuous quality improvement and promote research and innovation, whilst reducing unwarranted clinical variation and progressing toward an 'Outstanding' organisation.	Chief Nurse and Director of Quality Governance / Medical Director	Quality Committee					**Q2 Update** - The second cohort of AQuA projects commenced. The Quality Faculty is under development led by the Deputy COO and supported by the Quality Teams. 6 further wards underwent their first Ward Accreditation Programme (ACE). Model Hospital data continues to be reviewed at speciality level in order to reduce unwarranted clinical variation

NHS Stockport NHS Foundation Trust

Board of Directors
Trust Strategic and Corporate Objectives
1 April 2018 to 31 March 2019

		Key for progress	Forecasted to achieve					
			Not forecasted to achieve					
	Strategic (longer term) and Corporate (annual) Objectives that will be monitored quarterly in 2018/19 are;	**Executive Director accountable**	**Assurance obtained from subcommittee:**	**Progress**				**Narrative on progress**
				Q1	**Q2**	**Q3**	**Q4**	
Strategic Objective 3	**To strive to achieve financial sustainability**	**Chief Executive**						
Corporate Objective 3a	To ensure full compliance with the NHS Provider Licence, ensuring financial sustainability, financial efficiency and financial controls, whilst safeguarding the quality of our services.	Director of Finance	Finance and Performance Committee					**Q2 Update -** The Trust has delivered the financial plan at the end of quarter 2. Whilst the Trust delivered the CIP plan to the end of September, there remains a significant shortfall for the financial year. The Trust has drafted a recovery plan to provide high level assurance in delivery of the plan. However, due to a number of risks including: i) Winter escalation plan ii) Elective and day case performance iii) Impact of penalties the Trust is only able to forecast a moderate level of assurance. This issue is discussed at Finance and Performance committee, Board of Directors and NHSI Enhanced Oversight meetings.
Corporate Objective 3b	To maintain compliance with, and aspire to achieve incremental improvements against, the NHS Improvement Single Oversight Framework Financial Performance Metrics, whilst safeguarding the quality of our services.	Director of Finance	Finance and Performance Committee					**Q2 Update** - At the end of quarter 2 the Trust has identified 10.8m in CIP against a 15m target. This is a gap of 4.2m. The Trust has financial provisions, contingencies and reserves to mitigate the gap. However, the Executive Team are continuing to exert focus on delivery of service improvements on the front line
Corporate Objective 3c	To review and monitor a revised performance management framework	Director of Support Services	Finance and Performance Committee					**Q2 Update -** The revised framework was agreed at the end of quarter two. Implementation of this framework will take place in October and November 2018.
Strategic Objective 4	**To achieve the best outcomes for patients through full and effective participation in local strategic partnership programmes including;** **a. Stockport Together/ Stockport Neighbourhood Care/ Integrated Service Solution** **b. Healthier Together** **c. Theme 3 & 4 Programmes (GM Health & Social Care Partnership)**	**Chief Executive**						
Corporate Objective 4a	i. To implement the new integrated service solution model of care working with our key partners ii. To realise the financial and non-financial benefits of the Stockport together business cases iii. To review SNC's systems, processes and governance in order to align to business as usual activities, where appropriate	Chief Operating Officer	Provider Board					**Q2 Update -** i. The key partners are established and working as a collaborative ii. The benefits of Stockport Neighbourhood Care are yet to be realised iii. The provider alliance board has been reformed and governance arrangements are clear. The board are clear on objectives for the rest of the financial year.

NHS Stockport NHS Foundation Trust

Board of Directors
Trust Strategic and Corporate Objectives
1 April 2018 to 31 March 2019

		Key for progress	Forecasted to achieve					
			Not forecasted to achieve					
	Strategic (longer term) and Corporate (annual) Objectives that will be monitored quarterly in 2018/19 are;	**Executive Director accountable**	**Assurance obtained from subcommittee:**	**Progress**				**Narrative on progress**
				Q1	**Q2**	**Q3**	**Q4**	
Corporate Objective 4b	To progress with planning for the realisation of the Healthier Together decision in line with GM defined timescales and investment	Director of Support Services	Finance and Performance Committee					**Q2 update -** The commercial case was submitted to GM/NHSI at the end of quarter two. Discussions regarding the approval process is on-going.
Corporate Objective 4c	To progress work streams relating to a)Theme 3 and b) Theme 4 in line with the GM Transformation Strategy	Director of Support Services/ Chief Operating Officer	Finance and Performance Committee					**Q2 update -** Theme three - McKinsey modelling of theme three specialities and DGH archetypes to be completed within quarter three. Theme four - HR discussions are taking place with the council. The Greater Manchester finance proposal is currently under consideration.
Strategic Objective 5	**To secure full compliance with the requirements of the NHS Provider Licence through fit for purpose governance arrangements (non-financial)**	**Chief Executive**						
Corporate Objective 5a	The Trust will complete an independently assessed Well Led Review by 30 September 2018	Director of Corporate Affairs	Audit Committee					**Q2 Update** - The Trust Board agreed not to proceed with this subject due to the proximity of a likely CQC well-led review in Q3 2018/19
Corporate Objective 5b	The Trust will maintain the 18 week RTT standards and achieve compliance with the cancer standards in order to improve access to care by 30 September 2018	Chief Operating Officer	Finance and Performance Committee					**Q2 Update -** The Trust has agreed a recovery plan with Stockport CCG on RTT/waiting list size. The success of this recovery plan is dependant on: i. A decrease in referrals from GPs ii. Cleansing/validating the patient pathway to avoid duplication iii. Additional activity to bridge the gap in capacity The cancer standards are improving but will be adversely affected by the two week breast capacity shortfall. The issue has been escalated to NHSI/Greater Manchester for support within the system
Corporate Objective 5c	The Trust will comply with its trajectory for improvement against the 4hr A&E target, with actions identified in the Stockport System Urgent Care Plan	Chief Operating Officer	Finance and Performance Committee					**Q2 Update -** The Trust failed to achieve the Q2 recovery actions. Future recovery will be focused on: i. Overnight breaches ii. Early discharges and ward processes iii. Decreasing the number of stranded patients Decreasing the number of stranded patients is imperative to plans and will have the most impact if not addressed. The lack of a system wide winter plan is a risk to achieving this target.
Corporate Objective 5d	The Trust will progress the economy-wide plan to deliver consistent provision of healthcare needs across 7 days a week	Medical Director	Quality Committee					**Q2 Update -** The latest seven day national audit results put the Trust in the upper quartile. The Trust continues to refine the Outline Business Case proposals by business group and seek opportunities to progress towards seven day standards.

NHS Stockport NHS Foundation Trust

Board of Directors
Trust Strategic and Corporate Objectives
1 April 2018 to 31 March 2019

		Key for progress	Forecasted to achieve					
			Not forecasted to achieve					
	Strategic (longer term) and Corporate (annual) Objectives that will be monitored quarterly in 2018/19 are;	**Executive Director accountable**	**Assurance obtained from subcommittee:**	**Progress**				**Narrative on progress**
				Q1	**Q2**	**Q3**	**Q4**	
Strategic Objective 6	**To develop and maintain an engaged workforce with the right skills, motivation and leadership**	**Chief Executive**						
Corporate Objective 6a	To develop our medical leaders into leaders of the future through a targeted development programme, on-going participation in triumvirate decision making through EMG and active attendance at the Clinical Directors Forum	Medical Director	Quality Committee					**Q2 Update -** The Clinical Director development programme continues and the Triumvirate coaching has been introduced during quarter 2.
Corporate Objective 6b	To continue to implement clinical leadership programmes which support the development of an inclusive and compassionate leadership culture, increase resilience and facilitate continuous improvement	Director of Workforce & Organisational Development	People Performance Committee					**Q2 Update -** The clinical leadership programme continues on a monthly basis. Clinical Leadership Development programmes continue at all levels of leadership across the Trust. The Business Group leadership team development programme is due to commence November 2018.
Corporate Objective 6c	To develop programmes of work to ensure the Health and Wellbeing Strategy is embedded across the trust and supports all staff in improving their health and wellbeing, delivering an environment where staff wellbeing is integrated into day-to-day practices	Director of Workforce & Organisational Development	People Performance Committee					**Q2 Update -** The Health and Wellbeing agenda now forms part of our Culture and Engagement plan, and has been included in the People Strategy and implementation plan. The occupational health team will be supporting a review of the programme to align with our People Strategy objective. Resilience and Managing Mental Health at work is a core module of the Business Group Triumvirate development programme to commence in November 2018.
Corporate Objective 6d	To develop a Workforce Strategy that reduces reliance and expenditure on contingent workforce through the continued streamlining of recruitment processes, improving nursing and AHP retention, expanding the medical bank and enhanced scrutiny of agency usage	Director of Workforce & Organisational Development	People Performance Committee					**Q2 Update -** The People Strategy was approved by the Board of Directors in September. Work to finalise the implementation plan is underway. Regular strategy updates will be provided to the People Performance Committee.
Strategic Objective 7	**To create an environment that maximises the use of resources to improve efficiency, patient experience and clinical quality**	**Chief Executive**						
Corporate Objective 7a	To implement an Acute EPR in line with the programme timescales to improve efficiency of systems and technology resulting in a positive impact on patient experience	Director of Support Services	Finance and Performance Committee					**Q2 Update -** Intersystem have changed their UK Senior Management Team. The Trust has written to Intersystem to initiate the dispute process outlined within the contract. There will be a paper presented to Trust Board in quarter three to consider options going forward.

Board of Directors
Trust Strategic and Corporate Objectives
1 April 2018 to 31 March 2019

		Key for progress	Forecasted to achieve					
			Not forecasted to achieve					
	Strategic (longer term) and Corporate (annual) Objectives that will be monitored quarterly in 2018/19 are;	**Executive Director accountable**	**Assurance obtained from subcommittee:**	**Progress**				**Narrative on progress**
				Q1	**Q2**	**Q3**	**Q4**	
Corporate Objective 7b	To refresh the Estates Strategy based on the six facet survey and master planning information	Director of Support Services	Finance and Performance Committee					**Q2 Update -** The Estates Strategy was agreed at Trust Board in September.
Corporate Objective 7c	To manage investment relating to the Trust's capital programme relating to; i. Medical equipment ii. IT iii. Estates iv. ED Patient Streaming	Director of Support Services/ Director of Finance	Finance and Performance Committee					**Q2 Update -** There is managed investment in the three elements of the capital programme which is monitored through governance meetings. The ED Patient Streaming scheme has started works on site and stage one, which is the main entrance and waiting area is due to be completed 21.12.2018. Stage two, which is the courtyard is expected to be completed by 08.02.2019

This page has been left blank

Stockport NHS
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	31 October 2018
Subject:	Freedom to Speak Up Report		
Report of:	Freedom to Speak Up Guardian	**Prepared by:**	P Gordon

REPORT FOR ASSURANCE

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

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

The purpose of this report is to provide the Board of Directors with assurance on the effective working of the Trust's Freedom to Speak Up arrangements.

Attachments:

This subject has previously been reported to:

☐ Board of Directors	X PP Committee
☐ Council of Governors	☐ SD Committee
☐ Audit Committee	☐ Charitable Funds Committee
☐ Executive Team	☐ Nominations Committee
☐ Quality Committee	☐ Remuneration Committee
☐ F&P Committee	☐ Joint Negotiating Council
	☐ Other

- THIS PAGE IS INTENTIONALLY BLANK -

1. INTRODUCTION

1.1 The purpose of this report is to provide the Board of Directors with continued assurance on the effective implementation of the Freedom to Speak Up agenda between April and September 2018.

2. NATIONAL GUARDIAN OFFICE (NGO): RECOMMENDATIONS AND DEVELOPMENTS

2.1 Organisations are now required to consider implementing NGO recommendations that arise from their surveys, guidance documents and case reviews. The Executive Lead for speaking up is accountable for ensuring these are met, overseen by the Non-Executive lead. The recommendations and any relevant actions are recorded and tracked by means of a Register & Action Log maintained by the Freedom to Speak Up Guardian (FTSUG). A copy of the Register is included for reference at Appendix 1.

2.2 Although the FTSUG can assist the Trust in meeting the NGO recommendations, their main priorities are to provide advice and support to all staff, and serve as a critical friend to senior leaders.

2.3 All Trusts are required to complete a self-review tool, vision and strategy. The FTSUG works in positive collaboration, and has experienced high levels of engagement and involvement with these tasks.

2.4 The FTSUG was interviewed by the CQC as part of its "Well Led" assessments: the FTSUG reported on recent and planned developments, with high levels of engagement and support from very senior leaders.

3. PROMOTION

3.1 The FTSUG featured in the Trust-wide weekly update in July.

3.2 October 2018 is Freedom to Speak Up month. A "Speaking Up Matters" newsletter will be distributed in online and paper format, and as part of FTSUG walkabouts where possible.

4. TRAINING

4.1 In the last two months the FTSUG provided training to thirteen Trainee Nurse Associates and thirteen Physiotherapists, with excellent feedback.

4.2 As part of a wider response to an anonymous concern, a training session with over twenty senior nurses is scheduled to be held on 30 October 2018.

4.3 Internal training sessions on raising concerns are currently provided on an ad-hoc basis. However, there are plans to include a module on raising and dealing with concerns, led by the FTSUG, on the leadership training programme from early 2019.

5. CULTURE

5.1 Monitoring

5.1.1 The reporting process for FTSUGs is still emergent. The FTSUG compares casework with internal reporting: this corroborates assurances where reported improvements are mirrored in FTSUG casework, and provides an opportunity to alert management if the FTSUG notices a trend that is not reflected in internal governance mechanisms.

5.1.2 The FTSUG now has access to CQC insight reports, and liaises with various internal staff to identify common trends and cultural insights, including:

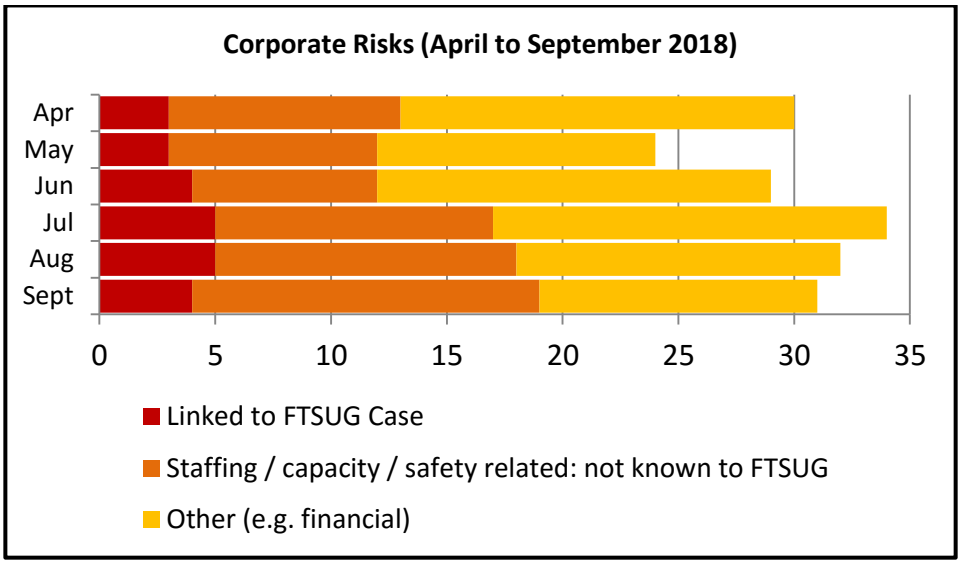
- The Deputy Director of Quality Governance
- The Head of Organisational Development and Learning
- The Associate Nurse Director who leads on the nursing retention "Itchy Feet" programme
- The Equality and Diversity Lead (with attendance to associated groups)
- Practice Education Facilitators

5.1.3 FTSUGs in some Trusts report the timescale for resolution of concerns to be a major problem. Appendix 2 demonstrates that the concerns raised via the FTSUG at Stockport NHS Foundation Trust are resolved within reasonable timescales.

5.2 Observed Trends

5.2.1 The NGO recommends that the FTSUG reports on levels of engagement with senior leaders. The FTSUG meets regularly with the Chief Executive, Executive Lead, Non-Executive Lead and Chair, and considers relationships with all senior leaders to be well established, transparent, bilateral and constructive.

5.2.2 The table below details the proportion of corporate risks that relate to safety, capacity or staffing, and the risks within those that are also touched upon in FTSUG casework. This implies that workers are suitably assured by internal processes in the majority of cases.



5.2.3 In April 2018, the FTSUG reported the three main influences on workers' perception of how well their concerns had been dealt with:

- Communication of timescales, with reasons given for delays
- Quality of communication / feedback
- Confidence that management selected and followed the most appropriate policies

These influences are not seen when concerns are raised to Executive Director level.

5.2.4 Individuals have approached the FTSUG regarding reports of a persistent bullying culture within a particular department, despite raising their concern with Executive Directors: this was independently corroborated by senior colleagues who reported being approached by additional individuals. The FTSUG notified the Chief Executive. The FTSUG has been informed of significant and ongoing engagement work with staff concerned involving senior staff, with support from Human Resources and guidance from the Head of Organisational Development.

5.2.5 The FTSUG was approached by a worker with a concern that the Trust may implement significant service changes without consulting staff. The individual feels that minimum care standards and targets will not be achieved: the FTSUG is advising and supporting the individual accordingly. However, the FTSUG is aware that the reported shortcomings have been highlighted in two previous organisational change processes affecting the same broad group of staff. This may lead to workers perceiving the Trust to lack willingness to learn lessons and meaningfully engage with its staff.

5.2.6 The above trends (5.2.4 / 5.2.5) fall within the same business group. The FTSUG:

- Met and engaged with the relevant Business Group Director
- Provided a training session on raising concerns with workers from the affected group
- Has arranged to meet with the Director of Workforce

6. CASEWORK

6.1 The NGO publishes quarterly speaking up data, and highlights specific elements. Fourteen individuals raised a total of nine concerns via the FTSUG between April and September 2018. Of these:

- 1 was raised anonymously
- 6 included a patient safety element
- 4 included elements of bullying, harassment or unacceptable behaviour
- 1 reported suffering detriment after initially raising the concern

6.2 Workers retain ownership of concerns raised via the FTSUG, including the right not to pursue them (excepting criminal offences and immediate safety / safeguarding issues). A group of workers reported a concern relating to staffing, capacity, safety, patient experience and staff well-being, with an underlying sense that the organisation was prioritising financial and operational targets above organisational values and patient care. The workers reported that if their concern was unresolved following the FTSUG's input, they would no longer speak up, and seek employment elsewhere. In the FTSUG's view the response addressed the operational concerns but not the cultural ones. Worker engagement with the FTSUG has waned, and if this creates the retention issues that the workers warned of, it may threaten achievement of the operational targets.

6.3 A senior colleague sought FTSUG advice: a frontline worker had approached them and reported a culture where the reporting of staffing incidents was discouraged. The FTSUG and senior colleague agreed an approach that would address the reported issues whilst maintaining the confidentiality of the individual. This is not included in FTSUG casework as the frontline worker chose to raise the issue internally, and there is no equivalent internal process to allow the senior colleague to demonstrate that they responded to the concern following best practice principles.

6.4 The above two examples demonstrate the need for an internal governance mechanism that monitors the quality of response to concerns and identifies lesson learnt. The FTSUG is currently liaising with Human Resources to address this.

7. EQUALITY, DIVERSITY AND INCLUSION

7.1 There are currently no equality monitoring arrangements for concerns raised within the organisation. The FTSUG is liaising with Human Resources to develop this.

7.2 There are no new indications of unequal treatment of workers based on their protected characteristics.

7.3 The FTSUG has identified a secondary trend from casework, contacts, and workplace discussions, relating to reported inconsistent application of policies (e.g. attendance / organisational change / dress code / flexible working). If staff perceive inconsistent or unfair treatment in the workplace, they may speculate that this also applies to those who speak up.

7.4 The above trend may naturally occur as part of the FTSUG role: workers who are not members of trade unions may approach the FTSUG, even though FTSUGs do not advocate for or represent individuals. The FTSUG will address this during a presentation to the Human Resources team in November 2018.

8. FORWARD VIEW

8.1 The FTSUG was given the freedom to conduct a Trust-wide survey throughout September. 395 responses were received, and the FTSUG is currently analysing the data.

8.2 The survey results will be initially presented to the Executive Management Group. This will also feature:

- The Trust position against NGO recommendations such as provision of training, and the monitoring of concerns raised internally
- Triangulation with existing workforce indicators, casework themes, trends and soft intelligence
- Recommended actions to be taken forwards and owned by management

8.3 This will be followed by an assurance report to the People and Performance Committee.

8.4 This demonstrates that the Trust is willing to invite open challenge, and commit itself to making improvements.

9. ASSURANCE

9.1 The content of the report provides the Board of Directors with positive assurance that the Trust is collaborating with the FTSUG to meet all NGO recommendations and continually improve its culture and processes around raising and dealing with concerns.

10. RECOMMENDATIONS

10.1 The Board of Directors is recommended to:

- Note the positive assurance on Freedom to Speak Up arrangements detailed in the report.

APPENDIX 1: REGISTER & ACTION LOG

Freedom to Speak Up Guardian Survey 2017			
	Recommendation	**Trust Position**	**Action Log Ref**
1	Appointment: We recommend that appointment of guardians is made in a fair and open way, and that senior leaders assure themselves that workers throughout their organisation have confidence in the integrity and independence of the appointee.	Met: Appointment of FTSUG resulted from a competitive recruitment process. Senior leader assurance provided by visibility of FTSUG and level of case referrals reported to PP Committee and Board.	
2	Potential conflicts of interest: We recommend that all guardians / ambassadors / champions reflect on the potential conflicts that holding an additional role could bring and that they devise mechanisms to ensure that there are alternative routes for Freedom to Speak Up matters to be progressed should a conflict become apparent when supporting someone who is speaking up. We see particular potential for conflicts to arise where a guardian also has a role as a human resources professional and recommend that guardians do not have a role in any aspect of staff performance or human resources investigations.	Met: FTSUG employed in a dedicated role with no shared responsibilities.	
3	Local networks: We recommend that all trusts consider developing a local network of ambassadors / champions, depending on local need, to help provide assurance that all workers have appropriate support and opportunities to speak up, and to give guardians alternative routes to pursue speaking up matters should they be faced with a real or perceived conflict. Members of a local network could also cover the guardian role when the guardian is absent, on leave etc.	Links established with the Trust's network of Cultural Ambassadors but room to strengthen this. Cover during FTSUG absence provided by Director of Corporate Affairs.	1
4	Diversity: We recommend that all trusts take action to ensure that all workers, irrespective of their ethnicity, age, sexuality or other diversity characteristics, have someone they feel able to go to for support in speaking up. Guardians should consult with relevant representative groups in developing their approach on this matter. Guardians should also take action to assure themselves that any potential barriers to speaking up that particular groups face are understood and tackled.	Met: Concerns raised via FTSUG are equality monitored. Reports do not yet assure that all workers regardless of protected characteristics feel free to speak up. Green RAG rated as related work is fully embedded and ongoing (FTSUG is a member of the E&D Steering Group).	
5	Communication and training: We recommend that all guardians use all appropriate communication channels to ensure that all staff know of their role, and work with colleagues to ensure that Freedom to Speak Up is incorporated in all relevant staff training and development programmes, and particularly in staff inductions. In conjunction with the relevant parts of their organisation, guardians should monitor the effectiveness of their communication and training activities. Guardians should ensure that the language and message of communications and training are consistent with national guidance.	Met. Variety of communication channels used for awareness and visibility e.g. visits, screen savers, leaflets and posters. FTSU incorporated in Corporate Induction. Training effectiveness is monitored by use of feedback forms. Effectiveness of FTSU communications is not specifically monitored but can be inferred in part by Staff Survey results.	
6	Partnership: We recommend that all guardians continue to develop working partnerships with all relevant parts of their organisation.	Met: Proactive development of working partnerships with the Workforce team and, in particular, the Head of Learning & Development and the Trust's EDI lead.	
7	Access to senior leadership: We recommend that all guardians have direct and regular access to their chief executive and non-executive director with responsibility for speaking up.	Met: FTSUG has regular access to and meetings with: - Chief Executive - Chair - Senior Independent Director - Director of Corporate Affairs.	
8	Board reporting: We recommend that guardians or a representative from a local network of champions / ambassadors personally presents regular reports to their board. Board reports should include measures of activity and impact and, where possible, include 'case studies' describing real examples of speaking up that guardians are handling.	Met: Quarterly reports presented to People Performance Committee with six-monthly reports to Board of Directors. Reports developed to include 'case studies' where appropriate.	
9	Feedback: We recommend that guardians always gather feedback on their performance, from their line managers, the partners they work with, and from those they are supporting.	Met: Feedback proactively sought by the FTSUG from a variety of sources.	
10	Time: We strongly recommend that all trusts provide ring-fenced time for anyone appointed as a guardian / ambassador / champion to carry out their role and attend training, regional and national network meetings, and other events.	Met: Dedicated 15 hours per week FTSUG role with no shared responsibilities.	

Case Review 1: Southport and Ormskirk Hospital NHS Trust (September 2017)			
	Recommendation	**Trust Position**	**Action Log Ref.**
1	Within three months the trust should publish its new speaking up policy.	Already met	
2	Within six months the trust should take steps to ensure all existing and new workers are aware of the contents of the new freedom to speak up policy.	Policy revised. Opportunity to refresh awareness. To prepare comms plan	2
3	Within 12 months the trust should implement all aspects of its draft Freedom to Speak Up action plan, by the plan's stated completion dates.	N/A: Case-specific	
4	Within three months the trust should ensure that, in accordance with its own policies and procedures and in accordance with good practice, all those managers and leaders responsible for handling concerns provide feedback to every individual who speaks up, including any actions they intend to take in response.	N/A: Case-specific	
5	Within six months the trust should put in place effective systems to monitor the development of a positive speaking up culture.	Already met via FTSU Board reports, but additional work ongoing (e.g. pilot survey)	
6	Within 12 months the trust should develop an action plan to develop a working culture that is free from bullying, including providing anti-bullying training for all staff.	N/A: Case-specific	
7	Within 3 months trust leaders should take appropriate steps to ensure that they are visible and accessible to all workers to promote a culture of visible leadership.	Can always be worked on: no indication that this is a prominent problem at Stockport, therefore the recommendation has been interpreted as case-specific	
8	Within three months the trust should ensure that it responds to the concerns raised by its workers strictly in accordance with its policies and procedures and in accordance with good practice and report to the board evidence of this.	N/A: Recommendation related to criticisms specific to case	
9	Within three months the trust should ensure that it responds to all concerns raised by its workers in relation to the recruitment of staff strictly in accordance with its policies and procedures and in accordance with good practice.	N/A: Case-specific	
10	Within 12 months the trust should provide all workers, including all managers, with regular, updated and mandatory training on speaking up and supporting and responding to people who speak up. The trust should monitor the effectiveness of this training.	Not met, but recommendation is highly difficult to achieve. Therefore considered as work ongoing	3
11	Within three months the trust should ensure that appropriate steps are taken to publicise the role of guardian and any staff supporting that role, using methods that reach all workers.	Already met via Trust-wide screensaver, several regular features in Trust-wide communications, and intranet site	
12	Within three months the trust should ensure that it provides appropriate resources for the role of Freedom to Speak Up Guardian, in line with guidance provided by the National Guardian's Office, including sufficient cover to support their work in their absence, and alternative routes to handle speaking up matters to overcome any possible conflicts.	Already met	
13	The trust should take appropriate steps to ensure that minority and vulnerable workers, including black and minority ethnic workers are free to speak up	Relevant, but case specific. This will always be work ongoing via E&D Steering Group, therefore marked as "met" as the Trust is "taking appropriate steps to ensure"	
14	Within six months the trust should look again at its appointment process for the role of Freedom to Speak Up Guardian and ensure a Guardian is appointed using a process that is open and fair.	N/A: Case-specific	
15	Within three months the trust should seek to share the learning of its cultural review with its workers, taking all necessary steps to protect the confidentiality of individuals.	N/A: Case-specific	
16	Within 12 months the trust should take appropriate steps to ensure that all aspects of its work are consistent with the Francis Freedom to Speak Up principles, including where it undertakes a Fit and Proper Person review.	Already met	
17	The Care Quality Commission should, where regulating matters relating to a fit and proper persons test under section 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, continue to develop its approach and include the need for information provided by people who speak up to be considered when assessing whether a satisfactory FPP review has been carried out.	N/A: Recommendation for CQC	
18	Within 12 months the trust should take steps to ensure that its policies and procedures are supportive of all workers affected by the speaking up process, including those who are the subject of concerns raised.	Already met	
19	Within 12 months the trust should take steps to actively promote the use of mediation, where appropriate, to resolve issues arising from speaking up.	Completed 20/09/18	4
20	Within six months the trust should take all appropriate steps to address the concerns raised by BME workers in the trust 2016 survey .	N/A: Case-specific	
21	Within six months the trust should appoint an equality and diversity lead and ensure that position is appropriately resourced.	N/A: Case-specific	
22	Within 12 months the trust should take action to implement all the recommendations of its cultural review.	N/A: Case-specific	
23	Within three months the trust should consider requesting support from the NHS England WRES Implementation Team to help meet the needs of its BME workers.	N/A: Case-specific	

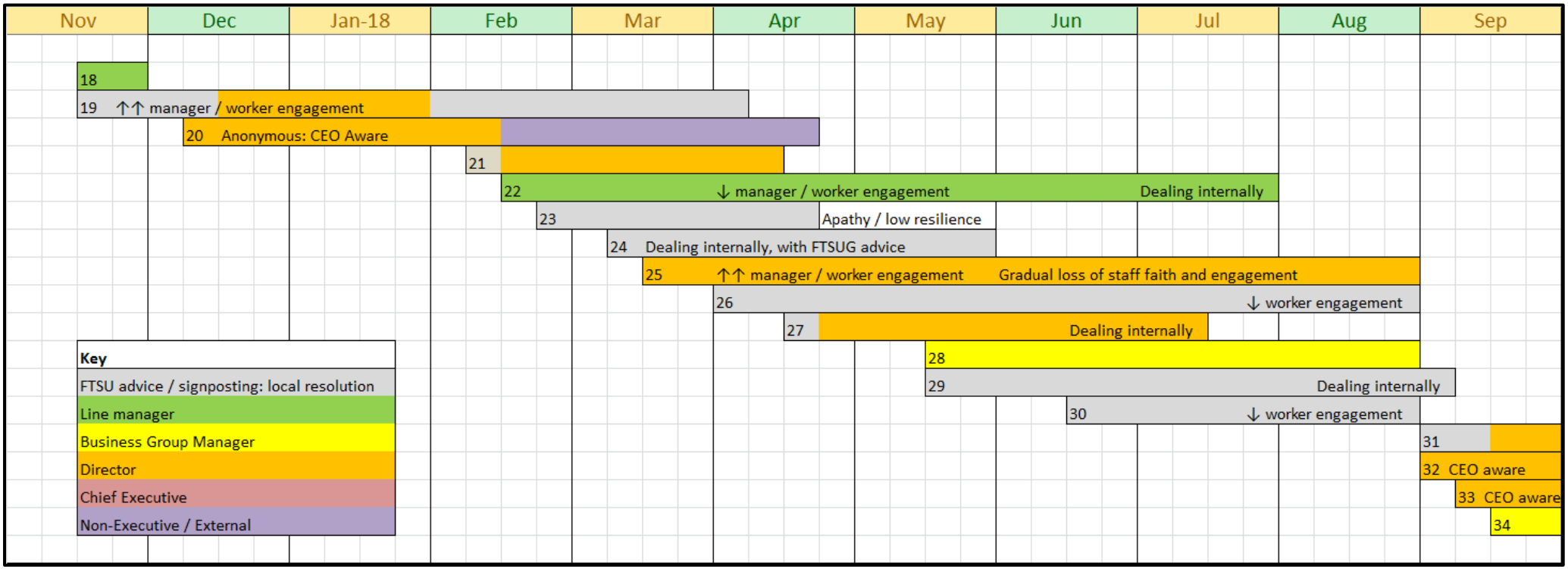
Case Review 2: Northern Lincolnshire and Goole NHS Foundation Trust (September 2017)			
	Recommendation	**Trust Position**	**Action**
1	Within 3 months the trust should revise its policies and procedures relating to the reporting and handling of incidents to ensure they refer to the support available for staff to do this from the trust Freedom to Speak Up Guardian and Associate Guardians.	Already met	
2	Within 3 months the trust should revise its policy for dealing with serious incidents to ensure it provides that feedback and any learning should be shared with staff who had spoken up regarding an incident.	Confirmed as already met 24/07/18	5
3	Within 3 months the trust should revise its current speak up policy to ensure that it is in accordance with good practice and reflects the minimum standards set out in the NHS Improvement speaking up policy for the NHS.	Already met	
4	Within 6 months the trust should take steps to ensure all existing and new workers are aware of the contents of its new speak up policy.	Policy revised. To prepare comms plan	2
5	Within 12 months the trust should begin work to ensure that, upon the scheduled review of any trust policy and/or procedure, the policy or procedure in question is in alignment with good practice in relation to the freedom to speak up.	Already met	
6	Within 6 months the trust board should articulate a vision of how it intends to support its workers to speak up, which encompasses a strategy containing deliverable objectives within fixed timescales and under appropriate executive oversight, and to effectively communicate this to trust workers.	Draft in progress: Executive Lead collating feedback	6
7	Within 6 months trust leaders should identify and employ a range of appropriate measures to monitor speaking up processes and culture within the trust, to ensure they are responsive to the needs of all workers and are developed in accordance with good practice.	Already met and under continual review / development	
8	Within 6 months the trust should ensure that its bullying and harassment policy and procedure is consistent with the standards set out in the bullying and harassment guidance issued by NHS Employers, including how the trust will implement and monitor the revised policy and ensure its contents are shared with all staff.	Confirmed as met on 30/07/18	7
9	Within 12 months the trust should take steps to address bullying behaviour, including training for all staff relating to the awareness and handling of such behaviour.	N/A: Case-specific	
10	Within 6 months the trust should continue to ensure that all investigations into the alleged conduct of workers who have previously spoken up also seek to identify whether any such allegations are motivated by a desire to cause detriment because that worker spoke up and, where such evidence is found, take appropriate action. This should include amending the trust disciplinary policy to require such action.	Completed 20/09/18	8
11	Within 3 months the trust should ensure that, in accordance with its own policies and procedures and in accordance with good practice, all managers and leaders responsible for handling speaking up provide feedback to every individual who raises an issue, including any actions they intend to take in response.	Already met (but work always ongoing)	
12	Within 3 months the trust should ensure that it responds to the issues raised by its workers strictly in accordance with its policies and procedures and in accordance with good practice, including, where appropriate, investigating matters that are raised.	N/A: Case-specific	
13	Because of the particular needs of the trust to improve its speaking up process and culture it is recommended that, within 12 months, the trust should provide all workers with mandatory, regular and updated training on speaking up, including for those with responsibility for handling concerns. This training should be in accordance with NGO guidance and the trust should monitor that it is effective.	N/A: Case-specific	
14	Within 3 months the trust should allocate sufficient ring-fenced time for the Freedom to Speak Up Guardian and any Associates to ensure they can appropriately support the needs of workers to speak up.	Already met	
15	Within 3 months the trust should take appropriate steps to ensure that the role and names and contact details of the Freedom to Speak Up Guardian and Associate Guardians are promoted to all workers across all three trust hospital sites.	N/A: Case-specific (though recommendation is relevant in principle and is being met)	
16	Within 6 months a communications and engagement strategy should be developed to promote the Freedom to Speak Up Guardian and Associate Guardian's role, and to evaluate the impact it is having, in the longer term. This should include strategies to provide feedback on actions taken in response to speaking up and actions to tackle barriers to speaking up.	Comms and engagement work completed. Evaluation of impact weakly implied by FTSUG report to Board. Not feeding back on actions and barriers.	9
17	Within 3 months the Freedom to Speak Up Guardian should ensure that their regular reports to the trust board are sufficiently detailed and comprehensive to support the development of a positive speaking up culture.	Already met	
18	Within 3 months the Freedom to Speak Up Guardian and any Associate Guardians should begin regular attendance at regional meetings of their peers to ensure that they have access to guidance and support to undertake their work, including to assist with the writing of board reports and in order to share learning and good practice with them.	Already met (and exceeded)	
19	Within 3 months the trust should ensure that all HR policies and procedures meet the needs of workers who speak up, including letters to suspended workers that accurately state their ability to access their Guardian or Associate Guardian.	Human resources revising suspension letters	10
20	Within 3 months the trust should continue its work to ensure that, where a worker is going through a disciplinary process that also encompasses potential patient safety issues or similar matters they have raised, the trust continues to provide that worker with all appropriate support to speak up about those matters and also takes all appropriate steps to maintain the worker's confidentiality.	Already met (as this is continually being worked on with all employees)	
21	Within 12 months the trust should take steps to actively promote the use of mediation, where appropriate, to resolve issues arising from speaking up.	Completed 20/09/18	4
22	Within 3 months the trust should consider requesting support from the NHS England WRES Implementation Team to help meet the needs of its BAME workers.	N/A: Case-specific	
23	Within 12 months the trust should take all appropriate steps to identify which staffing groups in the trust feel particularly vulnerable when speaking up, why this is the case and how those groups can be supported to speak up freely and protected from any detriment for having done so.	Already met in terms of approach (can never permanently achieve and therefore must be approached on an ongoing basis)	

Case Review 3: Derbyshire Community Health Services NHS Foundation Trust (June 2018)			
	Recommendation	**Trust Position**	**Action Log #**
1	Within 3 months the trust should publish its new speaking up policy. The new policy should be written in a way that encourages workers to speak up and is easily understood. Unnecessary references to PIDA and malicious intention in speaking up should not be present.	Already met	
2	Within 6 months the trust should take steps to ensure all existing and new workers are aware of the contents of the new freedom to speak up policy.	Room to refresh awareness of policy	2
3	Within 3 months the trust should ensure that workers who wish to raise matters with the trust nonexecutive director responsible for speaking up are able to do so via routes of communication that appropriately support their confidentiality.	Arrangements for SID access verified: policy appendix to be updated accordingly	11
4	Within 3 months the trust should ensure that, in line with its practices, it continues to value the views of its workers, including consulting staff about changes to their services where appropriate.	N/A: Case specific	
5	Within 3 months the trust should take all appropriate steps to ensure that all cases of speaking up are investigated within reasonable timescales and without undue delay.	N/A: Case specific, and no indication that undue delay is a recurring theme at Stockport NHS FT	
6	Within 3 months the trust should take appropriate steps to ensure that all cases of speaking up are investigated by suitably independent persons.	N/A: Case specific, and where this has been called into question at Stockport NHS FT, it has been identified and assurances received by the FTSUG	
7	Within 3 months the trust should take all appropriate steps to ensure that responses to cases of workers speaking up, including decisions relating to the investigation of those cases, are not focused on whether or not the matters in those cases are qualifying disclosures under the Public Interest Disclosure Act.	Completed 20/09/18	12
8	Within 12 months the trust should develop a plan for embedding speaking up in the organisation. This plan should consider the use of staff inductions, team meetings, leadership training and other mechanisms to ensure that all staff have the necessary skills and knowledge to speak up well and respond to issues being raised appropriately. As part of this plan, a communication strategy should be developed to promote the trust's Freedom to Speak Up Guardian and encourage workers to speak up to them when they feel they cannot speak up using other channels.	Already met and work ongoing	
9	Within 3 months the trust should ensure that their speaking up arrangements, including the support provided by the Freedom to Speak Up Guardian, appropriately protect workers' confidentiality, and demonstrates appropriate understanding and empathy for the needs of individuals.	Already met, and no indications to the contrary	
10	Within 3 months the trust should ensure that the Freedom to Speak Up Guardian records all instances of speaking up raised to them, not just those cases where workers state that they are raising a matter 'formally'.	Already met	
11	Within 3 months the trust should take appropriate steps to ensure that where the grievance process is used to respond to a worker speaking up the trust's grievance policies and procedures are correctly followed, including in respect of providing an initial scoping meeting to discuss the matter the worker is speaking up about and the range of alternative processes for handling it.	N/A: Case specific, and no theme identified to suggest this is a problem at Stockport NHS FT	
12	Within 12 months the trust should take appropriate steps to ensure that all workers who speak up are meaningfully thanked for doing so, in accordance with trust culture, training and good practice.	Stated in policy, and covered in training and factsheets	
13	Within 3 months Capsticks HR Advisory Service should take all appropriate steps to ensure that it communicates to workers at their first contact whose speaking up concerns it is investigating of the actions it takes to ensure the independence of its investigations. This assurance should be provided to the workers concerned prior to the commencement of the investigation.	N/A: Action for Capsticks	
14	Within 12 months, The Department for Health and Social Care should commission NHS Employers to develop and communicate guidance to NHS trusts and foundation trusts that will help ensure HR policies and processes do not present real or perceived barriers to speaking up. This should focus on how trusts can ensure that investigations into speaking up matters are undertaken by suitably independent persons and are completed within reasonable timescales, to enable workers who speak up to have trust and confidence in the process. Guidance should also be provided on how to support individuals who are speaking up about a grievance to prevent undue burdens being placed on those individuals and to ensure that they receive the support they need at what is likely to be a difficult and stressful time	N/A: Action for DoH	

Guidance for Freedom to Speak Up Guardians: Recording Cases and Reporting Data			
	Recommendation (lifted and summarised from main text)	**Trust Position**	**Actions (for FTSUG)**
1	Record **all** cases of speaking up	Already met	
2	Confidential, systematic recording, complying with data, information management, and security policies	Already met	
3	Number of cases raised: anonymously / with an element of patient safety / quality / bullying or harassment element / detriment / professional background/ feedback / learning	Met 24/07/18	13
4	Details: include previous instances of speaking up, desired outcome and action taken, outside referral, open / closed status, demographics	Already met	

Action Log					
No.	**Summary of Recommendation**	**Ref(s).**	**Actions**	**Next Steps**	**Lead**
1	…"consider developing a local network of ambassadors / champions"...	Survey (3)	13/09/18 and 18/10/18 FTSUG attended cultural ambassadors meeting	Continue liaison with Cultural Ambassadors	FTSUG
2	…"ensure all existing and new workers are aware of the contents of the new freedom to speak up policy"…	CR1 (2) CR2 (4) CR3 (2)	07/08/18 reviewed at policy review group 20/09/18 Policy approved by PP Committee	Prepare Comms Plan on basis of revised policy	FTSUG
3	…"provide all workers, including all managers, with regular, updated and mandatory training on speaking up"…	CR1 (10)	Recommendation is highly difficult to realistically achieve: FTSUG is continually identifying ways to sustainably increase training / understanding / awareness (e.g. poster presentations / masterclasses)		FTSUG
4	…"actively promote the use of mediation…to resolve issues arising from speaking up."	CR1 (19) CR2 (21)	20/09/18 Policy updated and approved by PP Committee	Complete	
5	…"revise its policy for dealing with serious incidents to ensure it provides that feedback and any learning should be shared"…	CR2 (2)	24/07/18 Deputy Director of Governance confirmed to FTSUG recommendation is being met	Complete	
6	…"the trust board should articulate a vision of how it intends to support its workers to speak up"...	CR2 (6)	Draft in progress and awaiting feedback	Executive Lead collating feedback	Board
7	…"ensure that its bullying and harassment policy and procedure is consistent with the standards set out in the bullying and harassment guidance issued by NHS Employers"…	CR2 (8)	30/07/18 Confirmed as met by Deputy Director of Workforce	Complete	
8	..."ensure that all investigations into the alleged conduct of workers who have previously spoken up also seek to identify whether any such allegations are motivated by a desire to cause detriment because that worker spoke up and, where such evidence is found, take appropriate action. This should include amending the trust disciplinary policy to require such action."	CR2 (10)	20/09/18 Update to disciplinary policy approved by PP Committee	Complete	
9	..."communications and engagement strategy should be developed to promote the Freedom to Speak Up Guardian and Associate Guardian's role, and to evaluate the impact it is having, in the longer term. This should include strategies to provide feedback on actions taken in response to speaking up and actions to tackle barriers to speaking up."	CR2 (16)	(Trust-wide blog circulated in summer) 28/09/18 Trust-wide survey closed (395 respondents), FTSUG analysing results	Present and communicate results through most appropriate governance and communication channels	FTSUG
10	…"the trust should ensure that all HR policies and procedures meet the needs of workers who speak up, including letters to suspended workers that accurately state their ability to access their Guardian"…	CR2 (19)	11/09/18 Human resources advised revising suspension letters and will share a draft copy with FTSUG	Seek update from Human Resources (mid-October)	FTSUG
11	…"the trust should ensure that workers who wish to raise matters with the trust nonexecutive director responsible for speaking up are able to do so via routes of communication that appropriately support their confidentiality."	CR3 (3)	20/09/18 - Confirmed confidential contact arrangements via FTSUG, Executive PA or Director of Corporate Affairs	Contact Human Resources to update policy appendix	FTSUG
12	..."the trust should take all appropriate steps to ensure that responses to cases of workers speaking up, including decisions relating to the investigation of those cases, are not focused on whether or not the matters in those cases are qualifying disclosures under the Public Interest Disclosure Act."	CR3 (7)	20/09/18 Policy approved by PP Committee with the addition: "The protections of this policy will apply for all concerns raised, whether they meet a legal definition or not."	Complete	
13	Record lessons learned in FTSUG casework governance	Data (4)	24/07/18 Created "lessons learned" column in casework log	Complete	

Appendix 2: Timeline of FTSUG Casework



NHS
Stockport
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	31 October 2018
Subject:	Freedom to Speak Up – Self-Review Tool		
Report of:	Director of Corporate Affairs	**Prepared by:**	Mr P Buckingham

REPORT FOR APPROVAL

Corporate objective ref:	**Summary of Report** The purpose of this report is to facilitate completion of a Freedom to Speak Up self-review tool by the Board of Directors.
Board Assurance Framework ref:	
CQC Registration Standards ref:	N/A
Equality Impact Assessment:	☐ Completed ☐ Not required

Attachments:	Annex A – Freedom To Speak Up: Guidance for Boards Annex B – Draft Self-Review Tool

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

- THIS PAGE IS INTENTIONALLY BLANK -

1. PURPOSE OF THE REPORT

1.1 The purpose of this report is to facilitate completion of a Freedom to Speak Up self-review tool by the Board of Directors.

2. BACKGROUND

2.1 The requirement for Providers to implement Freedom to Speak Up arrangements was a key recommendation from the Francis Report following events at Mid-Staffordshire NHS Foundation Trust. The Trust subsequently established a Freedom to Speak Up Guardian (FTSUG) role in 2016 and the current FTSUG has been in post for approximately 18 months.

2.2 A Guide for Boards and Self-Review Tool were jointly published by the National Guardian's Office and NHS Improvement on 9 May 2018. Trusts were required to confirm their commitment to using the self-review tool to NHS Improvement by 31 May 2018, and NHS Improvement contacted trusts in August 2018 to confirm whether an initial self-review had been completed. A copy of the Guide for Boards is included for reference at Annex A to this report.

2.3 The Board undertook an initial review of the self-review tool on 26 July 2018 and agreed that Board members should be invited to offer views on content and approach to inform further development of content prior to re-presentation. Feedback from Board members was subsequently sought by the Director of Corporate Affairs.

3. CURRENT SITUATION

3.1 The draft Self-Review Tool, originally completed by Mr P Gordon, FTSUG, and Mr P Buckingham, Executive Lead for Freedom to Speak Up, has been updated to incorporate feedback received from a number of Board members following initial review by the Board on 26 July 2018. The draft document is included for reference and consideration at Annex B to this report.

3.2 The Self-Review Tool provides an effective framework for assessing the Trust's Freedom to Speak Up arrangements and testing these arrangements against best practice requirements. It is suggested that the outcomes of the draft Self-Review indicate the benefits of the Trust having had a distinct Freedom to Speak Up Guardian role in place since 2016, and much progress has been made to develop and embed arrangements in the last 12-18 months. That said, the outcomes of the self-review also signpost areas where further developments can be made to strengthen arrangements and improve practice.

3.3 While feedback from Board members contributed to development of self-review tool content, the majority of feedback focused on the need for the Board to guard against the risk of viewing Freedom to Speak as a stand-alone agenda. The need to consider Freedom to Speak as an integral part of an open and transparent organisational culture was emphasised by most respondents. Specific themes for Board consideration were identified as follows:

- The need for Board members to do more to role model visibility, approachability and be seen as engaged at all levels across the organisation

- Consider how the Board can better demonstrate to the organisation that it is safe and normal to be open when things go wrong and that such an approach is an integral feature of a learning organisation
- Consider the relationship between annual staff survey participation levels and the degree of assurance provided from freedom to speak / culture responses
- Consider the feasibility of adapting the self-review tool for use by Business Groups and Departments as a means for cascading reflection and learning

3.4 Given the context and scope set out in the Self-Review Tool, it is recommended that Board members actively consider whether current arrangements for the FTSUG are sufficient to effectively manage what is an increasingly important and expanding subject area. Our FTSUG is employed in a dedicated role for two days per week, which means that the time available to manage referrals, raise awareness and develop practice in accordance with the scope set out in the Self-Review Tool is relatively limited. This has a potential impact in relation to both delivery of training and engagement with stakeholders. There is also a potential risk in terms of service continuity on the days when the FTSUG is not on site.

3.5 Board members will be aware that the subject of Freedom to Speak Up was a recurring theme across a range of interviews during the recent CQC Well-Led Review, with an emphasis on whether there is sufficient time allocated to the FTSUG role to effectively undertake engagement and awareness-raising across an organisation of over 5,000 employees. While the time currently allocated to the role compares well with other organisations, with the Trust in the top 30% in terms of time commitment, the level of interest during the Well-Led Review suggests that the Board should assure itself that the Trust's current arrangements are sufficiently robust.

4. RECOMMENDATIONS

4.1 The Board of Directors is recommended to:

- Consider the areas detailed at s3.3 of the report and agree the current status for each of the areas
- Consider whether the time currently allocated to the FTSUG role is sufficient for effective discharge of responsibilities, s3.5 of the report refers
- On completion, approve the content of the draft Self-Review Tool at Annex B to the report

National Guardian
Freedom to Speak Up

NHS
Improvement

Guidance for boards on Freedom to Speak Up in NHS trusts and NHS foundation trusts

May 2018

Contents

Introduction

Effective speaking up arrangements help to protect patients and improve the experience of NHS workers. Having a healthy speaking up culture is an indicator of a well-led trust.

This guide sets out our expectations of boards in relation to Freedom to Speak Up (FTSU). Meeting the expectations set out in this guide will help a board to create a culture responsive to feedback and focused on learning and continual improvement.

This guide is accompanied by a self-review tool. Regular and in-depth reviews of leadership and governance arrangements in relation to FTSU will help boards to identify areas of development and improve.

The Care Quality Commission (CQC) assesses a trust's speaking up culture during inspections under key line of enquiry (KLOE) 3 as part of the well-led question. This guide is aligned with the good practice set out in the well-led framework, which contains references to speaking up in KLOE 3 and will be shared with inspectors as part of the CQC's assessment framework for well-led.

Completing the self-review tool and developing an improvement action plan will help trusts to evidence their commitment to embedding speaking up and oversight bodies to evaluate how healthy the trust's speaking up culture is.

About this guide

This guide has been produced jointly by NHS Improvement and the National Guardian's Office and represents current good practice.

We want boards to treat this guide as a benchmark; review where they are against it and reflect on what they need to do to improve. We expect that the board, and in particular the executive and non-executive leads for FTSU, will complete the review with proportionate support from the trust's FTSU Guardian.

The good practice highlighted here is not a checklist: a mechanical 'tick box' approach to each item is not likely to lead to better performance.

The attitude of senior leaders to the review process, the connections they make between speaking up and improved patient safety and staff experience, and their judgements about what needs to be done to continually improve, are much more important.

Key terms used in this guide

- **The board**: we use this term when we mean the board as a formal body.
- **Senior leaders**: we use this term when we mean executive and non-executive directors.
- **Workers**: we use this term to mean everyone in the organisation including agency workers, temporary workers, students, volunteers and governors.

We will review this guide in a year. In the meantime, please provide any feedback to enquiries@improvement.nhs.uk

Our expectations

Leaders are knowledgeable about FTSU

Senior leaders are knowledgeable and up to date about FTSU and the executive and non-executive leads are aware of guidance from the National Guardian's Office. Senior leaders can readily articulate the trust's FTSU vision and key learning from issues that workers have spoken up about and regularly communicate the value of speaking up. They can provide evidence that they have a leadership strategy and development programme that emphasises the importance of learning from issues raised by people who speak up. Senior leaders can describe the part they played in creating and launching the trust's FTSU vision and strategy.

Leaders have a structured approach to FTSU

There is a clear FTSU vision, translated into a robust and realistic strategy that links speaking up with patient safety, staff experience and continuous improvement. There is an up-to-date speaking up policy that reflects the minimum standards set out by NHS Improvement. The FTSU strategy has been developed using a structured approach in collaboration with a range of stakeholders (including the FTSU Guardian). It aligns with existing guidance from the National Guardian. Progress against the strategy and compliance with the policy are regularly reviewed using a range of qualitative and quantitative measures.

Leaders actively shape the speaking up culture

All senior leaders take an interest in the trust's speaking up culture and are proactive in developing ideas and initiatives to support speaking up. They can evidence that they robustly challenge themselves to improve patient safety, and develop a culture of continuous improvement, openness and honesty. Senior leaders are visible, approachable and use a variety of methods to seek and act on feedback from workers. Senior leaders prioritise speaking up and work in partnership with their FTSU Guardian. Senior leaders model speaking up by acknowledging mistakes and making improvements. The board can state with confidence that workers know how to speak up; do so with confidence and are treated fairly.

Leaders are clear about their role and responsibilities

The trust has a named executive and a named non-executive director responsible for speaking up and both are clear about their role and responsibility. They, along with the chief executive and chair, meet regularly with the FTSU Guardian and provide appropriate advice and support. Other senior leaders support the FTSU Guardian as required. For more information see page 8 below.

Leaders are confident that wider concerns are identified and managed

Senior leaders have ensured that the FTSU Guardian has ready access to applicable sources of data to enable them to triangulate speaking up issues to proactively identify potential concerns. The FTSU Guardian has ready access to senior leaders and others to enable them to escalate patient safety issues rapidly, preserving confidence as appropriate.

Leaders receive assurance in a variety of forms

The executive lead for FTSU provides the board with a variety of reliable, independent and integrated information that gives the board assurance that:

- workers in all areas know, understand and support the FTSU vision, are aware of the policy and have confidence in the speaking up process
- steps are taken to identify and remove barriers to speaking up for those in more vulnerable groups, such as Black, Asian or minority ethnic (BAME), workers and agency workers
- speak up issues that raise immediate patient safety concerns are quickly escalated
- action is taken to address evidence that workers have been victimised as a result of speaking up, regardless of seniority
- lessons learnt are shared widely both within relevant service areas and across the trust
- the handling of speaking up issues is routinely audited to ensure that the FTSU policy is being implemented
- FTSU policies and procedures are reviewed and improved using feedback from workers.

In addition the board receives a report, at least every six months, from the FTSU Guardian. For more information see page 11 below. Boards should consider inviting workers who speak up to present their experience in person.

Leaders engage with all relevant stakeholders

A diverse range of workers' views are sought, heard and acted on to shape the culture of the organisation in relation to speaking up; these are reflected in the FTSU vision and plan.

The organisation is open and transparent about speaking up internally and externally. Issues raised via speaking up are part of the performance data discussed openly with commissioners, CQC and NHS Improvement. Discussion of FTSU matters regularly takes place in the public section of the board meetings (while respecting the confidentiality of individuals). The trust's annual report contains high level, anonymised data relating to speaking up as well as information on actions the trust is taking to support a positive speaking up culture. Reviews and audits are shared externally to support improvement elsewhere.

Senior leaders work openly and positively with regional FTSU Guardians and the National Guardian to continually improve the trust's speaking up culture. Likewise, senior leaders encourage their FTSU Guardians to develop bilateral relationships with regulators, inspectors and other local FTSU Guardians. Senior leaders request external improvement support when required.

Leaders are focused on learning and continual improvement

Senior leaders use speaking up as an opportunity for learning that can be embedded in future practice to deliver better quality care and improve workers' experience. Senior leaders and the FTSU Guardian engage with other trusts to identify best practice. Executive and non-executive leads, and the FTSU Guardian, review all guidance and case review reports from the National Guardian to identify improvement possibilities. Senior leaders regularly reflect on how they respond to feedback, learn and continually improve and encourage the same throughout the organisation.

The executive lead responsible for FTSU reviews the FTSU strategy annually, using a range of qualitative and quantitative measures, to assess what has been achieved and what hasn't; what the barriers have been and how they can be overcome; and whether the right indicators are being used to measure success.

The FTSU policy and process are reviewed annually to check they are fit for purpose and realistic; up to date; and takes account of feedback from workers who have used them. A sample of cases is audited to ensure that:

- the investigation process is of high quality; outcomes and recommendations are reasonable and the impact of change is being measured
- workers are thanked for speaking up, are kept up to date throughout the investigation and are told of the outcome
- investigations are independent, fair and objective; recommendations are designed to promote patient safety and learning; and change will be monitored.

Positive outcomes from speaking up cases are promoted and as a result workers are more confident to speak up. This is demonstrated in organisational data and audit.

Individual responsibilities

Chief executive and chair

The chief executive is responsible for appointing the FTSU Guardian and is ultimately accountable for ensuring that FTSU arrangements meet the needs of the workers in their trust. The chief executive and chair are responsible for ensuring the annual report contains information about FTSU and that the trust is engaged with both the regional Guardian network and the National Guardian's Office.

Both the chief executive and chair are key sources of advice and support for their FTSU Guardian and meet with them regularly.

Executive lead for FTSU

The executive lead is responsible for:

- ensuring they are aware of latest guidance from National Guardian's Office
- overseeing the creation of the FTSU vision and strategy
- ensuring the FTSU Guardian role has been implemented, using a fair recruitment process in accordance with the example job description and other guidance published by the National Guardian
- ensuring that the FTSU Guardian has a suitable amount of ringfenced time and other resources and there is cover for planned and unplanned absence.
- ensuring that a sample of speaking up cases have been quality assured
- conducting an annual review of the strategy, policy and process
- operationalising the learning derived from speaking up issues
- ensuring allegations of detriment are promptly and fairly investigated and acted on
- providing the board with a variety of assurance about the effectiveness of the trusts strategy, policy and process.

Non-executive lead for FTSU

The non-executive lead is responsible for:

- ensuring they are aware of latest guidance from National Guardian's Office
- holding the chief executive, executive FTSU lead and the board to account for implementing the speaking up strategy. Where necessary, they should robustly challenge the board to reflect on whether it could do more to create a culture responsive to feedback and focused on learning and continual improvement
- role-modelling high standards of conduct around FTSU
- acting as an alternative source of advice and support for the FTSU Guardian
- overseeing speaking up concerns regarding board members – see below.

We appreciate the challenges associated with investigating issues raised about board members, particularly around confidentiality and objectivity. This is why the role of the designated non-executive director is so important. In these circumstances, we would expect the non-executive director to take the lead in determining whether:

- sufficient attempts have been made to resolve a speaking up concern involving a board member(s) and
- if so, whether an investigation is proportionate and what the terms of reference should be.

Depending on the circumstances, it may be appropriate for the non-executive director to oversee the investigation and take on the responsibility of updating the worker. Wherever the non-executive director does take the lead, they should inform the FTSU Guardian, confidentially, of the case; keep them informed of progress; and seek their advice around process and record-keeping.

The non-executive director should inform NHS Improvement and CQC that they are overseeing an investigation into a board member. NHS Improvement and CQC can then provide them with support and advice. The trust would need to think about how to enable a non-executive director to commission an external investigation (which might need an executive director to sign-off the costs) without compromising the

confidentiality of the individual worker or revealing allegations before it is appropriate to do so.

Human resource and organisational development directors

The human resource (HR) and/or organisational development (OD) directors are responsible for:

- ensuring that the FTSU Guardian has the support of HR staff and appropriate access to information to enable them to triangulate intelligence from speaking up issues with other information that may be used as measures of FTSU culture or indicators of barriers to speaking up
- ensuring that HR culture and practice encourage and support speaking up and that learning in relation to workers' experience is disseminated across the trust
- ensuring that workers have the right knowledge, skills and capability to speak up and that managers listen well and respond to issues raised effectively.

Medical director and director of nursing

The medical director and director of nursing are responsible for:

- ensuring that the FTSU Guardian has appropriate support and advice on patient safety and safeguarding issues
- ensuring that effective and, as appropriate, immediate action is taken when potential patient safety issues are highlighted by speaking up
- ensuring learning is operationalised within the teams and departments they oversee.

FTSU Guardian reports

Reports are submitted frequently enough to enable the board to maintain a good oversight of FTSU matters and issues, and no less than every six months. Reports are presented by the FTSU Guardian or a member of the trust's local Guardian network in person.

Reports include both quantitative and qualitative information and case studies or other information that will enable the board to fully engage with FTSU in their organisation and to understand the issues being identified, areas for improvement, and take informed decisions about action.

Data and other intelligence are presented in a way that maintains the confidentiality of individuals who speak up.

Board reports on FTSU could include:

Assessment of issues

- information on what the trust has learnt and what improvements have been made as a result of trust workers speaking up
- information on the number and types of cases being dealt with by the FTSU Guardian and their local network
- an analysis of trends, including whether the number of cases is increasing or decreasing; any themes in the issues being raised (such as types of concern, particular groups of workers who speak up, areas in the organisation where issues are being raised more or less frequently than might be expected); and information on the characteristics of people speaking up (professional background, protected characteristics)

Potential patient safety or workers experience issues

- information on how FTSU matters relate to patient safety and the experience of workers, triangulating data as appropriate, so that a broader picture of FTSU culture, barriers to speaking up, potential patient safety risks, and opportunities to learn and improve can be built

Action taken to improve FTSU culture

- details of actions taken to increase the visibility of the FTSU Guardian and promote the speaking up processes
- details of action taken to identify and support any workers who are unaware of the speaking up process or who find it difficult to speak up
- details of any assessment of the effectiveness of the speaking up process and the handling of individual cases
- information on any instances where people who have spoken up may have suffered detriment and recommendations for improvement
- information on actions taken to improve the skills, knowledge and capability of workers to speak up and to support others to speak up and respond to the issues they raise effectively

Learning and improvement

- feedback received by FTSU Guardians from people speaking up and action that will be taken in response
- updates on any broader developments in FTSU, learning from case reviews, guidance and best practice

Recommendations

- suggestions of any priority action needed.

Resources

Care Quality Commission (2017): Driving Improvement Accessed at: www.cqc.org.uk/sites/default/files/20170614_drivingimprovement.pdf

National Guardian Office (2017): Example job description Accessed at: http://www.cqc.org.uk/sites/default/files/20180213_ngo_freedom_to_speak_up_guardian_jd_march2018_v5.pdf

National Guardian Office (2017): Annual report Accessed at www.cqc.org.uk/sites/default/files/20171115_ngo_annualreport201617.pdf

NHS Improvement (2014) Strategy development toolkit Accessed at https://improvement.nhs.uk/resources/strategy-development-toolkit/

NHS Improvement (2016) Freedom to speak up: whistleblowing policy for the NHS Accessed at https://improvement.nhs.uk/resources/freedom-to-speak-up-whistleblowing-policy-for-the-nhs/

NHS Improvement (2017): Creating a vision https://improvement.nhs.uk/resources/creating-vision/

NHS Improvement (2016/17): Creating a culture of compassionate and inclusive leadership Accessed at https://improvement.nhs.uk/resources/culture-leadership/

NHS Improvement (2017): Well Led Framework Accessed at: https://improvement.nhs.uk/resources/well-led-framework/

National Framework (2017): Developing People - Improving Care Accessed at: https://improvement.nhs.uk/resources/developing-people-improving-care/

National Guardian Office (2018): Guardian education and training guide

Accessed at: http://www.cqc.org.uk/sites/default/files/20180419_ngo_education_training_guide.pdf

NHS Improvement
133-155 Waterloo Road
London
SE1 8UG

0300 123 2257
enquiries@improvement.nhs.uk
improvement.nhs.uk

@NHSImprovement

National Guardian's Office
151 Buckingham Palace Road
London
SW1W 9SZ

0300 067 9000
enquiries@nationalguardianoffice.org.uk
cqc.org.uk/national-guardians-office/content/national-guardians-office

@NatGuardianFTSU

This publication can be made available in a number of other formats on request.

May 2018 Publications code: CG 64/18

This page has been left blank

National Guardian
Freedom to Speak Up

NHS
Improvement

Freedom to Speak Up self-review tool for NHS trusts and foundation trusts

19 July 2018

How to use this tool

Effective speaking up arrangements help to protect patients and improve the experience of NHS workers. Having a healthy speaking up culture is evidence of a well-led trust.

NHS Improvement and the National Guardian's Office have published a guide setting out expectations of boards in relation to Freedom to Speak Up (FTSU) to help boards create a culture that is responsive to feedback and focused on learning and continual improvement.

This self-review tool accompanying the guide will enable boards to carry out in-depth reviews of leadership and governance arrangements in relation to FTSU and identify areas to develop and improve.

The Care Quality Commission (CQC) assesses a trust's speaking up culture during inspections under key line of enquiry (KLOE) 3 as part of the well-led question. This guide is aligned with the good practice set out in the well-led framework, which contains references to speaking up in KLOE 3 and will be shared with Inspectors as part of the CQC's assessment framework for well-led.

Completing the self-review tool and developing an improvement action plan will help trusts to evidence their commitment to embedding speaking up and help oversight bodies to evaluate how healthy a trust's speaking up culture is.

Self review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
Our expectations			
Leaders are knowledgeable about FTSU			
Senior leaders are knowledgeable and up to date about FTSU and the executive and non-executive leads are aware of guidance from the National Guardian's Office.	Annual Report presented to the Board by the FTSUG on 26 April 2018. NGO guidance routinely circulated amongst senior leaders.		Board Report 26 April 2018
Senior leaders can readily articulate the trust's FTSU vision and key learning from issues that workers have spoken up about and regularly communicate the value of speaking up.	FTSUG currently drafting a vision and strategy document for review by the Board. Key learning is featured in regular FTSUG reports to the Board and People Performance Committee.	Develop and approve FTSU vision / strategy	Approval of vision and strategy scheduled to be completed on 29 Nov 2018. Assurance on key learning provided through FTSUG reports to the Board and People Performance Committee.
They can provide evidence that they have a leadership strategy and development programme that emphasises the importance of learning from issues raised by people who speak up.	In development. Proposal endorsed for FTSUG to pilot stand-alone training sessions for managers	Implement and deliver training sessions.	Feedback from training sessions is incorporated in FTSUG reports to the Board and People Performance Committee.

Senior leaders can describe the part they played in creating and launching the trust's FTSU vision and strategy.	Planned FTSUG engagement with senior leaders during preparation of the vision and strategy document.	• Engagement with senior leaders • Review and recommendation from EMG prior to Board approval.	Assurance to be provided in subsequent report to the Board.
Leaders have a structured approach to FTSU			
There is a clear FTSU vision, translated into a robust and realistic strategy that links speaking up with patient safety, staff experience and continuous improvement.	Planned FTSUG engagement with senior leaders during preparation of the vision and strategy document.	• Engagement with senior leaders • Review and recommendation from EMG prior to Board approval	Assurance to be provided in subsequent report to the Board. Approval of vision and strategy scheduled to be completed on 29 November 2018.
There is an up-to-date speaking up policy that reflects the minimum standards set out by NHS Improvement.	Policy reviewed by FTSUG to ensure incorporation of minimum standards, local best practice, guidance from external organisations / arm's length bodies and increased worker protection ahead of anticipated legislative changes		Policy approved by People Performance Committee.
The FTSU strategy has been developed using a structured approach in collaboration with a range of stakeholders (including the FTSU Guardian) and it aligns with existing guidance from the National Guardian.	Stakeholder engagement to be incorporated in strategy development.	FTSUG to complete relevant engagement.	Assurance on stakeholder engagement to be incorporated in report to Board seeking strategy approval.

Progress against the strategy and compliance with the policy are regularly reviewed using a range of qualitative and quantitative measures.	Policy compliance incorporated in regular reports to Board and People Performance Committee. FTSUG reports casework trends and level of engagement to Board and People Performance Committee. Strategy currently under development.	FTSUG to identify relevant measures to assess progress against policy / strategy. FTSUG collaborating with HR to review monitoring arrangements for quality of response to concerns.	Regular reports to Board and People Performance Committee.
Leaders actively shape the speaking up culture			
All senior leaders take an interest in the trust's speaking up culture and are proactive in developing ideas and initiatives to support speaking up.	Senior leaders fully supportive of engagement with FTSUG through relevant meeting forums and one-to-one contacts.	Senior leader engagement to be incorporated in FTSUG reports.	Regular reports to Board and People Performance Committee.
They can evidence that they robustly challenge themselves to improve patient safety, and develop a culture of continuous improvement, openness and honesty.	Level of challenge demonstrated through minutes of meetings. Board approval / consideration of: • Quality Improvement Plan • Bawa-Garba Case Report		Minutes of meetings.

Senior leaders are visible, approachable and use a variety of methods to seek and act on feedback from workers.	Senior leader participation in Patient Safety Walkrounds and informal staff engagement activities.	Board to consider means of enhancing visibility.	• Records of Patient Safety Walkrounds • Exec & Non-Exec Visit Registers
Senior leaders prioritise speaking up and work in partnership with their FTSU Guardian.	All senior leaders work in positive partnership with the FTSUG		Regular reports to Board and People Performance Committee.
Senior leaders model speaking up by acknowledging mistakes and making improvements.	Board review of Learning from Deaths reports. Development of Complaint responses and open nature of discussion at Patient Safety Summit meetings.		Board agenda and minutes.
The board can state with confidence that workers know how to speak up; do so with confidence and are treated fairly.	Assurance provided through FTSUG reports to Board and People Performance Committee.	Review monitoring arrangements for concerns raised internally	Regular reports to Board and People Performance Committee.
Leaders are clear about their role and responsibilities			
The trust has a named executive and a named non-executive director responsible for speaking up and both are clear about their role and responsibility.	• Executive Lead - Mr P Buckingham, Director of Corporate Affairs • Non-Executive Lead - Dr M Cheshire, Senior Independent Director	Identify replacement for role as Executive Lead.	Roles and responsibilities clearly stated in the Raising Concerns at Work Policy.

They, along with the chief executive and chair, meet regularly with the FTSU Guardian and provide appropriate advice and support.	The FTSUG meets regularly with the named Executive lead and CEO. Contact with Non-Executive lead and Chair are for assurance as standard, with right of direct access as required	Consider the introduction of scheduled periodic meetings with the Non-Executive lead and Chair.	FTSUG to evidence meetings in regular reports to Board and People Performance Committee.
Other senior leaders support the FTSU Guardian as required.	FTSUG reports high levels of engagement and support from all senior leaders		Reports from FTSUG
Leaders are confident that wider concerns are identified and managed			
Senior leaders have ensured that the FTSU Guardian has ready access to applicable sources of data to enable them to triangulate speaking up issues to proactively identify potential concerns.	FTSUG and Director of Workforce have agreed this principle, and FTSUG has access to agendas / papers / minutes for relevant committees.		FTSUG engagement with Executive lead and CEO. Reports by exception from FTSUG.
The FTSU Guardian has ready access to senior leaders and others to enable them to escalate patient safety issues rapidly, preserving confidence as appropriate.	FTSUG reports this to be the case		Casework timeline
Leaders receive assurance in a variety of forms			

Workers in all areas know, understand and support the FTSU vision, are aware of the policy and have confidence in the speaking up process.	Vision and Strategy currently under development.	• Develop, endorse and share FTSU vision and strategy • Measure awareness of Raising Concerns at Work Policy / vision / strategy	Subsequent assurance report to People Performance Committee.
Steps are taken to identify and remove barriers to speaking up for those in more vulnerable groups, such as Black, Asian or minority ethnic (BAME), workers and agency workers	FTSUG liaising with E&D lead for increased involvement in minority networks, and sits on the E&D steering group		WRES / Staff Survey / FTSUG Report
Speak up issues that raise immediate patient safety concerns are quickly escalated	Patient safety issues raised via the FTSUG are escalated without resistance		Timeline of casework in Board report
Action is taken to address evidence that workers have been victimised as a result of speaking up, regardless of seniority	The FTSUG has observed that appropriate action has been taken in such circumstances.		Quarterly data reported to NGO includes cases where the worker has experienced detriment as a result of speaking up. Low returns indicate positive assurance.
Lessons learnt are shared widely both within relevant service areas and across the trust	No formal lessons learned arrangements currently in place.	FTSUG and Executive lead to agree process for periodic sharing of lessons learned.	Board members to be included in cascade of lessons learned information.

The handling of speaking up issues is routinely audited to ensure that the FTSU policy is being implemented	Issues raised via the FTSUG are monitored. The handling of concerns raised internally, but separate from the FTSUG, is not.	The FTSUG is collaborating with HR to embed new monitoring arrangements	Updates in FTSUG reports to Board and People Performance Committee.
FTSU policies and procedures are reviewed and improved using feedback from workers	The Policy is reviewed regularly with staff side involvement in the review process.	Policy review currently in progress.	Policy reviewed and improvements tracked
The board receives a report, at least every six months, from the FTSU Guardian.	FTSUG report presented to Board in April and October.		• Sample Board report • Board Business Cycle
Leaders engage with all relevant stakeholders			
A diverse range of workers' views are sought, heard and acted upon to shape the culture of the organisation in relation to speaking up; these are reflected in the FTSU vision and plan.	To be taken into account during preparation of vision and strategy.		
Issues raised via speaking up are part of the performance data discussed openly with commissioners, CQC and NHS Improvement.	Freedom to Speak Up arrangements featured in a range of interviews during CQC Well-Led Review.		Board member feedback from Well-Led interviews.
Discussion of FTSU matters regularly takes place in the public section of the board meetings (while respecting	Reports from the FTSUG considered at meetings held in public.		FTSUG Annual Report April 2018

the confidentiality of individuals).			
The trust's annual report contains high level, anonymised data relating to speaking up as well as information on actions the trust is taking to support a positive speaking up culture.	Yes		FTSUG Annual Report April 2018
Reviews and audits are shared externally to support improvement elsewhere.	Annual report publicly available: FTSUG shares experiences with peers across North-West		FTSUG Annual Report April 2018
Senior leaders work openly and positively with regional FTSU Guardians and the National Guardian to continually improve the trust's speaking up culture	The FTSUG engages proactively with regional peers and the National Guardian's Office. The National Guardian accepted an invitation from the FTSUG to visit the Trust. The FTSUG has been supported to undertake duties beyond the Trust e.g. hosting and participation at regional meetings, acts as a panel member for the Whistleblowers' Support Scheme and acts as a Trainer for other FTSUGs.		FTSUG Annual Report April 2018

Senior leaders encourage their FTSU Guardians to develop bilateral relationships with regulators, inspectors and other local FTSU Guardians	The FTSUG reports feeling fully supported in developing such relationships. The FTSUG's approach to Board reporting was discussed with a FTSUG who is also Head of Analysis for NHS England		FTSUG Annual Report April 2018
Senior leaders request external improvement support when required.	To date, there have been no instances where a need for FTSU external support has been identified.		
Leaders are focused on learning and continual improvement			
Senior leaders use speaking up as an opportunity for learning that can be embedded in future practice to deliver better quality care and improve workers' experience.	No formal lessons learned arrangements currently in place.	FTSUG and Executive lead to agree process for periodic sharing of lessons learned.	Board members to be included in cascade of lessons learned information.
Senior leaders and the FTSU Guardian engage with other trusts to identify best practice.	FTSUG works across two Trusts with full support from both to share support and learning. Engagement also achieved via FTSUG network		
Executive and non-executive leads, and the FTSU Guardian, review all guidance and case review reports from the National Guardian to identify improvement	The FTSUG maps the Trust position against updated recommendations and reports via Executive lead and	Ensure that the Non-Executive lead is included in guidance / case	

possibilities.	assurance channels	review cascade.	
Senior leaders regularly reflect on how they respond to feedback, learn and continually improve and encourage the same throughout the organisation.	The Board regularly reflects on the effectiveness of meetings and the practice has been adopted by Board Committees. Increased time dedicated to Board development activities in 2018/19.	Consider use of a 360 feedback tool.	Minutes of meetings. Board Development programme.
The executive lead responsible for FTSU reviews the FTSU strategy annually, using a range of qualitative and quantitative measures, to assess what has been achieved, what hasn't; what the barriers have been and how they can be overcome; and whether the right indicators are being used to measure success.	Vision and Strategy currently under development.	Executive lead to complete review as per the requirement.	Outcomes of the review to be incorporated in the FTSUG Annual Report.
The FTSU policy and process is reviewed annually to check they are fit for purpose and realistic; up to date; and takes account of feedback from workers who have used them.	The Policy is reviewed regularly with staff side involvement in the review process.		Policy reviewed and improvements tracked
A sample of cases is quality assured to ensure: • the investigation process is of high quality; that outcomes and recommendations are reasonable and that the impact of change is being measured	Practice not currently in place.	Process for review of case sample to be prepared by the FTSUG in conjunction with the Executive lead.	Outcomes of reviews to be incorporated in regular reports to Board and People Performance Committee.

• workers are thanked for speaking up, are kept up to date though out the investigation and are told of the outcome • Investigations are independent, fair and objective; recommendations are designed to promote patient safety and learning; and change will be monitored			
Positive outcomes from speaking up cases are promoted and as a result workers are more confident to speak up.	Practice not currently in place.	Incorporate practice in lessons learned process.	
Individual responsibilities			
Chief executive and chair			
The chief executive is responsible for appointing the FTSU Guardian.	Compliant	Incorporate in Chair & Chief Executive Responsibilities document.	Revised document endorsed by the Board 26 July 2018.
The chief executive is accountable for ensuring that FTSU arrangements meet the needs of the workers in their trust.	Compliant	Incorporate in Chair & Chief Executive Responsibilities document.	Revised document endorsed by the Board 26 July 2018.

The chief executive and chair are responsible for ensuring the annual report contains information about FTSU.	Compliant	Incorporate in Chair & Chief Executive Responsibilities document.	Revised document endorsed by the Board 26 July 2018.
The chief executive and chair are responsible for ensuring the trust is engaged with both the regional Guardian network and the National Guardian's Office.	Compliant	Incorporate in Chair & Chief Executive Responsibilities document.	Revised document endorsed by the Board 26 July 2018.
Both the chief executive and chair are key sources of advice and support for their FTSU Guardian and meet with them regularly.	FTSUG meets with CEO routinely, and provides assurance to Chair, with right of direct access as required.	FTSUG to incorporate in Board reports.	FTSUG reports to the Board.
Executive lead for FTSU			

Ensuring they are aware of latest guidance from National Guardian's Office.	The Executive lead is the line manager for the FTSUG who routinely provides details of NGO guidance. National and regional developments are considered during regular one-to-one meetings.		
Overseeing the creation of the FTSU vision and strategy.	The Executive lead is working collaboratively with the FTSUG to develop the vision and strategy.		
Ensuring the FTSU Guardian role has been implemented, using a fair recruitment process in accordance with the example job description and other guidance published by the National Guardian.	Role-specific post fully embedded and post holder appointed following a fair and competitive recruitment process.	Current job description to be assessed against example job description and related NGO guidance.	
Ensuring that the FTSU Guardian has a suitable amount of ring fenced time and other resources and there is cover for planned and unplanned absence.	FTSUG employed for 15 hours per week with cover for absences currently provided by the Executive lead.		

Ensuring that a sample of speaking up cases have been quality assured.	Practice to be developed as detailed above.		
Conducting an annual review of the strategy, policy and process.	Practice to be developed as detailed above.		
Operationalising the learning derived from speaking up issues.	Practice to be developed as detailed above.		
Ensuring allegations of detriment are promptly and fairly investigated and acted on.	No such instances reported to date.		
Providing the board with a variety of assurance about the effectiveness of the trust's strategy, policy and process.	Features in FTSUG Board reports	Executive to lead to ensure variety of assurances are provided.	FTSUG reports to Board and People Performance Committee.
Non-executive lead for FTSU			
Ensuring they are aware of latest guidance from National Guardian's Office.	Practice of routinely sharing guidance to be developed.	Incorporate Non-Executive lead responsibilities in Raising Concerns at Work Policy.	
Holding the chief executive, executive FTSU lead and the board to account for implementing the speaking up strategy.		Incorporate Non-Executive lead responsibilities in Raising Concerns at Work Policy.	Key Issues Report from Quality Committee.

		Incorporate Quality Committee consideration of Non-Exec lead activities in Committee Work Plan.	
Robustly challenge the board to reflect on whether it could do more to create a culture responsive to feedback and focused on learning and continual improvement.	The Non-Executive lead regularly challenges the Board to reflect on whether processes sufficiently empower and make accountable the clinical community.	Incorporate Non-Executive lead responsibilities in Raising Concerns at Work Policy.	Minutes of meetings.
Role-modelling high standards of conduct around FTSU.	The Non-Executive lead consistently models high standards of conduct in response to matters raised through both FTSU and Senior Independent Director role.	Incorporate Non-Executive lead responsibilities in Raising Concerns at Work Policy.	
Acting as an alternative source of advice and support for the FTSU Guardian.	Compliant	Incorporate Non-Executive lead responsibilities in Raising Concerns at Work Policy.	FTSUG has access to Non-Executive Lead as and when required.
Overseeing speaking up concerns regarding board members.	Compliant	Incorporate Non-Executive lead responsibilities in Raising Concerns at Work Policy.	

Human resource and organisational development directors			
Ensuring that the FTSU Guardian has the support of HR staff and appropriate access to information to enable them to triangulate intelligence from speaking up issues with other information that may be used as measures of FTSU culture or indicators of barriers to speaking up.	Principles agreed with Director of Workforce. FTSU incorporated in the Culture & Engagement agenda.	Development of Culture & Engagement Dashboard.	FTSUG meets regularly with the Interim Director of Workforce. Culture & Engagement Group key issues reports to People Performance Committee.
Ensuring that HR culture and practice encourage and support speaking up and that learning in relation to workers' experience is disseminated across the trust.	Culture & Engagement Plan Open culture embedded into all Leadership training programmes.		Staff Survey outcomes. Culture & Engagement Dashboard.
Ensuring that workers have the right knowledge, skills and capability to speak up and that managers listen well and respond to issues raised effectively.	Culture & Engagement Plan		Staff Survey outcomes. Culture & Engagement Dashboard. People Strategy incorporates Open & Transparent Culture.

Medical director and director of nursing			
Ensuring that the FTSU Guardian has appropriate support and advice on patient safety and safeguarding issues.	FTSUG has access to support and advice from relevant Executive Directors and Senior Managers.		
Ensuring that effective and, as appropriate, immediate action is taken when potential patient safety issues are highlighted by speaking up.	Relevant Executive Directors take appropriate action in such circumstances.		
Ensuring learning is operationalised within the teams and departments that they oversee.	Relevant Executive Directors take appropriate action in such circumstances.		

This page has been left blank

NHS
Stockport
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	31 October 2018
Subject:	Draft Planning Framework and Operational Plan 2019/20		
Report of:	Deputy Chief Executive/Director of Support Services	**Prepared by:**	Associate Director Strategy & Planning

REPORT FOR APPROVAL

Corporate objective ref:	S1	**Summary of Report** This report presents the draft Planning Framework for approval by the Board of Directors. The Planning Framework was reviewed and recommended for approval by the Finance & Performance Committee on 24 October 2018. The report also includes updates provided on national Planning Guidance, Annex B refers.
Board Assurance Framework ref:	-----	
CQC Registration Standards ref:	-----	
Equality Impact Assessment:	☐ Completed ☒ Not required	

Attachments:	Annex A – Draft Planning Framework Annex B – Joint NHSE/I letter

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

- THIS PAGE IS INTENTIONALLY BLANK -

1. INTRODCUTION

1.1 This report presents the draft Planning Framework for approval by the Board of Directors.

2. PLANNING FRAMEWORK

2.1 A draft Planning Framework is attached as Annex A. This has been created in order to provide a clear and structured process for planning at a trust level and specifically for production of the Trusts' annual operational plan. The framework also:

- Supports delivery of Strategic Objective 1 for 2018/19
- Has been developed with input and advice from our NHSI Improvement Director
- Will provide assurance to the Board on our planning process; and
- Delivers against a recommendation from the MIAA report on last year's operational plan

2.2 The framework has been considered through Senior Management Team and Executive Management Group on 16 October 2018. The document serves to help formalise arrangements already in place in terms of developing the plan. Following board discussion and subject to approval, the monitoring, delivery and escalation arrangements described will need to be put in place more formally.

3. OPERATIONAL PLAN DEVELOPMENT 2019/20

3.1 A task and finish group has been established to develop and submit the Trust Operational Plan 2019/20. This group commenced in early October and has to date:

- Reviewed the Operational Planning process 2018/19 reflecting on lessons learned
- Defined the detail of 2019/20 plan development and submission (of which the framework is a key part)
- Established an Executive Oversight Meeting to monitor development of the plan
- Agreed a joint session to be held at EMG in November to collectively agree and discuss priorities for the year ahead
- Set up meetings with Business group triumvirates to review in the detail of activity, finance and operational performance requirements

3.2 The planning framework sets out the approach to this development of the 2019/20 plan. Detailed discussion has already taken place within corporate teams to amalgamate a more detailed timetable (finalised by 20 October) alongside core information for business groups to consider as part of their planning.

4. NATIONAL PLANNING GUIDANCE

4.1 NHS England and NHS Improvement published a joint letter setting out their *'Approach to planning'* on 16 October 2018. This is attached for reference as Annex B .

4.2 A high level timetable has been produced (shown below) which indicates key submission dates

as follows:

- Activity and efficiency submission – 14 Jan 2019
- Draft organisation operating plans – 12 Feb 2019
- Draft system operating plans – 19 Feb 2019
- Final organisation operating plan submission – 4 Apr 2019
- Final system plan submission – 11 Apr 2019

Outline timetable for planning	Date
NHS Long Term Plan published	Late November / early December 2018
Publication of 2019/20 operational planning guidance including the revised financial framework	Early December 2018
Operational planning	
Publication of • CCG allocations for 5 years • Near final 2019/20 prices • Technical guidance and templates • 2019/20 standard contract consultation and dispute resolution guidance • 2019/20 CQUIN guidance • Control totals for 2019/20	Mid December 2018
2019/20 Initial plan submission – activity and efficiency focussed with headlines in other areas	14 January 2019
2019/20 National Tariff section 118 consultation starts	17 January 2019
Draft 2019/20 organisation operating plans	12 February 2019
Aggregate system 2019/20 operating plan submissions and system operational plan narrative	19 February 2019
2019/20 NHS standard contract published	22 February 2019
2019/20 contract / plan alignment submission	5 March 2019
2019/20 national tariff published	11 March 2019
Deadline for 2019/20 contract signature	21 March 2019
Organisation Board / Governing body approval of 2019/20 budgets	By 29 March
Final 2019/20 organisation operating plan submission	4 April 2019
Aggregated 2019/20 system operating plan submissions and system operational plan narrative	11 April 2019
Strategic planning	
Capital funding announcements	Spending Review 2019
Systems to submit 5-year plans signed off by all organisations	Summer 2019

5. SUMMARY & RECOMMENDATIONS

5.1 The Board of Director is recommended to:

- Approve the Planning Framework included at Annex A.

NHS
Stockport
NHS Foundation Trust

DRAFT v2.0

PLANNING FRAMEWORK

Recommended by	Executive Team
Approved by	
Approval date	
Version number	1.0
Review date	October 2019
Responsible Director	Director of Support Services
Responsible Manager (Sponsor)	Associate Director Strategy & Planning
For use by	All Trust employees

Version Control and Change Log

Version	Date of change	Date of release	Changed by	Reason for change
x.1				Document Creation
1.0	27/09/18	14/10/2018	A Bailey	First Draft
2.0	21/10/18		A Bailey	Incorporated comments from K Wiss & H Mullen

Contents

1. Introduction

1.1 This Planning Framework (PF) outlines the principles and approach to developing annual and medium term Trust level plans for Stockport NHS Foundation Trust (SFT).

1.2 The Trust strategy 2018-2022 provides the basis for the strategic direction of the organisation and our priorities for more detailed planning to achieve these aims.

1.3 The PF is designed to support how plans are developed and aligned across the Trust in order to deliver our mission, aims and values.

2. What is planning?

2.1 Planning is the fundamental management function, which involves deciding beforehand, what is to be done, when is it to be done, how it is to be done and who is going to do it. It is a process which lays down an organisation's objectives and develops various courses of action, by which the organisation can achieve those objectives.

2.2 Planning often involves the formulation of one or more detailed plans to achieve optimum balance of needs or demands with the available resources.

2.3 The planning process:

- Identifies the goals or objectives to be achieved
- Formulates strategies to achieve them
- Arranges or creates the means required, and;
- Implements, directs, and monitors all steps in their proper sequence.

2.4 Planning within an organisation that provides healthcare services is a dynamic process and, as such, should allow the Trust to respond to day to day pressures without losing sight of how we plan to align key services, staff, finance and the public to delivering the outcomes intended for the populations we serve over a medium term (three year) time frame.

2.5 Importance of planning:

- It helps managers to **improve future performance**, by establishing objectives and selecting a course of action, for the benefit of the organisation
- It **minimises risk and uncertainty**, by looking ahead into future
- It **facilitates coordination of activities**. Thus, reduces overlapping among activities and eliminates unproductive work
- It states in advance, what should be done in future, so it provides **direction for action**
- It uncovers and identifies **future opportunities and threats**
- It **sets out standards for controlling**. It compares actual performance with the standard performance and efforts are made to correct the same

3. Scope

3.1 The intention is to simplify and clarify the planning requirements and process within the Trust, with the Trust's annual operational plan as the key organisational planning document.

3.2 The scope of the Trust's annual operational plan should cover the following:

- Progress in delivering our plans (previous years)
- Strategic Context
- Performance and activity
- Quality Improvement
- Sustainability plans and initiatives
- Workforce & organisational development
- Financial plans
- Capability and delivery (enabling and support plans)
- Governance & Assurance

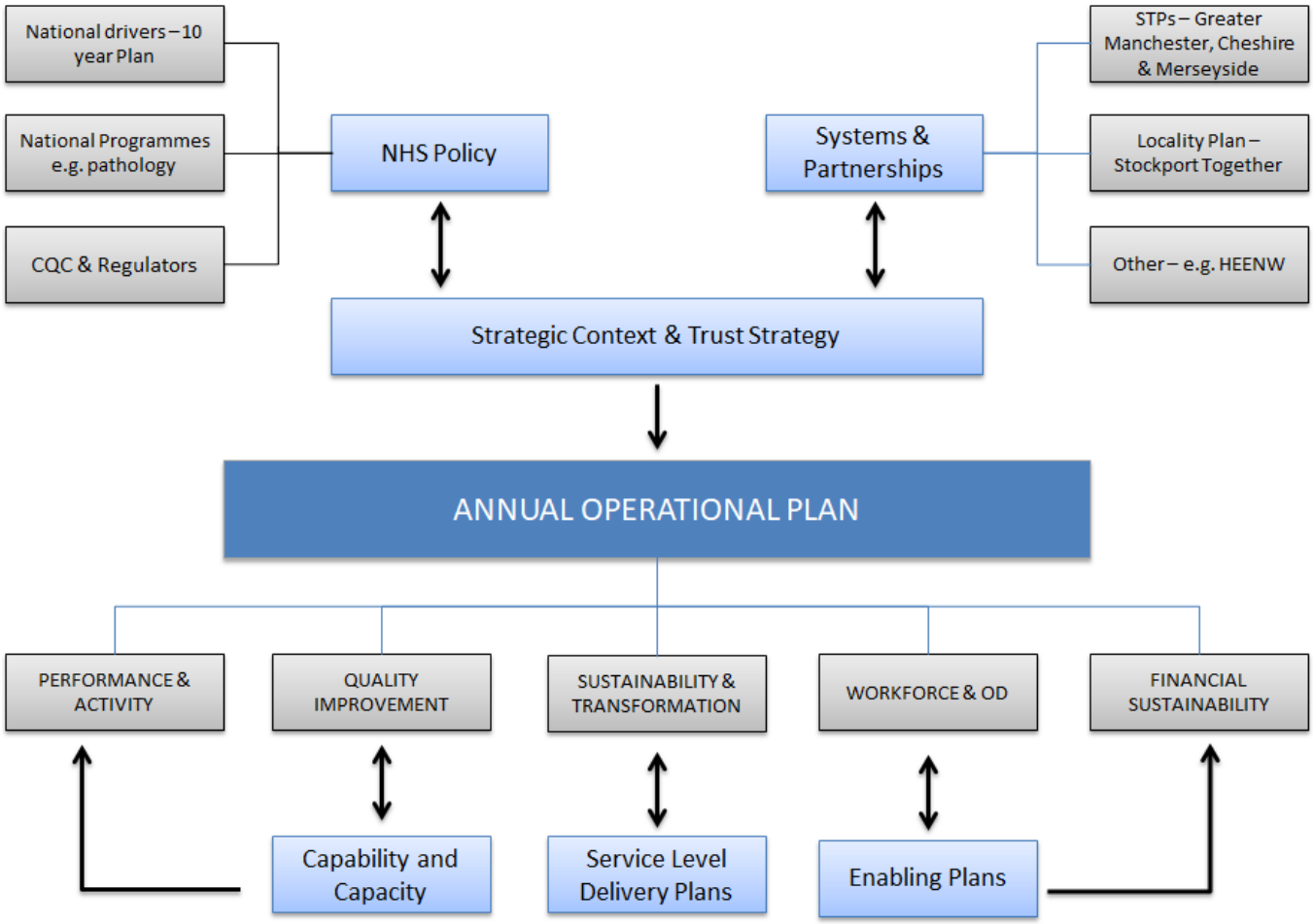
3.3 Detail of the content our plans should cover is outlined in Appendix A

3.4 Plans will be set in the context of national, regional and local policy and strategies.

3.5 As well as demonstrating corporate priorities and actions, our plans must also be the vehicle for strengthening partnership working across existing and developing healthcare systems (notably Stockport Together and as part of Greater Manchester's ambitions for a truly Integrated Health Care System), acknowledging that securing many health outcomes will depend upon more than one organisation playing their part.

3.5 Whilst the ambition for ensuring the organisation has in place a robust planning framework is clear, it is recognised that the Trust is on a developmental pathway and improvement journey and it will take time before this shared vision for planning is embedded in every part of the service and system.

3.6 The top down and bottom up drivers for development of our operational plan are set out in the diagram below



4. Benefits

4.1 The benefits of establishing and delivering plans within a clear and structure framework are that this will provide:

- Greater transparency to staff, public and partners of the strategic vision and priorities
- Greater assurance to the Trust Board and our regulatory partners that high quality care is being provided efficiently and sustainably
- A focus on demonstrating how greater value will be secured through investment in our services
- A clear overview of balancing our priorities of quality, finance and performance
- Increased emphasis on improving quality and experience for patients & service users
- Planning services designed to meet the health needs of the resident population
- A clearer focus on developing and improving services that are evidence-based and within an ethos of engagement and co-production with patients, staff, partners and the public
- Development of workforce plans that identify the required skills, capacity and shape of the workforce
- Robust modelling of activity, demand, and capacity across the whole system, using a consistent approach and agreed data sets, addressing changes in need and demand and demonstrating delivery of key targets in the context of available resources;
- Accurate financial projections and risks, based on well-developed programmes; and;
- Stronger organisational change programmes and supported targeted investment in infrastructure, equipment and IM&T.

5. Roles and Responsibilities

5.1 It is important to clarify the respective roles of individuals and teams in the development and delivery of the plan. These are outlined in the table below:

Team/Individual	Role & Responsibility
Trust Board	To be assured that the Trust is delivering their clinical services and corporate responsibilities in line with national, regional and local priorities. Drive a culture of forward planning by providing a clear vision of the Trusts' priorities, goals and objectives and by holding the executive to account for the delivery of our plans and strategy
Board Committees	To receive assurance that all development, monitoring and reporting activities undertaken associated to the planning framework are being delivered as per agreement by the Board. To advise and provide recommendations to the Board on any significant change to development or delivery of the plan
Chief Executive	Has overall statutory responsibility for planning and is accountable to the Trust Board
Executive Director of Support Services	Ensures robust systems are in place for the planning in line with national guidance and policy Ensures governance arrangements are in place and are robust and effective for both development and delivery of the plan Oversees continual development and production of the planning framework and annual operational plan, highlighting areas of excellence and concern to the Board
Executive Management Group	Ensure a continuous improvement culture is embedded within each clinical service in respect to planning across the Trust. Review and evaluate the effectiveness of the planning framework and operational planning cycle and take corrective action as appropriate. Collectively ensure all areas of planning requirements are delivered by internal challenge, support and facilitation, and that robust plans are in place to ensure delivery of all aspects of the plan. Provide assurance to the Board of Directors of the process and delivery Each director has responsibility for the development, analysis and review of their respective part of the operational plan and associated actions as part of delivering the plan
Strategy & Planning Team	To provide guidance and advice to all staff on the planning framework and planning cycle process, including a clear timeline for development of the plan with detailed roles and responsibilities outlined To lead coordination of the planning cycle process providing support to clinical and corporate teams as appropriate. To coordinate and facilitate all monitoring, delivery and assurance processes put in place
Business Group Triumvirates	To ensure the Business Group develops the required activity, financial, quality and operational standards/targets as part of the planning process To analyse the Business Group's overall delivery of the plan on a minimum monthly basis, establishing variances, trends, discrepancies or gaps. To scrutinise the root cause of variances, trends, discrepancies or gaps and act upon this to eliminate continued issues and to establish action plans for corrective actions. To be held accountable for the implementation and success of the associated elements of the plan within each Business Group. To ensure all staff understand the importance of development and delivery of the plan and its role within the organisation

Corporate Support Teams	To provide information on activity, finance, operational performance, quality, workforce, estates and capital to support teams in their planning To support the development of the planning cycle via tailored support and training as required To provide key information, performance indicators and reports in order to monitor progress and delivery of the plan agreed
All Staff	To contribute towards improvements in planning by being encouraged and supported to identify improvement opportunities and to take the required action To own the plans developed that are relevant to their services and understand how that translates to the overall plans of the organisation

6. The Planning Cycle

6.1 A clear planning cycle brings a discipline into the planning system, ensuring that the development or refresh of Trust plans does not become an annual "one off" event but is a dynamic and iterative activity, embedded into the way an organisation conducts and manages its business and critically delivers improved outcomes for patients and staff.

6.2 The cycle demonstrates three key components:

- Plan Development
- Plan Approval
- Plan Delivery, Monitoring and Escalation

6.4 These three main components of the cycle provide the structure of the Trust's Planning Framework with expectations clarified under each section in 6.5.

6.5 Timetable

6.5.1 The Trust timetable is based on internal plans being submitted for consideration by the Trust Board in January of each year. The rationale for asking for completed plans to be submitted in January is to allow sufficient time for review, challenge and improvement before final plans are signed off by the Trust Board in either February or March.

6.5.2 Publication of national planning guidance from NHS Improvement and NHS England can vary each year, in terms both timescales and the requirements of submission by Providers. External submissions may vary to the timetable depicted under 6.5.4 but this is considered on an annual basis.

6.5.3 It is one of the Board's core responsibilities to agree a plan before the start of the financial year to ensure that they have a clear route map for the coming 1-3 year period.

6.5.4 The timetable for the development, scrutiny and approval of the Plan is as follows

	Action	Timescale	Responsibility	Business Group	Executive Team	Trust Board
PLAN DEVELOPMENT	Integrated Planning Framework developed or refreshed	Jul - Sep	- Director of Support Services - Planning Team		✓	✓
	Establish all 'MUST DO' priorities; triangulation with commissioners and partners	Sep-Oct	- Executive Team - Trust Board		✓	✓
	Planning Information packs issued to clinical and corporate teams	Oct	- Corporate Teams	✓	✓	✓
	Indicative budget and financial assumptions issued	Oct - Nov	- Director of Finance - Finance Team	✓	✓	
	Consideration of national planning priorities and financial allocation (currently Provider Sustainability Fund)	Dec	- Executive Team - Trust Board		✓	✓
	Engagement and development of draft plans	Oct-Dec	- Business Groups	✓		

	Action	Timescale	Responsibility	Business Group	Executive Team	Trust Board
PLAN APPROVAL	Check and challenge process and triangulation of priorities	Dec	- Executive Team - Business Groups - Corporate Teams	✓	✓	
	Executive Team approve 'Final Draft' version of Operating Plan	Dec - Jan	- Executive Team - Trust Board		✓	
	Trust Board approves Draft Plan	Jan	- Trust Board			✓
	SFT submits Draft Plan to regulators (NHSI)	Jan - Feb	- Chief Executive - Planning Team		✓	
	Regulation scrutiny process	Jan - Mar	- Executive Team - Trust Board			
	Boards respond to feedback from scrutiny process and amend Plans accordingly. Boards then approve final versions	Prior to 31 Mar	- Executive Team - Trust Board		✓	✓

	Action	Timescale	Responsibility	Business Group	Executive Team	Trust Board
PLAN DELIVERY	Delivery agreements for Operational Plan	Feb-Apr	- Executive Teams - Business Groups - Corporate Teams	✓	✓	
	Approval of delivery plans by Trust Board	Apr-May	- Trust Board		✓	✓
	Quality & Delivery Meetings	Bi-monthly or Monthly	- Executive Teams - Business Groups - Corporate Teams	✓	✓	
	Joint Board and Executive Review meeting	Six monthly	- Trust Board - Executive Team		✓	✓
	Quarterly Planning Review meetings	Jun, Sep, Dec, Mar	- Executive Teams - Business Groups	✓	✓	

7. Plan Development

7.1 Plans should be developed in the following context:

- National & local policy and drivers for change
- Current regulation and Inspection framework
- Existing and emerging partnerships
- Utilising benchmarking & best practice - Model Hospital & Use of Resources
- Establishing Must DO priorities
    - Service line reviews to confirm opportunities, risks and priorities
    - Corporate enablers – developing organisation capability and capacity

7.2 Overall Aims

7.2.1 To create an operational plan which has is owned by the organisation and the people who will be responsible for delivering it and which is a balanced representation of the challenges ahead. This should articulate:

- High quality innovative services
- Efficient and effective services
- Financial sustainability
- Highly trained workforce

7.2.2 Objectives for developing the plan:

- To agree quality and safety priorities
- To create demand and capacity plans for every speciality which are owned by the specialty and translate into a resource plan which has a common understanding
- To create a risk based income and expenditure plan which is an accurate reflection of the challenges that the Trust faces and is in line with demand and capacity assumptions
- To agree contracts which underpin the income and expenditure plan within the nationally agreed timeframe
- To create a sustainability and CIP programme underpinned by Quality Improvement Methodology, which is understood and agreed by the SROs responsible for its delivery
- To develop a risk based capital programme that is in line with supporting strategies (clinical, estates and digital)
- To translate the implications of regional and local change programmes (GM/Stockport Together) into the operational plan so that the impact on all business groups is understood and reflected in the risk based plan

7.3 Key Priorities

The table below depicts our 5 strategic aims from the refreshed strategy. Each year, the detailed priorities under each heading will be developed and agreed via a planning session between the Executive Management Group and key corporate and clinical teams. This will form the basis of focus for each year's operational plan.

KEY PRIORITIES				
Quality Improvement	**Financial Resilience**	**Operational Performance**	**Partnership Working**	**Leadership Development**
Content to be developed	Content to be developed	Content to be developed	Content to be developed	Content to be developed

7.4 Planning Information & briefing

7.4.1 A detailed timeline with associated expectations will be prepared each year based on the core requirements for development of the operational plan. Key briefings will be scheduled for staff and support will be provided from corporate teams.

7.4.2 Information packs will be produced and circulated for use by clinical business group and corporate teams. These will include key information on the following areas:

- Policy and strategy
- Contract position, provider intentions and market analysis
- Current activity plans; finance and contract activity
    - Capacity & demand outputs
    - Clinical service review outcomes & actions
- Workforce baseline data
    - Workforce tracker / staff impacts on service developments
    - Agency spend
- Budget setting policy
- Finance summary of I&E
    - Current plan
    - Cost pressures
    - CIP position
- Quality standards and priorities
- Efficiency and productivity benchmarking
- Overview of enabling strategies and their priorities e.g. Estates/Digital

7.4.3 Key documents and guidance can also be found on the Planning Microsite

7.5 Triangulation of plans

7.5.1 Triangulation of our plans is essential to balance the priorities of quality, performance and finance in order to be a high performing and well led organisation. It is essential that time is set aside for check and challenge of draft plans and assumptions to ensure these are clear and the associated impacts are agreed and understood,

8. Plan approval

8.1 Plan approval will take place at the following levels:

- **Business Groups** – the Business Group Triumvirates have responsibility for approving the detailed activity, quality, workforce, finance, capital and transformation plans that directly impact their services. This will include agreement and sign off for the overall business group activity plans, budget and timescales set out for delivery of plans.

- **Executive Team** - the primary responsibility for plan approval and delivery rests with the Executive Team. It is their responsibility to agree key investment priorities, approach to budget setting and resource allocation. The Executive Team also has responsibility to agree the draft and final plan before presentation to the Board.

- **Board Committees** – the Finance & Performance Committee has responsibility for sub-board assurance of the plan. They must have confidence that the plan is robust and detailed enough in order to make a recommendation of approval to the Trust Board

- **Board of Directors** – ultimate responsibility for plan approval and delivery rests with the Board. They must have complete confidence that what is set out within the plan can be delivered, with a robust approach to the management of risk

- **Partners -** this may include commissioners, local authorities, other Trusts, the Greater Manchester Partnership or any other supporting organisations. Where the delivery of an element of the plan depends upon another organisation providing a service, it is essential that the relevant part of the plan is agreed between both organisations

- **Regulators** – NHS Improvement are the national body responsible for approval of the Trust's plan. Approval signals a high level of confidence that the Board can deliver the plan as set out, including the delivery of national priorities. Approval of the plan does not mean that the fine detail is specifically approved and does not remove the need to follow other approvals processes where relevant, such as the business case process for capital investment.

9. Delivery, monitoring and escalation

9.1 Plans can only be defined as good when they are implemented and result in improved outcomes, service delivery and patient experience for the populations served. The importance of delivering the agreed plan is clear:

- Patients, staff and service users will rightly expect the improvements described within the plan to be delivered

- The Board will expect its vision of improvement and outcomes to be delivered; and

- Regulators will expect key local and national priorities to be delivered and will hold the Trust to account against the key aspects of the plan. Metrics and performance will be scrutinised through the Use of Resources framework.

9.2.1 The development and approval of the Operational Plan must be accompanied by a robust approach to delivery, including effective management, monitoring and escalation. This should include the following:

- Robust arrangements to be in place for monitoring and, where necessary intervening with business groups, directorates & corporate departments that have the responsibility for delivering the plan within the organisation

- The high level plan will be distilled into a clear set of milestones and trajectories that are highly visible to the Board, and clearly address the delivery of national and local priorities and targets in year.

- The Executive Team must monitor delivery against plan on a monthly basis. In addition the Board should receive an overall assessment of progress against plan at least biannually (e.g. through mid and end of year reviews); and

- Clear governance arrangements to oversee plan delivery. As a minimum, there should be an executive group to oversee plan delivery and a Board sub-committee or group to be scrutinising and challenging progress on a routine basis.

9.4 Escalation

9.4.1 The Trust must have strong local escalation arrangements in place both for the development and delivery of the plan, including:

- Agreed governance and escalation measures where timescales and deadlines associated to development of the plan are not being met

- Where aspects of the plan are not being delivered, contingency arrangements which will be acted upon to promptly recover the position; and

- A range of local actions, incentives and sanctions being available to be deployed in the event of non-delivery

9.4.2 Where delivery of the approved plan is not progressing as set out, The Trust can also expect its regulators; NHSI and CQC to instigate additional monitoring and escalation arrangements in line with their responsibilities.

10. Appendices

APPENDIX A - Content for the Operational Plan

APPENDIX A

As a guide, the Operational Plan should cover the following headings and suggested content:

1. Overview of Progress in delivering previous year's plan

2. Trust Profile

This section should give an overview of headline issues, in the following areas rather than a fully comprehensive profile.

- Provider services
- Overview progress in areas of:
    - Quality & Patient Experience – Annual Quality Statement as a starting point
    - Workforce
    - Finance (revenue and capital)
    - Performance
    - Partnerships
    - Teaching & Research

3. Strategic Context

This section should set the organisation in the context of the national and local strategic framework:

- National drivers , outcomes frameworks and strategies, workforce drivers
- Local strategic direction (strategy/vision)
- Future state – what does success look like in three years? What will patients, public, and stakeholders see from investment in organisations
- Workforce – key themes to deliver clinical strategy
- Commissioning Intentions

This section demonstrates that an organisation has done the essential diagnostic in terms of understanding its operating environment, especially the local environment and pressures based on:

- Health needs
- Service pressures
- Workforce pressures
- Internal operating environment

4. Quality Improvement

Quality and the focus on it should be a thread that runs through all components of the plan. This section provides opportunity to highlight particular Quality Improvement approaches and could include:

- Quality Improvement approaches
- Quality assurance overview
- Base lining of Quality indicators
- Projections of improvements
- Identification of actions required to improve

5. Service Change Plans & Initiatives

This is a critical section in the plan – it essentially describes the key service change/transformational programmes that have emerged as priorities based on our initial diagnostic. These programmes must be described in an integrated way and will cover commissioned services from both in house and externally provided services. Service changes and reconfiguration agreed as part of wider regional planning initiatives should be reflected here

These priority programmes are likely to emanate from:

- Trust initial diagnostic (needs assessment, engagement activities, service pressures etc.)
- Planning requirements (strategic and specific)

For each priority service change programme/plan should as a minimum include:

- Baseline position (performance, key measures etc.)
- Define future state
- Detail the service change and milestones (for year 1 service plans milestones by qtr.)
- Relevant whole system demand & capacity plan
- Workforce implications and actions
- Describe in context impact on quality, workforce, activity (delivery, finance (revenue and capital)
- Partnership issues and sign off if appropriate
- Risks of delivery including workforce risks

Not all of this would necessary be documented in the overarching plan, but assurance around a process that exists to deliver the above requirements

6. Organisational Development

Workforce elements must be embedded in all sections of the plan (particularly service change areas).

This is an opportunity to focus on key organisational development priorities including engagement, leadership and any other priority elements of the Workforce & OD Framework.

Organisational development should also recognise the need to engage other partners in delivery.

7. Finance

Revenue section that includes as a minimum:

- Income and cost assumptions
- Income and expenditure summary
- Details of savings plans
- Capital expenditure plans
- Cash flow forecast

Reflect resource assumptions as a basis for its plan, providing a rationale for departure from these. These will include assumptions regarding:

- Pay awards
- Non pay inflation
- Changes to resource allocations, in particular details of inflation funding
- Capital planning envelopes
- Impact of:
    - Policy changes
    - Changes in Partnerships
    - Demographic change
    - Technology change (including impact of NICE)
    - Specific service demand changes arising from policy initiatives and any associated changes

Reflect commissioning and contractual proposals by local and national partner CCGs.

Financial risk strategy as part of overall financial management plan.

Plans identify integrated services and budgets and the outcomes for which they are intending, including shifts of services from hospital to primary and community care settings.

The organisation has aligned performance, quality, workforce and financial plans to demonstrate consistency.

8. Building Capability & Delivery

This section provides some detail on the critical enablers for delivery, such as:

- Innovation
- ICT

- Service and process improvement
- Infrastructure – capital and estate
- Organisational Development (e.g. clinical leadership, engagement)
- Research & Development
- Collaborations and partnerships
- Systems for technology adoption

Infrastructure section

- The impact of capital investment on revenue sustainability should be demonstrated.
- Impact of investment/non-investment on service sustainability
- Infrastructure/capital investment template which:
    - captures high level revenue information linked to each scheme
    - a description of this in the associated scheme narrative
    - Captures details of asset key performance indicators (KPI's).

The narrative should provide a clear statement of assets' current condition and performance. It should also describe how the KPI's will develop over time and how key issues in terms of asset condition and performances are being addressed through investment and/or disposal.

9. Governance & Assurance

This section describes our planning, engagement, approval, delivery and assurance model for the plan

- Operating model – planning model and cycle
- Engagement and approval arrangements, including partner and stakeholder engagement and support – including any engagement and consultation issues
- Delivery/Management arrangements
- Corporate Governance
- Risk Management
    - top risks
    - sensitivity analysis
    - risk management strategy
- Assurance – Performance Management and reporting Framework
- Financial Controls, reporting and audit arrangements

To:
CCG AO
Trust CE

CC:
NHS Improvement and England Regional Directors
NHS Improvement and England Regional Finance Directors

NHS Improvement and NHS England
Wellington House
133-155 Waterloo Road
London SE1 8UG

020 3747 0000

www.england.nhs.uk

www.improvement.nhs.uk

Publications Gateway Reference 08559 16 October 2018

Approach to planning

The Government has announced a five-year revenue budget settlement for the NHS from 2019/20 to 2023/24 - an annual real-term growth rate over five years of 3.4% - and so we now have enough certainty to develop credible long term plans. In return for this commitment, the Government has asked the NHS to develop a Long Term Plan which will be published in late November or early December 2018.

To secure the best outcomes from this investment, we are overhauling the policy framework for the service. For example, we are conducting a clinically-led review of standards, developing a new financial architecture and a more effective approach to workforce and physical capacity planning. This will equip us to develop plans that also:

- improve productivity and efficiency;
- eliminate provider deficits;
- reduce unwarranted variation in quality of care;
- incentivise systems to work together to redesign patient care;
- improve how we manage demand effectively; and
- make better use of capital investment.

This letter outlines the approach we will take to operational and strategic planning to ensure organisations can make the necessary preparations for implementing the NHS Long Term Plan.

Collectively, we must also deliver safe, high quality care and sector wide financial balance this year. Pre-planning work for 2019/20 is vitally important, but cannot distract from operational and financial delivery in 2018/19.

Planning timetable

We have attached an outline timetable for operational and strategic planning; at a high-level. During the first half of 2019-20 we will expect all Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs) to develop and agree their strategic plan for improving quality, achieving sustainable balance and delivering the Long Term Plan. This will give you and your teams sufficient time to consider the outputs of the NHS Long Term Plan in late autumn and the Spending Review 2019 capital settlement; and to engage with patients, the public and local stakeholders before finalising your strategic plans.

Nonetheless, it is a challenging task. We are asking you to tell us, within a set of parameters that we will outline with your help, how you will run your local NHS system using the resources available to you. It will be extremely important that you develop your plans with the proper engagement of all parts of your local systems and that they provide robust and credible solutions for the challenges you will face in caring for your local populations over the next five years. Individual organisations will submit one-year operational plans for 2019/20, which will also be aggregated by STPs and accompanied by a local system operational plan narrative. Organisations, and their boards / governing bodies, will need to ensure that plans are stretching but deliverable and will need to collaborate with local partners to develop well-thought-out risk mitigation strategies. These will also create the year 1 baseline for the system strategic plans, helping forge a strong link between strategic and operational planning. We will also be publishing 5-year commissioner allocations in December 2018, giving systems a high degree of financial certainty on which to plan.

We are currently developing the tools and materials that organisations will need to respond to this, and the timetable sets out when these will be available.

Payment reform

A revised financial framework for the NHS will be set out in the Long Term Plan, with detail in the planning guidance which we will publish in early December 2018. A number of principles underpinning the financial architecture have been agreed to date, and we wanted to take this opportunity to share these with you.

Last week we published a document on ‘NHS payment system reform proposals’ which sets out the options we are considering for the 2019/20 National Tariff.

In particular, we are seeking your engagement on proposals to move to a blended payment approach for urgent and emergency care from 2019/20. The revised approach will remove, on a cost neutral basis, two national variations to the tariff: the marginal rate for emergency tariff and the emergency readmissions rule, which will not form part of the new payment model. The document will also ask for your views on other areas, including price relativities, proposed changes to the Market Forces Factor and a proposed approach to resourcing of centralised procurement. As in

previous years, these proposals would change the natural 'default' payment models; local systems can of course continue to evolve their own payment systems faster, by local agreement.

We believe that individual control totals are no longer the best way to manage provider finances. Our medium-term aim is to return to a position where breaking even is the norm for all organisations. This will negate the need for individual control totals and, in turn, will allow us to phase out the provider and commissioner sustainability funds; instead, these funds will be rolled into baseline resources. We intend to begin this process in 2019/20.

However, we will not be able to move completely away from current mechanisms until we can be confident that local systems will deliver financial balance. Therefore, 2019/20 will form a transitional year, in which we will set one year, rebased, control totals. These will be communicated alongside the planning guidance and will take into account the impact of distributional effects from any policy changes agreed post engagement in areas such as price relativities, the Market Forces Factor and national variations to the tariff.

In addition to this, we will start the process of transferring significant resources from the provider sustainability fund into urgent and emergency care prices. The planning guidance will include further details on the provider and commissioner sustainability funds for 2019/20.

Incentives and Sanctions

From 1 April 2019, the current CQUIN scheme will be significantly reduced in value with an offsetting increase in core prices. It will also be simplified, focussing on a small number of indicators aligned to key policy objectives drawn from the emerging Long Term Plan.

The approach to quality premium for 2019/20 is also under review to ensure that it aligns to our strategic priorities; further details will be available in the December 2018 planning guidance.

Alignment of commissioner and provider plans

You have made significant progress this year in improving alignment between commissioner and provider plans in terms of both finance and activity. This has reduced the level of misalignment risk across the NHS. We will need you to do even more in 2019/20 to ensure that plans and contracts within their local systems are both realistic and fully aligned between commissioner and provider; and our new combined regional teams will help you with this. We would urge you to begin thinking through how best to achieve this, particularly in the context of the proposed move to blended payment model for urgent and emergency care.

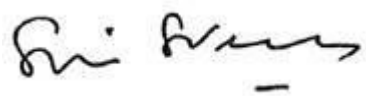
Good governance

We are asking all local systems and organisations to respond to the information set out in this letter with a shared, open-book approach to planning. We expect boards and governing bodies to oversee the development of financial and operational plans, against which they will hold themselves to account for delivery, and which will be a key element of NHS England's and NHS Improvement's performance oversight. Early engagement with board and governing bodies is critical, and we would ask you to ensure that board / governing body timetables allow adequate time for review and sign-off to meet the overall timetable.

The planning guidance, with confirmation of the detailed expectations, will follow in December 2018. In the meantime, commissioners and providers should work together during the autumn on aligned, profiled demand and capacity planning. Please focus, with your local partners, on making rapid progress on detailed, quality impact-assessed efficiency plans. These early actions are essential building blocks for robust planning, and to gauge progress we will be asking for an initial plan submission in mid-January that will be focussed on activity and efficiency (CIP / QIPP) planning with headlines collected for other areas.

Thank you in advance for your work on this.

Yours sincerely



Simon Stevens
Chief Executive
NHS England

Ian Dalton
Chief Executive
NHS Improvement

Annex

Outline timetable for planning	Date
NHS Long Term Plan published	Late November / early December 2018
Publication of 2019/20 operational planning guidance including the revised financial framework	Early December 2018
Operational planning	
Publication of • CCG allocations for 5 years • Near final 2019/20 prices • Technical guidance and templates • 2019/20 standard contract consultation and dispute resolution guidance • 2019/20 CQUIN guidance • Control totals for 2019/20	Mid December 2018
2019/20 Initial plan submission – activity and efficiency focussed with headlines in other areas	14 January 2019
2019/20 National Tariff section 118 consultation starts	17 January 2019
Draft 2019/20 organisation operating plans	12 February 2019
Aggregate system 2019/20 operating plan submissions and system operational plan narrative	19 February 2019
2019/20 NHS standard contract published	22 February 2019
2019/20 contract / plan alignment submission	5 March 2019
2019/20 national tariff published	11 March 2019
Deadline for 2019/20 contract signature	21 March 2019
Organisation Board / Governing body approval of 2019/20 budgets	By 29 March
Final 2019/20 organisation operating plan submission	4 April 2019
Aggregated 2019/20 system operating plan submissions and system operational plan narrative	11 April 2019
Strategic planning	
Capital funding announcements	Spending Review 2019
Systems to submit 5-year plans signed off by all organisations	Summer 2019

This page has been left blank

NHS
Stockport
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	31 October 2018
Subject:	Trust Risk Register		
Report of:	Chief Nurse & Director of Quality Governance	**Prepared by:**	Deputy Director Quality Governance

REPORT FOR ASSURANCE

Corporate objective ref:	2a,3a,3b	**Summary of Report** **The data for this report was collated on 6 September 2018.** This paper provides an overview of the current Trust Risk Register. This report includes all current risks of 15 and above for the members to review. There are currently 338 live risks recorded on the Risk Register systems. There are 33 risks rated 15 or above on the Trust Risk Register with corporate approval. Across the 33 risks rated 15 or higher that have been corporately approved; • 11 risks are associated with staffing issues (124, 231, 50, 67, 75, 78, 505, 125, 408, 587, 624) • 10 risks are associated with capacity issues or increase in demand (130, 400, 586, 96, 183, 429, 506, 407,576, 457) • 7 risks associated with statutory or regulatory activity (134, 135, 162, 513,476, 499,638) • 4 risks are associated with financial issues (469, 127, 461, 466,) • 1 risk is associated with equipment (46) Members are asked to note the risks and the identified actions to mitigate those risks
	SO2, SO3, SO5, SO6	
CQC Registration Standards ref:	17	
Equality Impact Assessment:	☐ Completed ☑ Not required	

Attachments:

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

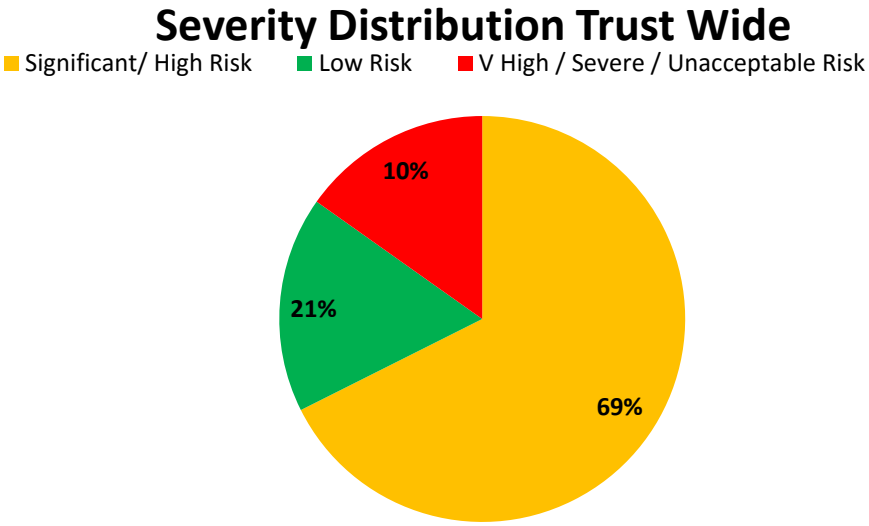
- THIS PAGE IS INTENTIONALLY BLANK -

1.0 Trust Wide Risk & Severity Distribution

1.1 There are currently 338 live risks recorded on the risk register system. This is an increase of 7 since last month. In addition there are 8 risks waiting for corporate approval and 47 risks waiting for business group approval

1.2 Trust wide distribution of risk is shown below:-

	Low				Significant			High			Very High		Severe	Unacceptable
	1	2	3	4	5	6	8	9	10	12	15	16	20	25
New System	1	3	15	48	1	38	37	58	13	73	9	13	9	0



1.5 Trust Risk (approved) distribution across Business Groups.

Business Group	Risk Score 15	Risk Score 16	Risk Score 20	Risk Score 25	Total
Corporate	4	1	6	0	11
Integrated Care	0	2	1	0	3
Medicine and Clinical Support	4	4	0	0	8
Surgery, GI and Critical Care	0	2	0	0	2
Women's and Children's	2	4	3	0	9

1.6 Risk movement of risks of 15 and above in month

The table below shows the movement of risks that are on the trust risk register and those that have been taken off in month.

Risk number	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18		Nov 18	Dec 18	Jan 19	Feb 19	Mar 19
46	16	20	20	20	20	20	20	20	↔					
130	20	20	20	20	20	20	20	20	↔					
134	20	20	20	20	20	20	20	20	↔					
135	20	20	20	20	20	20	20	20	↔					
231	20	20	20	20	20	20	20	20	↔					
469				20	20	20	20	20	↔					
586							20	20	↔					
124							12	20	↑					
624								20	N					
400							15	20	↔					
429			20	20	20	16	16	16	↔					
461			16	16	16	16	16	16	↔					
466				16	16	16	16	16	↔					
505							16	16	↔					
506						16	16	16	↔					
125	16	16	16	16	16	16	16	16	↔					
127	16	16	16	16	16	16	16	16	↔					
183	16	16	16	16	16	16	16	16	↔					
50						16	16	16	↔					
67				16	16	16	16	16	↔					
75	16	16	16	16	16	16	16	16	↔					
78	20	20	20	20	16	16	16	16	↔					
96	16	16	16	16	16	16	16	16	↔					
407						15	15	15	↔					
408			15	15	15	15	15	15	↔					
162	15	15	15	15	15	15	15	15	↔					
513						15	15	15	↔					
576						15	15	15	↔					
499				15	15	15	15	15	↔					
587							15	15	↔					
638							15	15	↔					
476							15	15	↔					
457								15	N					
101	20	20	20	20	20	20	20	10	↓					
458				16	16	16	16	C	↔					
167	16	16	16	16	16	16	16	C	↔					
286		15	15	15	15	15	15	C	↔					

Key	
↓	Risk rating reduced in month
↑	Risk rating increased in month
↔	Risk rating stayed the same in month
C	Risk closed in month
N	New risk in month

1.7 Risk movement in previous months

The table below shows when risks have been removed from the trust risk register.

Risks removed from the Trust Risk register in previous months														
Risk number	**Mar 18**	**Apr 18**	**May 18**	**Jun 18**	**Jul 18**	**Aug 18**	**Sep 18**	**Oct 18**	**Nov 18**	**Dec 18**	**Jan 19**	**Feb 19**	**Mar 19**	
53	16	12												
76	16	16	16	16	4									
74	25	10												
87	16													
91	15													
108	16	16	16	16	16	16	8							
109	16	16	1											
126	16	16	16	16	12									
137	16	16												
145	16													
159	20	20	16	12										
160	15	15	8											
177	15	12												
261	16	16	16	16	16	16	C							
282	15	15	12											
288	15	15	9											
296	15	15												
305				15	15	10								
318	15	6												
319	15													
354	16	16	16	16	16	**C**								
355	15	15	12											
362	15	15	15	9										
399		15	15	15	C									

2.0 New Risks Identified

2.1 There have been 2 new risks approved at Safety and Risk Group this month (624 and 457)

3.0 Existing Risks

3.1 There are 33 risks rated 15 or above on the trust risk register with corporate approval.

3.2 Movement this month;

- 2 new risks were added to the register this month
- 1 risk has increased from 12 to 20
- 3 risks have been closed

4.0 Trends

4.1 The risk register is presented in order of current rating

4.2 Across the 31 risks rated 15 or higher that have been corporately approved;

- 11 risks are associated with staffing issues (124, 231, 50, 67, 75, 78, 505, 125, 408, 587, 624)
- 10 risks are associated with capacity issues or increase in demand (130, 400, 586, 96, 183, 429, 506, 407,576, 457)
- 7 risks associated with statutory or regulatory activity (134, 135, 162, 513,476, 499,638)
- 4 risks are associated with financial issues (469, 127, 461, 466,)
- 1 risk is associated with equipment (46)

RISK ASSESSMENT SCORING/RATING MATRIX

LIKELIHOOD OF HAZARD

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

The risk factor = severity x likelihood

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

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

QUALITATIVE MEASURE OF CONSEQUENCE

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

Risk Register Type	Risk ID	Risk Owner	Business Group	Risk Title	Controls in place	Rating (initial)	Consequence (current)	Likelihood (current)	Rating (current)	Title	Due date	Rating (Target)
Trust Risk (score 15 and above)	624	O'Neill, Mrs Melanie	Women Children and Diagnostics Business Group	There is a risk to patient safety due to the lack of capacity for Breast 2WW appointments	Proactive management of bookings to ensure maximum slot usage. CCG made aware during contracts meeting 23/7/18. Daily monitoring of situation.	20	4	5	20	Explore Outsourcing to the private sector	31/10/2018	8
										Explore Staffing Options	31/10/2018	
Risk Assessment	457	Zaman, Ms. Raisa	Women Children and Diagnostics Business Group	There is a risk to patient safety due to a lack of Haematology/TransfusionStaff in Post	2x BMS adverts have been approved on 19/04/18. 1xBMS advert will be submitted for approval on 23/04/18. Seeking to compile a business case for locum BMS cover ASAP till staff numbers on the OOH rota stabilizes. 06/08/18 1XWTE locum obtained as of	12	3	5	15	recruitment of BMS posts	31/10/2018	6
										Recruitment	31/10/2018	

This page has been left blank

Risk Register	Risk ID	Risk Owner	Business Group	Risk Title	Rating (initial)	Controls in place	Consequence (current)	Likelihood (current)	Rating (current)	Title of Action	Due date	Rating (Target)
Corporate Risk	46	Smethurst, Mr Richard	Women Children and Diagnostics Business Group	There is a risk that the Telepath Server will Fail	16	•Telepath has 24/7 365 day support (hardware 11 years old). This system also has a failover server (also 11 years old). •Mirrored Hard Disks •Daily data tape backup, with monthly operating system backups •Manual processes to book requests directly into analysers for emergency requests. •Send routine work to other laboratories This emergency service would mean manual transcription of lab results, and greatly increases risks of serious errors. This service could only be maintained for a relatively short period of time (up to 48 hrs) and has a significant impact on departmental staffing requiring additional hours, and all managerial staff aiding in keeping the emergency service functioning.	5	4	20	Replacement Telepath Server	16/1/19	5
Corporate Risk	130	Plummer, Susan	Integrated Care Business	There is a risk that the ED 4 Hour Target will not be met	20	Existing internal escalation processes	4	5	20	High Impact Priority Action Plans	1/11/18	10
Strategic Risk	134	Kershaw, Helen	Corporate Nursing	There is a risk that the statutory requirements and billing will not be met due to lack of capacity in the medico-legal team	20	Workload is discussed weekly between band 3 and Risk and Customer Services Manager. All mail is checked on arrival and priority is given to court orders, emails are checked and the same principle applies	4	5	20	Continue Weekly updates from Team	31/10/18	8
										Use volunteers and bank staff to increase throughput	31/12/18	
		n	T	There is a risk that	20	1. Medico Legal Team adhere closely to	4	5	20	Determination of	31/10/18	8

Risk Register	Risk ID	Risk Owner	Business Group	Risk Title	Rating (initial)	Controls in place	Consequence (current)	Likelihood (current)	Rating (current)	Title of Action	Due date	Rating (Target)
Strategic Risk	135	Lehnert, Mrs Jea	Information and I	Subject Access Provisionis not adequate to meet GDPR requirements		guidance (see earlier risk re pressures) 2. There is a clear process (doesn't include all areas) 3. Health Records follow process				requirements to meet legislation post review		
Corporate Risk	231	Glynn, Marie	Corporate Nursing	lack of medical and nursing staff resulting in mandatory work only being undertaken resulting in an inefficient IP service.	20	•2 Consultant Microbiology posts have been advertised with one including the IP doctor role •Pathology have provided the IP service team a member of staff for an hour per week to input the information on to the MESS data collection system •Monthly meetings have taken place between the DIPC and the IP strategic lead nurse •Business case was produced in May 2017 and taken to SMG twice	4	5	20	review long term option for IV service	24/12/18	8
										review BG for wider IP team	28/11/18	
										review links with sepsis agenda	24/12/18	
										Current work load undertaken by the IP service team	31/10/18	
										To produce a gap analysis against the Health & Social Care Act	24/12/18	
										present compliance data against the H&SC act	24/12/18	

Risk Register	Risk ID	Risk Owner	Business Group	Risk Title	Rating (initial)	Controls in place	Consequence (current)	Likelihood (current)	Rating (current)	Title of Action	Due date	Rating (Target)
Business Group Risk	400	Sperring, Mrs Carol	Women Children and Diagnostics Business Group	Capacity V Demand Issues in Children's Therapies	15	The service has published its 'local offer' as required by the Special Educational Needs and Disabilities (SEND) code of practice. This defines what the NHS in Stockport provides to children with a Stockport GP. The therapists will recommend what a child needs and if this is above what the NHS provides then this duty falls to a school if this is an educational need (that which trains or educates a child. However in practice it is very hard to define the educational versus the health aspect. Where the local offer does not meet the health needs of a child then the service puts a case forward to the CCG to provide an enhanced individual package for the child on a case by case bases.	4	5	20	Selective Mutism bid to increase capacity	31/3/19	6
Risk		Emma	ources	Use of Temporary Staffing	25	Weekly ECP meetings / Nursing Staffing Meeting / Weekly Agency Usage Review Meetings / Weekly ECP meetings / Nursing Staffing Meeting / Monthly KPI Meetings / Agency Usage Review Meetings / Agency performance monthly reporting to WEG/PPC/F&P Review of current expenditure in order to ascertain the current position against the	4	5	20			12

Risk Register	Risk ID	Risk Owner	Business Group	Risk Title	Rating (initial)	Controls in place	Consequence (current)	Likelihood (current)	Rating (current)	Title of Action	Due date	Rating (Target)
Strategic	124	Stimpson,	Human Res			monitor cap rates and the impact of the future sliding scale. Action taken to address those who are outside the agency cap levels to bring the cost within the available cap parameters, whilst continuing to review the rationale for the use of the temporary staff to identify actions to reduce overall need for continued use. Weekly tracker meeting. Centralised Temporary Staffing Team.						
Corporate Risk	469	Wiss, Kay	Finance	There is a risk that the Trust will not deliver its 2018/19 financial performance	20	The performance management framework implemented in April 2017 will be refreshed for 2018/19 and used to ensure under-performance is escalated and managed. This will be through bi-monthly business group performance review meetings chaired by the Deputy CEO. A monthly financial improvement group (FIG) chaired by the CEO will hold SROs to account for their respective delivery programmes. The Trust has implemented an Executive Management Group attended by triumvirate leadership to review and manage the overall performance of the organisation. This group will be supported by an operational management group and SMT both chaired by the COO. Corporate resource support to the SROs has been refocused on the delivery of CIP in 2018/19. Stockport Together benefits will be managed by the Alliance Provider Board as part of the strengthened governance arrangements.	5	4	20	Ensure that the Business Groups are held to account on the delivery of their respective operational plans	29/3/19	10
										Develop a demand and capacity model	28/9/18	
										Preparation of a workforce plan	30/11/18	
										To regularly report the key issues facing the Trust as part of the Stockport Together Programme	29/3/19	
										CIP Recovery Plan	31/12/18	

Risk Register	Risk ID	Risk Owner	Business Group	Risk Title	Rating (initial)	Controls in place	Consequence (current)	Likelihood (current)	Rating (current)	Title of Action	Due date	Rating (Target)
Corporate Risk	586	Statham, Mr David	Estates and Facilities	There is a risk due to the significant Estate Backlog Maintenance Increase	20	The significant increase is a fair reflection of the estate at the present time. The implications of the report have highlighted a large number of high and significant risks which the directorate are prioritising. The current available capital expenditure is insufficient therefore posing a risk to the Trust. The updated survey provides individual risk assessments for each element to understand where the risks are associated to. Prioritisation of high and significant risk areas identified within the 5 facet survey and individually risk assessed. Ensuring areas with associated statutory requirements are prioritised. Planned Preventative Maintenance (PPM) schedule of works. Regular walkrounds/visual checks undertaken by Estates Staff. Estates Helpdesk: Facility to report jobs. On-going review & monitoring of DATIX Incidents & appropriate	4	5	20	Prioritise Identified High Risks	1/1/19	8
porate Risk	505	ay, David	Diagnostics Business Group	The risk of the lack of capacity in Cellular Pathology on turnaround times and patient pathways	16	Locum pathologist employed on part time basis. Forwarding work to Source Bioscience for reporting	4	4	16	Recruit to vacant histopathologist posts	31/10/18	4
										Appoint additional Locum	31/10/18	

Risk Register	Risk ID	Risk Owner	Business Group	Risk Title	Rating (initial)	Controls in place	Consequence (current)	Likelihood (current)	Rating (current)	Title of Action	Due date	Rating (Target)
Cor		M	Women Children and							Recruit Cancer Tracker in laboratory	18/10/18	
Corporate Risk	506	Tunnicliffe, Mr Andrew	Surgery GI and Critical Care	There is a risk that winter pressures on ED, patient flow and capacity will affect delivery of 2018-19 elective plan in Ortho	16	weekly monitoring and tracking of elective activity weekly meeting with waiting list teams to ensure optimal theatre utilisation fortnightly tracking of elective activity in business group finance meeting Ring fence protocol agreed for elective orthopaedic unit. Support from executive team to continue elective inpatient orthopaedic operating throughout the winter to maintain activity and as part of financial recovery plan	4	4	16	weekly monitoring and tracking of elective activity weekly meeting with waiting list teams to ensure optimal theatre utilisation fortnightly tracking of elective activity in business group finance meeting Ring fence protocol agreed for elective orthopaedic unit. Support from executive team to continue elective inpatient orthopaedic operating throughout the winter to maintain activity and as part of financial recovery plan		8

Risk Register	Risk ID	Risk Owner	Business Group	Risk Title	Rating (initial)	Controls in place	Consequence (current)	Likelihood (current)	Rating (current)	Title of Action	Due date	Rating (Target)
Strategic Risk	183	KEH	Executive teams	Failure to meet the 62 day Cancer target standards	12	Monthly Cancer Board chaired by Trust Lead Cancer Clinician There is an established team of experienced Cancer Trackers and Cancer MDT Coordinators who are tracking all cancer patients to ensure they are treated within 31 and 62 days. Cancer Services Manager monitors performance on a daily basis using the 'Predictor tool' Cancer Access Manager undertakes weekly Tumour specific PTL meetings with Business Manager and Cancer Pathway Tracker. Weekly Trust-wide PTL chaired by the Director of Operations An escalation policy is in place to alert business groups of any issues causing delay to patient pathways	4	4	16	Cancer Services Manager to review Department roles and responsibilities to ensure staff are engaged with targets	30/9/18	8
										Action plan being created with input from Business Groups to ensure sustained performance	30/9/18	
										Awaiting outcome of discussions on potential loss of Urology cancer activity and impact on Trust 62 day Cancer performance, this is dependent on the future service model design. (scenario paper produced by Performance Team)	30/9/18	
Corporate Risk	125	MR1	grated Care Business Group	Reduced Emergency Department Medical Staffing	20	Dependant on internal cover and locum bookings	4	4	16	Plan for increase to midnight finish and Healthier Together implementation	31/10/18	8

Risk Register	Risk ID	Risk Owner	Business Group	Risk Title	Rating (initial)	Controls in place	Consequence (current)	Likelihood (current)	Rating (current)	Title of Action	Due date	Rating (Target)
			Integ									
Corporate Risk	127	Armitage, Nadine	Medicine and Clinical Support	There is a risk that the M&CS BG overspends due to agency costs	16	Monthly reporting of finance and performance; including review of Clinical Income (including activity), Expenditure budgets and CIP. Documentation highlighting financial position shared to Business Group senior management team and cascaded as appropriate. Weekly local meeting with Business Accountant to review requirement for medical locums and position against national agency cap. Twice weekly local meeting with Medical Staffing and Business Accountant to review locum rates and contractual arrangements.	4	4	16	Introduction of medical e-rostering	25/10/18	12
Corporate Risk	429	Curtis, Mrs Kelly	Women Children and Diagnostics Business Group	Inadequate capacity to meet demand in Paediatric ADHD Services	20	Capacity deficit raised with Stockport Commissioner Additional OWL lists monthly (not covering current demand)	4	4	16	Paper to SMT to agree resource requirement for increase demand on service	15/10/18	8
										Advertise additional consultant PA's to provide ADHD Service	31/10/18	
										Additional Consultant PA's in post to provide ADHD service	31/10/18	
										Review pathway for ADHD service	31/10/18	
			Care	There is a risk that Surgery, GI & Critical	16	Profiling of elective activity to take into account her winter period	4	4	16	Monitoring weekly of activity v plan	1/9/18	12

Risk Register	Risk ID	Risk Owner	Business Group	Risk Title	Rating (initial)	Controls in place	Consequence (current)	Likelihood (current)	Rating (current)	Title of Action	Due date	Rating (Target)
Corporate Risk	461	Hatchell, Karen	Surgery GI and Critical	Care will not deliver the financial position required for 2018-19		Proactively reviewing alternative options with recruitment eg, physician associates, ANP's etc Validation of all activity with a view to alternativer modes of delivery eg., virtual clinics Robust financial controls in place across the Business Group						
Corporate Risk	466	Armitage, Nadine	Medicine and Clinical Support	There is a risk that the BG will fail to deliver the CIP Target	16	Inability to deliver CIP due to: Capacity to deliver Capability to deliver Service demands	4	4	16	Programme Management for CIP	19/9/18	8
Corporate Risk	50	Cotton, Mrs Janet	Women Children and Diagnostics Business Group	Risk of maternity diverts and clinical incidents related to unsafe staffing levels in maternity.	16	Profiling of elective activity to take into account her winter period Proactively reviewing alternative options with recruitment eg, physician associates, ANP's etc Validation of all activity with a view to alternativer modes of delivery eg., virtual clin	4	4	16	Birth Rate Plus staffing review undertaken June 2017 - Business case collated and submitted August 2017 - additional staff recruited. Additional case to be resubmitted July 2018 - Midwife to Birth Ratio reviewed on a monthly basis and reported on dashboard - Evaluation of maternity service diverts undertaken June 2018 - Escalation of concern reports formally submitted to Quality Board, Quality Governance Committee		8

Risk Register	Risk ID	Risk Owner	Business Group	Risk Title	Rating (initial)	Controls in place	Consequence (current)	Likelihood (current)	Rating (current)	Title of Action	Due date	Rating (Target)
										and People and Performance Committee as appropriate (see documents) Ongoing recruitment		
Corporate Risk	75	Waterman, David	Integrated Care Business Group	There is a risk that there could be management of palliative atients due to lack of Specialist Palliative Care Medical Cover	20	During absences if Specialist palliative care medical advice is required the medics at St Ann's Hospice will provide telephone advice but not face to face assessments. Clinical Nurse Specialists attend some cancer MDT's if they have capacity Current Consultant is available for telephone advise in own personal time	4	4	16	There is a risk that Macmillan will not fund ongoing costs of new recruitment in palliative care	30/11/18	9
Corporate Risk	78	Ingleby, Mrs Sarah	Medicine and Clinical Support	There is a risk to patient safety and BG finances due to the excessive registered nursing staffing deficit within Medicine & CS	20	Twice daily assessment of staffing across the Business Group Band 7 on each ward to regularly monitor off duty for changes, ensure accurate numbers, significant gaps to be escalated to Matrons Daily staffing safety Huddle with Surgery Staff re-deployed to balance the risk across the Business Group Reference to the Minimum safe staffing escalation policy Monitor of DATIX and Red Flags Pro-actively put shifts out to NHSP and Agency Ongoing local and international recruitment Quarterly organisational one stop recruitment events Management of sickness in line with Trust policy Effective and efficient duty rostering, completed 6 weeks in advance and as per rostering policy Effective and efficient duty rostering in line with agreed levels for annual leave	4	4	16	Reference to the Minimum safe staffing escalation policy	8/2/19	8
										Local recruitment	8/2/19	

Risk Register	Risk ID	Risk Owner	Business Group	Risk Title	Rating (initial)	Controls in place	Consequence (current)	Likelihood (current)	Rating (current)	Title of Action	Due date	Rating (Target)
						Matrons scrutinise ward rosters to ensure they are fit for purpose and approved appropriately Planned week day Matron rounds each morning Monthly monitoring of turnover and sickness				Supporting the retention of staff	8/2/19	
Corporate Risk	96	Edwards, Joanne	Medicine and Clinical Support	There is a risk of lack of capacity for timely outpatient reviews in the Ophthalmology	16	Waiting list sessions are undertaken by Consultants, middle grade doctors to backfill current lists and clinics where possible. Constant validation is also taking place and urgent cases and short term follow ups are being prioritised Glaucoma and DRS patients are given top priority for capacity	4	4	16	Review spend on WLI and convert to substantive	19/10/18	8
										Create an OP SOP in line with RC Ophth guidance	26/10/18	
										Implement new EPR to ensure appropriate coding of patients	26/10/18	
Strategic Risk	162	Kershaw, Helen	Corporate Nursing	There is a risk to the Trust maintaining unconditional CQC registration which may have a detrimental effect on patient safety, q	20	NHSI improvement Board Patient Quality Summit weekly Safe, High Quality care action plan Quality Governance Framework Regular contact with the CQC	5	3	15	Deliever safe, High Quality CAre Action plan	31/10/18	5
sk		ne	l Support	There is a risk to patient safety due to the number and length of the Respiratory Overdue Waiting List (non	12	- Urgent OWL codes used to identify patients who need to be prioritised for urgent Follow Up. - Consultants doing some validation of longest waiting patients to see if may be better managed in Primary Care.	3	5	15	Recruit to Navigator post (pilot)	19/10/18	6
										Locum (Resp Medicine) LAKHANPAL to perform	15/10/18	

Risk Register	Risk ID	Risk Owner	Business Group	Risk Title	Rating (initial)	Controls in place	Consequence (current)	Likelihood (current)	Rating (current)	Title of Action	Due date	Rating (Target)
Corporate Ri	407	Cartner, Jani	Medicine and Clinica	confirmed cancer)		- monitoring of OWL in Trust performance meetings. - Capacity and Demand work underway. - Admin and clerical navigator role to be piloted to arrange surveillance chest x-rays for patients on surveillance for lung nodules.				WLI		
Corporate Risk	408	damant, Mrs gillian	Medicine and Clinical Support	There is a risk that if we have insufficient pharmacy resources to manage the increasing Haematology demand	15	To maintain a pharmacy service the following controls are in place. •Suspended input to palliative care patients •Reduced pharmacist prescribing input to support chemotherapy prescribing on EMPE •Capacity planning review prior to initiation of new treatments. •Reduced support to oncology •Staff working outside hours to complete financial reports •Delayed provision of information to NHSE •Delaying patients treatment if numbers at an unsafe level	3	5	15	Bank pharmacist	12/10/18	3
										electronic prescribing system	16/11/18	
Corporate Risk	513	Whitehead, Mr Stephen	Estates and Facilities	There is a risk that ward kitchens in a poor state of repair may impact upon the ability to clean to required standards.	15	Survey Specification	3	5	15	EHO Advice/Guidance	15/10/18	9
										Review cleaning programme for Ward Kitchens	15/10/18	
										Programme of Food Safety Training for Ward Based Staff	31/10/18	

Risk Register	Risk ID	Risk Owner	Business Group	Risk Title	Rating (initial)	Controls in place	Consequence (current)	Likelihood (current)	Rating (current)	Title of Action	Due date	Rating (Target)
Corporate Risk	576	Cartner, Janine	Medicine and Clinical Support	There is a risk to patient safety due to the long wait of time to be seen by the Respiratory Team for new patients	15	- ring-fenced capacity for 2ww and Cancer upgrade patients - clinical triage of all referrals - patients booked into clinic by clinical urgency / longest wait - monitoring of wait times in Trust performance meetings. - Capacity and Demand work completed. - Consultants offering WLI's where able but often focused on seeing the 2WW or cancer upgrade patient. - Business case in the process of being written to highlight the risk and request permission to expand the Respiratory Team.	3	5	15	Business Case for expansion to be developed	12/11/18	6
										Service Review	19/11/18	
										Clinic Utilisation	15/10/18	
										Additional Clinics	19/11/18	
										Capacity and Demand Modelling	19/11/18	
										Review of Lung function provision	12/11/18	
Corporate Risk	587	Fox, Mrs Paddy	Information and IT	There is a risk to the operation of the Trust electronic syst/ntwrk due to the need to recruit Senior IT Technical Support	15	1. Deputy Systems Manager is being trained up but can not yet do the majority of security updates and patching. 2.Asst Director IT (Infrastructure) has signed a document to say he accepts he needs to work more than 45 hours per week - some additional payment. 3. Re-advertising both posts following JD and advert reviews 4. ECP agreed could recruit agency in interim	5	3	15	Recruit to 2 senior IT posts	25/9/18	10
Business Group Risk	638	Hatch, Mrs Catherine	Women Children and Diagnostics Business Group	There is a risk to non compliant with HSE guidleines due to CL3 room access and sealing	15	Access is restricted by a digital lock system Room is risk assessed yearly by the external company who would perform the emergency fumigation in the event that a spillage occurs, findings of the report are sent to the estates department for repair by Trust staff	3	5	15	Awaiting a quote for the new CL3 swipe card access	9/10/18	9
										Sealing of CL3 ROOM LEAKS	15/10/18	
		n	upport	There is a risk of not achieving the empiric	15	Guidelines on reviewing antibiotics exist and should be embedded in practice already.	3	5	15	Consider additional antibiotic pharmacist post	12/10/18	6

Risk Register	Risk ID	Risk Owner	Business Group	Risk Title	Rating (initial)	Controls in place	Consequence (current)	Likelihood (current)	Rating (current)	Title of Action	Due date	Rating (Target)
Corporate Risk	476	damant, Mrs gillia	Medicine and Clinical Su	review of antibiotic prescriptions &reduction in antibx consumption CQUIN 18/19		Antibiotic stewardship ward rounds and education sessions are carried out when staffing allows – currently less than 10% of planned activity.						
Corporate Risk	499	Buckley, Lisa	Corporate Nursing	There is a risk that complaints responses are not being completed within Trust timescales	15	Action plan set up for business groups to have cleared their backlog and be working in real time by 31 July 2018. Monitored by the reporting process	3	5	15	weekly monitoring of complaints that are overdue	31/10/18	4

Stockport NHS
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	31 October 2018
Subject:	Board Assurance Framework		
Report of:	Chief Nurse & Director of Quality Governance	**Prepared by:**	Deputy Director of Quality Governance

REPORT FOR APPROVAL

Corporate objective ref:	N/A	**Summary of Report** The purpose of this report is to present the Quarter 2 summary of risks associated with the delivery of the strategic objectives outlined in the Board Assurance Framework. The risk rating against 3 principle risks has decreased and 1 risk rating has increased. Work to refine the presentation of the Board Assurance Framework continues. This includes striking a balance of content across the strategic objectives. The development also needs to include Board consideration of its risk appetite in relation to each of its strategic objectives. The Board of Directors is asked to note the contents of the report and support the proposed developments.
Board Assurance Framework ref:	SO 2	
CQC Registration Standards ref:	10,17,18	
Equality Impact Assessment:	☐ Completed X Not required	

Attachments:	Annex A – Board Assurance Framework

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

- THIS PAGE IS INTENTIONALLY BLANK -

1. INTRODUCTION

1.1 The purpose of this report is to present the Quarter 2 summary of risks associated with the delivery of the strategic objectives outlined in the Board Assurance Framework.

2. BACKGROUND

2.1 The Stockport NHS Foundation Trust Board Assurance Framework identifies the strategic objectives and the principle risks facing the organisation in achieving them.

2.2 The format of the current Board Assurance Framework was introduced in April 2018 alongside the Risk Management Framework. It is updated at the end of each quarter by the executive director responsible for the delivery of each strategic objective. The document included at Annex A represents the current position of the Board Assurance Framework.

3. CURRENT SITUATION

3.1 The current Board Assurance Framework, which is included for reference at Annex A of the report, has been reviewed by the relevant risk owners and updated accordingly. Movements in residual risk are summarised as follows:

- Risk 1: Failure to implement the Trust's refreshed strategy – decrease from 16 to 12
- Risk 2: Failure to deliver the 2018/19 developments set out in the Quality Improvement Plan - decrease from 20 to 15
- Risk 3: Failure to maintain financial stability – decrease from 16 to 12
- Risk 5: Failure to deliver the full compliance with the requirements if the NHS Provider License – increase from 15 to 20

3.2 With regard to Risk 1, failure to implement the Trust's refreshed strategy , the decreased risk rating is based on the decision taken by the Board to approve the draft refreshed strategy in September 2018. A plan of engagement and implementation is in place to implement the strategy by March 2019

3.3 With regard to Risk 2, failure to deliver the 2018/19 developments set out in the Quality Improvement Plan, the decreased risk rating reflects the progress of the Quality Improvement Plan which is on track to deliver.

3.4 With regard to Risk 3, failure to maintain financial stability, the decreased risk rating is based on the Trust delivering the financial plan at the end of Quarter 2.

3.5 With regard to Risk 5, failure to deliver the full compliance with the requirements if the NHS Provider License, the increased risk rating is based on the deterioration of the timeliness of treatment in urgent care, which has a direct correlation to the increased number of stranded patients.

4. NEXT STEPS

4.1 Work to refine the presentation of the Board Assurance Framework continues. This includes striking a balance of content across the strategic objectives. The development also needs to include Board consideration of its risk appetite in relation to each of its strategic objectives

5. RECOMMENDATIONS

5.1 The Board of Directors is asked to note the contents of the report and support the proposed developments.

BAF - Board Assurance Framework (October 2018)

NHS Stockport NHS Foundation Trust

Strategic Objective 1:
To achieve full implementation of the Trusts refreshed strategy

Principal risk	**Risk of failure to implement the strategy will result:** - in missed opportunities to improve the quality of care we provide, leading to poor patient and staff experience - inability to modernise services - delays in delivering integration - failure to engage effectively and lead developments with key partners - adverse partner perceptions of working with Stockport NHS Foundation Trust

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHS Improvement Oversight Framework	Accountable Executive Director	Executive Management Group	Designated Board Committee
11 June 2018	July 2018	October 2018	Well Led NHSI – Use of Resources	Director of Support Services	Board of Directors	Finance and Performance

Risk Rating by Quarter

Graph here

Initial Risk Rating (Unmitigated)			Current Risk Rating (Mitigated)			Target Risk Rating (Tolerance / Risk Appetite)			
Consequence	**Likelihood**	**Risk Rating**	**Consequence**	**Likelihood**	**Risk Rating**	**Consequence**	**Likelihood**	**Risk Rating**	**Target Date**
4	5	20	4	3	12	4	1	4	March 19

Executive commentary for the Current Risk Score

The mitigated score relates to the strategy being drafted, agreed by board and 3 month consultation commencing therefore complete within timeline is possible

Corporate objectives

1a. To develop a comprehensive, integrated delivery/business plan in order to achieve realisation of the Strategy
1b. To lead the annual operational planning cycle in line with NHSI guidance.

Links to other Strategic Objectives: SO2, SO3, SO4, SO5, SO6, SO7

Links to the Trust Risk Register (Current Risk Rating 15 & above)

Risk ID	Risk Title	Risk Rating	Date of Initial Assessment	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19
	No risks identified above 15						

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

BAF - Board Assurance Framework (October 2018)

NHS Stockport NHS Foundation Trust

SO2							
Key Controls / Influences Established (What are we currently doing about the risk?)		**Key Controls / Influences (What additional controls should we seek?)**	**Assurance Providers 2018 / 2019 (How do we know if the things we are doing are having an impact?)**			**Gaps in Assurance on Controls / Influences (What additional assurances should we seek?)**	**Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)**
			Local Management (1st Line of Defence	**Corporate Oversight (2nd Line of Defence)**	**Independent / External (3rd Line of Defence)**		
1	2018- 20 Strategy in place	• Timescales for delivery of refreshed Strategy	• 1:1s • Team meetings • Stakeholder events	• Executive Management Group • Board of Directors • EMG minutes • Board minutes	• NHSI Oversight	• Monitoring of Strategy and annual review	• Strategy review in progress • Communication Plan in place
Adequacy of Assurance (Level of Confidence)							
Overall Assessment of Assurance			Partial				
Quarter 1 Commentary:		Strategy has not been finalised and embedded. Trust has sought external support from ATTAIN to assist with final product					
Quarter 2 Commentary:		The draft refreshed trust strategy was approved at the Board in September 2018 and agreed to go out a three month consultation with staff and stakeholders.					
Quarter 3 Commentary:							
Quarter 4 Commentary:							

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

Strategic Objective 2:
To deliver outstanding clinical quality and patient experience

Principal risk	There is a risk that the Trust will fail to achieve the 2018/19 developments set out in the Quality Improvement Plan resulting in not consistently providing the safest, highest quality care to patients, their families and carers.

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHS Improvement Oversight Framework	Accountable Executive Director	Executive Management Group	Designated Board Committee
13 April 2018	n/a as 1st assessment	October 2018	Safe, Effective, Responsive, Caring & Well Led NHSI – Quality Metrics	Chief Nurse & Director of Quality Governance Medical Director	Quality Governance Group Patient Experience Group Safeguarding Group Medicines Management Group Infection Prevention and Control Group	Quality Committee

Risk Rating by Quarter

Graph here

Initial Risk Rating (Unmitigated)			Current Risk Rating (Mitigated)			Target Risk Rating (Tolerance / Risk Appetite)			
Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Target Date
5	5	25	5	4	20	5	2	10	March 2019

Executive commentary for the Current Risk Score

The mitigated risk score is 20 which relates to early improved engagement internally and externally. Strengthening is required of the current action plans, the risk management strategy and framework, and the quality governance framework in order to provide sustained demonstrable improvements and associated assurances at ward, department and business group levels

Corporate objectives

2a. To aspire to the delivery of 'outstanding' clinical quality, safety and experience, which is equitable, person centred and supported by an effective quality governance framework and Quality and Safety Improvement Strategy

2b. To drive continuous quality improvement and promote research and innovation, whilst reducing unwarranted clinical variation and progressing toward an 'Outstanding' organisation.

Links to other Strategic Objectives:	SO3, SO4, SO5, SO7

Links to the Trust Risk Register (Current Risk Rating 15 & above)

Risk ID	Risk Title	Risk Rating	Date of Initial Assessment	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19
46	There is a risk that the telepath server will fail	20	06/04/2018				
130	Failure to deliver the 4 hour target	20	01/09/2017				

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

231	Lack of consultant microbiologists and nursing team in IP service	20	02/10/2017				
505	The risk of the lack of capacity in cellular pathology on turn round times and patient pathways	16	02/07/2018		Approved		
183	Failure to meet the 62 day Cancer target standards	20	20/04/2010		16 ↓		
429	Inadequate capacity to meet demand in Paediatric ADHD Services	16	14/02/2018				
506	There is a risk that winter pressures on ED, patient flow and capacity will affect delivery of 2018-19 elective plan in Ortho	16	11/06/2018				
261	There is a risk that, if the JetAer automated scope reprocesser fails, we will fail our Cancer Targets	16	27/10/2017		Closed		
125	Medical staff vacancies in Emergency Department	16	10/05/2016				
50	Risk of maternity diverts and clinical incidents related to unsafe staffing levels in maternity.	16	11/03/2015				
67	There is a risk to service delivery due to the lack of Consultant Microbiologist Cover	16	18/07/2017				
75	Lack of consultant in palliative care team	16	02/11/2016				
78	Registered Nurse Vacancies	16	21/11/2016	↓ from 20			
96	There is a risk of lack of capacity for timely outpatient reviews in the Ophthalmology	16	23/03/2017				
476	There is a risk of not achieving empiric review of antibiotic prescriptions and reduction in antibiotics CQUIN 18/19	15	09/05/2018		approved		
286	There is a risk to patient experience and safety due to Endoscopy Capacity and Demand	15	22/11/2017				
407	There is a risk to patient safety due to the number and length of the Respiratory Overdue Waiting List (non confirmed cancer)	15	04/03/2018				
408	There is a risk that if we have insufficient pharmacy resources to manage the increasing Haematology demand	15	05/03/2018				
576	There is a risk to patient safety due to the long wait of time to be seen by the Respiratory Team for new patients	15	01/06/2018				
499	There is a risk that complaints responses are not being completed within Trust timescales	15	07/06/2018				
126	Surges in demand in the Emergency Department	16	11/05/2016	↓ to 12			
137	Pressure ulcers	16	01/09/2016	↓ to 9			
160	Policies and procedures	15	17/11/2011	↓ to 8			
288	Central Venous Access Device Service	15	27/11/2017	↓ to 9			
362	Ketone Testing	15	04/02/2018	↓ to 9			

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

296	Blood Pressure monitors	15	06/12/2017	Closed			
358	Location of the AI unit	15	26/01/2018	↓ to 9			
346	Use of escalation beds	15	09/01/2018	Closed			

SO2							
Key Controls / Influences Established (What are we currently doing about the risk?)		**Key Controls / Influences (What additional controls should we seek?)**	**Assurance Providers 2018 / 2019 (How do we know if the things we are doing are having an impact?)**			**Gaps in Assurance on Controls / Influences (What additional assurances should we seek?)**	**Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)**
			Local Management (1st Line of Defence	**Corporate Oversight (2nd Line of Defence)**	**Independent / External (3rd Line of Defence)**		
1	Quality Governance Framework in place 2018/2020	• Revised monthly governance reports • Well-Led / Use of Resources initial review required (NHSI Framework).	• 1:1 Meetings • Team Meetings • Monthly Business Group Quality Boards • Quarterly Performance Meetings • Patient Quality Summit	• Quality Governance Group • QG and sub-groups key issues reports (KIR) • Quality Committee • QC KIR • Integrated Performance Report • Board of Directors • Alliance Provider Board • Quarterly BAF / Risk Register Report • Well-Led Review	• Quality Account • CQC rating RI in October 2017 • NHSI Improvement Board • Annual Governance Statement- April 2018 • Quarterly Review Meetings with NHSI • MIAA Review of Committees Report: Partial Assurance • CQC insights report	• Mock CQC inspection June 2018 • Externally facilitated Developmental Review NHSI Well Led Framework required in 2018	• Reports to Quality Committee from December 2017 with quarterly monitoring • Well-Led / Use of Resources Initial Review April 2018

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

2	Risk Management Strategy & Framework 2018/2020 in place with 6 key priorities	• Revised quarterly risk register reports at business group/corporate level in development. • Well-Led / Use of Resources initial review required (NHSI Framework).	• 1:1 Meetings • Team Meetings • Monthly Business Group Quality Boards • Quarterly Performance Meetings	• Quality Committee • QC KIR • Audit Committee • AC KIR • Board of Directors • Alliance Provider Board • Quarterly BAF / Risk Register Report • Well-Led Reviews	• Internal Audit Programme • Annual Governance Statement- April 2018 • MIAA Risk Management & Corporate Governance Report: Partial Assurance • Planned approval of new strategy May 2018 • Quarterly Review Meetings with NHSI • NHSI Improvement Board	• Externally facilitated Developmental Review NHSI Well Led Framework required in 2018	• Reports to Quality Committee from April 2018 and Audit Committee from May 2019 with quarterly monitoring • Well-Led / Use of Resources Initial Review April 2018
3	Infection Prevention & Control (IPC) Team and supporting strategies & policies	• MRSA Bacteraemia x 2 • Business case relating to IPC Service	• 1:1 / Team Meetings • Harm Free Care Panels • Monthly Business Group Quality Boards • Quarterly Performance Meetings	• Infection Prevention and Control Group • IPCG KIR • Quality Committee • QC KIR • Board of Directors • Integrated Performance Report	• CQC RI rating- October 2017 • CCG Contract meetings monthly • CCG Quality Visits • NHSE/NHSI Feedback • Single Oversight Framework		• Business Case being progressed

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

				• Monthly MESS data return • Account-April 2018	Segmentation • Quality Account-April 2019		
4	Maternity Dashboard	tbc					
5	Quality Improvement Strategy 2018/2019 implementation	• Data access & collective intelligence • Quarterly CQUIN reports	• 1:1 Meetings • Monthly Business Group Quality Boards • Monthly CQUIN report • Quarterly Performance Meetings	• Professional Advisory Group • Quality Safety and Improvement Strategy Group • Quality Governance Group • Quality • Committee • QC KIR • Board of Directors • Integrated Performance Report • Alliance Provider Board • Quarterly BAF / Risk Register Report • Well-Led Reviews	• CQC RI rating-October 2017 • CCG contract meetings monthly • CCG Quality Visits • NHSI Improvement Board • Monthly QIS reports • CQC Inpatient Survey-March 2019 • Internal Audit Programme • Quality Account-April 2019		• Quarterly review to commence June 2018 • Development of reports / data collection in progress including Model Hospital data.
6	Patient & Public Involvement Strategy implementation	PPI Strategy Patient Experience Strategy Carers Strategy	1:1 / Team Meetings	• Patient Experience Action Group	• CQC RI rating-October 2017 • CCG contract	• There is no current PPI, Patient	• Strategies to be developed and in place by Q4 2018/19

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

		Equality and Diversity Strategy		• Patient Experience Group • Quality Governance Group • Quality • Committee • QC KIR • People and Performance Committee • PPC KIR • Board of Directors • Integrated Performance Report • Alliance Provider Board • Quarterly BAF / Risk Register Report • Well-Led Reviews	meetings monthly • CCG Quality Visits • Monthly QIS reports • CQC Inpatient Survey-March 2019 • Internal Audit Programme • Quality Account-April 2019	Experience or Carers Strategy • An E&D strategy is in place	
7	Processes in place to deliver the CQUINs & Quality Schedule	• Data access & collective intelligence • Quarterly Performance Quality Reviews	• 1:1 / Team Meetings • Safety Collaboratives • Monthly CQUIN meetings	• Quality Governance Group • Quality • Committee • QC KIR • People and Performance Committee • PPC KIR	• CQC RI rating-October 2017 • CCG Contract meetings monthly • CCG Quality Visits • CQUIN Report exceptions: Internal Audit		• Development of reports / data collection in progress Q1

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

				• Board of Directors • Integrated Performance Report • Alliance Provider Board • Quarterly BAF / Risk Register Report • Well-Led Reviews	Programme • Quality Account-April 2019		
8	Safety Team established with objectives and associated policies & procedures	Data access & collective intelligence. Dashboards by CQC Domains Accreditation for Continued Excellence (ACE) Quarterly Quality Reviews Business Case to support Quality improvements completed	• 1:1 Meetings • Patient Safety Summit • Monthly Business Group Quality Boards • Monthly CQUIN report • Quarterly Performance Meetings	• Quality Governance Group • Quality • Committee • QC KIR • Board of Directors • Integrated Performance Report • Alliance Provider Board • Quarterly BAF / Risk Register Report • Well-Led Reviews	• CQC RI rating-October 2017 • CCG Contract meetings monthly • CCG Quality Visits • CQUIN Report exceptions: Internal Audit Programme • Quality Account-April 2019		• Progress Business Case
9	Governance Teams in place	• Review of Governance Team	• 1:1 Meetings • Patient Safety Summit	• Quality Governance Group	• CQC RI rating-October 2017 • CCG Contract	• Improving triangulation of data and	• Complete and progress Governance Team review

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

			• Patient Quality Summit • Monthly Business Group Quality Boards • Quarterly Performance Meetings	• Quality Committee • QC KIR • Board of Directors • Integrated Performance Report • Alliance Provider Board • Quarterly BAF / Risk Register Report • Well-Led Reviews	meetings monthly • CCG Quality Visits • Quality Account-April 2019	oversight in reports.	
10	Systems in place to address external clinical alerts		• 1:1 Meetings • Monthly Business Group Quality Boards • Quarterly Performance Meetings	• Quality Governance Group • QGG KIR • Quality Committee • QC KIR • Board of Directors • Integrated Performance Report • Alliance Provider Board • Quarterly BAF / Risk Register Report • Well-Led Reviews	• CQC RI rating-October 2017 • Quality Account-April 2019		

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

11	Quality Impact Assessment (QIA) Process	• QIA process in place – requires overarching document from May 2018.	• Programme/Project Team in place	• Medical Director & Chief Nurse reviews • Finance Improvement Group • FIG KIR • Finance and Performance Committee • F&P KIR • Board of Directors Board of Directors • Integrated Performance Report • Alliance Provider Board • Quarterly BAF / Risk Register Report • Well-Led Reviews	• Single Oversight Framework Segmentation • NHSI Improvement Board • CQC Good rating-January 2015 • CQC RI rating-October 2017 • Quality Account-April 2019 • Quarterly Review Meetings with NHSI	• Strengthen reporting and monitoring of QIA process	• Revised QIA Procedure to be implemented •
12	Adult & Child Safeguarding Team & policies & procedures.		• 1:1 Meetings • Patient Safety Summit • Patient Quality Summit • Monthly Business Group Quality Boards	• Safeguarding Group • SG KIR • Quality Committee • QC KIR • Board of Directors • Annual	• Local Safeguarding Adult's Board • Local Safeguarding Children's Board		

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

			• Quarterly Performance Meetings	Safeguarding Report (July 2018) • Alliance Provider Board • Quarterly BAF / Risk Register Report • Well-Led Reviews			
13	Nursing, Midwifery and Allied Health Professionals Strategy	Annual Strategic Staffing Reviews	• 1:1 Meetings	• Nurse Leadership walkarounds • Professional Advisory Group • Quality Governance Group • QGG KIR • Quality • Committee • QC KIR • Board of Directors • Integrated Performance Report • Alliance Provider Board • Quarterly BAF / Risk Register Report • Well-Led Reviews	• Single Oversight Framework Segmentation • NHSI Improvement Board • CQC Good rating-January 2015 • CQC RI rating-October 2017 • Quality Account-April 2019 • Quarterly Review Meetings with NHSI		

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

14	Learning from Deaths Policy & Mortality Review Process	Report to Quality Committee	• Mortality and Morbidity Reviews • Learning from Deaths Process • 1:1 Meetings • Patient Safety Summit • Patient Quality Summit • Monthly Business Group Quality Boards • Quarterly Performance Meetings	• Trust Mortality Reduction Group • CHKS and BIU data & reports • Quality Governance Group • QGG KIR • Quality • Committee • QC KIR • Board of Directors • Integrated Performance Report • Alliance Provider Board • Quarterly BAF / Risk Register Report • Well-Led Reviews • Quarterly Learning from Deaths Report from December 2017 • Quality Account-April 2019	• CQC RI rating-October 2017 • NHS Improvement data • CCG Contract meetings monthly • CCG Quality Visits • CQC Outlier Alert process • Nationally benchmarked mortality data • Advancing Quality Quarterly Safety Reports • Internal Audit Programme:	• Mortality data / reporting systems • Lack of triangulation	• Triangulated learning from deaths report • Mortality review structured assessment process • Deteriorating Patient Safety Collaborative April 2018
15	7 Day Clinical	Clinical Directors Forum	1:1 / Team	Quality Governance			

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

	Services		meetings • Business Group Quality Boards • Quarterly Performance Meetings	Group			
Adequacy of Assurance (Level of Confidence)			Significant				
Overall Assessment of Assurance			Partial				

Quarter 1 Commentary:	Clinical Services review was completed on the second of July to asses our position and improvement journey. Positive assurance for delivery of care. Areas of concern identified included safeguarding, polices and documentation. Safety and Quality Leadership meetings have commenced. Walk rounds by senior teams and governors have given positive assurance about patient experience.
Quarter 2 Commentary:	CQC unannounced inspection has been undertaken. Feedback has been mainly positive. Review and progress update has been undertaken on the Quality Governance Framework and Risk Management Framework and been viewed by sub-board committees. Review demonstrated partial assurance with both frameworks with further work to be undertaken.
Quarter 3 Commentary:	
Quarter 4 Commentary:	

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

Strategic Objective 3:
To strive to achieve financial sustainability

Principal risk	Risk of failure to maintain financial stability which may impact on the Trust's compliance with the NHS Improvement Provider Licence

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHS Improvement Oversight Framework	Accountable Executive Director	Executive Management Group	Designated Board Committee
July 2018	n/a as 1st assessment	October 2018	Well led NHSI -Finance and use of resources	Director of Finance	Executive Management Group Financial Improvement Group	Finance and Performance Committee

Risk Rating by Quarter

Graph here

Initial Risk Rating (Unmitigated)			Current Risk Rating (Mitigated)			Target Risk Rating (Tolerance / Risk Appetite)			
Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Target Date
4	5	20	4	3	12	4	1	4	31/03/2019

Executive commentary for the Current Risk Score

The mitigated risk score relates to urgent actions that the Trust must enact in order to deliver the financial plan. The Trust has delivered the financial plan at the end of quarter 2. Whilst the Trust delivered the CIP plan to the end of September, there remains a significant shortfall for the financial year.
If the action come within the planned parameters then the risk will reduce to a likelihood of 1

Corporate objectives

3a. To ensure full compliance with the NHSI Provider Licence, ensuring financial sustainability, financial efficiency and financial controls, whilst safeguarding the quality of our services
3b. To maintain compliance with, and aspire to achieve incremental improvements against, the NHS Improvement Single Oversight Framework Financial Performance Metrics, whilst safeguarding the quality of our services
3c. To review and monitor a revised performance management framework

Links to other Strategic Objectives:	SO1

Links to the Trust Risk Register (Current Risk Rating 15 & above)

Risk ID	Risk Title	Risk Rating	Date of Initial Assessment	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19
586	There is a risk due to the significant estate backlog in maintenance	20	21/06/2018		approved		
101	There is a risk that the Trust will not have sufficient cash reserves to operate	20	05/07/2017		10↓		
469	There is a risk that the Trust will not deliver its 2018/19 financial performance	20	30/04/2018				

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

458	There is a risk of not achieving the Theatre & Endoscopy CIP Programme 2018-19	16	19/04/2018				
461	There is a risk that Surgery, GI & Critical Care will not deliver the financial position required for 2018-19	16	23/04/2018				
466	There is a risk that the BG will fail to deliver the CIP Target	16	28/04/2018				
127	There is a risk that the BG overspends due to agency costs	16	22/06/2017				
476	There is a risk of not achieving empiric review of antibiotic prescriptions and reduction in antibiotics CQUIN 18/19	15	09/05/2018		approved		
305	There is a risk that the Trust will be unable to deliver statutory reporting responsibilities and core finance requirements	15	14/11/2017		↓10		
469	There is a risk that the Trust will not deliver its 2018/19 financial performance	20	30/04/2018		↓10		

SO2

Key Controls / Influences Established (What are we currently doing about the risk?)		Key Controls / Influences (What additional controls should we seek?)	Assurance Providers 2018 / 2019 (How do we know if the things we are doing are having an impact?)			Gaps in Assurance on Controls / Influences (What additional assurances should we seek?)	Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)
			Local Management (1st Line of Defence	Corporate Oversight (2nd Line of Defence)	Independent / External (3rd Line of Defence)		
1	Annual Plan & delegated budgets	• Availability / access to capital funding • Agency spending – medical & nursing • Long term health economy with clear governance structure	• COO & DOF bi-weekly meetings with SRO's • 1:1 / Team Meetings • Business Group Accountants 1:1s • Bi-weekly Exec-BG finance meetings • FIG • *FIG minutes/KIR* • EMG	• Bi-monthly Performance Meetings • Finance & Performance Committee • Internal Audit Reports to Audit Committee • Board of Directors • Board of Directors minutes	• NHS Improvement Segment 3 (July 2017) (Segment 3= Providers identified as 'Challenged' status). • NHS Improvement-submitted annual plans & feedback provided • Internal Audit	• Use of Resources metric assessment • Routine use of Model Hospital • Wider understanding of the Trust's financial challenge	• Transformation projects • Cost Improvement Plan • Quality Impact Assessments • CCG contract in place.
2	Identified CIP schemes	• Well-Led / Use of Resources initial review required (NHSI Framework).					
3	Monthly finance & activity review meetings	• Review of financial /activity delivery					

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

4	Performance management reporting systems	• Review of delivery and identification of improvement plan		• F&P Minutes/KIR • Annual budget/planning • Monthly Integrated Performance Report Contracting and activity finance group Quality Governance Committee	Programme • NHSI enhanced financial oversight meetings monthly • External interim CIP support • Executive contract Group with CCG		
5	Job descriptions contain financial responsibilities	• Clear accountability	Recruitment process				
6	CCG Contract	Review performance and agree improvement trajectories	Monthly CCG meetings				
7	CQUIN Schemes & process to deliver	Monthly meetings to ensure compliance	Monthly CCG meetings				
8	Monthly Performance Report	Identify any variance to plan or changes to forecast	• 1:1 / Team Meetings • Business Group Accountants 1:1s • Weekly CIP development meetings chaired by COO • Operational performance group to hold Business Group directors to account				
Adequacy of Assurance (Level of Confidence)							
Overall Assessment of Assurance			Partial				

Quarter 1 Commentary:	The trust has achieved its Q1 financial performance and is slightly behind on the CIP performance in the period. The trust faces considerable financial risk described above and needs to continue with close monitoring
Quarter 2 Commentary:	The Trust has delivered the financial plan at the end of quarter 2. Whilst the Trust delivered the CIP plan to the end of September, there remains a significant shortfall for the financial year.

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

	The Trust has drafted a recovery plan to provide high level assurance in delivery of the plan. However, due to a number of risks including: i) Winter escalation plan ii) Elective and day case performance iii) Impact of penalties the Trust is only able to forecast a moderate level of assurance. This issue is discussed at Finance and Performance committee, Board of Directors and NHSI Enhanced Oversight meetings.
Quarter 3 Commentary:	
Quarter 4 Commentary:	

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

BAF - Board Assurance Framework (October 2018)

NHS Stockport NHS Foundation Trust

Strategic Objective 4:
To achieve the best outcomes for patients through full and effective participation in local strategic partnership programmes including Stockport Together / Stockport Neighbourhood Care / Integrated Service Solution

Principal risk	**Risk of not continuing to develop effective external partnerships and alliances leading to failure to improve the health of the local population and reduce health inequalities, failure to develop new care pathways and failure to achieve long term clinical and financial sustainability and viability due to:** - **Lack of full engagement – being a key partner** - **Failure to engage effectively and lead the development of the local health economy** - **Lack of pace and appropriate scale to recognise the quality, economics and clinical benefits of change** - **Partners perceptions of working relationships with Stockport NHS Foundation Trust**

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHS Improvement Oversight Framework	Accountable Executive Director	Executive Management Group	Designated Board Committee
July 2018	n/a as 1st assessment	October 2018	Safe, effective, responsive and well led NHSI – Quality of care, operational performance, strategic change	Director of Support Services / Deputy Chief Executive	Executive Management Group	Alliance Provider Board

Risk Rating by Quarter

Graph here

Initial Risk Rating (Unmitigated)			Current Risk Rating (Mitigated)			Target Risk Rating (Tolerance / Risk Appetite)			
Consequence	**Likelihood**	**Risk Rating**	**Consequence**	**Likelihood**	**Risk Rating**	**Consequence**	**Likelihood**	**Risk Rating**	**Target Date**
4	5	20	4	5	20	4	5	20	31/03/2019

Executive commentary for the Current Risk Score

The governance arrangements have been reviewed a revised provider board is in place; however there is still ongoing delay with implementing the new models of care within the neighbourhoods and within outpatients. There is also the need to review progress with the ambulatory care model.

Corporate objectives

Links to other Strategic Objectives:

Links to the Trust Risk Register (Current Risk Rating 15 & above)

Risk ID	Risk Title	Risk Rating	Date of Initial Assessment	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19
	No risk on trust risk register						

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

BAF - Board Assurance Framework (October 2018)

NHS Stockport NHS Foundation Trust

SO2								
Key Controls / Influences Established (What are we currently doing about the risk?)		**Key Controls / Influences (What additional controls should we seek?)**	**Assurance Providers 2018 / 2019 (How do we know if the things we are doing are having an impact?)**			**Gaps in Assurance on Controls / Influences (What additional assurances should we seek?)**	**Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)**	
			Local Management (1st Line of Defence	**Corporate Oversight (2nd Line of Defence)**	**Independent / External (3rd Line of Defence)**			
1	Engagement in Stockport Provider Alliance Board	• Trust Strategy	• 1:1's • Team meetings	• Executive Management Group • Board of Directors	Greater Manchester Combined Authority	• Scale & pace of change • Relationship building with key partners • Governance Arrangements		
Adequacy of Assurance (Level of Confidence)								
Overall Assessment of Assurance			Partial					
Quarter 1 Commentary:		Revised arrangements are in place, however timescales within this are ambitious and may lead to further delay in expected outcomes						
Quarter 2 Commentary:		The governance arrangements have been reviewed a revised provider board is in place; however there is still ongoing delay with implementing the new models of care within the neighbourhoods and within outpatients. There is also the need to review progress with the ambulatory care model.						
Quarter 3 Commentary:								
Quarter 4 Commentary:								

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

BAF - Board Assurance Framework (October 2018)

NHS Stockport NHS Foundation Trust

Strategic Objective 5:
To secure full compliance with the requirements of the NHS Provider Licence through fit for purpose governance arrangements

Principal risk	Risk of not delivering the NHS Improvement Single Oversight Framework Operational Performance Metrics impacting on the quality of care we provide, patient and staff experience and the Trust's provider licence.

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHS Improvement Oversight Framework	Accountable Executive Director	Executive Management Group	Designated Board Committee
July 2018	n/a as 1st assessment	October 2018	Well led, safe NHSI Leaderhip and improvement capability	Chief Operating Officer	Executive Management Group	Finance and Performance Committee

Risk Rating by Quarter

Graph here

Initial Risk Rating (Unmitigated)			Current Risk Rating (Mitigated)			Target Risk Rating (Tolerance / Risk Appetite)			
Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Target Date
5	5	25	5	4	20	5	2	10	31/10/2018

Executive commentary for the Current Risk Score

Concerns around emergency Department performance, cancer waits and RTT. Plans are in place to enable improve the position recovery by end of Quarter 3

Corporate objectives

5a. The Trust will complete an independently assessed Well Led Review by 30 September 2018
5b. The Trust will maintain the 18 week RTT standards and achieve compliance with the cancer standards in order to improves access to care by 30 September 2018
5c. The Trust will comply with its trajectory for improvement against the 4 hour A&E target, with actions identified in the Stockport System Urgent Care Plan
5d. The Trust will progress the economy-wide plan to deliver consistent provision of healthcare needs across 7 days a week

Links to other Strategic Objectives:

Links to the Trust Risk Register (Current Risk Rating 15 & above)

Risk ID	Risk Title	Risk Rating	Date of Initial Assessment	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19
505	The risk of the lack of capacity in cellular pathology on turn round times and patient pathways	16	02/07/2018		Approved		
130	Non delivery of ED 4 hour performance	20	01/09/2017				
183	Failure to meet the 62 day cancer target standards	20	20/04/2010		↓16		

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

506	There is a risk that winter pressure son ED, patient flow and capacity will affect the delivery of the 2018 – 19 elective plan in ortho	16	11/06/2018				
96	There is a risk of lack of capacity for timely outpatient reviews in the ophthalmology department	16	23/03/2017				
286	There is a risk to patient experience due to Endoscopy capacity and demand	15	22/11/2017				
407	There is a risk to patient safety due to the number and length of the Respiratory Overdue Waiting List (non confirmed cancer)	15	04/03/2018				
408	There is a risk that if we have insufficient pharmacy resources to manage the increasing Haematology demand	15	05/03/2018				
162	There is a risk to the Trust maintaining unconditional CQC registration which may have a detrimental effect on patient safety, quality experience and Trust reputation	15	06/07/2017				

SO2

Key Controls / Influences Established (What are we currently doing about the risk?)		Key Controls / Influences (What additional controls should we seek?)	Assurance Providers 2018 / 2019 (How do we know if the things we are doing are having an impact?)			Gaps in Assurance on Controls / Influences (What additional assurances should we seek?)	Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)
			Local Management (1st Line of Defence	Corporate Oversight (2nd Line of Defence)	Independent / External (3rd Line of Defence)		
1	Bi- Monthly Performance Reports	External influences on medically fit for discharge patients Insufficient community capacity Failure to deliver sustainable Stockport Together programme	1:1/ 2:1 meetings Team Meetings Monthly Senior Management Team Meetings Monthly BG Boards Bi-Monthly Performance Management Group Meetings Operational	Finance & Performance Committee F&P minutes and KIR Board of Directors Executive Management Group	CQC rating overall NHSI Quarterly Review Meetings Cancer Peer Review Monthly CCG Contract Meetings Urgent and		

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

			Performance Group OPG minutes and KIR		Emergency Care Delivery Board Internal Audit Programme:		
	Improving patient flow programme	Staff engagement Transformation support Finance support Winning hearts and Minds Changing culture Embedded new practice	1:1/ 2:1 meetings Team Meetings Monthly Senior Management Team Meetings Monthly BG Boards Bi-Monthly Performance Management Group Meetings Finance improvement Group Operational Performance Group OPG minutes and KIR	Finance & Performance Committee F&P minutes and KIR Board of Directors Executive Management Group	CQC rating overall NHSI Quarterly Review Meetings Cancer Peer Review Monthly CCG Contract Meetings Urgent and Emergency Care Delivery Board Internal Audit Programme:		
	Quality Impact Assessment Process	Development of overarching document Completing the Quality Impact Assessments	1:1/ 2:1 meetings Team Meetings Monthly Senior Management	Medical Director and Chief Nurse & Director of Quality Governance	CQC rating Monthly CCG meetings NHSI Oversight	Strengthen reporting and monitoring of QIA process	

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

			Team Meetings Monthly BG Boards Bi-Monthly Performance Management Group Meetings Financial Improvement Group (FIG)	approval of QIAs F&P Committee Board of Directors			
	Emergency Planning (EP) & Business Continuity		1:1 meetings Desktop exercises	Emergency Planning Group Board of Directors *NHSE Emergency Preparedness, Resilience and Response Self-Assessment Substantial Assurance Return-October 2017 – did that go in*	Emergency Preparedness, Resilience and Response NHS England submitted-when did we submit?		
	Non elective performance	Capacity and demand oversight Analysis reports Data and KPI Performance monitoring	Urgent care operational group Programme development group	Urgent care delivery Board Executive management Group Finance and performance committee	CQC NHSI GMCA		

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

	Elective performance	Business Group PTL's Trust wide PTL's RTT and Cancer Monitoring OWL Clinical pathways Staff training	Operational performance group Cancer Board	Executive management Group Finance and performance committee	CQC NHSI GMCA		
Adequacy of Assurance (Level of Confidence)			Significant				
Overall Assessment of Assurance			Partial				

Quarter 1 Commentary:	Emergency department performance met improvement trajectory. RTT diagnostics and Cancer did not meet target. Quarter 2 trajectories have been realigned for improved performance. Significant assurance for diagnostics and cancer for quarter 2
Quarter 2 Commentary:	There has been a deterioration in the emergency department performance which has a direct correlation to the increased number of stranded patients which represent more than 50% of the acute trust bed base. The Board has agreed that patient flow will be the prime focus for improvement by reducing overnight breaches, earlier in the day discharges and stranded patients. It is recognised that the reduction of stranded patients requires a system wide solution. Diagnostics is compliant. Improvement trajectories for cancer are in place for Q3. The area of concern would be breast 2WW and this has been escalated to GM and NHSI for partner support and resolution. The RTT recovery plan has been complied in partnership with colleagues from the CCG based in the reduction of GP referred activity through CCG-led referral management schemes. Comprehensive data validation. A clinical review of discharge criteria and clinical management. We have commenced a review of inpatient medical ward management. The delivery director has commenced and has undertaken a full review of flow across the organisation and implemented a robust monitoring system to meet expected standards. Well led review in October.
Quarter 3 Commentary:	
Quarter 4 Commentary:	

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

BAF - Board Assurance Framework (October 2018)

NHS Stockport NHS Foundation Trust

Strategic Objective 6:
To develop and maintain an engaged workforce with the right skills, motivation and leadership

Principal risk	There is a risk that the trust fails to recruit, develop and retain suitably skilled and motivated workforce

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHS Improvement Oversight Framework	Accountable Executive Director	Executive Management Group	Designated Board Committee
July	n/a as 1st assessment	October 2018	Safe, effective responsive caring NHSI – use of resources	Director of Workforce & Organisational Development	Workforce efficiency Group Culture and Engagement Group	People and Performance Committee

Risk Rating by Quarter

Graph here

Initial Risk Rating (Unmitigated)			Current Risk Rating (Mitigated)			Target Risk Rating (Tolerance / Risk Appetite)			
Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Target Date
5	4	20	5	3	15	5	2	10	31/03/2019

Executive commentary for the Current Risk Score

Current mitigation includes recruitment and retention strategy. Comprehensive 3-5 year People Strategy approved at September Board. Comprehensive leadership and skills training and development programmes in place and emerging culture and engagement work using the NHSi Culture Programme.

Corporate objectives

6a. To develop our medical leaders into leaders of the future through a targeted development programme, on-going participation in triumvirate decision making through EMG and active attendance at the Clinical Directors Forum

6b.To continue to implement clinical leadership programmes which support the development of an inclusive and compassionate leadership culture, increase resilience and facilitate continuous improvement

6d. To develop a Workforce Strategy that reduces reliance and expenditure on contingent workforce through the continued streamlining of recruitment processes, improving nursing and AHP retention, expanding the medical bank and enhanced scrutiny of agency usage

Links to other Strategic Objectives:	SO2, SO3

Links to the Trust Risk Register (Current Risk Rating 15 & above)

Risk ID	Risk Title	Risk Rating	Date of Initial Assessment	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19
124	Use of temporary staffing	25	07/01/2016		↑20 from 12		

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

231	Lack of consultant microbiologists and nursing team in IP service	20	02/10/2017				
108	Failure to provide a robust imaging service due to reduced radiographer staffing	16	01/08/2016		↓8		
125	Medical staff vacancies in Emergency Department	16	10/05/2016				
50	Risk of maternity diverts and clinical incidents related to unsafe staffing levels in maternity.	16	11/03/2015				
67	There is a risk to service delivery due to the lack of Consultant Microbiologist Cover	16	18/07/2017				
75	Lack of consultant in palliative care team	16	02/11/2016				
78	Registered Nurse Vacancies	16	21/11/2016				
587	There is a risk to the operation of the Trust electronic systems due to the need to recruit senior IT Technical support	15	25/05/2018		approved		
408	There is a risk that if we have insufficient pharmacy resources to manage the increasing Haematology demand	15	05/03/2018				

SO2

Key Controls / Influences Established (What are we currently doing about the risk?)		Key Controls / Influences (What additional controls should we seek?)	Assurance Providers 2018 / 2019 (How do we know if the things we are doing are having an impact?)			Gaps in Assurance on Controls / Influences (What additional assurances should we seek?)	Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)
			Local Management (1st Line of Defence	Corporate Oversight (2nd Line of Defence)	Independent / External (3rd Line of Defence)		
1	Recruitment and retention strategy	GM theme 3 – employer banding and streamlining	WEG CEG Staff survey Workforce reports Staff friends and family Workforce KPI's Temporary staff meetings JLMC JNC Training needs analysis	People and performance Committee Executive management board Trust Board	Greater Manchester Combined authority NHSI CQC	Employment market – key skills shortage Building leadership skills to support change and improvement	Workforce remodelling Proactive workforce plan Just culture programme
2	Culture plan	Embedding the plan					
3	People strategy	Signed off strategy Embedded processes					
4	Operational plan	Delivery of plan					

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

			Schwartz rounds				
Adequacy of Assurance (Level of Confidence)			Partial				
Overall Assessment of Assurance			Partial				
Quarter 1 Commentary:	Good performance against workforce KPI's and significant progress in the development of the people strategy with active engagement from workforce groups						
Quarter 2 Commentary:	Key workforce KPIs remain stable. Recruitment to key medical posts. Agency spend above cap. Enhanced retention strategy and culture plan.						
Quarter 3 Commentary:							
Quarter 4 Commentary:							

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

BAF - Board Assurance Framework (October 2018)

NHS Stockport NHS Foundation Trust

Strategic Objective 7:
To create an environment that maximises the use of resources to improve efficiency, patient experience and clinical quality

Principal risk	Risk in not delivering the trust capital programme in a planned and efficient manner

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHS Improvement Oversight Framework	Accountable Executive Director	Executive Management Group	Designated Board Committee
July 2018	Not applicable	October 2018	Well led NHSI finance and use of resources	Director of Support Services / Deputy Chief Executive	Executive Management Group	Finance and Performance Committee

Risk Rating by Quarter

Graph here

Initial Risk Rating (Unmitigated)			Current Risk Rating (Mitigated)			Target Risk Rating (Tolerance / Risk Appetite)			
Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Target Date
4	3	12	4	4	16	4	3	12	31/03/2019

Executive commentary for the Current Risk Score

The mitigated risk score is 16 which relates to a reduced planed spend, agreed capital programme against risk assessed concerns. Benefits of EPR have not yet been realised and there is a delay in go live.

Corporate objectives

7a. To implement an Acute EPR in line with the programme timescales to improve efficiency osf systems and technology
7b. To refresh the Estates Strategy based on the six facet survey and master planning information
7c. To manage investment relating to the Trust's capital programme to:

I. Medical equipment
II. IT
III. Estates

Links to other Strategic Objectives:

Links to the Trust Risk Register (Current Risk Rating 15 & above)

Risk ID	Risk Title	Risk Rating	Date of Initial Assessment	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19
586	There is a risk due to the significant estate backlog in maintenance	20	21/06/2018		approved		
46	There is a risk that the telepath server will fail	20	06/04/2018		closed		

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

261	There is a risk that, if the JetAer automated scope reprocesser fails, we will fail our Cancer Targets	16	27/10/2017		closed		
167	Due to Lack of secure storage facilities on wards / units causing insecure patient records leading to failure of CQC / ICO standards in relation to confidentiality of patient information	16	29/09/2017				
513	There is a risk that ward kitchens in a poor state of repair may impact upon the ability to clean to required standards	15	14/06/2018		approved		
638	There is a risk to non compliant with HSE guidelines due to CL3 room acess and sealing	15	28/08/2018		approved		
399	There is a risk to patient care due to the potential Failure of PACs Infrastructure	15	27/02/2018	Closed			
354	The risk of abduction or paediatric patient absconding.	16	18/01/2018		closed		

SO2

Key Controls / Influences Established (What are we currently doing about the risk?)		Key Controls / Influences (What additional controls should we seek?)	Assurance Providers 2018 / 2019 (How do we know if the things we are doing are having an impact?)			Gaps in Assurance on Controls / Influences (What additional assurances should we seek?)	Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)
			Local Management (1st Line of Defence	Corporate Oversight (2nd Line of Defence)	Independent / External (3rd Line of Defence)		
1	Risk assessment for each area	Further review on all risks	CPDG	Executive management Group Finance and performance committee	Greater Manchester CA		
2	Signed off capital programme for 18/19 operational plan	Review when changed information	CPDG	Executive management Group Finance and performance committee	Greater Manchester CA		
Adequacy of Assurance (Level of Confidence)			Significant				
Overall Assessment of Assurance			Partial				

Quarter 1 Commentary:	There is a reduced planed spend, agreed capital programme against risk assessed concerns. Benefits of EPR have not yet been realised and there is a delay in go live.
Quarter 2 Commentary:	Use of resources has been completed. Our service improvement strategy is being developed to incorporate model hospital and other benchmarking systems. These will then be linked to the cost improvement programme. Financial risk around the capital programme

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

BAF - Board Assurance Framework (October 2018)

Quarter 3 Commentary:	
Quarter 4 Commentary:	

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

This page has been left blank

NHS
Stockport
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	31 October 2018
Subject:	Health Care Worker Flu Vaccination		
Report of:	Interim Director of Workforce & OD	**Prepared by:**	Deputy Director of Workforce & OD

REPORT FOR APPROVAL

Corporate objective ref:	S06
Board Assurance Framework ref:	S06
CQC Registration Standards ref:	E5
Equality Impact Assessment:	☐ Completed ☒ Not required

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

The purpose of this paper is to present the Healthcare worker flu vaccination best practice management checklist which is required to be completed and published for public assurance via trust boards by December 2018

The Board of Directors are asked to approve the self-assessment detailed at appendix one

Attachments: Appendix 1 – Healthcare worker flu vaccination best practice management checklist

This subject has previously been reported to:

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

- THIS PAGE IS INTENTIONALLY BLANK -

1. INTRODUCTION

1.1 The purpose of this paper is to present the Healthcare worker flu vaccination best practice management checklist which is required to be completed and published for public assurance via trust boards by December 2018. This checklist was provided in a letter in September to all NHS Providers from representatives from NHS England, Public Health England, National Social Partnership Forum, Royal College of Nursing, Academy of Medical Royal Colleges, NHS Improvement, the Academy for Healthcare Science & the Royal College of Midwives. A copy of this letter is available at the following: http://www.nhsemployers.org/-/media/Employers/Documents/Flu/20180907-HCW-flu-vaccination-letter-FINAL.pdf?la=en&hash=B7DE4FCF28A044BB12D7C3FB18D8A6E007437D4D

2. BACKGROUND

2.1 In September 2018 a letter from representatives of the organisations detailed above was sent to all NHS providers in which it requires a request that organisations demonstrate they are doing everything possible as an employer to protect patients and staff from seasonal flu we ask that you complete the best practice management checklist for healthcare worker vaccination [appendix 1] and publish a self-assessment against these measures in your trust board papers before the end of 2018.

The request also requires that by February 2019 we expect each trust to use its public board papers to locally report their performance on overall vaccination uptake rates and numbers of staff declining the vaccinations, to include details of rates within each of the areas you designate as 'higher-risk'. This report should also give details of the actions the Trust has undertaken to deliver the 100% ambition for coverage this winter.

3. CURRENT SITUATION

3.1 The Trust Flu Immunisation Campaign commenced on 1st October 2018 and is supported by a robust immunisation plan, with link nurses; OH clinics and the pharmacy shop all providing access to the flu jab. There is a monthly workforce flu strategy group, reporting to people performance committee, monitoring the update of the vaccinations and ensuring the ongoing communications and promotional messages to support staff in ensuring that they are vaccinated.

3.2 The performance of the number of vaccinations is provided weekly to all staff; Business Group Managers are also supported by receiving a monthly staff list which details those staff who have and those who are yet to have their vaccination. The list will also detail the staff who have declined a vaccination and the reason for this, as required by appendix 2 of the letter available in the link detailed above. Performance will also be reported via the IPR to the Board of Directors from November, throughout the 'flu season'.

4. RISK & ASSURANCE

4.1 The Board of Directors are can be assured by the governance process described in section 3 above and the detail provided in the attached appendix one that all appropriate actions are being taken and the impact monitored in order to work towards the aim of achieving the ambition of 100% of front line healthcare workers being vaccinated

5. RECOMMENDATIONS

5.1 The Board of Directors are asked to approve the self-assessment detailed at appendix one and to note the following specific actions:

- Board record commitment to achieving the ambition of 100% of front line healthcare workers being vaccinated, and for any healthcare worker who decides on the balance of evidence and personal circumstance against getting the vaccine should anonymously mark their reason for doing so.
- Agree on a board champion for flu campaign
- All board members receive flu vaccination and publicise this

Appendix 1 - Healthcare worker flu vaccination best practice management checklist – for public assurance via trust boards by December 2018

A	Committed leadership	Trust self-assessment
A1	Board record commitment to achieving the ambition of 100% of front line healthcare workers being vaccinated, and for any healthcare worker who decides on the balance of evidence and personal circumstance against getting the vaccine should anonymously mark their reason for doing so.	✓
A2	Trust has ordered and provided the quadrivalent (QIV) flu vaccine for healthcare workers.	✓ - this is complete
A3	Board receive an evaluation of the flu programme 2017-18, including data, successes, challenges and lessons learnt	✓ - Presented to PPC in April 2018
A4	Agree on a board champion for flu campaign	✓ - Director of Workforce & OD
A5	Agree how data on uptake and opt-out will be collected and reported	✓ - this is complete a process has been designed
A6	All board members receive flu vaccination and publicise this	TBC
A7	Flu team formed with representatives from all directorates, staff groups and trade union representatives	✓ - representatives at the Workforce Flu Strategy Group
A8	Flu team to meet regularly from August 2018	✓ - monthly meetings
B	**Communications plan**	
B1	Rationale for the flu vaccination programme and myth busting to be published – sponsored by senior clinical leaders and trade unions	✓ - flu communications have commenced. Weekly Update from Medical Director complete.
B2	Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper	✓ - this is complete
B3	Board and senior managers having their vaccinations to be publicised	✓ - this is ongoing
B4	Flu vaccination programme and access to vaccination on induction programmes	✓ - this is complete, the flu link nurses attend induction.
B5	Programme to be publicised on screensavers, posters and social media	✓ - this is complete, screen savers have been loaded and posters and social media campaign is in place.
B6	Weekly feedback on percentage uptake for directorates, teams and professional groups	✓ - weekly performance information is provided.
C	**Flexible accessibility**	
C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered	✓ - we have trained a number of flu link nurses and continue to train more as required.
C2	Schedule for easy access drop in clinics agreed	✓ - this is complete and the pharmacy shop are vaccinating during opening hours.
C3	Schedule for 24 hour mobile vaccinations to be agreed	✓ - 2 night matrons vaccinating
D	**Incentives**	
D1	Board to agree on incentives and how to publicise this	✓ - we have a costa voucher for all vaccinated up to 14/10/18; but need to consider how we are going to incentivise after this initial 2 week period.
D2	Success to be celebrated weekly	✓ - this is complete, see B6 above

This page has been left blank

NHS
Stockport
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	31 October 2018
Subject:	2018/19 Emergency Preparedness, Resilience & Response (EPRR) Assurance		
Report of:	Accountable Emergency Officer (Hugh Mullen)	**Prepared by:**	EPRR Manager

REPORT FOR APPROVAL

Corporate objective ref: -----	**Summary of Report** *Identify key facts, risks and implications associated with the report content.* NHS organisations are required to participate in an annual Emergency Preparedness, Resilience & Response (EPRR) assurance process. The Trust has undertaken a self-assessment against the NHS England Core Standards for EPRR, and declares itself as **substantially** compliant against the 2018/19 standards. The Board is asked to approve the EPRR Core Standards Action Plan 2018/19, which when completed will ensure full compliance against the standards.
Board Assurance Framework ref: -----	
CQC Registration Standards ref: -----	
Equality Impact Assessment: ☐ Completed ☒ Not required	

Attachments:	Annex A – Overall Assessment of Compliance 2018/19 Annex B – EPRR Core Standards Action Plan 2018/19

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

- THIS PAGE IS INTENTIONALLY BLANK -

1. INTRODUCTION

1.1 As part of the NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework, providers and commissioners of NHS funded services must show they can effectively respond to major, critical and business continuity incidents whilst maintaining services to patients.

1.2 NHS England Core Standards for EPRR set out the minimum requirements expected of providers for NHS funded services in respect of EPRR.

2. BACKGROUND

2.1 The purpose of this self-assessment process is to assess levels of preparedness within the NHS (commissioners and providers) against common NHS EPRR Core Standards.

3. CURRENT SITUATION

3.1 The Trust has undertaken a self-assessment against the NHS England Core Standards for EPRR, and declares itself as **substantially compliant** against the 2018/19 standards.

3.2 Substantial compliance means there are EPRR arrangements in place across the Trust, however, they do not appropriately address a small number (9) of the Core Standards that the organisation is expected to achieve.

4. RISK & ASSURANCE

4.1 In the period immediately following the Manchester Arena Attack and up until this point last year engagement around EPRR within the Trust was good, however since then engagement has slipped and a number of key individuals have left the Trust.

4.2 The Board need to be aware that the last two scheduled meetings of the Trust EPRR Group had to be cancelled due to poor attendance – the group last met in March 2018. Regular, well attended meetings with representation across the Trust is key to maintaining the momentum of the group, and ensuring the Trust's overall resilience.

4.3 The decline in engagement and loss of key individuals is evident in a number of the standards assessed as 'Partially Compliant'.

4.4 An action plan is attached (see Annex B) detailing improvement/actions required to achieve full compliance.

5. CONCLUSION

5.1 The Trust has EPRR arrangements in place. The action plan in Annex B will address areas of Non-Compliance (1) and Partial Compliance (8), and will ensure full compliance.

6. RECOMMENDATIONS

6.1 It is recommended that the Board approve the EPRR Core Standards Action Plan.

ANNEX A:

Please select type of organisation: **Acute Providers**

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	14	13	1	0
Command and control	2	2	0	0
Training and exercising	3	3	0	0
Response	7	7	0	0
Warning and informing	3	3	0	0
Cooperation	4	6	1	0
Business Continuity	9	7	2	0
CBRN	14	11	3	0
Total	64	60	7	0

Deep Dive	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Incident Coordination Centres	4	3	1	0
Command structures	4	3	0	1
Total	8	6	1	1

Overall assessment:	Substantially compliant

Instructions:
Step 1: Select the type of organisation from the drop-down at the top of this page
Step 2: Complete the Self-Assessment RAG in the 'EPRR Core Standards' tab
Step 3: Complete the Self-Assessment RAG in the 'Deep dive' tab
Step 4: Ambulance providers only: Complete the Self-Assessment in the 'Interoperable capabilities' tab
Step 5: Click the 'Produce Action Plan' button below

Produce Action Plan (Populate Action Plan tab)

ANNEX B:

Overall assessment:			Substantially compliant					
Ref	**Domain**	**Standard**	**Detail**	**Self assessment RAG**	**Action to be taken**	**Lead**	**Timescale**	**Comments**
17	**Duty to maintain plans**	**Mass Countermeasures**	In line with current guidance and legislation, the organisation has effective arrangements in place to distribute Mass Countermeasures - including the arrangement for administration, reception and distribution, eg mass prophylaxis or mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop Mass Countermeasure distribution arrangements. These will be dependant on the incident, and as such requested at the time. CCGs may be required to commission new services dependant on the incident.	Partially compliant	See GM response in 'Comments' Section.	J.Kilheeney	31/12/2018	GM have advised the compliance for this has been recorded as partial as it is unclear what the expectations are. It is difficult to realistically assess as the field is too extensive and does not provide a context for nationally led intervention and/or guidance.

40	**Cooperation**	**LRHP attendance**	The Accountable Emergency Officer, or an appropriate director, attends (no less than 75%) of Local Health Resilience Partnership (LHRP) meetings per annum.	Partially compliant	Clarity to be sought (via GMAG) around the expectation of AEO attendance.	J.Kilheeney	31/12/2019	Whilst there is Acute Trust representation and attendance at the GM LHRP by an acute AEO / ED Consultant and GMAG Chair who feedback to their peer groups. There is currently no agreement in GM for AEO's to attend no less than 75% of LHRP meetings as they have not been invited to attend.
51	**Business Continuity**	**Business Continuity Plans**	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to:• people• information and data• premises• suppliers and contractors• IT and infrastructureThese plans will be updated regularly (at a minimum annually), or following organisational change.	Partially compliant	Review Service Classifications	J. Kilheeney / EPRR Group	31/03/2019	Trust Services have a Business Continuity Plan which are reviewed as per their service classification. Their service classification is based on the maximum period of tolerable disruption (MPTD). Services with a classification of 0 or 1 (for example ED & Theatres) are reviewed annually. Services classed as 2 or 3 and able to tolerate a longer period of disruption (e.g. clinic administration & training) are reviewed every 2 years (class 2) or every 3 years (class 3).

55	**Business Continuity**	**Assurance of commissioned providers / suppliers BCPs**	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers arrangements work with their own.	Partially compliant	Action to be picked up as a work stream of the Trust EPRR Group.	EPRR Group	31/03/2019	There is no system in place to check/ensure robust BC arrangements are in place with other NHS Providers we commission services from. NHS Supplies (our largest supplier of consumables) has a business continuity plan which has been shared with the Trust. In addition, procurement request BC plans from suppliers when awarding large tenders.
65	**CBRN**	**HAZMAT / CBRN training lead**	The current HAZMAT / CBRN Decontamination training lead is appropriately trained to deliver HAZMAT / CBRN training	Partially compliant	Increase the number of ED staff able to deliver HAZMAT/CBRN training	S. Plummer	31/03/2019	There is currently only one member of ED staff trained to deliver HAZMAT/CBRN training. ED management have plans in place to increase this number.
66	**CBRN**	**Training programme**	Internal training is based upon current good practice and uses material that has been supplied as appropriate. Training programme should include training for PPE and decontamination.	Partially compliant	Increase the frequency of training sessions.	S. Plummer	31/03/2019	To ensure there are CBRN trained staff on every shift and they are able to respond (full response requires minimum of 5 staff).

67	**CBRN**	**HAZMAT / CBRN trained trainers**	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.	Partially compliant	Increase the number of ED staff able to deliver HAZMAT/CBRN training	S. Plummer	31/03/2019	
3	**Incident Coordination Centres**	**Equipment testing**	ICC equipment has been tested every three months as a minimum to ensure functionality, and corrective action taken where necessary.	Partially compliant	Functionality of rooms are currently undertaken every 6 mths. EPRR Work Plan to be amended to reflect 3 mthly requirement.	J. Kilheeney	31/12/2018	
8	**Command structures**	**Recovery planning**	The organisation has a documented process to formally hand over responsibility from response to recovery.	Non compliant	Document to be written.	J. Kilheeney	31/03/2019	