NHS
Stockport
NHS Foundation Trust

BOARD OF DIRECTORS

PUBLIC MEETING

24 MAY 2018

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Board of Directors bundle - PUBLIC MEETING - 24 May 2018

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Board of Directors Meeting
Thursday, 24 May 2018

Held at 9.30am in Lecture Theatre A, Pinewood House, Stepping Hill Hospital

AGENDA

Time			Enc	Presenting
0930	**1.**	Apologies for absence		
	2.	Declaration of Interests		
	3.	Opening Remarks by the Chair		
0935	**4.**	Patient Story		**A Lynch**
	5.	**OPENING MATTERS**		
0950	5.1	Minutes of Previous Meeting: 26 April 2018	✓	**A Belton**
0955	5.2	Chair's Report	✓	**A Belton**
1000	5.3	Chief Executive's Report	*Verbal*	**H Thomson**
1005	5.4	Key Issues Reports from Assurance Committees • Quality Committee • Finance & Performance Committee • People Performance Committee	✓	**Committee Chairs**
	6.	**PERFORMANCE**		
1020	6.1	Performance Report	✓	**H Mullen**
1050	6.2	Presentation - Urgent & Emergency Care Improvement Director	*Verbal*	**J Wood**
	7.	**FINANCE & QUALITY**		
1100	7.1	Quality Improvement Plan	✓	**A Lynch**
1110	7.2	Risk Management Strategy & Framework	✓	**A Lynch**
	8.	**GOVERNANCE**		
1120	8.1	Review of Undertakings – Progress Report	✓	**H Thomson**
1130	8.2	Annual Governance Statement 2017/18	✓	**P Buckingham**
1140	8.3	Governance Declarations	✓	**P Buckingham**
1150	8.4	Trust Risk Register	✓	**A Lynch**
	9.	**CONSENT AGENDA**		
1200	9.1	• Code of Governance Compliance Report	✓	

10. DATE, TIME & VENUE OF NEXT MEETING

10.1 Thursday, 28 June 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, 26 April 2018 2018 10.00am in Lecture Theatre A, Pinewood House, Stepping Hill Hospital

Present:

Mr A Belton	Chair
Mrs C Anderson	Non-Executive Director
Mrs C Barber-Brown	Non-Executive Director
Dr M Cheshire	Non-Executive Director
Mr J Sandford	Non-Executive Director
Ms A Smith	Non-Executive Director
Mr M Sugden	Non-Executive Director
Mr P Buckingham	Director of Corporate Affairs
Mrs H Brearley	Interim Director of Workforce & OD
Mrs 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
Dr C Wasson	Medical Director

In attendance:

Mrs S Curtis	Membership Services Manager
Ms C Drysdale	Managing Director, Stockport Neighbourhood Care
Mr S Goff	Deputy Chief Operating Officer
Mr P Gordon	Freedom to Speak Up Guardian
Dr R Bell	Consultant Endocrinologist
Ms K Marsden	Diabetes Specialist Nurse
Ms J O'Brien	Diabetes Specialist Midwife
Ms L O'Shaughnessy	Diabetes Specialist Nurse
Ms R Thurlow	Diabetes Educator
Ms A White	Diabetes Specialist Nurse

91/18 Apologies for Absence

An apology for absence had been received from Ms S Toal. The Chair welcomed Mr S Goff who was deputising for the Chief Operating Officer. The Chair also welcomed Mrs H Brearley, Interim Director of Workforce & OD, to her first Board meeting.

92/18 Declaration and Annual Review of Interests

The Director of Corporate Affairs presented a report, the purpose of which was to present the Board of Directors' Register of Interests for annual review. He noted that the current Register of Directors' Interests was included for reference at Annex A to the report and requested Board members to review the Register and confirm that the current content was accurate and up to date. Mrs C Barber-Brown noted an amendment to the following interest:

- Co-opted Governor, Gorsey Bank Primary School.

The Board of Directors:

- Completed an annual review of the Register of Interests and confirmed that content was accurate subject the above amendment to the entry for Mrs C Barber-Brown.

(1 minute)

93/18 Patient Story

The Board of Directors welcomed the Diabetes Team to the meeting. The Medical Director noted that this was an opportunity to showcase and reflect on the positive progress made in Diabetes care. He also wished to thank the Diabetes Team for the way in which the new hypoglycaemia guidance had been cascaded across the Trust. The Diabetes Team advised the Board that the new hypoglycaemia guidance had been launched during the previous week to all wards and departments and that it had received a positive response. The Board received a brief overview of the hypoglycaemia guidelines and quality initiatives and was advised that the use of intravenous insulin guidelines had also been relaunched.

The Board then received an overview of Diabetes training and the Trust's participation in a Quality Improvement Hub. The Medical Director thanked the Diabetes Team for the useful overview and wished to commend the team for the significant work they had undertaken over the past 12 months. In response to a question from the Managing Director of Stockport Neighbourhood Care, regarding educating patients about Diabetes care, Dr R Bell noted that majority of the team worked across both the hospital and the community and were excellent educators. He noted that the issue was that not all patients had access to the team. Dr R Bell also commented on the importance of the environment when educating patients and noted that this was better undertaken post discharge, away from the hospital. The Board was advised that proforma guidance was being prepared to inform patients about Diabetes self-management.

Dr R Bell raised a concern about the lack of a community-wide hypoglycaemia strategy in Stockport and agreed to discuss this issue further with the Managing Director of Stockport Neighbourhood Care. In response to a question from the Chair regarding patient feedback, the Board was advised that patient satisfaction would be a focus of the Quality Improvement Hub and that questionnaires would be undertaken in this area. Dr R Bell commented that work was still required to empower patients to administer their insulin at hospital. In response to a question from the Chair, the Board was advised that that Diabetes work was being promoted via a number of communications channels, including Facebook and Twitter.

The Board of Directors:

- Received and noted the Patient Story.

(17 minutes)

Dr R Bell, Ms K Marsden, Ms J O'Brien, Ms L O'Shaughnessy, Ms R Thurlow and Ms A White left the meeting.

94/18 Minutes of the previous meeting

The minutes of the previous meeting held on 29 March 2018 were agreed as a true and accurate record of proceedings. The action log was reviewed and annotated accordingly.

(2 minutes)

95/18 Report of the Chair

The Chair presented a report which included information with regard to notable events, matters concerning the development of the Board, Chair engagements, any significant regulatory developments that the Chair had been involved in and a forward look to significant events or possible developments. He noted that as part of his visit to the Estates Department on 24 April 2018, he had undertaken an interesting tour of the hospital's underground tunnels. It was consequently proposed that to link in with the Board's consideration of the Estates Strategy in June 2018, the Director of Support Services would organise a similar tour of the hospital site and tunnels for the Board of Directors.

The Board of Directors:

- Received and noted the Report of the Chair.

(1 minute)

96/18 Report of the Chief Executive

The Interim Chief Executive presented a report which included information with regard to national and local strategic and operational developments. She briefed the Board on the content of the report and advised the Board of the outcome of the most recent Quarterly Review Meeting held with NHS Improvement representatives on 12 April 2018. The Interim Chief Executive noted that the subject of the Review of Undertakings had been discussed and that it had been agreed that a progress report against the recommendations arising from the review would be prepared for consideration by the Board on 24 May 2018. She advised that the Trust's preparations for a Well Led Review had also been discussed and that it had been noted that the Trust would be subject to a CQC Well Led Review by 31 March 2019. The Interim Chief Executive concluded her report by advising the Board that NHS Improvement had appointed Ms Jayne Wood as the Trust's Urgent & Emergency Care Improvement Director for a period of six months, with effect from 30 April 2018.

The Board of Directors:

- Received and noted the Report of the Chief Executive.

(1 minute)

97/18 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 17 April 2018 and provided a brief overview of content. He made reference to the Committee's agreement that a standard set of questions should be developed for use by Groups and Committees when considering Risk Register content. In response to a comment from Mr J Sandford, it was agreed that progress on preparation of 'standard questions' for Risk Register reviews would be reported to the Board of Directors on 24 May 2018. Dr M Cheshire noted that another positive development was the continued improvement of the Quality Metrics. On a less positive note, he reported that the Committee had noted a continuing deterioration of discharge summary performance and advised that this was an area which would be closely monitored by the Committee.

In response to a question from the Chair, the Chief Nurse noted concerns regarding the impact of the introduction of the General Data Protection Regulations (GDPR), including potential resource issues, and commented that this subject area was still very much an unknown quantity. She advised that GDPR was included on the Trust's Risk Register and that the Trust had a plan in place, as far as it was able to at this stage. Mr J Sandford advised that the Audit Committee received regular updates with regard to the Trust's readiness for GDPR implementation and commented that the Trust was currently on track to meet the implementation deadline of 25 May 2018. He noted a concern regarding the potential increase in the number of subject access requests and was pleased to hear that the Trust had plans in place regarding resources.

(6 minutes)

Finance & Performance Committee

Mrs C Barber-Brown presented a Key Issues Report which detailed matters considered at a meeting of the Finance & Performance Committee held on 18 April 2018 and provided a brief overview of content. She reported that the Committee had spent considerable time discussing the content for a comprehensive report to accompany the Final Operational Plan 2018/19. Mrs C Barber-Brown advised that the Committee had been pleased to note that the Trust's Stroke service had been A-rated in recently released national data. On another positive note, the Committee had been advised of good progress made on closure of winter escalation beds.

The Director of Corporate Affairs made reference to the Trust's achievement of the agency ceiling target for 2017/18 which, he noted, was particularly commendable given the Trust's position six months ago. In response to a question from the Chair, the Director of Corporate Affairs commented that the improved position was testament to the ongoing work to enhance substantive recruitment and a joint effort by the clinical leadership, the workforce team and nursing team regarding increased rigour around agency staffing. In response to a question from the Chair, regarding embedding the improvements, the Interim Chief Executive noted a lower agency ceiling for 2018/19 and the associated challenges for the Trust. Ms A Smith made reference to lessons learnt during the year, an improved quality of reporting and proactive work undertaken in this area.

Dr M Cheshire noted a national issue relating to a cap on the number of Visas that could be issued to overseas Doctors. In response to a question from the Chair, the Interim Chief Executive advised that this was a national issue out of the Trust's control. Ms A Smith commented that this issue had been discussed at the most recent People Performance Committee meeting and advised that conversations were ongoing between the Home Office and the Department of Health with regard to the matter. The Board of Directors raised a collective concern with regard to the issue and the Interim Director of Workforce & OD agreed to raise it with the Greater Manchester HR Directors. In response to a request from the Interim Chief Executive, the Improvement Director agreed to raise the issue with NHS Improvement.

In response to a question from Mr M Sugden regarding availability of performance metrics for Stockport Neighbourhood Care, the Managing Director of Stockport Neighbourhood Care confirmed that metrics were being progressed. The Director of Support Services noted production of a revised Integrated Performance Report and previous agreement that incorporation of Stockport Neighbourhood Care metrics would be reviewed at the end of Quarter 1 2018/19.

(9 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 19 April 2018 and provided a brief overview of content. With regard to the key subject areas, Ms A Smith noted the national issue with regard to a cap on Visas issued for overseas Doctors, which had been raised earlier at the meeting. She also noted positive assurance with regard to agency expenditure and reports presented by the Freedom to Speak Up Guardian and the Guardian of Safe Working. Ms A Smith advised that the Committee had considered the results of the 2017 Staff Survey in detail and noted that a report on this subject would be considered later on the agenda. She also noted the Committee's consideration of the Corporate Risk Register, a report on progress made against patient safety issues highlighted by Health Education England North West and a report on lessons learnt with regard to the flu vaccination programme.

(3 minutes)

The Board of Directors:

- Received and noted the Key Issues Reports.

98/18 Trust Performance Report – Month 12

The Deputy Chief Operating Officer presented the Performance Report which summarised the Trust's performance against the NHSI Single Oversight Framework for the month of March 2018, including the key risks to delivery. He advised that the report also provided a summary of the key risk areas within the Integrated Performance Report which was attached in full in Annex A. The Deputy Chief Operating Officer advised that there were three areas of non-compliance in month which were the non-achievement of the Accident & Emergency (A&E) 4-hour target,

the Referral to Treatment (RTT) standard and the 6-week Diagnostic target. He noted that the Trust had achieved the Cancer 62-day standard in month. The Deputy Chief Operating Officer noted the direct impact of winter pressures on the non-achievement of the RTT standard and advised that non-compliance of the 6-week Diagnostic target had been due to the lack of availability of additional capacity that was routinely required to support delivery of this standard.

The Deputy Chief Operating Officer advised the Board of a significant improvement in the Trust's A&E performance over the past two weeks. He also reported that the Trust had fully recommenced its surgical programme and closed all winter escalation beds. The Deputy Chief Operating Officer and the Medical Director commented that these were significant achievements which had had a consequent positive effect on staff morale. In response to a question from Dr M Cheshire, the Deputy Chief Operating Officer advised that the cause for the change was multi-factorial. He noted that the cumulative effect of a number of initiatives and increased rigour put into the system over the winter period was finally bearing fruit which had led to increased discharges and improved flow. The Deputy Chief Operating Officer noted that the acuity of patients had changed which had also contributed to the improved position. The Medical Director endorsed these comments and advised that planning had already commenced for next year with regard to admission avoidance and discharge planning.

In response to a question from the Chair, who queried how routinely the effectiveness of initiatives was evaluated and how best practice was embedded at system level, the Deputy Chief Operating Officer advised the Board that a session led by the Clinical Commissioning Group would be held at Edgeley Park on 27 April 2018 to undertake this evaluation. In response to a question from Mr M Sugden, the Deputy Chief Operating Officer advised that the Trust was working with the North East Commissioning Support Unit to ensure that embedding the changes become part of Business Group ownership, therefore reducing senior oversight. In response to a question from Mr J Sandford, who queried actions taken to reduce the daily variation in A&E performance, the Deputy Chief Operating Officer reiterated his earlier comment around embedding processes to enable the reduction in senior oversight. He also noted the importance of 7-day services in enabling sustainable improvement.

In response to a question from Mrs C Anderson, the Medical Director briefed the Board on challenges in the area of 7-day working and noted ongoing work with Business Groups to consider the possibility of realignment of existing resources. He also advised that the Trust was learning best practice through regional engagement and noted that Dr S Krishnamoorthy was leading a 7-day services audit during week commencing 30 April 2018. In response to a further question from Mrs C Anderson, the Medical Director briefed the Board on the way in which the Trust was prioritising areas for 7-day services to ensure maximum benefits. The Managing Director of Stockport Neighbourhood Care also commented on the challenges with regard to 7-day services and provided an overview from a community services and Stockport Together perspective. The Director of Finance endorsed the comments made by the Medical Director and the Managing Director of Stockport Neighbourhood Care and noted the need to realign existing resources as the physical resource was not available locally or nationally.

In response to a question from Mr J Sandford, Mrs C Barber-Brown advised that the Finance & Performance Committee had requested an update report from the Chief

Operating Officer on Outpatient Waiting List performance. The Interim Director of Workforce & OD then briefed the Board on the Workforce section of the report and made particular reference to the improved performance in medical appraisals. She commented on the Trust's focus to improve sickness absence, vacancy rates and retention to improve organisational performance and stability. In response to a question from Ms A Smith, the Interim Director of Workforce & OD advised that basic life support training was mandatory for clinical staff and agreed to include further information in next month's report with regard to the Trust's compliance in this area.

The Director of Finance briefed the Board on the Finance section of the report and was pleased to report that the Trust had achieved the financial position agreed with NHS Improvement for 2017/18. On another positive note, he reported that the Trust had not required support from the Independent Trust Financing Facility during 2017/18. On a less positive note, the Director of Finance briefed the Board on performance with regard to Elective income and Cost Improvement Programme, both which were behind plan. He noted that the issue of financial challenges would be further discussed later on the agenda during consideration of the Operational Plan report.

The Chief Nurse briefed the Board on the Quality section of the report and was pleased to report that the Trust had achieved the Clostridium Difficile target and partially achieved the Falls target. She advised that, as expected, the Trust had not achieved the Pressure Ulcer target and briefed the Board on actions following non-achievement of the MRSA target. The Chief Nurse advised that information with regard to STEIS reported incidents would be included in future Integrated Performance Reports. She advised that there had been 14 STEIS reported incidents in March 2018, none of which had resulted in physical harm to patients. In response to a question from Ms A Smith, the Interim Chief Executive advised that progress against the Urgent & Emergency Care Recovery Plan would be reported to the Board on 26 July 2018.

The Board of Directors:

- Received and noted the contents of the Trust Performance Report
- Noted the position for Month 12 compliance standards
- Noted the future risks to compliance and corresponding actions to mitigate
- Noted the key risk areas from the Integrated Performance Report.

(28 minutes)

99/18 Corporate Objectives 2017/18 – Quarter 4 Update

The Director of Support Services presented a report which provided an update on progress with regard to Corporate Objectives 2017/18 as at the end of Quarter 4. He provided a brief overview on the content of the report and noted that the Trust objectives for 2017/18 had been included in Appendix 1 of the report. The Director of Support Services also advised that the Strategic and Corporate Objectives for 2018/19 had been included in Appendix 2 of the report.

The Board of Directors:

- Received and noted the report.

(1 minute)

100/18 Operational Plan 2018/19

The Director of Support Services presented a report which included the final Operational Plan and Winter Plan narrative which the Trust was required to submit to NHS Improvement by 30 April 2018. The Director of Support Services and Director of Finance briefed the Board on the content of the report and provided an overview of summary of key changes relating to the contract position, capital plan and final budget as well as assurance on the management and governance arrangements in place to ensure delivery of the component parts of the Operational Plan. The Director of Support Services advised that a version of the report had been presented to the Finance & Performance Committee and noted that the Trust continued to receive a number of queries from NHS Improvement with regard to the draft submission.

The Chair referred to a letter issued to all Acute Trust and Foundation Trust Chief Executives from Mr I Dalton, Chief Executive of NHS Improvement, a copy of which had been included in Annex A of the report. The Chair queried whether the Board could take assurance that the Operational Plan was fit for purpose and that the Trust was not merely submitting the Plan to meet the deadline. The Director of Support Services advised that the Trust would make it clear in the submission that the Winter Plan was the Trust's element of the system-wide plan, as the CCG's element of the Winter Plan was still awaited. He also commented that a review of the Winter Plan by NHS Improvement was expected. The Director of Support Services advised that the Trust was undertaking a specific review of the profiling of activity, as referenced in Mr I Dalton's letter.

In response to a question from Mr M Sugden, the Director of Support Services noted that the expectation was that the Urgent Care Delivery Board would approve a system-wide Winter Plan on 8 May 2018. In response to a follow up question from Mr M Sugden, the Deputy Chief Operating Officer noted that it was anticipated that the plan would be finalised at a system-wide workshop on 27 April 2018. In response to a comment from Mr M Sugden, the Board of Directors wished to note its disappointment that the Trust was having to submit its own Winter Plan in lieu of available information from partner organisations. The Interim Chief Executive noted that this point would also be raised at the Urgent Care Delivery Board. In response to a question from the Chair, regarding the availability of an Urgent & Emergency Care Plan, the Interim Chief Executive advised that the Trust was currently receiving support from the North East Commissioning Unit in this area and noted that a report would be produced at the end of the process which would be presented to the Board of Directors on 26 July 2018. She added that a more granular plan, including rota information, was anticipated to be available in September 2018.

The Director of Support Services made reference the Capital Programme and noted that £5.3m related to Healthier Together. He advised the Board that consequently the total Capital Programme for 2018/19 was £14.9m. The Director of Finance commented that the Regulators were fully sighted on the Capital Programme. He then referred the Board to s4.6.1 of the report and provided an overview of the contract position. In response to a question from Mr J Sandford, regarding elective income assumptions, the Director of Finance confirmed that the Plan did not include many transformational assumptions. He advised that the Trust was reviewing the feasibility of delivering 12 months' worth of activity over 10 months in certain Business Groups. The Director of

Finance noted that, if deemed feasible, the initiative would support the Winter Plan by freeing up bed capacity over the winter period.

In response to a question from Dr M Cheshire, the Director of Support Services commented that he believed the Operational Plan 2018/19 to be realistic. He, however, noted challenges with regard to elective activity, staffing vacancies and the need to be sighted on the CCG's element of the Winter Plan. With regard to the financial position, the Director of Support Services advised that the Trust was beginning to see traction following the introduction of bi-weekly meetings held between the Interim Chief Executive, the Director of Finance and the Business Groups. Mr J Sandford commented that history would support that the Trust was being realistic with regard to finances as it had always achieved, or over-achieved, budgets. He also made reference to the Trust's decision to turn down the control total last year, and probably again this year, to ensure the plans remained realistic. The Director of Finance endorsed these comments and noted the considerable risk associated with the Cost Improvement Programme. He commented that the Trust was required to decide how it would use the financial envelope differently.

Mr M Sugden noted a concern with regard to the lack of assurance available on the delivery of the Operational Plan and the Cost Improvement Programme. He commented that it was difficult to take assurance without an associated implementation plan. The Interim Chief Executive advised the Board that clear expectations had been set out with Business Groups regarding quality, finance and workforce and noted that performance was being tracked during the bi-weekly meetings referred to earlier. Dr C Wasson made reference to the Winter Plan and noted that a considerable number of lessons had been learnt during this exceptionally challenging winter. The Interim Chief Executive commented on the Emergency Department performance and noted that the key focus was to improve the resilience of the system.

The Board of Directors:

- Approved an annual budget of £34m deficit
- Approved a Capital Programme value of £14.9m, of which £5.3m related to Healthier Together
- Noted further amendments required to Final Operational Plan and Winter Plan narrative and delegated authority to the Chief Executive to approve documents for submission on 30 April 2018
- Noted the risks set out at s1 of the Final Operational Plan together with the risk relating to progress of Stockport Together developments
- Acknowledged the assurance provided to date on management and governance arrangements and stated its expectation that assurance levels would be strengthened.

(31 minutes)

101/18 Safe Staffing Report

The Chief Nurse presented a report which provided an overview of actual versus planned staffing levels for the month of March 2018. She briefed the Board on the content of the report and advised that Registered Nursing and Midwifery vacancies

across the Trust equated to 174 whole time equivalents. The Chief Nurse reported that average fill rates for Registered Nurses, Registered Midwives and non-registered care staff remained above 90% for both day and night duty. She advised that temporary staff had been utilised in the clinical areas to support safe staffing levels and noted that staffing levels remained extremely challenging.

The Chief Nurse then referred the Board to the 'Quality, Safety & Experience' table on page 6 of the report which provided further information on staffing levels, including performance against previous month. In response to a question from Mr J Sandford regarding the Ward Accreditation Scheme, the Chief Nurse briefed the Board on developments in this area.

The Board of Directors:

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

(3 minutes)

102/18 Staff Survey 2017

The Interim Director of Workforce & OD presented a report which provided an overview of key findings of the 2017 Staff Survey. She briefed the Board on the content of the report and advised that the Staff Survey results had been subject to detailed consideration at the People Performance Committee meeting on 19 April 2018. The Interim Director of Workforce & OD referred the Board to s2 of the report and provided an overview of the key findings. She noted that the survey results would provide rich data to facilitate conversations with staff groups, including detailed discussions with Business Groups. The Interim Director of Workforce & OD then briefed the Board on actions to date and next steps and noted that the Culture & Engagement Group would oversee the implementation of the Culture Plan. The Interim Director of Workforce & OD raised a concern with regard to decreased levels of staff engagement and noted that the subject of organisational leadership would be discussed at the Board Away Day on 27 April 2018.

In response to a question from the Chair, Ms A Smith commented that the People Performance Committee had identified the need to select three or four themes that would 'turn the dial' on engagement and culture activity. Dr M Cheshire commented on the short timescale between the publication of the survey results and the commencement of the next survey and noted that it was not possible to know if the mitigating actions had been effective before the next survey began. The Interim Director of Workforce & OD acknowledged these concerns and noted the need for a 3-5 year plan instead of aiming for 'quick wins'. Mrs C Barber-Brown noted that the plan should include information to understand resource requirements for its delivery. In response to a comment from the Chair, the Interim Director of Workforce & OD briefed the Board on initiatives to improve staff participation levels and commented on the usefulness of 'Pulse surveys'.

In response to a comment from Mr J Sandford, the Interim Director of Workforce & OD acknowledged his frustration that some previous plans had not been seen to conclusion. She noted the importance of listening to staff and identifying three or four themes that would have the greatest impact on improving culture and engagement.

Ms A Smith endorsed these comments and commented on the need to improve internal communications, including "you said, we did" style communications to staff. In response to a question from the Chair, it was agreed that a progress report on the 3-5 year plan would be presented to the Board of Directors on 28 June 2018.

The Board of Directors:

- Received and noted the Staff Survey 2017 report.

(11 minutes)

Mr P Gordon joined the meeting.

103/18 Freedom to Speak Up Annual Report

Mr P Gordon, Freedom to Speak Up Guardian, presented a Freedom to Speak Up Guardian (FTSU) Annual Report which provided positive assurance on the effective working of the Trust's Freedom to Speak Up arrangements. He briefed the Board on the content of the report and noted a recommendation from the National Guardian Office that "Trust Boards should articulate a vision of how it intends to support its workers to speak up". The FTSU Guardian noted that a proposed vision was included in Appendix 1 of the report. He then briefed the Board on triangulation with cultural indicators, FTSU Guardian casework and inclusion. He advised the Board that Appendix 2 provided a timeline of concerns with FTSU Guardian oversight with levels of escalation and awareness. The FTSU Guardian then referred the Board to s7 of the report and provided an overview of seven proposals aimed at enhancing compliance with monitoring and training recommendations. He made particular reference to a survey which would provide baseline data on the culture of speaking up.

In response to a question from the Chair, the Interim Director of Workforce & OD advised that she would meet with the FTSU Guardian to discuss staff engagement and inclusion. The FTSU Guardian also noted his membership on the Culture & Engagement Group. In response to a question from Mrs C Anderson, the FTSU Guardian provided further clarity with regard to the table included in s5.1.3 of the report. Mrs C Barber-Brown referred to the proposed vision included in Appendix 1 of the report and commented that, whilst she was supportive of the vision in principle, it would be useful to receive some feedback on it. The FTSU Guardian noted that there was still considerable variation nationally with regard to FTSU reporting and that he would welcome comments on the report content going forward. The Director of Corporate Affairs advised the Board that the FTSU Guardian would present quarterly update reports to the People Performance Committee and six-monthly reports to the Board.

The Board of Directors:

- Received and noted and report and noted positive assurance on the Trust's Freedom to Speak Up arrangements.

(8 minutes)

Mr P Gordon left the meeting.

104/18 Corporate Risk Register

The Chief Nurse presented the Corporate Risk Register and provided an overview of content. She advised that ordering of risks in the register was now based on the level of consequence and noted the inclusion of a 'risk movement' table. The Chief Nurse reported that the Quality Committee had endorsed the revised presentation and had acknowledged progress made in reviewing risk content. In response to a comment from the Interim Director of Workforce & OD, the Board endorsed a proposal to add a risk regarding Staff Engagement to the Risk Register.

Mrs C Anderson commended the ordering of risks based on the level of consequence and noted that it would also be helpful to include a thematic breakdown of risks. The Chief Nurse commented that consideration of themes would be undertaken at assurance committee level and noted that this information would not be broken down within the Risk Register itself. Mr J Sandford noted the need for a greater degree of automation in the production of registers to reduce the manual work currently required in the process. He also commented on the Board risk appetite and the need to take a risk based decision with regard to the use of resources. The Chief Nurse acknowledged these comments and noted that the strategic objectives would be prioritised accordingly.

The Board of Directors:

- Received and noted the Corporate Risk Register.

(9 minutes)

105/18 Consent Agenda

a) Use of Common Seal 2017/18

The Board of Directors received and noted the report.

b) Non-Executive Directors – Declarations of Independence

The Board of Directors received and noted the report and confirmed that it considered the Chairman and Non-Executive Directors to be independent.

106/18 Date, time and venue of next meeting

There being no further business, the Chair closed the meeting and advised that the next scheduled meeting of the Board of Directors would be held on Thursday, 24 May 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
20/17	28 Sep 17	225/17	Draft Alliance Provider Agreement	In response to a question from the Chair, the Interim Provider Director advised that he would provide an update with regard to the risk and gain share agreement at the next Board meeting. **Update 27 Oct 17** – The Interim Provider Director advised that he had written to all Directors of Finance with regard to the risk and gain share agreement and noted that the issue would be discussed at the Locality Finance Meeting on 6 November 2017. **Update 30 Nov 17** – The Director of Finance reported that this issue was yet to be resolved as a legal agreement. The Interim Provider Director noted that he would ensure that a risk and gain share agreement was in place by 28 February 2018 at the latest. **Update 28 Feb 18** – The Director of Finance advised that while a number of principles had been agreed regarding the risk and gain share agreement, this issue was yet to be resolved as a legal agreement. It was agreed that the Director of Support Services and the Director of Finance would take this action forward and report back at the Board meeting on 29 March 2018. **Update 29 Mar 18** – The Director of Finance briefed the Board on developments in this area but noted that the risk and gain share agreement was still being enacted without a legal agreement. He commented that there were two aspects to the risk and gain share agreement; one with the Council and the CCG and one between the four providers of Stockport Together. Mr M Sugden noted the importance of ensuring that the basis of both agreements was equitable. The Director of Finance noted that the intention was to have resolved this issue by the next Board meeting on 26 April 2018. **Update 26 Apr 18** – The Director of Finance briefed the Board on progress with preparing a formal risk and gain share agreement and noted ongoing discussions with SMBC.	K Spencer (Interim Provider Director) H Mullen (Director of Support Services) & F Patel (Director of Finance)

03/18	28 Feb 18	52/18	Stockport Together Progress Report	In response to a number of question and comments from Board members, the Managing Director of Stockport Neighbourhood Care agreed to revise the Deployment Status table (Fig 1) to provide greater clarity in future reports, with effect from March/April 2018 reports. The Director of Finance requested that more granular information be provided to the Board as an appendix to the report. **Update 29 Mar 18** – The Managing Director of Stockport Neighbourhood Care advised that the table would be included in the April update report. **Update 26 Apr 18** – The Managing Director of Stockport Neighbourhood Care briefed the Board on ongoing work and advised that the information would be included in the May Board report.	C Drysdale (Managing Director, SNC)
04/18	28 Feb 18	52/18	Stockport Together Progress Report	In response to a comment from the Director of Corporate Affairs, it was agreed that the final Stockport Together business cases would be submitted to the Board for approval. **Update for 29 Mar 18 –** Scheduled for presentation to Board on 26 April 2018. **Update 26 Apr 18** – It was noted that the final Stockport Together business cases would now be submitted to the Board for approval on 24 May 2018.	C Drysdale (Managing Director, SNC)
05/18	29 Mar 18	79/18	Audit Committee Key Issues Report	Mr J Sandford advised that the Committee had recommended that the People Performance Committee undertook a 'deep dive' on e-rostering to assess whether optimum benefits were being derived from the system. It was proposed that the 'deep dive' be undertaken at the People Performance Committee meeting on 17 May 2018, with an audit on the system to be held in Quarter 4 2018/19.	E Stimpson (Deputy Director of Workforce & OD)
06/18	29 Mar 18	79/18	Finance & Performance Committee Key Issues Report	It was agreed that the Executive Team would determine the approach for preparation of a comprehensive implementation plan for the 2018/19 Operational Plan at its meeting on 3 April 2018 and that outcomes of the discussion would be shared with the Board of Directors as soon as practicable following that meeting. **Update 26 Apr 18** – Item on agenda. Action complete.	H Thomson (Interim Chief Executive)

07/18	26 Apr 18	95/18	Report of the Chair	It was proposed that to link in with the Board's consideration of the Estates Strategy in June 2018, the Director of Support Services would organise a tour of the hospital site and tunnels for the Board of Directors.	H Mullen (Director of Support Services)
08/18	26 Apr 18	97/18	Key Issues Report – Quality Committee	It was agreed that progress on preparation of 'standard questions' for Risk Register reviews would be reported to the Board of Directors on 24 May 2018.	A Lynch (Chief Nurse) & C Wasson (Medical Director)
09/18	26 Apr 18	98/18	Performance Report	It was agreed that progress against Urgent & Emergency Care Recovery Plan would be reported to the Board on 26 July 2018.	H Thomson (Interim Chief Executive)
10/18	26 Apr 18	100/18	Operational Plan 2018/19	In response to a question from the Chair, regarding the availability of an Urgent & Emergency Care Plan, the Interim Chief Executive advised that the Trust was currently receiving support from the North East Commissioning Unit in this area and noted that a report would be produced at the end of the process which would be presented to the Board of Directors on 26 July 2018.	H Thomson (Interim Chief Executive)
11/18	26 Apr 18	102/18	Staff Survey 2017	It was agreed that a progress report on the 3-5 year plan would be presented to the Board of Directors on 28 June 2018.	H Brearley (Interim Director of Workforce & OD)

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Report to:	Board of Directors	**Date:**	24 May 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 Assurance Committee ☐ F&P Committee ☐ PP Committee ☐ SD Committee ☐ Charitable Funds Committee ☐ Nominations Committee ☐ Remuneration Committee ☐ Joint Negotiating Council ☐ Other

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1. PURPOSE OF THE REPORT

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

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

2. NOTABLE EVENTS

2.1 Board members will note that local elections were held by Stockport Metropolitan Borough Council on 3 May 2018 which brought to a close the associated period of purdah. The outcomes of the elections ensured continuity of the political leadership and therefore mitigated the risk of a degree of disruption to continued partnership working.

3. BOARD DEVELOPMENT

3.1 Interviews of the shortlisted candidates for the substantive Chief Executive position were held on 1 May 2018 and it is disappointing that we were not able to recommend an appointment on completion of a thorough and fair assessment process. I would like to thank all of the various people, including stakeholder representatives, who participated in the process. The search for a substantive candidate continues and I am grateful that Mrs H Thomson will remain in post to provide stability and continuity of leadership in the interim.

3.2 Interviews for a Non-Executive Director to replace Mr J Sandford, whose term of office expires on 30 June 2018, were held on 15 May 2018. There was a successful outcome and a recommendation for appointment is scheduled to be considered by the Council of Governors on 23 May 2018. I hope to be in a position to announce the outcome at the Board meeting on 24 May 2018.

3.3 Board members participated in a facilitated Board Development day on 27 April 2018. This was a productive event which generated suggestions for a further range of development activities which will serve to enhance Board effectiveness and forms part of our preparations for a Well Led Review. The first of what will be a series of 'bite-size' development sessions is scheduled to be held on 17 May 2018 and we will look to broaden the scope of such sessions with the participation of external speakers.

4. CHAIR ENGAGEMENTS

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

1 May 2018	Chief Executive Interviews

10 May 2018	Visited the Maternity Unit and the Obstetrics and Gynaecology.
15 May 2018	Non-Executive Director Interviews
15 May 2018	Visited the Bereavement Services and Mortuary
17 May 2018	Visited Ward C4
17 May 2018	Board Development session
23 May 2018	Council of Governors meeting

5. REGULATORY DEVELOPMENTS

5.1 Ms J Wood was appointed as Urgent & Emergency Care Improvement Director with effect from 1 May 2018 and will be attending meetings as a non-voting member of the Board. We anticipate that the initial appointment will be for a six-month period and Ms J Wood will provide an overview of her role at the meeting on 24 May 2018.

5.2 No Enhanced Oversight meeting was held in May 2018 but monthly meetings are firmly in diaries for the remainder of the year.

6. FORWARD LOOK

6.1 The draft report from the CQC Local System Review is scheduled to be available on 31 May 2018.

6.2 The Non-Executive Directors are scheduled to meet with their counterparts from Tameside & Glossop Integrated Care NHS Foundation Trust on 11 June 2018 as part of work to develop relationships and consider potential for closer working.

7. RECOMMENDATIONS

7.1 The Board of Directors is recommended to:

- Receive and note the content of the report.

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Board of Directors' Key Issues Report

Report Date: 24/05/18		**Report of:** Quality Committee
Date of last meeting: 08/05/18		**Membership Numbers:** Quorate
1.	**Agenda**	The Committee considered an agenda which included the following: • CQC Plan Update • Quality Improvement Plan • Draft Annual Quality Report 2017/18 • Management Group Key Issues Reports • Draft Annual Governance Statement 2017/18 • Corporate Risk Register
	Alert	• The Chief Nurse & Director of Quality Governance informed the Committee that there had been twenty instances since May 2017 where the Trust's Maternity Unit had been either closed or subject to a divert status. The Committee was advised that this level was higher than the norm and that a recovery plan had been requested by the Chief Nurse. A status report will be presented to the Committee on 10 July 2018. • The Committee reviewed a Key Issues Report from the Infection Prevention Group. The Medical Director alerted the Committee to continuing resource issues for the microbiology service and noted a consequent impact on Antibiotic Stewardship ward rounds. The Committee was given assurance that the matter is recorded in the Trust's Risk Register.
	Assurance	• The Committee considered the draft Annual Governance Statement 2017/18 and recommended the document to the Board of Directors for approval, subject to incorporation of provider licence conditions and CQC regulatory requirements as recommended by Mrs C Griffiths, Improvement Director. • The Committee reviewed the latest draft of the Annual Quality Report 2017/18 together with a draft Quality Improvement Plan the Committee recommended both documents to the Board of Directors for approval subject to a comprehensive proof read to ensure consistency of content presentation. • The Committee received a Key Issues Report from the Medicines Optimisation Group and received positive assurance that Executive-level input to the Group would be provided by the Medical Director.

	Advise	• In reviewing the CQC Action Plan, the Committee was advised by the Deputy Director Quality Governance that the Trust had achieved compliance rates of circa 91% for mandatory training on Safeguarding Adults. This represents a significant improvement in the last 12 months. • Again in relation to the CQC Action Plan, the Committee noted that an action related to improved timeliness for Discharge Summaries remains red-rated. The Chief Operating Officer provided the Committee with an overview of the current situation and agreed to prepare an improvement plan, including milestones and key dates, for consideration by the Committee on 19 June 2018. • With regard to the Corporate Risk Register, the Committee endorsed an approach for a 'vertical' review of the Register by; the Safety & Risk Group, the Quality Governance Group, Quality Committee and the Board of Directors. The approach will be supplemented by subject specific reviews by other Assurance Committees and work based on the effectiveness of the risk management system undertaken by the Audit & Risk Committee. • With regard to the work of the Medicines Optimisation Group, the Committee can advise the Board of a risk of medication incidents relating to the use of paper charts and Electronic Prescribing & Medicines Administration (EPMA). The Committee noted mitigation of the risk through the use of purple wristbands to clearly identify patients with paper charts.		
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: 24/05/18		**Report of:** Finance & Performance Committee
Date of last meeting: 16/05/18		**Membership Numbers:** Quorate
1.	**Agenda**	The Committee considered an agenda which included the following: • Month 1 Operational Performance Report • Month 1 Agency Utilisation Report • Month 1 Finance Report • CIP Progress Report • EPR Programme Report • Information Governance Toolkit • Capital Projects Development Group – Key Issues Report • Committee Work Plan
	Alert	• The Committee reviewed the Month 1 Operational Performance Report and noted a positive upturn in performance against the A&E 4-hour standard during April 2018. The performance level of 87.6% was in excess of the improvement trajectory for the month of 78%. However, the Committee was alerted to a downturn in performance during the previous week which appeared to be related to both access to primary care services, resulting in 'evening surges' of attendance levels, and performance management practice within the Emergency Department. These factors are subject to analysis by the Chief Operating Officer who will provide an update to the Board on 24 May 2018. • Also in relation to the Operational Performance Report, the Committee was provided with verbal assurance on progress with the Trust's Winter Plan, which is being led by Ms J Wood, U&EC Improvement Director. However, the Committee noted the need for similar assurance on development of the system winter plan for Stockport where there was a lack of clarity on progress to date. • The Committee considered the Month 1 Finance Report and noted an adverse position of £0.3m for elective income. While the position is influenced by re-commencement of the full elective programme on 9 April 2018, the Committee has requested an assurance report at its next meeting on 20 June 2018 to detail the activity plan for the year, including day-case activity, together with a risk assessment on plan delivery.
	Assurance	• On the basis of the Month 1 Finance Report, the Committee can report a high level of assurance on delivery of the 2018/19 financial plan with a deficit position

		of £4m against a plan position of £4.1m. The Committee noted factors relating to; STF funding, Winter Funding and Asset Impairment Reversal which had contributed to 2017/18 outturn position. • A less positive position was set out in the CIP Progress Report with a shortfall of £0.3m against the Month 1 plan position of £0.5m. The Committee will be receiving a presentation on Bed Utilisation, one of the major work streams of the programme, at its next meeting and acknowledged that savings associated with a planned ward closure at the end of April 2018 were not reflected in the Month 1 position. • The Committee noted positive assurance on compliance levels provided by an Information Governance Toolkit report which was underpinned by a Significant Assurance outcome from Internal Audit work on the Trust's toolkit submission for 2017/18.		
	Advise	• The Committee noted an increase in agency expenditure, in comparison with positive performance in previous months, which resulted in an overshoot against the agency ceiling for Month 1. The Interim Director of Workforce is assessing factors influencing the increase and the Committee will continue to closely monitor the situation. • The Committee reviewed a report on progress against the Electronic Patient Record (EPR) programme and noted continuing uncertainty around a date for the Phase 1 go-live. • The Committee considered work being undertaken to prepare a Medium Term Financial Strategy (MTFS) and was advised by the Director of Finance of plans to develop proposals for review by the Committee on 20 June 2018 prior to submission for approval by the Board on 28 June 2018. • The Committee reviewed a version of the Trust Risk Register, which detailed all high level finance-related risks, and Committee members noted the benefit of the revised format in facilitating focused discussion.		
2.	Risks Identified	• Elective income • Delivery of the cost improvement programme		
3.	Actions to be considered at the *(insert appropriate place for actions to be considered)*	Nil		
4.	Report Compiled by	Malcolm Sugden, Non-Executive Director	Minutes available from:	Company Secretary

Board of Directors' Key Issues Report

Report Date: 24/05/18		**Report of:** People Performance Committee
Date of last meeting: 17/05/18		**Membership Numbers:** Quorate
1.	**Agenda**	The Committee considered an agenda which included the following: • Workforce Plan & Culture Plan • Guardian of Safe Working Report • Leadership & Development Plan • Schwartz Rounds - Presentation • HR Systems Optimisation - Presentation • Workforce Annual Report • Workforce Flash Report • Medical Revalidation Report • Agency Utilisation Report • Trainee Doctors Monitoring Update • Corporate Risk Register • WEG Key Issues Report • Policies for Validation: - Disciplinary Policy - Capability Policy - DBS Policy - Acting Up & Secondment Policy - Managing Work Related Stress Policy
	Alert	• The Committee was alerted to an increase in agency expenditure in comparison with positive performance in previous months. It was noted that whilst the spend was much reduced from this time last year, the ceiling forecast for Month 1 had been exceeded and the Committee noted mitigating actions to bring agency spend back on track. The Committee was advised of the continued national issue relating to visa restrictions which were adversely impacting the Trust's overseas medical recruitment. The Trust had seen 15 visas refused in recent months for fellow posts, with a further six visa requests outstanding, and the Committee noted that national discussions continued to resolve this issue. The Committee was also alerted to a recent issue with regard to national trainee recruitment for ST3+ grades in medical disciplines. It was noted, however, that current updates suggested that this issue would be resolved without delay to start dates. • The Committee considered a report relating to the monitoring of Trainee Doctors

		working hours, for doctors who remained on the 2002 contract. It was noted that the Trust had not achieved the required return rate of 75% during the monitoring period, which invalidated the returns, and the Committee noted that Doctors had been reminded that it was a contractual obligation to comply with the monitoring exercise. In reviewing the report, the Committee was alerted to recent cases of historic claims for banding, dating back six years, and noted a potential financial risk if the cases led to "piggy-back" claims against the Trust.
	Assurance	• The Committee took positive assurance from a Guardian of Safe Working Quarter 4 2017/18 Report and noted an improved position with regard to exception reporting by trainee doctors. Whilst noting an improved position with regard to the engagement of Educational and Clinical Supervisors in the process, the Committee acknowledged that further work was required to ensure timely closure of exception reports. The Committee was also advised of staffing issues in Gastroenterology and it was agreed that this issue would be further reviewed by the Deputy Medical Director and the Deputy Director of Workforce. • The Committee took positive assurance from a report on Medical Appraisal and Revalidation presented by the Deputy Medical Director. The Committee noted an improved position with regard to appraisals, including an enhanced Quality Assurance process. The report also provided an overview of a recent publication examining the impact of medical revalidation in the United Kingdom and the Committee noted that the Trust's processes compared favourably in this area. • The Committee considered an Annual Workforce Performance Report 2017/18 and commended its improved format in providing a clear overview of workforce metrics. The report is included for information of the Board in Annex A of the Key Issues Report.
	Advise	• Board members are invited to review and comment on an outline plan for a Workforce Strategy which is available in the office of the Interim Director of Workforce. The Committee was advised that the Workforce Strategy would be subject to consideration at a future Board workshop session. • The Committee considered an update report with regard to Leadership Development and noted a number of courses and workshops available for staff as part of the Leadership Development Programme. The Committee was advised of partnership working with NHS Improvement and AQuA in this area and noted that Leadership Development plans would be monitored by the Culture & Engagement Group. The Committee noted the importance of evaluation in measuring the impact of the programme and requested an update at the next meeting. • The Committee received an informative presentation on Schwartz Rounds which the Trust was introducing as an opportunity for staff to reflect on emotional and social aspects of their role. • The Committee received a presentation on the HR Systems Optimisation Programme. This followed a recommendation by the Audit Committee for the People Performance Committee to undertake a 'deep dive' on e-rostering to assess whether optimum benefits were being derived from the system. The presentation provided an overview of the Allocate HealthRoster System, roll out achieved to date, key benefits and next steps. The Committee was advised that the Trust was liaising with an external company to ensure optimum use of the programme and would prioritise the programme accordingly against other priorities, such as the Electronic Patient Record. It was agreed that an update

		would be provided at the Committee meeting in October once further clarity was available with regard to expectations. • In considering the Trust Risk Register, the Committee requested that a review be undertaken of the workforce related risks to ensure relevance of the deadline dates. It was noted that the outcome of the review would be reported at the next meeting. • The Committee received a Key Issues Report from the Workforce Efficiency Group and noted that positive assurance had been received from the Clinical Administration Transformation Programme Board that the productivity from support secretaries had been sustained. It was noted that further improvements were expected as dictation standards improved.		
2.	Risks Identified	• Adverse effect on medical recruitment as a consequence of the cap on Visas issued to overseas Doctors. • Potential financial risk to the Trust if the Trust was to receive historic claims for banding from former Trainee Doctors.		
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

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Report to:	People Performance Committee	**Date:**	17 May 2018
Subject:	Annual Workforce Performance Report 2017/18		
Report of:	Director of Workforce & OD	**Prepared by:**	Deputy Director of Workforce

REPORT FOR NOTING

Corporate objective ref: -----	**Summary of Report** Further to the discussions and agreement reached at the Committee the presentation of the Workforce quarterly report will now be produced on an annual basis. This is the first annual workforce performance report. This report is designed to provide an update of workforce information and actions for the financial year of 2017/18 (April 2017 to March 2018). The report highlights changes and progress during this 12 month period and provides assurance against the actions identified. It also highlights new initiatives and progress made in key areas. The Committee members are requested to note the contents of this report.
Board Assurance Framework ref: -----	
CQC Registration Standards ref: -----	
Equality Impact Assessment: ☒ Completed ☐ Not required	

Attachments: Annual Workforce Performance Report 2017/18

This subject has previously been reported to:	☐ Board of Directors ☐ Council of Governors ☐ Audit Committee ☐ Executive Team ☐ Quality Assurance Committee ☐ FSI Committee	☐ People & Performance Committee (formerly WOD) ☐ BaSF Committee ☐ Charitable Funds Committee ☐ Nominations Committee ☐ Remuneration Committee ☐ Joint Negotiating Council ☐ Other

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Stockport
NHS Foundation Trust

Annual Workforce Performance Report

April 2017 to March 2018

Contents

1. Introduction

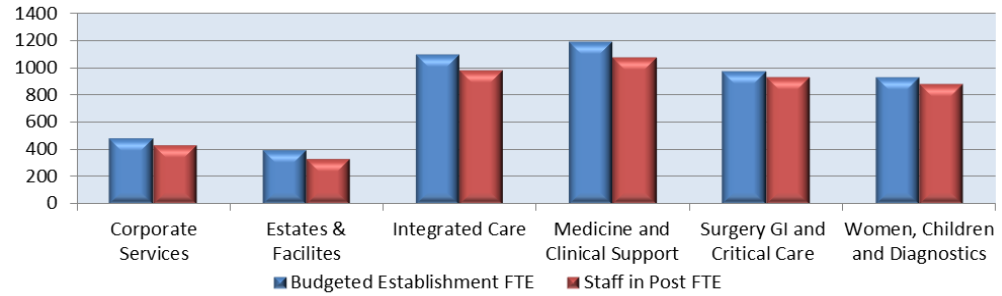
This report is designed to provide an update of workforce information and actions for the financial year of 2017/18 (April 2017 to March 2018). The report highlights changes and progress during this 12 month period and provides assurance against the actions identified. It also highlights new initiatives and progress made in key areas.

Key HR Indicators as at 31st March 2018:

- 5,262 directly employed staff (excluding Lead Employer Trainee Doctors and zero hours contracts).
- 12 month turnover rate of 14.05%; a reduction of 2.04% compared to 31st March 2017 (16.09%).
- 12-month sickness absence rate of 4.08%; an increase of 0.11% compared to 31st March 2017 (3.97%).
- The appraisal rate was 94.42%; an increase of 5.07% compared to 31st March 2017 (89.35%).
- The Statutory and Mandatory training rate was 90.05%; an increase from 89.95% as at 31st March 2017
- There were 890 starters and 813 leavers over the 12-month period.
- Bank and agency usage was 11.36% of the overall pay spend in the 12-month period.
- 129 employee relations cases in the 12-month period.

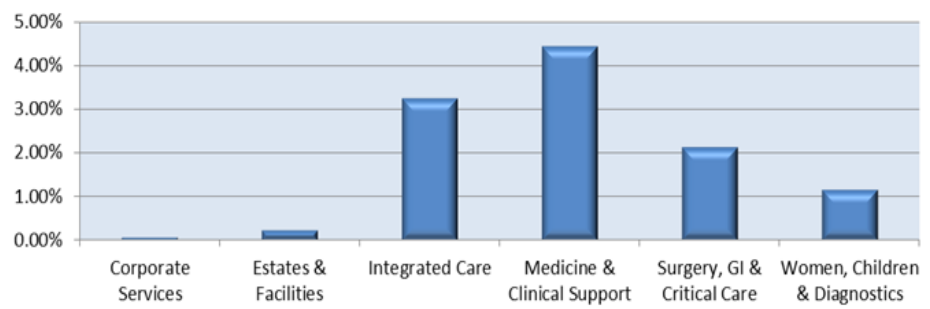
2. Trust Dashboard - Detail

Establishment FTE



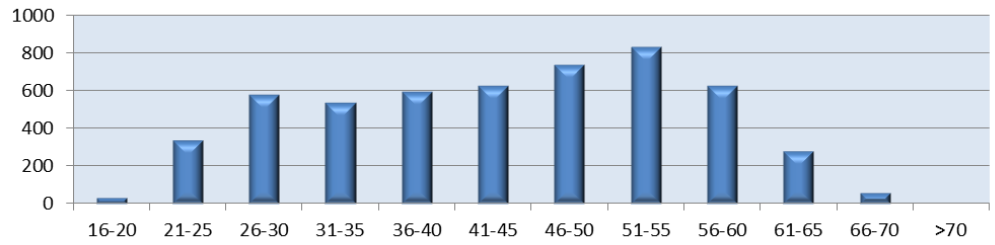
- The Trust has filled 91% of the establishment with a vacancy rate of just 9%.
- The Integrated Care business group has the highest full time equivalent vacancy rate of 120 FTE (a vacancy rate of 11%).
- The Registered Nursing and Midwifery staff group have the highest full time equivalent vacancy rate of 174 FTE (11%).
- The Medical vacancy rate is 41 FTE (8%).

Bank and Agency Usage - % of Total Paybill



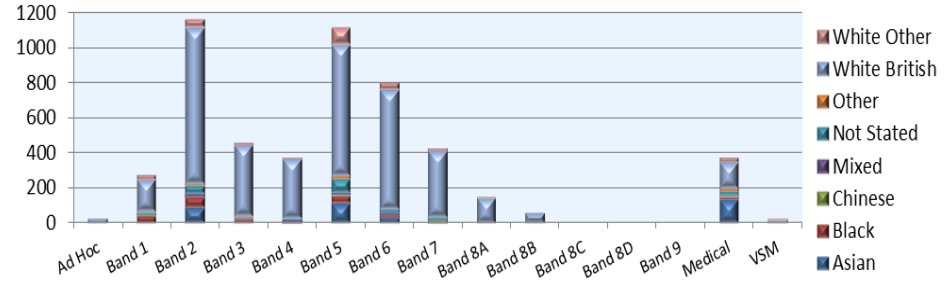
- The total paybill for 2017/18 was £212.89m.
- The total spend on bank was £12.21m (5.73% of the total paybill).
- The total spend on agency was £11.98m (5.63% of the total paybill).

Age Profile



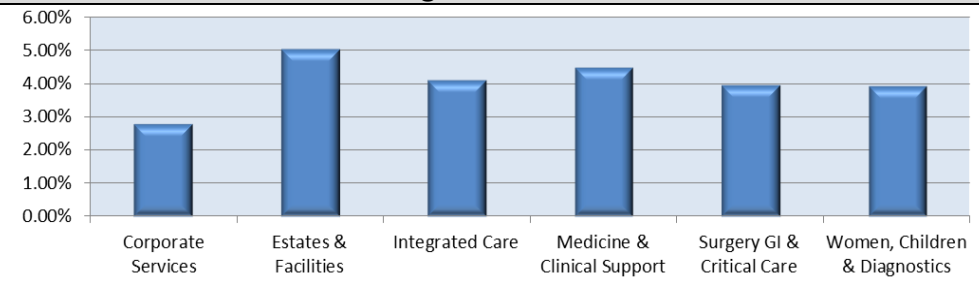
- 19% of staff are aged over 55 with 7% over 60.
- 15% of Registered Nursing and Midwifery staff are aged over 55 with the ability to retire on their NHS pension.
- Only 7% of staff are under 25.
- The gender profile of the Trust is 80% female; 20% male.

Pay Band and Ethnicity Profile



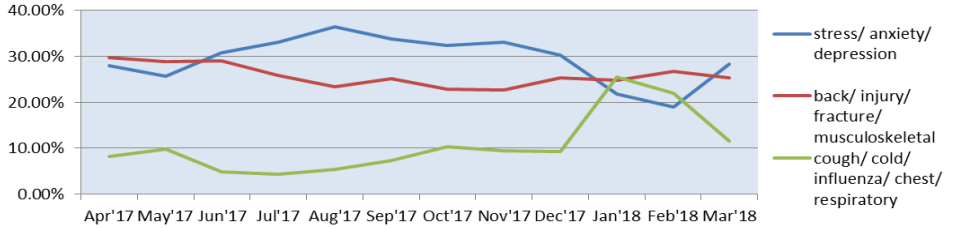
- 77% of staff are White British; 5% are White Other; 14% are Mixed, Asian, Black, Chinese, Other; 4% of staff have not declared their ethnicity.
- 76% of bands 1 to 5 are White British; 19% are BME.
- 78% of bands 6 and above are White British; 19% are BME.

Sickness Absence – rolling 12-months



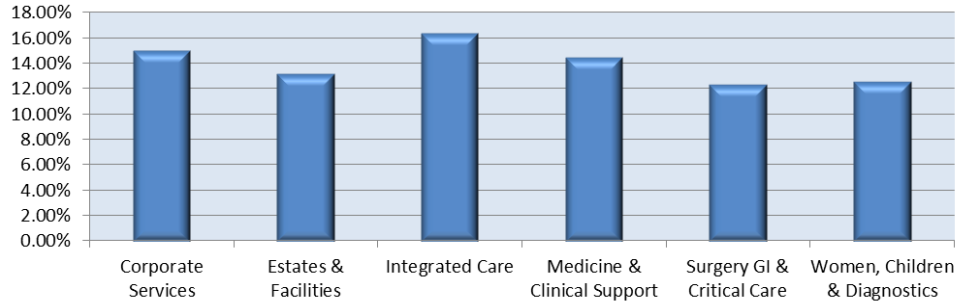
- The 12-month sickness rate for the Trust was 4.08%. This is 0.11% higher than the same period last year (3.97%), and 0.58% above the Trust target of 3.5%.
- The short term sickness rate (<21 days) was 1.25%; the long term sickness rate (=>21 days) was 2.83%.

Top 3 Sickness Reasons



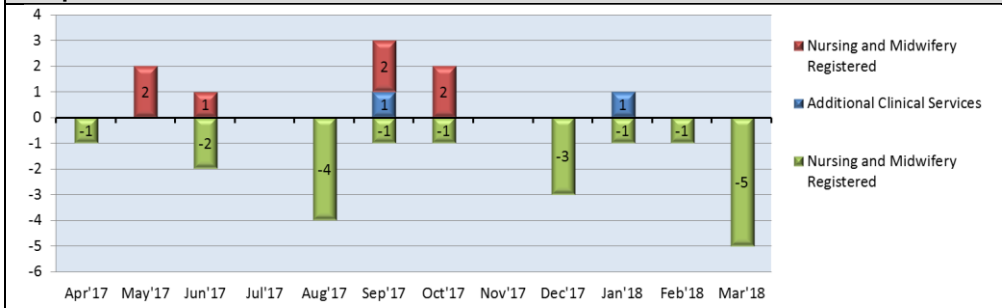
- Cough/cold/influenza were higher in the winter months, as would be expected. During the same period, there was a decrease in stress/anxiety/depression related absences.
- 926 counselling referrals were received in the 12 month period. 100% were seen with 5 days. 268 musculoskeletal referrals were made to OH in the 12 month period. 93.28% of referrals were passed to SHH Physio for ongoing support.

Turnover



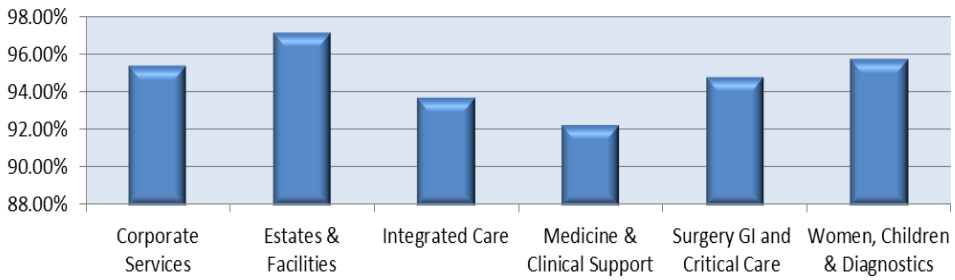
- The unadjusted permanent headcount turnover for 2017/18 was 14.05%.
- The turnover, adjusted for flexible retirements, is 12.95%.
- The most common leaving reasons were relocation, retirement and work life balance.

Impact of Brexit



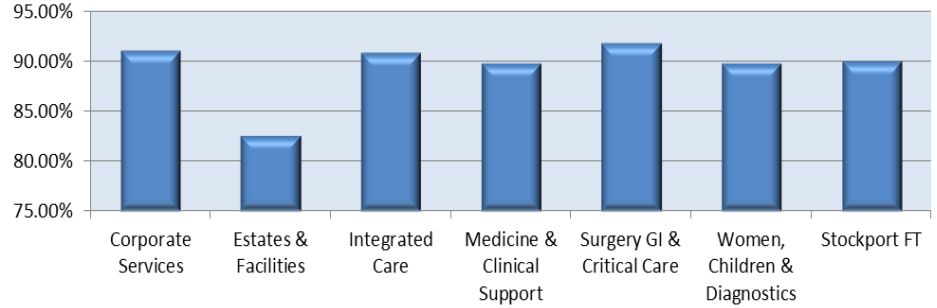
- Between April 2017 and March 2018, there were 9 new starters from the EU and 19 leavers from the EU moving abroad (15 of which were originally recruited from abroad).
- There were a total of 62 leavers with EU nationality, of which 18 moved to other NHS Trusts and 12 had no further employment.
- Recruitment of international nurses continues but the pace has slowed somewhat with 9 recruited so far this year (2018).

Appraisal



- The Trust appraisal rate for 2017/18 was 94.42%, an increase of 2.72% from March 2017 (91.70%),
- The target for appraisals is 95%.
- The medical staff appraisal rate for 2017/18 was 97.33%.

Statutory and Mandatory Training



- The target for mandatory training is 90%.
- The Trust statutory and mandatory training compliance rate for 2017/18 was 90.05%. In March 2017 this was 85.57%; an increase of 4.48%.
- The accessibility to e-learning and availability of face to face taught sessions impacts negatively on the compliance within Estates & Facilities.

CPD Uptake

- In 2017/18 there was a reduced amount of CPD money from Health Education England (HEE).The trust continued to support staff with external learning opportunities and spent £153,753.
- An extensive training needs analysis was carried out and adhered to for 2017.This process will be utilised again to ensure equity and service needs are kept paramount in skilling the workforce for the future.

Staff Survey Headlines

- The 2017 staff survey was a mixed mode approach with a 41.8% response rate a 2.3% improvement from 2016.
- Of the 32 key findings the Trust scored better than the national average in 3 areas, average in 16 and worse than average in 13 areas.
- Areas for concern are being incorporated in the ongoing culture plan to ensure robust and effective improvement for the coming year.

3. Greater Manchester Benchmarking (data as at January 2018)

NHS Trust	Contracted FTE	Headcount	Headcount - 12 Months Previous	Joiners - 12 Month	Leavers - 12 Month	Joiner Rate - 12 Month	Leaver Rate - 12 Month	Stability Index - 12 Month	Absence Rate	Basic Pay Per Fte 12 Month	Total Earnings 12 Month
Manchester Uni FT	17,865	19,935	19,325	Unpublished data.					5.15%	Unpublished data.	
Pennine Acute	11,605	12,855	12,490	2,060	1,695	16.26%	13.39%	86.41%	4.61%	£31,587	£34,693
Salford Royal FT	7,145	7,930	7,510	1,235	815	16.00%	10.54%	89.16%	4.74%	£31,158	£32,157
Bolton FT	5,080	5,910	5,670	790	550	13.67%	9.53%	90.27%	5.96%	£28,987	£28,102
Pennine Care FT	4,830	5,510	5,420	790	700	14.50%	12.83%	87.06%	5.72%	£29,761	£27,561
Stockport FT	4,475	5,245	5,125	805	685	15.48%	13.21%	86.64%	4.78%	£28,882	£28,322
Great Manchester MH FT	4,450	4,830	4,735	795	700	16.60%	14.60%	85.26%	6.54%	£30,486	£30,367
Wrightington Wig & Leigh FT	4,345	5,075	5,065	530	520	10.50%	10.28%	89.71%	5.39%	£28,667	£29,014
Tameside & Glossop FT	3,365	3,875	3,695	610	425	16.12%	11.28%	88.44%	5.83%	£28,315	£28,683
Christie FT	2,620	2,860	2,725	505	370	18.13%	13.30%	86.38%	4.07%	£32,642	£32,580

Source: i-View

In order to evaluate our performance, we have benchmarked our data against other Trusts in Greater Manchester, where data is available. The information currently provided is at January 2018.

The benchmarking information is restricted and unpublished and must not be made public.

- Stockport FT is 6th in the table of trusts with regard to FTE headcount.
- Stockport FT is 4th in the table for the number of joiners and % leaving rate (assuming Manchester University FT are highest).
- Stockport FT is 5th in the table for the number of leavers (assuming Manchester University FT is highest).
- Stockport FT has the 4th lowest sickness % rate.
- Stockport FT is the 3rd lowest Trust for the average basic pay and average total earnings.

4. Business Group Overview

Integrated Care

The Sickness rate has fluctuated over the year mainly due to the restructure of the Business Group in September 2017. Sickness has been consistently above the target. Stress/anxiety/depression is the highest reason for absence followed closely by musculoskeletal.

The average turnover for the year was 20.75%, above the Trust target of 13.93%. This is compounded by a number of TUPE transfers. Since September 2017 this has decreased to an average of 15.87%. The most common reason for leaving was relocation, followed by promotion.

The appraisal rate has increased month on month since September 2017 and has nearly reached the Trust target (93.7% in March 18).

The number of agency shifts above cap remains consistently high due to the pressures within ED. There were 353 shifts above cap in March 2018.

Medicine & Clinical Support

Sickness has increased over the last 12 months and has been above the Trust target for 9 months. Stress/anxiety/depression is the highest reason for absence. Sickness has increased over the year, from 3.85% in March 2017 to 4.34% in March 2018.

The average turnover for the year was 14.53%, above the Trust target of 13.93%. The most common reason for leaving was relocation, followed by work life balance.

Over the last 12 months, the business group has seen an increase in the appraisal rates from 86.76% in March 2017 to 92.28% in March 2018.

On average, over the last 12 months, essential training has been below the Trust target at 84.39%.

The number of agency shifts above cap has reduced significantly from 1294 in April 2017 to 263 in December 2017. The increase in shifts since January (400+) is as a result of winter pressures and providing medical cover for the escalation areas.

Surgery, GI & Critical Care

Sickness has reduced over the year, from 4.23% in April 2017 to 3.66% in March 2018. Back/other musculoskeletal problem/injury is the highest reason for absence. Departments have had bespoke Attendance Management training to ensure they are managing staff in line with the policy.

Turnover remains consistently below the Trust target.

Over the last 12 months, the business group has seen an increase in the appraisal rate, with April 2017 being 90% and the year end position being 94.79%, which is close but just short of target.

On average, over the last 12 months, essential training has been below the Trust target at 86.44%.

Since November 2017 the number of agency shifts above cap has reduced significantly from 254 to 128 per month.

Women, Children & Diagnostics

Over the last 12 months the two main reasons for sickness absence have consistently been Stress and Musculoskeletal. Sickness absence was at its highest levels in October-March when coughs/cold/flu were also prevalent and created on average an additional 8.82% of sickness absence over the winter months despite 80% of the workforce having had the flu vaccine. Turnover remains consistently below the Trust target.

The appraisal rate has averaged 94.68% which is slightly below Trust target. However, since November 2017 managers have achieved appraisal rates ranging between 97.74% in December 2017 to 95.81% in February. On average over the last 12 months essential training has been below the Trust target at 87.73%.

Since September 2017 the number of agency shifts above cap has reduced significantly from 200 to 47 per month.

4. Business Group Overview

Estates & Facilities

Sickness has increased over the last 12 months and has now been above the Trust target for 9 months. Back/other musculoskeletal problem/injury is the highest reason for absence. Sickness was below target at 3.01% in June 2017 however this has steadily increased over the year to a high of 6.74% in November 2017. Managers and Supervisors are attending bespoke Attendance Management training to ensure they are able to manage staff consistently and in line with the policy.

Turnover remains consistently above the trust target. The average for the year being 14.93%.

The appraisal rate has been above the Trust target for seven months in a row. The appraisal rate in March 2018 was 97.13%.

Corporate Services

The average sickness absence for Corporate Services was 2.86% which is below Trust target. The 3 highest sickness periods were in July, August and January. Across each of these months there were high levels of absence due to stress and gastrointestinal problems, however, in January 2018, sickness absence peaked at 3.91% and this appears to have related to 26 absences related to flu despite an 88% uptake of the flu vaccine across Corporate Services by the end of December 2017.

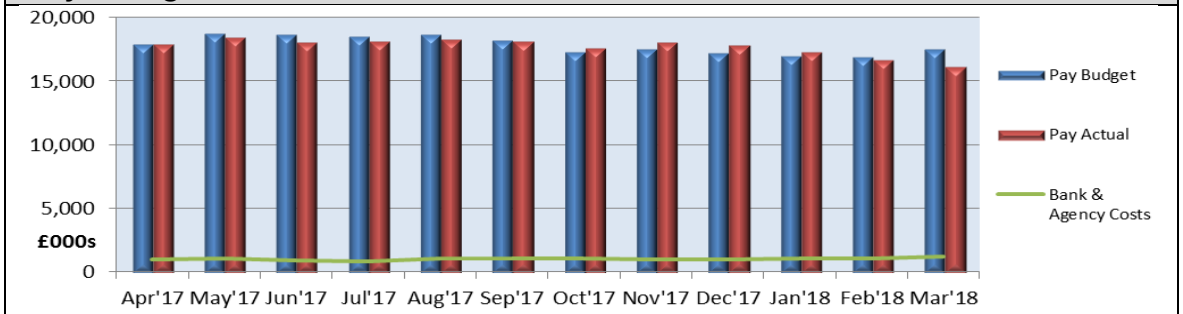
The appraisal rate has averaged 92.81%. Appraisal rate attainment has significantly improved over the last quarter reaching the target in March 2018.

Turnover remains consistently above the Trust target. The number of fixed term contracts equates to 52.79 FTE which, at 12.36%, is significantly higher than the Trust average of 5.50%.

Since September 2017 the number of agency shifts above cap has reduced from 56 to 10.

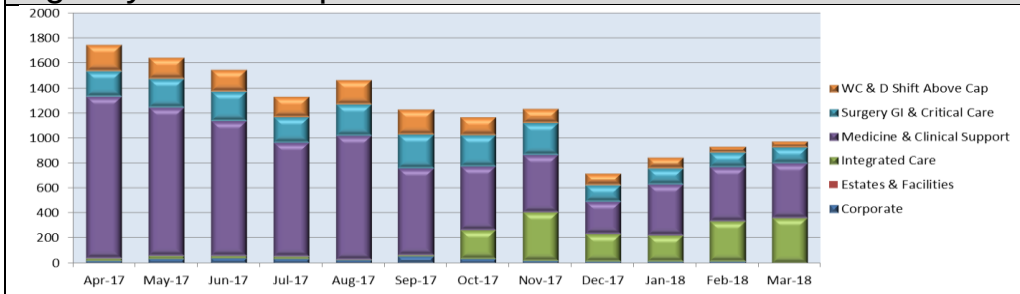
5. Pay Spend – Fixed and Variable Pay

Pay Budget



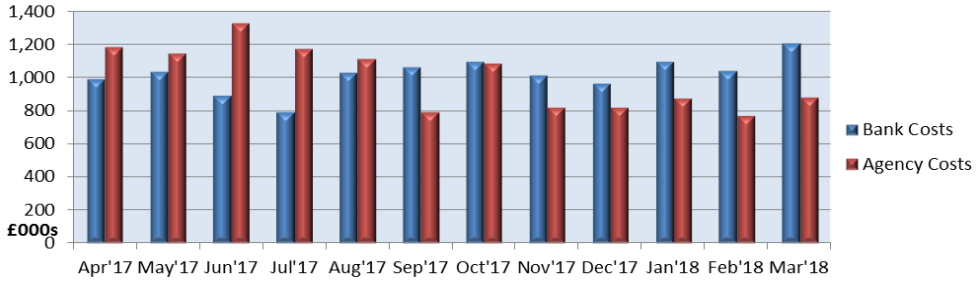
- The total pay budget was £214.463m for 2017/18.
- The total actual pay was £212.885m for 2017/18.
- The total bank and agency costs were £24.19m for 2017/18 which was 11.36% of the actual pay.

Agency Above Cap



- Since the re-structure in August 2017, Integrated Care Business Group's shifts above cap have increased and Medicine & Clinical Support have decreased, owing to the Emergency Department move in the management structure.
- There has been a significant effort to appoint medical staff onto the Trust bank by either encouraging them to move from their agency or by recruiting via NHS Jobs.

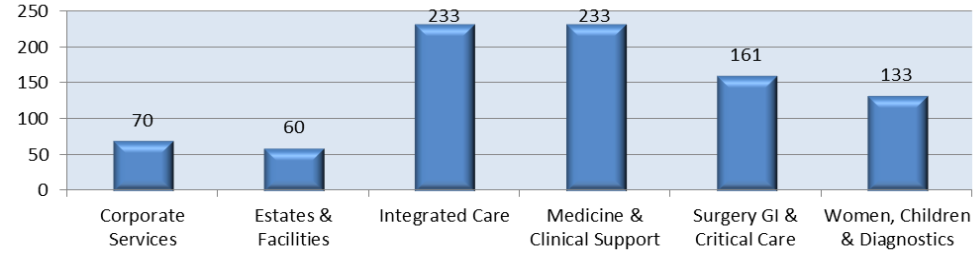
Bank and Agency Spend



- The above graph shows the swap in bank and agency spend since October 2017, with a decrease in the amount spent on agency staff and an increase on the amount of bank spend.

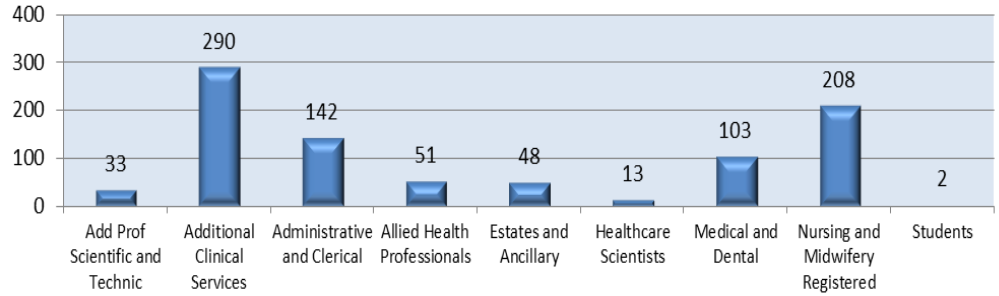
6. Recruitment and Retention – Starter Analysis

Starters by Business Group



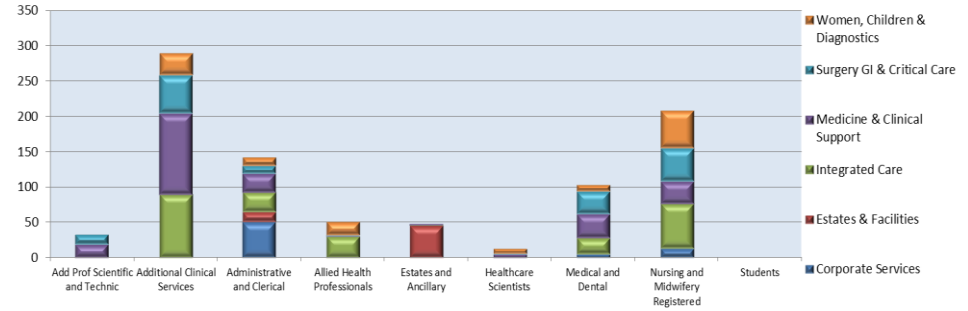
- There were a total of 890 starters in 2017/18.
- Integrated Care, Medicine & Clinical Support and Surgery GI & Critical Care have recruited more staff than the number of leavers during the period.

Starters by Staff Group



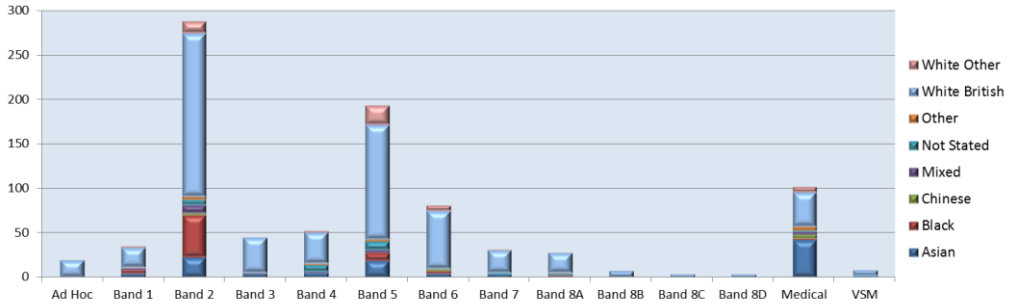
- 33% of new starters were from Additional Clinical Services staff group.
- 23% of new starters were Registered Nurses.
- 11% were Medical and Dental staff.

Starters by Staff Group and Business Group



- The majority (45%) of new starters were recruited from other NHS organisations, with 35% coming from the private sector.

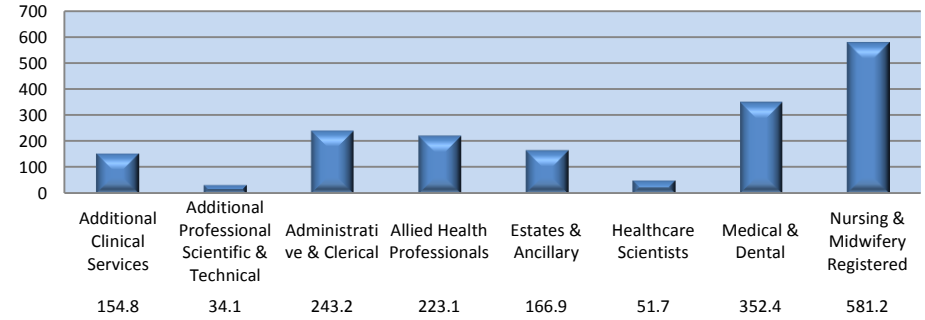
Starters by Ethnicity and Pay Band



- 67% of new starters are White British; 6% are White other; 24% are mixed, Asian, Black, Chinese, Other; 4% of staff have not declared their ethnicity.
- 68% of bands 1 to 5 are White British; 28% are BME.
- 65% of bands 6 and above are White British; 32% are BME.

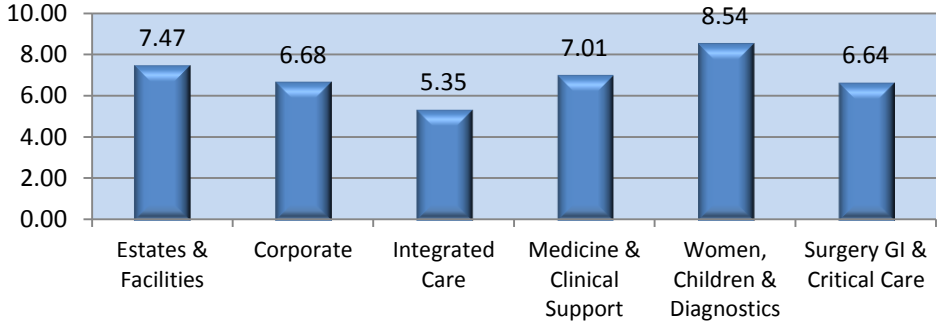
6. Recruitment and Retention – Recruitment Activity

Advertised Vacancies by Staff Group



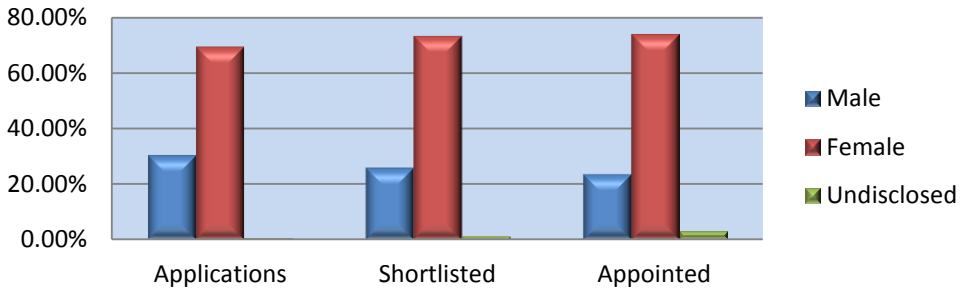
- 1807.4 wte vacancies were advertised during 17/18, an average of 34.75 wte per week.
- The total number of applicants was 13,811
- The average number of applicants per advert was only 7.6
- Nursing & Midwifery continue to have the most advertised vacancies, followed by Medical & Dental.

Time to Hire by Business Group



- The Trust average time to hire since Sept 17 is 6.95 weeks compared to 6.49 weeks last year, against a target of 10 weeks.
- Due to the Business Group restructure the above figures are taken from September 2017-March 2018 and recorded in average weeks.

Applications by Gender

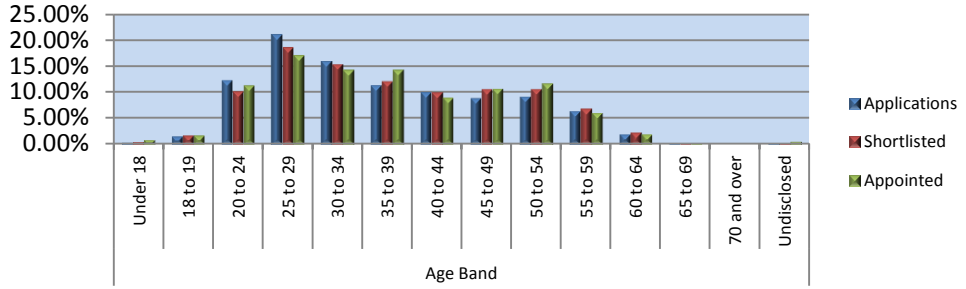


- Male applicants accounted for 30% of the overall applications. 25.70% of the shortlisted applications and 23.5% of the appointed applicants were male. This is consistent with the Trust profile (20% males)

Disabled Applicants

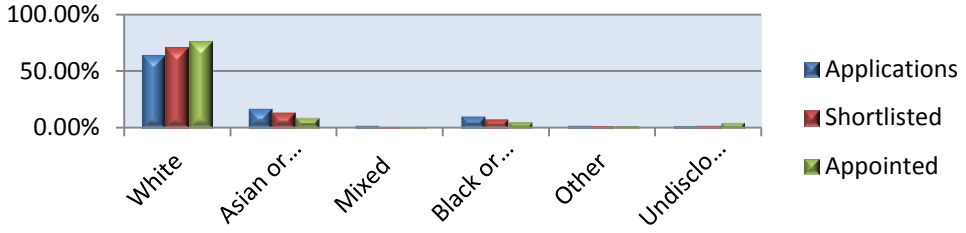
- 3.7% of applications received were from candidates with a disclosed disability. The guaranteed interview scheme initiatives provide disabled applicants with an interview where they meet the essential criteria. 4% of shortlisted applications had a disclosed disability. However, only 1.9% of appointed applicants had a disclosed disability. This compares to the trust profile of 2.93% of staff declaring a disability.
- 1.4% of applications received were from candidates who did not disclose if they had a disability or not.

Applications by Age



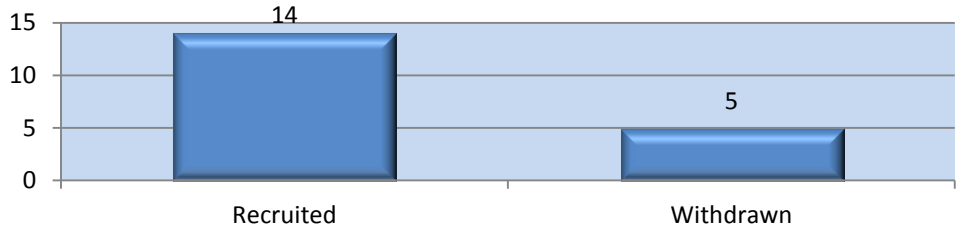
- There are no significant differences between the numbers of applications received and those appointed based on age across the age bands with the exception of the 25 to 29 band. 21% of applications were received from applicants in this age band, but only 17% were appointed.
- The number of applicants from those under 24 is encouraging and is equivalent to the numbers appointed.

Applications by Ethnicity



- 17.4% of applications were from Asian applicants, 10.7% from Black applicants, 2.8% from other and 2.7% from mixed ethnicity applicants. Ethnicity data is not available to managers when completing shortlisting.
- 9.5% of appointed applicants were Asian, 5.5% were Black, 2.0% from other and 1.4% from mixed ethnicity. In all cases the percentage of appointed BME candidates was lower than the applicants, significantly so in the case of Asian and Black applicants. This is a concern and requires further analysis.

Disclosure & Barring Service (DBS)



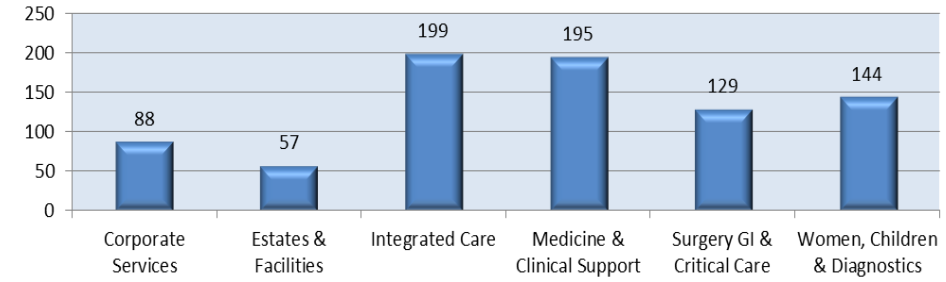
During the period 01 Apr 2017 to 31 March 2018, 900 applicants / staff were subject to DBS checks and 19 of these had positive disclosures. Following investigation by the HR team, 14 candidates were recruited into post and 5 were withdrawn.

Occupational Health Clearances

- Occupational Health received and triaged 979 Work Health Assessment forms for successful applicants during 17/18.
- 96.12% of these were processed with 48 hours of receipt. 40.6% were cleared via a paper screening and 16.4% required a full health interview. The remainder were cleared via a telephone consultation.
- Of the 161 applicants requiring a health interview only 59.63% of these obtained an appointment within 10 working days.
- 96.12% of FiT slips were sent to HR within 48 hours of the decision.

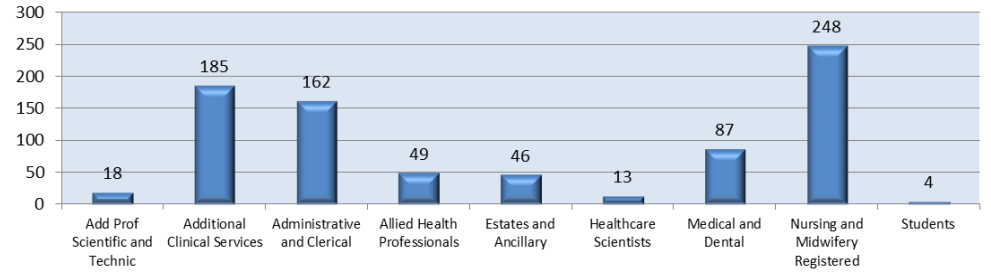
6. Recruitment and Retention – Leavers Analysis

Leavers by Business Group



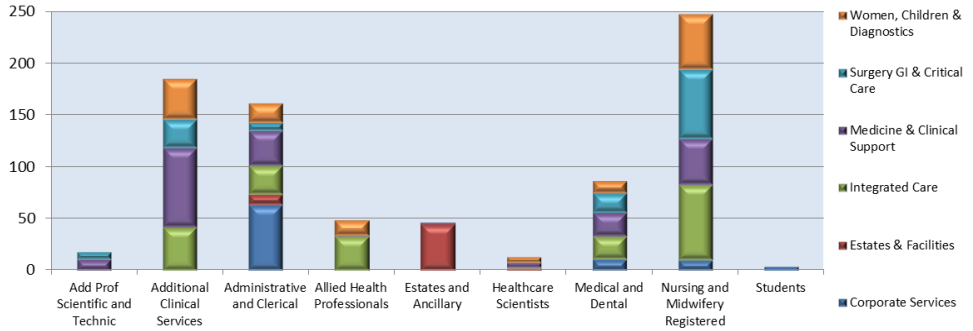
- There were a total of 812 leavers in 2017/18, with the highest number of leavers coming from the integrated Care and Medicine & Clinical Support business groups.

Leavers by Staff Group



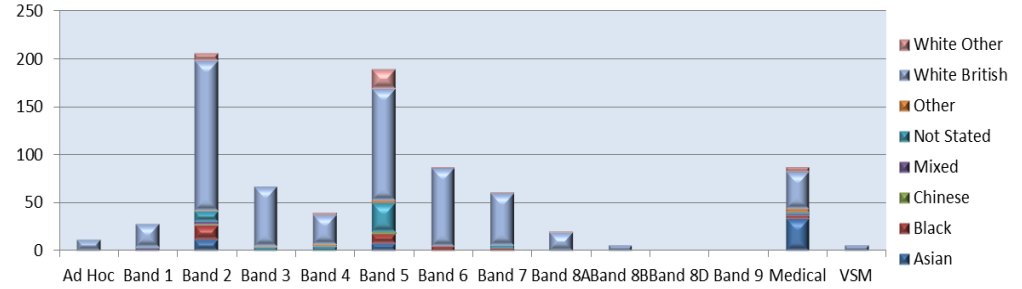
- Of the 812 leavers, 248 (31%) were registered nurses, however, 46 of those returned under the flexible retirement option.

Leavers by Staff Group and Business Group



- 24% of leavers have less than 1 years' service.
- 59% of leavers have less than 5 years' service.

Leavers by Ethnicity and Pay Band



- 75% of levers are White British; 4% are White other; 15% are mixed, Asian, Black, Chinese, Other; 6% of staff have not declared their ethnicity. This is consistent with the Trust profile.
- 74% of bands 1 to 5 are White British; 18% are BME.
- 76% of bands 6 and above are White British; 29% are BME.

6. Recruitment and Retention Strategies

Completed Actions in the last 12 months

The Recruitment and Retention Strategy was refreshed in October 2017. In addition NHS Improvement (NHSI) has launched a three year workforce retention programme in conjunction with the Trust with the objective of stabilising and subsequently reducing nursing leaver rates. A significant amount of work is ongoing across four workstreams; Graduate Nurses, Career Crossroads, Top 10 Leavers and Retire & Return, to support this initiative.

Monthly audits of vacancy advertisements continue to ensure compliance against the guidance and advert template to ensure the quality of information provided and to further develop the Trust branding and promote the Trust values.

All staff benefits and rewards are centrally located on the intranet. Trust and NHS rewards are communicated to applicants and new employees.

The Nursing recruitment campaign has been refreshed with a view to focusing on Community nursing roles and hard to fill medical wards. There has also been an increased presence at jobs and careers fairs. The Trust also attended the annual Stockport Councils jobs fair at the Town Hall and have re-established contacts with the Job Centre to improve the flow of applicants into a number of Facilities roles.

The first cohort of the Pre-Employment Programme (PEP) was launched in January 2018. This programme was developed in conjunction with Stockport/Trafford College, the Job Centre and the Trust comprising of a 10 week programme, 4 weeks level 1 accreditation and a 6 week work placement. 15 placements were offered in a variety of entry level roles within the Trust from portering and catering to administrative and MLA roles. 9 of these completed the 10 week placement and 6 have been offered roles within the Trust. This has been a great success and the second cohort of the programme commenced in April 2018.

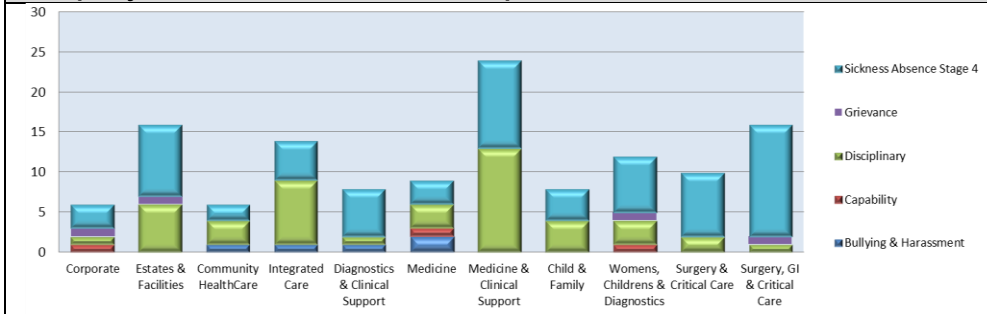
There are currently 13 staff on the Trainee Nurse Associate programme who are due to complete in February 2019. Agreement was made for a second cohort of 40 TNA's split over two intakes for 2018. 17 of these will commence in post on the 30th March 2018. The majority of the training costs for these are funded via the Apprenticeship levy.

In order to support well defined career pathways and contribute to improved retention rates, the Trust approved funding to uplift 17 Band 5 inpatient nursing posts to Band 6. 15 of these have commenced in post. It was also agreed in September 2017 to reimburse the DBS and Professional Registration cost for all newly qualified nurses and remunerate them on the mid-point of Band 4 whilst awaiting their PIN. This was in response to the high withdrawal rate of newly qualified staff and competition from neighbouring Trusts.

The Trust has provided 191 work experience placements, of up to 5 days each, during 2017/18. These placements offer an insight into working for the NHS for school and college students to enable them to make decisions about future careers. The placements have been provided mainly on the hospital wards with a few in pharmacy, physiotherapy and administrative areas.

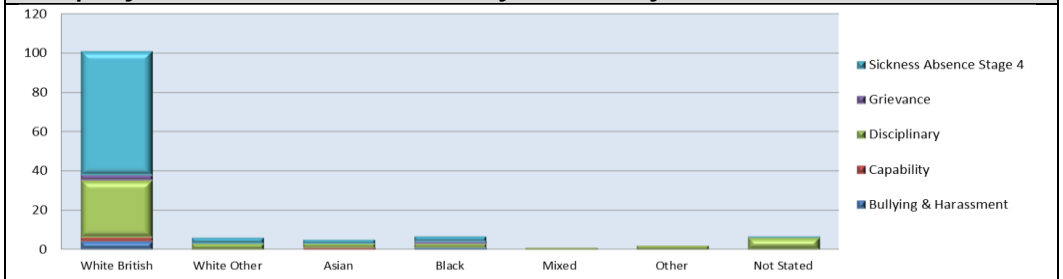
7. Employee Relations

Employee Relations Cases April'17 to March'18



- The following data relates to closed cases during the period.
- The table above shows the Business Groups pre and post the changes in September 2017.
- 129 ER cases were completed during the year; 72 Stage 4 Sickness Absence hearings, 45 Disciplinary Investigations, 5 Bullying & Harassment investigations, 4 Formal Grievance hearings and 3 Formal Capability hearings.

Employee Relations Cases by Ethnicity

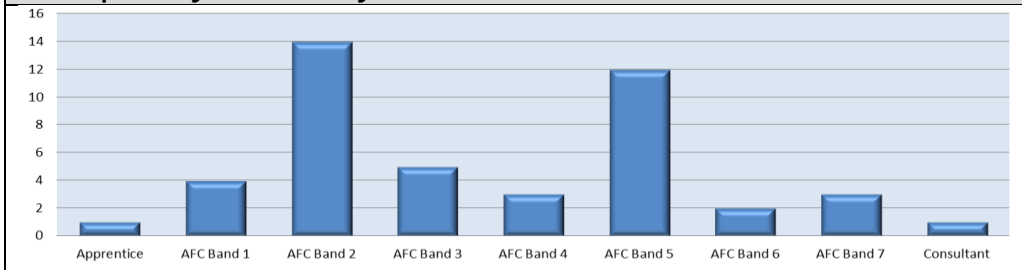


- The ethnicity data shows a lower number of mixed, Asian, Black, Chinese, Other staff going through ER processes (11.6%) compared with the Trust profile of 14%.
- When reviewing the disciplinary outcomes, there is no evidence of negative bias between sanctions (informal action, fast track, hearing) based on ethnicity.

Review of Suspensions

- There were 7 suspensions during the year; Medicine & Clinical Support 3, Integrated Care 3, Estates & Facilities 1.
- The bands and ethnicity were consistent with the Trust profile (3 x Band 2, 3 x Band 5, 1 x Band 6. 3 x White British, 1 x Asian, 3 x not declared.)
- The gender split however was not consistent with the Trust profile with 4 of the 7 suspended staff being male. However following a review of the allegations, suspension was appropriate in all cases. 2 were dismissed, 1 received a final written warning and the other resigned prior to hearing.
- 3 were Additional Clinical Services, 2 Nursing & Midwifery Registered, 1 Healthcare Scientist and 1 Additional Prof, Scientific & Tech.

Disciplinary Cases by Band / Grade



- 45 Disciplinary investigations were conducted during the year. 10 resulted in informal action, 16 in a fast track first written warning and 17 resulted in a disciplinary hearing. Of these 5 were dismissed, 7 received a final warning, 1 a first warning and the remainder resigned prior to the hearing.
- The grades of staff are consistent with the Trust profile with the majority of staff being with bands 2 and 5.

8. HR & OD Developments

The **E-Rostering implementation plan** has been divided into two separate plans; clinical and non-clinical. The non-clinical was recognised as requiring significantly less training resource, as the system will be used as mainly an absence tool for standard rota pattern users. From June 2017 to November 2017, 9 clinical units were transferred from SMART onto Health Roster, against the initial plan of 31 units. It is evident that the initial plan was over ambitious in terms of the complexities involved and the level of engagement and training required. Significant delays have occurred in the delivery of the plan and therefore a decision was made to place the plan on hold in November 2017 due to absence of a key member of the team. Without the resources and the system expertise and as this system has the potential to impact pay when not managed thoroughly, the business as usual activity was prioritised and the plan was temporarily paused. The non-clinical implementation plan has progressed on track with the transfer of 38 units onto Health Roster during 2017/18. Moving forward, 151 units, (of varying size) require the full implementation. This accounts for the remaining 3,000 SMART licences required. A review of the workforce resources required to support the roll out is underway.

ESR Self Service has been available for staff and managers for a number of years, however, the Trust took the decision to move from paper payslips to an electronic version, accessed through ESR, early in 2017. This was introduced over a number of months and all staff (with the exception of bank staff and leavers) should now access their payslips electronically. The move to electronic payslips was also intended to make staff aware of the wider benefits of ESR Self Service e.g. the ability for staff to amend their own personal details, managers to access their team details. Information from the national ESR team shows that 80.45% of Trust staff have accessed the Self Service portal, which has ranked us in the top 20 Trusts in England for accessing ESR Self Service. The next steps are to highlight the benefits of Self Service for managers/supervisors. Therefore, current guidance on the type of available information is being refreshed and drop-in sessions will be available over the coming months. This will provide managers with the knowledge of where to access commonly requested workforce information to enable them to manage their staff more effectively.

Last year a **Health and Wellbeing** Day was organised to raise awareness of the initiatives the Trust provides to support mental and physical health and wellbeing. This was very successful and another date is being arranged in the Summer, including access to a suitable community based site to reach as many staff as possible. The revised Health and Wellbeing leaflet will be re-launched shortly detailing initiatives and signposting appropriate support mechanisms and facilities.

Work is continuing with the **cultural ambassadors** to drive the wider message of integrating our common Trust values, visions and goals. This includes supporting colleagues in living the values, capturing best practice in each area that can contribute to a positive culture, supporting the Health and Wellbeing Initiatives and professionally challenging poor practice and behaviour. This is a voluntary initiative to help promote and sustain a positive culture.

A programme of work specific to the needs of the Trusts current and emerging leaders has been designed, developed and implemented. A theoretical framework along with practical expertise led to the development of a toolkit that supports learning and is sustainable – e.g., coaching, mentoring, large group work, small group discussions, skills workshops or individual development.

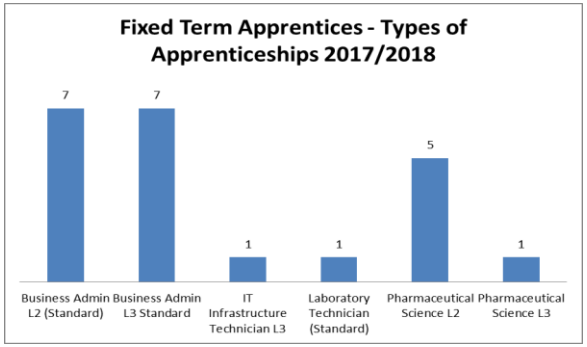
The Trust's **Leadership Programme** has delivered the following to date:

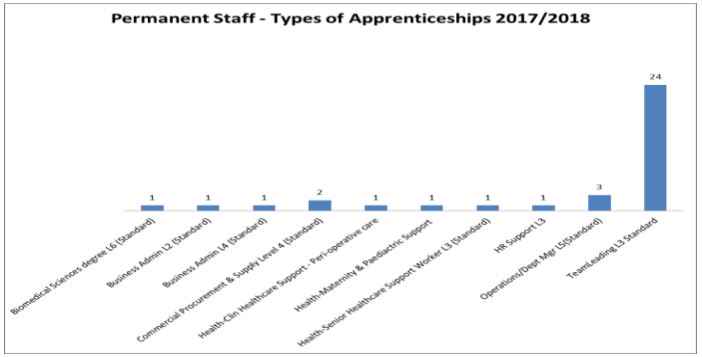
- Holding to Account: delivered to five hundred managers, this course was designed to support managers to offer a range of strategies to effectively

monitor and motivate performance in a 'high challenge – high support culture.

- Team Resilience (including MBTI): To identify resilience for self and teams, identify negative and positive states; determine external factors that impact on resilience and a toolkit to support resilience in others (20 teams supported to date).
- Fully accredited Coaching/Neuro Linguistic Programming (15 senior leaders): further dates in September 2018 and January 2019. The Coaches will join the internal network and support coaching in-house through the Organisational Development Team.
- Clinical Directors Induction based on Compassionate Leadership, Resilience and Coaching
- Nursing and AHP Development (commenced 9th May 2018): including, Resourceful Leadership, Resilience, Personality Profiling, Compassionate Leadership, Mindfulness, Goal Setting Self-Awareness. First cohort commenced and will run throughout the year until 2019.
- Human Factors in Healthcare: Global Air Specialists have developed a bespoke programme for the Trust and are delivering three practical based full day sessions.
- Series of Masterclasses that offer learning from all key areas:
    - Project Management
    - Transformation
    - Performance
    - Coaching
    - Courageous Conversations
    - IT
    - Raising Concerns.

The **apprenticeship levy** commenced in April 2017 with the Trust paying 0.5% of its monthly payroll into its Digital Apprenticeship Account. This may be used for apprenticeship training for fixed term apprentices or for permanent staff to gain qualifications and career development. From April 2017 to March 2018, the Trust spent £53,336.76 on apprenticeship training programmes. To the end of March 2018, there was £723,223.90 in the Trust's Digital Apprenticeship Account. A breakdown of the types of apprenticeship training programmes:





In addition, the Trust has a public sector target of 2.3% of their staff to be employed as new starts over each financial year. This can be new recruits or as part of career development for permanent staff. The Trust's target for 2017/18 was 119 apprenticeships starts. In 2017/2018, 22 fixed term apprentices started (new recruits) and 36 permanent staff started apprenticeships, totalling 58 apprenticeship starts.

9. Future Plans

A further 151 units require transfer from SMART onto Health Roster. A review of the additional workforce resources required to support the roll out is underway. The implementation plan will be reviewed to prioritise the remaining units according to Trust preferences, based on those areas already using both SMART and E-Roster. A full engagement plan will be undertaken with the Business Groups prior to commencing the implementation plan.

Managers are asked to consider recruiting apprentices when jobs are considered at the Establishment Control Panel and more apprenticeship standards are being developed e.g. nurse degree, management degree and advanced clinical nurse practitioner apprenticeships. Permanent staff may perceive apprenticeship training as only suitable for apprentices and not recognise the opportunities for further development.

There is a comprehensive programme of work underway to support the reduction of agency expenditure. This includes:
Substantive recruitment from within the UK targeted at newly qualified professional groups. International recruitment to source professionals with appropriate qualifications to attract registration with an enhanced induction to the NHS. Development and growth of the nursing and medical bank to better use a more affordable, flexible workforce rather than rely on the agency workforce at much more premium rates. Increased booking and approval controls to ensure that agency staff are only brought in when truly needed. Retention strategies to address the core reason that substantive staff leave the Trust. Job re-design to make hard to fill specialities more attractive, to include rotation, joint specialty posts etc.

We are developing a new Workforce strategy for 2018 -2020 and this will have separate OD strategy aligned to that will incorporate Leadership, engagement and culture.

Ensure appropriate support is provided to the strategic & tactical change programme, for example sharing of services.

Stockport Neighborhood Care (SNC) is a major transformation programme across the health and social care partners in Stockport. Following a year of operational deployment of the workforce models within the Neighbourhood and Borough Wide models of care, the services across Stockport Neighbourhood Care have identified areas where the current staffing levels are not fit for purpose. The teams have carried out reviews of the original workforce plans and business case proposals and have identified a number of operational changes to meet the current needs of the services. The alternative skill mix within the teams remains within the current financial envelope.

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Report To:	Board of Directors	**Date:**	24 May 2018
Subject:	Trust Integrated Performance Report (Reporting Period: Month 1 2018/19)		
Report of:	Director of Support Services	**Prepared by:**	Information & Performance Teams

REPORT FOR ASSURANCE

Corporate Objective Ref:	☐ Completed ☑ Not Required	**Summary of Report** Trust Integrated Performance Report enclosed.
Board Assurance Framework Ref:	☐ Completed ☑ Not Required	
CQC Registration Standards Ref:	☐ Completed ☑ Not Required	
Equality Impact Assessment:	☐ Completed ☑ Not Required	

Attachments:

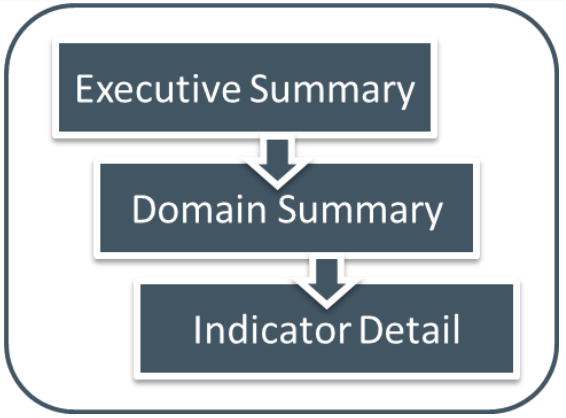
This subject has previously been reported to:	☐ Board of Directors	☐ SD Committee
	☐ Council of Governor	☐ Charitable Funds Committee
	☐ Audit Committee	☐ Nominations Committee
	☐ Executive Team	☐ Remuneration Committee
	☐ Quality Assurance Committee	☐ Joint Negotiating Council
	☐ F&P Committee	☐ Other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

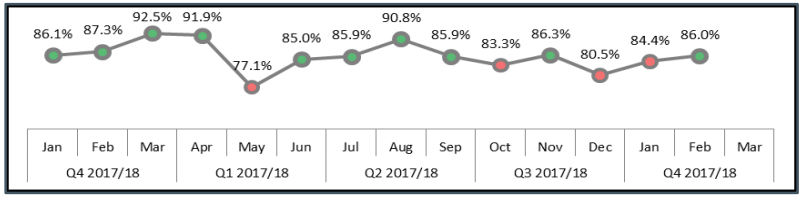
Domain Summary: Provides a summary of indicator level performance, arranged by Care Quality domain. For each indicator, performance against target is shown at Trust and Business Group level (where applicable). A grey marker reflects there is no target at this point in time. Page numbers on this level of the report advise where the detailed information for each indicator can be located.



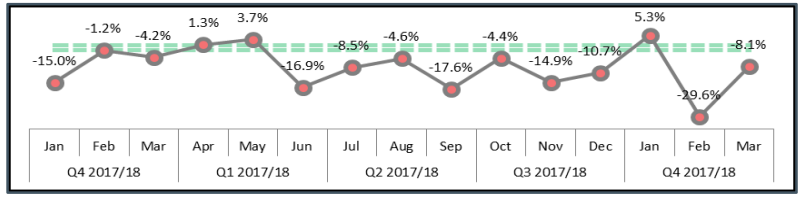
Indicator Detail: Provides detailed information for each indicator. This includes a chart representing the performance trend, and narrative describing the actions that are being undertaken in relation to performance. Specific Quality metrics will be reported a month in arrears as agreed by the Chief Nurse and Medical

Chart Summary

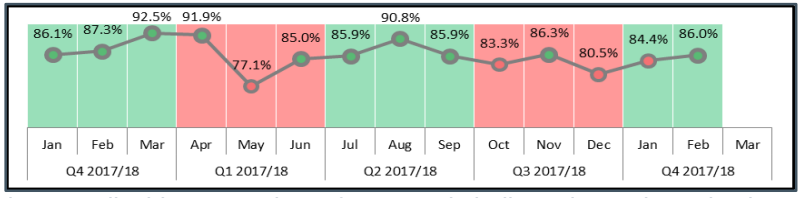
The following chart types are in use throughout the report:



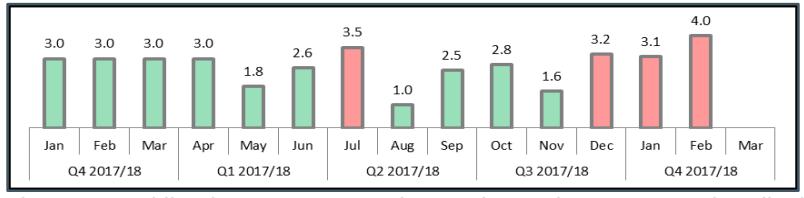
Trends are represented as a line where possible, with each monthly marker coloured to indicate achievement or non-achievement against target.



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.

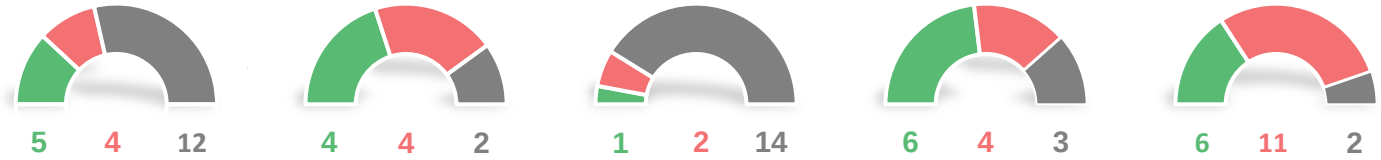


Where a trend line is not as appropriate, column charts are used to display information on indicator counts and totals.

Executive Summary

Stockport NHS Foundation Trust

Performance



Indicators

C.Diff Infection Count (lapses)	Bank & Agency Costs	Complaints Rate	A&E: 4hr Standard	Agency Spend: Cap
C.Diff Infection Rate	Emergency C-Section Rate	DSSA (mixed sex)	Cancer 62 Day Standard	I&E Position
E.Coli Infection Rate	HSMR Mortality Ratio	Friends & Family: A&E	Dementia: Finding Question	I&E Margin
MRSA Infection Rate	SHMI Mortality Ratio	Friends & Family: Inpatient	Diagnostics: 6 Week Standard	Financial Sustainability
MSSA Infection Rate	Never Events	Friends & Family: Maternity	RTT: Incomplete Pathways	Sickness Absence Rate
VTE Risk Assessment	Patient Safety Incident Rate	Patient Safety Alerts		Workforce Turnover

Key Changes to the indicators in this period are:
Safe:
Effective:
Caring:
Responsive:
Efficient:

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													
C.Diff Infection Rate	CN&DQG	Mar-18		9.35							12.78		32
C.Diff Infection Count (lapses in care)	CN&DQG	Mar-18	<=17 *	0							4		32
MRSA Infection Rate	CN&DQG	Mar-18		0.89							0.40		33
MSSA Infection Rate	CN&DQG	Mar-18		8.46							7.87		33
E.Coli Infection Rate	CN&DQG	Mar-18		20.03							21.60		34
E.Coli Infection Count	CN&DQG	Mar-18	<=37 *	5							45		34
Falls: Total Incidence of Inpatient Falls	CN&DQG	Apr-18	<=115 *	120							120		35
Falls: Causing Moderate Harm and Above	CN&DQG	Apr-18	<=15 *	1							1		35
Pressure Ulcers: Hospital, Stage 2	CN&DQG	Mar-18		7							78		36
Pressure Ulcers: Hospital, Stage 3	CN&DQG	Mar-18		1							11		36
Pressure Ulcers: Hospital, Stage 4	CN&DQG	Mar-18		0							3		37
Pressure Ulcers: Community, Stage 2	CN&DQG	Mar-18		11							192		37
Pressure Ulcers: Community, Stage 3	CN&DQG	Mar-18		2							29		38

* Target calculated against Cumulative/YTD performance
** YTD figures related to 2017/18

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, Stage 4	CN&DQG	Mar-18		1		↑					9	Δ	38
Safety Thermometer: Hospital	CN&DQG	Apr-18	>= *95%*	95.3%		↑					95.3%	Δ	39
Medication Errors: Overall	CN&DQG	Apr-18		64		↓					64		39
Medication Errors: Moderate Harm and Above	CN&DQG	Apr-18		3.1%		↑					3.1%		40
VTE Risk Assessment	CN&DQG	Mar-18	>= *95%*	96.5%		↓					96.3%		40
Clinical Correspondence	COO	Apr-18	>= *95%*	71.8%		↑					71.8%		41
Flu Vacination Uptake	DoW&OD	Mar-18	>= *70%*	78.6%		↑					71.1%	Δ	41
Discharge Summaries	MD	Apr-18	>= *95%*	85.3%		↑					85.3%		42

* Target calculated against Cumulative/YTD performance
** YTD figures related to 2017/18

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
Effective													
Patient Safety Incident Rate	CN&DQG	Apr-18		47.22		↓							20
Emergency C-Section Rate	CN&DQG	Apr-18	<= 15.4%	16.6%		↓					16.6%		21
Never Event: Incidence	CN&DQG	Apr-18	<= 0	0		↑					0	Δ	21
Duty of Candour Breaches	CN&DQG	Apr-18		0		↓					0	Δ	22
Stranded Patients	COO	Apr-18	<= 35%	47.0%		↓					47.0%		22
Delayed Transfers of Care (DTOC)	COO	Apr-18	<= 3.3%	2.1%		↓					2.1%		23
Medical Optimised Awaiting Transfer (MOAT)	COO	Apr-18	<= 40	110		↓					110		23
Bank & Agency Costs	DoW&OD	Apr-18	<= 5%	11.3%		→					11.3%	Δ	24
Mortality: HSMR	MD	Feb-18	<= 100	93.22		↓							24
Mortality: SHMI	MD	Nov-17	<= 1	0.95		↓						Δ	25

* Target calculated against Cumulative/YTD performance
** YTD figures related to 2017/18

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	Apr-18	>= 100%	80.0%							80.0%		12
DSSA (mixed sex)	CN&DQG	Apr-18	<= 0	0							0	Δ	12
Complaints Rate	CN&DQG	Apr-18		1.0%							1.0%		13
Complaints: Response Rate 25	CN&DQG	Apr-18		1.9%							1.9%		13
Complaints: Response Rate 45	CN&DQG	Apr-18		9.3%							9.3%		14
Complaints: Ombudsmen Cases	CN&DQG	Apr-18		0							0		14
Complaints Closed: Overall	CN&DQG	Apr-18		54							54		15
Complaints Closed: Upheld	CN&DQG	Apr-18		9							9		15
Complaints Closed: Partially Upheld	CN&DQG	Apr-18		25							25		16
Complaints Closed: Not Upheld	CN&DQG	Apr-18		20							20		16
Compliments	CN&DQG	Apr-18		2							2		17
Friends & Family Test: Response Rate	CN&DQG	Apr-18		28.3%							28.3%		17
Friends & Family Test: Inpatient	CN&DQG	Apr-18		95.0%							95.0%		18

* Target calculated against Cumulative/YTD performance
** YTD figures related to 2017/18

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: A&E	CN&DQG	Apr-18		90.0%		↑					90.0%		18
Friends & Family Test: Maternity	CN&DQG	Apr-18		96.3%		↓					96.3%		19
Staff Friends & Family Test	CN&DQG	Mar-18		73.7%		↓					76.4%		19
Diabetes Reviews	MD	Apr-18	>= 90%	59.5%		↑					59.5%		20

* Target calculated against Cumulative/YTD performance
** YTD figures related to 2017/18

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													
Dementia: Finding Question	CN&DQG	Mar-18	>= 90%	93.3%							92.9%		25
Dementia: Assessment	CN&DQG	Mar-18	>= 90%	100.0%							92.2%		26
Dementia: Referral	CN&DQG	Mar-18	>= 90%	100.0%							98.1%		26
Serious Incidents: STEIS Reportable	CN&DQG	Apr-18		6							6		27
Litigation: Claims	CN&DQG	Apr-18		5							5		27
Litigation: Key Risk Claims Rate	CN&DQG	Apr-18		100.0%							100.0%		28
A&E: 4hr Standard	COO	Apr-18	>= 95%	80.2%							80.2%		28
A&E: 12hr Trolley Wait	COO	Apr-18	<= 0	7							7		29
Cancer 62 Day Standard	COO	Apr-18	>= 85%	88.6%							88.6%		29
Diagnostics: 6 Week Standard	COO	Apr-18	>= 99%	99.4%							99.4%		30
Referral to Treatment: Incomplete Pathways	COO	Apr-18	>= 92%	87.8%							87.8%		30
Outpatient Activity vs. Plan	COO	Apr-18	<= 1%	-0.5%							-0.5%		31
Elective Activity vs. Plan	COO	Apr-18	+/- 1%	-6.1%							-6.1%		31

* Target calculated against Cumulative/YTD performance
** YTD figures related to 2017/18

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													
Financial Efficiency: I&E Margin	DoF	Apr-18	<= 2	4							4		42
Financial Controls: I&E Position	DoF	Apr-18	<= 1%	-2.3%							-2.3%		43
Cash	DoF	Apr-18	+/- 1%	5.6%							5.6%		43
Financial Use of Resources	DoF	Apr-18	<= 3	3							3		44
Elective Income vs. Plan	DoF	Apr-18	+/- 1%	-9.8%							-9.8%		44
CIP Cumulative Achievement	DoF	Apr-18	+/- 1%	-53.2%							-53.2%		45
Capital Expenditure	DoF	Apr-18	+/- 10%	-20.9%							-20.9%		45
Financial Sustainability	DoF	Apr-18	<= 2	4							4		46
Sickness Absence Rate	DoW&OD	Apr-18	<= 3.5%	4.1%							4.1%		46
Appraisal Rate: Non-medical	DoW&OD	Apr-18	>= 95%	95.1%							95.1%		47
Appraisal Rate: Medical	DoW&OD	Apr-18	>= 95%	95.7%							95.7%		47
Statutory & Mandatory Training	DoW&OD	Apr-18	>= 90%	91.3%							91.3%		48
Workforce Turnover	DoW&OD	Apr-18	<= 13.94%	13.9%									48

* Target calculated against Cumulative/YTD performance
** YTD figures related to 2017/18

Domain Summary

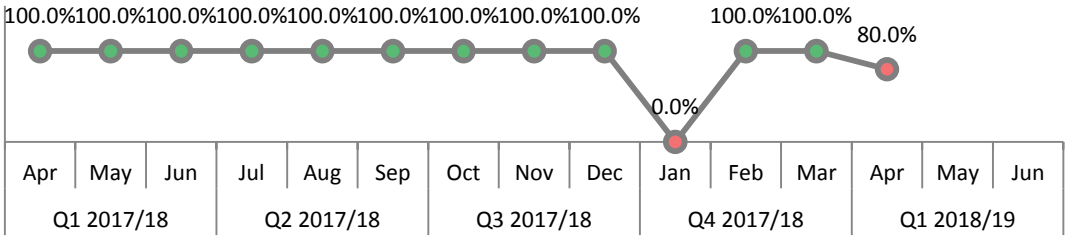
Indicator	Exec	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Efficient / Well Led													
Staff in Post	DoW&OD	Apr-18	>= 90%	89.7%							89.7%		49
Agency Shifts Above Cap	DoW&OD	Apr-18	<= 0	783							783		49
Agency Spend: Distance from Cap	DoW&OD	Apr-18	<= 3%	14.6%							14.6%		50
Mortality: Deaths in ED or as Inpatient	MD	Apr-18		107							107		50
Mortality: Case Note Reviews	MD	Apr-18		33							33		51
Emergency Readmission Rate	MD	Feb-18	<= 7.9%	8.4%							8.6%		51

* Target calculated against Cumulative/YTD performance
** YTD figures related to 2017/18

Indicator Detail

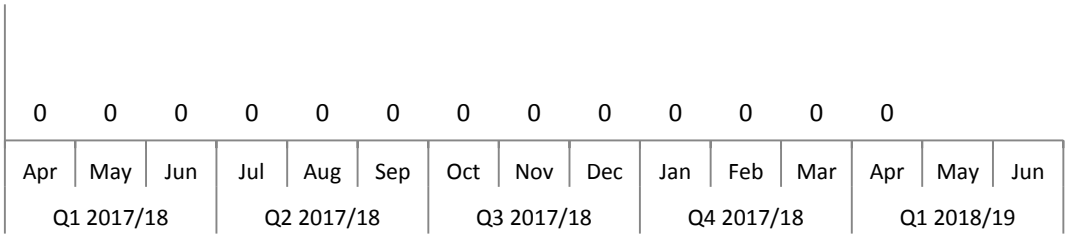
Apr-18	Patient Safety Alerts: Completion
1	The percentage of Patient Safety Alerts that are completed within their due date.
Target	In April 2018, 5 patient safety alerts were due to be closed with all actions taken. There was a delay in closing one alert.
>= 100%	

Actions
The CAS alert system is in use and this will prevent a reoccurrence of the delay of alerts being circulated.



Apr-18	DSSA (mixed sex)
0.0%	Total number of occasions sexes were mixed on same sex wards
Target	Our aim is to have no breaches of the delivery of single sex accommodation. There were no breaches in April 2018.
<= 0	

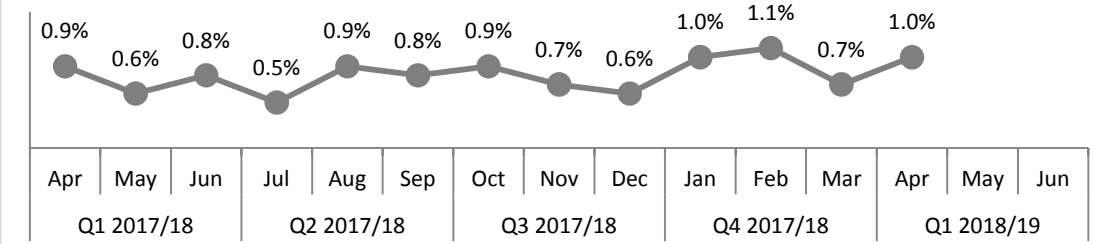
Actions
This standard is monitored through the patient experience group. There is no current actions required as we are meeting this standards.



Indicator Detail

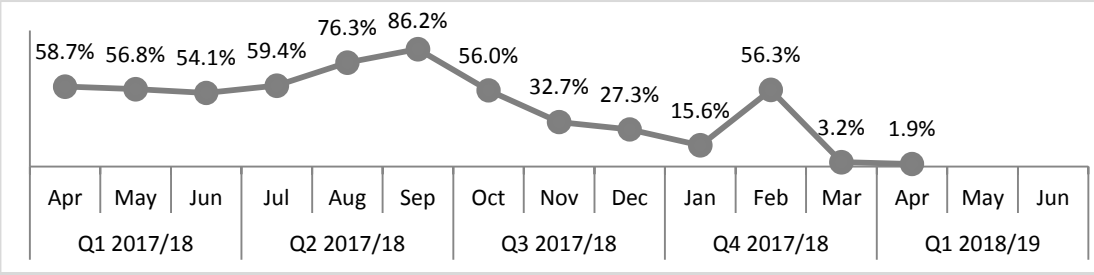
Apr-18	Complaints Rate
1.0%	The total number of formal written complaints received compared with the whole time equivalent staff.
Target	The management of complaints is under review and this has resulted in a delay in how efficiently complaints are being managed.

Actions
A full review of the complaints process is in progress.



Apr-18	Complaints: Response Rate 25
1.9%	The percentage of formal complaints responded to within 25 days.
Target	Following discussions with our commissioners, there has been an agreement to change the timescales of formal complaints being handled within 25 days to 45 days.

Actions
These changes will be incorporated within the complaints policy which is currently under review.

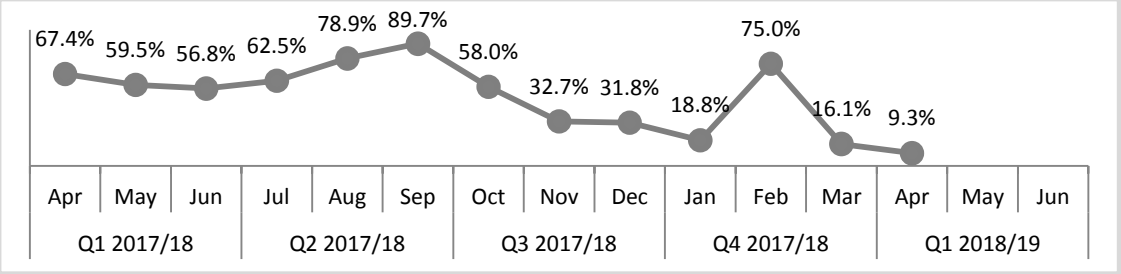


Indicator Detail

Apr-18	Complaints: Response Rate 45
9.3%	The percentage of formal complaints responded to within 45 days.
Target	The management of complaints is under review and this has resulted in a delay in how efficiently complaints are being managed.

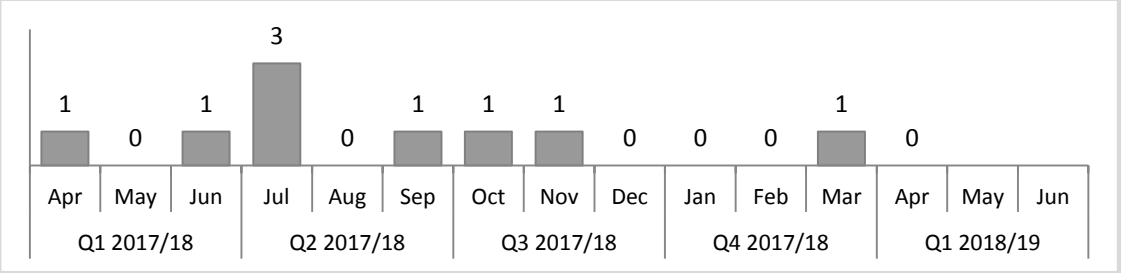
Actions

During quarter 1 a trajectory will be developed to record and monitor improvements in complaint responses.
The triangulation of data will enable us to give a thematic analysis of overall patient experience at the trust.



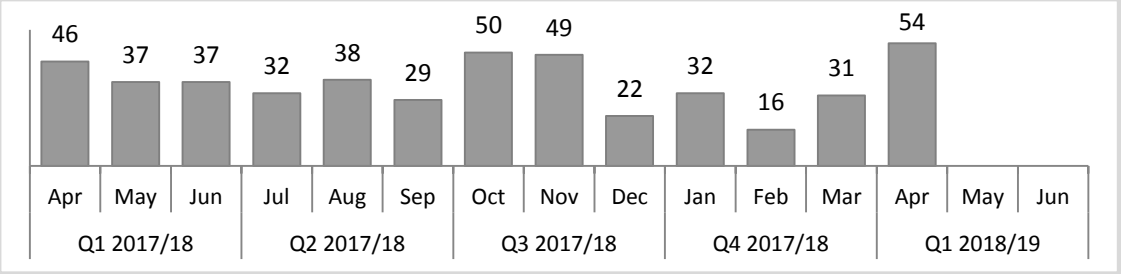
Apr-18	Complaints: Ombudsmen Cases
0	The total number of open Ombudsmen cases.
Target	The management of complaints is under review and this has resulted in a delay in how efficiently complaints are being managed.

Actions



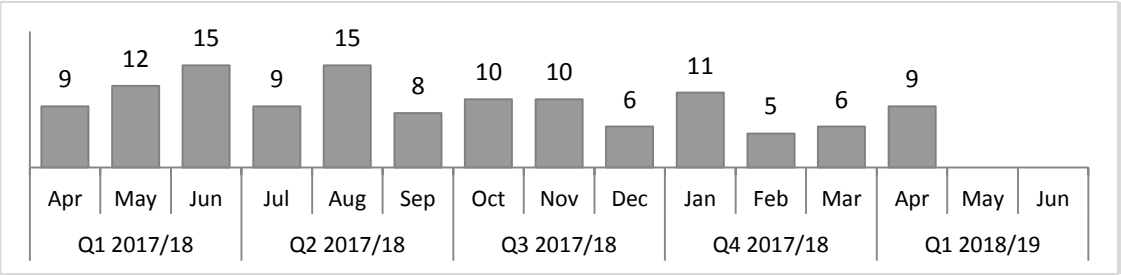
Indicator Detail

Apr-18	Complaints Closed: Overall
54	The total number of formal complaints that have been closed.
Target	The management of complaints is under review and this has resulted in a delay in how efficiently complaints are being managed.



Actions
During quarter 1 a trajectory will be developed to record and monitor improvements in compliant responses.

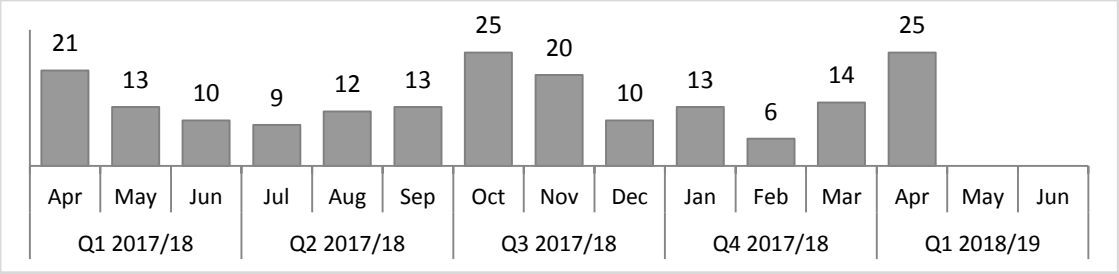
Apr-18	Complaints Closed: Upheld
9	The total number of upheld formal complaints that have been closed.
Target	The management of complaints is under review and this has resulted in a delay in how efficiently complaints are being managed.



Actions
We are developing a process whereby themes from closed complaints will available following the review of the complaints policy.

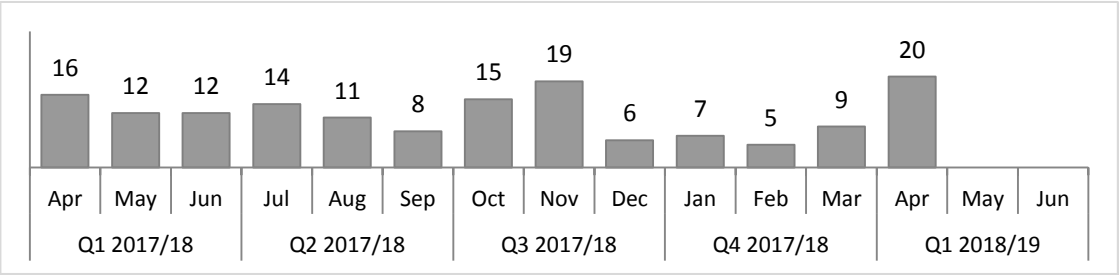
Indicator Detail

Apr-18	Complaints Closed: Partially Upheld
25	The total number of partially upheld formal complaints that have been closed.
Target	The management of complaints is under review and this has resulted in a delay in how efficiently complaints are being managed.



Actions
We are developing a process whereby themes from closed complaints will available following the review of the complaints policy.

Apr-18	Complaints Closed: Not Upheld
20	The total number of not upheld formal complaints that have been closed.
Target	The management of complaints is under review and this has resulted in a delay in how efficiently complaints are being managed.

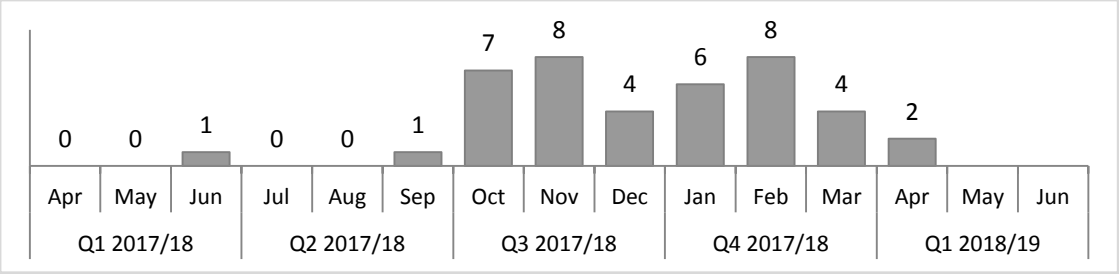


Actions
We are developing a process whereby themes from closed complaints will available following the review of the complaints policy.

Indicator Detail

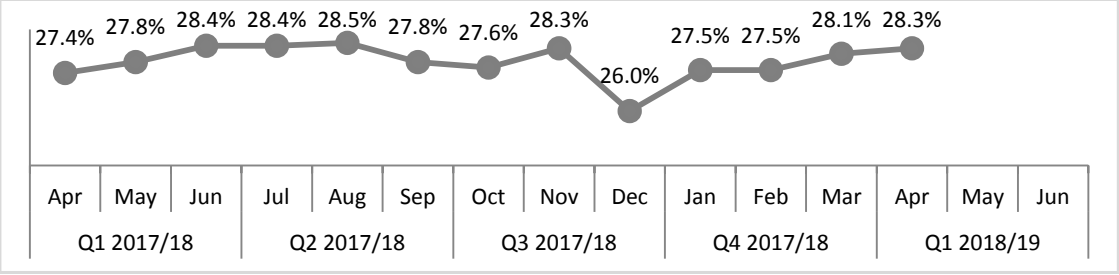
Apr-18	Compliments
2	Total number of compliments received.
Target	The collection of compliments is not a well established process currently.

Actions
The complaints policy is currently under review and will include the recording of compliments going forward.



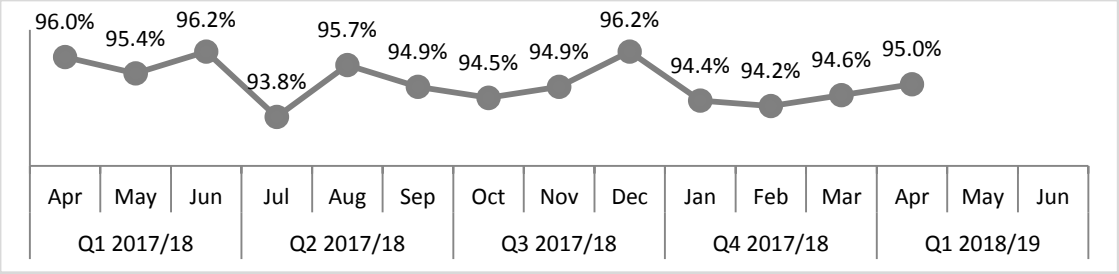
Apr-18	Friends & Family Test: Response Rate
28.3%	The percentage of eligible patients completing an FFT survey.
Target	There is not a required response rate for the Family and Friends Test for the organisation.

Actions
The importance of feedback from patients and relatives is crucial to supporting the quality improvement plan for the organisation. The patient experience strategy is in development and will outline the key areas of focus in line with the objectives of the quality improvement plan.



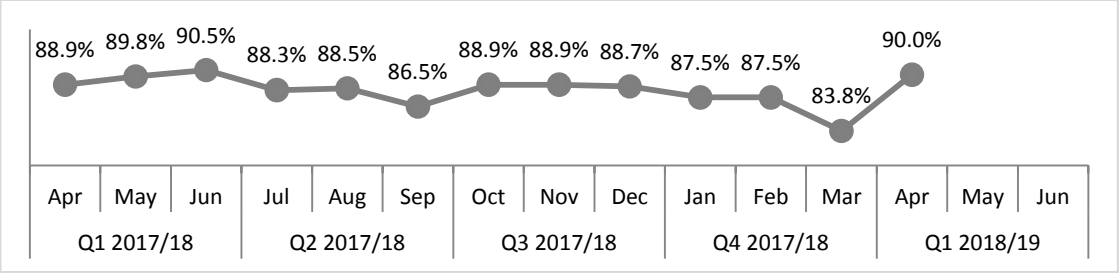
Indicator Detail

Apr-18	Friends & Family Test: Inpatient
95.0%	The percentage of surveyed inpatients who are extremely likey or likely to recommend the Trust for care.
Target	Positive comments received for inpatient areas were related to kind, friendly, professional staff. Negative comments continue to relate to the lack of nursing staff, poor cleanliness in some areas and poor communication.



Actions
Ensure feedback is provided to the teams involved in providing care. The triangulation of data related to patient experience is being developed to ensure the themes are captured and will be shared in the patient experience report going forward. The Trust is working with NHS Improvement to support the workforce strategy with a number of work streams developed. These include: Supporting staff to move ward areas Recruitment fairs and events International recruitment

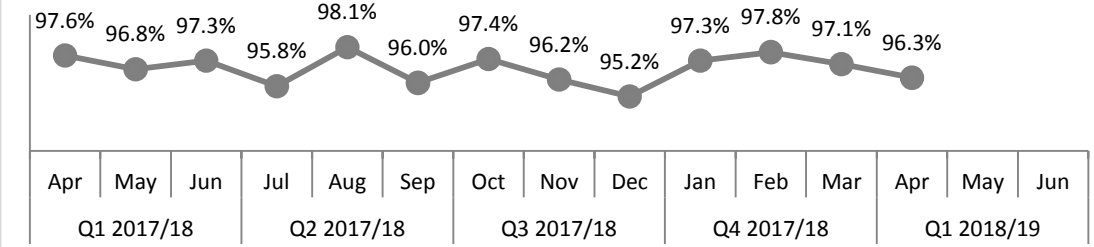
Apr-18	Friends & Family Test: A&E
90.0%	The percentage of surveyed A&E patients who are extremely likey or likely to recommend the Trust for care.
Target	Positive comments related to caring staff working extremely hard under challenging circumstances. Many positive comments related to friendly, cheerful staff. Negative comments continue to relate to long waiting times.



Actions
Ensure the positive feedback is received to the teams involved in providing care. The waiting times in the emergency department remain a challenge and there is a workstream associated with improving overall performance.

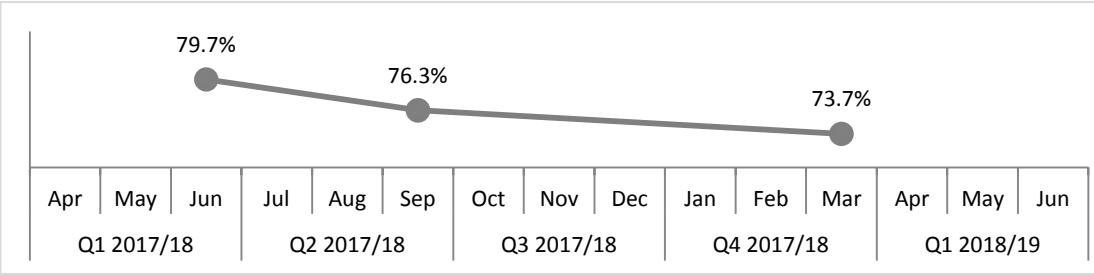
Indicator Detail

Apr-18	Friends & Family Test: Maternity
96.3%	The percentage of surveyed maternity patients who are extremely likey or likely to recommend the Trust for care.
Target	All comments continue to be positive and continue to be related to caring and compassionate staff. Many positive comments were made about the excellent advice and support given in relation to breastfeeding.



Actions
Ensure the feedback is received to the teams involved in providing care.

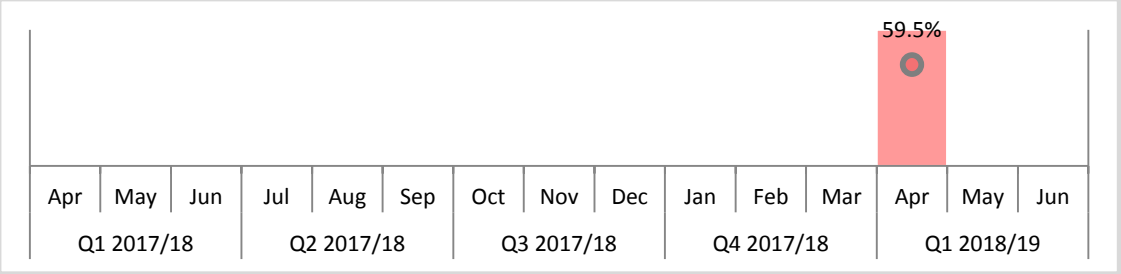
Mar-18	Staff Friends & Family Test
73.7%	The percentage of all surveyed staff who are extremely likely or likely to recommend the Trust for care.
Target	The survey is undertaken on a quarterly basis.



Actions

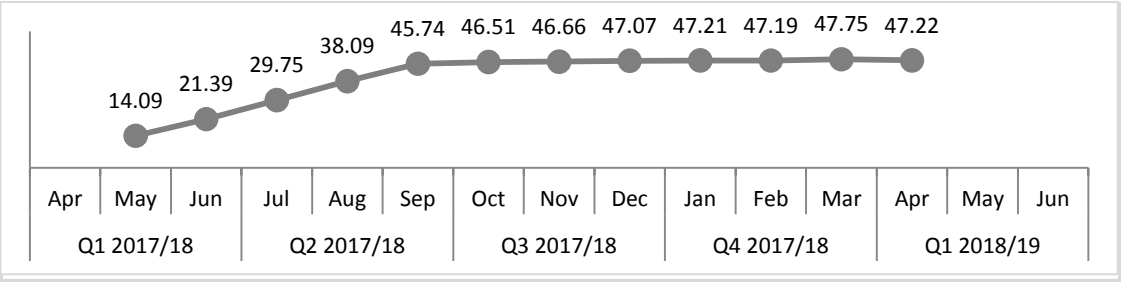
Indicator Detail

Apr-18	Diabetes Reviews
59.5%	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	This is a new metric, and represents a first attempt to summarise the management of clinically significant hypoglycaemia by the specialist diabetes team. 59.5% of Inpatients with clinically significant hypoglycaemia in the month of April 2018 were reviewed by a member of the Diabetes specialist team.
>= 90%	



Actions
We will continue to work on the collection of this data and the improvement in the performance against this metric.

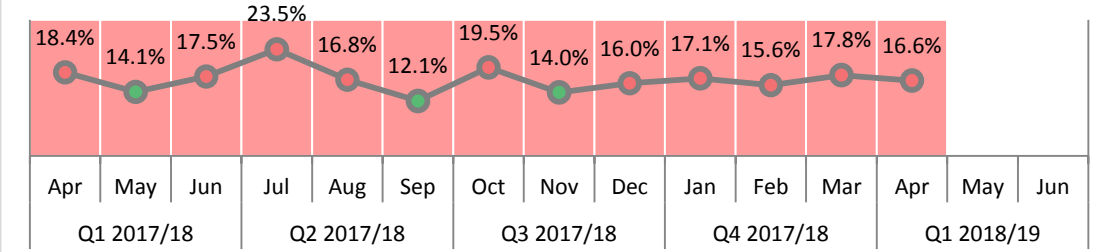
Apr-18	Patient Safety Incident Rate
47.22	Average number of patient safety incidents for every 1000 bed days, calculated using a rolling 6 month number of reported patient safety incidents compared to the rolling 6 month average number of bed days per 1000.
Target	There have been 810 incidents reported in April. The most common occurring incidents are those associated with Pressure Ulcers, followed by slips, trips and falls.



Actions
Incidents are reviewed in the business groups, with scrutiny and oversight provided by the weekly Patient Safety Summit. Lessons learned are immediately shared through the Patient Safety Summit update sent to all staff.

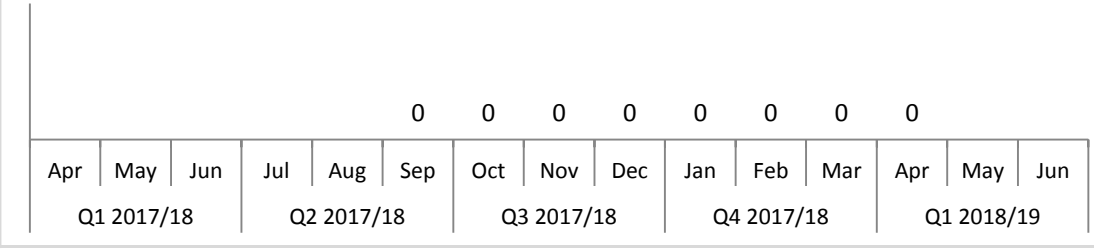
Indicator Detail

Apr-18	Emergency C-Section Rate
16.6%	The percentage of births where the mother was admitted as an emergency and had a c-section.
Target	
<= 15.4%	



Actions

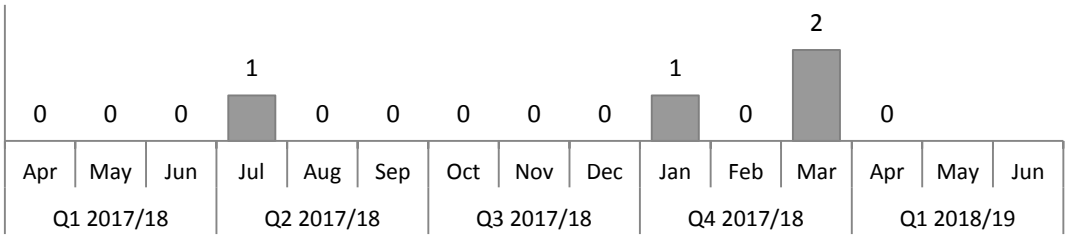
Apr-18	Never Event: Incidence
0	Total number of never events. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
Target	There have been no never events in month
<= 0	



Actions
The updated never events list can be found on the Trust Intranet. Information has been circulated through the newsletter "Risky Business" The trajectory for never events is 0

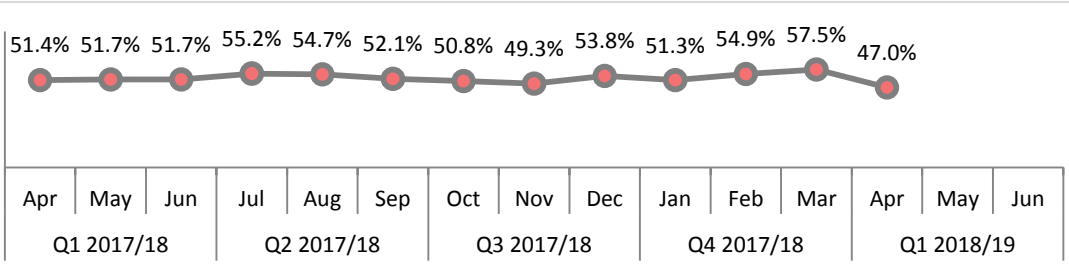
Indicator Detail

Apr-18	Duty of Candour Breaches
0	Total number of Duty of Candour breaches in month.
Target	There has been 1 incident during the month of April 2018 where Duty of Candour was required. This was completed by the Business Group



Actions
The process of Duty of Candour is recorded within the Datix system. Business Groups have been requested to ensure that Duty of Candour, both opening and closing, is accurately recorded within the datix system. Business Groups have also been requested to record 'being open' conversations with patients when an incident of moderate harm has occurred.

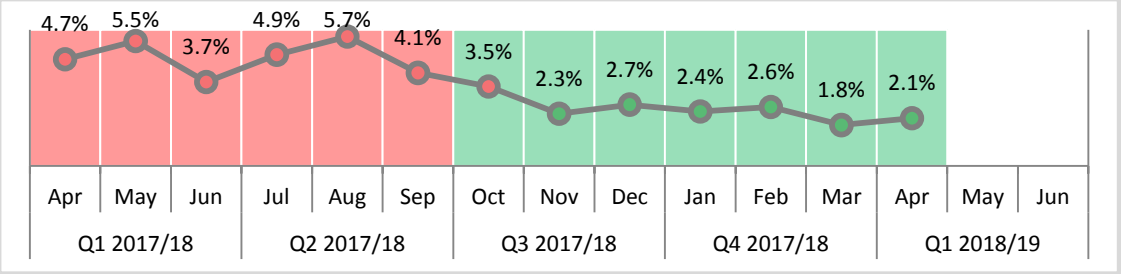
Apr-18	Stranded Patients
47.0%	The percentage of patient that have had a length of stay of 7 days or more. This is an average number calculated using daily snapshot data.
Target	The number of stranded patients has reduced significantly in month and has continued during May to date.
<= 35%	



Actions
To support further improvement on this position, the following actions are happening: Weekly 'Grand Rounds' are now taking place Advantis Ward is being further developed to enable daily reports for interrogation. Programmes of work are taking place around specific themes that have emerged.

Indicator Detail

Apr-18	Delayed Transfers of Care (DTOC)
2.1%	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	DTOC performance continues to meet the set standard.
<= 3.3%	

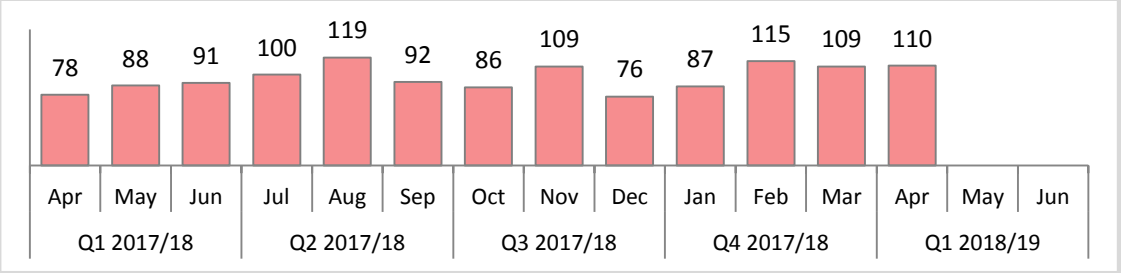


Actions

Early indications for May show an upward trend toward the upper limits of compliance.

Nursing Home Placements being the main concern. We are working with SMBC as lead commissioners to ensure this does not escalate further

Apr-18	Medical Optimised Awaiting Transfer (MOAT)
110	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 number of MOATs remain significant yet static with Nursing home placements and awaiting assessment being the major causes of delay
<= 40	



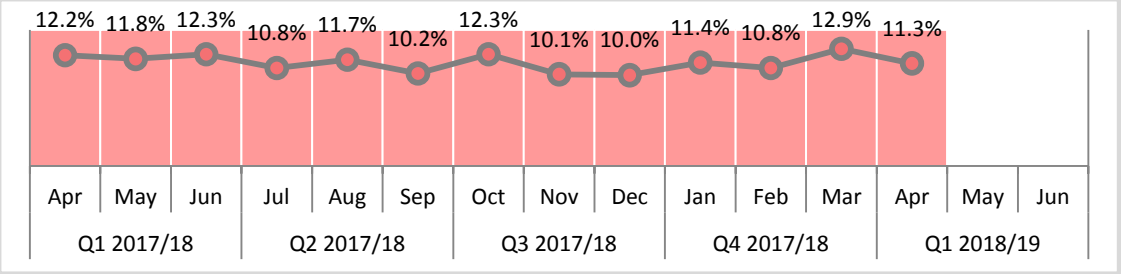
Actions

Actions are monitored through the Grand Rounds and Improving Patient Flow Steering group programmes of work:

- Red to Green
- AQuA project - Discharge Planning / Ward Round Checklist
- Fractured Neck of Femur Length of Stay
- Development of a Transfer to Assess Unit (Bluebell Ward)

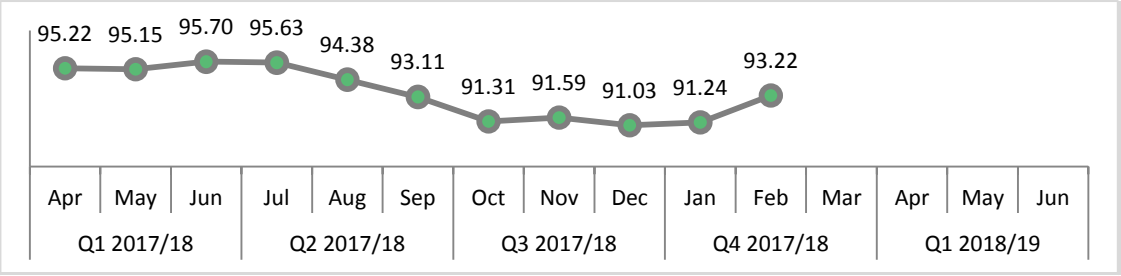
Indicator Detail

Apr-18	Bank & Agency Costs
11.3%	The total bank & agency cost as percentage of the total pay costs
Target	Bank and agency costs in April 2018 account for 11.28% (£2.81M) of the £18.510M total pay costs. This is a £0.72M increase from the position reported in March 2018 (£2.09M).
<= 5%	



Actions
Substantive recruitment from within the UK targeted at newly qualified professional groups. International recruitment to source professionals with appropriate qualifications to attract registration with an enhanced induction to the NHS. Development and growth of the bank. Increased booking and approval controls to ensure that agency staff are only used when essential. Retention strategies to address the core reason that substantive staff leave the Trust Job re-design to make hard to fill specialties more attractive, including rotations and joint specialty posts.

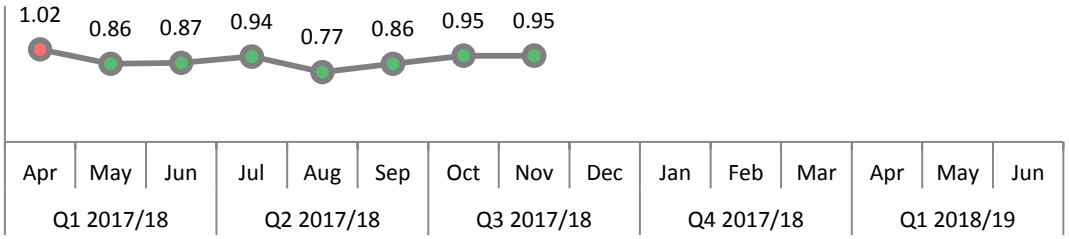
Feb-18	Mortality: HSMR
93.22	This is the ratio between the actual number of patients who either die while in hospital compared to the number of patients that would be expected to die based on whether patients are receiving palliative care, and socio-economic deprivation.
Target	This data represents a rolling twelve month mortality ratio. We need to ensure that our data is consistent with that published elsewhere, such that we do not get false reassurance from these results. Further clarity in next months report. Traditionally low levels of palliative care coding push our HSMR above average, but our SHMI below.
<= 100	



Actions
We need to triangulate these results with other sources to ensure consistent reporting.

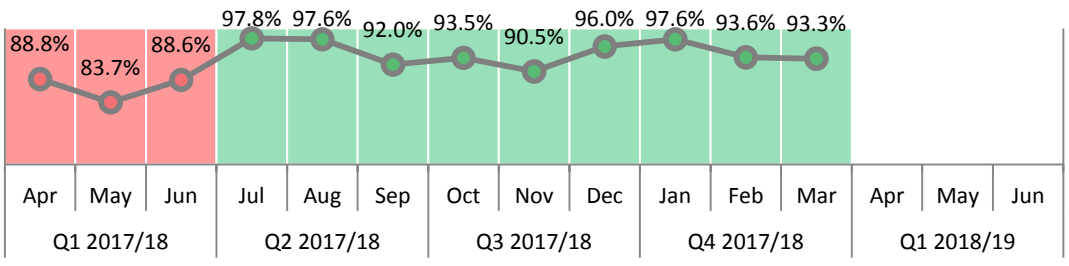
Indicator Detail

Nov-17	Mortality: SHMI
0.95	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	We have been anticipating an increase in SHMI, following a change in our coding practice relating to pneumonia. Fortunately our SHMI remains above average, and the second best in the region. We anticipate a slight worsening over the first quarter, with recovery over the second quarter of the year.
<= 1	



Actions

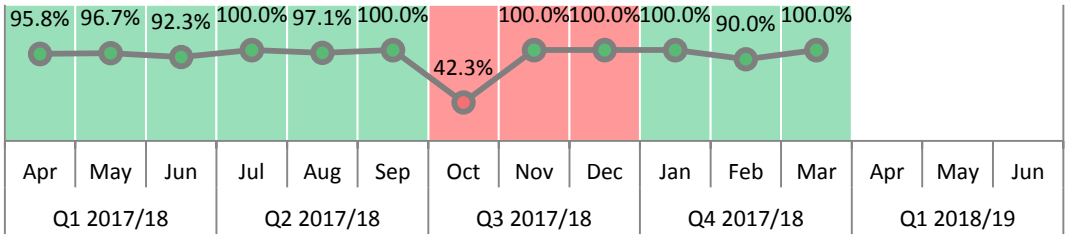
Mar-18	Dementia: Finding Question
93.3%	The percentage of eligible patients who have a diagnosis of dementia or delirium or to whom case finding is applied.
Target	The target has been achieved in month.
>= 90%	



Actions

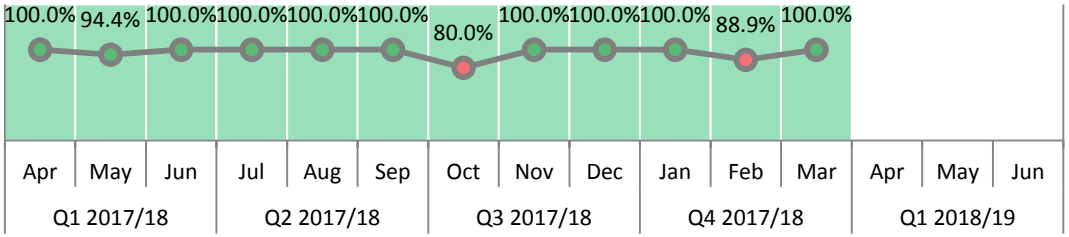
Indicator Detail

Mar-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 has been achieved in month
>= 90%	



Actions

Mar-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 has been achieved in month.
>= 90%	

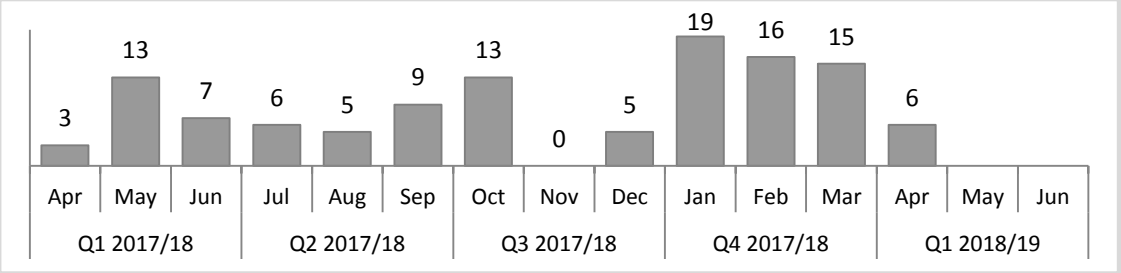


Actions

Indicator Detail

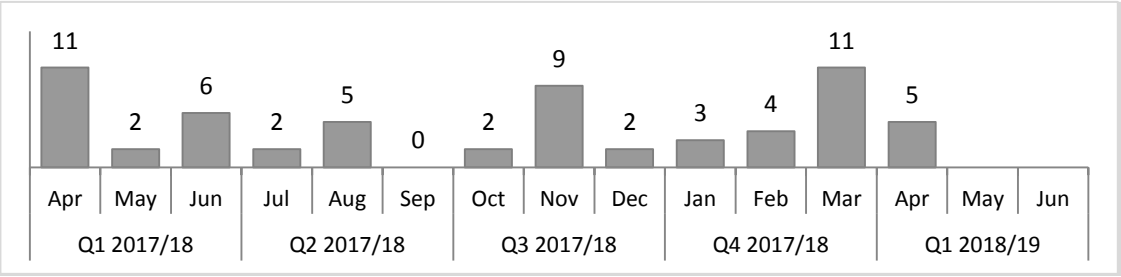
Apr-18	Serious Incidents: STEIS Reportable
6	The total number of STEIS reportable incidents.
Target	There have been 6 STEIS reportable incidents identified in month. 2 relating to a number of 12 hour breaches. 1 maternity divert. 1 patient death relating to treatment 1 delay in treatment

Actions
Each incident is subject to a Level 2 investigation.



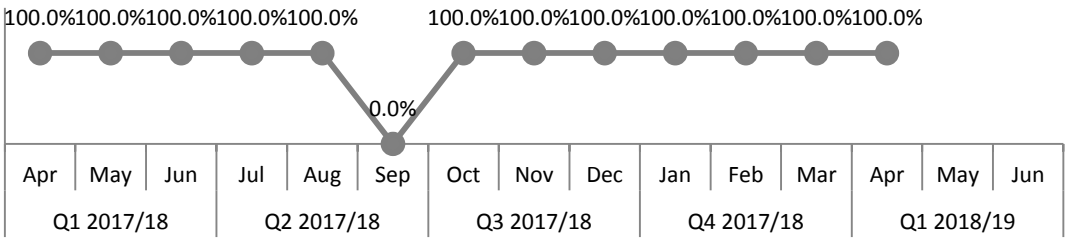
Apr-18	Litigation: Claims
5	Total number of claims opened in month.
Target	In April the Trust received 5 litigation claims, all were potential medical negligence claims.

Actions
The process for investigating the claims received has commenced.



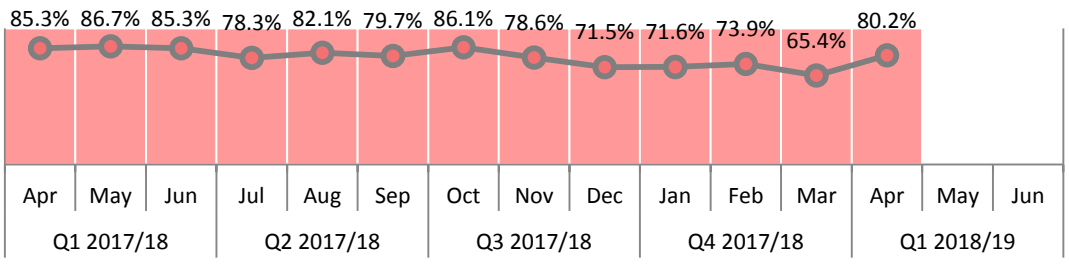
Indicator Detail

Apr-18	Litigation: Key Risk Claims Rate
100.0%	The percentage of claims opened in month that are related to key risk areas.
Target	5 litigation claims were received in April, all were potential medical negligence claims.



Actions

Apr-18	A&E: 4hr Standard
80.2%	The percentage of patients who were admitted, discharged, or leave A&E within 4 hours of their arrival.
Target	Performance against the 4hr standard significantly improved to 80.2% in April against the improvement trajectory of 78% for M1. Performance in May has continued to improve with the month to date position standing at 90.0%, at the time of writing against the 82% trajectory plan.
>= 95%	



Actions

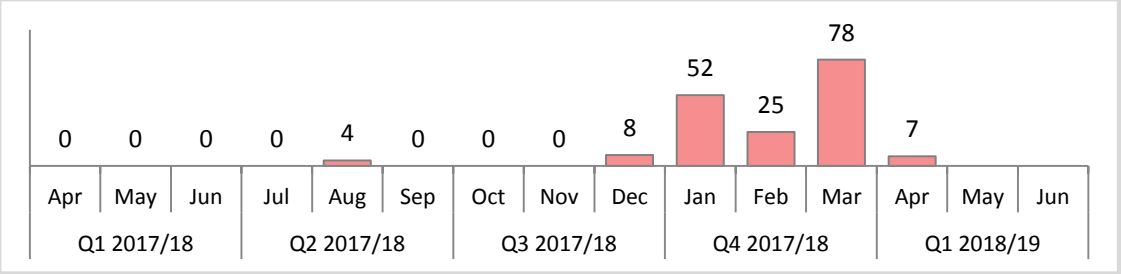
ED are focusing on an initiative called 'driving time to decide'. A set of metrics has been developed to help improve decision making time and ensure minimal delays at each stage of the patient pathway through the Emergency Department.

The Trust is also mindful of the need for a robust Winter plan, and as such Senior Executives are exploring innovative ways to flex and increase capacity and workforce to deal with inevitable seasonal demand.

In response to the Urgent Care pressures and workload, a Delivery Director has now been appointed, whose remit will be to operationally manage these daily pressures and processes.

Indicator Detail

Apr-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	A significant improvement in the number of 12 hour trolley waits in April with none reported to date for May.
<= 0	

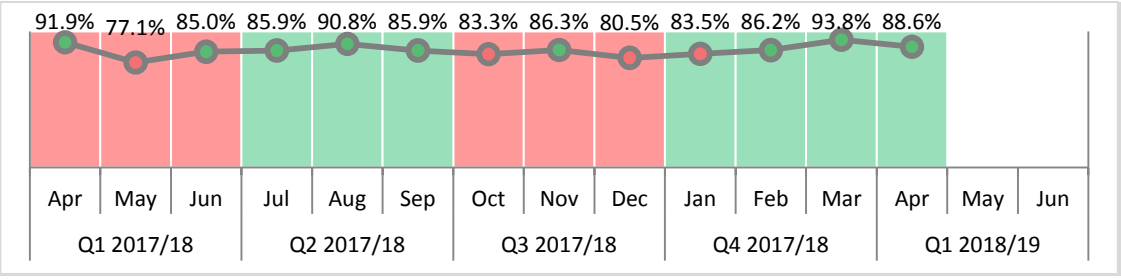


Actions

A root cause analysis is undertaken for each 12hr trolley wait.

To date, no patient harm events have been identified.
A review of the standard Operating procedure for recording 12 hour trolley waits is underway. This may see an increase in the number reported but will not adversely affect the patient journey and standard of care.

Apr-18	Cancer 62 Day Standard
88.6%	The percentage of patients on a cancer pathway that have received their first treatment within 62 days of their GP referral.
Target	The Trust is predicting to achieve the cancer standard for April. Whilst the position is not yet closed, the latest figures suggest a performance of 88.6%.
>= 85%	Waits for pathology reporting are generally increasing due to resource issues within the Clinical team.



Actions

Histopathology are outsourcing reporting in the short-medium term to minimise delays.

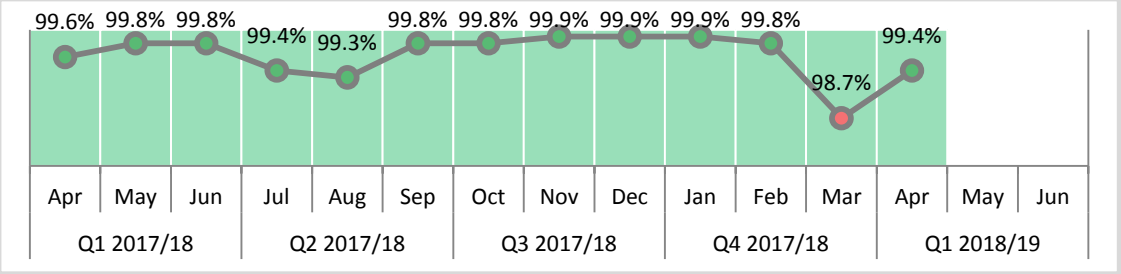
Colorectal are due to commence a "Straight to test" model.

More general themes of work across all tumour groups include:

- Clinically led review of pathways to facilitate the Faster Diagnosis Standard
- Increasing the number of patients being given an appointment by Day 7 of the pathway through daily monitoring and clinically-led prioritising of workload.

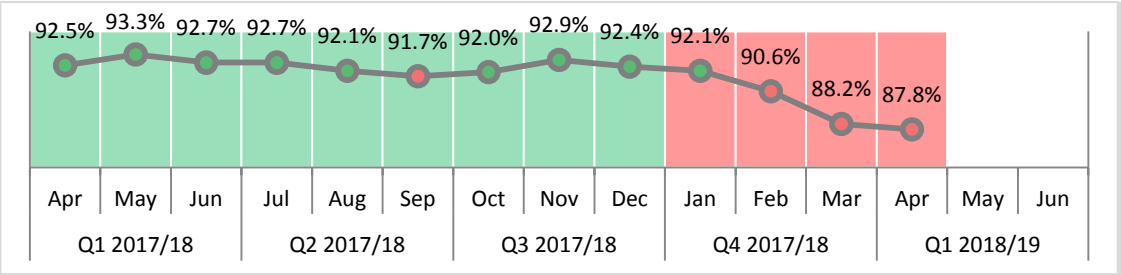
Indicator Detail

Apr-18	Diagnostics: 6 Week Standard
99.4%	The percentage of patients refered for diagnostic tests who have been waiting for less than 6 weeks.
Target	The Trust is predicting to achieve the diagnostic target in April, following a marginal fail in March which was due to capacity issues in Non-obstetric ultrasound and Echocardiography.
>= 99%	



Actions
Echocardiography is reliant on regular additional sessions in order to meet the 6 week standard. A capacity and demand piece of work is being undertaken, supported by the Transformation Team. An action plan will subsequently be compiled. Radiology have recently recruited to positions, and are undertaking a strategic service wide review of future capacity and resource requirements. The planned replacement of the Gamma Camera may adversely impact on the diagnostic standard for the next 12 weeks. Mitigation involves outsourcing to GM partners

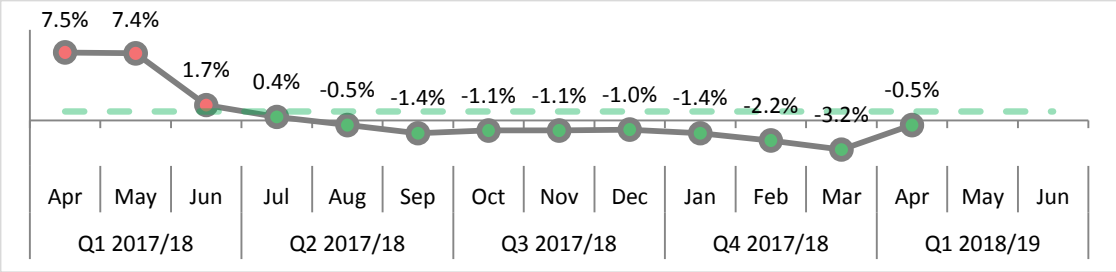
Apr-18	Referral to Treatment: Incomplete Pathways
87.8%	The percentage of patients whose pathway is still open and their clock period is less than 18 weeks.
Target	Although the Trust forecast non-compliance with the RTT standard throughout Q1, performance for April is below predicted levels. This is mainly due to the increased number of patients waiting beyond 18 weeks on a non-admitted pathway.
>= 92%	



Actions
The full elective operating programme resumed in April, which will start to impact on the admitted waiting list from May. Initial forecasts are looking positive for month end. The main areas of variance in the non-admitted waiting list are ENT, Urology, General Surgery and Cardiology. As resource issues in the Outpatient Booking Team are impacting on the ability to maximise clinic templates, a review of the processes and workload is due to be undertaken to ensure future resilience.

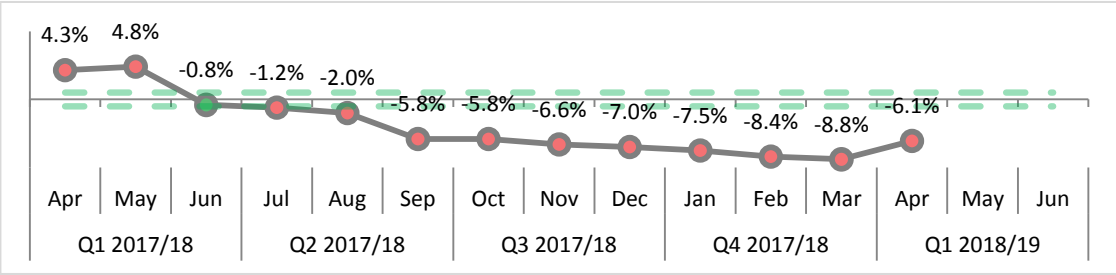
Indicator Detail

Apr-18	Outpatient Activity vs. Plan
-0.5%	The percentage variance between planned outpatient activity and actual outpatient activity.
Target	The Trust was 115 Outpatient attends adverse to plan in month 1 at aggregate level. WC&D and IC over-performed against plan, whilst the Medicine and Surgical Business Groups under-performed.
<= 1%	



Actions
Actions being undertaken in the main areas of negative variance are: Urology: renegotiating continued use of waiting list initiative sessions, as funded at out-turn. Oral surgery: reviewing the Service Level Agreement. The service is reliant on visiting Consultants maintaining monthly activity levels. Chest service: recruiting physiologists to strengthen lung function capacity which closely supports Out-Patient clinics General Surgery and Knees are expected to recover planned activity levels within Q1.

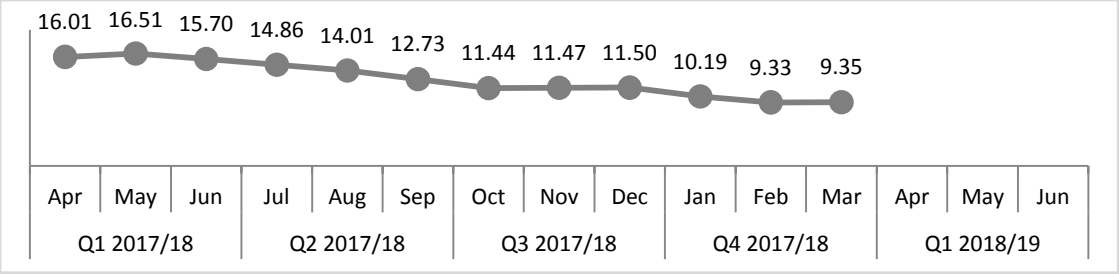
Apr-18	Elective Activity vs. Plan
-6.1%	The percentage variance between planned elective activity and actual elective activity.
Target	The Trust position for elective and day-case activity was 182 spells adverse to plan for month 1. The main areas negatively adverse to plan were Endoscopy, Urology, T&O and Oral Surgery.
+/- 1%	



Actions
The full elective programme resumed on 9th April, which will enable T&O to meet plan going forward. Other actions include: -An additional Nurse Endoscopist is being explored to increase nurse-delivered activity and help maximise throughput. -Additional HDU step-down capacity is being created to enable higher throughput of major cases. -T&O will be undertaking 4 joint replacements per operating list and adapting a senior Consultant job plan to accommodate an additional all day list. -Urology are looking to re-instate a locum Consultant post to maximise activity throughput.

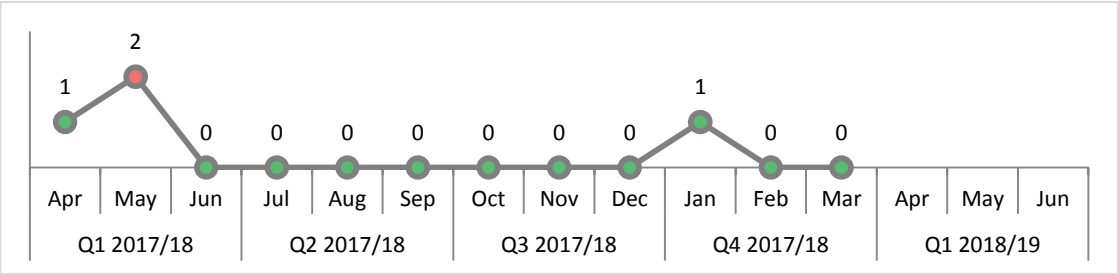
Indicator Detail

Mar-18	C.Diff Infection Rate
9.35	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 overall target set for Clostridium Difficile for 2017/18 was 39 cases in total with a target of 17 where lapses in care have been identified.



Actions
The target is monitored through the infection prevention committee.

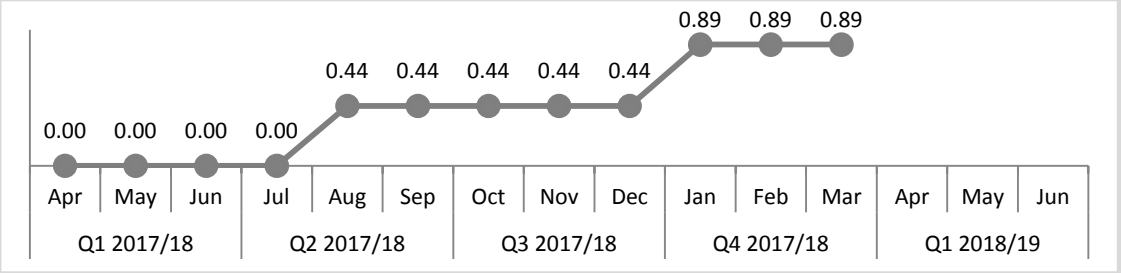
Mar-18	C.Diff Infection Count (lapses in care)
0	Total number of C.Diff infections due to lapses in care.
Target	Clostridium difficile data represented within this section relates to March 2018 due to incident reporting timescales. In March 2018 there were zero cases where lapses in care were identified.
<=17 *	During 2017-18 there has been 4 cases of Clostridium difficile that were found to have



Actions
The Infection Prevention and Control Team are undertaking the following actions to reduce the number of cases where lapses in care have been identified, these include: * Reviewing the new NICE draft guidance to combat drug resistant UTI's with the antibiotic pharmacists and consultant microbiologist * Working with the new clinical site coordinator team in relation to isolation of patients

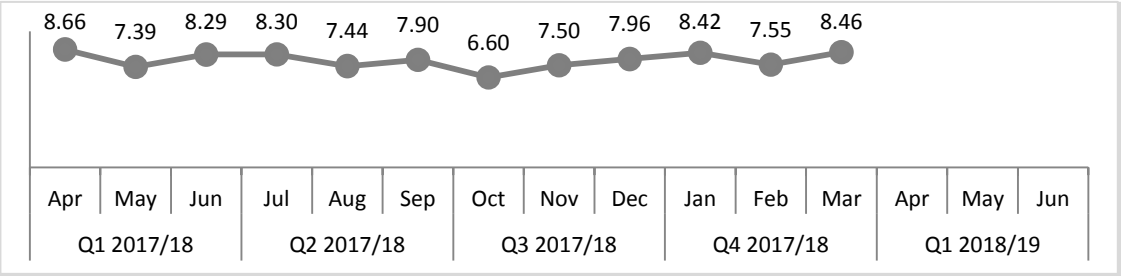
Indicator Detail

Mar-18	MRSA Infection Rate
0.89	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	The target for MRSA cases remains zero for 2018/19.



Actions
The target is monitored through the infection prevention committee.

Mar-18	MSSA Infection Rate
8.46	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	The MSSA infection rate is being viewed as a whole health economy rather than by individual trust.

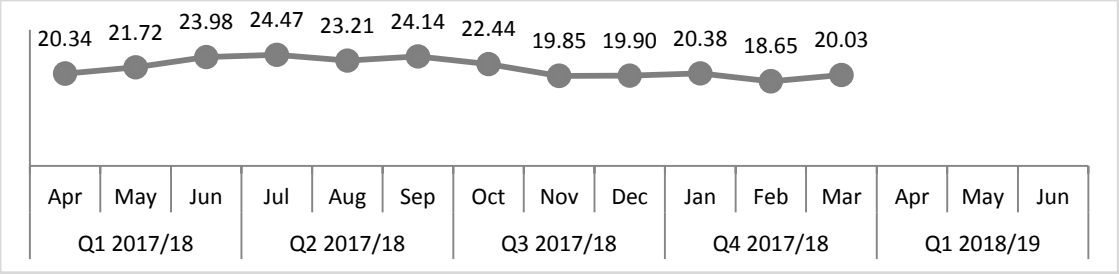


Actions
This will remain an agenda item on the trusts infection prevention committee.

Indicator Detail

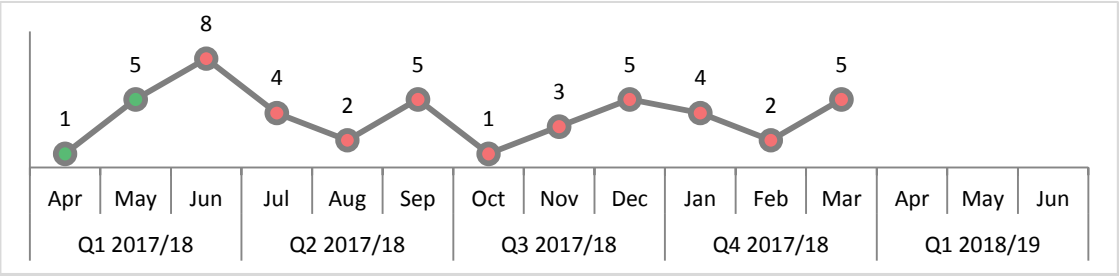
Mar-18	E.Coli Infection Rate
20.03	Average number of E.Coli infections for every 100,000 bed days, calculated using a rolling 12 month number of Trust-attributable E.Coli infections compared to the rolling 12 month average number of bed days per 100,000.
Target	Nationally there is an aim to reduce healthcare associated gram-negative blood stream infections by 50% by March 2021, firstly focusing on E coli infection as one of the largest groups.

Actions
This will be monitored through the infection prevention committee with a baseline being established during quarter 1 of 2018/19.



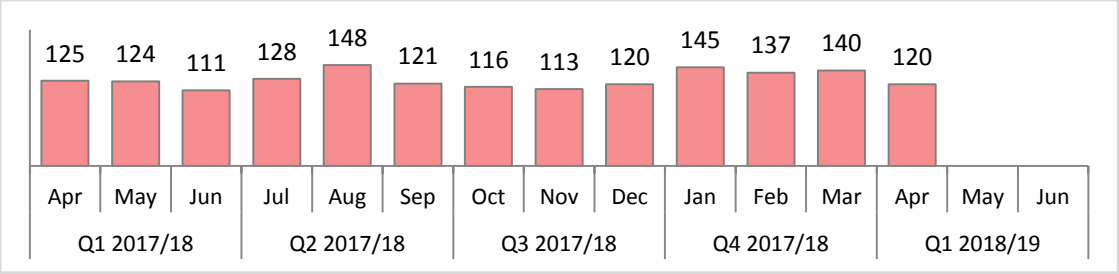
Mar-18	E.Coli Infection Count
5	Total number of E.Coli infections.
Target	Nationally there is an aim to reduce healthcare associated gram-negative blood stream infections by 50% by March 2021, firstly focusing on E coli infection as one of the largest groups.
<=37 *	

Actions
This will be monitored through the infection prevention committee with a baseline being established during quarter 1 of 2018/19.



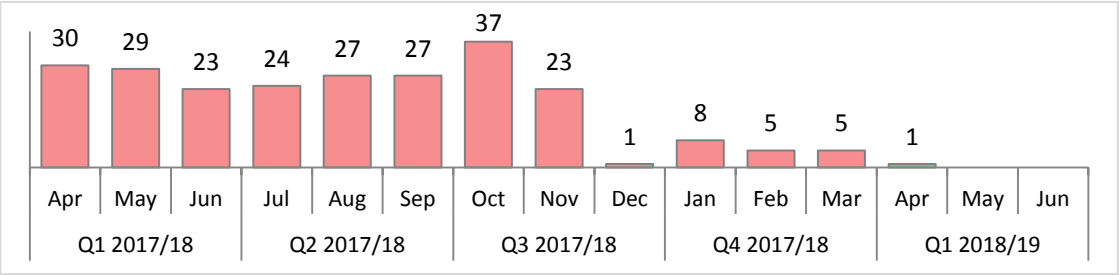
Indicator Detail

Apr-18	Falls: Total Incidence of Inpatient Falls
120	Total number of Inpatient falls
Target	Our Quality Improvement Aim is to reduce all in-patient falls by 10% compared to the total falls recorded in 2017/2018. In April 2018, 122 patients falls have occurred.
<=115 *	



Actions
As part of our Quality Improvement Plan, we have agreed a number of patient safety collaboratives. During Q1 208/19 we aim to introduce our patient mobility safety collaborative, which will support us in our drive to reduce the number of in-patient falls.

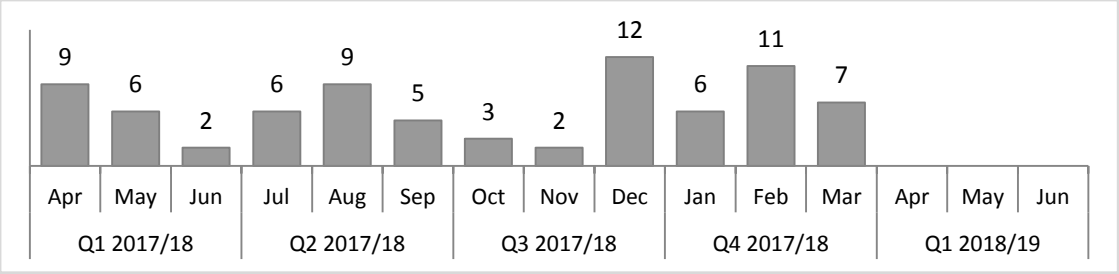
Apr-18	Falls: Causing Moderate Harm and Above
1	Total number of falls causing moderate harm and above.
Target	Our Quality Improvement aim is to reduce in-patient falls with harm by 25% compared to the total falls recorded in 2017/2018. The total number of falls with harm for April was 1. This resulted in a fractured pubic rami. This has been reported through the Strategic Executive Incident System. The total number of falls with harm for 2017/18 was 239.
<=15 *	



Actions
As part of our Quality Improvement Plan, we have agreed a number of patient safety collaboratives. During Q1 208/19 we aim to introduce our patient mobility safety collaborative, which will support us in our drive to reduce the number of in-patient falls. The fall in April 2018 is currently under investigation by the business group.

Indicator Detail

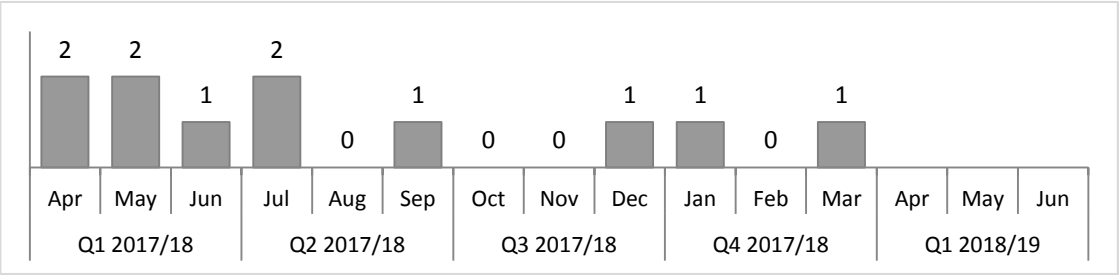
Mar-18	Pressure Ulcers: Hospital, Stage 2
7	Total number of stage 2 pressure ulcers in a hospital setting.
Target	Through our Quality Improvement Plan, it is our aim to reduce hospital acquired stage 2 pressure ulcers by 50% by end March 2019. The figure represented here relates to March 2018 as stage 2 pressure ulcers that relate to April 2018 are not yet validated.



Actions

In line with our Quality Improvement Plan, we launched our Pressure Ulcer Safety Collaborative in March 2018. The collaborative provides a Trust wide approach to reducing hospital acquired pressure ulcers through a series of work-streams, these include:
The introduction of a specific assessment tool
The development of a link nurse steering group
The role out of React to Red training package
The use of safety crosses across all wards

Mar-18	Pressure Ulcers: Hospital, Stage 3
1	Total number of stage 3 pressure ulcers in a hospital setting.
Target	Through our Quality Improvement Plan, it is our aim to reduce hospital acquired stage 3 pressure ulcers by 50% by end March 2019. The figure represented here relates to March 2018 as stage 3 pressure ulcers that relate to April 2018 are not yet validated.



Actions

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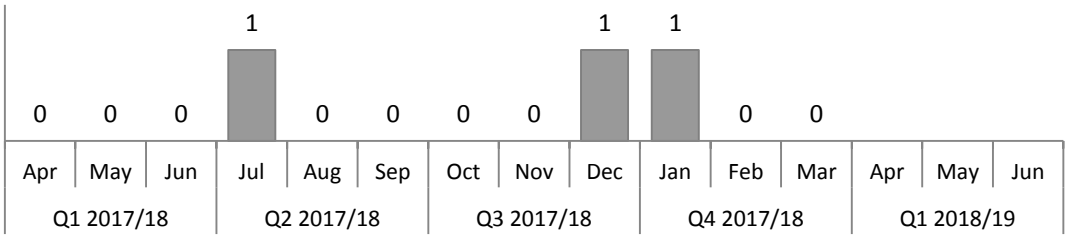
The introduction of a specific assessment tool
The development of a link nurse steering group
The role out of React to Red training package
The use of safety crosses across all wards

It is possible due to an increase in vigilance and visibility of concern, an increase in incident reporting may be seen, as staff education and awareness is raised.

Indicator Detail

Mar-18	Pressure Ulcers: Hospital, Stage 4
0	Total number of stage 4 pressure ulcers in a hospital setting.
Target	Through our Quality Improvement Plan, it is our aim to reduce hospital acquired stage 4 pressure ulcers by 50% by end March 2019. The figure represented here relates to March 2018 as stage 4 pressure ulcers that relate to April 2018 are not yet validated.



Actions

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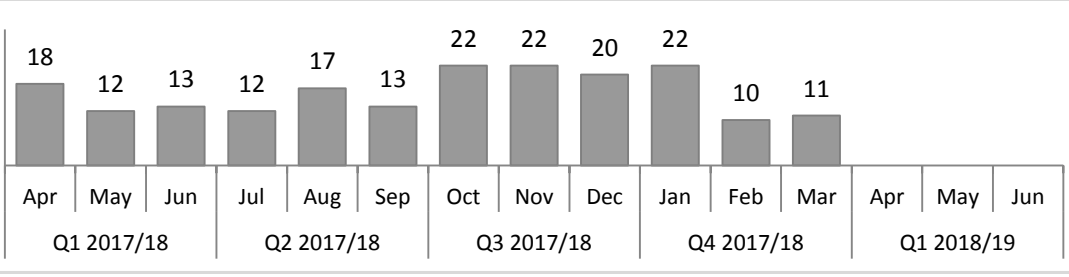
The introduction of a specific assessment tool
The development of a link nurse steering group
The role out of React to Red training package
The use of safety crosses across all wards

It is possible due to an increase in vigilance and visibility of concern, an increase in incident reporting may be seen, as staff education and awareness is raised.

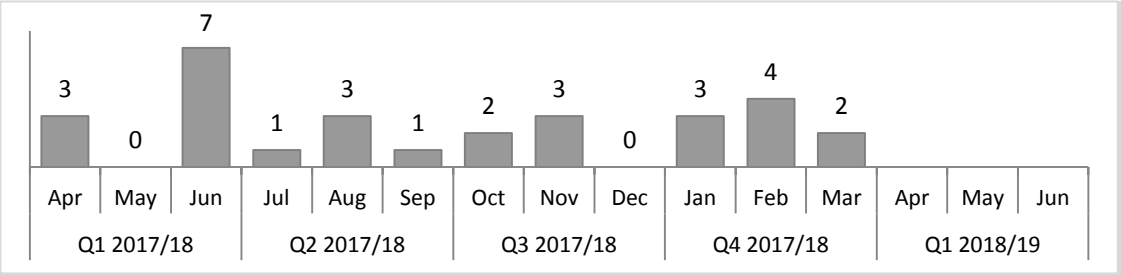
Mar-18	Pressure Ulcers: Community, Stage 2
11.00	Total number of stage 2 pressure ulcers in a community setting.
Target	Through our Quality Improvement Plan, it is our aim to reduce community acquired stage 2 pressure ulcers by 50% by end March 2019. The figure represented here relates to March 2018 as stage 2 pressure ulcers that relate to April 2018 are not yet validated.



Actions

In line with our Quality Improvement Plan, we launched our Pressure Ulcer Safety Collaborative in March 2018. The collaborative provides a Trust wide approach to reducing community acquired pressure ulcers through a series of work-streams, these include:
The introduction of a specific assessment tool
The development of a link nurse steering group
The role out of React to Red training package

Mar-18	Pressure Ulcers: Community, Stage 3
2	Total number of stage 3 pressure ulcers in a community setting.
Target	Through our Quality Improvement Plan, it is our aim to reduce community acquired stage 3 pressure ulcers by 50% by end March 2019. The figure represented here relates to March 2018 as stage 3 pressure ulcers that relate to April 2018 are not yet validated.



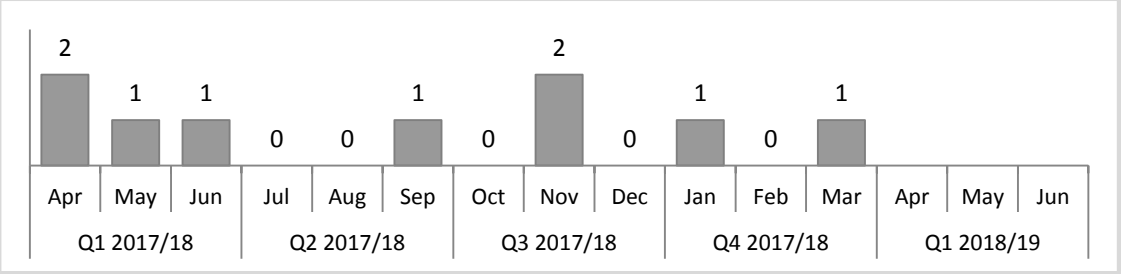
Actions

In line with our Quality Improvement Plan, we launched our Pressure Ulcer Safety Collaborative in March 2018. The collaborative provides a Trust wide approach to reducing community acquired pressure ulcers through a series of work-streams, these include:

The introduction of specific assessment tool
The development of a steering group link nurse group
The role out of React to Red training package

It is possible due to an increase in vigilance and visibility of concern, an increase in incident reporting may be seen, as staff education and awareness is raised.

Mar-18	Pressure Ulcers: Community, Stage 4
1	Total number of stage 4 pressure ulcers in a community setting.
Target	Through our Quality Improvement Plan, it is our aim to reduce community acquired stage 4 pressure ulcers by 50% by end March 2019. The figure represented here relates to March 2018 as stage 4 pressure ulcers that relate to April 2018 are not yet validated.



Actions

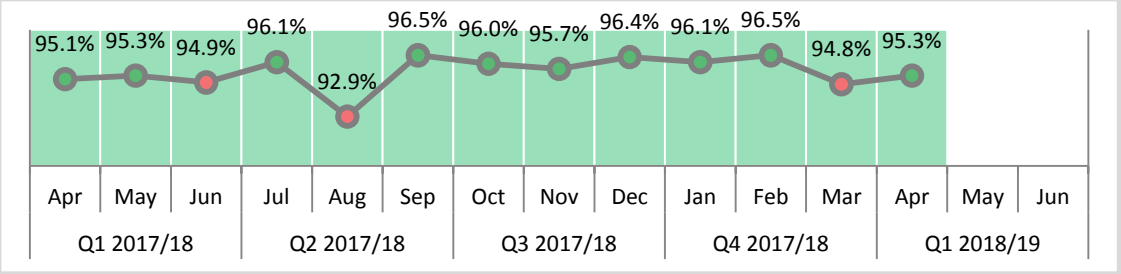
In line with our Quality Improvement Plan, we launched our Pressure Ulcer Safety Collaborative in March 2018. The collaborative provides a Trust wide approach to reducing hospital acquired pressure ulcers through a series of work-streams, these include:

The introduction of specific assessment tool
The development of a steering group link nurse group
The role out of React to Red training package

It is possible due to an increase in vigilance and visibility of concern, an increase in incident reporting may be seen, as staff education and awareness is raised.

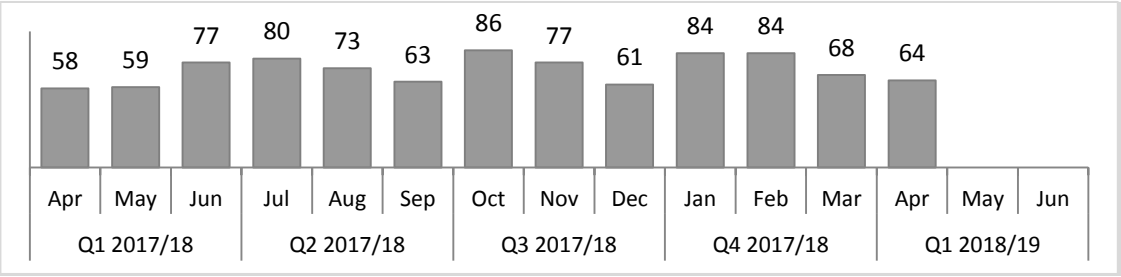
Indicator Detail

Apr-18	Safety Thermometer: Hospital
95.3%	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 the Safety Thermometer. In April 2018, 95.3% of our patients received harm free care as measured by the Safety Thermometer.
>= 95%	



Actions
The Safety Thermometer data includes catheter associated urinary tract infections, new and old pressure ulcers, falls, and VTE. Information is collected during the morning on a weekly basis and is collected by nursing staff on duty on the ward assisted by the corporate nursing team. There has been an increased awareness of both the collection and validation of the safety thermometer data across the organisation. All wards present their data weekly with specialist nurse involvement, to ensure there is a robust approach to the process and that the data is accurate.

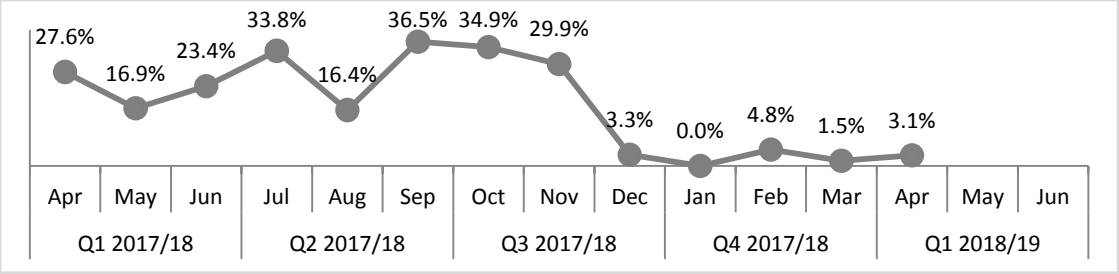
Apr-18	Medication Errors: Overall
64	Total number of Medication Errors.
Target	In April 2018, there have been 64 medication incidents reported. In 2017/18 the total number of medication incidents was 870, with an average therefore of 72 a month



Actions
All medication incidents are reviewed weekly by a trust executive at the Patient Safety Summit. A theme has been identified following the reviews that relates to the duplication of medications using both a paper and electronic prescription. An alerting system has been developed which includes the introduction of an orange arm band, to alert staff to the use of a paper kardex being in progress. Learning from medication incidents is included in the weekly Patient Safety Summit Update and shared widely across the organisation.

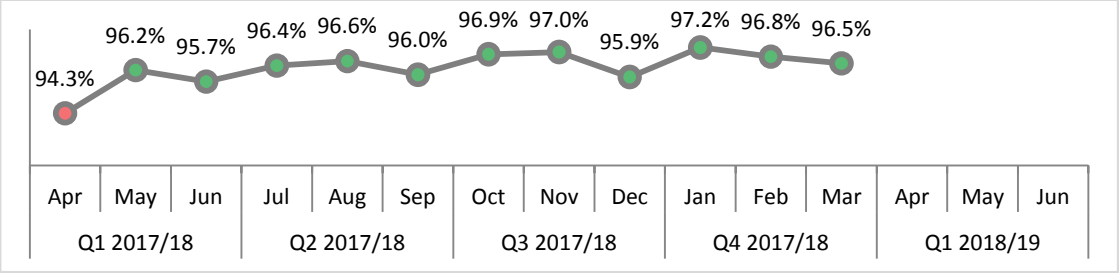
Indicator Detail

Apr-18	Medication Errors: Moderate Harm and Above
3.1%	The percentage of medication errors causing moderate harm and above.
Target	In April 2018/19, 2 medication errors were reported as incidents where moderate harm had occurred. In 2017/18 a total of 166 medication incidents were recorded as causing moderate harm or above.



Actions
The two incidents reported in April 2018/19 are currently under investigation by the Business Groups. In December 2017/18 the number of medication incidents causing moderate harm or above dropped significantly. This coincided with the new datix system being introduced and the introduction of the weekly Patient Safety Summit . A trajectory for medication incidents causing moderate harm or above is to be agreed by the end of Quarter 1 2018/19.

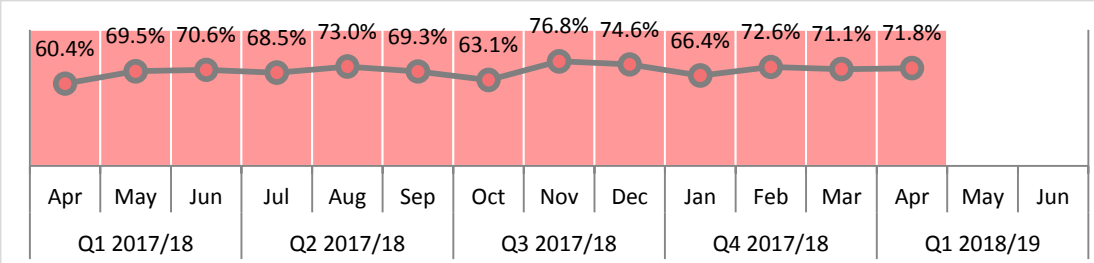
Mar-18	VTE Risk Assessment
96.5%	The percentage of eligible admitted patients who have been given a VTE risk assessment.
Target	Our aim is to have >95% compliance with VTE Risk Assessment. This month we are slightly above target at 96.5%
>= 95%	



Actions
The VTE specialist nurses make contact with all senior nursing staff to raise the raise the awareness of the need for risk assessment completion and this is escalated in a report to the Thrombosis Committee. Going forward the VTE specialist nurses will be included in the weekly validation meeting to support the safety thermometer programme.

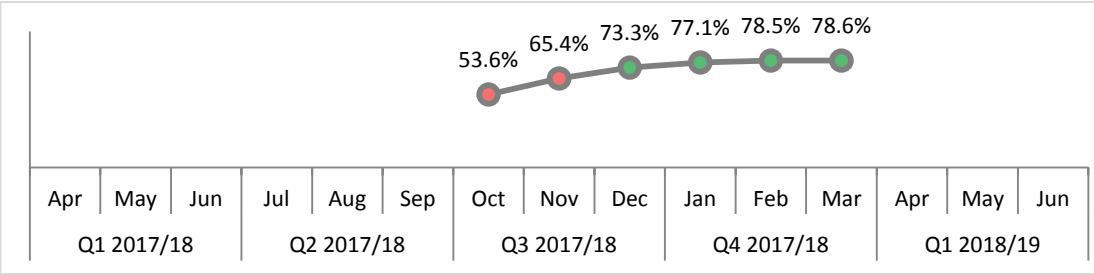
Indicator Detail

Apr-18	Clinical Correspondence
71.8%	The percentage of clinical correspondence typed within 7 days.
Target	Whilst 7 day performance remains below target, the wait for letters to be typed has reduced significantly in month in all but one area, which is Paediatrics.
>= 95%	



Actions
The Paediatric service has approval to outsource typing in the short –term, whilst recruitment to vacant posts is underway. The clinical team is also exploring the possibility of adopting the 'Dragon' voice recognition system. Continuing actions include: Recruitment to the significant number of vacant posts. Commencement of the second phase of the Admin & Clerical review, meaning further specialties will join the Correspondence Hub team. Ongoing feedback with clinicians regarding the use of standard SAIL (Sheffield Assessment Instrument for Letters) criteria and clarity of dictation.

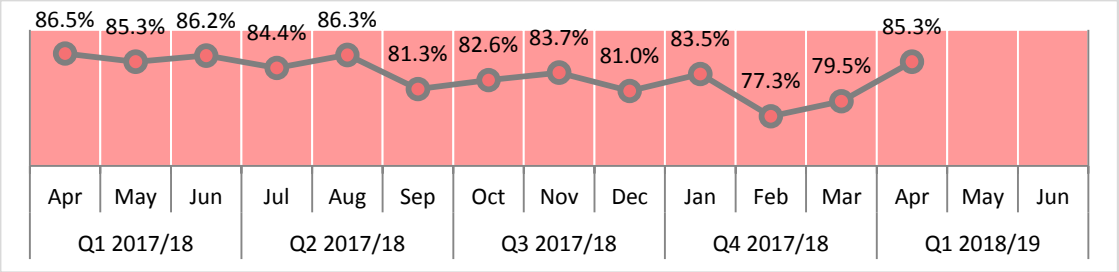
Apr-18	Flu Vacination Uptake
78.6%	The percentage of staff receiving the flu vaccination.
Target	This was the final position as of March 2018.
>= 70%	



Actions
The flu campaign will restart in September 2018.

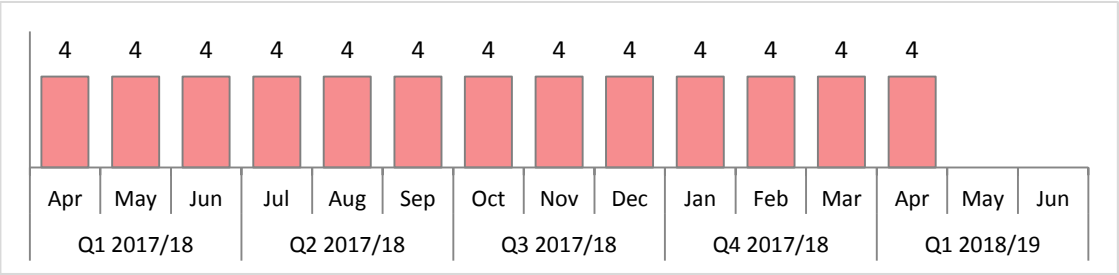
Indicator Detail

Mar-18	Discharge Summaries
85.3%	The percentage of discharge summaries published within 48hrs of patient discharge.
Target	Performance is on an upward trend, with a significant improvement seen in April. This is as a result of the daily reminder process embedding in across the Trust.
>= 95%	



Actions
AMU have implemented a daily process of lead Clinician assigning specific patient HCRs to the junior doctors during the whiteboard rounds. A system message 'reminder' has also been implemented to highlight when documents have been re-opened for editing and not signed off. Continuing actions include: - a process for operations cancelled on the day - resolving remaining IT issues that have been identified

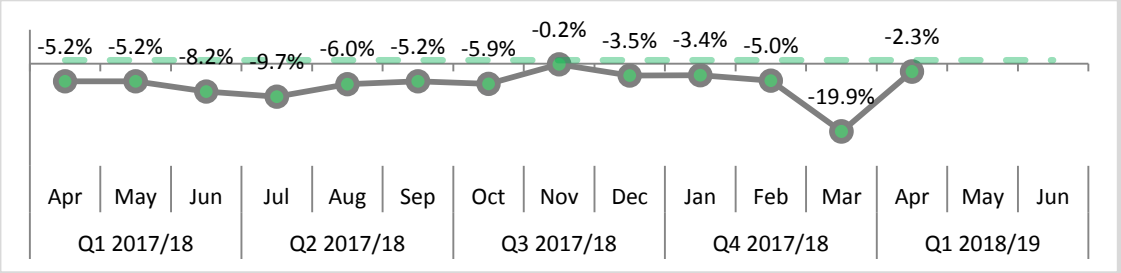
Apr-18	Financial Efficiency: I&E Margin
4	A calculated score based on the Income & Expenditure surplus or deficit against total revenue.
Target	The Trust's planned £34m loss scores a 4 (worst) under the NHSI Use of Resources (UoR) metric in the Single Oversight Framework.
<= 2	



Actions
To improve to a 3 the planned deficit would need to improve by £31.5m to a deficit of £2.5m (within 1% of planned operating income). The Trust is currently developing a Medium Term Financial Strategy (MTFS) to demonstrate the delivery of available opportunities to improve this rating.

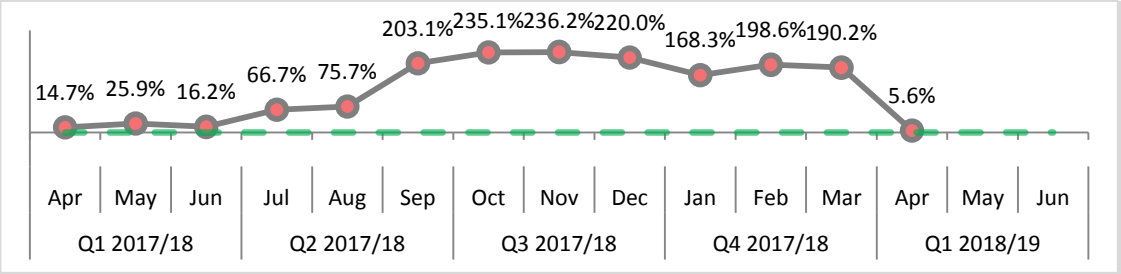
Indicator Detail

Apr-18	Financial Controls: I&E Position
-2.3%	The percentage variance between planned financial position and the actual financial position.
Target	In the first month of the new financial year the Trust has lost £4.0m. The planned deficit was £4.1m so this is £0.1m favourable to plan. The loss is £0.3m worse than April last year, and the average loss is £133,000 per day.
<= 1%	



Actions
As the Trust is favourable to plan this scores a 1 (best) under the NHSI Use of Resources (UoR) metric in the Single Oversight Framework. The Trust Finance & Performance Committee has been given significant assurance at this stage in the financial year that the forecast plan will be delivered. However there are a number of risks which will need to be actively managed to maintain that level of assurance.

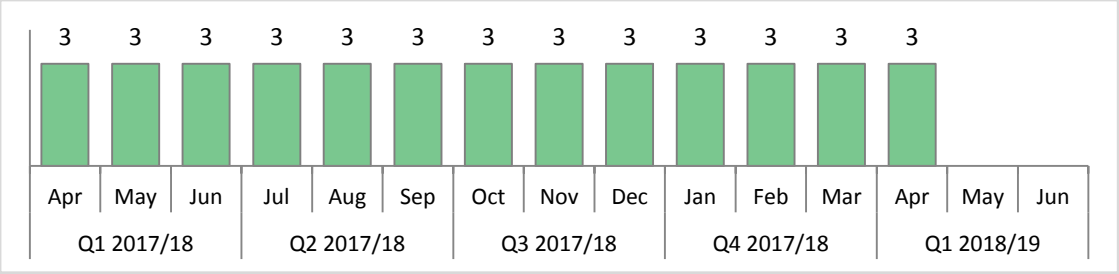
Apr-18	Cash
5.6%	The percentage variance between planned borrowing-to-date and the actual borrowing-to-date.
Target	Cash in the bank on 30th April 2018 was £13.4m, which is £2.9m less than last month and £0.7m better than planned.
+/- 1%	



Actions
Cash is carefully managed and the requirement for a working capital support facility loan is now likely to be in July 2018. The planned level of borrowing July 2018 to March 2019 is £24.7m. The Trust is continuing to model a 13 week cash-flow through the Trust's Cash Action Group and is submitting the information to NHSI's Cash and Capital Team to ensure swift agreement of the revenue financing.

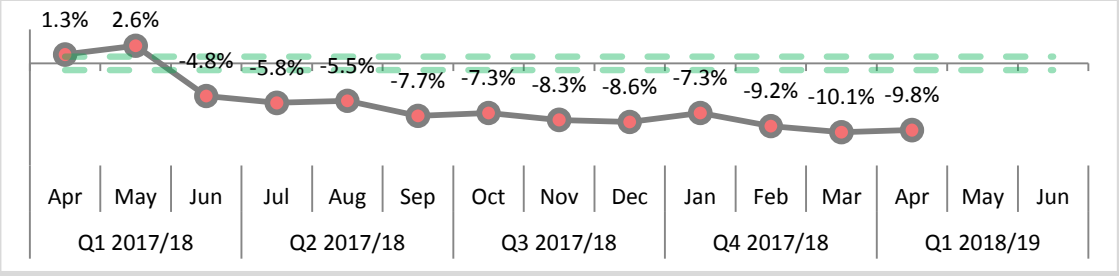
Indicator Detail

Apr-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 draft Use of Resources (UOR) score under the Single Oversight Framework is a 3, classified by NHSI as triggering significant concerns. The Trust only reports key data to NHSI for April's financial position so there is no formal calculation to verify this score until M02 (May) reporting.
<= 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 has breached the agency ceiling in month so this score has moved from 1 (best) to 2. If the planned deficit is not delivered, then the overall Trust score will deteriorate to a 4 and fall into the special measures segment. At this point NHS Improvement (NHSI) could chose to invoke regulatory action against the Trust. This is a forward risk for the organisation.

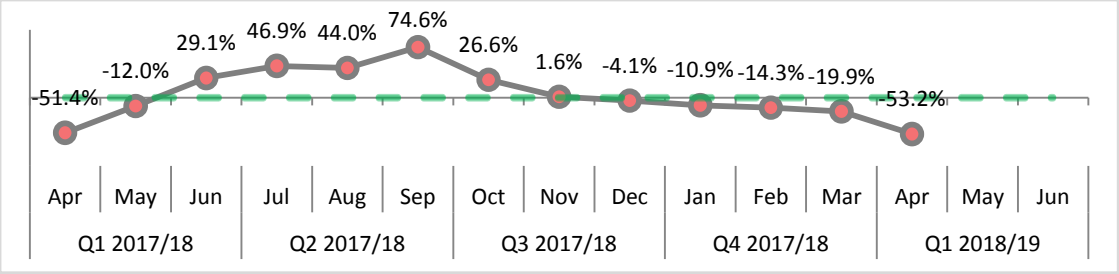
Apr-18	Elective Income vs. Plan
-9.8%	The percentage variance between planned elective income and the actual elective income.
Target	Elective income is £0.3m adverse to plan in April 2018. This is as a result of the full elective inpatient operating programme not recommencing until 9th April 2018, particularly affecting orthopaedics which is 144 cases behind plan. The operating restrictions of the past few months has resulted in a backlog of major cases in April, resulting in more single case lists in orthopaedics and urology in particular.
+/- 1%	



Actions
The shortfall in activity this month presents the Surgical business group with a significant challenge to recover the lost activity from April alongside delivering the activity plan for the remainder of the financial year. The number of lists undertaken and average cases per list must be closely monitored to ensure the agreed level of income is delivered in year, with particular focus on urology and orthopaedics. Sickness/absence, annual leave patterns, winter cancellations and recruitment issues all pose a risk to delivery of the overall plan. Focus on theatre list utilisation, beds and maximising of day case opportunities continue in order to absorb the required activity levels.

Indicator Detail

Apr-18	CIP Cumulative Achievement
-53.2%	The percentage variance between planned CIP achievement and the actual CIP achievement.
Target	The Cost Improvement Programme (CIP) is £0.3m adverse to the profiled plan in month; £0.5m (3.3%) was expected by this stage in the year when £0.2m (1.6%) has been transacted.
+/- 1%	

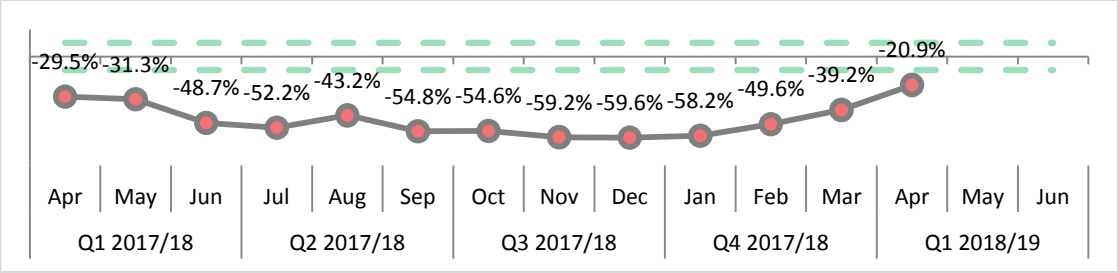


Actions

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

Whilst there is robust support for each of the programmes and a large amount of work is being undertaken, there is currently a lack of evidence for this without the production of supporting documentation. This was raised at the Financial Improvement Group (FIG) in April and the SROs for each theme were tasked with driving this forward.

Apr-18	Capital Expenditure
-20.9%	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 £0.2m have been incurred in April against a plan of £0.3m and so is £0.1m behind plan.
+/- 10%	



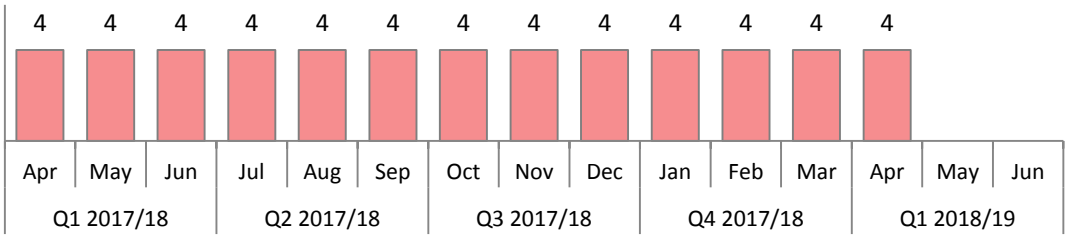
Actions

The externally funded Healthier Together schemes are fundamental to the delivery of the capital programme but is reliant on external parties and their approval processes via the Greater Manchester Devolution Team (GM Devo). This has taken much longer than envisaged and the projects still do not have an expected start date.

All other schemes are progressing in line with the agreed plan.

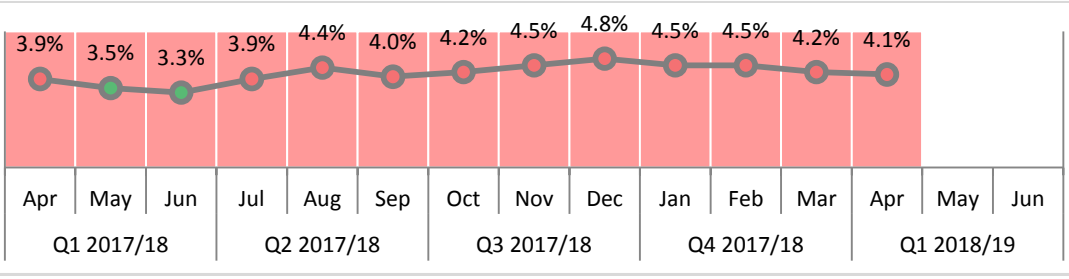
Indicator Detail

Apr-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 in the short-term.
<= 2	



Actions

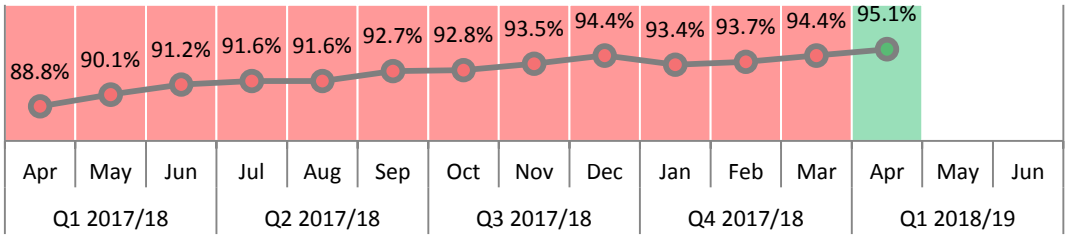
Apr-18	Sickness Absence Rate
4.1%	The percentage of staff on sickness absence, based on whole time equivalent.
Target	The in-month unadjusted sickness absence figure for April 2018 is 4.07% (a 0.35% reduction from March 2018 4.42%). All Business Groups, with the exception of Corporate Services and Surgery, GI & CS are above the 3.5% target in April 2018. Estates & Facilities and Medicine & CS have seen an increase since March 2018.
<= 3.5%	



Actions
Ongoing dedicated HR support is provided to assist managers with the management of attendance. Continued regular audits to ensure policy and procedural compliance.

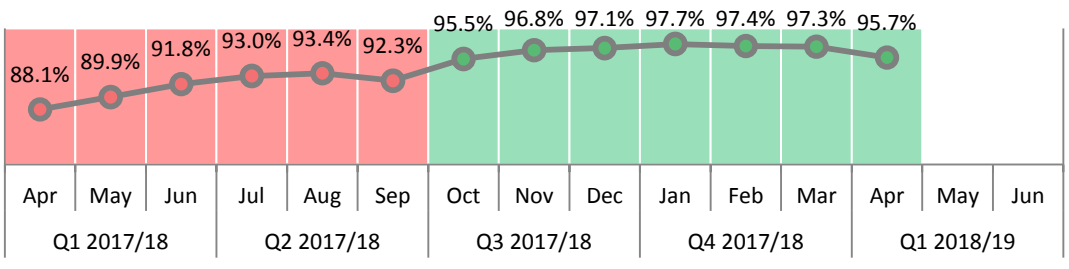
Indicator Detail

Apr-18	Appraisal Rate: Non-medical
95.1%	The percentage of non-medical staff that have been appraised within the last 15 months.
Target	The Trust has achieved the compliance standard for month 1 2018/19. This has been due to the considerable efforts and commitments of the business groups working in collaboration with OD and learning.
>= 95%	



Actions
OD and learning will continue to actively support the areas that are below 95% and address any key issues

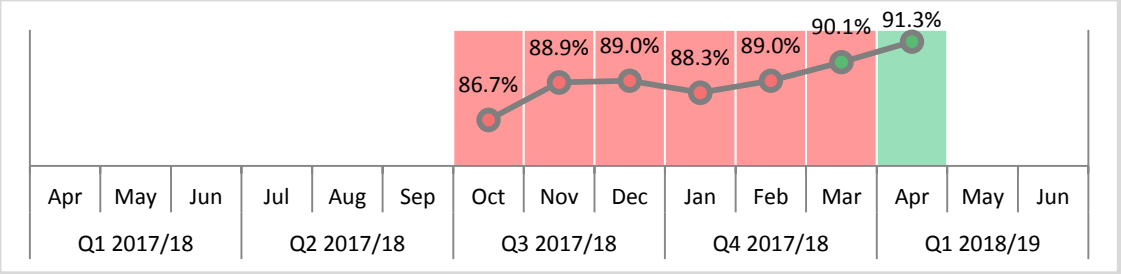
Apr-18	Appraisal Rate: Medical
95.7%	The percentage of medical staff that have been appraised within the last 15 months.
Target	309 of the 323 required medical appraisals have been completed (95.7%).
>= 95%	



Actions
Compliance against this standard is monitored via Business Group performance meetings.

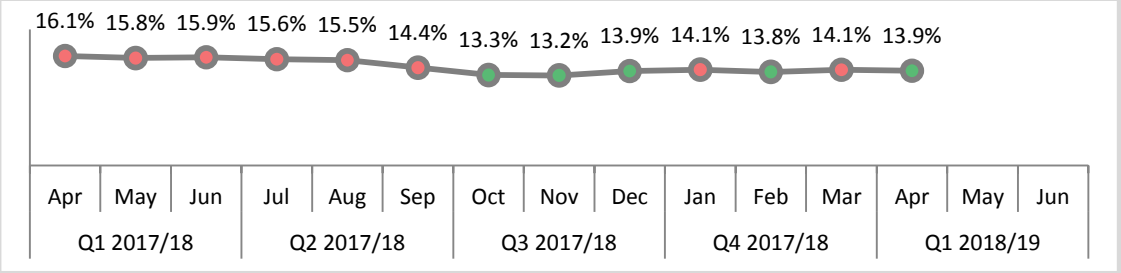
Indicator Detail

Apr-18	Statutory & Mandatory Training
91.3%	The percentage of statutory & mandatory training modules showing as compliant.
Target	Statutory and Mandatory training has achieved the compliance standard in month 1, 2018/19. This is due the commitment of staff to complete the core skills and learning and development offering diverse ways of completing the training.
>= 90%	



Actions
The e-learning system is being reviewed by the system provider to streamline access to improve user experience. Workbooks are being produced for all topics to support teams with limited access to IT.

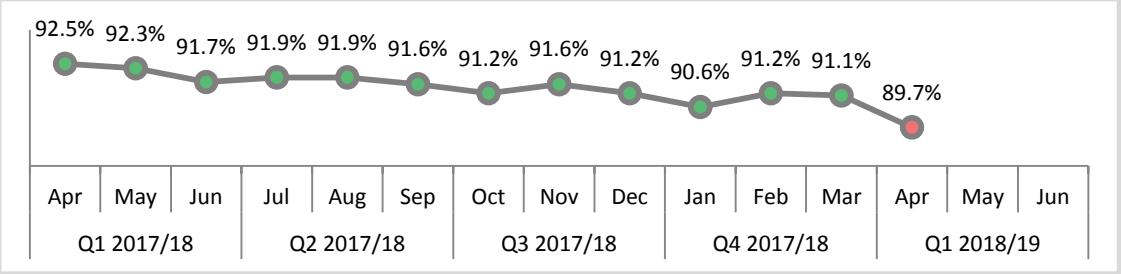
Apr-18	Workforce Turnover
13.9%	The percentage of employees leaving the Trust and being replaced by new employees.
Target	The rolling 12-month unadjusted April turnover rate is 13.91% (April 2017 2.96%). Reasons for leaving: Relocation 20%, Retirement 18.60%, Work Life Balance 16.59%. Integrated Care has the highest turnover rate at 17.02% (adjusted figure is 15.43%). The Registered Nursing & Midwifery turnover has decreased by 0.09% from March.
<= 13.94%	



Actions
Action to deliver the recruitment and retention programme is ongoing.

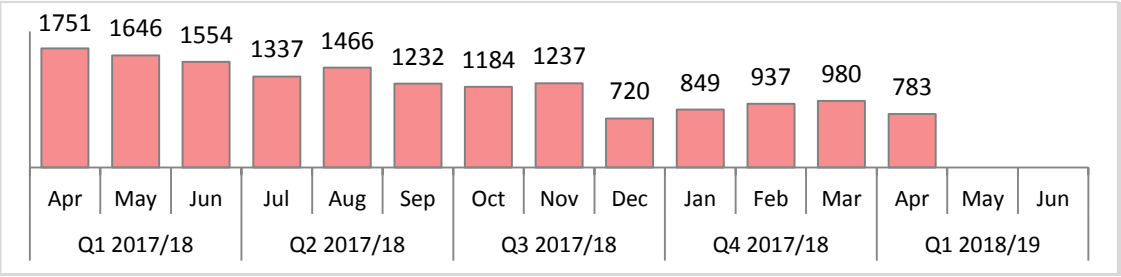
Indicator Detail

Apr-18	Staff in Post
89.7%	The percentage of whole time equivalent staff in post compared with the current establishment.
Target	The staff in post figure (89.70%) is a decrease of 1.39% from March 2018. IC has the highest vacancy rate at 18% (212.09 FTE vacancies) attributed to the realigning of budgets within Stockport Neighbourhood Care. (recruitment to posts is underway).
>= 90%	



Actions
Action to deliver the recruitment and retention programme is ongoing.

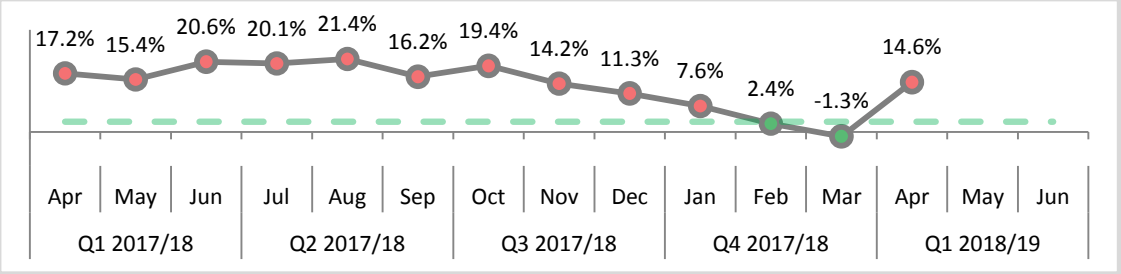
Apr-18	Agency Shifts Above Cap
783	Number of agency shifts above above the provider spend cap.
Target	There were a total of 783 agency shifts paid above the price cap in April. The Medicine & CS Business Group spend has increased by £52K to £848K in April 2018 (continuing with the highest spend on bank & agency equating to 4.58% of the paybill), attributable to clinical vacancies.
<= 0	



Actions
Continue to promote the Trust bank. Requirement for Agency usage and rate to be risk assessed against clinical need and appropriately escalated for approval.

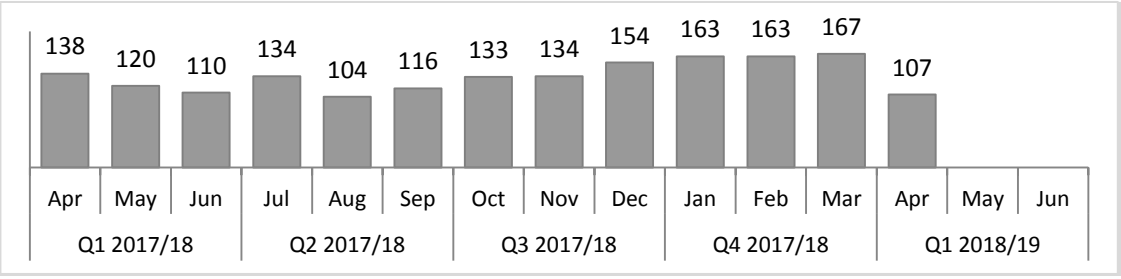
Indicator Detail

Apr-18	Agency Spend: Distance from Cap
14.6%	The percentage variance between Trusts expenditure on agency and external locums across all staff groups and the cap set by NHSi.
Target	The total pay spend in April 2018 was £16.422M, excluding bank and agency spend. This is an increase of £2.315M compared to March 2018.
<= 3%	Total spend, including bank and agency, equates to £18.510M, which is £0.115M under the total pay budget for the month.



Actions
Continue to promote the Trust bank. Requirement for Agency usage and rate to be risk assessed against clinical need and appropriately escalated for approval.

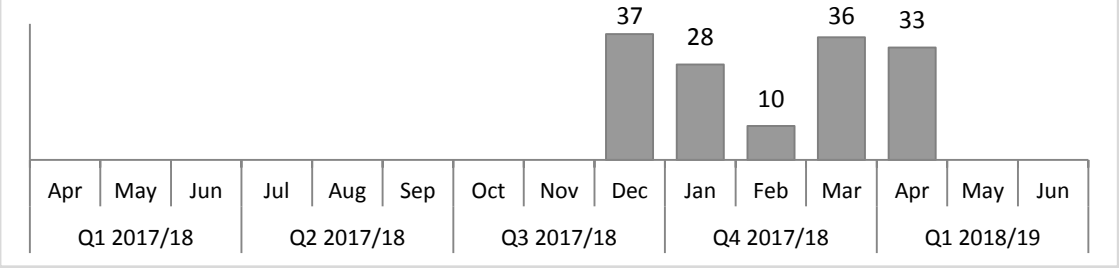
Apr-18	Mortality: Deaths in ED or as Inpatient
107	Total number of patient deaths while patient was in the emergency department or as an inpatient.
Target	Higher number of deaths over the winder months typical of a national picture of high acuity of illness, particularly in the frail elderly population. This may alter mortality data - but is likely to do so across all peer hospitals.



Actions
Monitor mortality ratio's relative to peer hospitals.

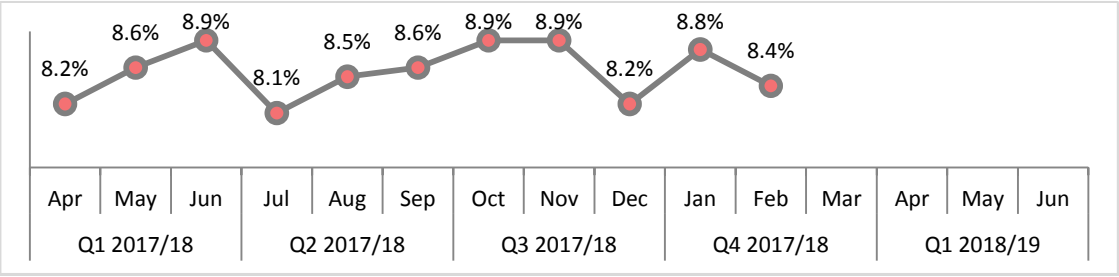
Indicator Detail

Apr-18	Mortality: Case Note Reviews
33	The total number of case note reviews undertaken of each death in ED or as inpatient
Target	Good progress in the numbers of 'learning from deaths reviews' undertaken. This month exceeded our 30% target.



Actions
Focus upon effective cascading of the learning from these reviews.

Apr-18	Emergency Readmission Rate
8.4%	The percentage of emergency re-admissions within 28 days following an inpatient discharge.
Target	Static picture, which should be improved by the investment in crisis response and Stockport Neighborhood integration.
<= 7.9%	



Actions

Safer Staffing Report

Apr-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	Falls with Harm	Catheters & UTIs	VTEs
AMU	3,960	3,654	3,240	3,013	3,600	3,061	2,970	3,262	92.3%	93.0%	85.0%	109.8%	1542	4.4	4.1	8.4	0	0	0	0
Clinical Decisions Unit	360	360	360	360	330	330	330	330	100.0%	100.0%	100.0%	100.0%	146	4.7	4.7	9.5	0	0	0	0
Short Stay Olders People's Unit	1,125	1,035	765	750	660	660	660	649	92.0%	98.0%	100.0%	98.3%	439	3.9	3.2	7.0	2	2	0	2
A3	1,377	1,295	945	923	990	869	660	660	94.0%	97.6%	87.8%	100.0%	700	3.1	2.3	5.4	0	0	0	0
A10	2,700	2,082	1,980	2,052	1,980	1,970	1,320	1,320	77.1%	103.6%	99.5%	100.0%	715	5.7	4.7	10.4	0	0	0	0
A11	1,530	1,358	1,575	1,575	660	660	660	638	88.7%	100.0%	100.0%	96.7%	855	2.4	2.6	4.9	1	0	0	0
A12	1,845	1,718	1,395	1,448	660	660	660	768	93.1%	103.8%	100.0%	116.4%	772	3.1	2.9	5.9	0	0	0	0
A15	1,170	765	585	891	660	660	660	660	65.4%	152.3%	100.0%	100.0%	482	3.0	3.2	6.2	0	0	0	1
B4	513	383	513	494	418	418	418	539	74.7%	96.2%	100.0%	128.9%	313	2.6	3.3	5.9	0	0	0	0
B6	1,170	1,068	1,035	1,109	660	693	660	884	91.3%	107.1%	105.0%	133.9%	655	2.7	3.0	5.7	0	0	0	0
Bluebell Ward	1,170	1,170	2,010	2,460	660	660	660	885	100.0%	122.4%	100.0%	134.1%	579	3.2	5.8	8.9	1	0	0	0
C4	1,170	1,035	585	827	660	660	660	748	88.5%	141.4%	100.0%	113.3%	460	3.7	3.4	7.1	0	0	0	2
Coronary Care Unit	810	810	450	351	660	660	330	319	100.0%	78.0%	100.0%	96.7%	173	8.5	3.9	12.4	0	0	0	0
Devonshire Centre for Neuro-Rehabilitation	1,035	1,035	1,935	1,871	660	660	660	671	100.0%	96.7%	100.0%	101.7%	552	3.1	4.6	7.7	0	0	0	0
E1	1,881	1,506	2,235	2,190	990	770	1,320	1,320	80.1%	98.0%	77.8%	100.0%	917	2.5	3.8	6.3	0	0	0	0
E2	2,205	2,183	1,530	1,963	990	990	990	1,320	99.0%	128.3%	100.0%	133.3%	990	3.2	3.3	6.5	0	0	0	0
E3	2,205	2,198	1,530	1,788	990	979	990	1,375	99.7%	116.9%	98.9%	138.9%	1036	3.1	3.1	6.1	0	0	0	1

Safer Staffing Report

Apr-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	Falls with Harm	Catheters & UTIs	VTEs
A1	1,395	1,313	1,170	1,118	990	990	990	968	94.1%	95.5%	100.0%	97.8%	750	3.1	2.8	5.9	0	0	0	2
B3	810	798	945	941	660	649	473	726	98.5%	99.6%	98.3%	153.5%	420	3.4	4.0	7.4	0	0	0	0
C6	810	804	945	855	660	660	660	660	99.3%	90.5%	100.0%	100.0%	459	3.2	3.3	6.5	0	0	0	0
D1	1,530	1,118	1,305	1,419	660	660	990	990	73.0%	108.7%	100.0%	100.0%	659	2.7	3.7	6.4	0	0	0	0
D2	1,092	942	945	915	660	638	561	570	86.3%	96.8%	96.7%	101.6%	399	4.0	3.7	7.7	0	0	0	0
D6	1,170	1,088	1,170	1,095	660	660	660	693	92.9%	93.6%	100.0%	105.0%	657	2.7	2.7	5.4	0	0	0	0
M4	1,508	1,299	1,620	1,594	660	594	990	979	86.2%	98.4%	90.0%	98.9%	738	2.6	3.5	6.1	0	0	0	0
SAU	1,755	1,701	945	837	990	902	660	627	96.9%	88.6%	91.1%	95.0%	413	6.3	3.5	9.8	0	0	0	0
Short Stay Surgical Unit	1,775	1,694	744	625	847	858	561	561	95.4%	83.9%	101.3%	100.0%	624	4.1	1.9	6.0	0	0	0	0
ICU & HDU	4,320	4,068	750	702	3,990	3,816	0	0	94.2%	93.6%	95.6%	na	317	24.9	2.2	27.1	0	0	0	0
Birth Centre	900	848	450	450	600	520	300	300	94.2%	100.0%	86.7%	100.0%	51	26.8	14.7	41.5	0	0	0	0
Delivery Suite	2,700	2,693	450	398	1,800	1,790	300	260	99.7%	88.3%	99.4%	86.7%	215	20.8	3.1	23.9	0	0	0	0
Maternity 2	1,575	1,575	900	878	600	600	300	280	100.0%	97.5%	100.0%	93.3%	467	4.7	2.5	7.1	0	0	0	0
Jasmine Ward	900	900	450	450	600	600	0	0	100.0%	100.0%	100.0%	na	204	7.4	2.2	9.6	0	0	0	0
Neonatal Unit	2,250	1,883	0	0	1,575	1,281	0	0	83.7%	na	81.3%	na	269	11.8	0.0	11.8	0	0	0	0
Tree House	3,150	2,925	450	450	2,100	1,803	0	0	92.9%	100.0%	85.9%	na	451	10.5	1.0	11.5	0	0	0	0
	53,865	49,298	35,907	36,787	34,280	32,381	22,053	23,962	91.5%	102.5%	94.5%	108.7%	18419	4.4	3.3	7.7	0	0	0	0

Safer Staffing Report

Apr-18	Registered midwives/nurses		Non-registered		Registered midwives/nurses		Non-registered		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	Falls with Harm	Catheters & UTIs	VTEs
Ward Name	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual												
Bramhall																	1	0	0	0
Brinnington																	0	0	0	0
Victoria																	0	0	0	0
Cheadle Hulme																	0	0	0	0
Stepping Hill																	0	0	0	0
Gatley																	0	0	0	0
Heald Green																	0	0	0	0
Heatons Central																	0	0	0	0
Marple																	1	0	0	0
South Reddish																	0	0	0	0
Werneth																	1	0	0	0
ENS																	0	1	0	0
Comm Rehab																	0	0	0	0
Active Recovery																	0	0	0	0
																	3	1	0	0

Safer Staffing Report

BOARD PAPERS – Quality, Safety & Experience Section : April 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.	91.5% 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.	April 2018 91.5% March 2018 90.8% Feb 2018 91.1%	The lowest RN staffing levels during the day were on Ward B4: 65.4%. The ward was closely supported by Matron to assure safety. Non registered staffing levels were increased to support safe care. Vacancies have been recruited to. Never less than 2 RNs on duty at all times.
Registered Nurses monthly expected hours by shift versus actual monthly hours per shift. Night time shifts only.	94.5% of expected Registered Nurse hours were achieved for night shifts.	April 2018 94.5% March 2018 93.8% Feb 2018 94.3%	The lowest RN staffing levels during the night were on Ward E1 77.8% due to vacancies and moving RN staff to support other wards. Associate Nurse Director and Matron closely monitor.

Non-registered staff monthly expected hours by shift versus actual monthly hours per shift. Day time shifts only.	102.5% of expected Non-registered hours were achieved for day shifts.	April 2018 102.5% March 2018 98.4% Feb 2018 99.9%	The lowest staffing levels during the day were on the coronary care unit: 78.0%. Vacancies have been recruited to. Support has been provided by Matron as well as aligning staffing levels for safety with the co- located ward A3.
Non-registered staff monthly expected hours by shift versus actual monthly hours per shift. Night time shifts only.	108.7% 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 Registered Nurse shifts.	April 2018 108.7% March 2018 106.9% Feb 2018 108.5%	The lowest staffing levels during the night were on the delivery suite with 86.7% due to a vacancy, which has been recruited to and short term sickness. Matron assures safety .

NHS
Stockport
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	24 May 2018
Subject:	Proud2Care: Our Quality Improvement Plan FINAL DRAFT		
Report of:	Chief Nurse and Medical Director	**Prepared by:**	Chief Nurse

REPORT FOR APPROVAL

Corporate objective ref:	S02
Board Assurance Framework ref:	S02
CQC Registration Standards ref:	Regulation 10, 12, 17 18,
Equality Impact Assessment:	☐ Completed ☒ Not required

Summary of Report

This is the FINAL Quality Improvement Plan which is in place to monitor the several plans that exist as vehicles to achieve improvements in the quality and safety of care received in sustainable ways.

We have made many changes since the CQC report was published in October 2017. The delivery of this plan, underpinned by good governance and staff development, will ensure that the changes made already are sustainable, and that those outstanding can be delivered in agreed timeframes. We all want our patients to receive consistent, high-quality care and we most certainly want Stockport NHS Foundation Trust to become the employer of choice.

The Board will apply focus and rigour to ensure the delivery of the plan through agreed reporting mechanisms.

The Board of Directors are recommended to commend this plan as the Trust overarching plan that is designed to start to signal a common purpose and priority for the organisation that is owned by frontline staff, and recognised externally as our blueprint for success. A recommendation for approval was made following review by the Executive Management Group on 15 May 2018.

Attachments: none

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

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1.	**INTRODUCTION**
1.1	The Trust is on a journey to becoming a recognised outstanding organisation, and we aim to demonstrate that the care and treatment delivered by all of our staff is of the best quality possible. We want to make sure that the high quality and safe care we aim to provide is recognised externally by our partners and colleagues because it has become *business as usual.* This plan describes the blueprint for our journey, it makes our objectives clear and sets timescales and performance indicators along the way.
1.2	We have made many changes since the CQC reports were published in October 2017 and the NHSI undertakings against our licence in September 2017. The delivery of this plan, underpinned by good governance and staff development, will ensure that the changes already made are sustainable, and that those outstanding can be delivered in agreed timeframes. We all want our patients to receive consistent, high-quality care and we most certainly want Stockport NHS Foundation Trust to become the employer of choice.
1.3	A core facet of the plan is the engagement of frontline staff in the improvement journey. This will ensure the impact of the improvement required is understood.
1.4	Further, it will allow us to take advantage of the expertise and knowledge of our staff, as well as key partnerships, to ensure the plan is delivered.
1.5	It will also start to signal a common purpose and priority for the organisation that is owned by frontline staff.
2.	**BACKGROUND**
2.1	The CQC report was published following their unannounced inspections of Urgent and Emergency Services and Medical Care at Stepping Hill Hospital on March and June 2017. The report was published on 3rd October 2017 and followed a letter from the CQC received in June 2017 relating to immediate findings from the June unannounced visit.
2.2	NHS Improvement wrote to the Trust in September 2017 setting out areas of concern in relation to our Provider Licence.
2.3	This plan addresses areas of concerns relating to patient safety that have been noted externally by the Care Quality Commission (CQC) and NHS Improvement, and that have also been recognised by us.
3.	**CURRENT SITUATION**
3.1	Since the inspections in March and June 2017, the Trust has made some significant and important changes, including strengthening the joint working of our doctors and nurses in the emergency department and medical care.
3.2	We have also developed a clear medical leadership structure under the Medical Director. We have improved how we care for our most vulnerable patients, including those who have lack capacity to make decisions.
3.3	

	We now have active, early risk assessments in our ED, a Mental Health Liaison Team working closely together and stronger cross-organisational working practices with colleagues from partners.
3.4	The Trust Board have made it clear that secrecy, not speaking up and not working together for the good of all our patients has no place in our Trust.
3.5	The Trust Board consider that we have the skills, dedication and ambition to address all the issues raised by the CQC and ensure we give the best possible care we can to every patient. The successful implementation of this Quality Improvement Plan will ensure that improvements are made and sustained for all Trust's services.
3.6	We have developed Seven Themes, underpinned by our strengthened Quality Governance Framework: • Quality Faculty • Reducing Unwarranted Variation in Clinical Practice • Safety Collaborative • Safe Staffing • Quality Improvement Initiatives • Urgent Care Delivery • High Quality Safe Care Plan
4.	**RISK & ASSURANCE**
4.1	Whilst the issues were identified within the Urgent and Emergency Services and Medical Care, we acknowledge that these findings are potentially translatable across the whole organisation. The identified aims align to the Trust Quality Account Priorities for 2018/2019 and to the Operational Plan 2018/2020.
4.2	The plan to demonstrate the requirements of 'Good' and beyond is very detailed within our High Quality Safe Care Plan.
4.3	We will approach our Quality Improvement Plan through: • Robust leadership to drive recovery • Focused Board oversight and scrutiny • Executive Accountability for delivery of improvement plans • Building strong leadership at all levels within the Trust • Extensive staff engagement and clinical leadership to drive innovation • A rigorous QI approach throughout the organisation • Supported Programme and Project management • A single reporting structure for Board, Commissioners and Regulators • Support and work with our partners • Support and involvement from patients, service users and the public • Relationships with the Acute and Mental Health Alliances • External support from experts to address capability
4.5	We will be evidence-based and will systematically monitor and test progress as well as look to outstanding organisations elsewhere to see how they do things and learn for our own development.

5.	**CONCLUSION**
5.1	This draft paper provides the blueprint for our improvement journey, it makes our objectives clear and sets timescales and performance indicators along the way. A timetable and trajectory for moving from enhanced oversight will be developed in communication with NHSI and other colleagues.
6.	**RECOMMENDATIONS**
6.1	The Board of Directors are asked to: • Agree that the plan brings together the most important quality improvement actions from information received via sub-committees and regular reports and to identify any specific omissions for inclusion • Approve the plan as the overarching plan to achieve improvements in patient safety

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Stockport NHS
NHS Foundation Trust

PROUD2CARE

Our Quality Improvement Plan 2018-2020: *FINAL DRAFT*

Contents

Foreword

I am delighted to be introducing the Quality Improvement Plan for Stockport NHS Foundation Trust. The trust was rated as 'Requires Improvement' in March 2016 and October 2017 by the Care Quality Commission. In the months since we have seen a tremendous commitment from our staff who, no matter where they work in the organisation, have come to work every day to contribute to, or deliver, high quality care in order to secure the best outcomes and experience for our patients.

Improving quality is essential to us all. Patients want to feel safe and secure when they receive care and treatment in our Trust. Our patients' families and carers want to know that we are taking the best possible care keeping them safe. We know that staff want to provide the highest quality care and treatment possible, and as a Trust we want to be recognised locally as a great place to work and as a health-care organisation that we can all be proud of.

We need to recognise this commitment and set a clear direction and approach to continuously improving quality recognising that everyone has a role to play and can contribute.

We are going to do this through being innovative and in developing a culture which supports continuous learning, improvement and develops compassionate leadership which inspires individuals, teams and services to be the best we can be.

Our goal is to be recognised as an outstanding organisation, and we aim to demonstrate that the care and treatment delivered by all of our staff is of the best quality possible. We want to make sure that the high quality and safe care we aim to provide is recognised externally by our partners and colleagues because it has become *business as usual.* This plan describes the blueprint for our journey, it makes our objectives clear and sets timescales and performance indicators along the way.

Our staff and key stakeholders have helped shape this plan, which is designed to be the golden thread in the direction of travel for quality improvement for the next two years

Best wishes

Helen Thomson

1. Introduction to our Quality Improvement Plan

We want our Quality Improvement Plan to take us from 'Requires Improvement' by being bold in taking us further on a trajectory to 'Good' and 'Outstanding'. Of course we must address areas of concerns relating to patient safety that have been noted externally by the Care Quality Commission (CQC) and NHS Improvement, and those that we have recognised ourselves. We all want our patients to receive consistent, high-quality care and our ambition is that the pride taken in delivering care to our patients helps us to become the employer of choice in the region.

The CQC rated the trust as 'requires improvement' overall, but also as 'inadequate' for *safe* in Medicine and in Urgent and Emergency Services, and as 'inadequate' in *well led* for Urgent and Emergency Services. Our status with NHS Improvement is that of a Trust challenged for quality, performance and finance in September 2017.

The dedication and efforts of all our staff has led to many improvements since the CQC reports were published in March and October 2017.

Quality Improvements include:

- Consistent approaches to reporting incidents, with a significant and sustained increase of 20% in reporting – leading to a greater opportunity to share immediate lessons learned and embed safer practice
- 60% improvement in the reporting of 'no and low harm' incidents – demonstrating an evolving safety culture and a passion to get things right
- Reduction in the number of complaints received and in those returned where the complainant did not feel the complaint was resolved
- Reduction in pressure ulcers, especially across surgery and critical care, although we did not achieve our stretch trajectory
- Introduction of our ward accreditation scheme – Accreditation for Continuous Excellence (ACE), resulting in immediate improvements in MUST scoring compliance
- Achievement of our 'no lapses in care' target for C-difficile cases that are healthcare acquired
- Every ward has a nurse on every shift who has up to date Basic Life Support training, meaning we are assured that our wards and departments have the right staff with the right skills on duty to respond if a patient were to suddenly deteriorate.
- In our Emergency Department we have improved patient experience by ensuring that privacy and dignity for patients who attend in an emergency is maintained.
- Introduction of a new Quality Governance Framework where assurance is monitored from 'ward to board'.

The delivery of our Quality Improvement Plan, underpinned by good governance and staff development, will ensure that the changes made already are sustainable, and that those outstanding can be delivered in agreed timeframes.

The Board of Directors are committed to provide full support, leadership and apply focus and rigour to ensure the delivery of the plan. The Board of Directors intend to ensure continuous focus on creating the conditions that allow staff to do their job well by removing blocks to success and making sure we are managing any risks to delivery.

Partner agencies have kindly offered their support to the Trust and this is warmly welcomed. We know that the Clinical Commissioning Group, Greater Manchester Health and Social Care Partnership, Local Authority, Health-Watch, NHS Improvement, NHS England and

others will play a key role in scrutinising assurance processes to ensure they are sufficiently robust.

A core facet of the Quality Improvement Plan is the engagement of frontline staff in the improvement journey, with everyone being able to influence and contribute and feel empowered to change and improve. We know that when our clinical, non-clinical support staff and managers work together then our patients get the best care possible.

We intend to continue to listen to our staff; making the most of their enthusiasm, expertise and knowledge and signalling a common purpose and priority for the organisation that is owned by everyone whether front-line staff providing direct patient care, human resource teams, staff working in information management and technology, estates and facilities, or finance and quality governance.

Delivery at pace

The Board of Directors is committed to ensuring that the Quality Improvement Plan is delivered at pace. Working with all staff in the Trust and with the support of partner organisations and agencies, the Board is confident that the plan will deliver an improved outcome at the next CQC inspection. Furthermore, by developing and embedding a culture of continuous improvement and supporting frontline staff to improve services through innovation, we have set our ambition to be rated "Good" by 2019 and "Outstanding" by 2020.

Our plan will help us to:

- improve quality and safety
- reduce variation and patient harm
- ensure every member of our staff has access to and has undertaken core learning and appraisal
- ensure all CQC Must Do actions and concerns are fully addressed and become the way we provide care for every patient every day
- act smart in the way we use our resources and prioritise safety and quality improvement to gain maximum impact
- work in conjunction with partner organisations to improve quality and safety for our most vulnerable patients

Purpose of the Quality Improvement Plan:

Patients will benefit from our Quality Improvement Plan

Successful delivery of our plan will mean that p*atients will have increased confidence in local services, that they have a better experience with better outcomes.*

Staff will benefit from our Quality Improvement Plan

Successful delivery of our plan will mean that staff will have increased pride and job satisfaction and knowing they have made a difference. We will become an employer of choice.

The Trust itself will benefit from our Quality Improvement Plan

Regulators will see our compliance improve and future inspections will focus on the improvements we have made. Stakeholders will know they are working with an organisation which is committed and has a clear plan for improvement. All of our community will see:

- Achievement of the Trust strategic objectives
- Delivery of sustainable, safe, effective, and high quality services for patients
- Lessons are learned and shared across the trust thus reducing the risk of incidents and improving responsiveness, quality of care and experience for patients

- Robust systems and processes in place thus reducing clinical and reputational risk
- Compliance with CQC regulations
- Compliance with NHSI Provider Licence
- Well trained and valued staff
- Sustainable trust-wide process and governance arrangements in place to move programme work into business as usual at local level when appropriate
- Senior oversight and scrutiny on progress and any slippage allows executives to re-prioritise work

2. Trust Values and Behaviours

Quality and Safety

- We deliver safe, high quality and compassionate care
- We ensure a clean and safe environment for better care

Communication

- We treat our patients, their families and our staff with dignity and respect
- We communicate with everyone in a clear and open way

Service

- We provide effective, efficient and innovative care
- We work in partnership with others, to deliver improved care, in the right place at the right time

3. Trust Strategy

The new strategic view for the Trust is one of cohesion and cooperation. We have taken into account the overarching priorities of; quality improvement, financial resilience, partnership working, operational effectiveness and leadership development and the drivers of change impacting the Trust. The following strategic view has emerged as critical to focus on and vital to now plan for in detail;

- Resilience and improvement (getting the basics right) such as Quality & Safety, Finance and Operational performance;
- Stockport integrated service solution (Stockport Together);
- Healthier Together implementation;
- The Trust's role in the Greater Manchester Sustainability and Transformation Plan and emerging Integrated Care System; and
- Preparation for future organisational form and function.

4. Trust Profile

The Trust provides acute hospital and community care for children and adults predominantly across Stockport and the High Peak area of Derbyshire. We employ over 5,200 staff working across hospital and community premises. Our major hospital is Stepping Hill Hospital situated on the A6, south of Stockport town centre. We also provide services from the Meadows, Swanbourne Gardens, the Devonshire Centre and in peoples' homes and the community within Stockport.

Services are delivered through our Business Groups which are led by a 'triumvirate' comprised of a Business Group Director, an Associate Medical Director (AMD) and an Associate Director of Nursing (ADN). Our Business Groups during 2017/18 were:

- Women's and Children's and Diagnostics
- Integrated Care
- Medicine and Clinical Support Services
- Surgery, Gastro-enterology and Critical Care

Our Business Groups are supported by corporate services which include:

- Finance
- Workforce and Organisational Development
- Learning and Education
- Corporate Quality and Governance (Corporate Nursing)
- Estates and Facilities
- Information Management and Technology and Communications

Some of our recent successes include:

- Opening of a new £20m Surgical & Medical Centre in October 2016, on time and within budget
- Reconfiguration of the Emergency Department to provide an additional seven cubicles and improve flow through to the hospital
- Introduction of primary care streaming from A&E facilitating G.P. treatment of patients who do not require specialist care
- Introduction of an Ambulatory Care Unit to treat patients direct from the Emergency Department together and patients directly referred by GPs
- Implementation of a multi-agency Crisis Response Team to respond to patients at risk of hospital admission within 2 hours
- Commencement of the hospital Electronic Patient Record (EPR) project and implementation of a Community EPR
- Hyper Acute Stroke Service officially rated 'best in the country'
- Stockport ranked in the top seven in the country for cancer care
- The national Bowel Cancer Audit shows high survival rates for patients who undergo surgery and treatment at Stepping Hill Hospital
- Data from the National Joint Registry shows Stepping Hill Hospital to be one of the best places in the country for knee and hip replacement surgery

5. How did we develop our Quality Improvement Plan?

Our Quality Improvement Plan has developed with the support/contribution/inputs from our key partners and stakeholders and not in isolation. It builds on the foundations and achievements from previous strategies; and was developed in collaboration with members of staff and local stakeholders. Staff from all areas of the organisation, along with Governors, the Clinical Commissioning Group (CCG) and HealthWatch were invited to provide their thoughts on key areas the organisation should focus its quality improvement efforts.

We have listened to feedback from the rich sources of information provided by our patients, their families and carers.

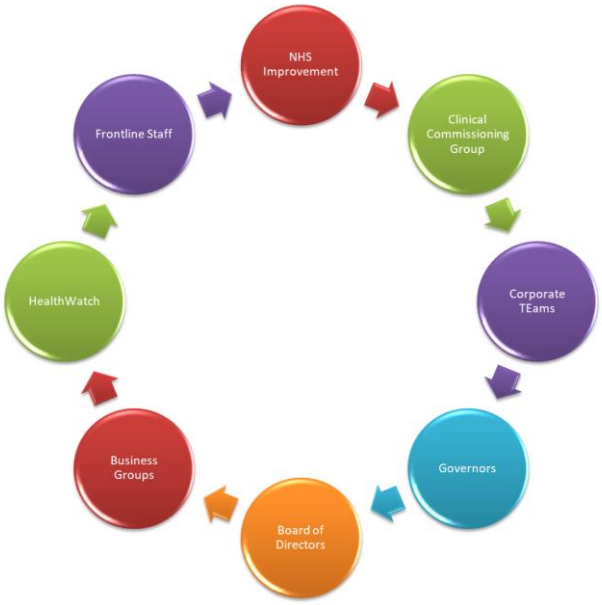
- In-patient surveys
- Staff surveys

- Complaints themes and trends
- Incident reports

The improvement work-streams in place to support urgent care delivery have been refreshed and aligned with GM Urgent Care Strategy. This has been an iterative process with support and engagement from Local Authority, Stockport Neighbourhood Care, CCG's, and NHSI improvement teams working alongside the Trust. All information and plans have been collated and merged to provide a clear map for our journey, based on the delivery of success of **seven themes.**

Stakeholder engagement

Through a series of engagement events, planned walkabouts, workshops and meetings, we listened to our stakeholders to ensure their views helped shape our Quality Improvement Plan.



6. CQC Report Findings 2017

The report was published following CQC unannounced inspections of Urgent and Emergency Services and Medical Care at Stepping Hill Hospital on March and June 2017. The report was published on 3rd October 2017 and followed a letter from the CQC received in June 2017 relating to immediate findings from the June unannounced visit.

The following ratings have been applied for Stepping Hill Hospital:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate	Requires improvement	Requires improvement	Requires improvement	Inadequate	Inadequate
Medical care	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Good	Good	Good	Good	Good	Good
Critical care	Good	Good	Good	Requires improvement	Good	Good
Maternity and gynaecology	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Services for children and young people	Requires improvement	Good	☆ Outstanding	Good	Good	Good
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	N/A	Good	Good	Good	Good
Overall	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

The following ratings have been applied for Stockport NHS Foundation Trust:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Concerns and key areas for improvement

A number of persistent concerns have been identified, recognised both by us as a Trust, and also by external agencies, which this plan intends to address:

Board governance and oversight
The need for a strategic plan reflecting Stockport Together and acute hospital services across Greater Manchester
Valuing the fundamentals of care such as Medicines management, Care of vulnerable patients, management of deteriorating patients and diabetes care
Safe staffing, access to mandatory training and Staff morale
The pressure or demand in emergency services and persistent problems with patient flow
Gaps in governance and risk management
Education and training opportunities for junior doctors
Recognising the importance of privacy, dignity and patient experience

Trust Board Response

The CQC reports made difficult reading for all of us working at the Trust. The Board of Directors have accepted the findings, acknowledging that the Trust had clearly fallen short in some key areas.

Since the inspections in March and June 2017, the Trust has made some significant and important infrastructure changes, including strengthening the joint working of our doctors and nurses in the emergency department and medical care. We have also developed a clear medical leadership structure under the Medical Director. We have developed and introduced our Quality Governance Framework, and our Risk Management Strategy is soon to be launched.

The Board of Directors have made it clear that a culture of being open and honest, speaking up and working together for the good of patients and staff is vital to the success of the Trust.

We have a strong belief in our staff – we know that we have the skills, dedication and ambition to address issues raised by the CQC and ensure we give the best possible care we can to every patient.

We believe that by ensuring there is clarity of our aim and ambition through a Quality Improvement Plan which is deliverable, then our staff will make sure it is delivered. We want to celebrate success whilst we deliver the aim and ambition, at the same time as developing a culture of continuous improvement.

7. Developing a Culture of Continuous Improvement

Patients are at the heart of everything we do at Stockport NHS Foundation Trust and we are committed to improving quality and achieving excellence in all that we do. Our aim is to be one of the most successful NHS trusts. We are committed to developing a culture of continuous learning and supporting continuous Quality Improvement (QI), as advocated within NHS Improvement's 'Developing People, Improving Care' document (2016).

For QI to be successfully embedded by all staff at all levels, a culture of improvement that spans the organisation is required. Importantly too, is the knowledge that a clear QI approach/methodology which is simple, effective and can be used by everyone.

The Trust has adopted the Advancing Quality Alliance QI methodology as our chosen QI approach. It is simple for all staff to use and is a widely understood methodology that has been successfully used in many healthcare settings. Furthermore it builds on the existing knowledge and skills of many of our staff, and harnessing that enthusiasm and knowledge from frontline staff will enable us to make progress faster.

Strong Leadership

Strong leadership is key to the development of an improvement culture, and organisations that have successfully implemented QI strategies have demonstrated improvements in standards and outcomes across all aspects of care. QI is distinctly different to quality strategies and audit and has been shown to bring about more sustained improvement as it enables those with the experiences to explore and co-create the process, resulting in it being more likely that the whole organisation will 'own' the approach.

Being bold – getting on at pace

The Quality Improvement Plan brings together all the actions that the Trust believes to be the most important. We want to be bold, though, and to deliver our aim and ambition at pace. Gaining traction quickly will deliver the improvements necessary to achieve the short-term goal of an overall Trust CQC rating of at least 'Good' by January 2019 and the longer-term ambition of an overall Trust CQC rating of 'Outstanding' by 2020.

We have already started with our weekly Quality Summit, where all staff are invited and the enthusiasm/attendance is growing exponentially.

We have already started our Quality Improvement Initiatives, with nine projects started in April 2018, all set to deliver demonstrable differences in areas where we knew we wanted to make changes. The nine projects align to the Trust Quality Account Priorities for 2018/2019 and to the Operational Plan 2018/2020.

The development of a virtual 'Quality Faculty' will support the delivery of the agreed Quality Improvement Strategy using QI training to build capability and capacity amongst the workforce. The vision of the 'Quality Faculty' is to oversee a 'hub' of QI Facilitators whose role will be to train, mentor and support staff working through QI projects.

We have already commenced work on a number of safety collaboratives providing a focused review of critical areas of patient care. The Pressure Ulcer Collaborative commencing ahead of time in March 2018.

We will approach our Quality Improvement Plan through:

- Board of Directors leadership, oversight and governance making quality are core aspect of our strategy and everything we do
- Executive Accountability for delivery of improvement plans
- Building strong leadership at all levels within the Trust
- Extensive staff engagement and clinical leadership to drive innovation
- A rigorous QI ethos and approach throughout the organisation
- Delivery supported through programme and project management
- Involving our patients, service users, membership/Governors and the public
- External support from experts to address capability

We will be evidence-based and will systematically monitor and test progress as well as look to outstanding organisations elsewhere to see how they do things and learn for our own development.

8. The Seven Themes of our Quality Improvement Plan

Underpinned by Trust Strategy and Quality, Finance and Operational Governance Frameworks

8.1 High Quality Safe Care Plan

The Trust has delivered to address gaps where fundamental standards relating to CQC regulations were not being fully met during the inspections of March and October 2017:

Regulation 10 – Dignity and Respect
Regulation 12 - Safe Care and Treatment
Regulation 17 – Good Governance
Regulation 18 – Staffing

The plan included our response to **Must and Should Do** actions, and was developed into 16 themes.

We knew when we had succeeded by measuring what matters, and by monitoring those measures:		
What matters	By when	Monitoring arrangements
Safe Staffing	Monthly monitoring	Quality Committee
Identifying the deteriorating patient	Monthly monitoring	Quality Committee
Medicines Management	Monthly monitoring	Quality Committee
Training and Development	Monthly monitoring	Quality Committee
Records Management	Monthly monitoring	Quality Committee
Cleanliness and Infection Prevention and Control	Monthly monitoring	Quality Committee
Privacy and Dignity	Monthly monitoring	Quality Committee
Mental Capacity Act	Monthly monitoring	Quality Committee
Incident and Risk Management	Monthly monitoring	Quality Committee
Mortality and Morbidity	Monthly monitoring	Quality Committee
Learning Organisation	Monthly monitoring	Quality Committee
Environment	Monthly monitoring	Quality Committee
Care of the Patient with Diabetes	Monthly monitoring	Quality Committee
Access and Flow	Monthly monitoring	Quality Committee
Emergency Department and Medicine Specific findings	Monthly monitoring	Quality Committee

8.2 Reducing Unwarranted Variation in Clinical Practice

We aim to improve patient care and increase efficiency by **reducing variation** in practice across the Trust.

We will know when we have succeeded by measuring what matters, and by monitoring those measures:		
Topic	By when	Monitoring arrangements
Using local and national benchmarking data to demonstrate consistently high quality clinical care with no unwarranted variation and performance in the top quartiles	March 2019	Bi-monthly performance meetings
Ensuring clinical service needs where required are delivered equitably across 7 days	March 2019	Bi-monthly performance meetings
Introduction of the Accreditation for Continued Excellence (ACE) programme	Launch in April 2018 for inpatient adult wards only. All wards to have undertaken assessment in the first 18months.	Monitored roll-out plan - Results & Action Plans to address short falls monitored by Business Group Quality Boards - Results reported to Quality Committee - Gold accreditation awarded by Quality Governance Group - Work will also be undertaken to develop ACE standards for specialist areas including Paediatrics, Maternity, Community, Theatre, ICU & OPD
Implementing advances in Information Technology, centred on a single electronic patient record across health and social care, which will support our journey of continuous improvement	Date to be confirmed	Electronic Patient Record Programme Board
Delivering the efficiencies identified through the model hospital and reduce unwarranted variation across a range of productivity and clinical effectiveness measures, including: GIRFT programme, NATSIPPs, LOCSIPP's	March 2019	Bi-monthly performance meetings Operational Management Group

8.3 Urgent Care Delivery

Our system is under pressure and we want to improve the urgent and emergency care system so patients get the right care in the right place, whenever they need it. We are working hard with our partners to embed good practice to enable appropriate patient flow, including admission avoidance, better and more timely hand-offs between the emergency department and clinicians and wards, streamlined continuing healthcare processes, better discharge processes and increased community capacity.

We will know when we have succeeded by measuring what matters, and by monitoring those measures:		
Topic	By when	Monitoring arrangements
Urgent Care Access: All patients to be seen by the most appropriate clinician for their needs within 2 hours and if they do not require inpatient specialty care to be discharged within 2 days.	30 June 2018 (GM Improvement Trajectory)	Urgent Care Cabinet, Urgent Care Access Daily touch point meeting
Patient Flow: Reduce to 35% the proportion of General & Acute beds occupied by patients staying longer than 7 days (Stranded Patients).	30 June 2018 (GM Improvement Trajectory)	Urgent Care Cabinet, Patient Flow Steering Group.
Complex Patients: To ensure that medically optimised patients are discharged home or an alternative community facility within 48 hrs.	30 June 2018 (GM Improvement Trajectory)	Urgent Care Cabinet, Borough Wide Keeping In Touch meeting
Community Capacity: To re-commission 60 fit for purpose Intermediate Tier beds.	31 March 2019	Urgent Care Cabinet, Bed configuration core action group

8.4 Safety Collaboratives

We want to introduce five Safety Collaboratives through 2018/20, to focus on delivering definitive and measurable improvements in specific patient safety issues that have been identified through incident reports, complaints, serious incidents or nursing care indicator reports.

We will know when we have succeeded by measuring what matters, and by monitoring those measures:		
Topic	By when	Monitoring arrangements
Pressure Ulcers: 50% reduction in avoidable stage 2, 3 and 4 pressure ulcers (in both acute and community)	31 March 2019	Quality Safety and Improvement Group Quality Committee
Falls: 10% reduction in in-patient falls (tbc following end of year figures) to be monitored quarterly	31 March 2019	Quality Safety and Improvement Group Quality Committee
Nutrition and Hydration: Improved nutrition and hydration (based on NHSI collaborative outcomes tbc)	31 March 2019	Quality Safety and Improvement Group Quality Committee
Deteriorating Patient: Deteriorating Patient and NEWS introduction (metrics to be determined through AQuA program)	30 September 2018	Quality Safety and Improvement Group Quality Committee
Safe Discharge: Delivery of Safe Discharge (metrics to be determined through AQuA program)	31 March 2019	Quality Safety and Improvement Group Quality Committee

8.5 Quality Improvement Initiatives

Our information tells us that we must make improvements in the quality of care and treatment in some areas. We have agreed our quality improvement methodology. Our ambition is that, across a range of identified areas, improvements are clinically led and managerially supported so that they are embedded in practice and focussed on getting the best outcomes for our patient, by the right staff and the right time.

We will know when we have succeeded by measuring what matters, and by monitoring those measures:		
Topic	By when	Monitoring arrangements
Improvement Methodology Training: Deliver workshops with key clinical and management teams to agree success measures. Stakeholders to agree Quality Improvement Priorities for 18/19 Quality Account	March 2018 October 2018 January 2019	N/A
Palliative Care: Improve team caseload flow (by an agreed number of days) for the Specialist Palliative Care team to deliver responsive equitable services and to support other professionals in delivering ace standards of general palliative care by end of March 2019	31 March 2019	Quality Safety and Improvement Group Quality Committee
Fracture Neck of Femur Pathways: To reduce the length of stay for our fractured neck of femur patients to below the national average by the end of March 2019.	31 March 2019	Quality Safety and Improvement Group Quality Committee
Intravenous Therapy (IV) in the community: 100% of AMU patients identified as socially and medically fit for discharge on the Acute Medical Unit who require IV therapy will be referred to the community IV team by the end of September 2018	30 September 2018	Quality Safety and Improvement Group Quality Committee
Optimising our discharge planning process: To reduce the number of adverse events (reported discharge incidents) from Medical wards by an agreed % from the 2017/18 baseline, by the end of March 2019	31 March 2019	Quality Safety and Improvement Group Quality Committee
Effective Management: By the end of March 2019 length of stay on ward A11 will be reduced by 50% from the January 2018 - March 2018 baseline	31 March 2019	Quality Safety and Improvement Group Quality Committee

Reducing variable care reviews in respiratory and endocrine areas: By end of March 2019 to reduce patients not reviewed by a doctor to 0% on any day By the end of March 2019 to increase daily senior reviews by 100% from 2017/18 baseline.	31 March 2019	Quality Safety and Improvement Group Quality Committee
Learning from deaths: 30 deaths per month will be subject to learning from deaths reviews by end of March 2019. 100% of all outcome 1 + 2s identified in the LFD reviews will be escalated for either Mortality and Morbidity review or investigation in line with Trust policies and procedures	31 March 2019	Quality Safety and Improvement Group Quality Committee
Reviewing our use of EWS and how we monitor and escalate deteriorating patients: To reduce by 5% the number of Stockport Foundation Trust inpatient cardiac arrests from the 2017/18 baseline by the end of March 2019	31 March 2019	Quality Safety and Improvement Group Quality Committee
Quality Improvement Practitioner	1 programme each quarter	Quality Safety and Improvement Group Quality Committee
Medical Clinical Leadership Programme – report to be produced	31 October 2018	People and Performance Committee
Nursing and AHP Clinical Leadership Programme - report to be produced	31 October 2018	People and Performance Committee

8.6 Safe Staffing

We aim to ensure safe staffing and a reduction on reliance on temporary staffing through a series of schemes associated with recruitment and retention.

We will know when we have succeeded by measuring what matters, and by monitoring those measures:		
Topic	By when	Monitoring arrangements
Recruitment programme – reduce vacancy rate	31 March 2019	People and Performance Committee
Retention Programme – reduce turnover rate by 1.5%	31 March 2019	People and Performance Committee
Improved efficiencies in e-rostering against a range of measures	30 November 2018	People and Performance Committee
Development of a suite of measures with NHS Professionals	30 June 2018	People and Performance Committee

8.7 Quality Faculty

We recognise improvement is more likely to succeed and be sustained if it is designed and led by the staff doing the job. In order to enable staff to make change happen they will be supported by improvement experts with quality improvement methodologies employed. We want to develop a hub of quality improvement champions working across the Trust, supporting and enabling the delivery of high quality, compassionate and continually improving care for all of our patients, their families and carers. The Faculty will encourage the sharing of best practice, improvement methods and approaches as widely as possible through the systems we work in.

We will know when we have succeeded by measuring what matters, and by monitoring those measures:		
Topic – What matters	By when	Monitoring arrangements
Agree the Trust Quality Improvement Methodology	31 March 2018	N/A
Scope feasibility of development of faculty	30 September 2018	Quality Committee
Describing what 'good' looks like in a quality faculty	30 September 2018	Quality Committee

9. Governance and Assurance

We want to extend from our emphasis placed on monitoring the Quality Improvement Plan and evaluating the impact and outcomes of the quality improvements made. From both a patient and staff perspective we intend that reports and updates about the plan will describe and evidence how we are safer, and how the improvements made are maintained and is sustainable.

We will use triangulation methods that involve describing how the improvements have made a difference for stakeholders or third parties; these will complement the usual range of business intelligence through a rigorous reporting programme both internally and to key stakeholders is now in place.

The Trust has established a series of groups that meet weekly or monthly to provide oversight and seek assurance against operational delivery of improvement plans:

Patient Safety Summit (weekly, chaired by Chief Nurse)
Patient Quality Summit (weekly, chaired by Chief Nurse)
Urgent Care Delivery Group (weekly, chaired by Chief Operating Officer)
Quality Safety and Improvement Strategy Group (chaired by Deputy Chief Nurse)

Sitting alongside the internal governance arrangements is the NHS Improvement Board, that is responsible for ensuring that as a health system there is ownership of issues and action taken to deliver system-wide improvements. Whilst this group has no formal reporting line into the Trust it provides external assurance to the Chief Executive and Executive Management Team.

10. Reporting arrangements

The ability for our organisation to deliver on all aspects of this plan also depends on our ability to measure progress against clear timeframes.

We have developed a mechanism for reporting on each of the seven themes to the Board of Directors and also to our external partners that will demonstrate delivery of our Quality Improvement Plan. We will do this by developing our Organisational Development accountability and compassionate leadership programmes; by improving our communication and engagement with staff and stakeholders via our safety bulletins, excellence awards and the introduction of our own annual Patient Safety Conference.

It is important to measure performance for improvement purposes as it enables us to fully understand the processes we are looking to improve, but also allows us to provide evidence that ideas for improvement work in practice and as a result increases the appetite for improvement amongst our staff toward helping us to realise successes.

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NHS
Stockport
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	24 May 2018
Subject:	Risk Management Strategy and Framework		
Report of:	Chief Nurse & Director of Quality Governance	**Prepared by:**	Chief Nurse

REPORT FOR APPROVAL

Corporate objective ref:	S02
Board Assurance Framework ref:	S02
CQC Registration Standards ref:	Regulation 10, 12, 17 18,
Equality Impact Assessment:	☐ Completed ☒ Not required

Summary of Report

The Risk Management Strategy and Framework 2018 – 20 replaces the current Risk Management Strategy following an extensive review of external sources and strategies. The Framework supports the Trust to follow good practice in risk management as described in ISO 31000 *Risk Management – principles and guidelines and UK Corporate Governance Code,* and provides the driver for good *governance* using the *Care Quality Commission (CQC) well-led framework: guidance for NHS trusts and NHS foundation trusts.*

The aim is to improve safety and reduce the probability of failure to meet regulatory compliance requirements or achieve strategic and operations objectives. This Framework describes the systems that the Trust will use to embed risk management throughout the organisation in order to provide assurance that risks are managed and an effective internal control, assurance and escalation system is in place.

The Board of Directors is recommended to approve the Risk Management Strategy and Framework and Endorse the Framework as the overarching plan to achieve our ambition to be a Risk Enabled organisation by 2020. A recommendation for approval was made following review by the Audit Committee on 17 May 2018.

Attachments: Annex A – Risk Management Strategy & Framework

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

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1.	**INTRODUCTION**
1.1	Since the CQC inspections in March and June 2017, and he Trust being placed in 'challenged trust status' since September 2017, we have made some significant and important changes, including developing the Quality Governance Framework, and the Quality Improvement Plan.
1.2	The Risk Management Strategy and Framework alongside other strategies/frameworks highlighted below is a key enabler for the successful delivery of the Trust's vision, values, behaviours and strategic objectives contained within the strategic domains, which we all have a part to play in delivering. The Board of Directors need to be assured that there is a clear assurance and escalation framework in place to enable staff to escalate issues and risks. In order to do this the Trust Board will foster a culture of transparency, openness and continual learning centred on patients, underpinned by our vision, values and behaviours.
2.	**BACKGROUND**
2.1	The Framework aims to follow good practice in risk management as described in ISO 31000 *Risk Management – principles and guidelines and UK Corporate Governance Code.* Monitoring and review of the development of the Framework will incorporate adoption of the *NHS Improvement - Developmental reviews of leadership and governance using the Care Quality Commission (CQC) well-led framework: guidance for NHS trusts and NHS foundation trusts*
2.2	The aim of effective risk management is to improve safety and reduce the probability of failure to meet regulatory compliance requirements or achieve strategic and operations objectives. This Framework describes the systems that the Trust will use to embed risk management throughout the organisation in order to provide assurance that risks are managed and an effective internal control, assurance and escalation system is in place.
2.3	This provides the Board of Directors with assurance about how the organisation is able to identify, monitor and escalate and manage risks in a timely manner at an appropriate level to enable effective decision-making. The Framework is a Trust wide document, and is applicable to employees, as well as seconded and sub-contracted staff at all levels of the organisation
2.4	Effective risk management is imperative not only to provide a safe environment and improved quality of care for service users and staff, it is also significant in informing the business planning process, links closely to the Operational Plan 2018-20, Quality Improvement Plan 2018-20, performance management framework and overall public accountability in delivering health services.
3.	**CURRENT SITUATION**
3.1	The Risk Management Strategy and Framework document has been developed in response to internal and external audit recommendations, an internal review of our risk management systems and processes and feedback from Board members regarding opportunities for improvement.
3.2	The document describes the following in clear terms: • 4 Step Approach to risk management. • 3 Lines of Defence Model

3.3	• Risk Management Early Warning System (under development) • Links to the Board Assurance Framework • The Six Priorities for 2018/20 that relate to risk management
4.	**RISK & ASSURANCE**
4.1 4.2 4.3	This is the first iteration of a new combined strategy and framework which will undergo an early review by October 2018, with subsequent at least annual reviews taking into account feedback from staff in divisional and corporate teams, internal / external audit and other external sources / inspections. Progression against implementation of the six key risk management priorities for 2018/20 will be monitored and reported on a quarterly basis from April 2018. The Six Priorities are: 1. New approved Risk Management and Strategy Framework 2018 / 2020 (April 2018) 2. New Board Assurance Framework (BAF) document development and implementation 3. Risk Registers established – Moderation exercise & controls assurance assessments required with education & training / support 4. New committee structure in place from April 2018. Review of lower group reporting structures is required 5. Safety Culture assessments undertaken: cycle of assessments to be implemented and triangulated with other information / data 6. Electronic system in place – requires development to embed web based solution with intelligent reporting and triangulation of data and information
5.	**CONCLUSION**
5.1	The Risk Management Strategy and Framework forms part of the Trust's wider internal control and governance arrangements. The Framework defines the strategy, policy, principles and mandatory requirements for how risk is managed across the organisation; highlights key aspects of the risk management and assurance process, and identifies the main reporting and escalation procedures. The Framework provides infrastructure to parts of our Well Led assessment. The draft Risk Management Strategy & Framework was reviewed and recommended for approval by the Audit Committee on 17 May 2018.
6.	**RECOMMENDATIONS**
6.1	The Board of Directors is recommended to: • Endorse the Framework as the overarching plan to achieve our ambition to be a Risk Enabled organisation by 2020 • Approve the Risk Management Strategy & Framework included at Annex A.

NHS
Stockport
NHS Foundation Trust

Risk Management Strategy and Framework

2018-2020

Contents

FOREWORD

Our mission is that our patients' health is our priority, and our staff work together to provide high quality, safe health care services across Stockport, the High Peak and surrounding areas. Stockport NHS Foundation Trust (the Trust) is a complex organisation with an annual budget of around £303 million and the Trust employs over 5,500 staff to provide access to care for over 500,000 patients a year.

This Risk Management Strategy and Framework (the Framework) forms part of the Trust's wider internal control and governance arrangements. The Framework defines the strategy, policy, principles and mandatory requirements for how risk is managed across the organisation; highlights key aspects of the risk management and assurance process, and identifies the main reporting and escalation procedures

The Framework aims to follow good practice in risk management as described in ISO 31000 *Risk Management – principles and guidelines and UK Corporate Governance Code.* Monitoring and review of the development of the Framework will incorporate adoption of the *NHS Improvement - Developmental reviews of leadership and governance using the Care Quality Commission (CQC) well-led framework: guidance for NHS trusts and NHS foundation trusts*

The aim of effective risk management is to improve safety and reduce the probability of failure to meet regulatory compliance requirements or achieve strategic and operations objectives. This Framework describes the systems that the Trust will use to embed risk management throughout the organisation in order to provide assurance that risks are managed and an effective internal control, assurance and escalation system is in place.

This provides the Board of Directors with assurance about how the organisation is able to identify, monitor and escalate and manage risks in a timely manner at an appropriate level to enable effective decision-making. The Framework is a Trust wide document, and is applicable to employees, as well as seconded and sub-contracted staff at all levels of the organisation

Effective risk management is imperative not only to provide a safe environment and improved quality of care for service users and staff, it is also significant in informing the business planning process, links closely to the Operational Plan 2018-20, Quality Improvement Plan 2018-20, performance management framework and overall public accountability in delivering health services

The Trust's primary objective is to provide high quality, safe health care and treatment to our patients and their families and has developed a Quality Governance Framework (QGF). The QGF defines the structures by which the Board of Directors can be assured that required quality, safety and experience standards are achieved.

The Trust recognises that the principles of governance must be supported by an effective risk management framework designed to deliver improvements in patient safety and the quality and effectiveness of care we provide as well as the safety of its staff, patients and visitors. Effective dynamic risk management at all levels, and a positive safety culture, is critical for the sustainability and on-going success of the Trust.

There are a number of strategy and policy documents which underpin this Framework. These documents include:-

- Trust Strategy
- Quality Governance Framework
- Quality Improvement Plan
- Clinical Audit Strategy
- Incident Reporting Policy (under review)
- Serious Incident Policy (under review)
- Complaints and Concerns Policy (under review)
- Operational Plan

Chief Nurse and Director of Quality Governance

1. INTRODUCTION

This framework, alongside other strategies/frameworks highlighted below is a key enabler for the successful delivery of the Trust's vision, values, behaviours and strategic objectives contained within the strategic domains, which we all have a part to play in delivering. The Board of Directors needs to be assured that there is a clear assurance and escalation framework in place to enable staff to escalate issues and risks. In order to do this the Board of Directors will foster a culture of transparency, openness and continual learning centred on patients, underpinned by our vision, values and behaviours.

2. DUTIES AND RESPONSIBILITIES

Chief Executive

The Chief Executive Officer (CEO) has overall responsibility for ensuring that an effective governance system, including risk management, is in place across the Trust, meeting all statutory requirements and adhering to guidance issued by NHS Improvement and the Department of Health in respect of governance and risk management. To fulfil this responsibility the CEO will ensure that:

- full support and commitment is provided and maintained in risk management activities;
- an appropriate Board Assurance Framework is in place; and
- the Annual Governance Statement adequately reflects the risk management issues within the organisation.

Chief Nurse & Director of Quality Governance

The Chief Nurse & Director of Quality Governance is the responsible Executive for the development and maintenance of the organisation wide risk management systems and processes

Executive Directors

The Executive Directors have delegated responsibility for their respective functions from the Chief Executive. However, responsibility for the day to day management of risk is devolved to the Business Groups and Corporate Departments.

Non-Executive Directors

Non-Executive Directors have a duty to ensure that the Trust has sufficient control measures in place to be able to effectively manage risk. Non- Executive Directors are members of both the Quality Committee, which is the Board sub-committee with overarching responsibility for organisational and clinical risk, the Performance and Finance Committee, which is the Board sub-committee with overarching responsibility for financial risk, and the Audit Committee with independent oversight of risk management systems and processes.

Deputy Director of Quality Governance

The Deputy Director of Quality Governance has lead responsibility for ensuring that the Trust has appropriate systems and processes in place to manage the function of integrated governance which include the following:

- Board Assurance Framework and processes
- Risk Management – systems and processes
- Incident Reporting
- Patient Safety
- Health and Safety, which includes manual handling and fire
- Governance, which includes Information Governance

Business Group Senior Management Teams / Heads of Corporate Departments

Accountability for the Business Groups lies with the Associate Medical Directors, Business Group Directors, and Associate Directors of Nursing (Senior Management Team). Corporate team escalation is via the Deputy Director of Quality Governance or Executive Lead membership.

Each Senior Management Team/Head of Corporate Department is accountable for the management of risk within their Business Group/Corporate Department. They will ensure that their risks on the Risk Register are reviewed in line with this strategy and framework. They are responsible for implementing and monitoring any identified risk management control measures needed within their designated area(s), ensuring that they are suitable and sufficient. Risks will be monitored corporately if they score 15 or above (guide) using the Trust's risk scoring matrix. Action must be undertaken by management in the Department/Business Group where the risk has been identified.

Business Group Governance Managers

The Business Group Governance Managers work within the four Business Groups and Corporate teams, including Estates and Facilities Department. They co-ordinate the risk management and governance agenda in the Business Groups and provide real time information to support risk mitigation. They are responsible for the day to day direction of the risk agenda in the Business Groups working with their Senior Management Teams. They are members of the Safety and Risk Group, providing a direct escalation route from the Business Groups through the Governance structure.

Other Managers in the Trust

All managers have a delegated responsibility for the management of risk in their Departments, Wards and any other areas. Risk management is integral to their day to day management responsibilities, and managers are authorised to mitigate risks identified at a local level wherever possible. If risks cannot be mitigated locally, issues should be escalated through the management lines of accountability, and action undertaken by management in the Department, Business Group or area where the risk has been identified.

All Trust Staff and Volunteers

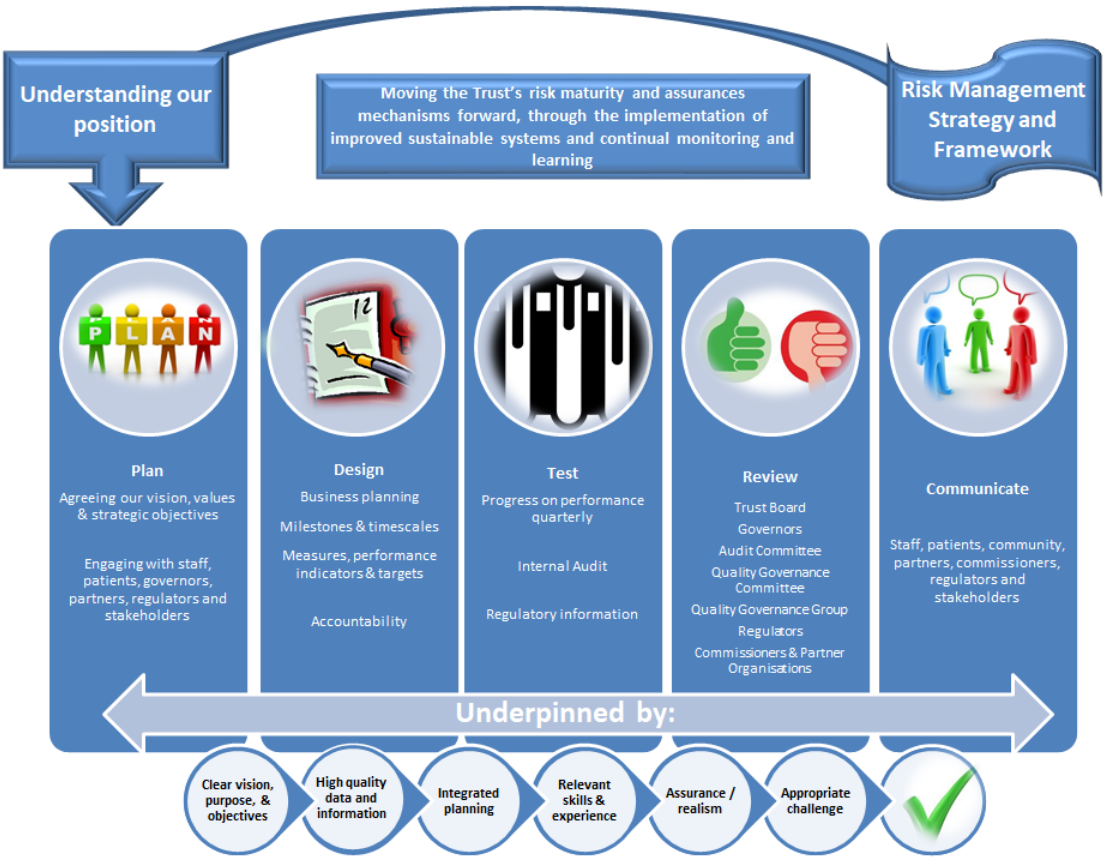
The management of risk is the responsibility of all managers, staff and volunteers throughout the organisation and they have a responsibility to be risk aware at all times. Every effort should be made to maintain a safe environment and safe systems of work, thereby reducing the potential to cause harm to patients, staff and others and hence negatively affect the reputation and assets of the organisation. The Trust aims to achieve this within a progressive, honest and open environment, where risks, incidents, accidents, mistakes / errors and 'near misses' are identified quickly and acted upon in a positive and constructive way, which either eliminates the risk or reduces the likelihood of future occurrence or impact. Staff will be provided with education, training and support to enable them to meet this responsibility through the mandatory training programmes as a minimum.

All employees and volunteers have a personal responsibility to, as appropriate:

- comply with Trust strategies, policies, procedures and guidelines;
- be aware of risks at all times and take reasonable action to identify, eliminate where possible, or control them;
- work within their own level of competence;
- notify line managers of risks they have identified which cannot be adequately managed;
- participate in risk management education and training;
- use any safety equipment, personal protective equipment and adopt safe working practices; and
- co-operate with management, representatives of enforcement agencies and auditors in respect of Health and Safety issues and the investigation of incidents.

3. THE RISK MANAGEMENT STRATEGY AND FRAMEWORK

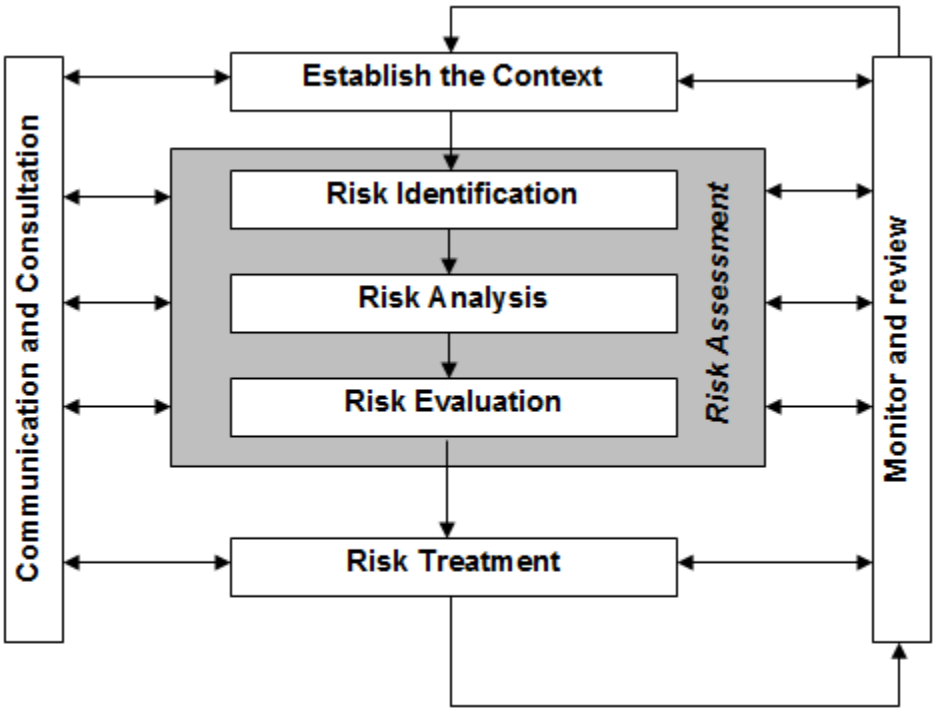
The Risk Management Strategy and Framework document has been developed in response to internal and external audit recommendations, an internal review of our risk management systems and processes and feedback from Board members regarding opportunities for improvement. This is the first iteration of a new combined strategy and framework which will undergo an early review by October 2018, with subsequent at least annual reviews taking into account feedback from staff in divisional and corporate teams, internal / external audit and other external sources / inspections. Progression against implementation of the six key risk management priorities for 2018/20 (Section 12) will be monitored and reported on a quarterly basis from April 2018. The diagram below details the steps we are taking on a continual basis to deliver this strategy & framework



4. IMPLEMENTING THE RISK MANAGEMENT STRATEGY AND FRAMEWORK

Risk management process

To ensure consistency the Trust operates a standard risk management process. The main stages are shown below, with a detailed overview of each step provided below



Source: ISO 31000

Step 1: Establish the context

To 'establish the context' or scope means to define the internal and external parameters to be considered when identifying and managing risks to objectives. One of the most important aspects of the risk assessment is accurately identifying the potential hazards and the Trust's Risk Assessment Procedure provides additional detail on how to approach this based on Health & Safety Executive guidance.

Establishing the context is basically answering the question ***'What are we trying to achieve?'*** as we cannot start any venture without first clearly defining its scope and clarifying the objectives that are at risk.

Internal context includes all the internal environmental parameters and factors that influence the Trust's ability to achieve its objectives. It includes its internal stakeholders, its approach to governance (structure, policies, objectives, roles, accountabilities, and decision-making process), its contractual relationships and its capabilities (knowledge and human, technological, capital, and systemic resources), culture and standards.

External context includes all the external environmental parameters and factors that influence the Trust's ability to achieve its objectives. It includes external stakeholders (values, perceptions, and relationships) as well as key external drivers and trends that influence objectives (social, cultural, political, legal, regulatory, financial, technological and economic environment).

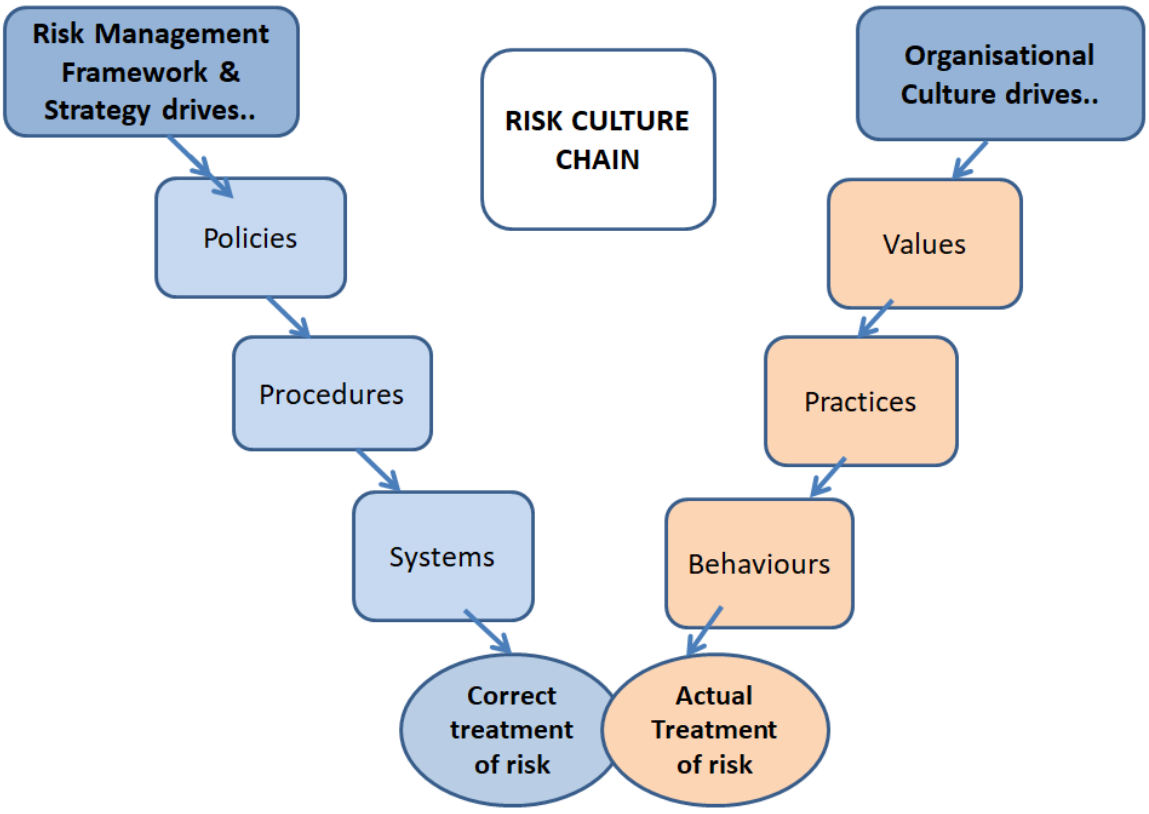
Risk Culture

Essentially risk management is a decision making process. We all make decisions about risk throughout our daily lives, influenced by our personal circumstances, health and safety considerations and our evaluation of the benefits or harm likely to come as a result of our decision. Generally we calculate how much risk will be involved by considering what has happened before in similar circumstances. Where the result was positive we are more inclined to make the same or similar decision than if the previous decision resulted in substantial loss or harm.

The Risk Culture Chain

The individual response towards risk greatly influences decision making and in the work setting this inevitably has an effect on organisational decision making and therefore risk management. Not everyone will have the same perception of the likelihood and possible consequence of each risk; each member of staff will have a strong preference for a specific response to risk based on their individual responses to risk. For effective risk management it is essential that, as far as possible, individual bias is removed and a subjective assessment of risk is made.

Managing risk effectively takes time but the rewards gained through **improved decision making**, **increased organisational resilience** and an increased **ability to take advantage of positive opportunities** are benefits which go beyond the assurances that risk management provides. Risk and safety culture surveys and associated actions should form part of our Quality Improvement Priorities for 2018/19.



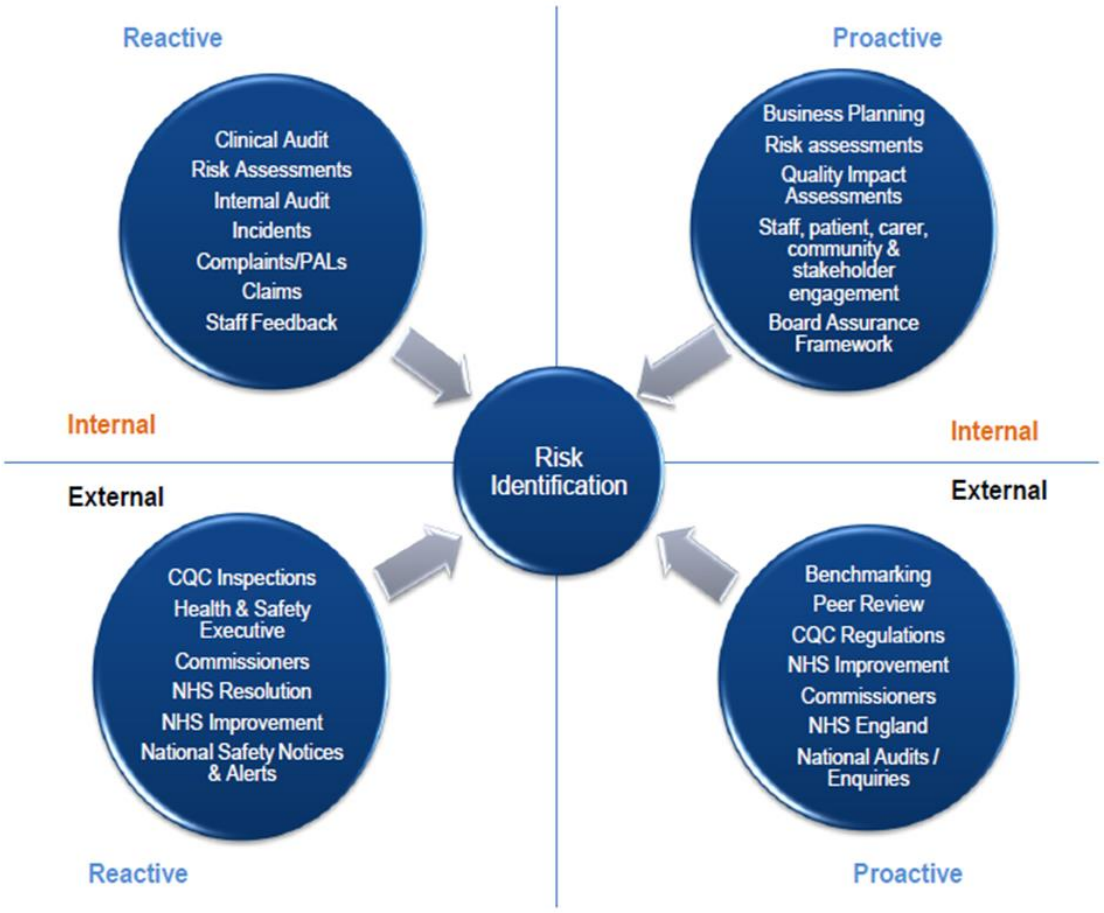
If Strategy and Culture are fully aligned then Actual and Correct Risk Treatment will match

Step 2: Risk assessment

Risk assessment is made up of three processes: identification, analysis and evaluation. In step two we are attempting to answer the following questions: **'What could affect us achieving our objectives?'** and **'Which of those things are most important?'**

Risk identification

Risk identification involves finding, recognising and describing the risks that could affect the achievement of objectives. It finds possible sources of risk as well as conditions, behaviours, events and circumstances that could affect objectives. It also includes identifying possible causes and potential consequences. There are a variety of risk identification techniques, each of which has strengths and weaknesses, so we should use more than one approach to identify risks. A specific risk owner should be identified for each risk. Ideally the risk owner will also own the related objective or significantly influence its achievement. If an individual owns a risk, it is more likely to be understood and monitored, and appropriate controls are more likely to be in place. The diagram below provides examples of risk identification / source

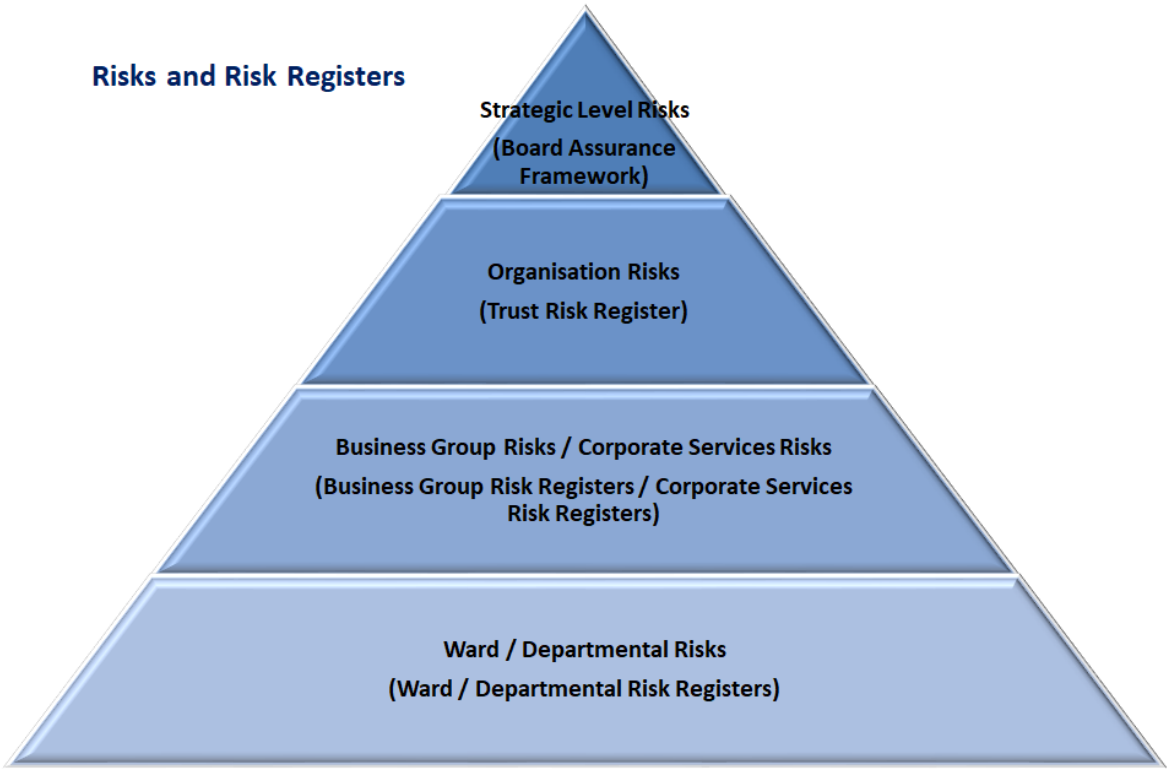


Risk analysis

Risk analysis determines a risk's significance by considering its potential impact/consequence if it were to occur and the likelihood of the risk occurring. Assessing impact/consequence and likelihood impact together produces an overall risk severity rating using the risk matrix. Each risk event on our risk registers has an initial, current, and target risk rating. Where risks are outside acceptable levels of tolerance, a target risk score should be agreed – the level that future mitigation should aim to achieve or better; this will vary over time and should be set and revised as per the policy in relation to authorities to manage risk.

Risk types (Risks and Risk Registers)

Authorities to manage risk and monitoring arrangements can be found in Step 4.



- **Strategic risks:** Impact on strategic objectives risks rated 20 & above*
- **Organisation risks:** Risks rated 15 & above*
- **Business Group /Corporate Services:** Risks rated 12 & above*
- **Ward/Department Risks** Risks rated 10 & below*

*Guide: lower rated risks may also be escalated – all risks must also sit on an operational risk register(s).

Risk categories

- Impact on the safety of patients, staff or public (physical/psychological harm)

  Includes, for example:
  - potential for or actual Injury/harm whether or not requiring treatment
  - increased length of hospital stay or time off work
- Quality/concerns/audit

  Includes, for example:
  - potential for adverse outcomes, treatment and overall service quality together with patient satisfaction.
- Human resources/organisational development/staffing/competence/training

  Includes, for example:
  - recruitment issues

- staffing levels
- staff satisfaction
- sickness/absence
- access to and attendance for training

- Statutory duty/ regulation/compliance

  Includes, for example:

  - breaches of regulation, statutory duties and/or compliance

- Adverse publicity/reputation

  Includes, for example:

  - potential for public concern
  - meeting expectation
  - media interest and rumour whether founded or not

- Business aims/projects

  Includes, for example:

  - potential for contract change
  - loss of service
  - income reduction
  - cost increase
  - schedule slippage

- Finance

  Including:

  - potential for small to major financial loss
  - claims
  - fraud

- Service/business interruption
  Includes, for example:
  - potential for short service interruption through to permanent loss of a service or facility including IT
- Environmental impact
  Includes, for example:
  - potential for minimal through to major impact on the hospital environment or more widely in the local area.

A summary of the matrices is provided below – a detailed matrix is provided in Frequently Used Forms on the intranet (Currently under review) and Step 4 details risk assessment categorisation, authority to manage risks and actions required.

Consequence / Likelihood	1	2	3	4	5
1	1	2	3	4	5
2	2	4	6	8	10
3	3	6	9	12	15
4	4	8	12	16	20
5	5	10	15	20	25

Likelihood	Definition	Estimated Probability	Lessons Learned
Almost certain	This event may be imminent or there are strong indications it will occur in the future. Not confident risk can be managed at this level and contingency is required	More than 80% chance of occurring	A regular occurrence. Circumstances found frequently
Likely	This event is likely to occur in most circumstances. Requires additional mitigation/contingency. Little confidence risk can be managed at this level	51% to 80% chance of occurring	Has occurred from time to time and may do so again in the future
Possible	This event is likely to occur at some time even if controls operate normally. Confident risk can be managed at this level	21% to 50% chance of occurring	Has occurred previously but not often, and may have been in a limited way
Unlikely	Not expected, this event has a small chance of occurring at some time	6% to 20% chance of occurring	Has not happened, or happened in a very limited way
Rare	Highly unlikely, will occur only in very exceptional circumstances Very confident risk can be managed at this level Controls operate normally	Less than a 5% chance of occurring	Has rarely happened

Use of Risk Registers in Assurance Committees

Each assurance committee will review specified sections of the Trust Risk Register (risks above 15). The Chair of each committee will ensure that there is a focus throughout the agenda on the controls in place to manage the risks identified in the Trust Risk Register that relate to their own key area. Additionally, they will assess from the assurance received that the Trust Risk Register contains any of the risks highlighted or identified through assurance papers received. Whilst the Quality Committee will review the Trust Risk Register in its entirety, the role of the Audit Committee is to seek assurance that the Trust has systems and processes in place to manage risk.

Risk evaluation

Risk evaluation involves deciding the risk level and the priority for attention. Not all risks are equally important, so we need to filter and prioritise them, to find the worst threats (and the best opportunities). This will help us decide how to respond. When prioritising risks, we could use various characteristics, such as how likely they are to happen, what they might do to our objectives, how easily we can influence them, when they might happen, and how might they be amplified etc..

Reputational risk

One consideration in risk analysis is why some relatively minor risks or risk events, as assessed by risk leads, often elicit strong public concerns and result in substantial higher impacts than anticipated or than our technical risk assessment predicts. This is because they interact with psychological, sociological, and cultural perceptions of risk and what constitutes 'risky' behaviour, which can amplify public responses to the risk or risk event. In other words, the news media, stakeholder groups/networks, and others may amplify risk and amplified risk often results in secondary impacts above what we might anticipate. We should be cognisant of this fact and include the assessment of potential social amplification when undertaking our technical assessment of a risk and its impact and likelihood.

Step 3: Risk treatment

In step three we are attempting to answer the following questions: **'What shall we do about these risks?'** and **'Having taken action, did it work?'** In this process, existing controls are improved or new controls are developed and implemented. It involves evaluating and selecting options to deal with risks that have negative and/or positive consequences.

The options are:

- Eliminate – stop undertaking the task completely
- Avoidance – undertaking the activity in a different way to prevent the risk occurring
- Reduction – taking action to reduce the risk
- Transfer – movement of the risk to another individual/organisation
- Acceptance – all of the above options are not possible and a contingency plan is developed

After identifying and assessing each risk, risk registers should be updated.

In most cases the chosen option will be to treat the risk. When considering the action to take remember to consider the cost associated with managing the risk, as this may have a bearing on the decision. The key questions in this instance are:

- Action taken to manage risk may have an associated cost. Make sure the cost is proportionate to the risk it is controlling.
- When agreeing responses or actions to control risk, remember to consider whether the actions themselves introduce new risks or affect other people in ways that they need to be informed about

Contingency Plans **–** if a risk has already occurred and cannot be prevented ***or*** if a risk is rated purple or red (extreme or high impact / consequence) then contingency plans should be in place should the risk materialise. Contingency plans should be recorded in the action plan column on the register. Good risk management is about being risk aware and able to handle the risk and not being risk averse.

Risk proximity

This indicates when the risk is likely to materialise or anticipated timescale. There are three categories:

- Within three months;

- Between three and twelve months; or
- Twelve months or longer.

Considering the proximity, or how soon a risk may occur, can help to compare risks for decision-making.

Note: We can plan to address risks, but nothing will change unless we actually do something. Planned responses must be implemented in order to tackle individual risks and change risk exposure, and the results of these responses should be monitored to ensure that they are having the desired effect. Our actions may also introduce new risks for us to address.

Step 4: Risk monitoring and review

Monitoring and review must be continual and repeated, so that appropriate action can be taken as new risks emerge and existing risks alter due to changes in the Trust's objectives or the internal and external environment. The table below defines both the authorities to manage risk and mandated review dates.

Risk Rating	Priority	Level of Action	Authority to Manage Risk	Minimum Review Requirements by Designated Lead
Green Very Low (1 to 3)	Very Low	• No further action or records required. Manage via routine process	All staff undertaking assessments	-
Yellow Low (4 – 6)	Low	• Departmental / ward management action required to reduce risk as low as reasonably practicable	Ward / Department Manager	Annually
Amber Moderate* (8 – 12)	Medium	• Business Group / Coporate Service actin required to reduce risk as low as reasonable practicable • Monitored by Business Group Quality Board / Subcommittee as appropriate *Note – some risks may require escalation at this level	Business Group Directors / Deputy Directors / Directors	6 monthly
Red High (15 to 16)	High	• Business Group management action required to reduce risk as low as reasonably practicable • Approval of rating by Business Group Board • Quarterly Risk Report to Business Group Board • Risks rated 15 & above approved at Quality Governance Group ahead of inclusion to the Trust Risk Register • Monitoring through Quality Governance Group quarterly reports, with assurance to the Quality Committee and onward escalation	Business Group Directors / Deputy Directors / Directors	Quarterly

		to the Board of Directors as required		
Purple Extreme (20 and 25)	Extreme	• Business Group management action required to reduce risk as low as reasonably practicable • Approval of rating by Business Group Board • Monthly Risk Report to Business Group Board • Quarterly Risk Report to Business Group Board • Risks rated 20 & above approved at Quality Governance Group ahead of inclusion to the Trust Risk Register • Monitoring through Quality Governance Group quarterly reports, with assurance to the Quality Committee and onward escalation to the Board of Directors as required	Business Group Directors / Deputy Directors / Directors	Monthly

Step 5: Communication and consultation

We must continually and repeatedly communicate with and consult internal and external stakeholders, where possible, to gain input and agree ownership of risk assessment results. It is also important to understand stakeholders' objectives so you can plan their involvement and take their views into account in agreeing whether a specified risk level is acceptable or tolerable. Discussions could be about the existence of risks, their nature, likelihood, impact and significance, as well as whether risks are acceptable or should be treated, and what treatment options to consider.

As a Trust we should take advantage of our experience to learn lessons and benefit future ventures. This means that we should spend time thinking about what worked well and what needs improvement, and recording our conclusions in a way that can be reused by ourselves and others.

5. RISK DOCUMENTATION

The Quality Governance Team provides a standard risk register template that should be used to capture risks. An exception would be if alternative, robust programme or project management arrangements were in place which includes / covers risks appropriately

Description of risk	A simple phrase that describes the risk: *"There is a risk that <risk event> as a result of <cause> which may lead to <impact>."*
Cause(s) and consequence(s) / impact	Causes (also referred to as risk drivers or influencing factors), both internal and external, should be explained. Consequences (also referred to as effects, impact or outcomes) should also be explained.
Link to objectives/ business plan priorities	Where possible, risks should be linked to our strategic objectives, legislative duties, major programmes/projects, business plan objectives or business-as-usual activities.
Existing controls	To aid risk assessment and action planning, the current measures to control the risk – and whether they are considered adequate – are recorded.
Assessment of risk and control	Risk ranking (impact and likelihood): to assist with prioritisation, risks are scored/given a ranking using the Trust's impact/consequence and likelihood matrix; this enables the 'most significant' risks to be identified. Current/residual scores and target risk scores are assigned.
Risk and control owner(s)	Owner (lead person): you need to assign risks and controls to a lead person responsible for ensuring they are adequately controlled and monitored.
Action(s)/treatment plans	Where a plan of action or treatments to address the risk have been agreed, they should form part of the register.
Dates	As the risk register is a 'living' document, it is important to record the date that risks are added or modified. If the register includes an action plan, you should provide target and completion dates for actions. To ensure all open risks are reviewed as per policy, you must provide a review date.
Comments/ updates	Where separate update/summary reports are not produced, risk registers should include a comments column to allow for useful updates, such as meetings to discuss the risk

Developmental areas to be included on the risk register include risk proximity, controls assurance assessment ratings, cost / benefit analysis and linkages to business continuity plans over the lifetime of this strategy & framework - Please refer to the six priority areas in Section 14

6. RISK APPETITE

The risk appetite of the Trust is the decision on the appropriate exposure to risk it will accept in order to deliver its strategy over a given time frame. In practice, an organisation's risk appetite should address several dimensions:

- The nature of the risks to be assumed;
- The amount of risk to be taken on; and
- The desired balance of risk versus reward.

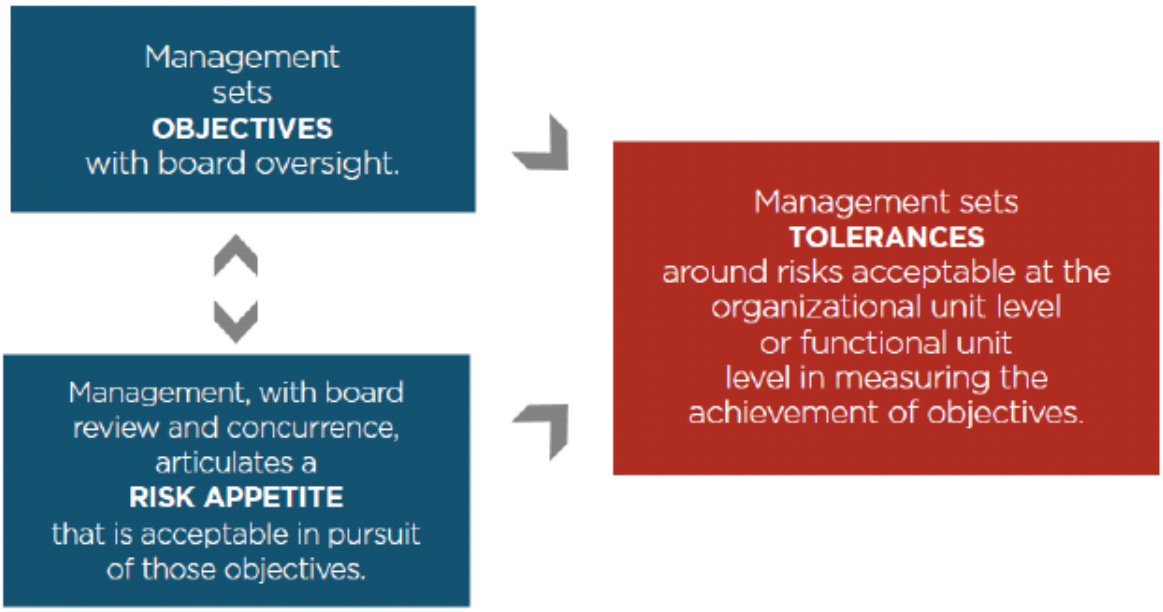
The Board of Directors recognise that it is impossible to deliver its services and achieve positive outcomes for its stakeholders without taking risks. Indeed, only by taking risks can the Trust realise its objectives. It must, however, take risks in a controlled manner, reducing its exposure to a level deemed acceptable by the Board of Directors and, by extension, external inspectors/regulators and relevant legislation. The range of identified risks which the organisation is prepared to accept, tolerate or be exposed to is its risk appetite.

Methods of controlling risks must be balanced in order that innovation and imaginative use of limited resources are supported when it is to achieve substantial benefit. In addition, the Trust may accept some high risks because of the cost of controlling them. As a general principle the Trust will seek to control all risks which have the potential to:

- cause harm to patients, staff, volunteers, visitors, contractors and other stakeholders
- endanger the reputation of the Trust
- have severe financial consequences which would jeopardise the Trust's ability to carry out its functions
- jeopardise significantly the Trust's ability to carry out its normal operational activities
- threaten the Trust's compliance with law and regulation.

As part of the development of the new Board Assurance Framework the Board of Directors are currently reviewing the risk appetite aligned to the strategic objectives. The statement will define the Board's appetite for each risk identified to the achievement of strategic objectives for the financial year in question. Risks throughout the organisation should be managed within risk appetite, or where this is exceeded, action taken to reduce the risk.

The diagram below demonstrates the link between objectives, risk appetite and tolerances



Source: COSO, *Enterprise risk management — integrated framework*

7. BOARD ASSURANCE FRAMEWORK (BAF)

Organisations exist to achieve a purpose and the primary function of the Trust is to drive the Trust forward in achieving this purpose, whilst upholding the values and behaviours of the organisation. The purpose (or mission) is translated into strategic objectives, operating across different components of the business that must work effectively together.

At any point in time the Trust needs to be aware of the current state of progress with regard to its strategic objectives. Whilst there will always be elements of uncertainty, the Board of Directors need to be assured (positively or negatively) as to what is feasible and practicable with regard to the delivery of its strategic objectives. In order for the Board of Directors to receive the necessary assurance, the following governance components and processes are in place:

Strategic Objectives (strategic/business group level) which must be clear and measureable (other components of governance cannot function effectively or efficiently unless these clear objectives and associated success measures are in place);
Controls (policies, procedures, structures, staffing etc.) which must be put in place by management in order to achieve core objectives (taking into consideration known risks to achievement);
Performance against tangible measures of success should be regularly reviewed (and shortfalls/weaknesses identified as a risk to the achievement of the objectives);
Risks to the achievement of objectives and individual tangible success measures should be identified. Risks should be assessed and graded in terms of their impact on a particular or specific aim/objective and escalated for consideration as required;
Risk management decisions should be taken in light of: risk appetite; risk tolerance; and the cumulative impact and likelihood of any or all of the risks threatening achievement of a single objective;
Action should be taken in response to risk, including additions or amendments to the control framework to ensure it is effective.

The Board of Directors reviews risk principally through the following three interlocking and related mechanisms:

a. The Board Assurance Framework (BAF) sets out the strategic objectives, identifies key risks in relation to each strategic objective along with the controls in place and assurances available on their operation. Additionally, the BAF is cross-referenced to significant risks included on the Trust Risk Register (TRR) and will be supported by a developing assurance mapping exercise which will identify both gaps and also where assurance is duplicated or is disproportionate to the
risk or activity leading to efficiency / resource gains.

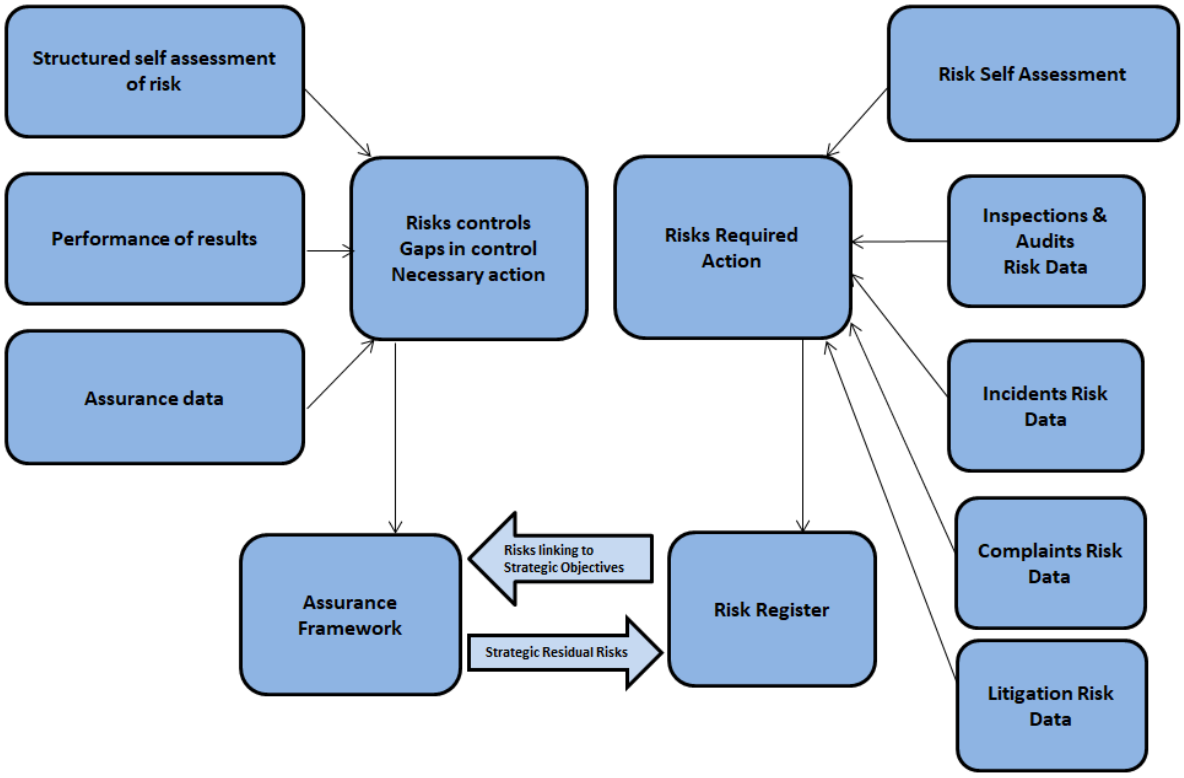
b. The Trust Risk Register (TRR) is the corporate high level operational risk register used as a tool for managing risks and monitoring actions and plans against them. The Executive Team are responsible for the escalation and de-escalation of risk from, and to the TRR.

c. The Annual Governance Statement is signed by the Chief Executive Officer. It sets out the organisational approach to internal control. This is produced at the year-end (following regular reviews of the internal control environment during the year) and scrutinised as part of the annual accounts process and brought to the Board of Directors with the accounts

Our new Board Assurance Framework will:

- be a succinct document of the assurances generated around each strategic objective, rather than principal risks;
- record the Board's confidence in achievement of each strategic objective at any given point in time, given all the information available to them;
- be 'live' and support effective decision-taking and provide evidence and justification for the decision making process;
- influence the Board of Directors agendas according to where the largest gaps are perceived to exist in either a) confidence in current position or b) achievement against strategic objectives.
- be considered for every piece of information the Board of Directors receive and how it may affect its confidence about the likely achievement of a strategic objective.
- provide an opportunity to identify gaps in assurance or where existing controls are failing in an efficient and effective manner; and
- identify assurance is duplicated or is disproportionate to the risk or activity leading to efficiency / resource gains.

The diagram below demonstrates the linkages between the Board Assurance Framework and the Trust Risk Register.



Divisional adoption of the Strategic Objectives

Divisional Boards develop divisional objectives based on the Trust's Strategic Domains and risks are identified through business planning processes with plans included in the overarching Trust Strategy 2017/18-2020/21, monitoring is via the Trust's performance management framework. Business Group Quality Boards may choose to adopt a divisional assurance framework locally, as appropriate

BOARD ASSURANCE FRAMEWORK – SUPPORTING OUR JOURNEY FROM REQUIRES IMPROVEMENT TO OUTSTANDING

Strategic Domain

Principal Risk	

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHS Improvement Oversight Framework	Accountable Executive Director	Executive Management Group	Designated Board 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
	Rationale for the Current Risk Score									
	Links to BAF Objectives									
	Links to the Trust Risk Register									

Strategic Domain

Q1	To aspire to the delivery of 'outstanding' clinical quality and safety, which is equitable, patient and family centred and supported by an effective quality governance framework

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)		
Adequacy of Assurance (Level of Confidence)			None	None		
Overall Assessment of Assurance						

Quarter 1 Commentary:
Quarter 2 Commentary:
Quarter 3 Commentary:
Quarter 4 Commentary:

Assurance Rating	*Significant Assurance*	*Significant Assurance with minor*	*Partial assurance with improvements*	*No assurance*

		improvement opportunities	*required*	

8. RISK GOVERNANCE

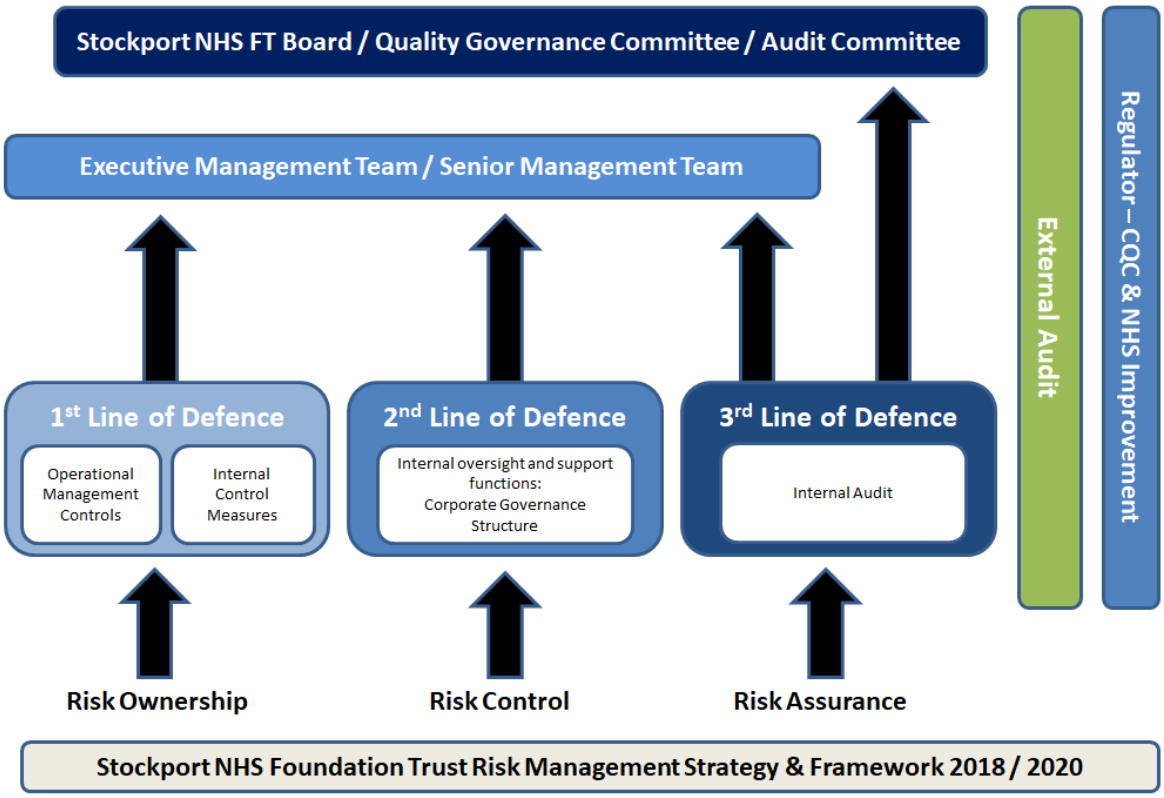
The Three Lines of Defence

The Three Lines of Defence model provides a simple and effective way to enhance communications on risk management and control by clarifying essential roles and duties. In the **Three Lines of Defence** model, management control is the first line of defence in risk management, the various risk control and compliance oversight functions established by management are the second line of defence, and independent assurance is the third. Each of these three 'lines' plays a distinct role within the Trust's wider governance framework.

First line – Information coming directly from front line operational teams may provide assurance that performance is monitored, risks identified and addressed and objectives are being achieved. Sources of assurance include, for example, good policy and performance data, risk registers and other management information.

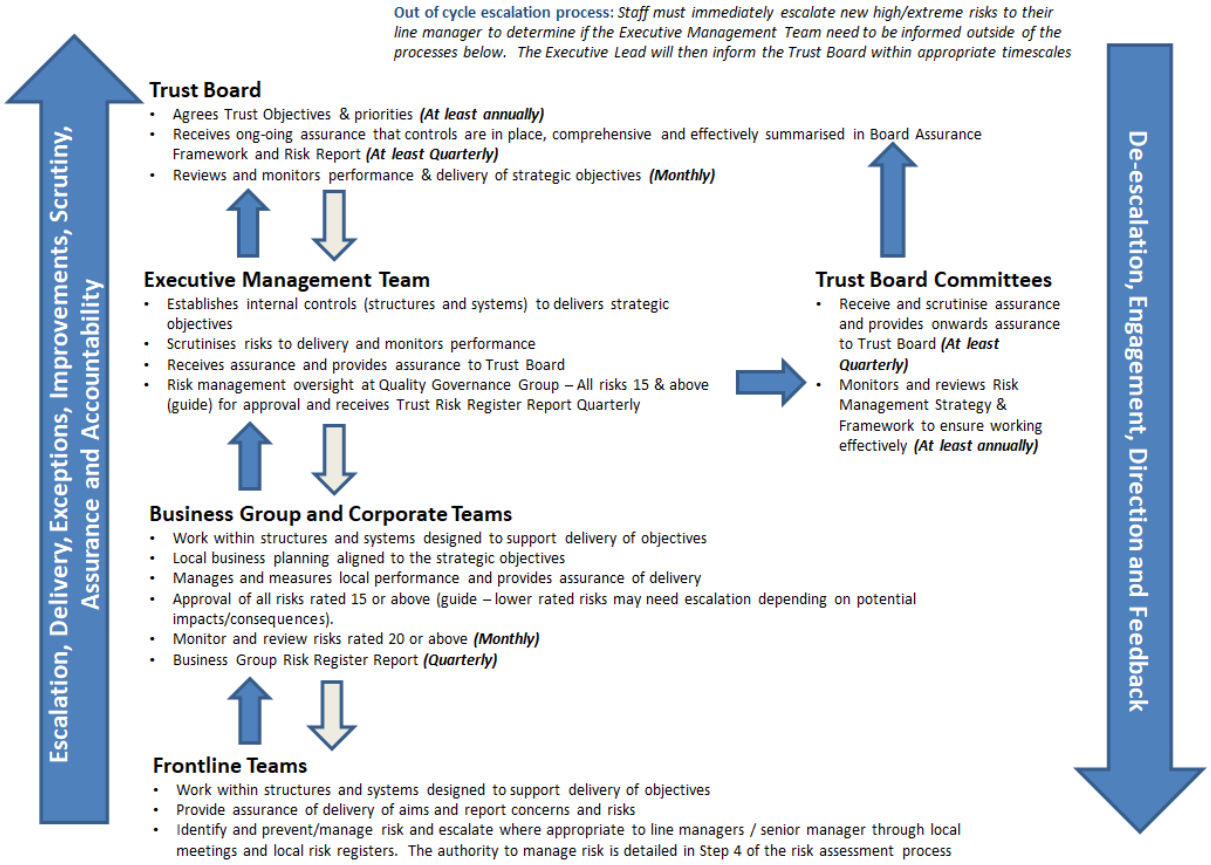
Second line - This work is associated with oversight of management activity and includes compliance assessments and reviews carried out to determine that policy or regulatory requirements are being met in line with expectations for specific areas of risk across the Trust; for example medicines management, health and safety and the delivery of the strategic objectives.

Third line - This level of assurance focuses on the role of internal audit, which carries out a programme of work specifically designed to provide an independent and objective opinion on the framework of governance, risk management and control. Internal audit will place reliance upon assurance mechanisms in the first and second lines of defence, where possible, to enable it to direct its resources most effectively, on areas of highest risk or where there are gaps or weaknesses in other assurance arrangements. It may also take assurance from other independent assurance providers operating in the third line, such as those provided by independent regulators, including NHS Improvement, the Care Quality Commission and the Health and Safety Executive.


Stockport NHS FT Board / Quality Governance Committee / Audit Committee
Executive Management Team / Senior Management Team
External Audit
Regulator – CQC & NHS Improvement
1st Line of Defence
Operational Management Controls
Internal Control Measures
2nd Line of Defence
Internal oversight and support functions: Corporate Governance Structure
3rd Line of Defence
Internal Audit
Risk Ownership
Risk Control
Risk Assurance
Stockport NHS Foundation Trust Risk Management Strategy & Framework 2018 / 2020

9. ESCALATION AND FEEDBACK MECHANISMS

Our process for reporting and escalating risks 'Ward to Board' is detailed in the diagram below. When we identify any significant control failings or weaknesses we must immediately report them, with details of corrective action, through local and corporate escalation routes.



Out of cycle escalation process

Staff must immediately escalate new high/extreme risks to their line manager / senior manager to determine if the Executive Management Team needs to be informed outside of the reporting and escalation process detailed above. The Executive Lead will then inform the Board of Directors within appropriate timescales.

Quarterly risk reports

The Trust Risk Register Quarterly Report (mitigated risks rated 15 and above / or lower rated risks which may significantly impact on objectives) will contain as a minimum: new/emerging risks, risks outside acceptable tolerance levels, progress of reviews and mitigation plans, shift, controls assurance assessment (in development), proximity of the risk and progress against the six key risk management priorities. This report will be presented for discussion and approval at the Quality Governance Group and for assurance at the Quality Committee with onward assurances / escalation to Board of Directors.

Quality Governance

This Framework, the Quality Governance Framework, and the Quality and Safety Improvement Plan 2018 – 2019 are intrinsically linked supporting the delivery of the Trust's Strategy 2017/18-20/21, incorporating the strategic objectives.

Quality governance is the combination of structures and processes at and below Board level to lead on Trust-wide quality performance which includes:

- ensuring required standards are achieved;
- investigating and taking action on sub-standard performance;
- planning and driving continuous improvement;
- identifying, sharing and ensuring delivery of best practice; and
- identifying and managing risks to quality of care

Quality Led Organisation

A well led organisation puts quality at the heart of the work of the Board of Directors. Our Trust has the building blocks in plan or in place to ensure that we can provide confidence that we are delivering the strategic objectives and priorities.

✓ **Quality and Safety Improvement Plan**
Sets out our quality priorities and commitment to quality improvement

✓ **Quality Governance Framework & Risk Management Strategy and Framework**
Focuses on managing the risks associated with the delivery of our services

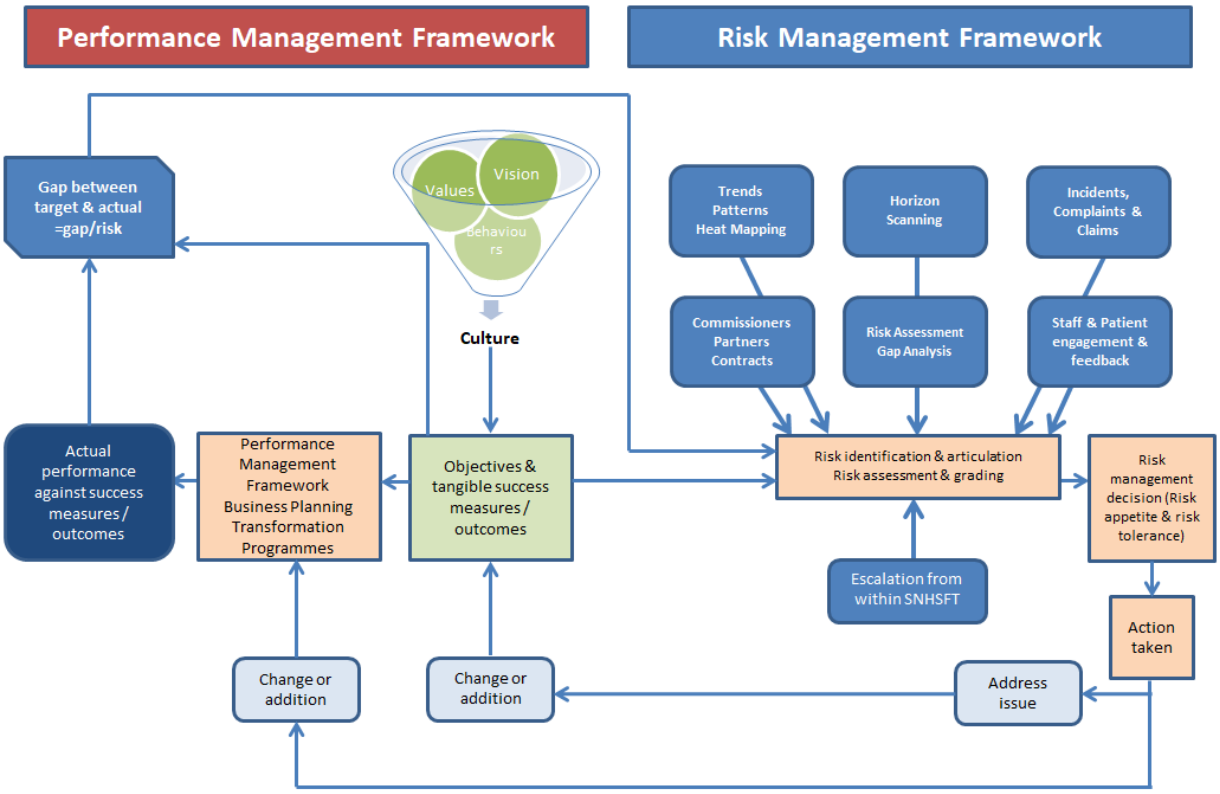
✓ **Assurance**
Providing confidence that the Trust is delivering the strategic objectives and priorities

✓ ✓ ✓ **Quality led organisation**

Together they put quality at the heart of the Trust Board's work

10. GOVERNANCE, RISK AND THE PLANNING & PERFORMANCE MANAGEMENT FRAMEWORK

Performance management and risk management are both integral parts of governance, as both are concerned with ensuring achievement of the strategic objectives. The Trust has a performance management framework in place with local business plans identifying risks to achieving objectives and service delivery improvements / changes. The diagram below details the components of governance and the relationship between performance management framework (currently under review) and risk management.



11. RISK MATURITY

We have identified six key priorities over the next three years to move along the risk maturity pathway. Risk Maturity is defined by the Institute of Internal Auditors as:

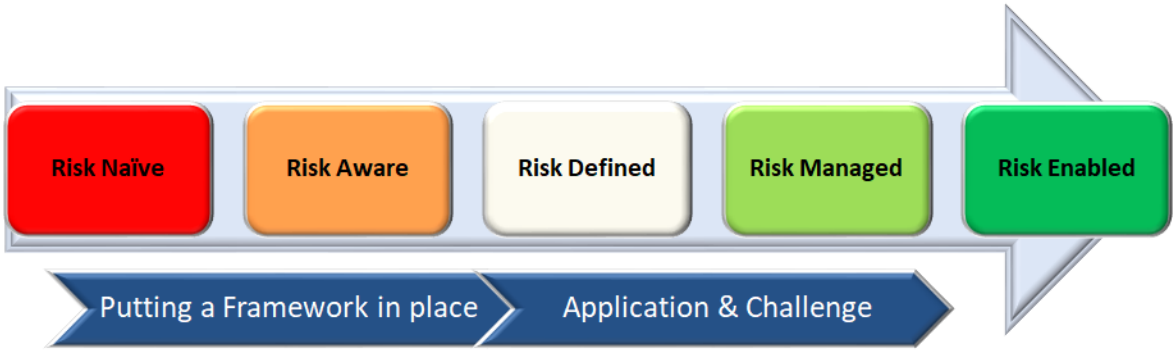
'The extent to which a robust risk management approach has been adopted and applied as planned by management across the organisation, to identify, assess, decide on responses to, and report on opportunities and threats that affect the achievement of the organisation's objectives.'

Risk maturity can be assessed on the basis of:

- the commitment to risk management by senior levels of management;
- the presence of working risk registers (with prioritised risks; assigned actions and assurances feeding back into the process) and an aggregated shortlist of highest risks reported to the Board;
- the extent to which risk management is embedded throughout the organisation; and
- co-ordination with strategic partners; and evidence that risks and opportunities are considered to inform decision making.

The Trust must assess itself against whether it is:

Risk Naïve
Risk Aware
Risk Defined
Risk Managed
Risk Enabled



Risk Naïve	No formal approach for risk management *(The organisation has little of no awareness of the importance of risk management)*
Risk Aware	Scattered silo based approach to risk management *(The organisation has considered risk management, and needs to embed systems)*
Risk Defined	Strategy and policies in place and communicated *(The organisation has considered risk management, and put in place strategies led by the risk management team. Strategy and policies are in place and communicated. Risk appetite is defined*)
Risk Managed	Trust-wide approach to risk management developed and communicated *(Staff throughout the organisation are aware of the importance and the organisations response to risk)*
Risk Enabled	Risk management and internal control fully embedded Trust wide (*Driven by the Board, staff at all levels actively consider issues of risk in all areas of activity and develop control and assurance processes to manage those risks. Risk management and internal controls are fully embedded into the operations*)

12. OUR SIX PRIORITIES FOR 2018/2020

1. New approved Risk Management and Strategy Framework 2018 / 2020 (April 2018)

Expected outputs and outcomes

1	The risk maturity of the organisation will progress from 'Defined to Enabled' by 2019/20.
2	The Board of Directors will be assured that the risk profile of the Trust is known and there is balance between local ownership and central monitoring and assurances with clear escalation routes.
3	Clear ownership of risks at senior management and sub-committee / group level.
4	Clearly defined risk appetite.
5	Moderation process of risks in place across the organisation.
6	Sighted on and managing risks with partner organisations (Governance between organisations).
7	Clear mechanisms in place to support front line teams and managers from Corporate Services.
8	Alignment with and supporting the 2020 Vision, Clinical Strategy, Workforce and Organisational Development Strategy, and the Quality & Safety Improvement Plan.

Priorities for 2018/2019
a) Review underpinning risk management and assurance policies, the categorisation matrix for risk assessment, procedures & guidance and update accordingly.
b) Engage with partner organisations in relation to shared governance, risk and assurances (governance Between Organisations) to enable a wider health economy approach to risk & assurance.
c) Develop a revised Quarterly Risk Management and Risk Register Report from quarter 1 2018/19 for Quality Governance Group and Business Group Quality Board versions.
d) Training needs analysis and delivery (risk based approach) to support delivery of the strategy and framework.
e) Develop the SNHSFT Risk Management Early Warning System metrics by Q1 2018/19
Monitoring progress: Quality Governance Group.
Board Sub-Committee: Quality Committee.
Internal assurances: Quarterly Risk Management Report, NHSI Well Led Framework Developmental Reviews and position against the NHSI Single Oversight Framework.
External assurances: Internal Audit 2018/19 programme, Care Quality Commission Well Led Assessments.

2. **New Board Assurance Framework (BAF) document development and implementation**

Expected outputs and outcomes

The BAF becomes a 'well thumbed' document by the Executive Team and is considered as part of the business planning processes.	
2	The Non-Executive Directors use the BAF as a tool to constructively challenge at sub-committee and Board level.
3	A 'Live' document supporting effective decision taking and provides evidence and justification for the decision making.
4	The BAF is used as an assurance mechanism with NHS Improvement, Care Quality Commission, Commissioners and other stakeholders.
5	Supports the Annual Governance Statement
Priorities for 201-2019	
a) Review underpinning risk management and assurance policies, the categorisation matrix for risk assessment, procedures and guidance and update accordingly. b) Engage with partner organisations in relation to shared governance, risk & assurances (Governance Between Organisations) to enable a wider health economy approach to risk & assurance. c) Develop a revised Quarterly Risk Management & Risk Register Report from quarter 1 2018/19 for Quality Governance Group and Business Group Quality Board versions. d) Training needs analysis and delivery (risk based approach) to support delivery of the strategy & framework. e) Develop the SNHSFT Risk Management Early Warning System metrics by Q3 2018/19.	
Monitoring progress: Quality Governance Group. **Board Sub-Committee:** Quality Committee. **Internal assurances:** Quarterly Risk Management Report, NHSI Well Led Framework Developmental Reviews and position against the NHSI Single Oversight Framework. **External assurances:** Internal Audit 2018/19 programme, Care Quality Commission Well Led	

3. Risk Registers established – Moderation exercise & controls assurance assessments required with education & training / support

Expected outputs & outcomes:	
1	The Board will be assured that the risk profile of the Trust is known and there is balance between local ownership and central monitoring and assurances.
2	Board members will be fully sighted on the risks and implications to the Trust with a strong association between risk management and managing the business.
3	Risk management informs the planning process with contingency arrangements in place.
4	Key component of supporting a quality led organisation.
5	Shift in risk profile with a lower proportion of higher rated risks.
Priorities 2018/19:	
a) Review of the description of risks and further analysis of the existing control measures with an assessment and definitions to ensure a consistent approach; b) Obtaining assurances that the existing control measures will lead to the desired outcome; c) Obtaining assurances that controls are implemented & adhered to; d) Linkage to the new Board Assurance Framework document; e) A full review of all risk registers including risk descriptors, ratings mitigating actions and control measures - supporting managers & leads; f) Review the process for assurances for high impact risks (those rated extreme for impact and low for likelihood); g) Develop a risk profiling approach on the system; h) Review other sources of risk identification including Control of Substances Hazardous to Health (COSHH) and manual handling; i) Continued horizon scanning and analysis of sources of risks; j) Triangulation of risk information with other sources including dashboard development at ward, department, business group and corporate level; k) Develop a register of risk registers; l) Undertaking a risk based training needs analysis for managers and clinicians regarding risk and assurance; m) Review the Risk management early warning system; and n) Work with internal audit to plan a year one review of progress and outcomes.	
Monitoring progress: Quality Governance Group. **Board Sub-Committee:** Quality Committee / Audit Committee **Internal assurances:** Quarterly Risk Management Report & NHSI Well Led Framework Developmental Reviews. **External assurances:** External / internal auditors reports, Annual Governance Statement, Care Quality Commission – Well Led Assessments	

4. New committee structure in place from April 2018. Review of lower group reporting structures is required.

Expected outputs & outcomes:	
1	There will be clear lines of reporting and escalation routes with the Board receiving the right quality assured information, in a timely manner in a format that allows the Board of Directors to make informed decisions about risks to the strategic objectives.
Priorities 2018/19:	
a) Review the lower group governance structure and implement changes accordingly. b) Review effectiveness post implementation annually.	
Monitoring progress: Quality Governance Group **Board Sub-Committee:** Quality Committee / Audit Committee **Internal assurances:** Quarterly Risk Management Report and NHSI Well Led Framework Developmental Reviews.	

External assurances: External auditors – Annual Governance Statement, Care Quality Commission – Well Led Assessments.

5. Safety Culture assessments undertaken: cycle of assessments to be implemented and triangulated with other information / data

Expected outputs & outcomes:	
1	Determine gaps in assurances regarding incident reporting and escalation systems.
2	Identify 'pre incident' issues – staff concerns / 'noise' in the system – early warnings.
3	Understanding practice regarding undertaking proactive risk and impact assessments when introducing change.
4	Survey can heat map and find out the 'what' is happening and interviews will find out 'why'.
Priorities 2018/19	
a. Review national tools; b. Implement a cycle of assessments with feedback mechanisms; c. Triangulate findings through dashboard development / collective intelligence; and d. Through continual staff engagement develop a feedback matrix with optimum feedback mechanisms for specific staff groups.	
Monitoring progress: Quality Governance Group **Board Sub-Committee:** Quality Committee, and others as appropriate to risk nature **Internal assurances:** Quarterly Risk Management Report, NHSI Well Led Framework Developmental Reviews and position against the NHSI Single Oversight Framework. **External assurances:** Inclusion on internal audit programme 2017/19, Care Quality Commission- Well Led Assessments.	

6. Electronic system in place – requires development to embed web based solution with intelligent reporting and triangulation of data and information

Expected outputs & outcomes:	
1	Centralisation will enable a whole systems review of risks, assurances and improvement plans and support the triangulation of information providing collective intelligence enabling prioritisation of improvements, alignment to the strategic objectives and support the business planning process.
2	Strengthening of our organisational learning through a programme of continual engagement, identifying preferred feedback routes by all staff groups and embedding improvements.
Priorities 2018/19	
a. Cleansing exercise of existing risks; b. Review capability of the system – developmental fields to enable cost / benefit analysis, risk profiling, controls assurance assessment and risk specific categories; c. Schedule of implementation to be agreed with governance managers and business group leads; d. Development of reports and 'live' access facilities at ward and departmental level; e. Development of dashboards at ward/department/corporate level with landing page; f. Development and roll out of the improvement planning module; g. Development of the information governance web form supporting; and h Development of a feedback matrix for preferred feedback an organisational learning routes for all staff groups.	
Monitoring progress: Quality Governance Group. **Board Sub-Committee:** Quality Committee / Audit Committee **Internal assurances:** Quarterly Risk Management Report, NHSI Well Led Framework Developmental Reviews and position against the NHSI Single Oversight Framework. **External assurances:** Inclusion on internal audit programme 2018/19, Care Quality Commission Well Led Assessments	

13. HORIZON SCANNING

Horizon scanning is about identifying, evaluating and managing changes in the risk environment, preferably before they manifest as a risk or become a threat to the business. Additionally, horizon scanning can identify positive areas for the Trust to develop its business and services, taking opportunities where these arise. The Trust will work collaboratively with partner organisations and statutory bodies to horizon scan and be attentive and responsive to change.

By implementing formal mechanisms to horizon scanning the Trust will be better able to respond to changes or emerging issues in a planned structured and co-ordinated way. Issues identified through horizon scanning should link into and inform the business planning process. As an approach it should consider ongoing risks to services.

The outputs from horizon scanning should be reviewed and used in the development of the Trusts strategic objectives, policy objectives and development. The scope of horizon scanning covers, but is not limited to:

- legislation;
- national clinical guidance;
- Government white papers;
- Government consultations;
- socio-economic trends;
- international developments;
- NHS England, NHS Improvement, Care Quality Commission, Health & Safety Executive, Information Commissioners Office and wider healthcare publications.

14. DUTIES/RESPONSIBILITIES OF GROUPS AND COMMITTEES

The terms of reference for groups/committees will be reviewed periodically. All groups/committees have a remit to provide assurance on risk relating to their specific terms of reference. Changes in the terms of reference for Trust groups/committees will be approved by the relevant committee/board to which they report. The committees within the governance structure will have standardised terms of reference, action points, an annual work plan and will produce an annual report.

The Board of Directors

The Board of Directors are ultimately responsible for managing risk. Board members have a corporate responsibility for the management of risk, and each member must be aware of the obligations to promote this and protect the public from risk in the normal course of events within local NHS provision. The Board will review its corporate objectives through the Board Assurance Framework on a minimum of a quarterly basis. Additionally the Director of Nursing and Quality and the Medical Director will provide information and assurances on any high level risks and incidents on a monthly basis to the Board. During the year, as additional risks to objectives are identified, these will be added to the Board Assurance Framework.

There is an established system of risk management throughout the Trust in accordance with the law and Government policy in order to:

- minimise the risk to the Trust's patients, assets, its employees, visitors and business
- comply with its contractual commitments with commissioning bodies and others for the volume and quality of its services, within its statutory responsibilities, financial and otherwise
- identify, prioritise and treat risks.

The Board is accountable for ensuring a system of internal control which supports the achievement of the organisation's objectives is in place. The system of internal control ensures that:

- the Trust's principal objectives are agreed;
- the principal risks to those objectives are identified;
- controls which eliminate or reduce these risks are implemented;
- the effectiveness of these controls are independently assured;
- reports on unacceptable or serious risks, and the effectiveness of control mechanisms, are received from the Executive Directors and independent assurors;
- action plans are agreed to improve control over serious or unacceptable risks; and
- policies are in place to determine what level of risks should be retained.

The Board of Directors receives minutes and assurances from the Audit Committee, the Quality Committee (QGC), the People and Performance Committee (PPC), the Finance and Performance Committee (F&PC) and the Remuneration Committee.

Audit Committee

The Audit Committee provides independent assurance to the Board of Directors that there are adequate controls in place to ensure that the Trust's key objectives and statutory obligations are being met (both clinical and non-clinical). This is the Board sub-committee with overarching responsibility for the scrutiny of risk management systems and processes, and the maintenance of an effective system of internal control on behalf of the Board. Membership comprises of Non-Executive Directors with attendance from other executives, senior managers and professionals as required. The Audit Committee's terms of reference are based on those recommended by the NHS Audit Committee Handbook and are compliant with the NHS Improvement Foundation Trust Code of Governance.

Quality Committee (QGC)

The Quality Committee is the Board sub-committee with delegated responsibility for providing the Board of Directors vwith assurances in matters relating to risk management and governance, for ensuring the effective implementation of this strategy and framework and for receiving reports on risk management and the steps taken to progress risk maturity. Links with this Committee and the Performance and Finance Committee are formed through shared Executive membership.

Finance and Performance Committee (F&PC)

The Finance and Performance Committee is the Board sub-committee with overarching responsibility for financial risk and performance. Links with this committee and the Quality Governance Group are formed through shared Executive membership.

People and Performance Committee (PPC)

The People and Performance Committee is the Board sub-committee with responsibility for providing assurance to the Board that the Trust is effectively leading, developing and delivering the Trust's People and Organisational Development Strategy, together with ensuring the development of the Trust's approach to transformation and overseeing delivery of the major transformation programmes (internal and external).

Quality Governance Group (QGG)

The Quality Governance Group is a subgroup of the Quality Committee and has overarching management responsibility for risk management and governance, for ensuring the effective implementation of this strategy and for receiving reports on the incidence of risk and the steps taken to manage it. Links with this committee and the Finance and Performance Committee are formed through shared Executive membership. Links to the Business Group Boards occurs through membership of the Associate Directors of Nursing and Associate Medical Directors.

Safety and Risk Group (S&RG)

The Safety and Risk Group is a subgroup of the Quality Governance Group and is chaired by the Deputy Director of Quality Governance. This group is responsible for the operational management of risk and governance and has membership from across the organisation.

Health and Safety and Risk Group (H&SG)

The Health and Safety Group is responsible for providing information and assurances to the Quality Governance Group that the Trust is monitoring, and continuously improving, compliance with health and safety legislation, and escalating any significant risk issues. The committee is chaired by the Deputy Director of Quality Governance with representation from management and staff side.

Business Group Boards (Risk/governance reporting arrangements)

Business Group Boards are responsible for reviewing all local risks pertaining to their area, ensuring robust action plans are in place and monitoring the action plans to ensure that they are delivered on time. The Business Group Boards will escalate risks which are outside of their control or which have financial implications which cannot be managed within the Business Group. As a minimum the following will be discussed and minuted at Business Group Boards on a monthly basis, this maybe in the form of exception reporting from the Business Group board sub-groups responsible for risk and governance issues:

- Business Group risk register – approve all risks rated 15 and above for escalation to the Quality Governance Group (Guide – lower graded risks / high impact low likelihood risks may also be escalated);
- Monitor risks rated 20 and above on a monthly basis;
- Receive a quarterly risk register report (Risks rated 12 and above (guide));
- Review significant incidents (graded major or catastrophic);
- Review serious complaints;
- Consider risk spanning more than one Business Group;
- Review significant claims;
- Responses to Safety Alert Broadcasts;
- External agency visits, inspections and accreditations involving the Business Group; and
- Will provide escalation of key areas of concern or achievement to the Board of Directors as required.

Council of Governors

The Council of Governors has no formal oversight or Executive role with regard to risk management. However, risk related information is provided to governors through standard reporting mechanisms. Governors can also address questions and issues to the Chair of the Board of Directors (who is also Chair of Council of Governors) and seek resolution of concerns via the appointed Senior Independent Director.

15.EXAMPLES OF CONTROL MEASURES AND SOURCES OF ASSURANCE

Examples of internal controls

- Board Sub Committee structure
- Management Committee structure
- Targets, standards and Key Performance Indicators
- Corporate services performance review
- Business plans, delivery plans, action plans & implementation plans
- Incident reporting and management
- Policies and Procedures
- Clinical Audit Programmes
- Staff Appraisals
- Business Group /Team meetings
- Staff education & development programmes
- IT systems and management information
- Delivery, exceptions, action, assurance, and accountability, direction, controls, scrutiny, monitor and feedback

Examples of assurance

Management Assurance

- Risk Register
- Finance Reports
- Annual Reports (e.g. Quality, Health & Safety)
- Integrated Performance Reports
- Clinical Audit Reports & improvement plans
- Project and programme plans
- Inspection and Walkabout Reports
- Quality, Safety & Risk Reports
- Quality Reports to Board
- Training Records/Statistics
- Performance Reports
- Workforce Report

Independent Assurance

- Internal Audit
- External Audit
- Care Quality Commission Inspections
- Health & Safety Executive
- Commissioners

16. RISK MANAGEMENT EARLY WARNING SYSTEM (UNDER DEVELOPMENT)

Level One

Level One No Concerns Identified	Action	Monitoring and Management
All risks on the Trust Risk Register are on plan for review, assurance on control measures and actions are with timescales	Business as usual as per Risk Management Policy (under review)	Continue review of control measures as per Risk Management Policy
Extreme risks on the register, and those with a possible catastrophic outcome (i.e. rated as 5 for consequence) are within review requirements, assurance on control measures and actions are with timescales	Business as usual as per Risk Management Policy and Risk Assessment Procedure	Continue review of control measures as per Risk Management Policy and Risk Assessment Procedure
Root cause analysis action plans are within timescales	Business as usual as per Incident Reporting Policy (under review)	Continue review of control measures as per Incident Reporting Policy (under review)
Harm free care >95%	Business as usual	Quality, Safety and Experience section of Board Integrated Performance Report
All Central Alerting System (CAS) Alert(s) remain within the required timeframes	Business as usual	Monthly Governance Report.
All incidents reported on the web are analysed within Trust timescales	Business as usual as per Incident Reporting Policy (under review)	Continue review of control measures as per Incident Reporting Policy (under review)
Compliant with external agencies inspection / regulatory requirements	Business as usual.	Monthly Governance Report
Assurance that NICE guidance is actioned within Trust timescales	Business as usual.	Monthly Governance Report

Level Two

Level Two Emerging Concern (Variance may be in one Business Group)	Action	Monitoring and Management
Risks on Trust Risk Register behind schedule and / or assurance on controls insufficient and / or timescales on actions have breached up to 2 weeks	Escalation to Business Group Director. Review as per Incident Reporting Policy (under review)	Continue review of control measures as per Incident Reporting Policy (under review)
Extreme risks on the register, and those with a possible catastrophic outcome (i.e. rated as 5 for consequence) are behind schedule and / or assurance on controls insufficient and / or timescales on actions have breached up to 2 weeks	Escalation to Business Group Director. Review as per Incident Reporting Policy (under review)	Continue review of control measures as Incident Reporting Policy (under review)
Root cause analysis action plans breaching timescales > 4 weeks	Escalation to Business Group Director	Safety and Risk Group monthly Quality Governance Group
Harm free care 85% - 94%	Trend analysis by Governance Team. Review by appropriate Business Group(s) and work-stream committee and initiate local actions	Quality, Safety and Experience section of Board Integrated Performance Report Quality Governance Group
CAS alert(s) due to breach within 2 weeks of specified timeframe	Escalation to Business Group Director.	Safety and Risk Group monthly Monthly Governance Report
All incidents reported on the web are analysed within Trust timescales	Business as usual as per Incident Reporting Policy (under review)	Continue review of control measures as per Incident Reporting Policy (under review)
Incidents reported on the web have breached Trust timescales for analysis by up to 10 days	Escalation to Business Group Director / Business Group Triumvirate Team	Monthly Web holding report Safety and Risk Group monthly
Delay in provision of evidence to comply with external agencies inspection / regulatory requirements within initial timescale	Escalation to Business Group Director / Business Group Triumvirate Team	Monthly Business Group Board Meetings
Lack of assurance that NICE Guidance is actioned and monitored within specified timescale (6 -12 weeks)	Escalation to Business Group Director / Business Group Triumvirate Team	1:1s with Business Group Governance Managers monthly

Level 3

Level Three Concern Requiring Investigation (Variances in more than one Business Group)	Action	Monitoring and Management
Risks on Trust Risk Register review behind schedule and / or assurance on controls insufficient and / or timescales on actions have breached up to 6 weeks	Escalation to Business Group Director / Business Group Triumvirate Team. Review as per Risk Management Policy (under review).	Continue review of control measures as per Risk Management Policy (under review)
Extreme risks on the register and those with a possible catastrophic outcome (i.e. rated as 5 for consequence) are behind schedule and / or assurance on controls insufficient and / or timescales on actions have breached up to 6 weeks	Escalation to Business Group Director / Business Group Triumvirate Team. Review as per Risk Management Policy (under review).	Continue review of control measures as per Risk Management Policy (under review)
Major patient safety incident occurs	Escalation to Executive Lead and Board of Directors Immediate actions to prevent recurrence. Investigation into incident as per Incident Reporting Policy (under review)	Monthly Governance monthly report to Quality Governance Group
Root Cause Analysis action plans breaching timescales > 8 weeks	Initiate trend analysis Targeted interventions based on analysis. Weekly analysis by Governance Team. Monthly monitoring by relevant work-stream committee	Escalation to Safety and Risk Group and Quality Governance Group Monthly Governance Report
Harm free care 74% - 84% for two consecutive months	Initiate trend analysis Targeted interventions based on analysis. Weekly analysis by Governance Team. Monthly monitoring by relevant work-stream committee	Escalation to Safety and Risk Group and Quality Governance Group Monthly Governance Report
CAS alert due to breach within 1 week of specified time frame	Daily monitoring by Governance Team. Escalation to Business Group Triumvirate Team	Escalation to Safety and Risk Group and Quality Governance Group Monthly Governance Report
Incidents reported on the web have breached Trust timescales for analysis by up to 30 days	Escalation to Business Group Director	Escalation to Safety and Risk Group and Quality Governance Group Monthly Governance Report
Delay in provision of evidence to comply with external agencies inspection / regulatory requirements within extended timescale	Escalation to Business Group Director	Escalation to Safety and Risk Group and Quality Governance Group Monthly Governance Report
Lack of assurance that NICE Guidance is actioned and monitored within 13-20 weeks	Escalation to Business Group Director / Business Group Triumvirate Team.	Escalation to Safety and Risk Group and Quality Governance Group Monthly Governance Report

	Action plan to be produced by Business Group within 1 month of escalation	

Level Four

Level Four Material Issue (Serious event occurs or highly likely to occur / variances Trust wide)	Action	Monitoring and Management
Risks on Trust Risk Register review behind schedule and / or assurance on controls insufficient and / or timescales on actions have breached up to 12 weeks	Escalation to Executive Lead Immediate actions taken to review risk and gain assurance Review as per Risk Management Policy (under review) Business Group Director presents recovery position to Quality Governance Group	Continue review of control measures as per Risk Management Policy (under review)
Extreme risks on the register and those with a possible catastrophic outcome (i.e. rated as 5 for consequence) are behind schedule and / or assurance on controls insufficient and / or timescales on actions have breached up to 12 weeks	Escalation to Executive Lead Immediate actions taken to review risk and gain assurance Review as per Risk Management Policy (under review) Business Group Director presents recovery position to Quality Governance Group	Continue review of control measures as per Risk Management Policy (under review)
Serious untoward incident occurs	Initiate investigation as per Incident Reporting Policy (under review) Immediate actions to prevent recurrence Support to affected area Escalation to Quality Governance Group and Board of Directors via Quality Committee External reporting as appropriate	Delivery and completion of action plan Action plan monitored by respective Business Group Quality Boards and overseen by the Governance Team.
Root Cause Analysis action plans breaching timescales > 12 weeks	Escalation to Executive Lead Continue escalation to Business Group Director Safety and Risk Group to intercede Business Group Director presents recovery position to Quality Governance Group	Quality Governance Group monthly
Breach of CAS alert specified time frame – potential for external agency scrutiny	Escalation to Executive Lead. Immediate actions to ensure compliance Governance Team to investigate reason for breach	Breached CAS alert report – Safety and Risk Group with escalation to Quality Governance Group monthly

Level Five

Level Five Significant Issue (Loss of control measures / Never Event occurs / failure to resolve material issue)	Action	Monitoring and Management
Risks on Trust Risk Register review behind schedule and / or assurance on controls insufficient and / or timescales on actions have breached by >12 weeks.	Support to mitigate risks and ensure risks are reviewed within 24-48 hours Escalation to Quality Governance Group and Board of Directors as appropriate, via Quality Committee	Continue review of control measures as per Risk Management Policy (under review)
Extreme risks on the register and those with a possible catastrophic outcome (i.e. rated as 5 for consequence) are behind schedule and / or assurance on controls insufficient and / or timescales on actions have breached by >12 weeks	Immediate actions taken to review risk and gain assurance. Escalation to Quality Governance Group and Board of Directors as appropriate, via Quality Committee	Continue review of control measures as per Risk Management Policy (under review)
Never Event occurs	Initiate investigation as per Incident Reporting Policy (under review) Immediate actions to prevent recurrence Support to affected area Escalation to Quality Governance Group and Board of Directors as appropriate, via Quality Committee. External reporting as appropriate	Delivery and completion of action plan Action plan monitored by respective Business Group Director(s) and overseen by Integrated Governance
Root Cause Analysis action plans breaching timescales > 16 weeks	Escalation to Executive Lead. Continued escalation to Business Group Triumvirate Team. Quality Governance Group to intercede	Governance Group monthly
Harm free care <73%	Trend analysis Targeted interventions based on analysis Daily / weekly monitoring by Integrated Governance Immediate escalation to Escalation to Quality Governance Group and Board of Directors as appropriate, via Quality Committee.	Monthly reporting to Safety and Risk Group with escalation to Quality Governance Group and Board of Directors
Non-Clinical Fatality	Immediate escalation to Chief Executive Officer, Health and Safety Executive and / or Police Immediate support to family and staff affected Internal investigation (where appropriate)	On-going support to family and staff Implementation of any required changes as a result of investigation, monitored by Safety and Risk Committee
Enforcement notice from external agencies inspection / regulatory requirements	Immediate escalation to Chief Executive Officer and Board of Directors as appropriate. Immediate escalation to Quality Governance Group	Implementation of any required changes as a result of the enforcement notice monitored by Quality Governance Group with escalation to Board of Directors as appropriate

Lack of assurance that NICE Guidance is actioned and monitored within 28 plus weeks	Escalation to Executive Lead Business Group Director invited to Quality Governance Group	Governance monthly report to Quality Governance Group with escalation to Quality Committee.

17. GLOSSARY OF TERMS

Term	Description
Assurance	A positive declaration intended to give confidence
Effectiveness	The degree to which controls are successful in producing a desired result
Impact	The consequences of risk events if they are realised
Internal control	A control is any measure or action that modifies risk. Controls include any policy, procedure, practice, process, technology, technique, method or device that modifies or manages risk. Controls are designed to provide reasonable assurance regarding the achievement of objectives
Likelihood	The probability of a risk event occurring
Operational risk	Major risks that affect an organisation's ability to execute its strategic plan. Operational risk is often defined as the risk of loss resulting from inadequate or failed internal processes, people and systems or from external events.
Principal risk	A 'principal risk' is a fundamental risk inherent in managing an organisation; it reflects the fact that there is always the possibility that through some set of circumstances, a particular risk could occur. For example, attracting and retaining competent people is key to delivering superior performance. However, there is a risk that we will fail to deliver our objectives if we cannot get the right people in the right roles at the right time and implement suitable controls to prevent human error.
Residual risk	Residual risk is the risk remaining after you have implemented your controls.
Risk	The effect of uncertainty on objectives
Risk appetite	The amount and type of risk that an organisation is willing to take to meet its strategic objectives
Risk culture	Risk culture consists of the norms and traditions of behaviour within an organisation that determine the way it identifies, understands, discusses and acts on the risk the organisation confronts and takes. Organisations get in trouble when individuals, knowingly or unknowingly, act outside the expected risk culture, or when the expected risk culture is either not well understood or enforced.
Risk driver, source or cause	Something that makes a difference to, or causes, a risk. A risk source is where a risk originates.
Risk exposure/ profile	Written description or summary of a set of risks. A risk profile or exposure can include the risks that the entire organisation must manage or only those that a particular directorate/region or part of the organisation must address
Risk interdependency	Where multiple risks could compound each other, or where a change in one risk can affect numerous others
Risk management	The systematic application of management policies, procedures and practices to the tasks of establishing the context, identifying, analysing, assessing, treating, monitoring and communicating risk.

Risk tolerance	The predetermined upper level of risk that can be posed to an objective. This might be set as an overall risk rating, or might specifically relate to an upper 'impact' or upper 'likelihood' rating which if reached must be mitigated at all cost

18. TRAINING AND SUPPORT

The Trust recognises that the successful implementation of this Strategy is dependent upon the provision of appropriate and sufficient training to all levels of the organisation. This is reflected into the Trust Training and Development Policy that includes the Trust Training Needs Analysis.

19. MONITORING OF THE STRATEGY

CQC Regulated Activities	Process for monitoring e.g. audit	Responsible individual/ group/ committee	Frequency of monitoring	Responsible individual/group/ committee for review of results	Responsible individual/group/ committee for development of action plan	Responsible individual/group/ committee for monitoring action plan and implementation
1,2,3,4,5,7,8,9 ,16,17,18,19	Annual Report to Board against progress	Deputy Director of Quality Governance	Annually	Chief Nurse & Director of Quality Governance Medical Director Quality Governance Group	Chief Nurse & Director of Quality Governance Medical Director Quality Committee Audit Committee	Board of Directors

20. SOURCES/ REFERENCES

Cabinet Office Framework (2017) Management of Risk in Government
COSO (2004) Enterprise risk management – Integrated framework
HM Treasury (2012) Assurance frameworks
HM Treasury (2005) Principles of managing risks to the public
HM Treasury (2009) Risk management assessment frameworks
HM Treasury (2001) The orange book: management of risk – principles and concepts
HM Treasury (2006) Thinking about your risk: setting and communicating your risk appetite
IRM/Alarm/AIRMIC (2002) A risk management standard
ISO 31000 (2009) Risk management principles and guidelines
ISO/IEC 31010 (2009) Risk management – risk assessment techniques
National Audit Office (2011) Managing risks in government
OCEG 'Red Book' 2.0 (2009) A governance, risk and compliance capability model
Public Risk Management Association (2010) A structured approach to enterprise risk management (ERM) and the requirements of ISO 31000
UK Corporate Governance Code
NHS Improvement Single Oversight Framework (2016)
CQC Inspection Regime and associated documents
National Quality Board Shared Commitment to Quality (2016)
Next Steps on the NHS Five Year Forward View (2017)
Developmental reviews of leadership and governance using the well-led framework; guidance for NHS Trusts and NHS Foundation Trusts (2017)

21. ASSOCIATED DOCUMENTS

The following internal documents support the implementation of the Risk Management Strategy and Framework – this list is not exhaustive. These can be found on the Trust intranet site:

Trust Strategy 2017/18-2020/21
Annual Plan 2018/19
Being Open Policy including the Duty of Candour
Health and Safety Policy
Incident Reporting Policy
Serious Incident Policy
Information Governance Policy
Risk Assessment Procedure
Whistleblowing (Raising Concerns) Policy
Emergency Preparedness and Business Continuity Plans
Security Policy
Complaints and Concerns Policy
Claims Management Policy
Datix system – User Guides

Key regional documents include:
Greater Manchester Health and Social Care Partnership
Stockport Together Plan
Commissioning Contractual Requirements

22. IMPACT ASSESSMENT

To be completed and attached to any policy or procedural document when submitted to the appropriate committee for consideration and approval.

Title Quality Strategy	
What is being considered?	Policy ☐ Guideline ☐ Decision ☐ Other (please state) ☐ Strategy Y
Is there potential for an adverse impact against the protected groups below? Age Disability Gender Reassignment Marriage and Civil Partnership Pregnancy and Maternity Race Religion and Belief Sex (Gender) Sexual Orientation Human Rights articles	Yes ☐ No x
If you are unsure, please contact the Equality and Diversity Specialist - 5229	
On what basis was this decision made? National Guidelines e.g. NICE / NSPA / HSE / DH (other) ☐ Committee / Other meeting x Previous Equality screening ☐	
With regard to the general duty of the Equality Act 2010, the above function is deemed to have no equality relevance Equality relevance decision by Date	
The Equality Act 2010 has brought a new equality to all public authorities, which replaced the race, disability and gender equality duties. This Equality Relevance Assessment provides assurance of the steps Stockport Hospital NHS Foundation Trust is taking in meeting its statutory obligation to pay due regard to: Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act Advance equality of opportunity between people who share a protected characteristic and those who do not Foster good relations between people who share a protected characteristic and those who do not For further information or guidance please contact – Safina.Nadeem@stockport.nhs.uk	

DOCUMENT INFORMATION BOX

Item	Value
Type of Document	Strategy
Title	Risk Management Strategy and Framework
Published Version Number	1
Publication Date	May 2018
Review Date	March 2019
Author's Name + Job Title	Alison Lynch. Chief Nurse & Director of Quality Governance
CQC Standard Measure	Outcomes 1,2,3,4,5,7,8,9,16,17,18,19,
Consultation Body/ Person	Executive Management Group Associate Directors of Nursing Business Group Directors Governance Leads
Consultation Date	December 2017, January and February 2018
Approval Body	Audit Committee
Approval Date	
Ratified by	Audit Committee
Ratification Date	
Author Contact	5078
Business Group	Corporate
Specialty (if local procedural document)	N/A
Ward/Department (if local procedural document)	N/A
Readership (Clinical Staff, all staff)	All Staff
Information Governance Class (Restricted or unrestricted)	Unrestricted

NHS
Stockport
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	24 May 2018
Subject:	Review of Undertakings – Progress Report		
Report of:	Interim Chief Executive	**Prepared by:**	Mr P Buckingham

REPORT FOR ASSURANCE

Corporate objective ref: -----	**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 progress to address weaknesses identified during the Review of Undertakings completed by NHS Improvement.
Board Assurance Framework ref: -----	
CQC Registration Standards ref: -----	
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 ☐ Finance & Performance Committee ☐ People Performance Committee ☐ Charitable Funds Committee ☐ Nominations Committee ☐ Remuneration Committee ☐ Joint Negotiating Council ☐ Other

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1. INTRODUCTION

1.1 The purpose of this report is to provide the Board of Directors with assurance on progress to address weaknesses identified during the Review of Undertakings completed by NHS Improvement.

2. BACKGROUND

2.1 On 24 April 2013 the Trust signed Enforcement Undertakings with Monitor in relation to the Trust's breaches of the A&E 4-hour target and highlighted potential weaknesses in Governance processes. Monitor's concerns were such that this was superseded on 4 August 2014 by imposition of an additional licence condition under section 111 of the Health and Social Care Act 2012. In July 2015 the additional licence condition relating to Governance was formally removed by Monitor in recognition of actions taken by the Trust in response to recommendations made following an independent Governance Review completed by Deloitte LLP during 2014/15.

2.2 However, sustainable delivery of the A&E 4-hour standard has continued to be a major challenge and has been a recurring theme of quarterly review meetings with NHS Improvement. In March 2017 NHS Improvement signalled its intention to conduct a formal review of the Enforcement Undertakings and the review was subsequently undertaken during the period June-July 2017. The review resulted in a Modification of the Additional Licence Condition dated 15 December 2017 requiring the Trust to address the following issues:

a. Failure to take the action necessary to ensure compliance with the A&E 4 hour maximum waiting time standard on a sustainable basis;
b. Lack of a clear vision and strategy around which the Licensee's board can determine its focus and priorities;
c. Lack of a long term financial recovery plan demonstrating how the Licensee aims to return to a financial break even position and of a credible plan to deliver the required cost improvement programme;
d. Failure to ensure that the Licensee's board and its committees have effective oversight of quality, safety, finances and A&E performance;
e. Failure to respond sufficiently and in a timely manner to concerns identified by the CQC in its inspection of January 2016; and
f. Any other issues relating to the operation of the Licensee's board and its other governance arrangements, including those identified in any independent assessment of its governance arrangements, that have caused or contributed to, or will cause or contribute to, the breach, or the risk of breach, of the conditions of the Licensee's licence.

3. CURRENT SITUATION

3.1 The Trust's progress in addressing these issues is subject to regular formal monitoring by means of monthly Enhanced Financial Oversight meetings and Quarterly Review Meetings with NHS Improvement. In addition, a Quality Improvement Board, jointly chaired by NHS Improvement and GM Health & Social Care Partnership meets on a monthly basis with a

specific focus on quality matters and urgent and emergency care.

3.2 The current position, along with future planned developments, is detailed in the following sections of the report.

3.3 **Failure to take the action necessary to ensure compliance with the A&E 4 hour maximum waiting time standard on a sustainable basis**

3.3.1 Since the review of undertakings the Trusts has implemented many changes to improve and effectively respond to the urgent care demands

- Restructure and revision of the clinical leadership teams that better facilitate integrated care and effective patient pathways
- The Quality Improvement plan is inclusive of improving patient flow and discharge
    - This plan includes 4 key workstreams reporting through to the system Delivery Board, The New Operational Management Group and to the Finance and Performance committee
        - Pre admission and pre attendance
        - Attends and Assessment
        - Admission and Management
        - Discharge
- Strengthening operational processes and performance management through a new Integrated Performance Report and the Performance Management Framework.
- New systems and processes to manage deflection, assessment, flow and discharge
    - Senior 24/7 Clinical Site Management Team
    - Integrated Transfer Team
    - Crisis Response
    - Active Recovery
    - Extended senior medical rotas and roles
    - Frailty Unit at the front door
    - GP streaming
- During this time the Trust has been supported by NHSI North, GM improvement team and has appointed to a senior Delivery Director to operationally manage the urgent care flow within the Trust from attendance through to discharge

3.3.2 Central to the management of performance against the A&E 4 hour waiting time standard is maintaining effective patient flow across the entire Health and Social Care system. In order to ensure this is reflected in our organisational form, a comprehensive restructure was undertaken in 2017/18 to create the Stockport Neighbourhood Care Business Group, moving away from the previous, more traditional, Acute Hospital based form. This restructure brought Acute and Emergency Medicine under the same leadership as community based services and the Neighbourhoods.

3.3.3 In addition to the change in organisational form, new services have been introduced in the Stockport Neighbourhood Care Business Group to form closer links and further integration

between the Acute Hospital and the Neighbourhoods. These services include the Integrated Transfer Team – a co-located team designed to ensure safe and timely discharge from the Acute Hospital, the Crisis Response Service – a team dedicated to helping patients receive the care they require in their homes where previously they would have attended the Emergency Department, and the Active Recovery team – a service to ensure patients get home as safely and swiftly as possible while a longer term plan for their care is formulated.

3.3.4 To strengthen the service provided by Acute and Emergency Medicine, there has been investment in additional nursing and medical staff that has allowed for the redesign of staffing models, in addition to models of care. An example of such a role is the introduction into the Emergency Department of a Consultant Educator to improve teaching that has subsequently improved recruitment and retention. In addition, a Frailty Unit has been developed as part of the "Emergency Village" approach, through the collaborative reconfiguration of Surgical wards, to provide a ward adjacent to the Acute Medical Unit that allows patients to access to the Frailty Service directly from the Emergency Department.

3.3.5 There have also been significant developments within the Acute Hospital, with the introduction of a new Clinical Site Management team, a senior clinical team dedicated to managing patient flow across the hospital and beyond. This team is central to improving performance against the 4 hour standard as they form a vital link between Acute and Emergency Medicine and the Specialty Medical wards through to discharge. The teams role is not solely focused on performance and flow however as they are also central to the Quality Improvement Plan, and a number of Quality Improvement initiatives, working alongside the team from AQUA and helping facilitate the delivery of key work streams such as SAFER and the reduction in Stranded patients.

3.3.6 To further support improvement across the system there has been significant investment in Clinical Leadership as it is recognised this is central to sustaining any improvements made. The new Clinical Director structure provides senior clinical leadership across a number of areas in addition to a vital strong clinical voice in decision making. In addition to the introduction of stronger Clinical leadership, there have been significant improvements in the oversight and delivery of the System Urgent Care plan. These improvements have been made supported by a team from the North of England Commissioning Support Unit and have ensured a more focused approach, with clear roles, responsibility and accountability for all key stakeholder organisations within the Stockport System. Further to this, the work has clarified the System Urgent Care governance structure, providing clear lines of escalation where required.

3.3.7 Future Developments/priorities

- Leadership development and resilience support identified for Urgent and Emergency Care
- Robust system winter resilience planning has commenced
- Further development maturity of the Neighbourhoods and primary care support
- Implement the single point of access model at the front door to better stream and deflect patients away from ED
- Capital Plan to create the estate to enable this model before winter?
- Improve & expand the emergency village footprint. Capital bid submission June 18
- Further expand the ambulatory and frailty pathways?

- To date the 18/19 Improvement trajectory for performance is on plan to achieve 85% by the end of Q1.

3.4 **Lack of a clear vision and strategy around which the Licensee's board can determine its focus and priorities**

3.4.1 The Trust's Strategy is currently being refreshed. The Vision, Mission and Corporate Objectives are complete and have been signed off by the Board of Directors. A draft Strategy has been developed and will be subject to a two way consultation process with internal stakeholders and externally with local partners and Third Sector organisations. The plan is to complete the Strategy refresh by 31 July 2018.

3.5 **Lack of a long term financial recovery plan demonstrating how the Licensee aims to return to a financial break even position and of a credible plan to deliver the required cost improvement programme**

3.5.1 There have been a number of factors that has caused delays in the development of the Medium Term Financial Strategy, such as:

- The focus on the 2017/18 financial recovery;
- Changes to leadership across the locality and the impact on the pace of delivery of the Stockport Together developments;
- Refreshing the 2018/19 Operational Plan and the development of the 2018/19 Financial plans including the CIP Programme; and
- The delayed development of the Trust's Overall strategy.

3.5.2 With support from the Non-Executive Directors, the Trust has now scoped the elements of the Medium term Financial Strategy in readiness for the NHSI Oversight meeting and submission to the GMH&SCP by the end of June 2018. A task and finish group has been established and work is progressing. It is expected that a draft of the MTFS will be reviewed by the Finance & Performance Committee in June and then approved by the Board of Directors on 28 June 2018.

3.5.3 The Stockport Locality has been requested by the GMH&SCP to "reset" the financial benefits of the Stockport Together benefits towards a much more realistic outcome using the latest available information. The Trust aims to utilise the latest agreed investment and benefit information however, this exercise will require input and agreement from both SCCG and SMBC. In the development of the MTFS, the Trust will utilise all available intelligence specifically ensuring the Trust is capturing all income pertaining to activity, maximising planned activity income. With regard to service developments and efficiency of services the Trust has agreed to adopt the AQUA (PDSA) methodology of service improvement, however the methodology will require a time to embed across the Trust.

3.6 **Failure to ensure that the Licensee's board and its committees have effective oversight of quality, safety, finances and A&E performance**

3.6.1 Committee level oversight of quality and safety, and finance and A&E performance, is provided by the Quality Committee and the Finance & Performance Committee respectively. Outcomes of the Review of Undertakings, and CQC inspections carried out in March and June 2017, resulted in a fundamental review of quality governance

arrangements which included a revised approach for reporting from Management Groups to the Quality Committee.

3.6.2 In parallel with the review described above, the Quality Committee reviewed both its Terms of Reference and practice in January 2018 and revised Terms of Reference were subsequently approved by the Board of Directors on 31 January 2018. The Committee now meets on a monthly cycle, as opposed to bi-monthly, to facilitate timely review and reporting to the Board of Directors. A revised work plan for the Committee was introduced with effect from 1 April 2018 to ensure comprehensive coverage of relevant quality and safety functions.

3.6.3 The Finance & Performance Committee continues to meet on a monthly basis with a remit which broadly covers financial performance, operational performance (including the A&E standard), strategic programmes and planning. The nature of reporting has been developed over the previous six months to provide more forward-looking reports and an assurance based approach. This development continues to be a work in progress.

3.6.4 The format for reporting was revised from January 2018. Reports from Management Groups to Committees, and from Committees to the Board of Directors, are submitted in the form of a Key Issues Report based on matters for Alert, Assurance and Advise. This approach facilitates both clarity of reporting to recipient groups and focused discussion on relevant subject areas.

3.6.5 The Board of Directors has reviewed the approach to Performance Reporting at Board meetings and commissioned a fundamental review of the Integrated Performance Report (IPR). Work to develop a revised IPR was undertaken during the period October 2018 - March 2019 with support and best practice advice from Mrs C Griffiths, Improvement Director. Progress Reports on development of a revised IPR were reviewed by the Board in November 2017, January 2018 and March 2018. The new IPR will be used to report performance against domains of Safe, Effective, Caring, Responsive and Efficient from 24 May 2018.

3.6.6 A continuous development approach has been adopted to both improving the quality of reporting and the effectiveness of meetings. Meeting packs for Board of Directors meetings are subject to joint review by the Chair and Chief Executive with feedback provided on any areas for development or improvement. There is also a greater degree of engagement between Committee Chairs and relevant Lead Executives in relation to agenda planning for meetings. In addition, report writing clinics were introduced as a means of developing the report writing skills of senior / middle managers. Board and Committee meetings now routinely conclude with a 'Review of Effectiveness' where members reflect on business conducted and consider how practice and/or approach could be further developed.

3.6.7 It is considered that good progress has been made to ensure effective Board and Committee oversight of the relevant areas. Work to further enhance oversight continues as part of preparatory work for a Well led Review with support from the Improvement Director.

3.7 **Failure to respond sufficiently and in a timely manner to concerns identified by the CQC in its inspection of January 2016**

3.7.1 The CQC reports made difficult reading for all of us working at the Trust. The Board of Directors have accepted the findings, acknowledging that the Trust had clearly fallen short in some key areas.

3.7.2 Since the inspections in March and June 2017, the Trust has made some significant and important infrastructure changes, including strengthening the joint working of our doctors and nurses in the emergency department and medical care. We have also developed a clear medical leadership structure under the Medical Director. We have developed and introduced our Quality Governance Framework, and our Risk Management Strategy is soon to be launched.

3.7.3 The CQC rated the trust as 'requires improvement' overall, but also as 'inadequate' for safety in Medicine and in Urgent and Emergency Services, and as 'inadequate' in well led for Urgent and Emergency Services. Our status with NHS Improvement is that of a Trust challenged for quality, performance and finance in September 2017.

3.7.4 We have worked hard together to address areas of concerns relating to patient safety that were noted by the Care Quality Commission (CQC), NHS Improvement, and those that we recognised ourselves. The dedication and efforts of all our staff has led to many improvements since the CQC reports were published in March and October 2017. We have:

- Introduced a new Quality Governance Framework where assurance is monitored from 'ward to board'.
- Developed a series of quality metrics to be reported at Board to commence in May 2018
- Strengthened the clinical leadership within the Business Groups with the introduction of an associate medical director and clinical director role to each area; to support this we have:
- Invested in our clinical leaders, providing a tailored leadership development programme designed to equip them to lead in complex and challenging times.
- Introduced a Quality Matron role which commenced in May 2018 to support the Business Groups to embed quality programmes at ward and department level.
- Embedded a weekly Patient Safety Summit where all moderate and above, staffing, medication and no harm incidents are discussed,; this has led to:
- Embedded a consistent approach to reporting incidents, with a significant and sustained increase of 20% in reporting – leading to a greater opportunity to share immediate lessons learned and embed safer practice
- Seen a 60% improvement in the reporting of no and low harm incidents – demonstrating an evolving safety culture and a passion to get things right
- Noted a reduction in pressure ulcers, especially across surgery and critical care, although we did not achieve our stretch trajectory
- Introduced our ward accreditation scheme – Accreditation for Continuous Excellence (ACE), resulting in immediate improvements in MUST scoring compliance
- Achieved our 'no lapses in care' target for C-difficile cases that are healthcare

acquired

- Ensured that there is a nurse on every shift who has up to date Basic Life Support training, meaning we are assured that our wards and departments have the right staff with the right skills on duty to respond if a patient were to suddenly deteriorate.
- Introduced redesigned pathways/guidelines for care of patients with diabetes.
- Improved patient experience in our Emergency Department so that privacy and dignity for patients who attend in an emergency is maintained.

3.7.5 Further, we have developed a Quality Improvement Plan 2018-20 which describes a seven themed approach to making improvements that are measurable and sustainable. The delivery of these seven themes will combine to take us from 'Requires Improvement' and, by being bold aim to take us further on a trajectory to 'Good' and 'Outstanding'.

4. LEGAL IMPLICATIONS

4.1 There are no direct legal implications associated with the content of this report.

5. RECOMMENDATIONS

5.1 The Board of Directors is recommended to:

- Note the assurance provided on progress to address weaknesses identified during the Review of Undertakings.
- Consider and determine whether any further actions are required to address identified weaknesses.

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NHS
Stockport
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	24 May 2018
Subject:	Annual Governance Statement 2017/18		
Report of:	Director of Corporate Affairs	**Prepared by:**	P Buckingham

REPORT FOR APPROVAL

Corporate objective ref:	N/A	**Summary of Report** *Identify key facts, risks and implications associated with the report content.* The purpose of this report is to present the draft Annual Governance Statement 2017/18 to the Board of Directors for approval.
Board Assurance Framework ref:	N/A	
CQC Registration Standards ref:	N/A	
Equality Impact Assessment:	☐ Completed X Not required	

Attachments:	Annex A – Draft Annual Governance Statement 2017/18

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

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1. INTRODUCTION

1.1 The purpose of this report is to present the draft Annual Governance Statement 2017/18 to the Board of Directors for approval.

2. BACKGROUND

2.1 The NHS Foundation Trust Annual Reporting Manual (ARM) 2017/18 requires that all entities covered by the requirements of the manual prepare an Annual Governance Statement. The ARM includes a model Annual Governance Statement which may be adapted and expanded to reflect the particular circumstances of individual NHS Foundation Trusts. The completed Annual Governance Statement is to be incorporated in the Annual Report & Accounts.

3. CURRENT SITUATION

3.1 A draft Annual Governance Statement, based on the guidance provided in the ARM has been prepared by the Director of Corporate Affairs, and is attached for reference at Annex A to this report. The draft document was reviewed by the Executive Team on 8 May 2018.

3.2 A copy of the draft Annual Governance Statement was forwarded to External Audit for review on 1 May 2018 and feedback on the draft statement was received on 9 May 2018. Feedback from auditors has been incorporated in the draft statement included at Annex A. The draft Annual Governance Statement was reviewed by the Quality Committee on 8 May 2018 and by the Audit & Risk Committee on 17 May 2018. Both Committees recommended the draft statement to the Board of Directors for approval.

3.3 Board members should note that, following approval, a signed copy of the Annual Governance Statement will be submitted to NHS Improvement by the due date of 29 May 2018 and the approved version will also be incorporated in the Trust's Annual Report & Accounts 2017/18.

4. LEGAL IMPLICATIONS

4.1 There are no direct legal implications associated with the content of this report.

5. RECOMMENDATIONS

5.1 The Board of Directors is recommended to:

- Approve the draft Annual Governance Statement 2017/18 at Annex A of the report.

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Annual Governance Statement 2017/18

Scope of Responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Foundation Trust Accounting Officer Memorandum*.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Stockport NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Stockport NHS Foundation Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

Leadership and management of the risk management process is provided through:

- The Board of Directors with responsibility for overseeing all aspects of risk management
- The Audit Committee whose role is to receive and review assurance on the systems in place to manage risk
- The Chief Executive and the designated Executive Directors with responsibility for specific aspects of risk management
- The Safety and Risk Group, a group which reports to a sub-group of the Quality Committee, which has responsibility for organisation-wide co-ordination and prioritisation of risk management issues. The Group adopts a 'peer review' approach to provide guidance and encourage learning from best practice.
- An assessment of the level of risk management training that is required for staff and its delivery
- Review of the Risk Management Training Needs Audit matrix by the Safety and Risk Group which strengthens assurance that risk management training is effective, inclusive of a monitoring and review process
- Ensuring that employees with specific responsibilities for co-ordinating and advising on aspects of risk management have adequate training and development to fulfil their role
- The Trust's Risk Management Strategy, which clearly defines managers' levels of authority to manage and mitigate risks, according to risk scored ratings.

The risk and control framework

The Trust has a Board-approved Risk Management Strategy which sets out our approach to the management of risk and the system which assists in the identification, assessment, control and monitoring of risk. Risk management is recognised as a fundamental part of the Trust's culture and is firmly embedded in our philosophy, practices and business plans by means of appropriate training and development for employees with specific responsibilities for coordinating and advising on risk management.

Our risk assessment process, incident reporting and investigation and matters arising from complaints and claims are the principal sources of risk identification. The Trust has an open and accountable reporting culture and staff are encouraged to identify and report incidents by means of an online incident reporting tool. The Trust's Incident Reporting and Management Policy, currently under review, aims to ensure that when a serious event or incident occurs, there are systematic measures in place for safeguarding patients, property, resources and reputation. The policy ensures that a thorough investigation is undertaken and that any lessons learned are disseminated throughout the Trust and, if applicable, to other agencies to reduce the likelihood of a reoccurrence. The use of equality impact assessments and quality impact assessments is embedded in the Trust's business arrangements with the outputs of such assessments being used to inform risk mitigation activities where appropriate.

We use a '5x5 matrix' to assess and rate risks on both the likelihood and consequence to generate a risk score of between 1 and 25. The risk score then determines an appropriate level of escalation, management and scrutiny. The Risk Assessment process applies to all types of risk; clinical, financial, and operational, and risk registers are maintained by each of our Business Groups with registers subject to regular review at Business Group Quality Board meetings. Any risks with a residual risk score of 15 or above are placed on the Trust Risk Register which is monitored on a monthly basis by the Safety and Risk Group, Board-level Committees and the Board of Directors.

Any data security risks are subject to this same process, with escalation through to the Trust Risk Register where appropriate. The subject of data security is incorporated in annual Information Governance training which is mandatory for all staff with compliance levels monitored by the Information Governance & Security Group. A specific area of focus during 2017/18 has been preparation for the introduction of the General Data Protection Regulations (GDPR) in May 2018. The Trust's readiness for introduction of GDPR has been monitored by the Audit & Risk Committee and was also subject to review by Internal Audit which resulted in an assessment of significant assurance.

The Board Assurance Framework details the principal risks associated with delivery of the Trust's strategic objectives. Control measures and sources of assurance are clearly detailed in the Board Assurance Framework, together with details of any gaps in either control or assurance, and each entry has an associated action plan. The Board assesses the risk appetite for each of the principal risks and determines an appropriate acceptable level of risk. The relevant risk appetite is clearly stated in the Board Assurance Framework entry. The Board Assurance Framework is reviewed by the Board of Directors on a bi-monthly basis and the Board considers developments in the external environment in relation to inform Board Assurance Framework content. An Internal Audit assessment completed in March 2018

confirmed that "*The organisation's Assurance Framework is structured to meet the NHS requirements, is visibly used by the Board and clearly reflects the risks discussed by the Board"*.

Management capability, in terms of leadership, the availability of knowledgeable and skilled staff and adequate financial and physical resources, to ensure that processes and internal controls work effectively is routinely monitored by the Executive Team. In November 2017 the Board of Directors completed a Well Led Review self-assessment against NHS Improvement Well Led Framework. Outcomes from the self-assessment will inform developments in practice and process in anticipation of an external Well Led Review in 2018/19. The Board monitors and reviews the system of internal control and, where necessary, will identify improvements to accountability arrangements, processes or capability in order to deliver better outcomes. In 2017/18 this included further development of the Board's Committee arrangements, each of which is chaired by a Non-Executive Director and reports directly to the Board. These Committees are:

- Finance & Performance Committee
- Quality Committee
- People Performance Committee

Reports from the Assurance Committees, which detail key issues considered by the Committees and associated risks, are presented by the Committee chairs at each Board of Directors meeting. The format of key issues reports was reviewed during 2017/18 and an approach based on Alert, Assure and Advise headings was introduced in January 2018.

The foundation trust is fully compliant with the registration requirements of the Care Quality Commission. Further information on this area is included on page 97.

Key Organisational Risk in 2017/18 and 2018/19

The risks to the principal objectives of the Trust, as identified in the Board Assurance Framework for 2017/18, were:

- Risk 1 - Emphasis on day to day operational delivery, in response to environmental pressures, results in lack of focus on strategic change programmes with consequent impairment or failure to deliver the Trust's Five Year Strategy
- Risk 2 - Failure to plan, resource and engage effectively with strategic change programmes impairs level of control and influence with a consequent detrimental impact on patient services.
- Risk 3 - Failure to achieve sustainable delivery of the 4-hour A&E target impairs quality of patient care and results in further regulatory intervention.
- Risk 4 - Inability to maintain and improve compliance with Care Quality Commission standards impairs patient experience, damages Trust reputation and results in regulatory intervention.
- Risk 5 - Failure to achieve the required level of cost improvement to deliver the Trust's financial plan with a consequent impact on patient services, increasing the likelihood of regulatory intervention.
- Risk 6 - Failure to prepare and deliver effective workforce plans supported by

continuous professional development impairs the availability of workforce resources with a consequent impact on the delivery of patient services.

- Risk 7 - Failure to ensure efficient management of the EPR Project will mean the inability to realise the benefits expected to accrue from implementation of a comprehensive electronic system.

The principal risks to compliance with condition FT4 of the Trust's provider licence ('the FT governance condition') are as follows:

- 4-hour emergency department waiting time (target breached in all four Quarters during 2017/18)

The Trust remained in breach of its provider licence throughout 2017/18 as a result of failure to achieve the 4-hour Emergency Department target and Board members have continued to meet with NHS Improvement representatives at regular intervals to discuss the effectiveness of measures being taken to address weaknesses in performance. Clearly, the Trust's performance against the 4-hour emergency department standard has continued to be a key area of scrutiny due to non-achievement of the target in any Quarter during 2017/18. Delivery of this standard remains a risk in 2018/19. The Trust implemented initiatives to manage patient flows, which included the provision of additional bed capacity over and above winter plan levels and the cancellation of some elective activity. However, a combination of increased levels of high acuity patients and difficulties experienced in managing the effective discharge of patients with social care needs, had a significant impact on capacity.

In July 2017, the Trust, together with its partners from Stockport CCG, Stockport Metropolitan Borough Council, Viaduct Care and Pennine Care NHS Foundation Trust, approved a series of business cases for the Stockport Together programme. This programme is based on a collaborative approach to the implementation of new models of care as part of a sustainable and resilient solution for the Stockport health and social care economy. Work on implementing an Integrated Service Solution (ISS) commenced in earnest in October 2017 and each of the 10 schemes that make up the ISS was fully deployed by 30 April 2018.

On 28 February 2018, the Board of Directors agreed a revised set of strategic objectives for 2018/19. The principal risks to the strategic objectives are as follows:

- Failure to achieve the Implementation Plan for delivery of the 2018/19 Operational Plan impairs progress against the Trust Strategy.
- Failure to achieve the 2018/19 developments set out in the Quality Improvement Plan may impair clinical quality and patient experience.
- Failure to recurrently deliver the 2018/19 Cost Improvement Programme will result in an increased deficit position.
- A lack of management capacity has an adverse impact on the Trust's ability to effectively participate in strategic programmes.
- Failure to achieve the A&E 4-hour standard prevents removal of the Trust's additional licence condition with a consequent risk of further regulatory action.
- Failure to recruit to establishment results in over-reliance on agency cover with a consequent impact on workforce engagement and motivation.

- Failure to produce an Estates Strategy, and deliver Year One developments, impairs efficient use of the estate with a potential impact on service developments.

The governance framework described above will ensure that risks are identified and, where necessary, escalated for action from Business Groups to the Executive Team, Committees and the Board of Directors. Risks or developments that may have a consequent impact on quality of care will be identified through completion of quality impact assessments for business cases and cost improvement schemes. The outcomes of quality impact assessments are subject to validation by the Medical Director and the Chief Nurse & Director of Quality Governance. The Trust will seek to engage proactively with public stakeholders in the management of any risks which may impact upon them.

The practice and processes incorporated in the risk and control framework, together with those incorporated in the quality governance framework serve to provide assurance on the validity of the Trust's Corporate Governance Statement as required under NHS foundation trust condition 4(8)(b).

Quality Governance Framework

Stockport NHS Foundation Trust has arrangements in place for monitoring and continually improving the quality of care provided to its patients. The Board of Directors monitors performance against a suite of indicators relating to clinical, access and partnership and efficiency metrics through consideration of an Integrated Performance Report at each Board meeting. This report incorporates specific quality metrics relating to the following seven domains:

- Mortality
- Pressure ulcers
- C Difficile
- Dementia FAIR
- Falls
- Discharge summary / clinical correspondence
- Patient experience

Work was undertaken during the period October 2017 – March 2018 to review the format and content of the Integrated Performance Report to enhance the reporting of performance metrics across all areas. This review resulted in a more comprehensive set of quality indicators which will enable a greater degree of Board oversight across a wider set of metrics together with forward-looking analysis for each metric. Use of the revised quality metrics was piloted by the Quality Committee from January 2018 and the new form IPR will be used to commence reporting to the Board from April 2018.

The Trust is fully compliant with the registration requirements of the Care Quality Commission and had been subject to a CQC inspection in January 2016. The outcomes of this inspection were published in August 2016 and resulted in an overall rating of 'Requires Improvement'. A comprehensive action plan was prepared to address weaknesses identified during the inspection, with progress monitored by the Quality Committee and the Board of Directors. However, while progress had been made to address weaknesses, a follow-up inspection

undertaken by the CQC on 22-23 June 2017 identified continuing weaknesses relating to nurse staffing, compliance with Deprivation of Liberty Standards, completeness of Do Not Attempt Resuscitation (DNAR) documentation, security of medicines and storage of hazardous products. The inspection report, published on 3 October 2017 included requirement notices under the following regulations:

- Regulation 10 Health & Social Care Act (RA) Regulations 2014 - Dignity and respect
- Regulation 12 Health & Social Care Act (RA) Regulations 2014 - Safe care and treatment
- Regulation 17 Health & Social Care Act (RA) Regulations 2014 - Good governance
- Regulation 18 Health & Social Care Act (RA) Regulations 2014 - Staffing

Immediate action was taken to address patient-safety related issues and a revised approach was taken to resolution of other action areas with support and advice from NHS Improvement (NHSI). This support included the appointment of an NHSI Improvement Director in September 2017 with a specific remit to support the Trust in implementing best practice quality developments, both short and long term. The Trust also strengthened its leadership arrangements, with the appointment of a Chief Nurse & Director of Quality Governance in October 2017 and the subsequent appointments of a Deputy Chief Nurse and Deputy Director of Quality Governance.

Work was undertaken towards the end of 2017 to prepare a revised Quality Governance Framework (QGF) which was approved by the Board of Directors on 31 January 2018. The QGF includes a clear and robust management group structure, which covers Quality Governance, Patient Experience, Infection Prevention & Control, Safeguarding and Medicines Management, and provides a clear framework for the escalation of issues and reporting of assurance through to the Quality Committee and Board of Directors.

Having established a robust Framework, a Quality Improvement Plan was produced which sets out targeted developments across the following seven themes:

- High Quality Safe Care Plan
- Urgent Care Delivery
- Quality Improvement Initiatives
- Safe Staffing
- Safety Collaboratives
- Reducing Unwarranted Variation in Clinical Practice
- Quality Faculty

This is an ambitious plan that the Trust believes will deliver the improvements necessary to achieve a short-term goal of fulfilling the requirements for a CQC rating of at least ‘Good’ by January 2019 and the longer-term ambition of meeting the requirements to achieve an overall Trust CQC rating of ‘Outstanding’ by 2020. Progress against the Quality Improvement Plan will be monitored internally by the Quality Committee and Board of Directors and externally by the system Quality Improvement Board jointly chaired by representatives from the Greater Manchester Health & Social Care Partnership and NHS Improvement.

No Never Events were identified by the Trust during 2017/18.

Information Risks

Specific risks relating to information governance, data protection and data quality are co-ordinated by the Information Governance and Security Group and overseen by the Finance & Performance Committee. As well as adopting proactive measures to prevent loss of data and improvements in data quality and cyber security, the Information Governance and Security Group ensures that specific procedures for detecting, reporting and dealing with any issues of data loss and breaches are in place. Other steps taken to safeguard against risks to information and cyber threats include:

- IT security controls for the encryption of all laptops and mobile devices including e-mail encryption software and restrictions on the use of removable media on all Trust computers.
- E-mail and web security controls and filters to protect against malicious software and websites
- Regular security updates and patching applied to computers and systems in accordance with NHS Digital threat advisories and alerts.
- Independent security assessments and penetration testing of IT infrastructure and systems.
- On-going review of information flows of person identifiable data, internally and externally, and ensuring appropriate measures to maintain secure transfer of data.
- On-going review of information assets to ensure that they are appropriately risk assessed and that security measures are in place to maintain confidentiality, integrity and availability of data.
- Review and continued focus on security policies, procedures and guidance issued around handling and sharing of personal data in compliance with the Data Protection Act and General Data Protection Regulations which come into force on 25 May 2018.
- All staff are required to complete information governance e-learning as part of the Trust's mandatory training programme.

The Trust has a Board-level Senior Information Risk Owner (SIRO) with lead responsibility for ensuring that information risk is properly identified, managed and that appropriate assurance mechanisms exist. The SIRO role is undertaken by the Director of Support Services.

The overall Information Governance Toolkit self-assessment score for version 14.1 (2017/18) achieved 68% with all 45 of the requirements met at Level 2 standard or above. Action plans are in place to further improve performance during 2018/19. An Internal Audit review of Information Governance Toolkit evidence resulted in an assessment of Significant Assurance.

The Trust reported five serious IG incidents (level 2) to the Information Commissioner's Office (ICO) that occurred during 2017/18 which related to data loss or confidentiality breaches. All incidents were the subject to a full investigation, with appropriate action taken to mitigate risk of reoccurrence. No regulatory action was taken by the ICO in relation to three of the five incidents. The outcomes of the two remaining incidents (March 2018) are awaited from the

ICO. A summary of the incidents is included below:

Date of Incident	Nature of Incident
July 2017	Disclosure of patient letter.
July 2017	Disclosure of handover sheet
December 2017	Disclosure of handover sheet
March 2018	Third party system failure resulting in misdirection of clinical correspondence
March 2018	Staff details passed to a third party

Other risk areas

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the scheme are in accordance with the scheme rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The foundation trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Review of economy, efficiency and effectiveness of the use of resources

The Board draws on a range of assurance sources and material in its on-going review of economy, efficiency and effectiveness of the use of resources. The annual internal audit programme, together with the reports from individual audits, provides assurance to the Audit Committee on the operational arrangements to secure economy, efficiency and effectiveness in the use of resources.

Assurance on the effectiveness of use of resources is also provided through scrutiny of performance against objectives and targets which is achieved through a number of channels, including:

- Approval of annual budgets by the Board of Directors
- Monthly reporting to the Board on key performance indicators covering access, finance, quality and workforce targets
- Scrutiny of performance against the financial plan and monitoring delivery of strategic change projects by the Finance & Performance Committee

- Board of Directors consideration of key issues reports from its Assurance Committees
- Executive team performance review meetings with Business Groups.

Compliance with the NHS Foundation Trust Code of Governance is reviewed by the Audit Committee on a six-monthly basis as a core element of the Committee's work plan. Outcomes of these reviews inform the compliance declarations included at page 76 of the report. Work of the Audit, Nominations and Remuneration committees is included on pages 42, 45 and 57 of the report.

NHS Improvement Review of Trust Position

On the 24 April 2013 the Trust signed Enforcement Undertakings with Monitor (a copy of which is on Monitor's website) in relation to the Trust's breaches of the A&E 4 hour target and highlighted potential weaknesses in Governance processes. Monitor's concerns were such that this was superseded on 4 August 2014 by imposition of an additional licence condition under section 111 of the Health and Social Care Act 2012 (a copy of which is available on Monitor's website). In July 2015 the additional licence condition relating to Governance was formally removed by Monitor in recognition of the actions taken by the Trust in response to recommendations made following an independent Governance Review completed by Deloitte LLP during 2014/15.

However, sustainable delivery of the A&E 4-hour waiting time standard has continued to be a major challenge, despite considerable efforts made by the Trust to improve performance against the target and this subject has continued to be a recurring theme of quarterly review meetings with NHS Improvement. In March 2017 NHS Improvement signalled its intention to conduct a formal review of the Enforcement Undertakings and this review was subsequently undertaken during the period June-July 2017. The review resulted in a Modification of the Additional Licence Condition dated 15 December 2017 requiring the Licensee i.e. the Trust, to address the following issues:

a. Failure to take the action necessary to ensure compliance with the A&E 4 hour maximum waiting time standard on a sustainable basis;
b. Lack of a clear vision and strategy around which the Licensee's board can determine its focus and priorities;
c. Lack of a long term financial recovery plan demonstrating how the Licensee aims to return to a financial break even position and of a credible plan to deliver the required cost improvement programme;
d. Failure to ensure that the Licensee's board and its committees have effective oversight of quality, safety, finances and A&E performance;
e. Failure to respond sufficiently and in a timely manner to concerns identified by the CQC in its inspection of January 2016; and
f. Any other issues relating to the operation of the Licensee's board and its other governance arrangements, including those identified in any independent assessment of its governance arrangements, that have caused or contributed to, or will cause or contribute to, the breach, or the risk of breach, of the conditions of the Licensee's licence.

The Trust's progress in addressing these issues is subject to regular formal monitoring by means of monthly Enhanced Financial Oversight meetings and Quarterly Review Meetings with NHS Improvement. In addition, a Quality Improvement Board, now jointly chaired by GM Health & Social Care Partnership and NHS Improvement, meets on a monthly basis with a specific focus on quality matters and urgent and emergency care. We expect that these monitoring arrangements will continue throughout 2018/19.

Annual Quality Report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. NHS Improvement (in exercise of the powers conferred on Monitor) has issued guidance to NHS Foundation Trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the *NHS Foundation Trust Annual Reporting Manual*.

The steps that the Board has taken to assure itself that the Quality Report presents a balanced view, and that there are appropriate controls in place to ensure the accuracy of data, include:

- Seeking feedback on presentation and content of the Quality Report from commissioners, governors and other key stakeholders
- The data used for reporting quality metrics is regularly reviewed and triangulated against other performance measures, using a variety of different methods, including internal audit review. The Trust also engages with national coding audits and uses external benchmarking provided through Capita Health Knowledge Services (CHKS) to compare its performance with similar organisations.
- The development of underpinning policies and procedures to embed and sustain quality improvement, thereby enhancing longer-term achievement of quality objectives.
- Trust policies are available through the intranet and all staff are encouraged to participate in consultation around new and updated policies
- Quality services are monitored through the Business Group structure through to the Board-level Committee tasked with oversight of Quality Governance.
- The Trust celebrates achievement at quarterly celebration events launched to recognise and celebrate individuals and teams that have made an exceptional contribution to patient care.

The Trust assesses the quality and accuracy of elective waiting time data through testing against indicators detailed in the Data Quality Self-Assessment tool. Elective pathways are subject to regular validation in accordance with the Trust's Referral to Treatment Validation Procedure. The Procedure document details roles and responsibilities of staff in ensuring data quality and describes the schedule of validation reports and actions to minimise error rates. The

implementation of Mandatory RTT training for relevant staff groups commenced in 2017/18 and supports local role based learning. Monthly RTT data quality audits are carried out by the Validation team to identify any areas of concern. Outcomes of audits have been regularly reported to the Audit & Risk Committee.

However, while there had been improvements in comparison to previous years, the external testing of mandated indicators, completed by Deloitte LLP to support a limited assurance opinion on the Quality Report, again identified weaknesses in data management process and practice relating to the 18-week incomplete Referral to Treatment indicator. The weaknesses resulted in a modified opinion for this specific indicator. Progress against actions to address the identified weaknesses will be monitored by the Audit & Risk Committee.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and the other committees that form part of the Trust's assurance structure and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The process for maintaining and reviewing the effectiveness of the system of internal control is based on a governance architecture with subject specific management groups at its foundations. Management groups, for example the Quality Governance Group or the Cash Action Group, report assurance, which may be positive or negative, and escalate emergent issues to a Board Assurance Committee. The Board-level Committees review reports from management groups, initiate further management action where necessary and report outcomes of each meeting to the Board of Directors by means of a key issues report based on an Alert, Assure and Advise approach.

The Audit & Risk Committee has a specific remit in assessing the effectiveness of internal control systems and considers the outcomes of work undertaken by Internal Audit to test system effectiveness at each meeting. This Committee also reviews assurance reports from management on system effectiveness and actions taken to address audit recommendations. The Audit & Risk Committee presents a key issues report to the Board following each meeting. The Board of Directors considers matters reported through the Committee key issues reports at each of its meeting and either acknowledges the assurances provided or determines where remedial action is required.

In describing the process that has been applied in maintaining and reviewing the effectiveness of the system of internal control I have detailed below some examples of the work undertaken during 2017/18.

My review has been informed by:

- The Board Assurance Framework which provides the Trust with evidence of the effectiveness of the system of internal controls that manage the principal risks to the organisation's strategic objectives. The Assurance Framework is subject to regular review by the Board of Directors.
- Internal Audit review of the Board Assurance Framework and the effectiveness of the overall system of internal control as part of the Internal Audit plan which is agreed by the Audit & Risk Committee.
- A positive Director of Audit Opinion which confirmed that there had been no deterioration in the control environment with an overall moderate assurance opinion on the system of internal control for 2017/18.
- The Trust continues to be registered with the Care Quality Commission without conditions.
- The process for the follow-up of audit recommendations which is monitored by the Audit Committee.
- Committees within the Board's committee structure having a clear timetable of meetings and a clear reporting structure which enables matters to be reported and/or escalated in a timely manner.
- Outcomes of the review of Enforcement Undertakings completed by NHS Improvement during the period June - July 2017.

The Trust has a comprehensive risk-based internal audit programme in place and the programme was delivered in full during 2017/18. Outcomes of the internal audit programme are reported to the Audit & Risk Committee and appropriately led action plans are in place to address any audits which result in a limited assurance assessment. The monitoring of governance processes is informed by an Integrated Performance Report, which includes a comprehensive set of indicators and is reviewed by the Board of Directors at each meeting. A data quality 'kite mark' is included for each indicator which indicates source of data, timeframe, method of calculation and whether data has been subject to validation. Data validation and availability is also tested as part of internal audit assessments, where appropriate.

The Trust has identified instances of 12-hour breaches over the winter period as a significant control issue. These instances are subject to incident investigation and outcomes used to identify means of strengthening controls to mitigate the risk of reoccurrence. The outcomes will be an area of specific focus in the development of our plans to manage the winter period 2018/19.

Conclusion

My review confirms that Stockport NHS Foundation Trust has generally sound systems of internal control that support the achievement of its policies, aims and objectives. However, challenges related to operational pressures during the winter of 2017/18, and the consequent impact on patient flow, resulted in an unacceptable level of patients who experienced extended waits in the emergency department, despite much improved wait to be seen times, and were subject to breach of the 12-hour standard. This situation is considered to constitute

a significant control issue. I am satisfied that each instance of a 12-hour breach was subject to comprehensive review and that no patient harm arose as a result of a breach. I am also assured that control arrangements are in place to mitigate the risk of reoccurrence,

Helen Thomson
Interim Chief Executive

24 May 2018

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NHS Stockport NHS Foundation Trust

Report to:	Board of Directors	**Date:**	24 May 2018
Subject:	Year-End Governance Declaration		
Report of:	Director of Corporate Affairs	**Prepared by:**	P Buckingham

REPORT FOR APPROVAL

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

Summary of Report

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

The purpose of this report is to allow the Board of Directors to determine a positive declaration against General Condition 6 and Continuity of Services Condition 7 of the NHS Provider Licence or identify why such a declaration cannot be made.

Attachments:	Appendix 1 - Condition G6 – Systems for compliance with licence conditions Condition CoS7 – Availability of Resources Appendix 2 – Declarations Template

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

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1. INTRODUCTION

1.1 The purpose of this report is to allow the Board of Directors to determine a positive declaration against General Condition 6 and Continuity of Services Condition 7 of the NHS Provider Licence or identify why such a declaration cannot be made.

2. BACKGROUND

2.1 The requirements of both Conditions are reproduced for reference at Appendix 1 of the report and a copy of the required declarations is included at Appendix 2. Guidance issued by NHS Improvement in late April 2018 advised that, while Boards are still required to complete relevant self-certifications, there is no longer a requirement to automatically submit the declarations to NHS Improvement. Instead, an audit process has been introduced whereby NHS Improvement will contact a select number of NHS trusts and foundation trusts to ask for evidence that they have self-certified.

2.2 Boards are required to sign off on self-certification of the G6 and Cos7 Conditions by 31 May 2018.

3. CURRENT SITUATION

3.1 <u>General Condition 6</u>

The form of the declaration is included for reference at Appendix 2 of the report and the nature of the declaration is both retrospective, in terms of arrangements in the Financial Year just ended, and prospective, in terms of continuation in meeting the relevant criteria.

3.2 The systems and processes for identifying and controlling risks are set out in the Annual Governance Statement 2017/18. In reaching a decision on the declaration, the Board of Directors will need to consider the arrangements described in the Annual Governance Statement and the effectiveness of the Risk Management Policy, Risk Registers and the Board Assurance Framework as key components of the risk management system. The Board should note the risk-based Internal Audit programme which was in place throughout 2017/18, the positive outcome of the Internal Audit assessment of the Board Assurance Framework and the outcome of the Head of Audit Opinion which resulted in an assessment of Moderate Assurance.

3.3 The Board should consider whether there have been, or there are planned to be, any changes to internal control arrangements that have the potential to impair the Trust's continuation of meeting the criteria for holding a licence. In particular, the Board should consider whether the Review of Undertakings carried out by NHS Improvement, and the consequent modification to the Trust's licence conditions, should be referenced in the Trust's declaration.

3.4 <u>Continuity of Services 7</u>

The nature of this self-certification is detailed at Appendix 1 and relates to the availability of resources for the delivery of services. The self-certification is forward-looking as the availability of resources, or not, relates to financial year 2018/19. The Board must select one of the three options for certification as detailed at Appendix 2 and provide a statement

of the factors taken into account in making the relevant declaration.

3.5 In considering an appropriate declaration, Board members should note that 'Required Resources' are defined as follows:

- Management Resources
- Financial Resources and facilities
- Personnel
- Physical and Other Assets

3.6 Factors to take into account as part of the self-certification should include; the Trust's contract arrangements for 2018/19, the Going Concern assessment agreed by the Board on 29 March 2018 and the External Auditor's report and opinion on both the financial statements and Going Concern. The likelihood of a requirement for external revenue funding during 2018/19 should also be taken into account.

The Board should also consider the implications of any planned or potential services changes, such as the Healthier Together programme or developments related to the Greater Manchester Theme 3 programmes, in the context of resource availability to accommodate/service such changes and the likelihood of any unplanned changes emerging during financial year 2018/19.

4. LEGAL IMPLICATIONS

4.1 Completion of the relevant declarations is a requirement of the NHS Provider Licence.

5. RECOMMENDATIONS

5.1 The Board of Directors is recommended to:

- Consider the content of the report and agree appropriate declarations against General Condition 6 and Continuity of Services Condition 7.

Appendix 1

Condition G6 – Systems for compliance with licence conditions and related obligations

1. The Licensee shall take all reasonable precautions against the risk of failure to comply with:

    a) The Conditions of this Licence,
    b) Any requirements imposed on it under the NHS Acts, and
    c) The requirements to have regard to the NHS Constitution in providing health care services for the purpose of the NHS.

2. Without prejudice to the generality of paragraph 1, the steps that the Licensee must take pursuant to that paragraph shall include:

    a) The establishment and implementation of processes and systems to identify risks and guard against their occurrence; and
    b) Regular review of whether those processes and systems have been implemented and of their effectiveness.

3. Not later than two months from the end of each Financial Year, the Licensee shall prepare and submit to Monitor a certificate to the effect that, following a review for the purpose of paragraph 2(b) the Directors of the Licensee are or are not satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with this Condition.

4. The Licensee shall publish each certificate submitted for the purpose of this Condition within one month of its submission to Monitor in such manner as is likely to bring it to the attention of such persons who reasonably can be expected to have an interest in it.

Condition CoS7 – Availability of resources

1. The Licensee shall at all times act in a manner calculated to secure that it has, or has access to, the Required Resources.

2. The Licensee shall not enter into any agreement or undertake any activity which creates a material risk that the Required Resources will not be available to the Licensee.

3. The Licensee, not later than two months from the end of each Financial Year, shall submit to Monitor a certificate as to the availability of the Required Resources for the period of 12 months commencing on the date of the certificate, in one of the following forms:

   (a) "After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate."

   (b) "After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services".

   (c) "In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate".

4. The Licensee shall submit to Monitor with that certificate a statement of the main factors which the Directors of the Licensee have taken into account in issuing that certificate.

5. The statement submitted to Monitor in accordance with paragraph 4 shall be approved by a resolution of the Board of Directors of the Licensee and signed by a Director of the Licensee pursuant to that resolution.

6. The Licensee shall inform Monitor immediately if the Directors of the Licensee become aware of any circumstance that causes them to no longer have the reasonable expectation referred to in the most recent certificate given under paragraph 3.

7. The Licensee shall publish each certificate provided for in paragraph 3 in such a manner as will enable any person having an interest in it to have ready access to it.

8. In this Condition:

"distribution"	includes the payment of dividends or similar payments on share capital and the payment of interest or similar payments on public dividend capital and the repayment of capital;
"Financial Year"	means the period of twelve months over which the Licensee normally prepares its accounts;
"Required Resources"	means such: (a) management resources, (b) financial resources and financial facilities, (c) personnel, (d) physical and other assets including rights, licences and consents relating to their use, and (e) working capital as reasonably would be regarded as sufficient to enable the Licensee at all times to provide the Commissioner Requested Services.

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Worksheet "G6 & CoS7"

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with license conditions (FTs and NHS trusts)

1 Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution. Please Respond

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. Please Respond

OR

3b After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services. Please Respond

OR

3c In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate. Please Respond

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

[e.g. key risks to delivery of CRS, assets or subcontractors required to deliver CRS, etc.]

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

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

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

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Report to:	Board of Directors	**Date:**	24th May 2018
Subject:	Trust Risk Register		
Report of:	Chief Nurse & Director of Quality Governance	**Prepared by:**	Deputy Director Quality Governance

REPORT FOR APPROVAL

Corporate objective ref:	**Summary of Report** **The data for this report was collated on 3 May 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 265 live risks recorded on the Risk Register systems. • There are 24 risks rated 15 or above on the Trust Risk Register with corporate approval. • Across the 24 risks rated 15 or higher that have been corporately approved; – 6 risks are associated with staffing issues causing a risk to patient safety, experience or timely care – 1 risk is associated with the financial position (101) – 1 risk is associated with an overspend due to agency spend (127) – 3 are associated with equipment that requires replacement (46, 339, 261) Members are asked to note the risks and the identified actions to mitigate those risks
Board Assurance Framework ref:	
CQC Registration Standards ref:	
Equality Impact Assess-ment: ☒ Not required	

Attachments: Nil

This subject has previously been reported to:	☐ Board of Directors ☐ Council of Governors ☐ Audit Committee ☐ Executive Team ☐ Quality Assurance Committee ☐ F&P Committee	☐ PP Committee ☐ SD Committee ☐ Charitable Funds Committee ☐ Nominations Committee ☐ Remuneration Committee ☐ Joint Negotiating Council x Other - Risk & Safety Group, People Performance Committee, Finance & Performance Committee, Quality Governance Group

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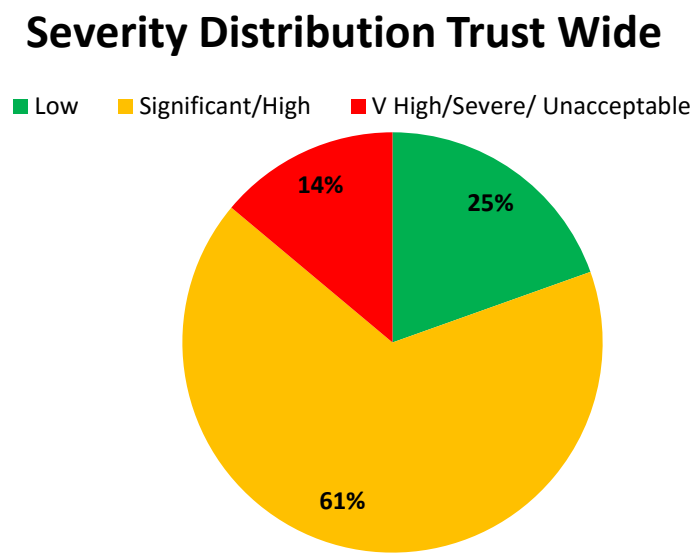
1.0 Trust Wide Risk & Severity Distribution

1.1 There are currently 264 live risks recorded on the new Risk Register system. This is an increase of 9 from last month

1.2 There is 1 live risk on the old risk register, a decrease of 3 since last month.

1.3 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
Old System	0	0	0	0	0	0	0	0	0	1	0	0	0	0
New System	1	4	11	36	2	31	31	39	9	67	8	15	9	0



1.5 Trust Risk (approved) distribution across Business Groups. This includes the risks that are currently under review

Business Group	Risk Score 15	Risk Score 16	Risk Score 20	Risk Score 25	Total
Corporate	2	1	4	0	7
Integrated Care	0	4	1	0	5
Medicine and Clinical Support	1	2	1	0	4
Surgery, GI and Critical Care	1	2	0	0	3
Women's and Children's	0	2	3	0	5

1.6 Risk movement of risks of 15 and above in April 2018

Corporate Approved Risks														
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											↔
53	16	12	12											↔
74	25	10	10											↔
75	16	16	16											↔
76	16	16	16											↔
78	20	20	20											↔
87	16													C
91	15													C
96	16	16	16											↔
101	20	20	20											↔
108	16	16	16											↔
109	16	16	1											↓
125	16	16	16											↔
126	16	16	16											↔
127	16	16	16											↔
130	20	20	20											↔
134	20	20	20											↔
135	20	20	20											↔
137	16	16	9											↓
145	16													C
159	20	20	16											↔
160	15	15	8											↓
162	15	15	15											↔
167	16	16	16											↔
177	15	12	12											↔
183	16	16	16											↔
231	20	20	20											↔
261	16	16	16											↔
282	15	15	12											↓
286		15	15											N
288	15	15	9											↓
296	15	15												C
318	15	6	6											↔
319	15													C
354	16	16	16											↔
355	15	15	12											↓
362	15	15	15											↔
399		15	15											↔
429			20											N

Business Group Approved Risks														
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	
64	16	16	16											↔
86	16	9	9											↔
193	20													C
207	16	12	12											↔
233	20	20	20											↔
263	15	12	12											↔
274			16											N
285	20													C
346	15	15												C
358		15	9											↓
360			16											N
400		15	15											↔
408			15											N
443			20											N
461			16											N

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
UR	Risk under review

2.0 New Risks Identified

2.1 There has been 1 new risk identified as scoring 15 or above and placed on the Trust Risk Register this month.

Risk Register Type	Risk ID	Risk Owner	Exec Director	Business Group	Risk Title	Controls in place	Rating (initial)	Consequence (current)	Likelihood (current)	Rating (current)	Rating (Target)	Outstanding Actions	Due date
Corporate Risk	429	Curtis, Mrs Kelly		Women Children & Diagnostics	There is a risk that there is inadequate capacity to meet demand in Paediatric ADHD services	Capacity deficit raised with Stockport Commissioner Additional OWL lists monthly (not covering current demand)	20	4	5	20	8	Define new ADHD pathway with CCG and HYMs	23/05/2018
												Paper to SMT to agree resource requirement for increase demand on service	14/05/2018
												Paper to contracting meeting to request additional resource from CCG	14/05/2018
												Advertise additional consultant PA's to provide ADHD Service	07/05/2018
												Additional Consultant PA's in post to provide ADHD service	27/08/2018

3.0 Existing Risks

3.1 There are 24 risks rated 15 or above on the Trust Risk Register with corporate approval. This is a decrease of 6, compared to last month.

3.2 There are 5 risks that have had a review requested.

- 1 new risks have been added as identified above
- 5 risks have been reduced to below a risk of 14
- 1 risk has been closed

4.0 Trends

4.1 The risk register is presented in order of consequence, with the highest consequence first

4.2 Across the 24 risks rated 15 or higher that have been corporately approved:-

- 6 risks are associated with staffing issues causing a risk to patient safety, experience or timely care
- 6 risks are associated with capacity issues within the services

Risk Register Type	Risk ID	Risk Owner	Exec Director	Business Group	Risk Title	Controls in place	Rating (initial)	Consequence (current)	Likelihood (current)	Rating (current)	Rating (Target)	Outstanding Actions	Due date
Assessed consequence rating 5													
Strategic Risk	101	Rigby, Susan	Patel, Feroz	Finance	There is a risk that the Trust will not have sufficient cash reserves to operate	Daily cash reconciliation Cash flow forecast on a 13 week basis with a 15 month look ahead Cash Action Group meets on a monthly basis Cash reporting to Finance and Performance Committee Cash reporting to Board of Directors as part of IPR Liquidity days reported to NHSI as part of the Trust's Use of Resources finance score Updated Finance and Performance Committee on the process to draw down a revolving working capital facility.	20	5	4	20	5	Stress testing of the 13 week cash flow by the Cash Action Group on a monthly basis	31/03/2019
												As part of Finance & Performance meetings highlight the Trust cash position and the inter-dependencies on a monthly basis	31/03/2019
												Implementation of No PO No Pay policy	01/06/2018
Strategic Risk	162	Kershaw, Helen	Lynch, Alison	Corporate Nursing	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	NHSI improvement Board Patient Quality Summit weekly Safe, High Quality care action plan Quality Governance Framework Regular contact with the CQC	20	5	3	15	5	Deliver Safe, High Quality Care Action Plan	31/07/2018
Corporate Risk	399	Lehnert, Mrs Jean	Mullen, Hugh	Information and IT	There is a risk to patient care due to the potential Failure of PACs Infrastructure	•GE currently supports PACs but will no longer guarantee SLAs due to inability to source essential components. •Our current business continuity can support short term downtime, and is normally associated with planned down time for software upgrades or unplanned outages for power and network, but would struggle to support any major long term issues.	15	5	3	15	6	Purchase and Deploy requisite VM Hardware	30/04/2018
												Data Migration	29/06/2018

Risk Register Type	Risk ID	Risk Owner	Exec Director	Business Group	Risk Title	Controls in place	Rating (initial)	Consequence (current)	Likelihood (current)	Rating	Rating (Target)	Outstanding Actions	Due date
Assessed consequence rating 4													
Corporate Risk	78	Carpenter, Jane	Lynch, Alison	Medicine & Clinical Support	There is a risk that the quality of care to patients and of poor documentation, due to high numbers of registered nurse vacancies compounded by long term sick and maternity leave. There is a risk that wards cannot reach their safe staffing standard of RNs on a ward shift by shift, causing higher use of agency resulting in overspend of nursing budgets.	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 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	20	4	5	20	8	Reference to the Minimum Safe Staffing Escalation Policy	13/07/2018
												Trial of ward based Band 5 pharmacy technicians	11/05/2018
												Local recruitment	13/07/18

Strategic Risk	159	Birch, Sylvia	Wasson, Colin	Corporate Nursing	There is a risk that staff will be unable to comply to Coroners' requests in a timely manner due to the increase in the number of inquests and therefore an increase in time required to complete the requests	Clear process for the: 1 triage of inquests 2 management of statement requests 3 pre inquest support	20	4	5	20	8	Review process for Writing statements	30/06/2018
												Deliver training for staff re Coroner court skills	30/03/2019
Corporate Risk	231	Glynn, Marie	Lynch, Alison	Corporate Nursing	There is a risk that the IP service is unable to meet all its obligations due to a lack of medical and nursing staff resulting in only mandatory work being undertaken.	• 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	20	4	5	20	8	Review BG for wider IP team	28/11/2018
												Review links with sepsis agenda	28/06/2018
												Options following business case review at SMG	31/05/2018
												Current work load undertaken by the IP service team	31/05/2018
												To produce a gap analysis against the Health & Social Care Act	29/06/2018
												Present compliance data against the H&SC Act	31/05/2018
Strategic Risk	134	Kershaw, Helen	Lynch, Alison	Corporate Nursing	There is a risk that Subject Access requests are not responded too in a timely manner, breaching the data protection act, due to vacancies and long term sickness within the team.	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.	20	4	5	20	8	Weekly updates from Team	30/06/2018
												Continue weekly monitoring of situation for 3 months	30/06/2018
												Use volunteers and bank staff to increase throughput	30/06/2018

Corporate Risk	130	Plummer, Sue	Toal, Sue	Integrated Care Business Group	There is a risk of poor patient experience, patient safety breaches, reputational issues with commissioners and financial penalties, due to the failure to deliver high quality care to patients in a timely manner and breaching the 4 hour target	Existing internal escalation processes	20	4	5	20	10	High Impact Priority Action Plans	01/11/2018
Strategic Risk	135	Lehnert, Jean	Lynch, Alison	Information & IT	There is a risk that the Subject Access Provision is not meeting data protection requirements	1. Medico Legal Team adhere closely to guidance (see earlier risk re pressures) 2. There is a clear process (doesn't include all areas) 3. Health Records follow process	20	4	5	20	8	Determination of requirements to meet legislation post review	30/04/2018
Corporate Risk	46	Smethurst, Richard	Mullen, Hugh	Women Children & Diagnostics	Telepath Server Failure Due to Obsolete 'live' and 'shadow' Telepath servers, causing potential loss of IT links between Lab Medicine and GPs / Wards and electronic access to results, leading to delayed treatment/diagnosis/discharge.	Telepath has 24/7 365 day support (hardware 7 years old). This system also has a failover server (also 7 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.	16	4	5	20	4	Replacement Telepath Server.	21/05/2018

Risk Assessment	261	Nuttall, Lynn	Toal, Sue	Surgery GI & Critical Care	There is a risk to patients of delays and cancelations to the endoscopy list due to an aging JetAer automated scope reprocesser. This could lead to the failure to meet Cancer waiting targets.	Silver service maintenance contract with 'Cantel' medical for quarterly service, Quarterly HTM and annual validation. Scopes are processed in Endoscopy in event of breakdowns.	12	4	4	16	4	Purchase new AER	31/07/2018
Corporate Risk	75	Waterman, David	Toal, Sue	Integrated Care Business Group	There is a risk that; patients may not receive timely and appropriate palliative care, reputational issues with commissioners and financial penalties may be incurred due to a single Consultant in Palliative Medicine for the Organisation. This may result in a failure to provide consultant cover over weekends and during the doctors absences to specialist palliative care patients.	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.	20	4	5	16	8	Awaiting outcomes with discussions with the CCG.	14/05/2018
Business Group Risk	126	Harrop, Jen	Toal, Sue	Integrated Care Business Group	There is a risk that when there is a surge in demand in the Emergency Department, Patients are cared for on trollies in the corridor , leading to poor patient experience, patient safety breaches, reputational issues, failure to meet national standards and CQC requirements.	Use of Trust escalation policy - this focuses on assessing demand in ED, assessing capacity in the Acute Medical units (AMU 1 and 2)) and hospital wards. There are RAG rated trigger thresholds that correspond with actions for senior manager, directors and executives.	20	4	4	16	8	Implementation of the Stockport Together programme at work aimed at Admission Avoidance. Includes Crisis Response Team (CRT) and neighbourhood models of care including maintenance at home an intermediate care.	01/06/2018

Business Group Risk	125	MR1	Toal, Sue	Integrated Care Business Group	Inability to recruit the number of medical staff needed to fulfil the rota for ED cover due to a tight labour market, resulting in an increased reliance on locum medical staff and internal staff covering extra shifts Consequence of uncertain delivery of key objectives / service due to lack of substantive staff and loss of key staff due to low staff morale.	Dependent on internal cover and locum bookings.	20	4	4	16	8	New Consultant rota to be negotiated.	31/05/2018
Strategic Risk	183	Hodgson, Karen	Toal, Sue	Executive Teams	Failure to meet the 62 day Cancer target standards	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	12	4	4	16	8	Cancer Services Manager to review Department roles and responsibilities to ensure staff are engaged with targets	29/06/2018
												Action plan being created with input from Business Groups to ensure sustained performance	29/06/2018
												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)	29/06/2018

Corporate Risk	108	Jones, David	Toal, Sue	Women Children & Diagnostics	Failure to provide a robust imaging service due to reduced Radiographer staffing	Service currently supported by extra sessions which is provided on a voluntary basis Part time staff working additional hours 2 x Locum Radiographers contracted until 26/08/16 Review of processes to optimise efficiency Rolling advert on NHS Jobs for Band 5 Radiographer posts	16	4	4	16	8	Staff vacancies recruited too. Awaiting Staff to commence	30/06/2018
Business Group Risk	127	Armitage, Nadine	Shaw, Jayne	Medicine & Clinical Support	There is a risk that the BG overspends due to agency costs	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.	16	4	4	16	12	Introduction of medical e-rostering	11/05/2018
												Increasing pool of medical bank staff	14/09/2018
												International recruitment	14/09/2018
												Domestic recruitment	14/09/2018
												Management of Nurse e roster	15/06/2018
Corporate Risk	76	Bryson, George	Mullen, Hugh	Integrated Care Business Group	Potential financial and operational risk of failure in retaining / finding new clinical accommodation to operate the Stockport Wheelchair Service	Business as usual whilst the Service prepares for 'worst case' scenario and develops a contingency plan, quality impact assessment and an action log which identifies potential issues and the mitigating actions	16	4	4	16	12	Clarify timescales for remedial building work	29/06/2018

Business Group Risk	96	Rogers, Stuart	Toal, Sue	Medicine & Clinical Support	There is a risk of lack of capacity for timely outpatient reviews in the Ophthalmology	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	16	4	4	16	8	Virtual clinics	14/05/2018
												Review spend on WLI and convert to substantive	01/06/2018
Business Group Risk	167	Connaughton, Michelle	Mullen, Hugh	Surgery GI & Critical Care	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	Patient records are stored notes trollies, most of which are placed in non-patient areas. The notes are accessed by multiple members of the clinical teams - medical, nursing, midwifery and therapy.	16	4	4	16	8	Install new kit on arrival	31/05/2018
Risk Assessment	354	Ainsworth, Simon	Lynch, Alison	Women Children & Diagnostics	The risk of abduction or paediatric patient absconding.	Staff are more vigilant on checking who people are but at busy times they are not able to visualise who is entering and leaving. Minimal ward clerk cover till the approx. 17:00	16	4	4	16	8	implementation of new access/exit control	04/06/2018
Assessed consequence rating 3														
CQC Action Plan	362	Kong, Ngai	Wasson, Colin	Medicine & Clinical Support	There is a risk that patients not getting ketone testing when required.	Current process meets national standards, but does not reflect best practice. Concerns raised by our external diabetes review.	15	3	5	15	4	Care of patients with hypoglycaemia and hyperglycaemia to be reviewed in light of best practice.	30/04/2018
												Trial Ketone Testing on the wards.	31/05/2018
												new ketone meters on order	31/05/2018

Business Group Risk	286	Wheelton, Mrs Fiona	Toal, Sue	Surgery GI and Critical Care	There is a risk to patient experience and safety due to Endoscopy Capacity and Demand	Current controls in place are waiting list initiative (WLI) sessions which are run on an adhoc basis and a premium cost which are covered by Consultants and Nurses. Mediscan is an insourcing company who we have a contract with to provide the extra capacity on a Saturday morning to ensure that patients receive timely and appropriate care.	15	3	5	15	3	Development of a Business Case	31/05/2018

5.0 Business Group Approved Risks

5.1 The new risks identified by the Business Groups are emerging issues, with controls and action plans yet to be determined.

Risk Register Type	Risk ID	Risk Owner	Exec Director	Business Group	Risk Title	Controls in place	Rating (initial)	Consequence	Likelihood (current)	Rating (current)	Rating (Target)	Outstanding Actions	Due date
Corporate Risk	443	Wood, Tracy		Information and IT	There is a risk to achieving national standards. All business groups must provide RA Actions and reference any RA's within their specialty teams which may affect the Trust's Elective Performance.	Business Group and Specialty Level Risk Assessments with mitigating actions.	20	4	5	20	12	There are 35 actions	31/03/2019
Business Group 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	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	15	3	5	15	3	Discuss pharmacy capacity issues with Richard Bell	31/05/2018
												Bank pharmacist	25/06/2018
												Agree with haematologists a business case requirement for more pharmacy staff	31/05/2018
Business Group Risk	461	Hatcher, Karen		Surgery and Critical Care	The Business Group have identified key risk to delivery - lost elective activity due to urgent care bed pressures, impacting on financial performance, RTT delivery	Profiling of elective activity to take into account her winter period Proactively reviewing alternative options with recruitment e.g., physician associates, ANP's etc. Validation of all activity with a view to	16	4	4	16	12	Monitoring weekly of activity v plan	01/06/2018

					and 62 day cancer standard - Dependency on agency staff arising from gaps on junior medical staffing rotations - Recruitment of retention issues, particularly in key areas such as theatre, nursing and medical posts	alternative modes of delivery e.g., virtual clinics Robust financial controls in place across the Business Group						Robust controls	01/06/2018
Business Group Risk	360	Wheelton, Mrs Fiona		Surgery GI and Critical Care	There is a risk to patient safety for lack of a full GI Bleed Rota	To address this risk we are implementing a phase one; launching the 'Unstable GI Bleed' rota from 2nd February which will provide weekend cover from Friday at 5pm to Monday morning at 9am. Endoscopy Nurse Consultation is now complete with staff signed up to deliver the rota. 24/7 bleed rota will go live following successful recruitment of two more Gastro Consultants. One advert is currently out to advert closing on 28.02.2017. The advert has been out 3 times, since October without any interest. The advert has been re-written and due to other service improvements developing this should make the job more inviting. Currently the Surgical 'HOT' team support the care of these patients which depending on who is on call can leave staff and patients in a precarious situation as not all of the General Surgeons are trained to deal with life threatening patients such as a Varicial bleed as it is not where their expertise lays.	16	4	4	16	4	Consultant Interviews	03/08/2018
												Completion of Job Planning	29/06/2018
Risk Assessment	274	James, Mr Adam		Information and IT	There is a risk to RTT compliant 2017-2018	Restorative and mitigating actions, such as capacity & demand programmes, theatre utilisation initiatives and waiting-list initiatives are being conducted to improve performance, as well as substantive recruitment to Consultant roles.	16	4	4	16	9	ENT Action 2	30/03/2018
												Ophthalmology Action 1	01/06/2018
												Gastroenterology Action 2	30/06/2018
												General Medicine Action 1	31/03/2018
												Outpatients Action 2	31/03/2018
												Outpatients Action 3	31/03/2018
												Outpatients Action 4	31/03/2018
												Outpatients Action 5	31/03/2018

																Rheumatology Action 5	30/11/2017
																18/19 RTT Action Plan Development	30/04/2018

5.2 The existing risks for the Business Groups are for information

5.3 There are 8 risks that score 15 or over that have been approved by the Business Groups

- 5 are new risks

Risk Register Type	Risk ID	Risk Owner	Exec Director	Business Group	Risk Title	Controls in place	Rating (initial)	Consequence (current)	Likelihood (current)	Rating (current)	Rating (Target)	Outstanding Actions	Due date
Business Group Risk	233	Buckley, Paul		Medicine & Clinical Support	There is a risk of the automated dispensing robot breaking down slowing the service causing delays in treatment and discharges	Super Users can currently solve basic problems. Two engineers from the company service the equipment twice a year and fix problems and we can manually obtain medicines when the system is down. However, this takes time to do.	20	4	5	20	3	Proposal to be written regarding replacing the robots	27/04/2018

Business Group Risk	64	Jones, David	Woodford, Claire	Women Children & Diagnostics	Inability to Provide Timely Radiology Report for Plain Film Imaging	• All imaging, excluding GP referrals, is reviewed by the referring clinician/team and findings/actions documented in the patient record. • Use of external reporting service (Medica/Atlas) for batch reporting waiting over 10 weeks • Chest reporter training now moved to September 2017 by course provider. • Radiologist appointed to commence August 2017. • SpR reporting under WLI	20	4	4	16	8	Complete National Benchmarking and review parameters for reporting	30/06/2018
Business Group Risk	400	Sperring, Mrs Carol		Women Children and Diagnostics Business Group	Capacity V Demand Issues in Children's Therapies	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.	15	3	5	15	6	Capacity needed to meet demand LOCAL OFFER DEFINED FOR 2018	30/06/2018 31/08/2018

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

NHS Stockport NHS Foundation Trust

Report to:	Board of Directors	**Date:**	24 May 2018
Subject:	Compliance with NHS Foundation Trust Code of Governance		
Report of:	Director of Corporate Affairs	**Prepared by:**	P Buckingham

REPORT FOR APPROVAL

Corporate objective ref:	N/A	**Summary of Report** *Identify key facts, risks and implications associated with the report content.* The purpose of this report is to seek approval from the Board of Directors for compliance statements relating to the NHS Foundation Trust Code of Governance. NHS Foundation Trusts are required to provide a specific set of disclosures to meet the requirements of the NHS Foundation Trust Code of Governance which should be submitted as part of the Annual Report (as referenced in the NHS Foundation Trust Annual Reporting Manual).
Board Assurance Framework ref:	N/A	
CQC Registration Standards ref:	N/A	
Equality Impact Assessment:	☐ Completed X Not required	

Attachments:	Appendix 1 – Draft Code of Governance Disclosures

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

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1. INTRODUCTION

1.1 The purpose of this report is to seek approval from the Board of Directors for compliance statements relating to the NHS Foundation Trust Code of Governance.

2. BACKGROUND

2.1 The NHS Foundation Trust Code of Governance (the Code of Governance) was first published in 2006 and was most recently updated in July 2014. The purpose of the Code of Governance is to assist NHS Foundation Trust Boards in improving their governance practices by bringing together the best practice of public and private sector corporate governance. The Code is issued as best practice advice but imposes some disclosure requirements.

2.2 NHS Foundation Trusts are required to provide a specific set of disclosures to meet the requirements of the NHS Foundation Trust Code of Governance which should be submitted as part of the Annual Report (as referenced in the NHS Foundation Trust Annual Reporting Manual).

3. CURRENT SITUATION

3.1 During 2017/18 the Audit Committee has completed six-monthly reviews of the Trust's compliance position against Code of Governance requirements. The reviews were completed on 12 September 2017 and 20 March 2018 and no issues were identified as a result of these reviews. A review of the draft Compliance Statements, as part of consideration of the draft Annual Report, was also completed by the Audit Committee on 17 May 2018.

3.2 Schedule A to the Code of Governance details disclosure requirements and is divided into six categories as follows:

i) Statutory requirements of the Code of Governance. This supersedes the "comply or explain" requirements of the Code. There is no need to report on these provisions in the Code disclosure.

ii) Provisions which require a supporting explanation even in the case that the NHS Foundation Trust is compliant with the provision. Where the information is already contained within the Annual Report, a reference to its location is sufficient to avoid unnecessary duplication.

iii) Provisions which require supporting information to be made publicly available even in the case that the NHS Foundation Trust is compliant with the provision. This requirement can be met by making supporting information available on request and on the NHS Foundation Trust's website.

iv) Provisions which require supporting information to be made available to Governors, even where the NHS Foundation Trust is compliant with the provision.

v) Provisions which require supporting information to be made available to members of the Trust, even where the NHS Foundation Trust is compliant with the provision.

vi) Other provisions where there are no special requirements as per i) to v) above. For these provisions the basic comply or explain requirement stands. The disclosure should therefore contain an explanation in each case where the Trust has departed from the Code explaining the reasons for the departure and how the alternative arrangements continue to reflect the main principles of the Code.

3.3 A disclosure is only required for departures from the Code. Trusts are welcome, but not required, to provide a simple of statement of compliance with each individual provision. However, this is useful in ensuring that the disclosure is comprehensive and helps to ensure that each provision has been considered in turn. For purposes of completeness, the Trust has commented on each requirement as detailed at Appendix 1 to this report.

4. LEGAL IMPLICATIONS

4.1 There are no direct legal implications associated with the content of this report.

5. RECOMMENDATIONS

5.1 The Board of Directors is recommended to:

- Approve the Code of Governance disclosures as presented at Appendix 1.

NHS Foundation Trust Code of Governance

The NHS Foundation Trust Code of Governance (the Code of Governance) was first published in 2006 and was most recently updated in July 2014. The purpose of the Code of Governance is to assist NHS Foundation Trust Boards in improving their governance practices by bringing together the best practice of public and private sector corporate governance. The Code is issued as best practice advice but imposes some disclosure requirements. Stockport NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

NHS Foundation Trusts are required to provide a specific set of disclosures in their annual report to meet the requirements of the NHS Foundation Trust Code of Governance. Schedule A to the Code of Governance specifies everything that is required within these disclosures. Schedule A is divided into six categories and the disclosures being made by the Trust for each of these categories are detailed below.

Below are the statutory requirements that we have highlighted in the Code. This supersedes the "comply or explain" requirements of the Code. **However, there is no need to report on these provisions in the Code disclosure.** For the purpose of completeness, the Trust will comment upon each requirement.

Reference	Statutory requirement:
A.2.2	The roles of chairperson and chief executive must not be undertaken by the same individual. ***The Trust complies with this requirement.***
A.5.10	The council of governors has a statutory duty to hold the non-executive directors Individually and collectively to account for the performance of the board of directors. ***The Board of Directors and the Council of Governors comply with this requirement.***
A.5.11	The 2006 Act, as amended, gives the council of governors a statutory requirement to receive the following documents. These documents should be provided in the annual report as per the *NHS Foundation Trust Annual Reporting Manual*: (a) The annual accounts; (b) Any report of the auditor on them; and (c) The annual report. ***The Trust complies with this requirement.***

Reference	Statutory requirement:
A.5.12	The directors must provide governors with an agenda prior to any meeting of the board, and a copy of the approved minutes as soon as is practicable afterwards. There is no legal basis on which the minutes of private sessions of board meetings should be exempted from being shared with the governors. In practice, it may be necessary to redact some information, for example, for data protection or commercial reasons. Governors should respect the confidentiality of these documents. ***The Trust complies with this requirement.***
A.5.13	The council of governors may require one or more of the directors to attend a meeting to obtain information about performance of the trust's functions or the directors' performance of their duties, and to help the council of governors to decide whether to propose a vote on the trust's or directors' performance. ***The Trust is aware of this requirement. This situation did not arise during 2017/18.***
A.5.14	Governors have the right to refer a question to the independent panel for advising governors. More than 50% of governors who vote must approve this referral. The council should ensure dialogue with the board of directors takes place before considering such a referral, as it may be possible to resolve questions in this way. ***The Trust is aware of this requirement. This situation did not arise during 2017/18.***
A.5.15	Governors should use their new rights and voting powers from the 2012 Act to represent the interests of members and the public on major decisions taken by the board of directors. These are outlined in full at A.5.15. ***The Trust complies with this requirement.***
B.2.11	It is a requirement of the 2006 Act that the chairperson, the other non-executive directors and – except in the case of the appointment of a chief executive – the chief executive, are responsible for deciding the appointment of executive directors. The nominations committee with responsibility for executive director nominations should identify suitable candidates to fill executive director vacancies as they arise and make recommendations to the chairperson, the other non-executives directors and, except in the case of the appointment of a chief executive, the chief executive. ***The Trust complies with this requirement.***
B.2.12	It is for the non-executive directors to appoint and remove the chief executive. The appointment of a chief executive requires the approval of the council of governors. ***The Trust complies with this requirement.***
B.2.13	The governors are responsible at a general meeting for the appointment, re-appointment and removal of the chairperson and the other non-executive directors. ***The Trust complies with this requirement.***

Reference	Statutory requirement:
B.4.3	The board has a duty to take steps to ensure that governors are equipped with the skills and knowledge they need to discharge their duties appropriately. ***The Trust complies with this requirement.***
B.5.8	The board of directors must have regard for the views of the council of governors on the NHS foundation trust's forward plan. ***The Trust complies with this requirement.***
B.7.3	Approval by the council of governors of the appointment of a chief executive should be a subject of the first general meeting after the appointment by a committee of the chairperson and non-executive directors. All other executive directors should be appointed by a committee of the chief executive, the chairperson and non-executive directors. ***The Trust complies with this requirement.***
B.7.4	Non-executive directors, including the chairperson should be appointed by the council of governors for the specified terms subject to re-appointment thereafter at intervals of no more than three years and subject to the 2006 Act provisions relating to removal of a director. ***The Trust complies with this requirement.***
B.7.5	Elected governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. ***The Trust complies with this requirement.***
D.2.4	The council of governors is responsible for setting the remuneration of non-executive directors and the chairperson. ***The Trust complies with this requirement.***
E.1.7	The board of directors must make board meetings and the annual meeting open to the public. The trust's constitution may provide for members of the public to be excluded from a meeting for special reasons. ***The Trust complies with this requirement.***
E.1.8	The trust must hold annual members' meetings. At least one of the directors must present the trust's annual report and accounts, and any report of the auditor on the accounts, to members at this meeting. ***The Trust complies with this requirement.***

The provisions listed below require a supporting explanation, even in the case that the NHS foundation trust is compliant with the provision. **Where the information is already contained within the annual report, a reference to its location is sufficient to avoid unnecessary duplication.**

Reference	Statutory requirement:
A.1.1	The schedule of matters reserved for the Board of Directors should include a clear statement detailing the roles and responsibilities of the Council of Governors. This statement should also describe how any disagreements between the Council of Governors and the Board of Directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the Board of Directors and the Council of Governors operate, including a summary of the types of decisions to be taken by each of the Boards and which are delegated to the executive management of the Board of Directors. ***See Annual Report page 35 and page 46.***
A.1.2	The annual report should identify the chairperson, the deputy chairperson (where there is one), the chief executive, the senior independent director (see A.4.1) and the chairperson and members of the nominations, audit and remuneration committees. It should also set out the number of meetings of the board and those committees and individual attendance by directors. ***See Annual Report pages 36, 42, 46 and 57.***
A.5.3	The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor. ***See Annual Report page 48.***
FT ARM	The annual report should include a statement about the number of meetings of the council of governors and individual attendance by governors and directors. ***See Annual Report page 48.***
B.1.1	The board of directors should identify in the annual report each non-executive director it considers to be independent, with reasons where necessary. ***See Annual Report page 35.***
B.1.4	The board of directors should include in its annual report a description of each director's skills, expertise and experience. Alongside this, in the annual report, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS foundation trust. ***See Annual Report page 41.***
FT ARM	The annual report should include a brief description of the length of appointments of the non-executive directors and how they may be terminated. ***See Annual Report pages 36 and 46.***

Reference	Statutory requirement:
B.2.10	A separate section of the annual report should describe the work of the nominations committee(s), including the process it has used in relation to board appointments. ***See Annual Report page 45.***
FT ARM	The disclosure in the annual report on the work of the nominations committee should include an explanation if neither an external search consultancy nor open advertising has been used in the appointment of a chair or non-executive director. ***See Annual Report page 45.***
B.3.1	A chairperson's other significant commitments should be disclosed to the council of governors before appointment and included in the annual report. Changes to such commitments should be reported to the council of governors as they arise, and included in the next annual report. ***See Annual Report page 36.***
B.5.6	Governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied. ***See Annual Report page 47.***
FT ARM	If, during the financial year, the Governors have exercised their power under paragraph 10C of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report. ***See Annual Report page 47.***
B.6.1	The board of directors should state in the annual report how performance evaluation of the board, its committees, and its directors, including the chairperson, has been conducted. ***See Annual Report page 41.***
B.6.2	Where there has been external evaluation of the board and/or governance of the trust, the external facilitator should be identified in the annual report and a statement made as to whether they have any other connection to the trust. ***See Annual Report page 90.***

Reference	Statutory requirement:
C.1.1	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report). ***See Annual Report pages 44 and 93.***
C.2.1	The annual report should contain a statement that the board has conducted a review of the effectiveness of its system of internal controls. ***See Annual Governance Statement on page 93.***
C.2.2	A trust should disclose in the annual report: a) If it has an internal audit function, how the function is structured and what role it performs; or b) If it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes. ***See Annual Report page 43.***
C.3.5	If the council of governors does not accept the audit committee's recommendation on the appointment, reappointment or removal of an external auditor, the board of directors should include in the annual report a statement from the audit committee explaining the recommendation and should set out reasons why the council of governors has taken a different position. ***This situation did not arise during 2017/18.***
C.3.9	A separate section of the annual report should describe the work of the audit committee in discharging its responsibilities. The report should include: • the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed; • an explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and • if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded. ***See Annual Report page 42.***

Reference	Statutory requirement:
D.1.3	Where an NHS foundation trust releases an executive director, for example to serve as a non-executive director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings. ***This situation did not arise during 2017/18.***
E.1.5	The board of directors should state in the annual report the steps they have taken to ensure that the members of the board, and in particular the non- executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, for example through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations. ***See Annual Report page 47.***
E.1.6	The board of directors should monitor how representative the NHS foundation trust's membership is and the level and effectiveness of member engagement and report on this in the annual report. ***See Annual Report page 52.***
E.1.4	Contact procedures for members who wish to communicate with governors and/or directors should be made clearly available to members on the NHS foundation trust's website and in the annual report. ***See Annual Report page 49.***
FT ARM	The annual report should include: • A brief description of the eligibility requirements for joining different membership constituencies, including the boundaries for public membership; • Information on the number of members and the number of members in each constituency; and • A summary of the membership strategy, an assessment of the membership and a description of any steps taken during the year to ensure a representative membership including progress towards any recruitment targets for members. ***See Annual Report page 50.***
FT ARM	The annual report should disclose details of company directorships or other material interests in companies held by governors and/or directors where those companies or related parties are likely to do business with the NHS foundation trust. As each NHS foundation trust must have registers of governors' and directors' interests which are available to the public, an alternative disclosure is for the annual report to simply state how members of the public can gain access to the registers instead of listing all the interests in the annual report. ***See Annual Report pages 41 and 49.***

'FT ARM' indicates that the disclosure is required by the NHS Foundation Trust Annual Reporting Manual rather than the Code of Governance.

The provisions listed below require supporting information to be made publicly available even in the case that the NHS foundation trust is compliant with the provision. This requirement can be met by making supporting information available on request and on the NHS foundation trust's website.

The information detailed below is available on request from the Director of Corporate Affairs.

Reference	Statutory requirement:
A.1.3	The board of directors should make available a statement of the objectives of the NHS foundation trust showing how it intends to balance the interests of patients, the local community and other stakeholders, and use this as the basis for its decision-making and forward planning.
B.1.4	A description of each director's expertise and experience, with a clear statement about the board of director's balance, completeness and appropriateness.
B.2.10	The main role and responsibilities of the nominations committee should be set out in publicly available, written terms of reference.
B.3.2	The terms and conditions of appointment of non-executive directors.
C.3.2	The main role and responsibilities of the audit committee should be set out in publicly available, written terms of reference.
D.2.1	The remuneration committee should make available its terms of reference, explaining its role and the authority delegated to it by the board of directors. Where remuneration consultants are appointed, a statement should be made available as to whether they have any other connection with the NHS foundation trust.
E.1.1	The board of directors should make available a public document that sets out its policy on the involvement of members, patients and the local community at large, including a description of the kind of issues it will consult on.
E.1.4	Contact procedures for members who wish to communicate with governors and/or directors should be made clearly available to members on the NHS foundation trust's website.

The provisions listed below require supporting information to be made available to governors, even in the case that the NHS foundation trust is compliant with the provision. This information should be set out in papers accompanying a resolution to re-appoint a non-executive director.

Reference	Statutory requirement:
B.7.1	In the case of re-appointment of non-executive directors, the chairperson should confirm to the governors that following formal performance evaluation, the performance of the individual proposed for re-appointment continues to be effective and to demonstrate commitment to the role.

There were two instances of Non-Executive Directors seeking re-appointment during 2017/18. Relevant information was provided to the Council of Governors by the Chair in relation to the re-appointment of Mr J Sandford, with effect from 1 July 2017, and Mr M Sugden, with effect from 1 April 2018.

The provisions listed below require supporting information to be made available to members, even in the case that the NHS foundation trust is compliant with the provision. This information should be set out in papers accompanying a resolution to elect or re-elect a governor.

Reference	Statutory requirement:
B.7.2	The names of governors submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to take an informed decision on their election. This should include prior performance information.

This information is included within the election material circulated to members by Electoral Reform Services who managed governor elections on behalf of the Trust in 2017/18.

For all provisions listed below there are no special requirements as per 1-5 above. For these provisions, the basic "comply or explain" requirement stands. The disclosure should therefore contain **an explanation in each case where the trust has departed from the Code, explaining the reasons for the departure and how the alternative arrangements continue to reflect the main principles of the Code.**

A disclosure is only required for **departures** from the Code for the provisions listed in this section. NHS foundation trusts are welcome but not required to provide a simple statement of compliance with each individual provision. This may be useful in ensuring the disclosure is comprehensive and may help to ensure that each provision has been considered in turn.

In providing an explanation for any variation from the *NHS Foundation Trust Code of Governance,* the NHS foundation trust should aim to illustrate how its actual practices are consistent with the principle to which the particular provision relates. It should set out the background, provide a clear rationale, and describe any mitigating actions it is taking to address any risks and maintain conformity with the relevant principle. Where deviation from a particular provision is intended to be limited in time, the explanation should indicate when the NHS foundation trust expects to conform to the provision.

The table below provides a summary of the provisions – the full provisions as listed in the document should be used for reference. In this summary '"the board" refers to the board of directors, "the council" to the council of governors, and "trust" refers to the NHS foundation trust.

Provision	Summary:

Provision	Summary:
A.1.4	The board should ensure that adequate systems and processes are maintained to measure and monitor the NHS foundation trust's effectiveness, efficiency and economy as well as the quality of its health care delivery ***The Trust is declaring compliance.***
A.1.5	The board should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and delivery of performance ***The Trust is declaring compliance.***
A.1.6	The board should report on its approach to clinical governance. ***The Trust is declaring compliance.***
A.1.7	The chief executive as the accounting officer should follow the procedure set out by Monitor for advising the board and the council and for recording and submitting objections to decisions. ***The Trust is declaring compliance.***
A.1.8	The board should establish the constitution and standards of conduct for the NHS foundation trust and its staff in accordance with NHS values and accepted standards of behaviour in public life. ***The Trust is declaring compliance.***
A.1.9	The board should operate a code of conduct that builds on the values of the NHS foundation trust and reflect high standards of probity and responsibility. ***The Trust is declaring compliance.***
A.1.10	The NHS foundation trust should arrange appropriate insurance to cover the risk of legal action against its directors. ***The Trust is declaring compliance.***
A.3.1	The chairperson should, on appointment by the council, meet the independence criteria set out in B.1.1. A chief executive should not go on to be the chairperson of the same NHS foundation trust. ***The Trust is declaring compliance.***
A.4.1	In consultation with the council, the board should appoint one of the independent non-executive directors to be the senior independent director. ***The Trust is declaring compliance.***
A.4.2	The chairperson should hold meetings with the non-executive directors without the executives present. ***The Trust is declaring compliance.***

Provision	Summary:
A.4.3	Where directors have concerns that cannot be resolved about the running of the NHS foundation trust or a proposed action, they should ensure that their concerns are recorded in the board minutes. ***The Trust is declaring compliance.***
A.5.1	The council of governors should meet sufficiently regularly to discharge its duties. ***The Trust is declaring compliance.***
A.5.2	The council of governors should not be so large as to be unwieldy. ***The Trust is declaring compliance.***
A.5.4	The roles and responsibilities of the council of governors should be set out in a written document. ***The Trust is declaring compliance.***
A.5.5	The chairperson is responsible for leadership of both the board and the council but the governors also have a responsibility to make the arrangements work and should take the lead in inviting the chief executive to their meetings and inviting attendance by other executives and non-executives, as appropriate. ***The Trust is declaring compliance.***
A.5.6	The council should establish a policy for engagement with the board of directors for those circumstances when they have concerns. ***The Trust is declaring compliance.***
A.5.7	The council should ensure its interaction and relationship with the board of directors is appropriate and effective. ***The Trust is declaring compliance.***
A.5.8	The council should only exercise its power to remove the chairperson or any non-executive directors after exhausting all means of engagement with the board. ***The Trust is declaring compliance.***
A.5.9	The council should receive and consider other appropriate information required to enable it to discharge its duties. ***The Trust is declaring compliance.***
B.1.2	At least half the board, excluding the chairperson, should comprise non-executive directors determined by the board to be independent. ***The Trust is declaring compliance.***
B.1.3	No individual should hold, at the same time, positions of director and governor of any NHS foundation trust. ***The Trust is declaring compliance.***

Provision	Summary:
B.2.1	The nominations committee or committees, with external advice as appropriate, are responsible for the identification and nomination of executive and non- executive directors. ***The Trust is declaring compliance.***
B.2.2	Directors on the board of directors and governors on the council should meet the "fit and proper" persons test described in the provider licence. ***The Trust is declaring compliance.***
B.2.3	The nominations committee(s) should regularly review the structure, size and composition of the board and make recommendations for changes where appropriate. ***The Trust is declaring compliance.***
B.2.4	The chairperson or an independent non-executive director should chair the Nominations committee(s). ***The Trust is declaring compliance.***
B.2.5	The governors should agree with the nominations committee a clear process for the nomination of a new chairperson and non-executive directors. ***The Trust is declaring compliance.***
B.2.6	Where an NHS foundation trust has two nominations committees, the nominations committee responsible for the appointment of non-executive directors should consist of a majority of governors. ***The Trust is declaring compliance.***
B.2.7	When considering the appointment of non-executive directors, the council should take into account the views of the board and the nominations committee on the qualifications, skills and experience required for each position. ***The Trust is declaring compliance.***
B.2.8	The annual report should describe the process followed by the council in relation to appointments of the chairperson and non-executive directors. ***The Trust is declaring compliance.***
B.2.9	An independent external adviser should not be a member of or have a vote on the nominations committee(s). ***The Trust is declaring compliance.***
B.3.3	The board should not agree to a full-time executive director taking on more than one non-executive directorship of an NHS foundation trust or another organisation of comparable size and complexity. ***The Trust is declaring compliance.***

Provision	Summary:
B.5.1	The board and the council of governors should be provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make. ***The Trust is declaring compliance.***
B.5.2	The board and in particular non-executive directors, may reasonably wish to challenge assurances received from the executive management. They need not seek to appoint a relevant adviser for each and every subject area that comes before the board, although they should, wherever possible, ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis. ***The Trust is declaring compliance.***
B.5.3	The board should ensure that directors, especially non-executive directors, have access to independent professional advice, at the NHS foundation trust's expense, where they judge it necessary to discharge their responsibilities as directors. ***The Trust is declaring compliance.***
B.5.4	Committees should be provided with sufficient resources to undertake their duties. ***The Trust is declaring compliance.***
B.6.3	The senior independent director should lead the performance evaluation of the chairperson. ***The Trust is declaring compliance.***
B.6.4	The chairperson, with assistance of the board secretary, if applicable, should use the performance evaluations as the basis for determining individual and collective professional development programmes for non-executive directors relevant to their duties as board members. ***The Trust is declaring compliance.***
B.6.5	Led by the chairperson, the council should periodically assess their collective performance and they should regularly communicate to members and the public details on how they have discharged their responsibilities. ***The Trust is declaring compliance.***
B.6.6	There should be a clear policy and a fair process, agreed and adopted by the council, for the removal from the council of any governor who consistently and unjustifiably fails to attend the meetings of the council or has an actual or potential conflict of interest which prevents the proper exercise of their duties. ***The Trust is declaring compliance.***

Provision	Summary:
B.8.1	The remuneration committee should not agree to an executive member of the board leaving the employment of an NHS foundation trust, except in accordance with the terms of their contract of employment, including but not limited to service of their full notice period and/or material reductions in their time commitment to the role, without the board first having completed and approved a full risk assessment. ***The Trust is declaring compliance.***
C.1.2	The directors should report that the NHS foundation trust is a going concern with supporting assumptions or qualifications as necessary. ***The Trust is declaring compliance.***
C.1.3	At least annually and in a timely manner, the board should set out clearly its financial, quality and operating objectives for the NHS foundation trust and disclose sufficient information, both quantitative and qualitative, of the NHS foundation trust's business and operation, including clinical outcome data, to allow members and governors to evaluate its performance. ***The Trust is declaring compliance.***
C.1.4	a) The board of directors must notify Monitor and the council of governors without delay and should consider whether it is in the public's interest to bring to the public attention, any major new developments in the NHS foundation trust's sphere of activity which are not public knowledge, which it is able to disclose and which may lead by virtue of their effect on its assets and liabilities, or financial position or on the general course of its business, to a substantial change to the financial wellbeing, health care delivery performance or reputation and standing of the NHS foundation trust. b) The board of directors must notify Monitor and the council of governors without delay and should consider whether it is in the public interest to bring to public attention all relevant information which is not public knowledge concerning a material change in: i. The NHS foundation trust's financial condition; ii. The performance of its business; and/or iii. The NHS foundation trust's expectations as to its performance which, if made public, would be likely to lead to a substantial change to the financial wellbeing, health care delivery performance or reputation and standing of the NHS foundation trust. ***The Trust is declaring compliance.***
C.3.1	The board should establish an audit committee composed of at least three members who are all independent non-executive directors. ***The Trust is declaring compliance.***
C.3.3	The council should take the lead in agreeing with the audit committee the criteria for appointing, re-appointing and removing external auditors. ***The Trust is declaring compliance.***

Provision	Summary:
C.3.6	The NHS foundation trust should appoint an external auditor for a period of time which allows the auditor to develop a strong understanding of the finances, operations and forward plans of the NHS foundation trust. ***The Trust is declaring compliance.***
C.3.7	When the council ends an external auditor's appointment in disputed circumstances, the chairperson should write to Monitor informing it of the reasons behind the decision. ***The Trust is declaring compliance.***
C.3.8	The audit committee should review arrangements that allow staff of the NHS foundation trust and other individuals where relevant, to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. ***The Trust is declaring compliance.***
D.1.1	Any performance-related elements of the remuneration of executive directors should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels. ***The Trust did not have a performance-related element of remuneration for Executive Directors during 2017/18.***
D.1.2	Levels of remuneration for the chairperson and other non-executive directors should reflect the time commitment and responsibilities of their roles. ***The Trust is declaring compliance.***
D.1.4	The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointments would give rise to in the event of early termination. ***The Trust is declaring compliance.***
D.2.2	The remuneration committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments. ***The Trust is declaring compliance.***
D.2.3	The council should consult external professional advisers to market-test the remuneration levels of the chairperson and other non-executives at least once every three years and when they intend to make a material change to the remuneration of a non-executive. ***The Trust is declaring compliance.***

Provision	Summary:
E.1.2	The board should clarify in writing how the public interests of patients and the local community will be represented, including its approach for addressing the overlap and interface between governors and any local consultative forums. ***The Trust is declaring compliance.***
E.1.3	The chairperson should ensure that the views of governors and members are communicated to the board as a whole. ***The Trust is declaring compliance.***
E.2.1	The board should be clear as to the specific third party bodies in relation to which the NHS foundation trust has a duty to co-operate. ***The Trust is declaring compliance.***
E.2.2	The board should ensure that effective mechanisms are in place to co-operate with relevant third party bodies and that collaborative and productive relationships are maintained with relevant stakeholders at appropriate levels of seniority in each. ***The Trust is declaring compliance.***