NHS
Stockport
NHS Foundation Trust

BOARD OF DIRECTORS

PUBLIC MEETING

27 JUNE 2019

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NHS Stockport NHS Foundation Trust

Board of Directors Meeting
Thursday, 27 June 2019

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		**A Belton**
0935	**4.**	Patient Story		**H Mullen**
0950	**5.**	Minutes of Previous Meeting: 28 May 2019	✓	**A Belton**
0955	**6.**	Chair's Report	✓	**A Belton**
1000	**7.**	Chief Executive's Report	✓	**L Robson**
	8.	**FOR ASSURANCE**		
1010	8.1	Performance Report	✓	**H Mullen**
1040	8.2	Key Issues Reports from Assurance Committees • Quality Committee • Finance & Performance Committee • People Performance Committee	✓	**Committee Chairs**
1050	8.3	Inpatient Survey Results (Presentation)		**A Lynch**
1105	8.4	Mortality Indicators	✓	**C Wasson**
1115	8.5	Fit & Proper Persons Report	✓	**G Moores**
	9.	**FOR DECISION / APPROVAL**		
1125	9.1	7 Day Services	✓	**C Wasson**
	10.	**FOR NOTING**		
1135	10.1	Primary Care Networks – Update on the Impact on Community Services	✓	**S Toal / M Malkin**
	11.	**CONSENT AGENDA**		
1145	11.1	Governance Declarations	✓	**C Parnell**
	12.	**DATE, TIME & VENUE OF NEXT MEETING**		
	12.1	Wednesday, 31 July 2019, 9.30am in Lecture Theatre A, Pinewood House, Stepping Hill Hospital.		

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STOCKPORT NHS FOUNDATION TRUST

Minutes of a meeting of the Board of Directors held in public
Tuesday, 28 May 2019
14.30am in Lecture Theatre B, Pinewood House, Stepping Hill Hospital

Present:

Mr M Sugden	Chair
Mrs C Anderson	Non-Executive Director
Mrs C Barber-Brown	Non-Executive Director
Ms H Brearley	Interim Director of Workforce and Organisation Development
Dr M Cheshire	Non-Executive Director
Mr J Graham	Director of Finance
Mr D Hopewell	Non-Executive Director
Ms A Lynch	Chief Nurse & Director of Quality Governance
Mr H Mullen	Director of Strategy, Planning & Partnerships
Mrs C Parnell	Director of Corporate Affairs
Mr F Patel	Director of Finance
Mrs L Robson	Chief Executive
Ms A Smith	Non-Executive Director
Ms S Toal	Chief Operating Officer
Dr C Wasson	Medical Director

In attendance:

Mr P Gordon	Freedom to Speak up Guardian
Mrs S Hyde	Head of Midwifery and Women's Health
Mrs S Katema	Committee Secretary
Mrs E Rogers	Matron for Patient Experience
Mrs P O'Sullivan	Senior Sister / Ward Manager

ACTION

134/19 Apologies for Absence

The Board noted apologies for absence from Mr A Belton.

135/19 Declarations of Interests

There were no declarations in relation to the agenda items.

136/19 Opening Remarks by the Chair

The Chair welcomed all Board members and observers to the meeting.

137/19 Staff Story

Mrs Rogers and Mrs O'Sullivan joined the meeting.

Dr Wasson introduced Mrs Rogers and Mrs O'Sullivan and advised that the patient story for the meeting focussed on dementia. The story showcased the collaborative work between the Trust and families of patients living with the condition. Dr Wasson informed the Board that the local Acute Frailty programme had been launched in the previous week. He highlighted that the increase in

referrals for dementia was linked to the discussions on frailty and patients with significant co-morbidities, which made their physiological reserve less than other patients.

Mrs Rogers presented the patient story about Barbara, who has Alzheimer's Dementia and had been admitted with a chest infection. Her quality of life was deteriorating and she suffered from lack of sleep which made her restless and agitated. The team sought ways to reduce the agitation and encourage Barbara to sleep. This early recognition by the team members enabled the Matron for Dementia to review medication and look into de-escalation therapy, which altered the discharge pathway for Barbara.

Mrs Rogers drew attention to the "This is me" leaflet which was produced by the Royal College of Nursing and the Alzheimer's Society. The Board also viewed a training video which showcased that "Dementia is everyone's business" and that everyone should "Keep the person at the heart of all we do".

The Board heard from Barbara's husband, Carlos, who acknowledged the intervention by staff in adapting the ward to suit Barbara's needs had made a difference and helped to improve her quality of life.

Mrs O'Sullivan acknowledged that whilst the cost of delivering 1:1 care was quite prohibitive, this could help the patient recover better.

Mrs O'Sullivan advised that the team had trialled different strategies including dressing for work at set times and putting on pyjamas for bed with a view to bringing routine and normality to the patient's day. Getting to know Barbara's likes and dislikes before the onset of Alzheimer's Disease enabled the ward team to develop activities to meet her needs and preferences.

Mrs O'Sullivan advised that the care given to Barbara was an example of the care given to every patient. She added that as a result of the person centred care; a very cheerful Barbara had been successfully discharged to a care home and was still dancing and listening to her record collection.

Dr Wasson thanked Mrs O'Sullivan and Mrs Rogers for presenting the patient story. He stated that the passion portrayed in the presentation was a trait that was shared by many of the staff. He applauded the professionalism with which patients were cared for and commended Mrs O'Sullivan for being a credit to the organisation.

Mr Sugden echoed Dr Wasson's comments and on behalf of the Board, formally thanked Mrs O'Sullivan and her team for the outstanding work in the delivery of care.

Mrs O'Sullivan and Mrs E Rogers left the meeting.

The Board of Directors:

- Noted the Patient Story.

138/19 Minutes of the previous meeting

The minutes of the previous meeting held on 25 April 2019 were agreed as a true

and accurate record of proceedings subject to amending minute ref 88/19 to reflect that "staff came from annual leave."

The action log was reviewed and annotated accordingly.

139/19 Chair's Report

Mr Sugden presented report which detailed the Chair's activities since the previous meeting. He advised that this would be the final Board of Directors meeting for both, Mr Feroz Patel and Ms Hilary Brearley. On behalf of the Board, he thanked them for their contribution to the Trust, and wished them well for the future as they took on new challenges away from Stockport.

The Board of Directors:

- Received and noted the Chair's Report.

140/19 Report of the Chief Executive

Mrs Robson presented her report to the Board which outlined national and local, strategic and operational developments. She highlighted that the Trust, along with partners in the local Clinical Commissioning Groups, had reached the difficult decision to temporarily suspend all new referrals to the Breast Service. Mrs Robson reassured the Board that all newly referred patients were being transferred to Manchester, East Cheshire and Tameside NHS Foundation Trusts to ensure they continued to receive safe and timely care.

Mrs Robson advised that the issues relating to workforce pressures and increasing demand were not unique to the Trust but highlighted the importance of partnership working with system partners and progressing the development of sustainable models of care. She added that it was expected that national workstreams such as the NHS People Plan led by Dido Harding (Chair of NHS Improvement) would highlight and address the workforce challenges faced by the Trust and other providers nationally. Of note, was that key themes from the NHS People Plan were aligned with the Trust People plan.

Mrs Robson drew attention to the following key issues:

- Leadership 360 degree evaluation feedback was considered at the Board development day was an important step in creating an open and learning culture with the Trust workforce and partners.
- The Trust would be launching culture champions and these were colleagues from anywhere within the Trust who were keen to take the Trust forward.
- A lot of work had been done with partners to review and evaluate performance during Easter following sustained pressure throughout the Easter period and into the May bank holidays period. The Trust had come close to Operational Pressure Escalation Level (OPEL) 4 and had required diversion of resources.
- The Frailty Network had been launched the previous week and was aimed at improving care and support for this group of patients who often came to the hospital through the Emergency Department.

There had been a number of inspection visits by outside agencies to Trust services, including a visit by the Health and Safety Executive to pathology,

which resulted in some for remedial work to the estate.

The Board of Directors:

- Received and noted the Report of the Chief Executive.

141/19 Performance Report – Month 1

Mr Mullen presented the Trust Performance Report for Month 1 which provided a summary of performance against key performance indicators. He informed the Board that the IPR had been refreshed to a new format for the financial year.

Chief Operating Officer

Ms Toal outlined the key issues and performance against indicators for April 2019. She advised that new indicators had been added and would map progress against NHSI trajectories:

- The Trust did not achieve the 1% Diagnostic standard in month due to capacity within Echocardiography; however, a small number of breaches occurred due to two CT scanners breaking down and the service having to prioritise. Impacting on outpatient activity.
- Cancer 62 day performance improved in month. It was expected that May performance would not be maintained at the same level and would be more in line with the improvement trajectory.
- Clinical correspondence performance in April did not reflect the significant length of wait for letters to be typed. As a result of outsourcing, the longest length of wait had reduced to 14 days.
- The number of stranded patients was 289, with 134 being classed as super stranded.
- Good progress was noted regarding the number of overnight breaches on Medical wards.

Medical Director

Dr Wasson presented the update in relation to the below indicators:

- ED performance in April was very challenging following a mild end to winter.
- Timely identification and treatment of Sepsis was a new indicator that was being tracked from April.
- The number of medication errors had decreased for the seventh consecutive month.
- There was good improvement in performance of the Discharge summaries. However, the challenge remained with the short stay / high turnover areas, which remained the subject of considerable focus.
- 18 STEIS reportable incidents of which 10 related to pressure ulcers, one related to an alleged assault and one related to delayed diagnosis.
- Mortality - Specialist Palliative Care length of stay was a new indicator which included specialist palliative patients who died in hospital only. Dr Wasson highlighted that there was a need to change the default of the patient dying in hospital, as well as giving consideration to how the Trust can meet people's needs when they die at home or in a hospital.

Mr Sugden welcomed the inclusion of the Sepsis indicator reflecting that the number seemed low in terms of the Trust's own target. Dr Wasson responded

that the Sepsis Steering Group was looking into the trajectories and aligning them to the national standard. Ms Lynch added that the target was for 80% compliance with Sepsis by the end of the year.

Chief Nurse and Director of Quality Governance

Ms Lynch provided an update on the following Quality and Safety indicators:

- Three C.Diff infection cases were recorded in March 2019. Ms Lynch reminded the Board that following the increase in the number of cases over the last few months, the Trust was receiving support as part of the NHSI CDiff collaboration. There had been a reduction in incidents where lapses in care had occurred, with further work being undertaken as part of the Quality Improvement Priorities.
- One fall was recorded in month, which caused moderate harm
- Two maternity indicators had been introduced - Emergency C-section rates and Term babies admitted to the Neonatal Unit at 37 weeks or more.
- The number of inpatients with a learning disability who have a reasonable adjustment care plan in place, as a percentage of all patients with a learning disability. 78.9% of patients which was equal to 14 patients have to be in place within six hours.
- 4 cases were recorded and a review of themes was underway for the new metric 52week Referral to Treatment

Director of Finance

Mr Patel advised that the financial position for the month of April was in line with plan; the Trust had delivered a deficit against the NHSI control total of £2.7m as planned. He advised that the Trust was on plan with elective activity and was £0.3m favourable to the profiled CIP plan to date. However, this had been delivered through a non-recurrent vacancy factor and there was a significant risk to the delivery of the total CIP programme in 2019/20.

Mr Patel advised that at month 1 the Trust had identified £8.3m of schemes and was working to identify schemes in order to bridge the £5.9m gap. A total of £1.7m of CIP had been delivered against the £14.2m in year target.

Mr Sugden observed that there was no reference to the recurrent saving given that month 1 had been delivered to recurrent activity. Mr Patel responded that this had been impacted by the delays to the actual setting up of the budget and the project had developed without funding. He added that the next two weeks would be spent reviewing the project and the QIA element from NHSI.

Mrs Barber-Brown commented that there was a need for more CQUIN reporting to enable Quality Improvement tracking. Ms Lynch commented that she had raised the issue of including CQUIN in the quarterly report with Jo Pemrick (Business Performance Manager).

Director of Workforce and Organisational Development

Ms Brearley presented the report and outlined that the total spent on bank and agency costs for April 2019 decreased from the reported position of £3.12m to £1.3m in March 2019. Actions to address areas of shortage supply were

continuing within Business Groups, alongside the continuing oversight and scrutiny arrangements. She reassured the Board that there were great results from a number of recruitment methods in the Trust.

Ms Brearley advised that the Workforce Turnover was one of the most predictable indicators, adding that there was a 13.7% increase in April from 13.3% recorded from January to March. She highlighted that the top leaving reasons included work-life balance, relocation, and retirement.

Ms Brearley drew attention to the following key points:

- There was a 1.23% increase since the previous quarter in staff recommending the Trust as a place to work. She added that this correlated with the response from the Staff Survey.
- There was a slight decrease of 0.19% from 91.73% recorded the previous month for the staff in post indicator.

Ms Lynch observed that the Staffing report had been published but had not been included on the Integrated Performance Report. She highlighted the staffing report was already publicly available and agreed to share with Board members after the meeting.

Mr Sugden thanked the executive directors for delivering the reports and welcomed the new format of the IPR which enabled better performance monitoring.

The Board of Directors:

- Received and noted the Integrated Performance Reports.

142/19 Key Issues Reports from Assurance Committees

With permission from the chair, all Key Issues Reports were tabled.
The Chair invited Committee Chairs to raise any key issues that had not been covered during consideration of the Performance Report.

Quality Committee

Dr Cheshire advised that the Quality Committee had identified a risk regarding the Memorandum of Understanding (MOU) between the Trust and Pennine Care. Ms Lynch advised that although the MOU was in place, further clarity was required in relation to ED provision. The Chief Nurse advised that discussions continue to help resolve the issue and a meeting was set up in the next few weeks.

Dr Cheshire advised that the Trust had not achieved the Joint Advisory Group (JAG) of Endoscopy Annual Review Accreditation. However, the Committee received positive assurance that there was an action plan in place to address the issues.

Finance and Performance Committee

Mr Sugden informed the Board that the Finance and Performance Committee had reviewed and recommended a number of business cases for approval by the Board. It was expected that one of the business cases would address the challenges currently faced by the Trust in relation to the provision of CT scanning

services. Mr Sugden advised that Committee had flagged the risk to the delivery of the CIP Programme for 2019/20.

Mr Mullen advised that due to commercial sensitivity regarding the nature of the business cases, the CT and Endoscopy, as well as the Unified Communications business cases had been approved during the Private session of the Board of Director's meeting.

Mr Patel notified the Board that the Committee had also made recommendations regarding commercial contracts and these had been discussed and approved in the private session of the Board of Director's meeting.

People Performance Committee

Mrs Barber-Brown advised that the Committee had received the reports from the Freedom to Speak up Guardian and the Guardian of Safe Working report. The latter had been delivered by Dr S Rendell, the Guardian of Safe Working and summarised progress made during the year. The Committee had noted the request to encourage the engagement of Educational and Clinical Supervisors and to reinforce the approach of timely actions in response to exception reports.

Mrs Barber-Brown highlighted that the Committee noted the progress of the action plan following the Medical Engagement Scale (MES) Survey and was assured by the ongoing work to address the areas of concern and the implementation of the action plan developed in response to the report. She added that it was good to see the actions underway to address the issues.

Ms Brearley informed the Board that Ms S Nadeem, Equality, Diversity and Inclusion Lead would be leaving the Trust. The Board formally thanked Ms Nadeem for her contribution and offered their best wishes for the future.

The Board of Directors:

- Received and noted the Key Issues Reports from its sub-committees.
- Noted the Approval of the CT, Endoscopy and Unified Communications business cases.

143/19 Year 2 Quality Improvement Plan 2018-20

Ms Lynch presented the Quality Improvement Plan advising that it had been refreshed to reflect the changes in the Trust as it continued on its improvement journey. She advised that there had been input from the Council of Governors regarding setting QIP targets.

Ms Lynch informed the Board that notable quality improvements included the development of the Trust's Quality Faculty with an emerging infrastructure that supported the quality improvements across the Trust. It was noted that the Quality Faculty would encourage sharing of best practice, improvement methods and approaches as widely as possible through the systems.

The Board:

- Received and approved the Year 2 Quality Improvement Plan 2018-20

144/19 Maternity Safety Champion Update

Mrs Hyde joined the meeting.

Mrs Lynch introduced Ms Hyde who had been newly appointed to the Trust. She advised that Mrs Hyde would be producing regular updates in relation to Clinical Negligence Scheme for Trusts Incentive Scheme (CNST) Maternity, which would be presented quarterly to Board.

Mrs Hyde informed the Board that the report clarified the Trust's position as of Q4 2018 in relation to the attainment of the ten defined maternity safety actions. The Trust can report full compliance with the evidential requirements of six (60%) of the ten required maternity safety actions as of Q4 2018.

The Board briefly discussed Maternity Safety Action 4 regarding the demonstration of an effective system of medical workforce planning to the required standard. It was noted that although the Trust was partially compliant, further work would be required prior to the deadline of June 2019. Mrs Hyde advised that the lack of a dedicated team meant that the Trust was not compliant with the ACSA Standard regarding Elective C-Section lists and dedicated theatre staff.

Mrs Hyde left the meeting.

The Board of Directors:

- Received and noted the Maternity Safety Champion Update

145/19 Freedom to Speak up Annual Report

Mr Gordon joined the meeting.

Mr Gordon presented the FTSU Annual Report, which sought to provide the Board with an update on Trust progress in the development of the FTSU agenda as well as providing assurance on the approach and activities of the FTSU Guardian.

Mr Gordon highlighted that between April 2018 and March 2019, a total of 22 concerns had been raised by 32 individuals. He added that when benchmarked against trusts of a similar size, the number of concerns handled by the FTSUG was lower. It was noted that there were no underlying themes with regards to a professional group, location, or the nature of the concerns raised.

Mr Gordon drew attention to the 25 concerns that were closed between April 2018 and March 2019. He provided detail in relation to how the concerns were resolved and the office that the concerns were escalated to.

Mr Gordon highlighted that further to the Board receiving the self-review tool in October 2018, some dimensions had been partly RAG rated. He advised that he had raised concerns regarding progress with Dr Cheshire and at People Performance Committee.

The Board discussed the report and noted that the Trust's Culture Plan was

aligned with the FTSUG's role. It was noted that FTSUG governance was in line with the National Guardian Office recommendations.

The Board of Directors:

- Received and noted the

146/19 Governance Declarations

Mrs Parnell presented the report advising 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 could not be made.

The Board of Directors:

- Received and noted the Governance Declaration report
- Agreed appropriate declarations against General Condition 6 and Continuity of Services Condition 7.

147/19 Non-Executive Director Declarations of Independence

Mrs Parnell presented the report which sought to facilitate a decision by the Board of Directors relating to the independence of Non-Executive Directors.

The Board of Directors:

- Confirmed the independence of the Chair and that of all Non-Executive Directors.

148/19 Audit Committee Annual Report

Mr Hopewell presented the Audit Committee Annual Effectiveness Report for the period from April 2018 to March 2019. The report outlined how the Committee fulfilled its responsibilities and duties regarding effective assurance on matters relating to monitoring and reviewing financial and other risks and associated controls, corporate governance and financial assurance.

The Board of Directors:

- Received and noted the Audit Committee Annual Report.

149/19 Closing remarks and feedback

In his closing remarks, the Chair informed the Board that this would be Mr Patel last Board of Director's meeting. He advised that as the longest serving executive on the Trust Board, Mr Patel had put a stamp on Finance and was well regarded by his peers within the Trust, as well as with external stakeholders including GM

and the CCGs.

Mr Sugden also informed the Board that this would be Ms Brearley's last Board of Director's meeting. He advised that since joining the Trust, Ms Brearley had shaped the agenda and this was showcased by the development of the People Strategy. Mr Sugden added that the impact of her work was evident across the organisation and that she had been a fantastic colleague.

The Board formally thanked both Mr Patel and Ms Brearley for their contributions to the Trust and wished them the very best of luck for the future.

In feedback from members of the public in attendance, a comment was raised in relation to the cancer screening referrals. It was noted that social media could be used to convey messages and reach a wider audience.

149/19 Date, time and venue of next meeting

There being no further business, the Chair thanked all for attending and brought the meeting to a close at 16.25.

Mr Sugden advised that the next public meeting of the Board of Directors would be held on Thursday, 27 June 2019, 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
37/18	29 Nov 18	280/18	Medium Term Financial Strategy	The Board approved the Medium Term Financial Strategy and agreed that the Strategy would be reviewed in March 2019. **Update 28 Mar 2019:** The action would be put on hold until the incoming Director of Finance is in a positon to review. An update to be provided at the June meeting.	Mr F Patel (Director of Finance)
01/19	31 Jan 19	09/19	Trust Performance Report – Month 9	In response to a comment from the Chair, it was agreed that Urgent & Emergency Care system resilience should be incorporated in the Winter Plan review in April 2019. **Update 28 Mar 2019:** This would be reviewed at the April Board meeting. **Update 29 May 2019 –** Ms Toal advised that this would come through in the next meeting.	S Toal (Chief Operating Officer)
03/19	31 Jan 19	18/19	Charitable Funds Annual Accounts and Report 2017/18	Mr D Hopewell commented that further work was required to review the Trust's fundraising activity and ensure optimum use of charitable funds. In response to a question from the Chair, Mr D Hopewell noted that the review of charitable funds arrangements was currently underway and advised that outcomes would be considered by the Charitable Funds Committee prior to presentation to the Board of Directors on 28 May 2019. **Update 28 Mar 2019:** Action carried forward. **Update 29 May 2019:** This action was completed in the Corporate Trustee meeting. **Action Closed**.	F Patel (Director of Finance)
04/19	28 Feb 19	30/19	Quality Committee Key Issues Report	In response to comments from a number of Board members, who endorsed and commended the safety collaborative method, it was agreed to invite the Matron of Tissue Viability to deliver the Pressure Ulcer presentation at a future Board meeting.	A Lynch (Chief Nurse)

				Update 28 Mar 2019: Action carried forward. **Update 25 April 2019:** The action was ongoing with the expectation that this would be presented as a patient story in September. **Update 27 June 2019**: Action in date and progressing	
05/19	28 Mar 19	54/19	Performance Report – Month 11	The Chief Nurse to provide report in July highlighting the implications and a gap analysis following publication of the National Patient Safety Strategy. **Update 27 June 2019**: Action in date and progressing	Ms Lynch (Chief Nurse)
06/19	28 Mar 19	54/19	Performance Report – Month 11	The Chief Operating Officer to facilitate a Winter Evaluation Workshop. **Update 25 April 2019**: Ms Toal to confirm date for Workshop for Board. **Update 27 June 2019**:	Ms Toal
08/19					

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Report to:	Board of Directors	**Date:**	27 June 2019
Subject:	Chair's Report		
Report of:	Chair	**Prepared by:**	Mrs C Parnell

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

This report advises the Board of Directors of the Chair's activities over the last month in relation to:

- Partnership working
- Board development
- Service visits
- External news

Attachments:

This subject has previously been reported to:

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

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1. PURPOSE OF THE REPORT

The purpose of this report is to advise the Board of Directors of the Chair's recent activities in relation to:

- Partnership working
- Board development
- Service visits
- External news

2. PARTNERSHIP WORKING

Partnership working may not always be easy, but locally our health and social care colleagues have always recognised that with us all facing constrained resources it is only through effective partnership working that we will be able to deliver the long term aspirations we have for the health and wellbeing of the communities we serve.

We have always striven to build strong and effective partnerships with a range of local and regional statutory and voluntary organisations. Those relationships will inevitably change as new people take up key leadership roles in partner organisations, and that's just what we've seen in the last couple of weeks.

As a result of the recent local government elections, Coun. Elise Wilson has become the Leader of Stockport Metropolitan Borough Council, and the Chief Executive and I are due to meet with her next week. Coun. Tom McGee has become the Deputy Leader. He previously held the health portfolio on the local authority, and as such was its appointed representative on our Council of Governors, where he has made a great contribution to the work of governors as well as the governance of our Trust. The local authority has now combined the health portfolio with adult care and it has passed to Coun. Jude Wells, who I met recently. She has been appointed as the local authority's representative on our Council of Governors and I am very much looking forward to welcoming her to future meetings.

The Chief Executive and I attended a recent meeting of the local Health and Wellbeing Board, and it was good to hear the council confirm its intent to work in partnership with health colleagues for the benefit of the people of Stockport. It was also great to get such positive feedback on the Trust, particularly in relation to our child death mortality reviews, medical examiners changes that have been supported by our pathology team, and our support for the CURE programme.

Another change to local health and social care leadership is the appointment of Andrea Green, who will soon be joining Stockport Clinical Commissioning Group (CCG) as their Accountable Officer. She will bring with her over 30 years of experience of working across a range of NHS services, and I am sure she will further strengthen local leadership of the health and care system.

But it is not just individuals that are changing, we are also seeing the development of seven GP-led primary care networks across Stockport. It is still early days in terms of us understanding how our services will be influenced by, and work with, these networks. But we are in a good place to forge new relationships with new individuals and organisations, as well as further strengthen existing partnerships.

Building and maintaining effective relationships is something I spend a lot of time on as Chair and it was great to meet up with Lynn McGill recently. She is the chair of East Cheshire NHS Trust, which is one of the organisation's helping to care for local breast cancer patients we are not currently able to diagnose and treat due to pressures that many trusts across the country are facing.

In recent weeks I have also met members of Stockport NHS Watch, a local group of volunteers committed to supporting local NHS services, and next week I am looking forward to welcoming Peter Wyman CBE to the Trust. He is the Chair of the Care Quality Commission (CQC), and following our most recent inspection by the CQC I invited him to visit us and learn more about our quality improvement journey.

3. BOARD DEVELOPMENT

Our performance against the four hour standard for A&E has often hit the headlines locally and nationally, and it is a key area of our service delivery that we want to improve. Last week we had a really interesting Board development session on the theme of urgent care.

As a Board we have reflected recently on the experiences of our urgent care services over the Easter and May Bank Holidays, but this session gave us the opportunity to delve further into what is affecting our performance, gain a better understanding of how system working impacts on our ability to deliver timely care, and the actions we are taking to try to improve the current situation.

Over the last couple of months I have spent a considerable amount of time with our Governors who are members of the Nominations Committee working on the appointment of a new Non-Executive Director. With the support of an external recruitment company we have had huge interest in the role, and it was a difficult task to narrow the field down to just six candidates, who we interviewed earlier this week. The successful candidate will be appointed by the Council of Governors and an announcement is expected following the next Council meeting on 17 July 2019.

We will shortly begin the process to recruit to a new Director-level post, who will take the strategic lead for improving our communications with a wide range of stakeholders, internally and externally, as well as corporate affairs. This role will complete our team of Executive Directors.

4. SERVICE VISITS

This month I have taken the opportunity to visit four key but very different areas of the Trust, and as always I was truly impressed with the dedication and team spirit of the staff I met.

It is about 18 months since I last visited Ward D4 so I was keen to see how it is continuing to provide short stay care for older people. This is a very busy ward with a constant demand for its services. The team is rightly proud of its Silver ACE accreditation, and is focussed on going for gold to publically demonstrate its commitment to providing the best possible care for patients.

On a visit to our theatres I was really impressed by the modern facilities, and the investment the Trust has made in this area was obvious. It was also a great opportunity to talk to colleagues about how we get the most out of these facilities, making sure patients get timely, high quality care and at the same time bring much needed income into the organisation.

My visit to the Critical Care Unit, including the intensive care and high dependency unit, demonstrated just how busy these teams are caring for some of our sickest patients. Despite the intense pressure on the service I was really impressed by the professionalism and absolute focus on safety and patient care shown by all the colleagues I met.

The importance of being able to continually invest in our estate was really brought home to me by a visit to Outpatient B. Despite the less than ideal environment, the colleagues that work in this key area of the Trust were really dedicated to providing the best possible service, and I was impressed by all the ideas I heard for improving the way they currently operate.

5. EXTERNAL NEWS

- Amanda Pritchard, Chief Executive of Guy's and St. Thomas' NHS Foundation Trust in London, has been appointed as the NHS Chief Operating Officer. She will take up this new role on 31 July reporting directly to Simon Stevens, Chief Executive of NHS England, and will be responsible for overseeing NHS operational performance and delivery, as well as the service transformation and patient care improvements set out in the NHS Long Term Plan.

- Rob Bellingham has been appointed to the role of Managing Director of the Greater Manchester (GM) Joint Commissioning team. He has over 20 years director level experience in NHS and public sector in GM, and in his new role he will have a significant part to play in its further evolution by building on, and strengthening existing commissioning arrangements, driving delivery of work to reduce inequalities in health and wellbeing, and supporting delivery of public sector reform across Greater Manchester.

- A report by the NHS Confederation has concluded that NHS Boards have become less diverse over the last 15 years with fewer women and people of black and minority ethnicity (BME). It found that the percent of BME Board members had dropped from 15% in 2010 to just eight per cent in 2019, and the percentage of women Non-Executive Directors had fallen over the same period from 47% to 38%. In our efforts to recruit a new Non-Executive Director we have actively searched for candidates that reflect the diverse communities we serve.

- Public Health England is due to launch a new campaign in July to support the annual flu immunisation campaign. Stockport had one of the best performances in the country in the 2018-19 campaign, with 78% of our staff vaccinated.

6. RECOMMENDATIONS

The Board of Directors is recommended to receive this report.

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NHS
Stockport
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	27 June 2019
Subject:	Chief Executive's Report		
Report of:	Chief Executive	**Prepared by:**	Mrs C Parnell

REPORT FOR NOTING

Corporate objective ref:	N/A	**Summary of Report** The purpose of this report is to advise the Board of Directors of national and local strategic and operational developments
Board Assurance Framework ref:	N/A	
CQC Registration Standards ref:	N/A	
Equality Impact Assessment:	☐ Completed X Not required	

Attachments:

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

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1. PURPOSE OF THE REPORT

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

2. GENERAL SUMMARY

A few months ago, we set up a “performance wall” and on Monday mornings clinical and managerial leaders from our Business Groups and corporate services start the week by reviewing the “wall”. It is a great way of understanding how we are doing against all our key performance standards, but most importantly ensuring we are identifying issues and taking action to continuously improve.

I attended a recent “performance wall” session and there was some very positive feedback about our progress on elective care, cancer and diagnostic standards. However, it was clear that we are not getting the traction we need to in making and sustaining the necessary improvements to our performance on waiting times in our Emergency Department.

While all hospitals across Greater Manchester have had challenges recently many are starting to improve more quickly than us. Despite being in late Spring/Summer, we are seeing the highest number of patients attending our Emergency Department that we have ever experienced. A particular current challenge for us is non-admitted patients breaching the four hour standard, overnight performance, and keeping patient flow moving at weekends.

We received and scrutinised a comprehensive overview of our emergency and urgent care pressures at our Board development session last week and supported the additional arrangements put in place recently to ensure progress. It is crucial that all staff and teams relentlessly focus on what they can do to support improved patient flow through the Trust, and this is also true of the essential role our partner organisations need to play in addressing demand and ensuring appropriate capacity across our system.

The Chair’s report this month very much focuses on the importance of partnership working, and it is something that also occupies a huge amount of my time and that of our Executive Director team. It is important to the services we provide that we build strong alliances not only in Stockport, but also across Greater Manchester and other parts of the region that we serve. The Chair mentions his very positive meeting with the Chair of East Cheshire NHS Trust, but we are also building wider partnerships with the whole East Cheshire patch, getting involved in their Cheshire PLACE work and looking forward to a seat around their Partnership Board table. A number of our services already work closely together and there are real opportunities ahead for us to build on those synergies and alliances.

Our work with Greater Manchester Health and Social Care Partnership continues to be an important part of what we do. Recently, I reported to the Board that it had been agreed to stand down the regular assurance meetings between the Partnership and stakeholders across Stockport. I recently received the minutes of that final meeting and it was really pleasing to see the Trust commended for the quality improvements we have made. As an active partner in the Stockport health and social care system it was also good to see praise for the quality of primary care services, mental health services having made good progress in access and waiting times, and children's services highlighted by Ofsted for the "exemplary" work they have done to ensure local children are ready to start school.

I am delighted to have been asked to give an introductory speech at a really important Orthopaedic Fractured Neck of Femur event this week. We are hosting this important event on behalf of the Greater Manchester Orthopaedic Network. Led by Professor David Johnson, clinical teams from all trusts in Greater Manchester and East Cheshire will be onsite at Stepping Hill, with the aim of developing a shared recovery protocol for patients with fractured neck of femur – the first in the country. This is a great example of clinically led innovation, proving that providing the best care achieves the best outcomes for patients and the best use of scarce NHS resources.

In my report last month, I mentioned the importance of having the right staff with the right skills in the right place, so I welcome the recent publication of NHS England's interim NHS People Plan. It sets out a vision for how people in the NHS will be supported to deliver care in line with the aspirations of the NHS Long Term Plan. It also highlights some actions that will make a difference in 2019-20 and some that will lay the ground work to grow the NHS workforce, support and develop NHS leaders, and make the NHS the best place to work.

The Interim NHS Plan very much aligns with our own People Strategy, and we will be looking closely at how the national plan can support us in achieving our ambitions to make the Trust the employer of choice and a great place to work.

I was very pleased to be able to attend the Trust's most recent nurse recruitment event with Greg Moores, our new Director of Workforce and Organisational Development. Our nursing recruitment team are putting in a tremendous effort to not only attract nurses to fill the vacancies we have, but also to encourage people to join us who have the right values and attitude. It was great to hear about the experience and enthusiasm of all those attending on the day and I am delighted that we will be able to offer most of them jobs with the Trust.

Part of making Stockport a great place to work is ensuring we have the right processes in place to communicate and engage with our staff. Our Human Resources team have recently launched some engagement events to get a

greater understanding of the comments and views our staff expressed in the recent national NHS staff survey. We are also revitalising our team briefing system, and are about to trial some “Meet the Execs” drop-in sessions where staff can meet informally with Executive Directors to share their ideas, ask questions about any aspect of the Trust, or raise concerns. The Medical Director, myself and Executive colleagues have begun a programme of engagement events with our Consultants, meeting with those from each Business Group. These are just some of the ways we are trying to improve communication and engagement with all of our staff, but there is always more that we can do and I look forward to sharing more developments in these areas over the coming months.

3. NEWS AND EVENTS

- **General surgery** - as part of our Healthier Together work we are trialling a new non-elective surgery pathway with the active involvement of our staff at Stepping Hill Hospital. We look forward to the outcomes of the trial that come have major benefits for us and other neighbouring Trusts.

- **Reserves Day** - we recognise the valuable contribution that reservists make to the UK Armed Forces, their communities and the civilian workplace, and we celebrated Reserves Day on 26 June 2019, by inviting Reservists to wear their military uniform to work for the day.

- ‘**One Year On’ event** - in 2018 we held a New World Launch to focus on our patient flow priorities. One year on, there has been an incredible amount of hard work across the Trust working on the standards that we all agreed at the launch, and there is also some very exciting projects being developed across all of the business groups. Much of this was showcased at a One Year On event yesterday (26 June 2019).

- **Snowden hike -** as part of our programme of staff health and wellbeing events a number of colleagues will be taking part in a guided walk up Snowden on 30 June 2019, and some will also be using their efforts to raise funds for the Trust’s charity with their efforts.

- **Health and wellbeing day** - Pinewood education centre will be the venue of for a day of physical and mental health activities on 29 July 2019 to give staff information about the wide range of opportunities the Trust offers to help improve their health and well-being.

4. RECOMMENDATION

The Board of Directors is recommended to receive this report.

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Report To:	Trust Board	**Date:**	27 Jun 2019
Subject:	Integrated Performance Report		
Report of:	Director of Strategy & Planning	**Prepared by:**	B.I & Performance Team

REPORT FOR ASSURANCE

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

Summary of Report

The Board is asked to note the performance against the reported metrics, particularly noting the key areas of change from the previous month.

Meetings have been arranged with the new Directors of Finance and Workforce & OD to review their suite of metrics. Any changes required will be incorporated from Q2.

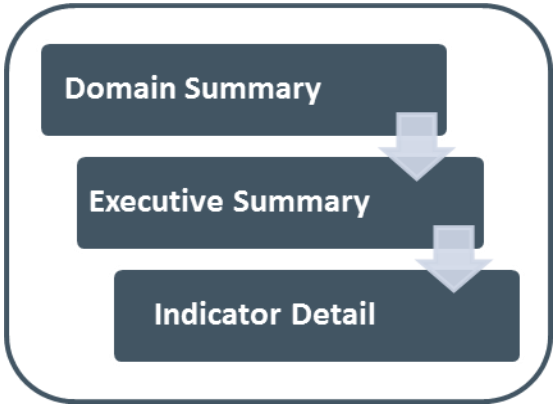
Attachments:

This subject has previously been reported to:

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

Introduction

The Board report layout consists of three sections:



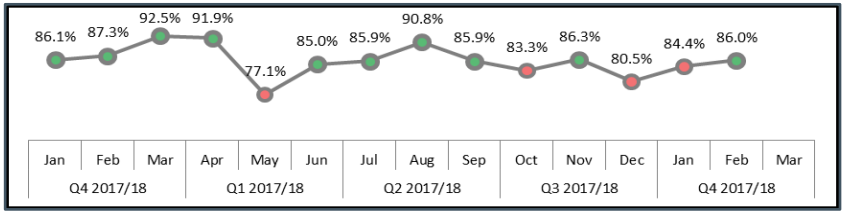
Domain Summary: Provides a high level summary of performance against the Trusts' Key Performance Indicators. The indicators are grouped by the Care Quality themes of Safe, Caring, Responsive, Effective and Efficient. The summary page reflects the Trusts' performance against the Single Oversight Framework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

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

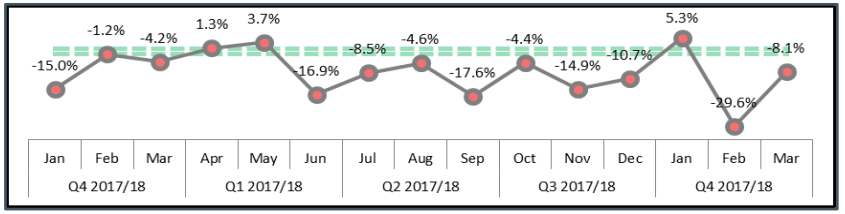
Indicator Detail: Provides detailed information for each indicator. This includes clear descriptions of the indicator, a chart representing the performance trend, and narrative describing the actions that are being undertaken to either maintain or improve performance.

Chart Summary

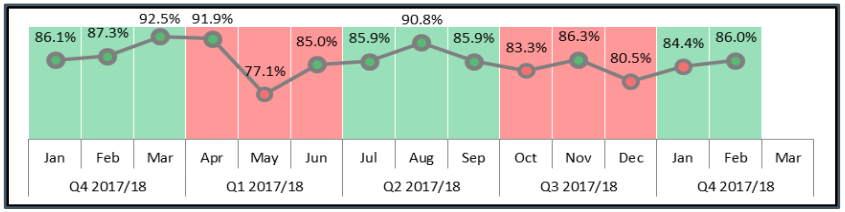
The following chart types are in use throughout the report:



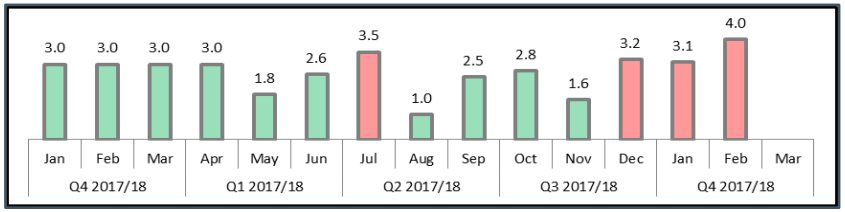
Trends are represented as a line where possible, with each monthly marker coloured to indicate achievement or non-achievement against target.



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



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



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

Domain Summary

Stockport NHS Foundation Trust

Key Changes to the indicators in this period are:

Metrics changing from green to red in month:
- Patient Safety Alerts Completion
- Outpatient activity v plan
- Theatre sessions v plan

Metrics changing from red to green in month:
- Dementia: Finding Question
- Hospital Acquired Device Related Bacteraemias
- Mandatory training
- Stranded/super-stranded patients
- Length of Stay (elective)
- Daycase activity v plan
- RTT Incomplete pathways

Areas of notable improvement:
- Clinical correspondence

Areas of notable exception:
- Agency shifts above cap

Executive Summary

NHS Stockport NHS Foundation Trust

Indicator	Domain	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Chief Operating Officer													
Diagnostics: 6 Week Standard	Responsive	May-19	<= 1%	1.2%							1.5%		12
Cancer: 62 Day Standard	Responsive	May-19	>= 72.7%	73.1%							79.6%		12
Cancer: 104 Day Breaches	Responsive	Apr-19	<= 0	1.0							1.0		13
Referral to Treatment: Incomplete Pathways	Responsive	May-19	>= 84.7%	84.7%							84.0%		13
Referral to Treatment: Incomplete Waiting List Size	Responsive	May-19	<= 24578	24049									14
Clinical Correspondence	Safe	May-19	>= 95%	65.0%							55.3%		14
Outpatient Hospital Cancellation Rate (UoR)	Responsive	May-19	<= 9%	11.0%							11.2%		15
Outpatient DNA rate (UoR)	Effective	May-19	<= 7.4%	6.5%							6.6%		15
Outpatient Clinic Utilisation (UoR)	Effective	May-19	>= 90%	82.3%							82.8%		16
Outpatient New to Follow-up Ratio (UoR)	Effective	May-19	<= 1.77	2.19							2.17		16
Theatres: Delivered Sessions vs. Plan	Effective	May-19	>= 100%	93.0%							96.4%		17
Theatres: Overall Touch-time Utilisation (UoR)	Effective	May-19	>= 85%	82.1%							80.5%		17
Theatres: In-Session Touch-time Utilisation (UoR)	Effective	May-19	>= 85%	73.2%									18

Executive Summary

NHS Stockport NHS Foundation Trust

Indicator	Domain	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Chief Operating Officer													
Elective Day Case Activity vs. Plan	Responsive	May-19	>= *0%*	0.9%							0.9%		18
Elective Day Case Income vs. Plan	Responsive	May-19	>= *0%*	4.1%							4.1%		19
Elective Inpatient Activity vs. Plan	Responsive	May-19	>= *0%*	-4.2%							-4.2%		19
Elective Inpatient Income vs. Plan	Responsive	May-19	>= *0%*	-4.8%							-4.8%		20
Outpatient Activity vs. Plan	Responsive	May-19	>= *0%*	-0.3%							-0.3%		20
Outpatient Income vs. Plan	Responsive	May-19	>= *0%*	-3.1%							-3.1%		21
Length of Stay: Non-Elective (UoR)	Effective	May-19	<= *9*	11.39							11.01		21
Length of Stay: Elective (UoR)	Effective	May-19	<= *2.6*	2.43							2.63		22
Stranded Patient Count (UoR)	Effective	May-19	<= *304*	290									22
Super-Stranded Patient Count (UoR)	Effective	May-19	<= *144*	134									23
Delayed Transfers of Care (DTOC) (UoR)	Effective	May-19	<= *3.3%*	4.1%							4.2%		23
Medical Optimised Awaiting Transfer (MOAT)	Effective	May-19	<= *40*	80							180		24
Discharges by Midday	Effective	May-19	>= *33%*	16.0%							16.6%		24

Executive Summary

Stockport NHS Foundation Trust

Indicator	Domain	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Medical Director													
A&E: 12hr Trolley Wait	Responsive	May-19	<= 0	12							52		26
Emergency Readmission Rate (UoR)	Effective	Mar-19	<= 7.9%	8.7%							8.8%		26
Diabetes Reviews	Caring	Mar-19	>= 90%	77.8%							79.5%		27
VTE Risk Assessment	Safe	May-19	>= 95%	97.0%							97.1%		27
Sepsis: Timely Identification	Safe	May-19		75.1%							85.0%		28
Sepsis: Timely Treatment	Safe	May-19	>= 90%	45.8%							44.9%		28
Medication Errors: Rate	Safe	May-19		4.00									29
Discharge Summaries	Safe	May-19	>= 95%	90.1%							91.0%		29
Mortality: Deaths in ED or as Inpatient	Effective	May-19		134							239		30
Mortality: Case Note Review Rate	Effective	May-19		35.8%							34.7%		30
Mortality: Specialist Palliative Care Length of Stay	Caring	May-19		17.55							21.71		31
Mortality: HSMR	Effective	Mar-19	<= 1	1.05									31
Mortality: SHMI	Effective	Dec-18	<= 1	0.96									32

Executive Summary

NHS Stockport NHS Foundation Trust

Indicator	Domain	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Medical Director													
Never Event: Incidence	Effective	May-19	<= 0	0							0		32
Duty of Candour Breaches	Effective	May-19		0							1		33
Serious Incidents: STEIS Reportable	Responsive	May-19		13							31		33

Indicator	Domain	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Chief Nurse & Director of Quality Governance													
C.Diff Infection Rate	Safe	Apr-19		16.66		↑					16.66	△	34
C.Diff Infection Count	Safe	Apr-19	<= 4 *	5		↑					5	△	34
MRSA Infection Rate	Safe	Apr-19		0.00		→					0.00	△	35
MSSA Infection Rate	Safe	Apr-19		4.63		↓					4.63	△	35
E.Coli Infection Rate	Safe	Apr-19		17.59		↑					17.59	△	36
E.Coli Infection Count	Safe	Apr-19		2		↓					2	△	36
Falls: Total Incidence of Inpatient Falls	Safe	May-19	<= 183 *	85		↑					167	△	37
Falls: Causing Moderate Harm and Above	Safe	May-19	<= 4 *	1		↓					3	△	37
Pressure Ulcers: Hospital, Category 2	Safe	Apr-19	<= 7 *	7		↓					7	△	38
Pressure Ulcers: Hospital, Category 3	Safe	Apr-19	<= 1 *	1		↑					1	△	38
Pressure Ulcers: Hospital, Category 4	Safe	Apr-19	<= 0 *	0		→					0	△	39
Pressure Ulcers: Community, Category 2	Safe	Apr-19	<= 16 *	14		↑					14	△	39
Pressure Ulcers: Community, Category 3	Safe	Apr-19	<= 3 *	2		↓					2	△	40

Executive Summary

NHS Stockport NHS Foundation Trust

Indicator	Domain	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Chief Nurse & Director of Quality Governance													
Pressure Ulcers: Community, Category 4	Safe	Apr-19	<= 0 *	1							1		40
Pressure Ulcers: Device Related, Category 2	Safe	Apr-19	<= 2 *	4							4		41
Pressure Ulcers: Device Related, Category 3	Safe	Apr-19	<= 0 *	0							0		41
Pressure Ulcers: Device Related, Category 4	Safe	Apr-19	<= 0 *	0							0		42
Safety Thermometer: Hospital	Safe	May-19	>= 95%	96.7%							97.0%		42
Safety Thermometer: Community	Safe	May-19	>= 95%	98.0%							98.3%		43
Patient Safety Incident Rate	Effective	May-19		53.67									43
Patient Safety Alerts: Completion	Caring	May-19	>= 100%	83.3%							91.7%		44
Emergency C-Section Rate	Effective	May-19	<= 15.4%	17.2%							17.1%		44
Term Babies Admitted to the Neonatal Unit	Effective	May-19	<= 5	3									45
Dementia: Finding Question	Responsive	Apr-19	>= 90%	95.6%							95.6%		45
Dementia: Assessment	Responsive	Apr-19	>= 90%	100.0%							100.0%		46
Dementia: Referral	Responsive	Apr-19	>= 90%	100.0%							100.0%		46

Indicator	Domain	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Chief Nurse & Director of Quality Governance													
Friends & Family Test: Response Rate	Caring	Apr-19		19.9%		⇩					19.9%	△	47
Friends & Family Test: Inpatient	Caring	Apr-19		94.8%		⇩					94.8%	△	47
Friends & Family Test: A&E	Caring	Apr-19		87.2%		⇩					87.2%	△	48
Friends & Family Test: Maternity	Caring	Apr-19		94.4%		⇩					94.4%	△	48
DSSA (mixed sex)	Caring	May-19	<= 0	0		⇨					0	△	49
Learning Disability: Adjusted Care Plans	Caring	Mar-19	>= 100%	78.9%		⇩						△	49
Compliments	Caring	May-19		146		⇧					291	△	50
Complaints Rate	Caring	May-19		0.7%		⇩					0.9%	△	50
Complaints: Response Rate 45	Caring	May-19	>= 95%	92.2%		⇧					81.7%	△	51
Complaints: Parliamentary & Health Service Ombudsman Cases	Caring	May-19		1		⇧					1	△	51
Complaints Closed: Overall	Caring	May-19		51		⇧					93	△	52
Complaints Closed: Upheld	Caring	May-19		8		⇨					16	△	52
Complaints Closed: Partially Upheld	Caring	May-19		23		⇧					37	△	53

Executive Summary

NHS Stockport NHS Foundation Trust

Indicator	Domain	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Chief Nurse & Director of Quality Governance													
Complaints Closed: Not Upheld	Caring	May-19		20		→					40	△	53
Litigation: Claims Opened	Responsive	May-19		3		↓					10	△	54
Litigation: Claims Closed	Responsive	May-19		4		↑					7	△	54
Referral to Treatment: 52 Week Breaches	Responsive	May-19	<= 0	6		↑					10	△	55

Executive Summary

NHS Stockport NHS Foundation Trust

Indicator	Domain	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Director of Finance													
Financial Controls: I&E Position	Well-Led / Efficient	May-19	>= 0%	0.2%									55
Cash	Well-Led / Efficient	May-19	<= 0%	-0.4%									56
Financial Use of Resources	Well-Led / Efficient	May-19	<= 3	3									56
CIP Cumulative Achievement	Well-Led / Efficient	May-19	>= 0%	35.1%									57
Capital Expenditure	Well-Led / Efficient	May-19	+/- 10%	-58.9%									57

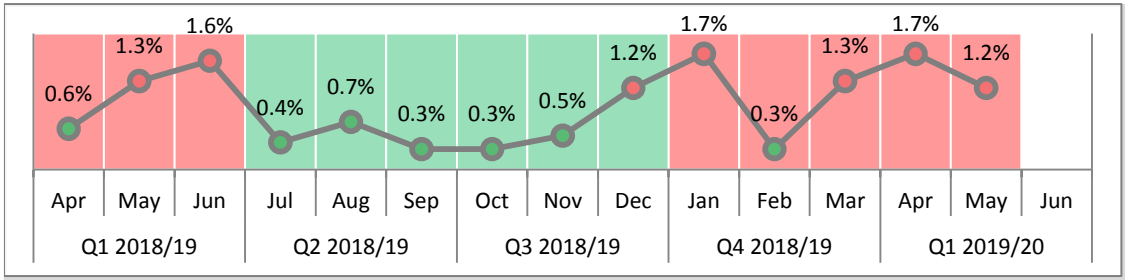
Domain Summary

NHS Stockport NHS Foundation Trust

Indicator	Domain	Report Month	Target	Actual	PAT Rating	Direction	BG PAT I	BG PAT M	BG PAT S	BG PAT W	YTD	Forecast Risk	Page
Director of Workforce & Organisational Development													
Staff in Post	Well-Led / Efficient	May-19	>= 90%	91.4%							91.4%		58
Sickness Absence Rate (UoR)	Well-Led / Efficient	May-19	<= 3.5%	4.5%							4.6%		58
Workforce Turnover (UoR)	Well-Led / Efficient	May-19	<= 13.94%	13.9%									59
Staff Friends & Family Test: Recommend for Work	Well-Led / Efficient	Mar-19		53.9%							55.1%		59
Appraisal Rate: Medical	Well-Led / Efficient	May-19	>= 95%	96.9%							97.0%		60
Appraisal Rate: Non-medical	Well-Led / Efficient	May-19	>= 95%	92.8%							92.5%		60
Statutory & Mandatory Training	Well-Led / Efficient	May-19	>= 90%	90.4%							89.9%		61
Bank & Agency Costs	Effective	May-19	<= 5%	11.5%							11.1%		61
Agency Shifts Above Capped Rates	Well-Led / Efficient	May-19	<= 0	790							1254		62
Agency Spend: Distance From Ceiling (UoR)	Well-Led / Efficient	May-19	<= 3%	-11.7%							-11.7%		62
Flu Vacination Uptake	Safe	Feb-19	>= 75%	75.3%									63
Staff Friends & Family Test: Recommend for Care	Caring	Mar-19		71.9%							71.6%		63

Indicator Detail

May-19	Diagnostics: 6 Week Standard
1.2%	The percentage of patients refered for diagnostic tests who have been waiting for less than 6 weeks.
Target	The Trust did not achieve the 1% diagnostic standard in May. This was due to a combination of echocardiography capacity and simultaneous failure of both CT scanners in month.
<= 1%	



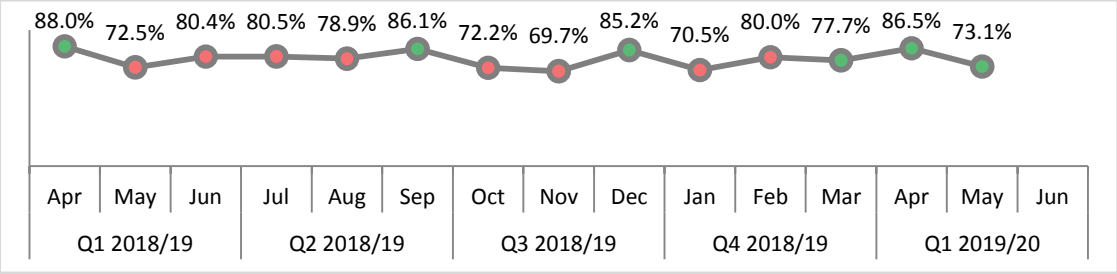
Actions

A review of the current service provision is underway in Echocardiography with a view to an extended hours /7 day working model.

Compliance with the diagnostic standard is predicted for June.

Future risks to compliance relate to the shortage of contrast for MR, and any the fragility of the CT scanners.

May-19	Cancer: 62 Day Standard
73.1%	The percentage of patients on a cancer pathway that have received their first treatment within 62 days of their GP referral. Please note: This indicator is measured against an agreed improvement trajectory, not the national standard.
Target	The Trust achieved the improvement trajectory milestone set for May.
>= 72.7%	



Actions

Bids for transformational monies have been submitted to GM Cancer to support the lung and colorectal straight to test pathways. The Trust awaits the outcome of the decision making process.

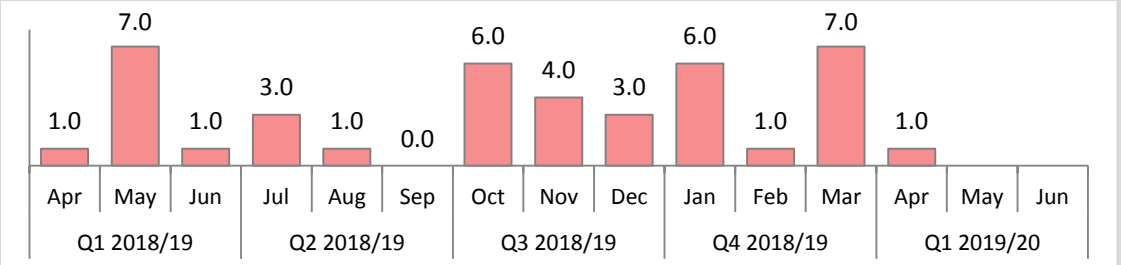
The Business cases for additional CT capacity and the 4th Endoscopy room have been approved by the Trust Board. Estimated implementation times are Q1 2020/21.

The impact of Histopathology workforce gaps have been highlighted as a contributory risk to cancer performance.

Trust-wide deep dive analysis of each patient that breaches 62 days.

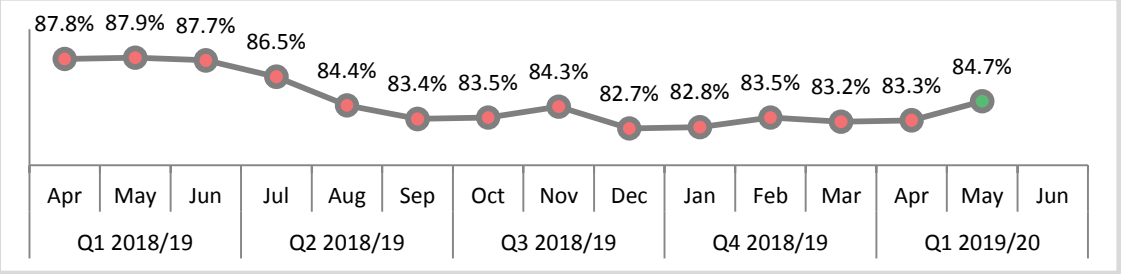
Indicator Detail

Apr-19	Cancer: 104 Day Breaches
1.0	The number of patients that have pathway length of 104 days or more at the point of treatment.
Target	One patient commenced treatment beyond day 104 of their pathway in May. The patient was a late transfer in from another hospital for further diagnosis and treatment at Stockport.
<= 0	



Actions
All cancer patients are tracked and pathway delays are escalated to ensure patients are treated as soon as possible. Root Cause Analysis is undertaken for any patient breaching 62 days of their pathway which includes a clinical harm review. These are shared as part of the Trusts' Cancer Quality & Service Improvement group. Any 104 day breach analysis is also subject to a serious untoward incident review.

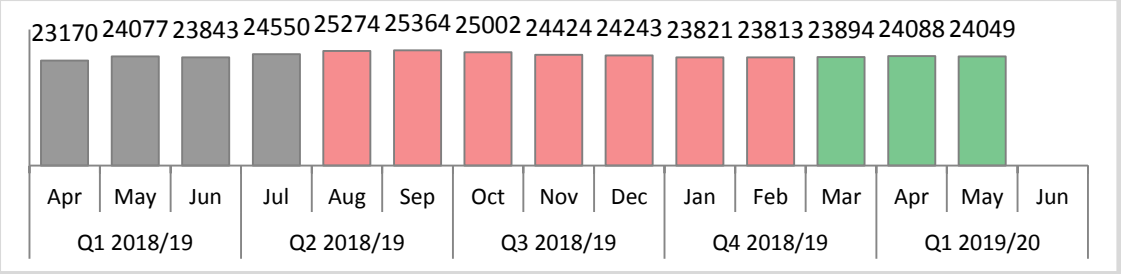
May-19	Referral to Treatment: Incomplete Pathways
84.7%	The percentage of patients on an open pathway, whose clock period is less than 18 weeks. Please note: This indicator is measured against an agreed improvement trajectory, not the national standard.
Target	The Trust has achieved its improvement trajectory milestone for May. This is despite significant increases in demand in some services.
>= 84.7%	



Actions
Options appraisals are being prepared for both Oral Surgery and Orthodontics following increased demand as a result of surrounding providers closing services. Weekly discussions with NHSE are taking place regarding these services.

Indicator Detail

May-19	Referral to Treatment: Incomplete Waiting List Size
24049	The total number of patients on an open pathway. Please note: This indicator is measured against an agreed improvement trajectory.
Target	The Trust remains well ahead of its improvement trajectory for RTT waiting list size.
<= 24578	

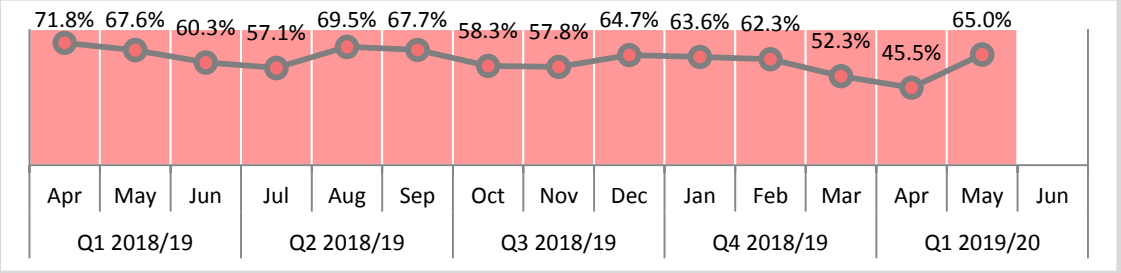


Actions

Refresher training for medical secretaries, pathway trackers and management teams is due to commence to ensure each service has efficient and effective processes for tracking patients through their journey.

Focus on real-time clinic outcome recording.

May-19	Clinical Correspondence
65.0%	The percentage of clinical correspondence typed within 7 days.
Target	Performance has started to reflect the positive impact of the Outsourcing project. Wait for typing continues to improve. At the time of writing, the longest wait is 10 days.
>= 95%	



Actions

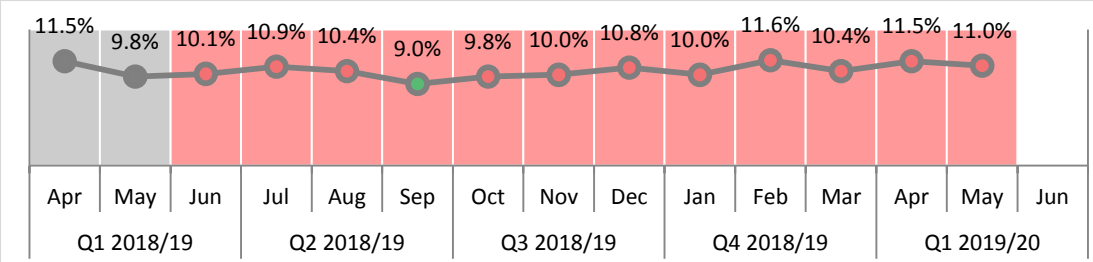
Options paper approved by ET.

Assurance given that time between dictation and being typed will be less than 7 days by the end of June.

Moving forward, the aim is a to achieve clinic attendance to distribution within 7 days.

Indicator Detail

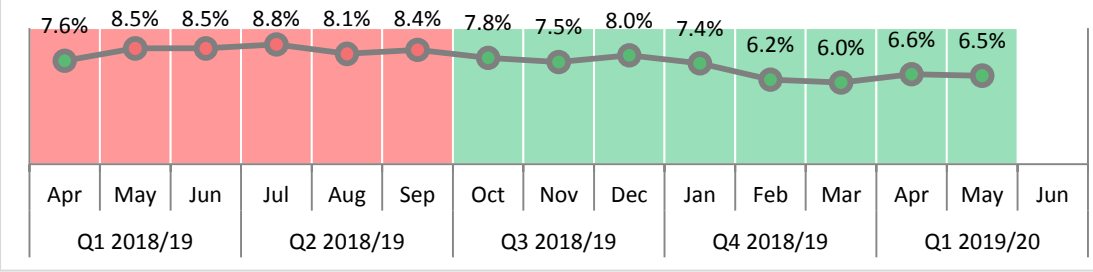
May-19	Outpatient Hospital Cancellation Rate (UoR)
11.0%	The percentage of outpatient appointments where the hospital has cancelled the appointment. This indicator combines new and follow-up appointment types.
Target	The cancellation rate improved slightly in month to 11%.
<= 9%	



Actions

The Outpatient improvement work will support efficient ways of working to minimise cancellations.

May-19	Outpatient DNA rate (UoR)
6.5%	The percentage of outpatient appointments where the patient did not attend (DNA). This indicator combines new and follow-up appointment types.
Target	DNA rate remains below peer group average.
<= 7.4%	

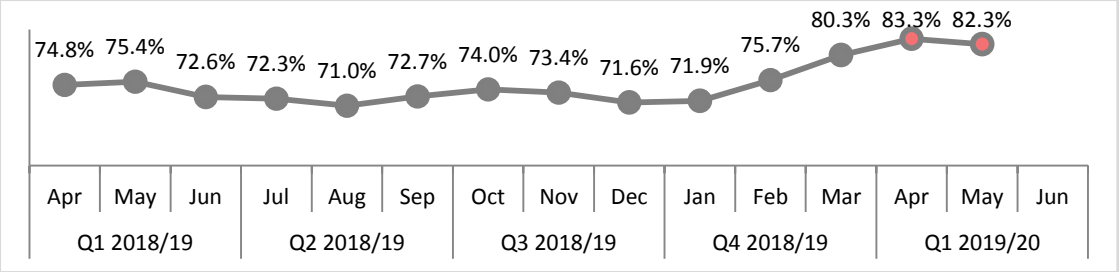


Actions

Continue to develop the reminder system as required.

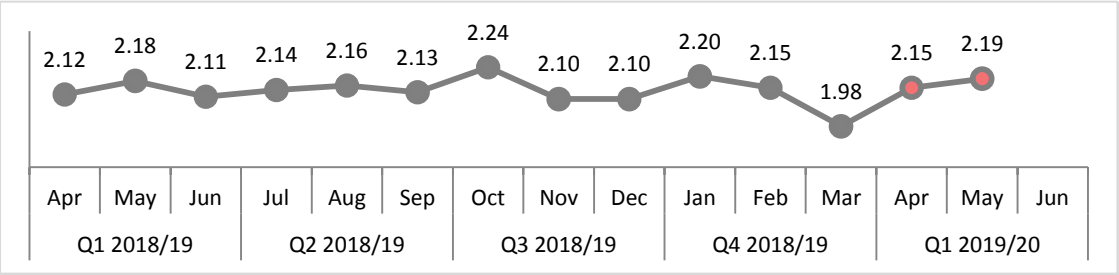
Indicator Detail

May-19	Outpatient Clinic Utilisation (UoR)
82.3%	The percentage of planned clinic appointment slots that were booked. Planned slots include all appointment slots on clinic templates that went ahead - cancelled clinic templates are excluded.
Target	Clinic utilisation has remained static this month.
>= 90%	



Actions
The Outpatient improvement work will include further clinic utilisation.

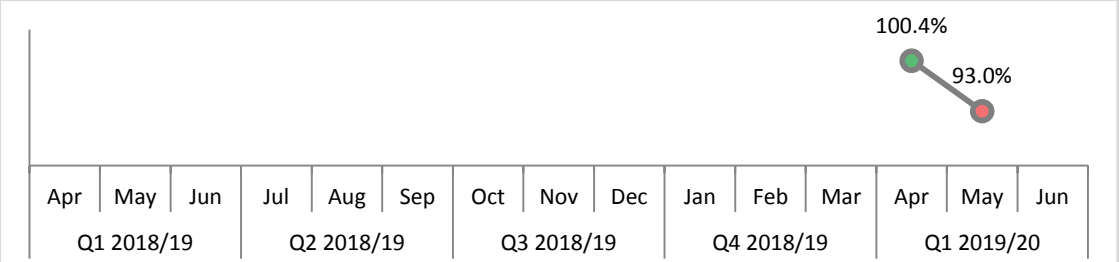
May-19	Outpatient New to Follow-up Ratio (UoR)
2.19	The number of outpatient follow-up attendances that took place for every one outpatient new attendance.
Target	The new:follow-up ratio remains static. This will in part be due to the reduction of new attendances within the Breast service.
<= 1.77	



Actions
Patient Initiated Follow-up (PIFU) continues to be embedded across the specialties.

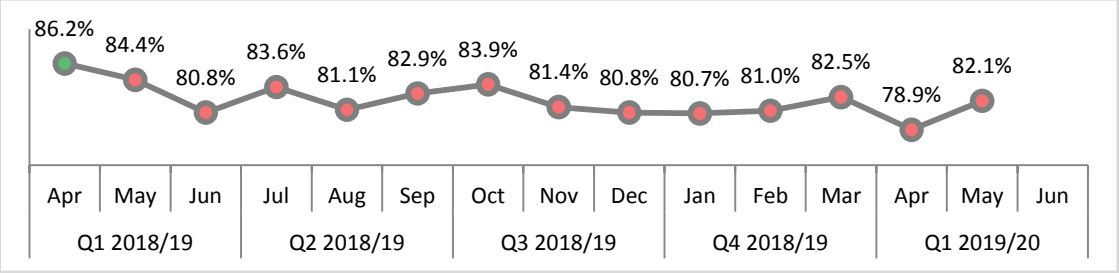
Indicator Detail

May-19	Theatres: Delivered Sessions vs. Plan
93.0%	The number of delivered sessions, as a percentage of the required sessions to deliver the activity plan. Excludes emergency/trauma sessions, obstetric and endoscopy activity. Planned session time based on delivered sessions only.
Target	The Trust was behind plan in delivering the required number of theatre sessions in month.
>= 100%	



Actions
The work undertaken to allocate theatre lists to specialties based on their plan requirements should start to take effect in July. Vacancies within the Anaesthetic team has been highlighted as a risk to activity delivery in the coming months. An impact and options paper is being prepared. Meanwhile, the Trust has approved to over-recruit Consultant Anaethetists at risk.

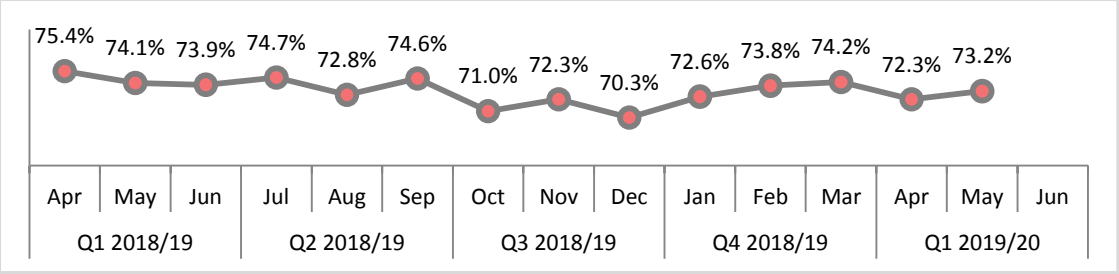
May-19	Theatres: Overall Touch-time Utilisation (UoR)
82.1%	The overall time spent operating, calculated as a percentage of the overall planned session time. Touch-time will include any case overlap time and session over-run time. Excludes emergency/trauma sessions, obstetric and endoscopy activity. Planned session time based on delivered sessions only.
Target	Utilisation improved slightly in month.
>= 85%	



Actions
A new suite of metrics is being developed to support monitoring of elective activity and theatre efficicency. These will form the basis of the monthly theatre specific meetings.

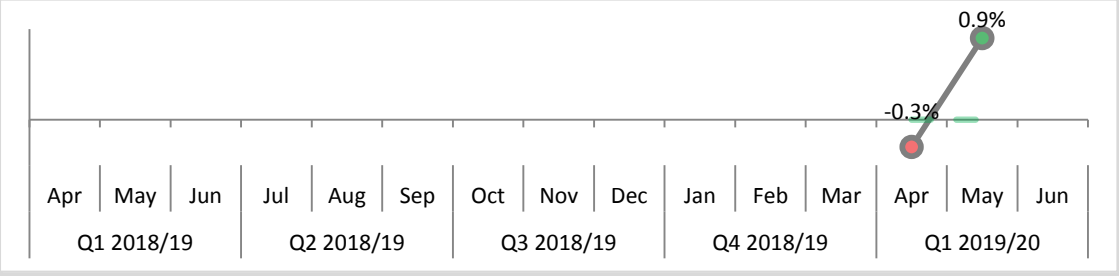
Indicator Detail

May-19	Theatres: In-Session Touch-time Utilisation (UoR)
73.2%	The overall time spent operating within the planned hours of the session, calculated as a percentage of the overall planned session time. Excludes emergency/trauma sessions, obstetric and endoscopy activity. Planned session time based on delivered sessions only.
Target	Utilisation improved slightly in month.
>= 85%	



Actions
A new suite of metrics is being developed to support monitoring of elective activity and theatre efficicency. These will form the basis of the monthly theatre specific meetings.

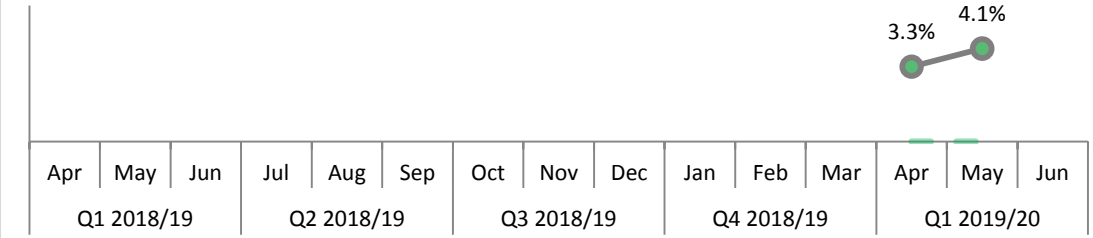
May-19	Elective Day Case Activity vs. Plan
0.9%	The percentage variance between planned elective day case activity and actual elective day case activity.
Target	Day-case activity is ahead of plan to month 2 by 48 cases.
>= 0%	



Actions
Continue weekly monitoring at the Executive start of the week meeting.

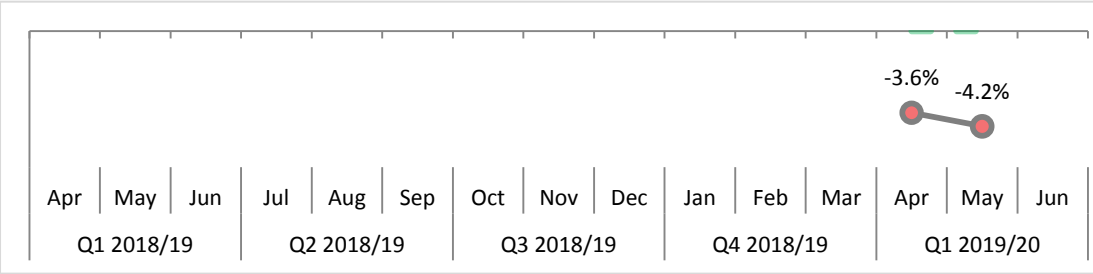
Indicator Detail

May-19	Elective Day Case Income vs. Plan
4.1%	The percentage variance between planned elective day case income and actual elective day case income.
Target	Day-case income is ahead of plan in-line with the activity variance.
>= 0%	



Actions
Continue weekly monitoring at the Executive start of the week meeting.

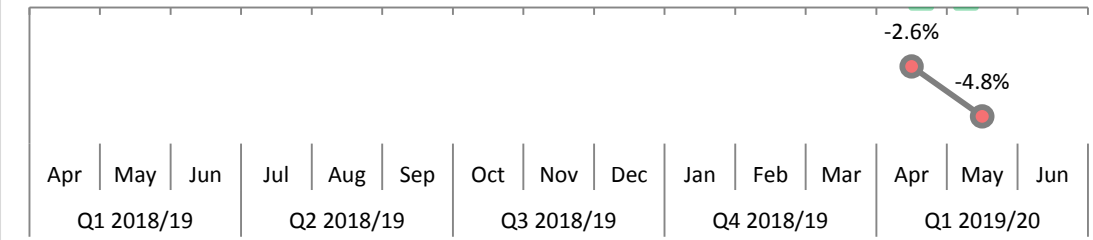
May-19	Elective Inpatient Activity vs. Plan
-4.2%	The percentage variance between planned elective inpatient activity and actual elective inpatient activity.
Target	In-patient activity is behind plan by 40 cases to month 2.
>= 0%	



Actions
Continue weekly monitoring at the Executive start of the week meeting.

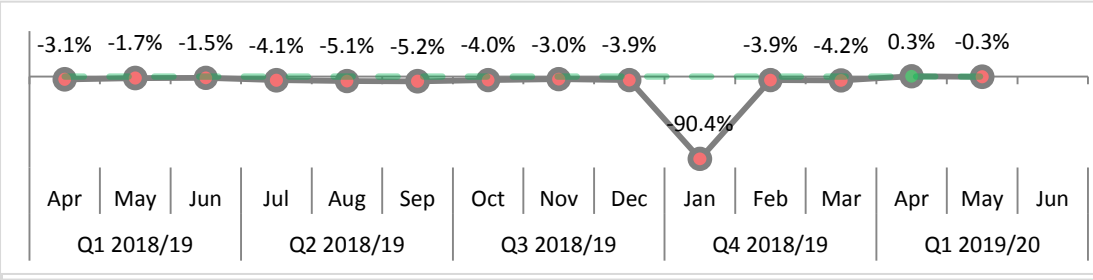
Indicator Detail

May-19	Elective Inpatient Income vs. Plan
-4.8%	The percentage variance between planned elective inpatient income and actual elective inpatient income.
Target	In-patient income is behind plan at month 2.
>= 0%	



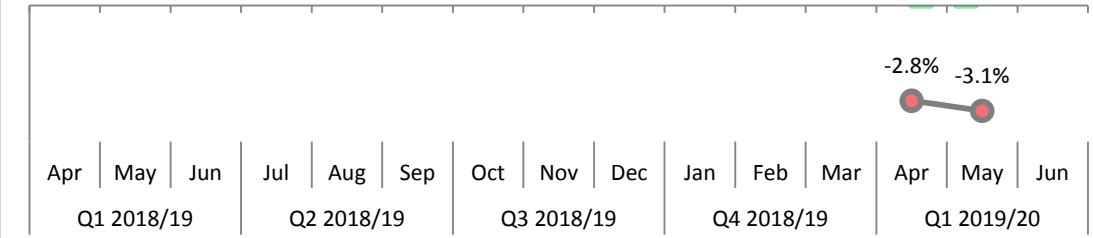
Actions
Continue weekly monitoring of activity at the Executive start of the week meeting.

May-19	Outpatient Activity vs. Plan
-0.3%	The percentage variance between planned outpatient activity and actual outpatient activity.
Target	Outpatient activity is 134 spells behind plan at month 2. Whilst OP procedures and follow-up attendances are over-plan, first attendances are significantly adverse to plan.
>= 0%	



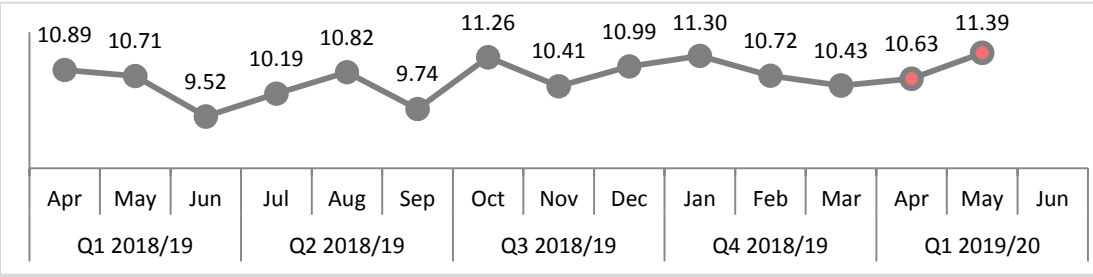
Actions
It should be noted that suspension of referrals into the breast service has impacted on new attendances. Medical staffing shortages in Diabetes are contributing to variance to plan. A locum Consultant has now been secured. A recovery trajectory for ENT is being developed which will inform how much of the gap can be closed.

May-19	Outpatient Income vs. Plan
-3.1%	The percentage variance between planned outpatient income and actual outpatient income.
Target	Outpatient income is adverse to plan at month 2. Whilst total attendances in the two months are only 134 behind plan, the split of appointment type varies and has adversely affected the income received.
>= 0%	



Actions
Focus on real-time clinic attendance recording.

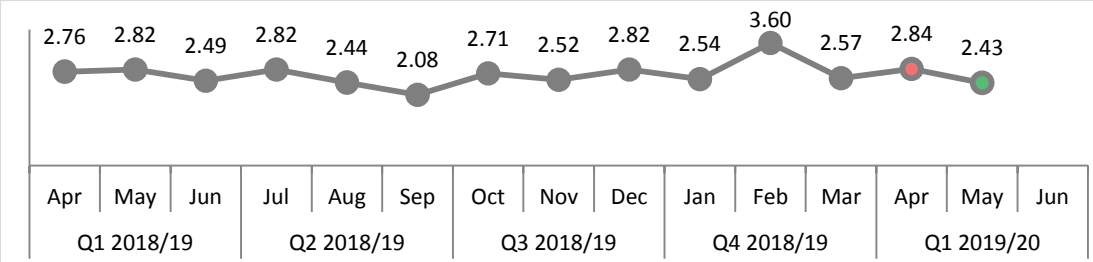
May-19	Length of Stay: Non-Elective (UoR)
11.39	The average length of a patient spell, from admission to discharge. Calculated using non-elective admissions only. Excludes Obstetrics/Maternity. Excludes admissions of 0 and 1 days length of stay. Reported by month of discharge.
Target	Length of stay for non-elective discharges in May increased. This is related to the reduction in stranded patients in the hospital in month.
<= 9	



Actions
Improvement actions are related to the programme of work on reducing stranded patient numbers.

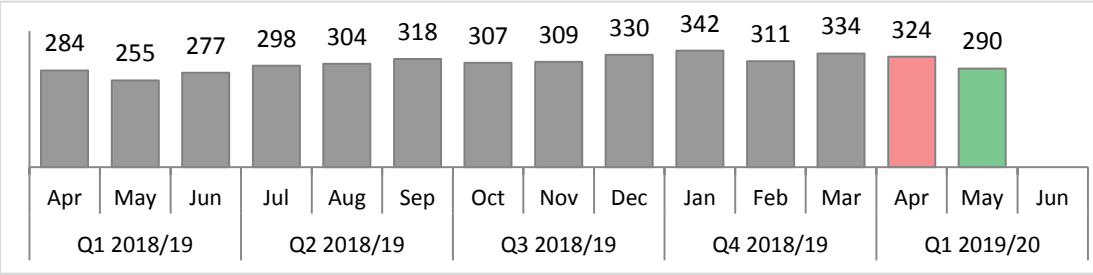
Indicator Detail

May-19	Length of Stay: Elective (UoR)
2.43	The average length of a patient spell, from admission to discharge. Calculated using elective admissions only. Excludes day case admissions with length of stay of 0 days. Excludes Obstetrics/Maternity. Reported by month of discharge.
Target	Elective length of stay is below the peer average in month.
<= 2.6	



Actions
Continued focus on discharging patients by mid-day across all Business Groups

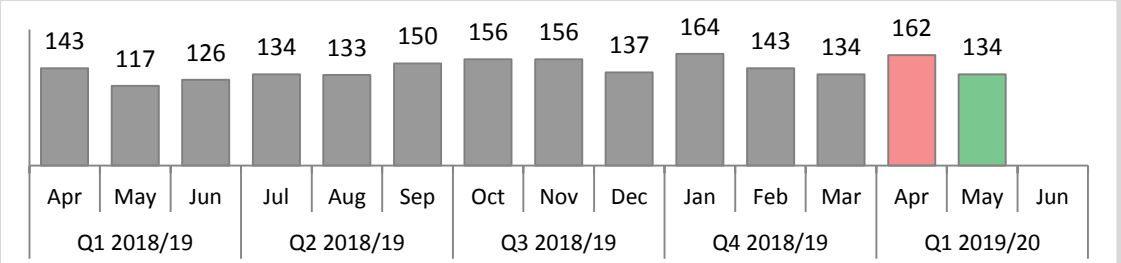
May-19	Stranded Patient Count (UoR)
290	The total number of patients with a length of stay of 7 days or more. Performance based on a snapshot taken on the last Monday of the reporting month. Please note: This indicator is measured against an agreed improvement trajectory.
Target	Longer length of stay (Stranded) patient numbers have reduced in month.
<= 304	



Actions
Improvement actions continue within the ITT with a weekly meeting with ITT Manager/Clinical Nurse Lead for CSC and the Delivery Director Trajectory set and monitored weekly focussing on not only +21 days but the +14 and +7 to reduce the number of patients who will then flip into the +21 day LOS. SRO's for Stay Well, Home First, Patient Flow and Discharge to continue with the workgroups to improve flow to reduce the number of admissions and increase the number of discharges in a timely manner.

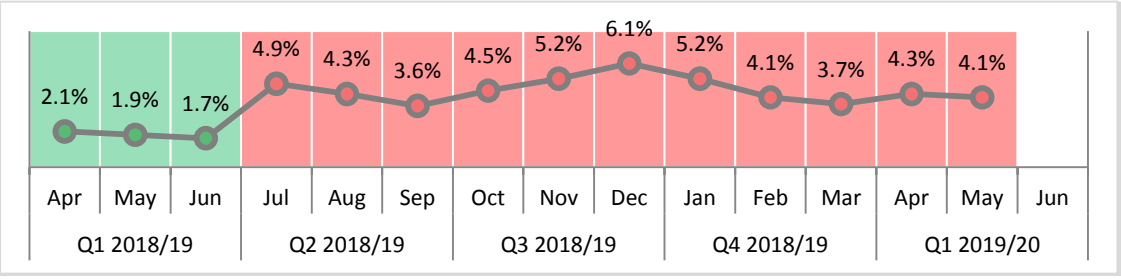
Indicator Detail

May-19	Super-Stranded Patient Count (UoR)
134	The total number of patients with a length of stay of 21 days or more. Performance based on a snapshot taken on the last Monday of the reporting month. Please note: This indicator is measured against an agreed improvement trajectory.
Target	There has been a national target (a 45% reduction) by March 2020 assigned to the longer length of stay patients (super-stranded). The Trust has reflected this within the monthly targets. Numbers have reduced in month.
<= 144	



Actions
Improvement actions continue within the ITT with a weekly meeting with ITT Manager/Clinical Nurse Lead for CSC and the Delivery Director Trajectory set and monitored weekly focussing on not only +21 days but the +14 and +7 to reduce the number of patients who will then flip into the +21 day LOS. SRO's for Stay Well, Home First, Patient Flow and Discharge to continue with the workgroups to improve flow to reduce the number of admissions and increase the number of discharges in a timely manner.

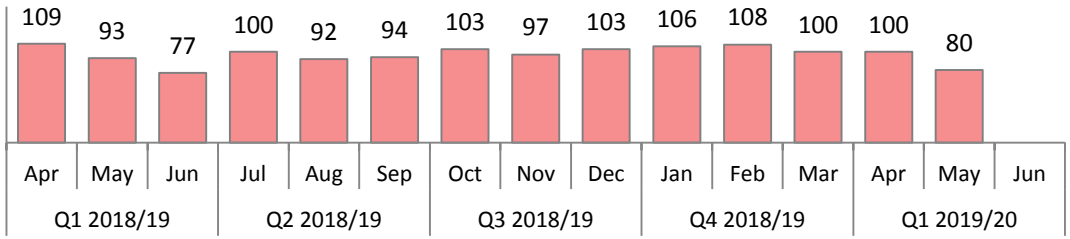
May-19	Delayed Transfers of Care (DTOC) (UoR)
4.1%	The percentage of patients that have remained in their hospital bed beyond their transfer of care date. This is an average number calculated using daily snapshot data.
Target	DTOC numbers have reduced slightly in month.
<= 3.3%	



Actions
Actions as per stranded patient work.

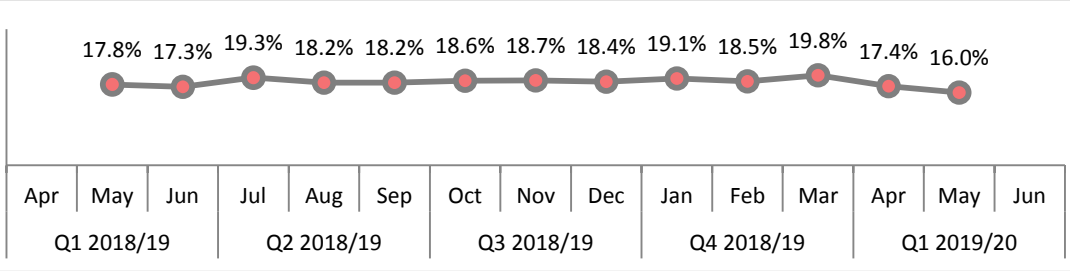
Indicator Detail

May-19	Medical Optimised Awaiting Transfer (MOAT)
80	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	MOAT number shave reduced in month.
<= 40	



Actions
Actions as per stranded patient work.

May-19	Discharges by Midday
16.0%	The total number of patients discharged by midday, calculated as a percentage of the total number of discharges for the period. Includes SAFER wards only.
Target	Discharges before midday are one of the standards that are measured at the in-hospital working group and then Programme Delivery Group. Although there has been success on a few wards the majority of the wards are still discharging patients later in the day and there is poor usage of the Discharge Lounge.
>= 33%	

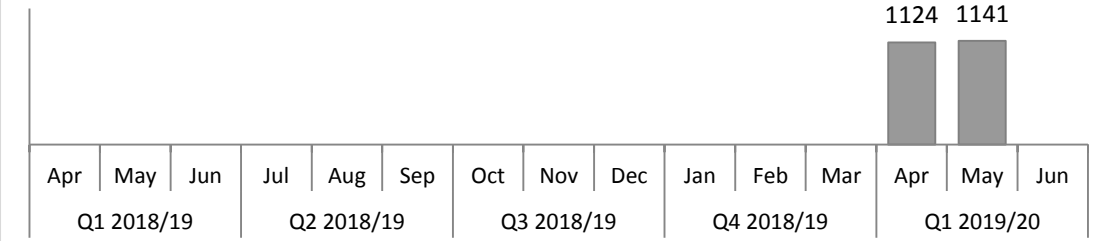


Actions
Continue to monitor and report through the In-Hospital Working Group and PDG. Re-launch of the Discharge Lounge now that it is fully staffed to get the wards confident in the discharge lounge. Holding a New World Launch - "One Year On" event to review and raise the profile of the New World Metrics. Implementation of the ITT Review with regards to "Discharge Trackers" on all medical wards.

Indicator Detail

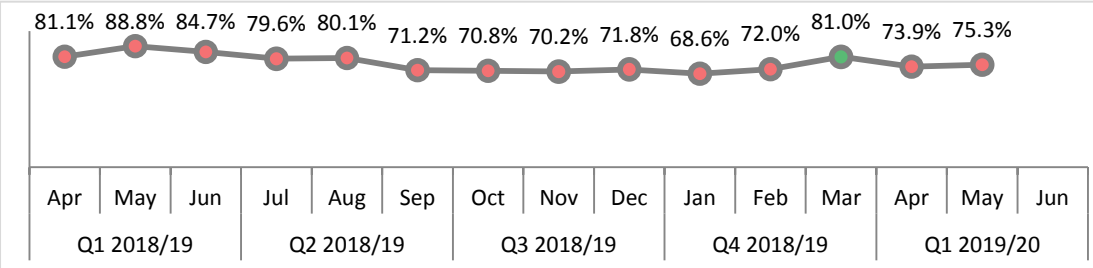
May-19	A&E: Overnight Breaches
1141	The total of patients who were admitted, discharged, or leave A&E over 4 hours after their arrival between 20:00 and 07:59.
Target	There continues to be a high number of overnight breaches of which a number are non-admitted patients. One of the main issues is the lack of space to see and treat patients when the department is over capacity. There is also an issue with delay in speciality assessment.

Actions
To look to have Consultant Cover until midnight 7 days a week An additional senior twilight (6pm to 2.00am) registrar level cover. Rota currently being reviewed. Operational Management team to have a rota which has one of them on site until 7.00pm to ensure there is a robust plan going into the night. Focus on earlier AMU discharges.



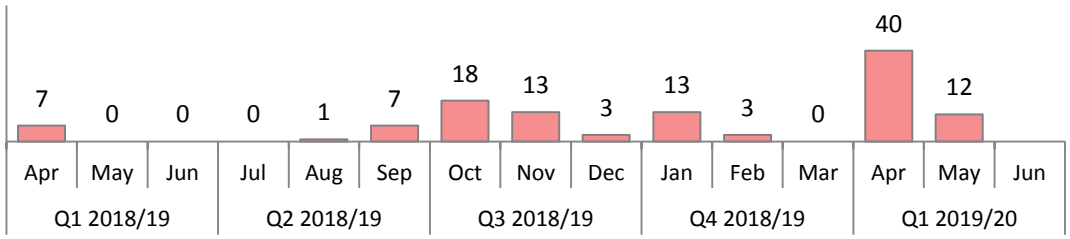
May-19	A&E: 4hr Standard
75.3%	The percentage of patients who were admitted, discharged, or leave A&E within 4 hours of their arrival. Please note: This indicator is measured against an agreed improvement trajectory, not the national standard.
Target >= 80%	Whilst performance against the 4hr standard improved from the previous month, it was below the improvement trajectory milestone. Attendances in May were slightly lower than predicted, but remain 2.3% above the level seen in May 2018 and are 6% up on the same two months last year.

Actions
Implementation plans for Project Phoenix continue to be progressed. A business case for the Urgent Care Treatment Centre is being finalised and will be considered by ET in early July. Bluebell (Transfer to Assess Model) – A start date of 1st August 2019 is now unrealistic as the Trust is still awaiting confirmation from the CCG of funding. Plans are in place to reduce overnight breaches by extending senior medical and managerial cover over a longer part of the evening /twilight.



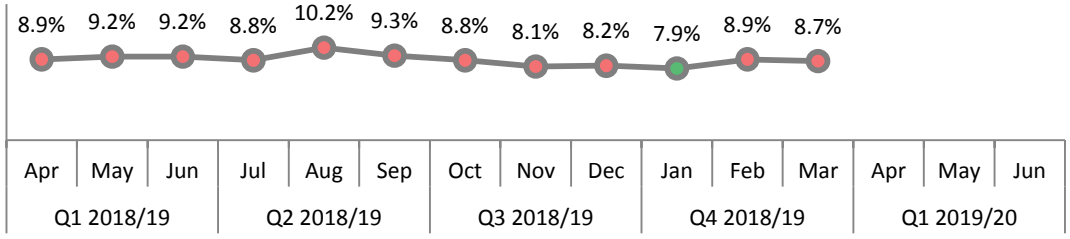
Indicator Detail

May-19	A&E: 12hr Trolley Wait
12	Total number of patients whose decision to admit from A&E was over 12 hours from their actual admission.
Target	The continued number of 12 hour trolley waits in spite of moving out of our winter period have been a cause for concern.
<= 0	



Actions
Meeting of key stakeholders to improve clarity about mitigating actions and escalation of patients approaching 12 hours since decision to admit. Once a patient reaches 10th hour of a DTA then an urgent meeting is held to discuss the plan for the patient. The Business Group Director will be contacted to discuss with their respective team how the patient can be safely transferred into a bed area. Delivery Director and Exec on Call to be informed at the 10th hour that there is not yet a plan in place for the patient to be transferred to a bed area. Clear guidelines to be drawn up as to what is acceptable when moving a patient who has been waiting for longer than 12 hour.

Mar-19	Emergency Readmission Rate (UoR)
8.7%	The percentage of emergency re-admissions within 28 days following an inpatient discharge. This indicator includes admissions for all conditions, and is not restricted to re-admissions for the same condition as the original admission.
Target	This indicator is a good index of effective communication and seamless transition from hospital into primary care.
<= 7.9%	

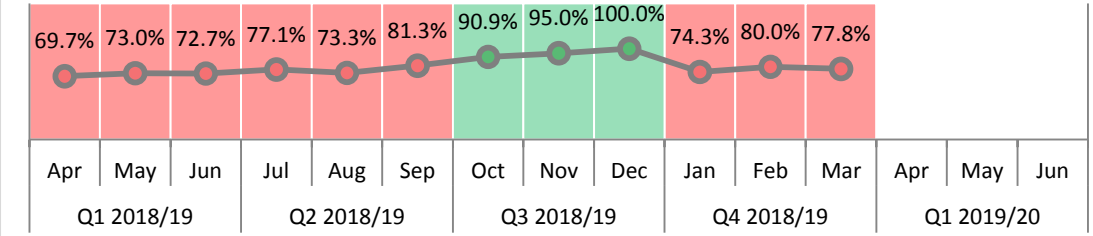


Actions
This metric aligns well with the principles of Stockport Together. Establishment of the GP networks offers further opportunity to improve engagement. Ongoing work with crisis response, the integrated transfer team, community support for palliative care, and enhanced care management will all have their part to play in improving this metric.

Indicator Detail

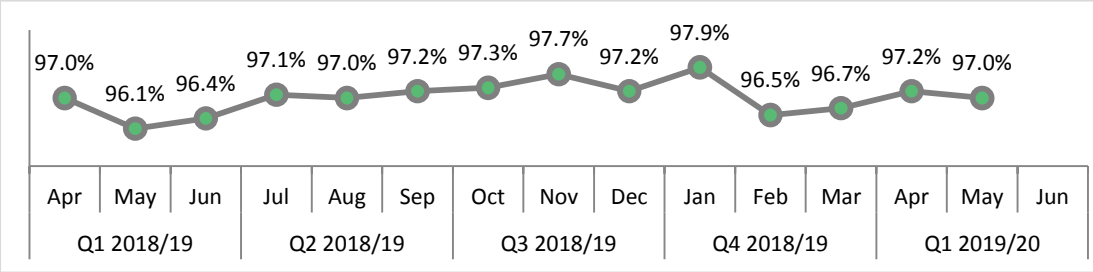
Mar-19	Diabetes Reviews
77.8%	The percentage of inpatients with known diabetes, on treatment and with a blood glucose of less than 3mmol/L, that have been reviewed by the diabetes team prior to discharge.
Target	We do not have data for this month, due to staffing challenges within the diabetes team.
>= 90%	

Actions
Medical Director to meet with Business Group Director, Associate Medical Director and Clinical Director to ensure that staffing risk is understood, that all measures to mitigate have been considered or are in place, and that any remaining risk is well represented on the risk register.



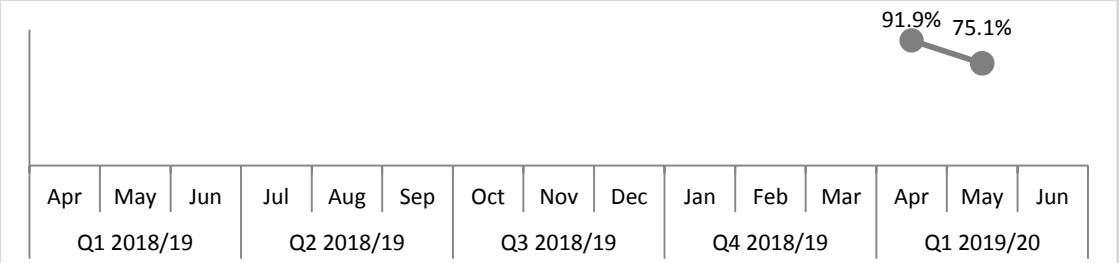
May-19	VTE Risk Assessment
97.0%	The percentage of eligible admitted patients who have been given a VTE risk assessment.
Target	The target is that >95% of agreed cohorts of patients admitted to the Trust receive an assessment relating to their individual risk of developing a venous thrombo-embolism (VTE).
>= 95%	

Actions
The target has been achieved in month.



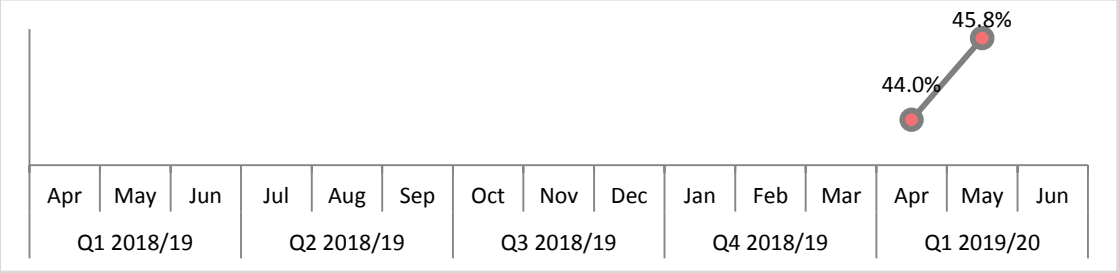
Indicator Detail

May-19	Sepsis: Timely Identification
75.1%	The number of patients who are screened for sepsis, as a percentage of all eligible patients who meet the criteria .
Target	PercentagDuring May a total of:- 599 patients triggered on the NEWS2 as a possible sepsis 309 patients were reviewed by the IP&C service team after the exclusion criteria was applied 237 patients were escalated by nursing staff to the medical teams for review



Actions
To review electronic sepsis screening system similar to ED using our patient track. Renewed challenge to ensure clinical support of the sepsis steering group. Monthly review at business group performance meetings.

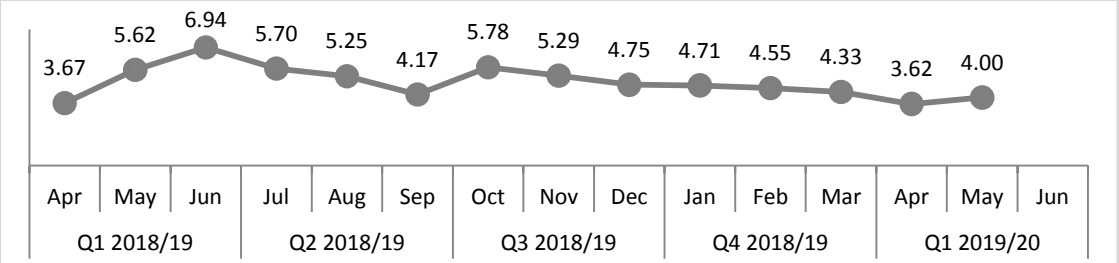
May-19	Sepsis: Timely Treatment
45.8%	The number of patients who received IV antibiotics within 1 hour, as a percentage of all eligible patients found to have sepsis.
Target	Percentage of inpatients clinically found to be septic and who received their antibiotics within an hour of the diagnosis
>= 90%	During May only 11 of the 24 patients were given antibiotics within the hour of diagnosis.



Actions
As for sepsis timely identification

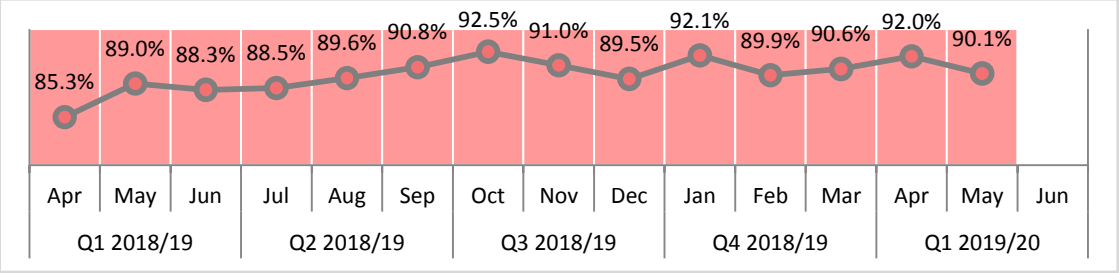
Indicator Detail

May-19	Medication Errors: Rate
4.00	Rate of medication errors, calculated as incidence per 1000 bed days.
Target	In May 2019, the medication error rate was 4.00 errors per 1000 bed days. This is an improved position from last year, but has increased from 3.62 last month



Actions
Medication errors are reviewed each week at the patient safety summit In May, reminders were sent to staff, via the Patient Safety Summit Update, regarding the following; - - Time critical antibiotics - Raising awareness about prescribing Enoxaparin and Fondaparinux - Safe use of syringe drivers Medication issues were also featured in the monthly bulletin, Risky Business. In May, staff were reminded about prescribing gastro-intestinal protection medication when prescribing NSAID therapy

May-19	Discharge Summaries
90.1%	The percentage of discharge summaries published within 48hrs of patient discharge.
Target	We have seen considerable improvement from a very poor position 18 months ago. The target of 95% is valid, and should be achievable.
>= 95%	

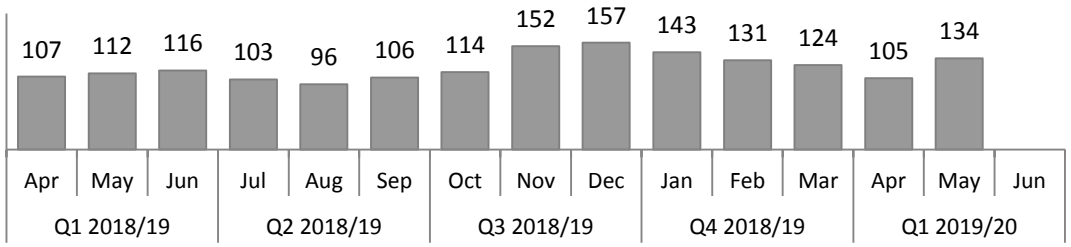


Actions
All business groups were challenged to present their ongoing actions at the business group performance reviews. The greatest challenges remain in high turnover assessment areas. None the less, effective communication with the patients primary care team after such discharges is of critical importance, so the focus will remain until the target is reached.

Indicator Detail

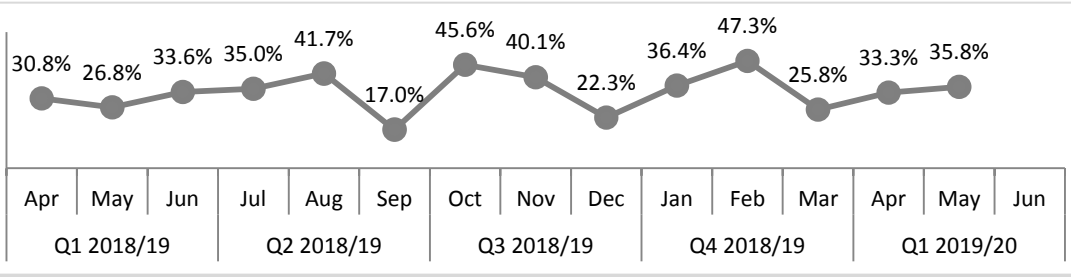
May-19	Mortality: Deaths in ED or as Inpatient
134	Total number of patient deaths while patient was in the emergency department or as an inpatient.
Target	In May, there were 134 death recorded in the Emergency Department or as an inpatient.

Actions
This metric is provided as a crude mortality statistic, and to serve as a denominator for the number of 'learning from deaths' reviews.



May-19	Mortality: Case Note Review Rate
35.8%	The number of case note reviews that taking place in month, as a percentage of all patient deaths while patient was in the emergency department or as an inpatient.
Target	In May, a case note review was undertaken in 35.8% of deaths. Currently a 'deep dive' into two mortality metrics with higher than expected deaths is being undertaken. This method has proven very useful in assessing such concerns.

Actions
This process is working well. Thank you to Dr McCluskey who has led for the past two years, and done an amazing job of establishing this process. A new lead for mortality review, Dr Collins has been appointed.

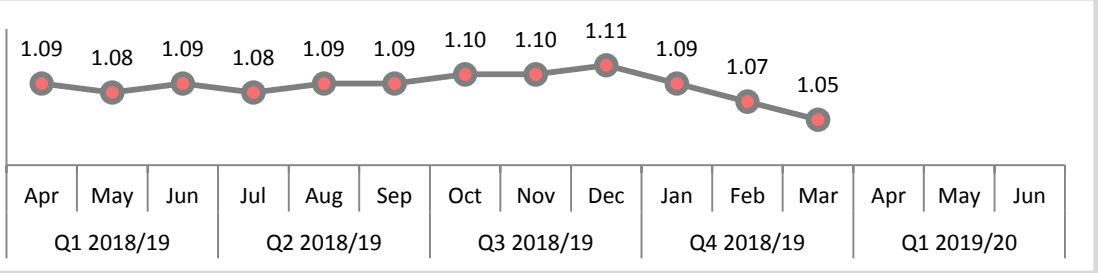


Indicator Detail

May-19	Mortality: Specialist Palliative Care Length of Stay
17.55	The average length of a patient spell, from admission to death. Includes specialist palliative patients who die in hospital only. Reported by month of discharge/death.
Target	We would hope to see the time of such admissions reduce as our palliative care services develop. There be a group of patients that hopefully do not require hospital that are given the choice not to be admitted.

Actions
This is a new metric and we hope that it will serve as a useful illustration of this service.

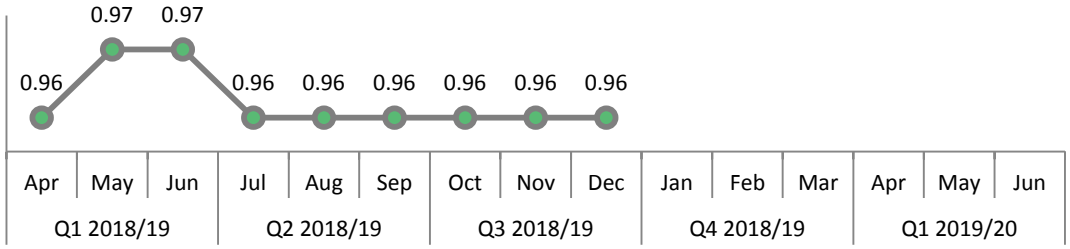
Mar-19	Mortality: HSMR
1.05	This is the ratio between the actual number of patients who either die while in hospital compared to the number of patients that would be expected to die based on whether patients are receiving palliative care, and socio-economic deprivation.
Target	A non significant improvement for the third consecutive month.
<= 1	



Actions
Mortality actions include an AQUA quality improvement project, improvements in the palliative care team, work on improved integration with primary care, Enhanced case management and crisis response. Giving patients little choice but to die in hospital increases the mortality statistic, but more importantly for many fails to meet their wishes relating to preferred place of death. Improving outcomes requires a close analysis of all diagnoses with excess deaths, optimising treatment of sepsis, reducing in patient falls and pressure ulcers, as well as a focus upon nutrition and hydration all have a part to play. A bi-annual report on mortality is submitted to the Quality Committee.

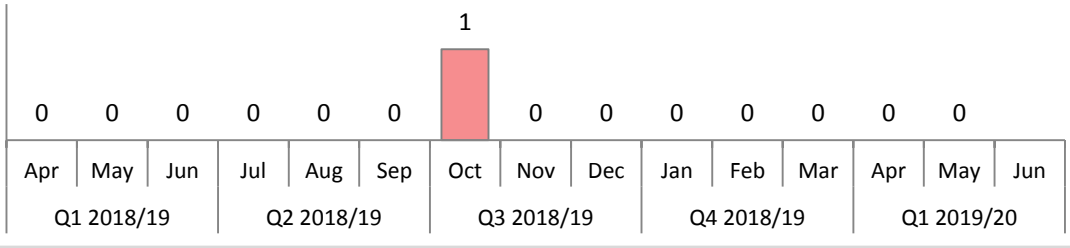
Indicator Detail

Dec-18	Mortality: SHMI
0.96	This is the ratio between the actual number of patients who either die while in hospital or within 30 days of discharge compared to the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated.
Target	Sustained above average performance.
<= 1	



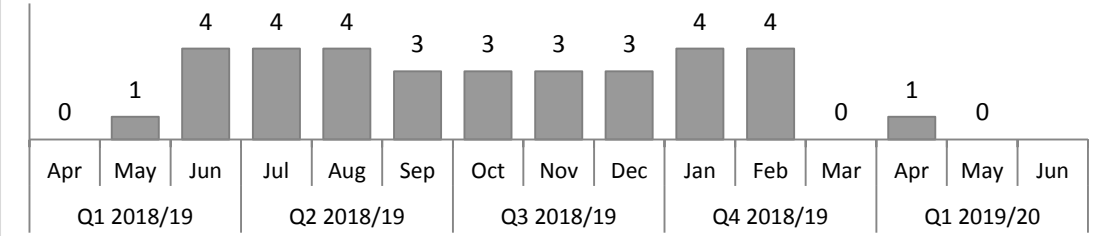
Actions

May-19	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	In May, there were no never events recorded.
<= 0	



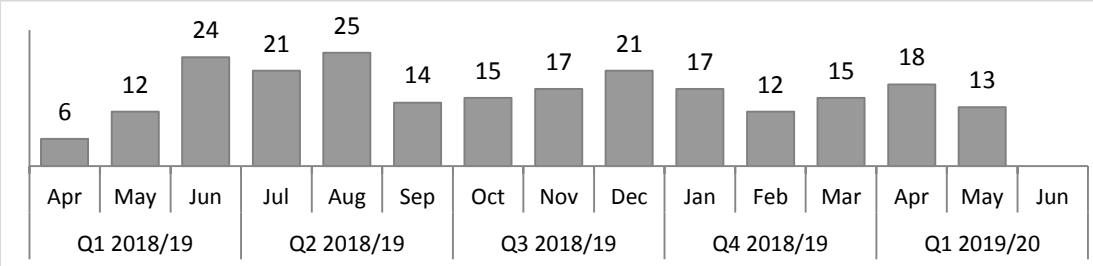
Actions
The last never event in the organisation occurred in October 2018.

May-19	Duty of Candour Breaches
0	Total number of duty of candour breaches of regulation in month.
Target	In May, there were no Duty of Candour breaches.



Actions
Duty of candour incidents are monitored on a weekly basis. Timeliness of the opening conversation and the written apology has improved.

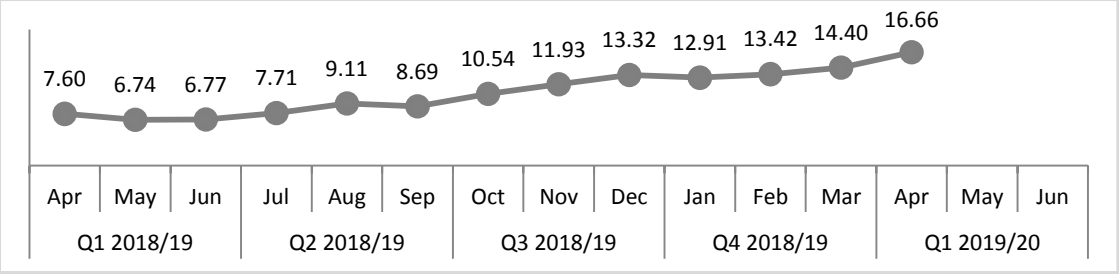
May-19	Serious Incidents: STEIS Reportable
13	The total number of STEIS reportable incidents.
Target	In May 2019 there were 13 incidents that were reported on the Strategic Executive Information System (StEIS). This was an decrease of 5, compared to last month.



Actions
The incidents reported on StEIS were •6 reported 12 hour emergency department breach incidents •3 maternity diverts •1 safeguarding incident •1 missed diagnosis •1 instance where a patient had a fall that resulted in a fractured neck of femur •1 incident where both CT scanners failed causing service disruption

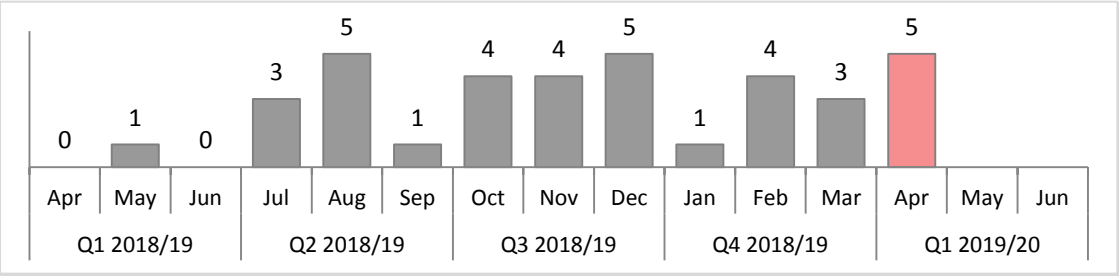
Indicator Detail

Apr-19	C.Diff Infection Rate
16.66	Average number of C.Diff infections for every 100,000 bed days, calculated using a rolling 12 month number of Trust-attributable C.Diff infections compared to the rolling 12 month average number of bed days per 100,000.
Target	The average number of Clostridium difficile infections for every 100,000 bed days, calculated using a rolling 12month number of Trust –attributable Clostridium difficile infections compared to a rolling 12 month average number of bed days per 100,00.



Actions
The target rate is monitored through the infection prevention & Control group Due to the increase in cases over the last few months, NHS improvement are supporting us in different ways of working to reduce number of cases

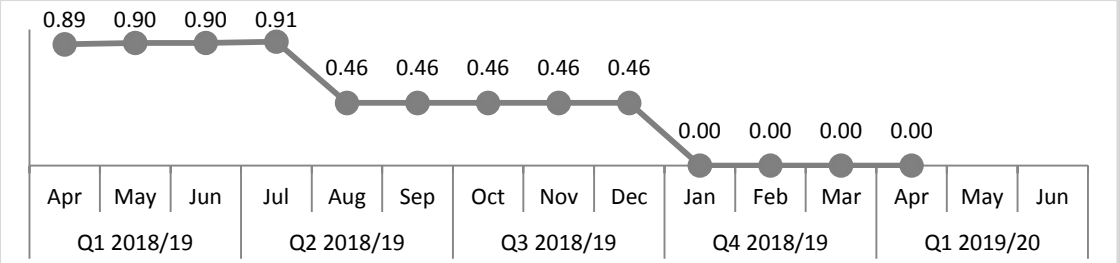
Apr-19	C.Diff Infection Count
5	Total number of C.Diff infections.
Target	The 2019-20 target set by the Department of Health for hospital acquired Clostridium difficile toxin positive cases is 51
<= 4 *	



Actions
During April there were 5 cases of Clostridium difficile The process around CDI investigations is currently under review Each CDI case will require investigating within 14 days The business group will then be require to present the case to a panel consisting of the DIPC, Matron for Infection prevention & control and the Consultant Microbiologist

Indicator Detail

Apr-19	MRSA Infection Rate
0.00	Average number of MRSA infections for every 100,000 bed days, calculated using a rolling 12 month number of Trust-attributable MRSA infections compared to the rolling 12 month average number of bed days per 100,000.
Target	Rolling 12-month count of all MRSA infections as a proportion of the average 12 month rolling occupied bed days per 100, 000 population

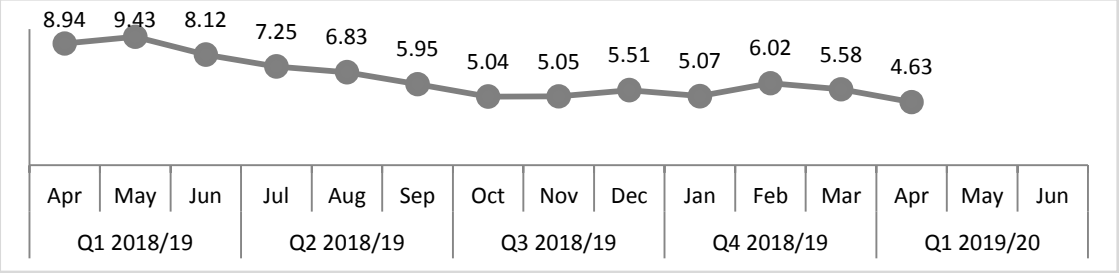


Actions

The MRSA target set by the Department of Health remains zero for2019-20.
In April there were zero cases of MRSA

The target is monitored through the infection prevention & control group

Apr-19	MSSA Infection Rate
4.63	Average number of MSSA infections for every 100,000 bed days, calculated using a rolling 12 month number of Trust-attributable MSSA infections compared to the rolling 12 month average number of bed days per 100,000.
Target	Rolling 12-month count of all MSSA infections as a proportion of the average 12 month rolling occupied bed days per 100, 000 population



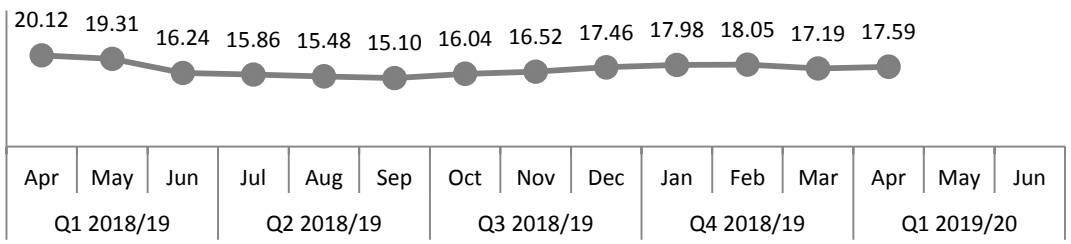
Actions

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

This is monitored through the Infection prevention & control group

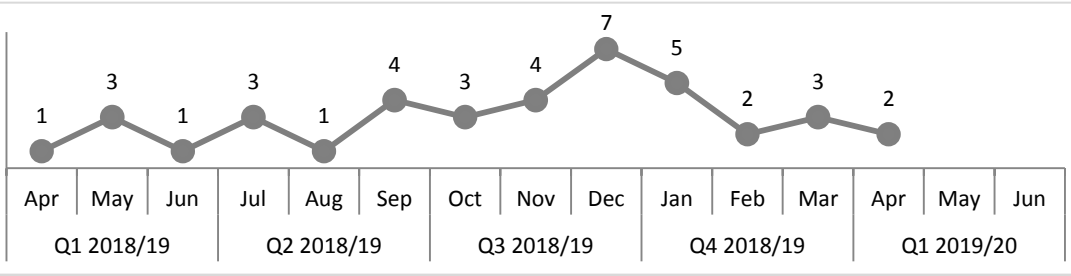
Indicator Detail

Apr-19	E.Coli Infection Rate
17.59	Average number of E.Coli infections for every 100,000 bed days, calculated using a rolling 12 month number of Trust-attributable E.Coli infections compared to the rolling 12 month average number of bed days per 100,000.
Target	Rolling 12-month count of all E. coli infections as a proportion of the average 12 month rolling occupied bed days per 100, 000 population



Actions
Nationally there is an aim to reduce healthcare associated gram-negative blood stream infections by 50% by March 2021, firstly focusing on E coli infection as one of the largest groups. The figures represented within this report are trust acquired cases A reduction plan owned by the CCG has been developed collaboratively between the Trust, Health protection nurses and CCG. This plan is monitored through the infection prevention & control group Each case is currently being reviewed following which trends and themes can be highlighted

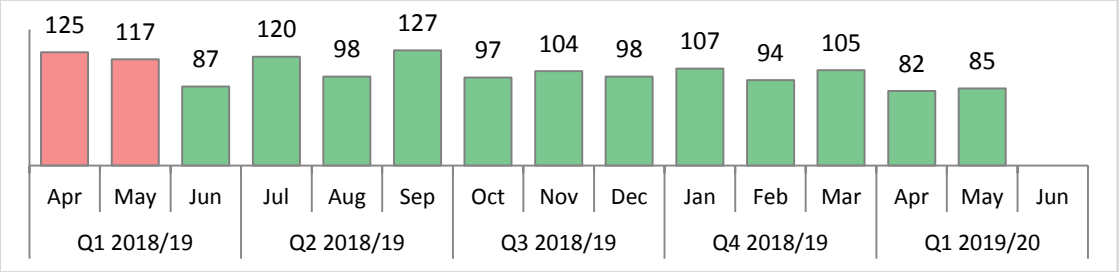
Apr-19	E.Coli Infection Count
2	Total number of E.Coli infections.
Target	The E Coli infection count is monitored as a whole health economy with no target. The figures represented within this report are trust acquired cases



Actions
This is monitored through the Infection prevention & control group Each case is currently being reviewed following which trends and themes can be highlighted

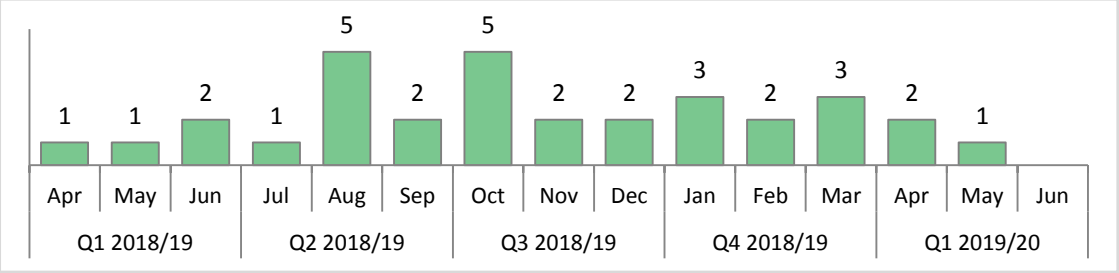
Indicator Detail

May-19	Falls: Total Incidence of Inpatient Falls
85	Total number of Inpatient falls
Target	The Trust has set a target of 10% reduction in in-patient falls for 2019/20 in comparison to 2018/19. This will be < 1100
<= 183 *	



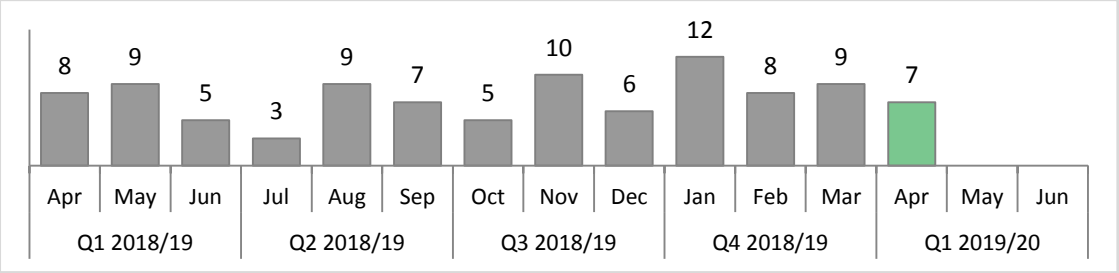
Actions
There have been a total of 85 in-patient falls during the month. May 19 continues the trend noted since December 18 with a month on month reduction in comparative data from the previous year (May 18- 102 falls; May 19- 85 falls). A sub category of “lowered to the floor” has been added to the incident reporting system this month to allow these to be removed from the actual falls numbers

May-19	Falls: Causing Moderate Harm and Above
1	Total number of falls causing moderate harm and above.
Target	The Trust has set a target of 10% reduction of in-patient falls resulting in moderate or above harm level for 2019/20 in comparison to 2018/19. This will be <26 falls with harm.
<= 4 *	



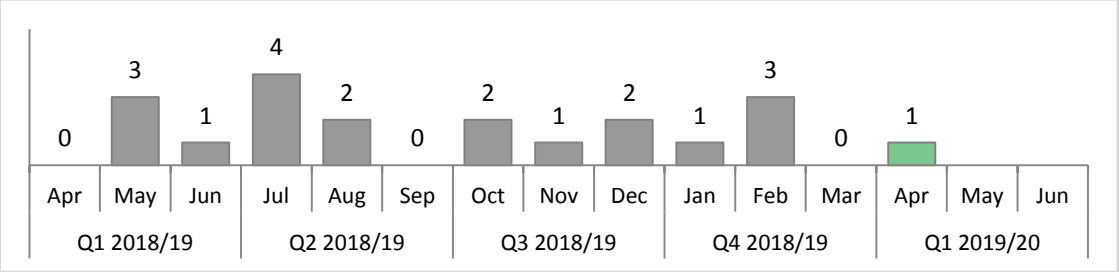
Actions
There has been 1 fall in month resulting in Moderate or above harm, resulting in a fractured neck of femur. The investigation is currently on-going. This fall occurred within Medicine and Clinical Support Running total for the year to date is 3

Apr-19	Pressure Ulcers: Hospital, Category 2
7	Total number of category 2 pressure ulcers in a hospital setting.
Target	The Trust has set a target to reduce the overall number of category 2 hospital acquired pressure ulcers (p u) by 10% over the next 12 months. This month (April data) we have had 7 category 2 p u develop.
<= 7 *	



Actions
This month on the 26th of June we are holding the Trusts Pressure Ulcer Collaborative event at the Alma Lodge Hotel. Pressure Ulcer Targets and actions to achieve will be discussed, this will form the foundations of our Trust wide improvement strategy over the next 12 month.

Apr-19	Pressure Ulcers: Hospital, Category 3
1	Total number of category 3 pressure ulcers in a hospital setting.
Target	The Trust has set a target to reduce the overall number of category 3 hospital acquired pressure ulcers (p u) by 10% over the next 12 months. This month (April data) we have had 1 category 3 p u develop.
<= 1 *	



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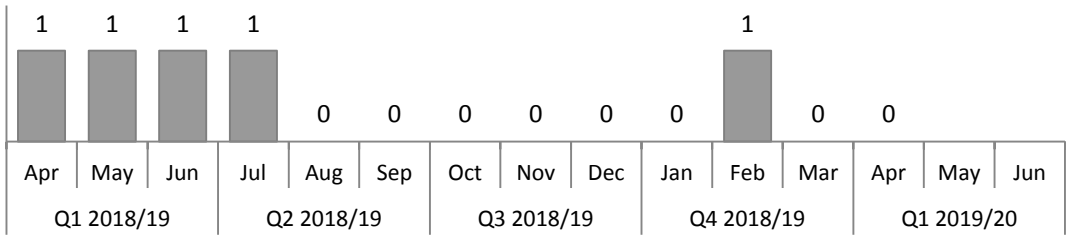
Indicator Detail

Apr-19	Pressure Ulcers: Hospital, Category 4
0	Total number of category 4 pressure ulcers in a hospital setting.
Target	The Trust has set a target to reduce the overall number of category 4 hospital acquired pressure ulcers (p u) by 10% over the next 12 months. This month (April data) we have had no category 4 p u develop.
<= 0 *	



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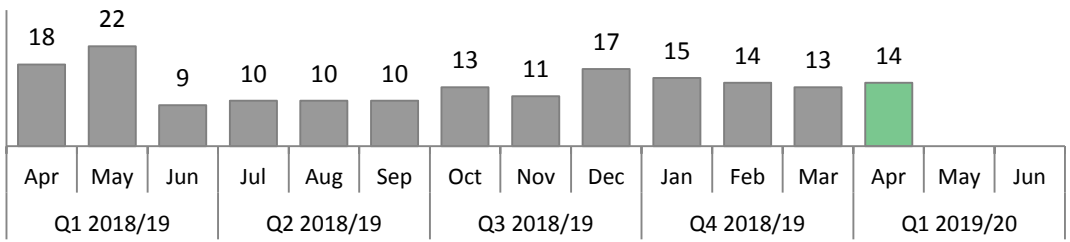
Apr-19	Pressure Ulcers: Community, Category 2
14	Total number of category 2 pressure ulcers in a community setting.
Target	The Trust has set a target to reduce the overall number of community acquired category 2 pressure ulcers (p u) by 10% over the next 12 months. This month (April data) we have had 14 category 2 pressure ulcer develop
<= 16 *	



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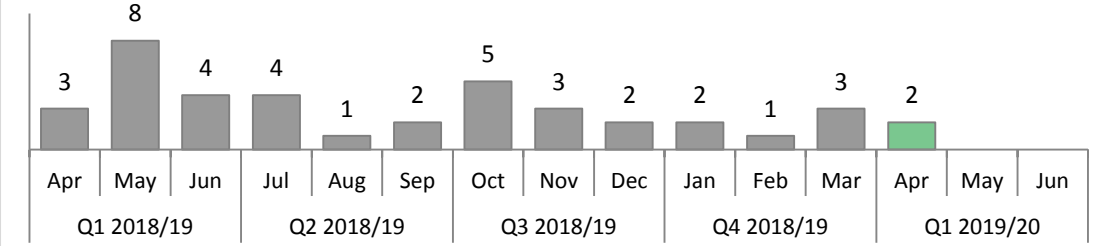
Apr-19	Pressure Ulcers: Community, Category 3
2	Total number of category 3 pressure ulcers in a community setting.
Target	The Trust has set a target to reduce the overall number of community acquired category 3 pressure ulcers (p u) by 10% over the next 12 months. This month (April data) we have had 2 category 4 pressure ulcer develop
<= 3 *	



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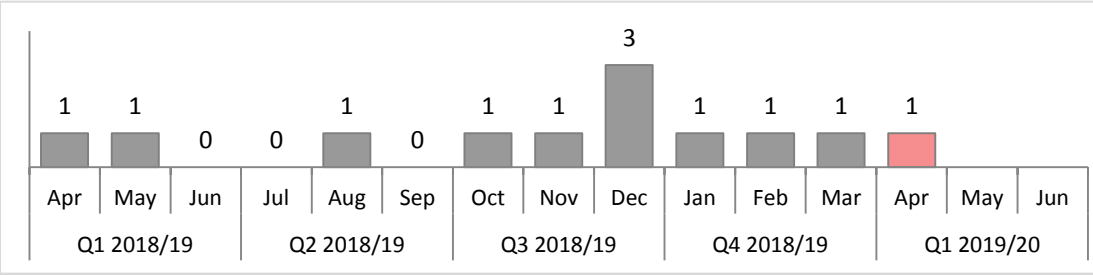
Apr-19	Pressure Ulcers: Community, Category 4
1	Total number of category 4 pressure ulcers in a community setting.
Target	The Trust has set a target to reduce the overall number of community acquired category 4 pressure ulcers (p u) by 10% over the next 12 months. This month (April data) we have had 1 category 4 pressure ulcer develop.
<= 0 *	



Actions

We are over trajectory for community acquired category 4 pressure ulcers, this has been reported and is now being investigated as a potential serious incident, and the outcome of this in terms of lessons learned is therefore awaited.

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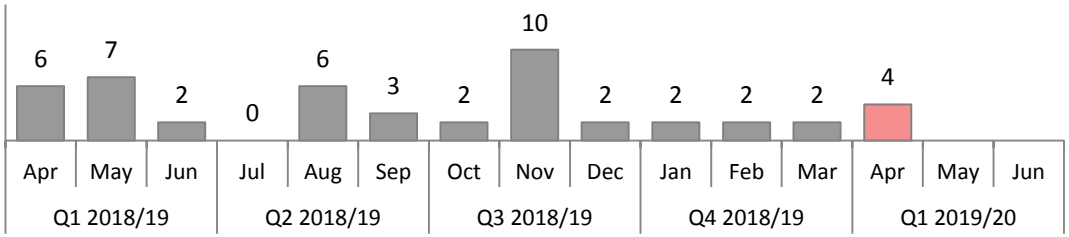
Indicator Detail

Apr-19	Pressure Ulcers: Device Related, Category 2
4	Total number of device-related category 2 pressure ulcers. Includes those from both a hospital and community setting.
Target	The Trust has set a target to reduce medical device related pressure ulcers (MDRPU) by 25% by the end of March 2020. This month (April data) there has been a total of four category 2 medical device related pressure ulcers that have occurred. This is 2 over our monthly trajectory
<= 2 *	



Actions

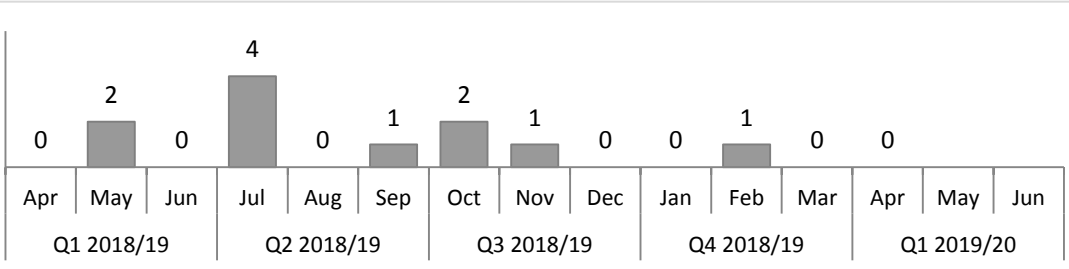
Two of these have developed within the medicine BG, one following the application of a POP and the other from a respiratory ventilation mask.

Two have developed under the care of integrated care, Podiatry and Orthotic services following the application of splints and braces.

The Medical Device Task and Finnish group is to be re-established to build on change initiatives already completed last year, and the tissue Viability service is asking that medical device pressure ulcers to be a standing agenda item on the Trusts Medical Device group going forward.

To date 55 staff have now received medical device tool box training across the trust, but has not yet included the clinical areas where MDRPU have occurred this month

Apr-19	Pressure Ulcers: Device Related, Category 3
0	Total number of device-related category 3 pressure ulcers. Includes those from both a hospital and community setting.
Target	The Trust has set a target to reduce medical device related pressure ulcers (MDRPU) by 25% by the end of March 2020. This month (April data) there has been no category 3 medical device related pressure ulcers that have occurred.
<= 0 *	



Actions

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<= 0 *	

Actions

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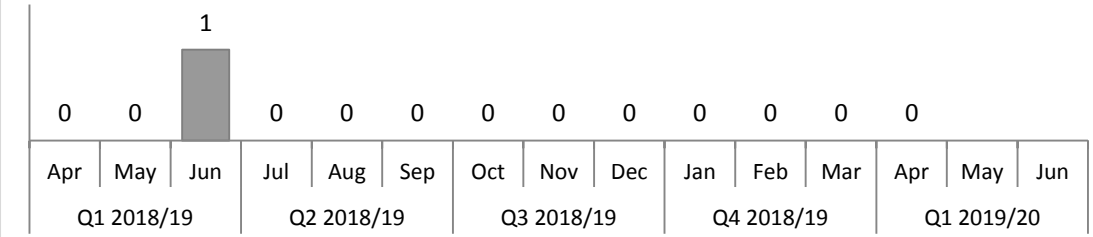
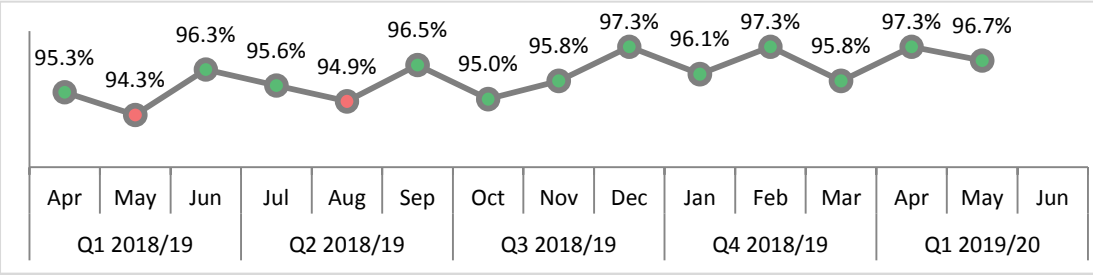


May-19	Safety Thermometer: Hospital
96.7%	The percentage of patients receiving harm-free care, calculated using a point prevelance sample based on falls, pressure ulcers, UTIs and VTE assessments.
Target	The trust aim is that >95% of patients receive harm free care as monitored by safety thermometer. Results for May show that we have achieved 96.7%.
>= 95%	

Actions

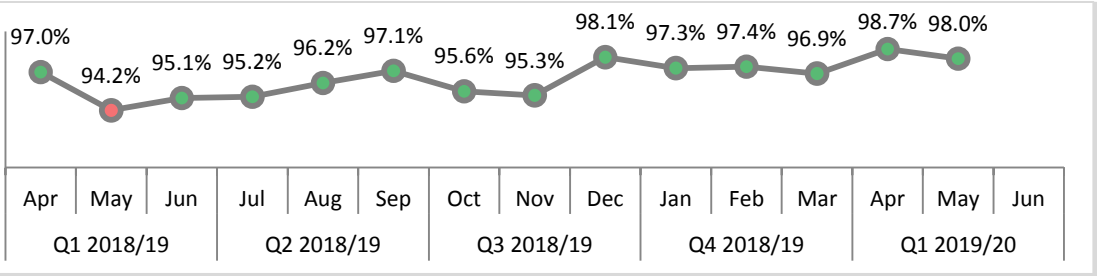
A training presentation was delivered to raise awareness within the Integrated Care business group in May at the senior nurse meeting.

Weekly validation meetings continue to be undertaken to improve the quality of the data.



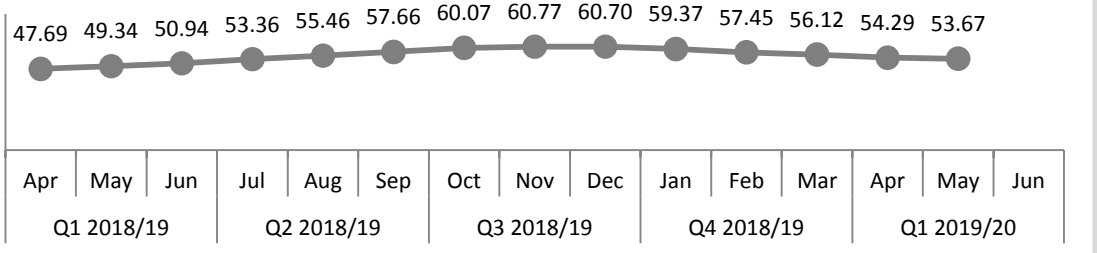
Indicator Detail

May-19	Safety Thermometer: Community
98.0%	The percentage of patients receiving harm-free care, calculated using a point prevelance sample based on falls, pressure ulcers, UTIs and VTE assessments.
Target	The Trust aim is that >95% of patients receive harm free care as monitored by safety thermometer. Results for May show that we have achieved 98.3%
>= 95%	



Actions
No actions required.

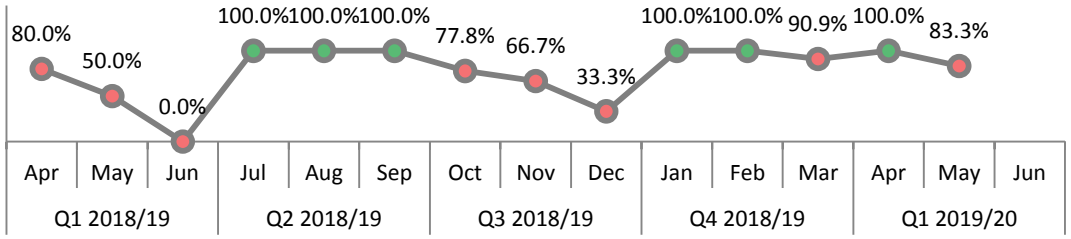
May-19	Patient Safety Incident Rate
53.67	Average number of patient safety incidents for every 1000 bed days, calculated using a rolling 6 month number of reported patient safety incidents compared to the rolling 6 month average number of bed days per 1000.
Target	The number of patient safety incidents for every 1000 bed days has slightly reduced this month for the 6th month in a row. 1036 patient safety incidents were reported for the month of May 2019.



Actions
The top five incidents in the month of May 2019: •Staffing issues •Pressure ulcers present on admission •Patient slip trip or fall •Uncooperative patient behaviour •Pressure ulcers developed during admission or whilst on case load There has been an increase in “Uncooperative patient behaviour” & “New PU or Skin damage during admission or caseload” incidents reported compared to the month of April. Each week, following the patient safety summit, an update is circulated to all staff. Key themes this month have been; •Needle stick and inoculation injuries •Safe discharge of patients who leave our care against medical advice •Stock of vital equipment •Escalation of potential mixed sex accomadation •Missing or absconding patients •Using the correct equipment

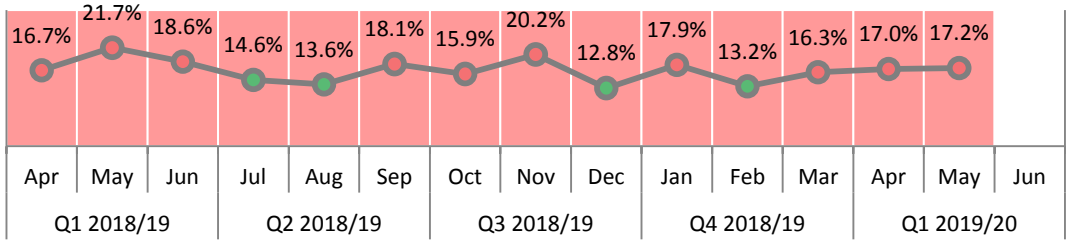
Indicator Detail

May-19	Patient Safety Alerts: Completion
83.3%	The percentage of Patient Safety Alerts that are completed within their due date.
Target	One NHS patient safety alert was not completed by the deadline in the month of May. NHS/PSA/RE/2018/007 Management Of Life Threatening Bleeds From Arteriovenous Fistulae And Grafts.
>= 100%	



Actions
In relation to the alert, information is available on the microsite and topic has been discussed at huddles. Further information from the regional transplant unit is being sought to incorporate into the guidelines as they are in the process of updating their policy and guidance. Work continues with business groups to ensure appropriate information is returned to the quality governance team in a timely manner. Additional processes are being implemented for patient safety alerts so that the business groups and relevant clinical review groups are involved in the oversight of the development and implementation of the action plans .

May-19	Emergency C-Section Rate
17.2%	The number of patients having an emergency c-section, as a percentage of all patients having registerable births.
Target	An increase in the Emergency C Section rate was reported in May. Although there has been an increase in the Emergency C. Section there has not been a negative impact on the outcomes for babies.
<= 15.4%	

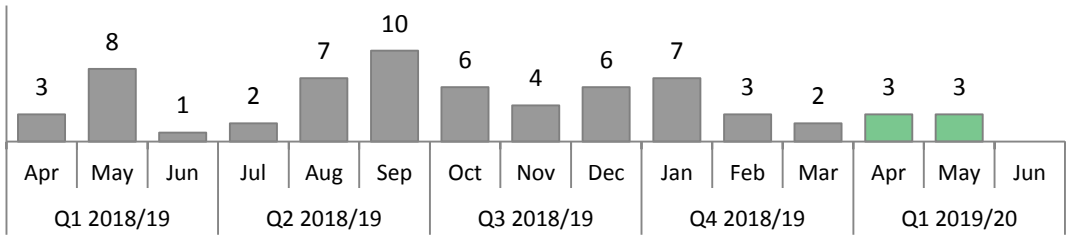


Actions
Emergency CS rate monitored at quality board. Review of the dashboard parameters planned to ensure that we are in line with GM.

Indicator Detail

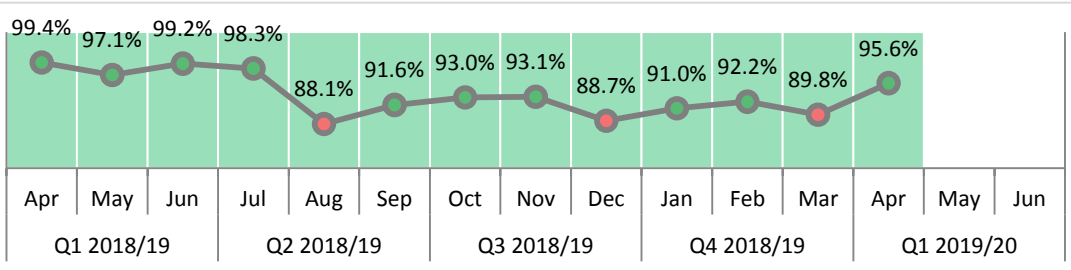
May-19	Term Babies Admitted to the Neonatal Unit
3	Number of term babies (greater than or equal to 37 weeks) admitted to SCBU/NICU, at birth, unexpectedly.
Target	In May, there were 3 babies admitted to the neonatal unit according to the RCOG definition of the number of term babies (greater than or equal to 37 weeks) admitted to SCBU/NICU, at birth, unexpectedly
<= 5	

Actions
All of these admissions are subject to a review. The target was achieved in month

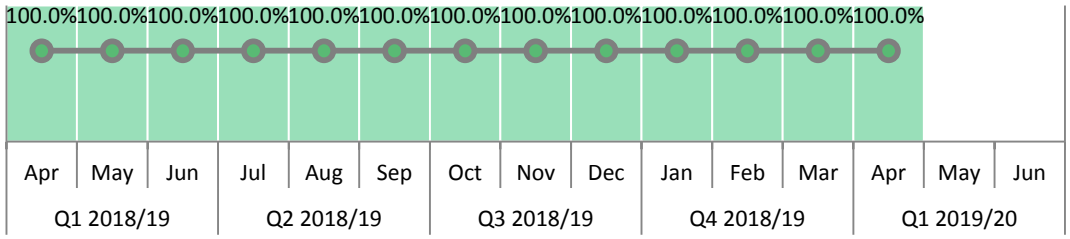


Apr-19	Dementia: Finding Question
95.6%	The percentage of eligible patients who have a diagnosis of dementia or delirium or to whom case finding is applied.
Target	The target has been achieved in month
>= 90%	

Actions
No Actions required

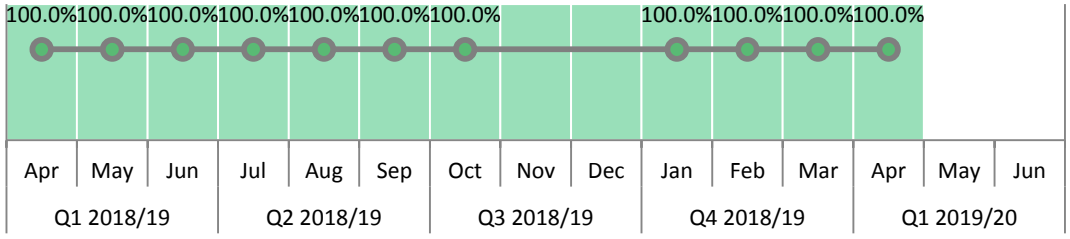


Apr-19	Dementia: Assessment
100.0%	The percentage of eligible patients who, if identified as potentially having dementia or delirium, are appropriately assessed.
Target	The target has been achieved in month
>= 90%	



Actions
No Actions required

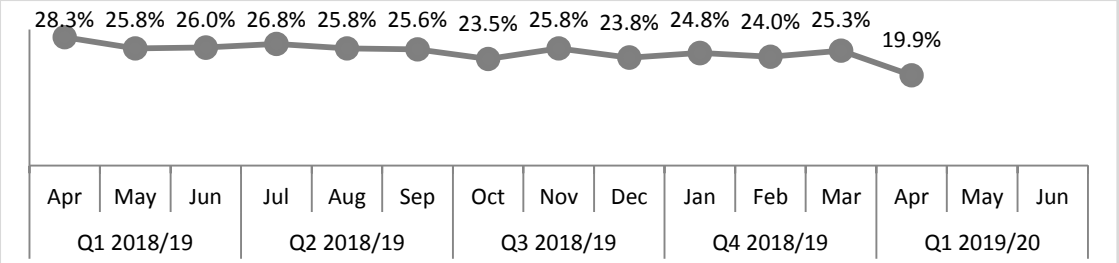
Apr-19	Dementia: Referral
100.0%	The percentage of eligible patients where the outcome was positive or inconclusive, are referred on to specialist services.
Target	The target has been achieved in month
>= 90%	



Actions
No Actions required

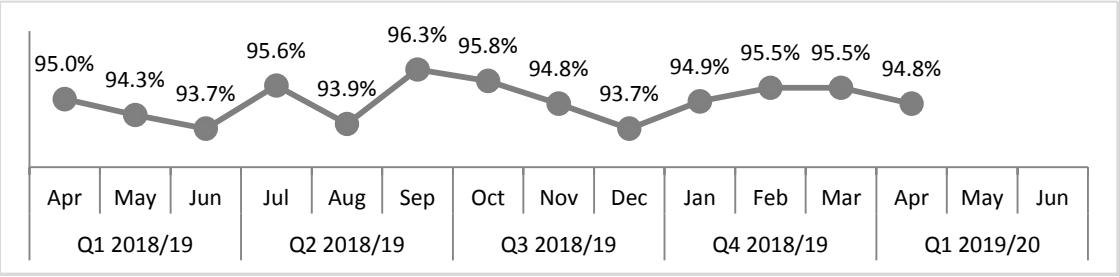
Indicator Detail

Apr-19	Friends & Family Test: Response Rate
19.9%	The percentage of eligible patients completing an FFT survey.
Target	The percentage of surveyed patients who are extremely likely or unlikely to recommend the Trust for care.



Actions
Although there is no national indicator for response rate, Business Groups, wards and departments are encouraged to ensure as many patients as possible to continue to provide feedback. This enables us to triangulate the information with other patient feedback mechanisms.

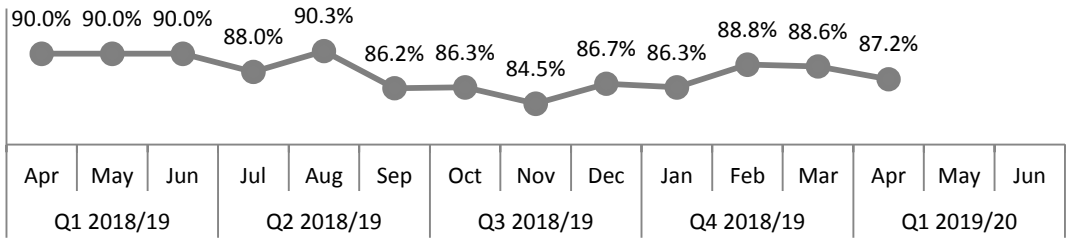
Apr-19	Friends & Family Test: Inpatient
94.8%	The percentage of surveyed inpatients who are extremely likey or likely to recommend the Trust for care.
Target	The percentage of surveyed inpatients who are extremely likely or likely to recommend the Trust for care.



Actions
Although there is no national indicator for response rate, Business Groups, wards and departments are encouraged to ensure as many patients as possible to continue to provide feedback. This enables us to triangulate the information with other patient feedback mechanisms. The top 3 themes collected by Healthcare Communications for Inpatients for FFT in May are: Positive: 1 .Staff attitude (303) 2. Implementation of care (188) 3. Environment (106) Negative: 1. Waiting time (7) 2. Patient mood/feeling (5) 3. Staff attitude (5)

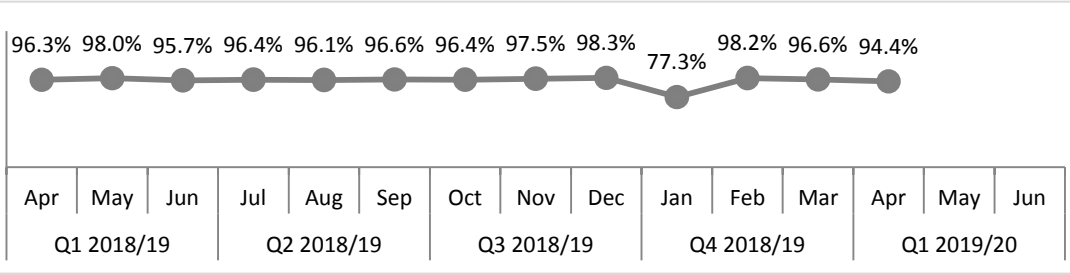
Indicator Detail

Apr-19	Friends & Family Test: A&E
87.2%	The percentage of surveyed A&E patients who are extremely likey or likely to recommend the Trust for care.
Target	The percentage of surveyed inpatients who are extremely likely or likely to recommend the Trust for care.



Actions
Although there is no national indicator for response rate, Business Groups, wards and departments are encouraged to ensure as many patients as possible to continue to provide feedback. This enables us to triangulate the information with other patient feedback mechanisms. The top 3 themes collected by Healthcare Communications for Inpatients for FFT in May are: Positive: 1. Staff attitude (519) 2. Implementation of care (189) 3. Waiting time (180) Negative: 1. Waiting time (46) 2. Staff attitude (41) 3. Environment (37)

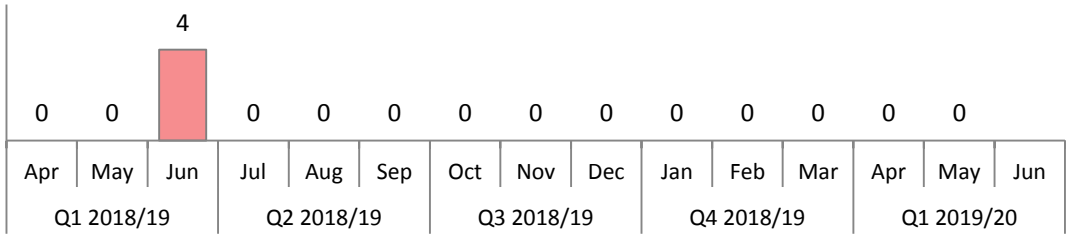
Apr-19	Friends & Family Test: Maternity
94.4%	The percentage of surveyed maternity patients who are extremely likey or likely to recommend the Trust for care.
Target	The percentage of surveyed maternity inpatients who are extremely likely or likely to recommend the Trust for care.



Actions
Although there is no national indicator for response rate, Business Groups, wards and departments are encouraged to ensure as many patients as possible to continue to provide feedback. This enables us to triangulate the information with other patient feedback mechanisms. The top 3 themes collected by Healthcare Communications for Inpatients for FFT in May are: Positive: 1.Staff attitude (45) 2. Implementation of care (23) 3. Communication (18) Negative: There were no negative comments.

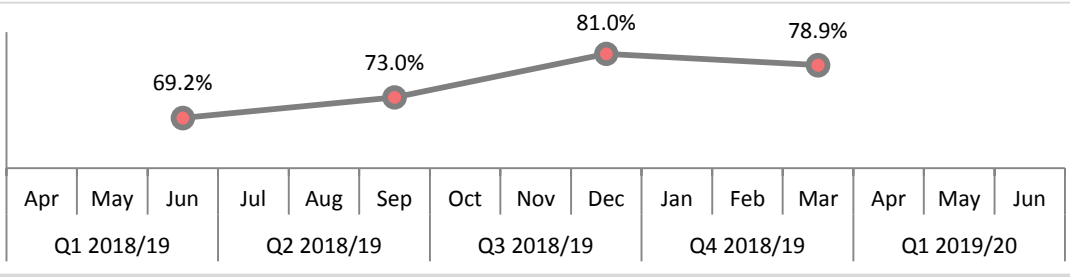
Indicator Detail

May-19	DSSA (mixed sex)
0	Total number of occasions sexes were mixed on same sex wards
Target	Total number of occasions that sexes were mixed as per trust standard operating procedure.
<= 0	



Actions
No patients were affected by a mixed sex breach in the month of May. A meeting has taken place with the Matron for Patient Experience, Associate Nurse Director for Medicine, Lead Nurse Patient Flow, Matron and Ward Manager for CCU to discuss improving the process and management of patients to prevent potential breaches. The standard operating procedure has been updated this month including a flow chart for procedures within the Coronary Care Unit.

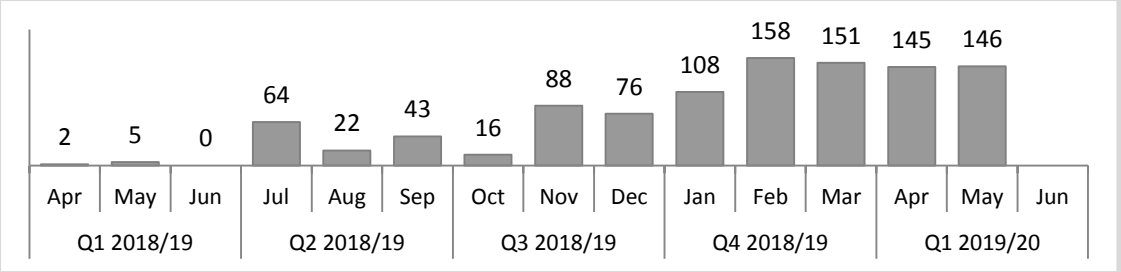
Mar-19	Learning Disability: Adjusted Care Plans
78.9%	The number of inpatients with a learning disability who have a reasonable adjustment care plan in place, as a percentage of all patients with a learning disability.
Target	The Trust has in place a flagging system to identify people who have learning disabilities. Adjusted care plans are formulated by referring to the Hospital Passport brought in with the patient and talking to the patient and / or their carers.
>= 100%	



Actions
To further underpin the leadership and management by the Business Groups in meeting the needs of patients with a learning disability in our care: •the Adult Safeguarding team established an audit process through the Audit Management and Tracking interface •Business Group Matrons will provide weekly evidence to the Adult Safeguarding Team in relation to the care and management of patients in our care with a learning disability. This data will be shared at Safety Quality and Leadership Group. •Weekly monitoring will be undertaken by the Adult Safeguarding team at ward level.

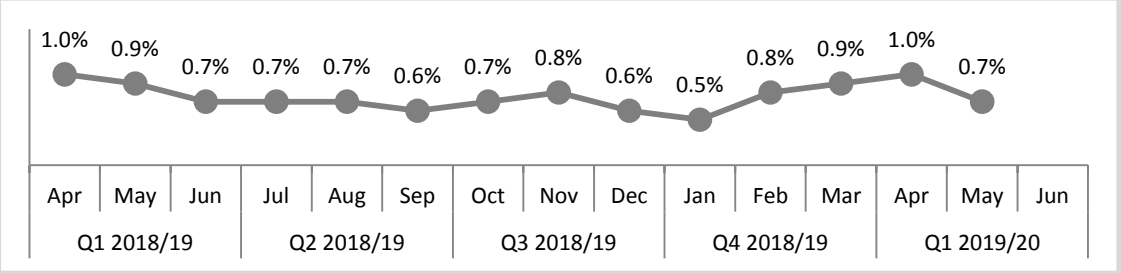
Indicator Detail

May-19	Compliments
146	Total number of compliments received.
May-19	For May 2019, 146 compliments have been received by the Trust. 7 compliments were received on Care Opinion.



Actions
Any compliments received by the patient and customers services team are shared with the chief nurse & director of quality governance who acknowledges them in writing. If a member of staff is identified, the chief nurse & director of quality governance will present them with a Proud to Care Certificate in recognition of their hard work. The matron for patient experience and quality improvement continues to work with business groups and wards to ensure compliments are being captured on the Datix system. This will enable the Trust to capture a wealth of information from thank you cards, letters, gifts and verbal feedback from service users and members of staff. The information is populated on a dashboard for each clinical area and their respective business group. Themes from the compliments are centred around compassion, caring, committed and professional staff.

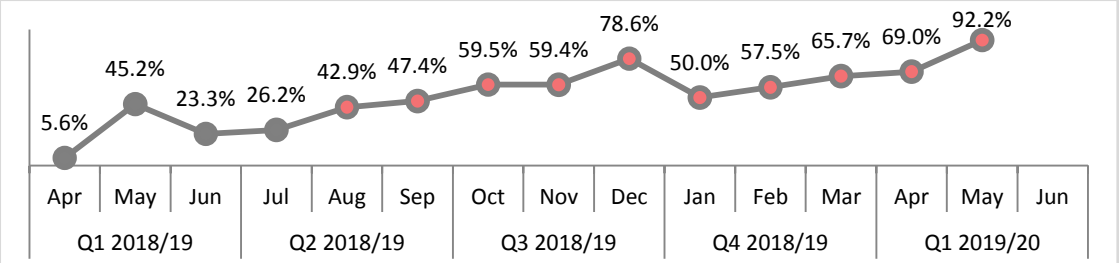
May-19	Complaints Rate
0.7%	The total number of formal written complaints received compared with the whole time equivalent staff.
Target	35 complaints were received in May 2019: Integrated Care = 5, Medicine = 7, Surgery = 14 and WCDS = 8



Actions
The Patient and Customer Services continue to focus on resolving concerns informally where appropriate with the hope to reduce the number of formal complaints.

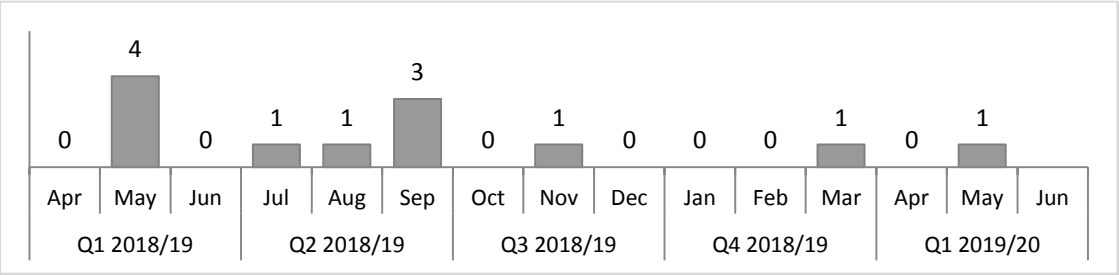
Indicator Detail

May-19	Complaints: Response Rate 45
92.2%	The percentage of formal complaints responded to within 45 days.
Target	In the month of May 2019, 51 responses were closed, 47 of which were responded to on time resulting in a 92.2% response rate. The business group response rate is as follows: integrated care: 100%, surgery: 100%, estates and facilities: 100%, WCDS: 92.8% and medicine: 82.4%
>= 95%	



Actions
There has been a significant improvement on the Trust's response rate as a result of the hard work undertaken within the business groups. The patient and customer services team continue to liaise with the business groups and the executive team with the aim of continuing to improve the Trust complaints response rate. Complainants are kept informed of any delays that occur resulting in the Trust not being to respond in the agreed timeframe

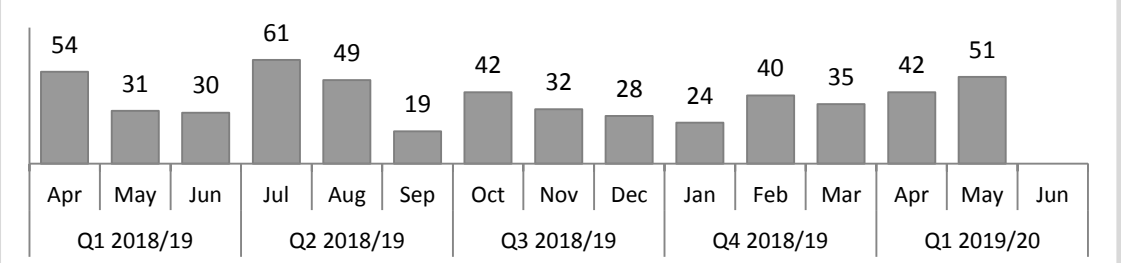
May-19	Complaints: Parliamentary & Health Service Ombudsman Cases
1	The total number of open Ombudsman cases.
Target	In May 2019, there was 1 new referrals received from the Parliamentary and Health Service Ombudsman and no final reports were received in month



Actions
The PALS and Complaints Team Lead is responsible for liaising with the Ombudsman to ensure continuity and a seamless service. It is hoped that by improving the quality of responses, the number of cases upheld by the Ombudsman will remain low.

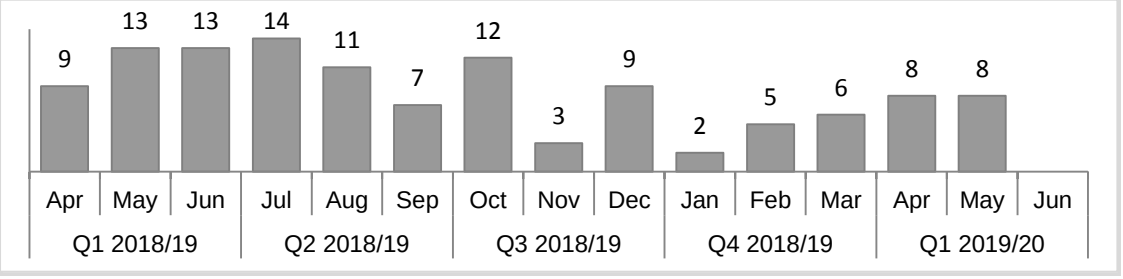
May-19	Complaints Closed: Overall
51	The total number of formal complaints that have been closed.
Target	In the month of May 2019, 51 responses were closed in month: integrated care closed 5, medicine closed 17, surgery closed 14, women, children & diagnostic services closed 14 and estates and facilities closed 1.

Actions
Work continues to ensure responses are sent in the timeframe initially agreed on the commencement of the investigation.

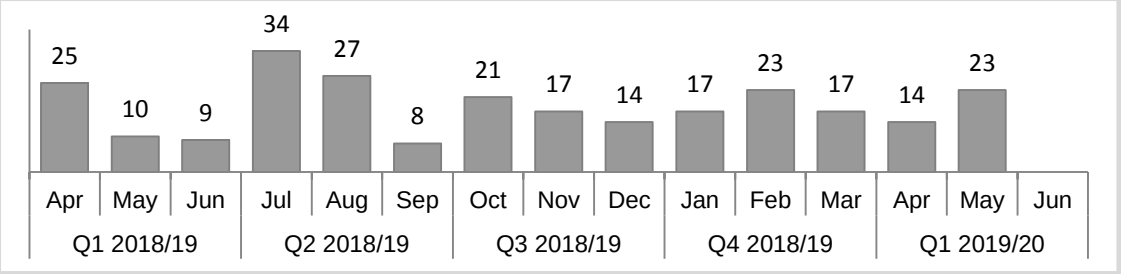


May-19	Complaints Closed: Upheld
8	The total number of upheld formal complaints that have been closed.
Target	For May 2019, 8 cases were upheld out of the 51.

Actions
The chief nurse & director of quality governance continues to monitor the learning from complaints and ensure requests that this is always shared with the complainant to provide them with reassurance.

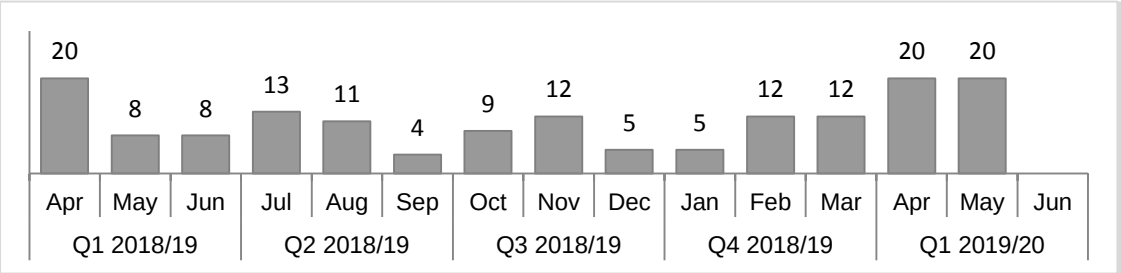


May-19	Complaints Closed: Partially Upheld
23	The total number of partially upheld formal complaints that have been closed.
Target	In May 2019, 23 of the cases were partially upheld of the 51 closed.



Actions
Complaints that have partially upheld often have learning points for staff to reflect on. If this is the case, these will be shared with the complainant and fed back to appropriate staff.

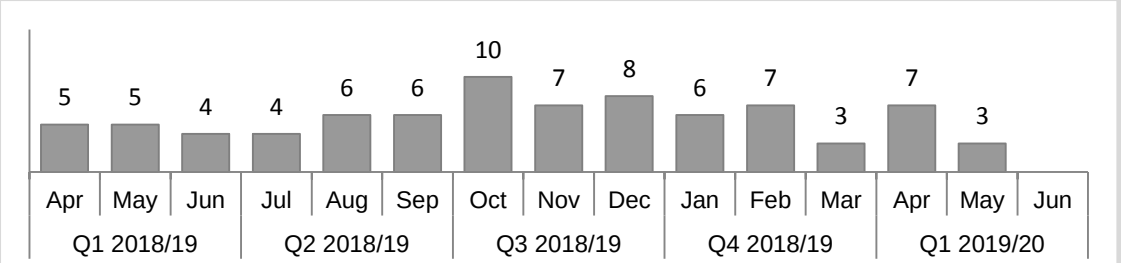
May-19	Complaints Closed: Not Upheld
20	The total number of not upheld formal complaints that have been closed.
Target	In May 2019, 20 of the cases were not upheld of the 51 closed.



Actions
Complaints that have not been upheld may still have learning points for staff to reflect on. If this is the case, this will be shared with the complainant and fed back to appropriate staff. If learning has not been identified, the complaint will still be shared with relevant staff for consideration for future practice.

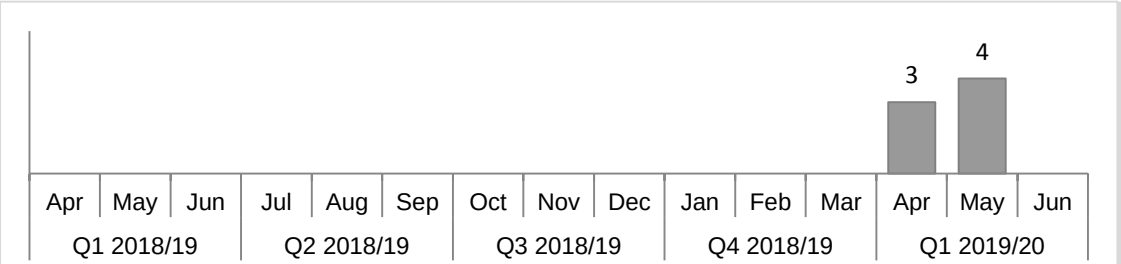
May-19	Litigation: Claims Opened
3	Total number of claims opened in month.
Target	In May 2019, 3 claims were received against the Trust. 2 medical negligence claims 1 employment liability claim

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



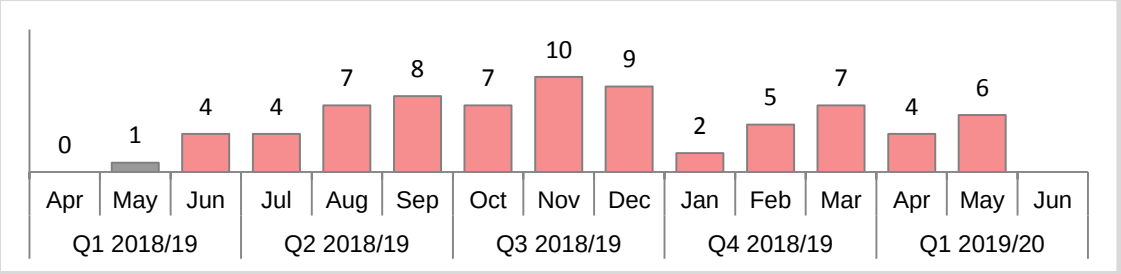
May-19	Litigation: Claims Closed
4	Total number of claims closed in month.
Target	In May 2019 there were 4 claims closed. 3 were medical negligence claims and were settled. 1 employment liability claim was repudiated.

Actions
The Trust robustly challenges claims to ensure payments are appropriate to the claim. The three claims settled were related to A missed diagnosis following a fall resulting in a delay in surgery A lost biopsy resulting in a repeat biopsy being undertaken The development of a category 4 pressure ulcer



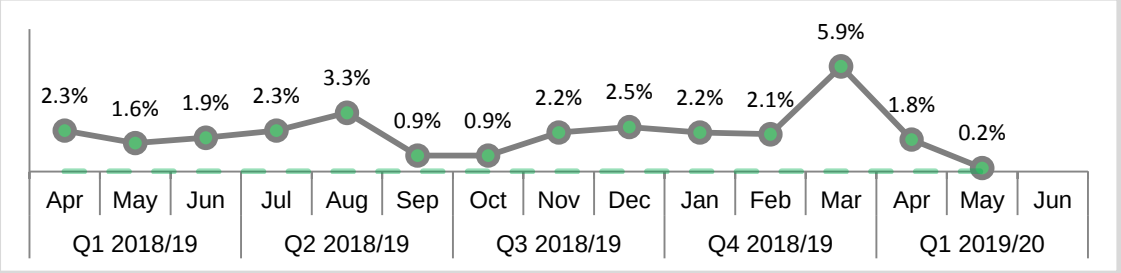
Indicator Detail

May-19	Referral to Treatment: 52 Week Breaches
6	The total number of patients whose pathway is still open and their clock period is greater than 52 weeks at month end.
Target	There were 6 patients reported beyond 52 weeks waiting for first definitive treatment. 2 patients still waiting for treatment have chosen to be treated in July.
<= 0	



Actions
Weekly review and escalation of any patient waiting beyond 38 weeks on their care pathway. Refresher training for administrative staff to ensure pathway waiting times are recorded accurately.

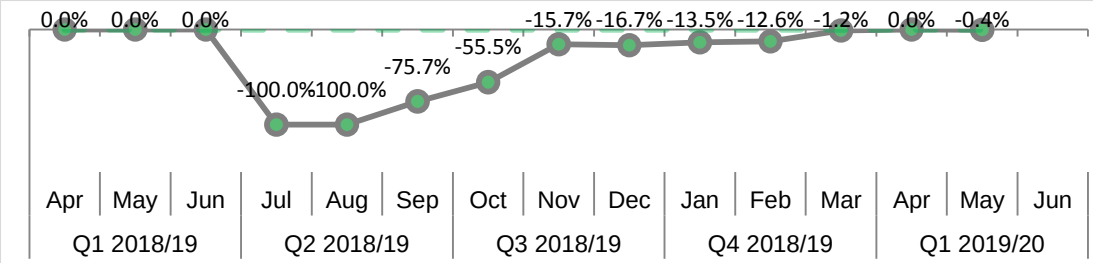
May-19	Financial Controls: I&E Position
0.2%	The percentage variance between planned financial position and the actual financial position.
Target	In the twelve months to 31st March 2020 the Trust has a planned underlying deficit of £24.5m after the planned achievement of a £14.2m CIP. This excludes non-recurring external support of £20.9m which will be received in full if the Trust achieves the agreed control total, reducing the overall planned deficit to £3.6m.
>= 0%	



Actions
The financial position for the first two months is in line with the overall plan; the Trust has delivered a deficit against the NHSI control total of £3.8m as planned. However in achieving this, the Trust has delivered less activity and income than plan, but also spent less than plan.

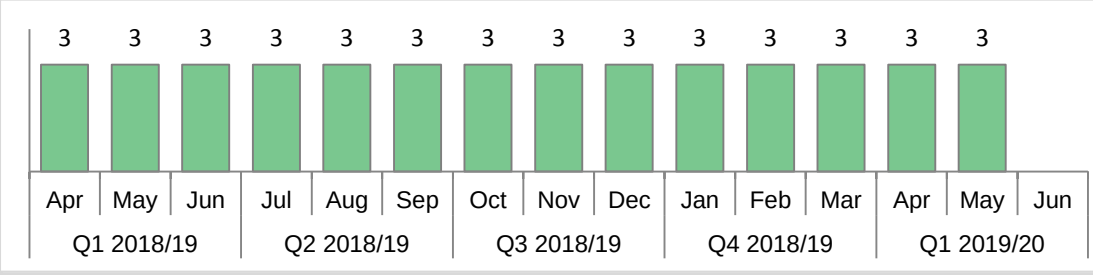
Indicator Detail

May-19	Cash
-0.4%	The percentage variance between planned borrowing-to-date and the actual borrowing-to-date.
Target	Cash in the bank on 31st May 2019 was £7.8m. The Trust has maintained a balance higher than the minimum cash balance allowed to protect working capital for the start of the financial year, where borrowing is limited.
<= 0%	



Actions
The Trust borrowed £1.6m in May, increasing the total borrowed to date to £27.6m since September 2018. Due to the external support agreed for 2019/20 borrowing has reduced to a lower level in April and May, and is expected to peak and trough during the year as cash is received in advance and arrears for various elements. The requirement for a working capital support facility loan is continually being reviewed as part of the 13 week rolling cash flow forecast and the Trust continues to be in dialogue with NHSI's cash and capital team about requirements for cash.

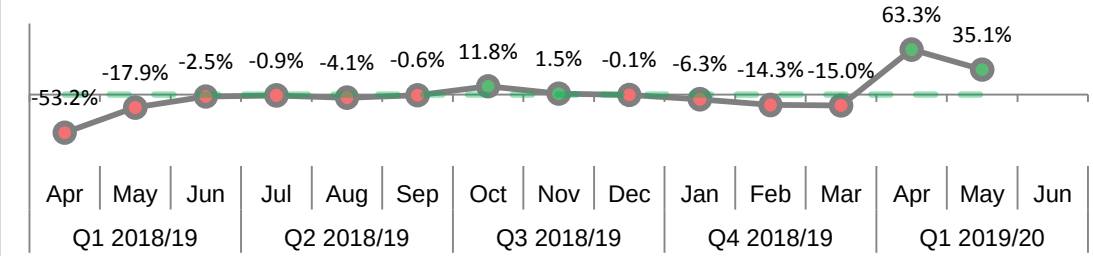
May-19	Financial Use of Resources
3	A calculated score based on capital service capacity, liquidity, income & expenditure margin, distance from financial plan, and agency spend.
Target	The Trust's Use of Resources (UOR) draft score under the Single Oversight Framework is a 3, which is in line with plan.
<= 3	



Actions
Individual scores under the Finance & Use of Resources Metrics are shown below: Capital service cover = 4 (worst) Liquidity = 4 (worst) I&E margin = 4 (worst) Variance from control total = 1 (best) Agency spend = 1 (best) For the Trust's overall score to improve to a 2 then the Trust cash balance and liquidity would need to improve under the financial sustainability scores. As these two metrics score 4 in the operational plan for 2019/20, then this triggers an over-ride in the overall Use of Resources metric and limits the overall score to a 3.

Indicator Detail

May-19	CIP Cumulative Achievement
35.1%	The percentage variance between planned CIP achievement and the actual CIP achievement.
Target	The cost improvement plan (CIP) is £0.3m favourable to date, with £1.3m delivered against the £1.0m year to date target, of which £0.7m is non-recurrent vacancy factor. The year to date target is less than 7% of the annual requirement.
>= 0%	



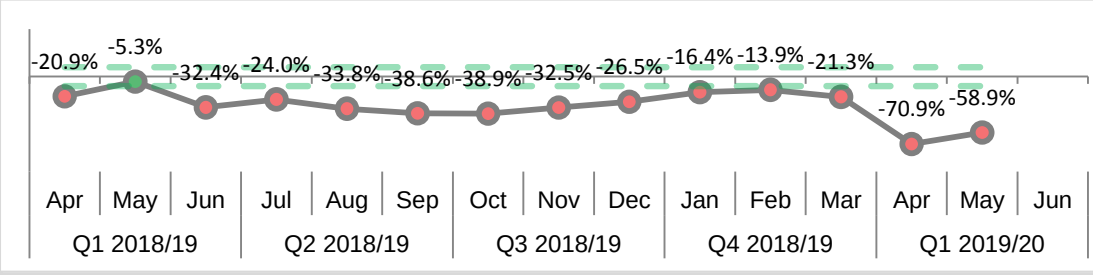
Actions

The Trust is £0.3m favourable to the profiled CIP plan to date, however this has been delivered through non-recurrent vacancy factor and there is a significant risk to the delivery of the total CIP programme in 2019/20. At month 2 the Trust has identified £9.1m of schemes, and is working to identify schemes in order to bridge the £5.1m gap to the £14.2m requirement for 2019/20.

£3.4m of CIP has been delivered against the £14.2m in year target, £1.9m of which is recurrent.

The phasing of the CIP means that the level of savings required increases in each quarter of the year.

May-19	Capital Expenditure
-58.9%	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 £0.6m have been incurred in the two months to date against a plan of £1.5m and so is £0.9m behind plan. This relates to equipment purchases (£0.4m), estates capital projects (£0.1m) and the early termination of a finance lease (£0.3m). This expenditure will now fall later in the year for IT system stabilisation.
+/- 10%	

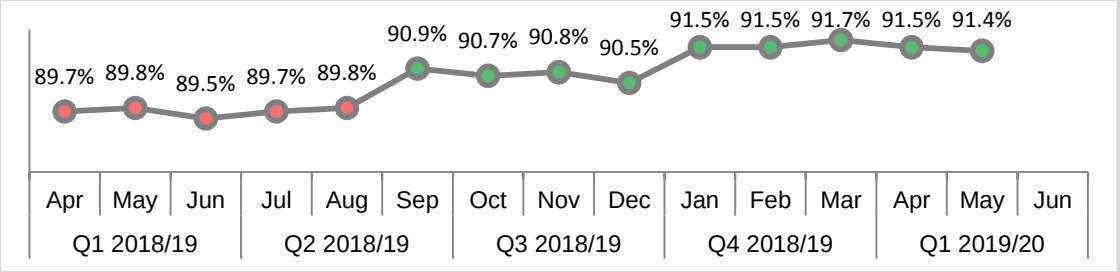


Actions

The full funding of Healthier Together schemes is fundamental to the delivery of the capital programme in 2019/20 with £11.5m (59%) of the Trust's capital forecast under this heading. These costs are currently expected to fall towards the end of the financial year, so any changes to the forecast will not impact the capital variance for several months.

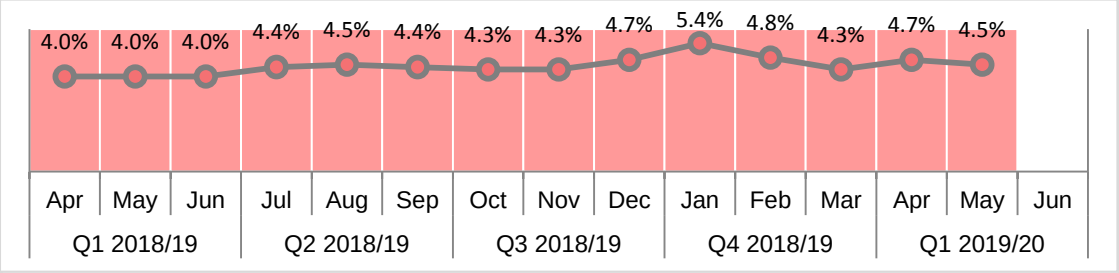
Indicator Detail

May-19	Staff in Post
91.4%	The percentage of whole time equivalent staff in post compared with the current establishment.
Target	The Trust staff in post figure for May 2019 is 91.36% of the establishment, which is a decrease of 0.18% from 91.54% the previous month.
>= 90%	



Actions
Following engagement with NHSI workshops a review of the recruitment and retention plans has been completed; . The recruitment and retention programme is being refreshed in response to ensure we are maximising opportunities.

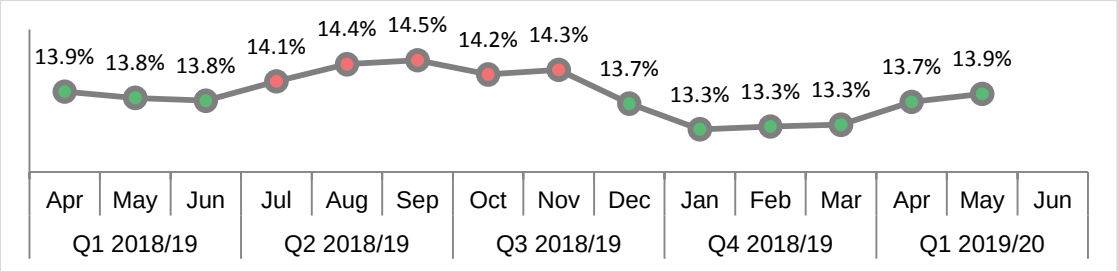
May-19	Sickness Absence Rate (UoR)
4.5%	The percentage of staff on sickness absence, based on whole time equivalent.
Target	The in-month unadjusted sickness absence figure for May 2019 is 4.46%; a decrease of 0.24% compared to the adjusted previous month's figure of 4.70%. The sickness rate for comparison in May 2018 was 4.04%.
<= 3.5%	



Actions
The unadjusted cost of sickness absence in May 2019 is £549,548; a decrease of £18,887 from the adjusted figure of £568,435 in the previous month. This does not include the cost to cover the absence. The top three reasons for sickness remain as Stress/Anxiety (30.46%), Back/Muscular Skeletal problems including Injury/Fracture (25.54%) and Cough Cold/Influenza (9.45%). Ongoing dedicated HR support is provided to assist managers with the management of attendance. A review of the managing attendance policy and associated support arrangements has been concluded and is progressing through our governance arrangements. This will continue to be supported by health and wellbeing initiatives, including access to staff counselling, fast track physiotherapy and physical health activities.

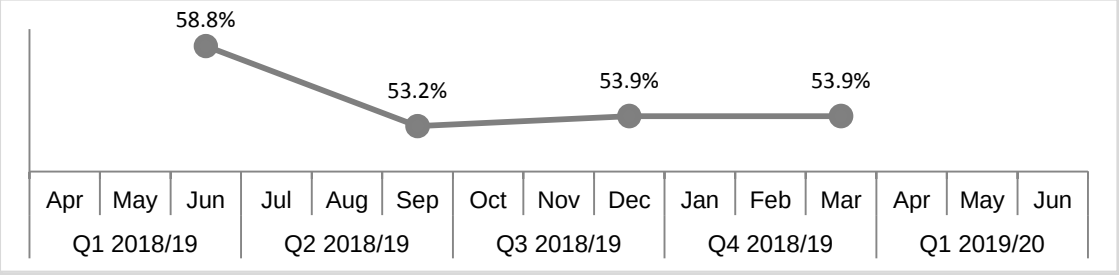
Indicator Detail

May-19	Workforce Turnover (UoR)
13.9%	The percentage of employees leaving the Trust and being replaced by new employees.
Target	The rolling 12-month permanent headcount unadjusted turnover figure at the end of May 2019 is 13.87%. which falls below the Trust target.
<= 13.94%	



Actions
The top adjusted leaving reasons are: Work Life Balance/Dependents 17.28%, Relocation 15.12%, Retirement 14.81%, and Promotion 14.81%.

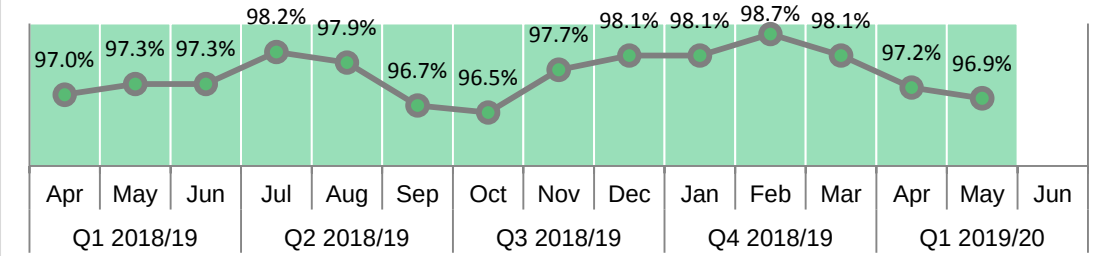
Mar-19	Staff Friends & Family Test: Recommend for Work
53.9%	The percentage of all surveyed staff who are extremely likely or likely to recommend the Trust as a place of work.
Target	There has been a 1.23% increase since the previous quarter in staff recommending the Trust as a place to work and correlates with the response from the Staff Survey.



Actions
The increase is positive although it is still considerably lower than quarter one. There are a number of initiatives generated in response to these results including:- - Cultural Engagement Change Programme. - Promotion of Health and Wellbeing initiatives - Schwartz Rounds - Recruitment and Retention Strategy - Leadership and Development Programmes

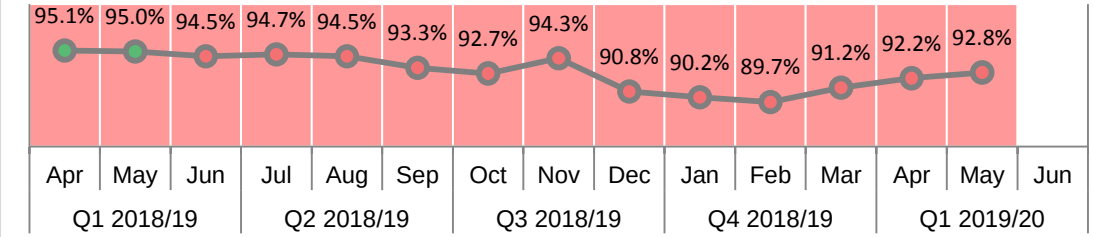
Indicator Detail

May-19	Appraisal Rate: Medical
96.9%	The percentage of medical staff that have been appraised within the last 15 months.
Target	The medical appraisal rate for May 2019 is 96.89%, a decrease on the last month's figure of 97.20% but above the Trust target of 95%.
>= 95%	



Actions
Performance above target.

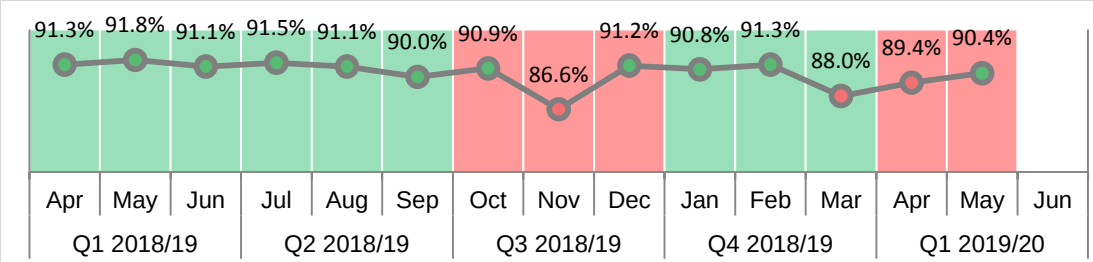
May-19	Appraisal Rate: Non-medical
92.8%	The percentage of non-medical staff that have been appraised within the last 15 months.
Target	The appraisal rate is 92.8% this month. This is 2.2% below the trajectory of 95%.
>= 95%	



Actions
Reporting arrangements continue, with mid-month reporting to support managers to focus efforts on areas of non-compliance.

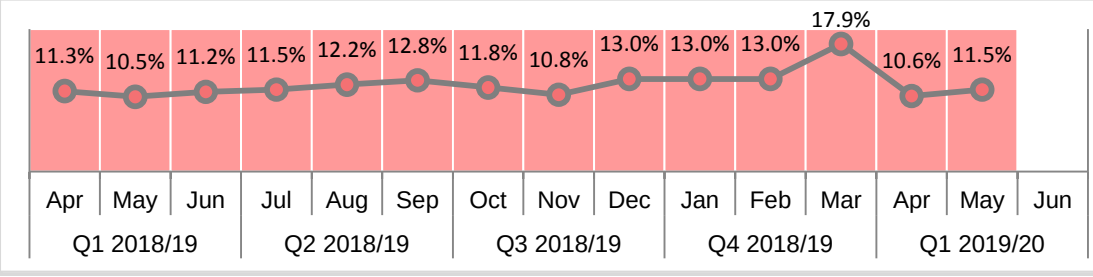
Indicator Detail

May-19	Statutory & Mandatory Training
90.4%	The percentage of statutory & mandatory training modules showing as compliant.
Target	Mandatory and statutory training compliance is 90.4%; an increase of 0.61% from the previous month .
>= 90%	



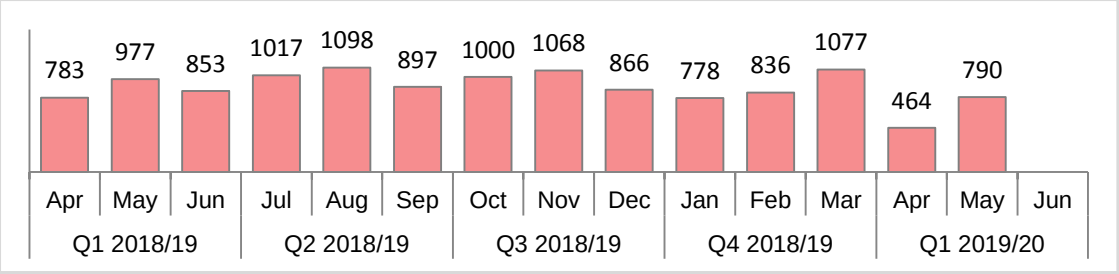
Actions
Although the KPI is on target, in order to ensure maintenance of compliance an increase of face to face sessions for both data security and fire training have been arranged.

	Bank & Agency Costs
11.5%	The total bank & agency cost as percentage of the total pay costs
Target	Total spend on bank staff this month was £1.4M, which is 7.12% of the total pay spend. Agency spend at £848k is 4.39% of the total pay expenditure; of which £482,000 is medical agency and £339,000 is non-medical clinical agency.
<= 5%	



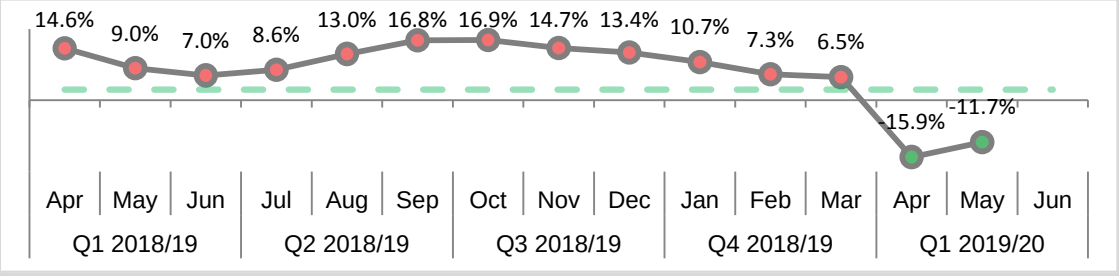
Actions
Action is on-going to address temporary staffing spend: Substantive recruitment from within both the UK & overseas to our hard to fill vacancies. Growth of the medical bank to reduce the reliance on agencies and avoid the commission payments. Further Physician Associate roles recruited. Medical rota re-design . CSEP processes to ensure timely actions in place to recruit to posts and avoid unnecessary agency spend. Increased senior challenge of locum rates and requirements at ECP. Renewed focus on nursing turnover to introduce further support, induction and training for nursing staff to avoid individuals feeling overwhelmed and wanting to find alternative roles.

May-19	Agency Shifts Above Capped Rates
790	Number of agency shifts above above the provider spend cap.
Target	There were a total of 790 shifts paid above NHSI capped rates during the 5 week period from 29th April to 2nd June 2019; equating to an average 158 shifts per week, an increase of 42 shifts per week compared to April's figures. However, this is a decrease compared to the 195 shifts per week in May 2018.
<= 0	



Actions
Medicine have seen the highest number of agency cap breaches with an average of 51 shifts per week (an increase of 8 compared to April), mainly attributable to an increase of medical locum shifts. This is followed by Surgery with 43 shifts per week (an increase of 8 shifts per week). Estates and Facilities have seen some agency use this month due to some senior vacancies within the management team.

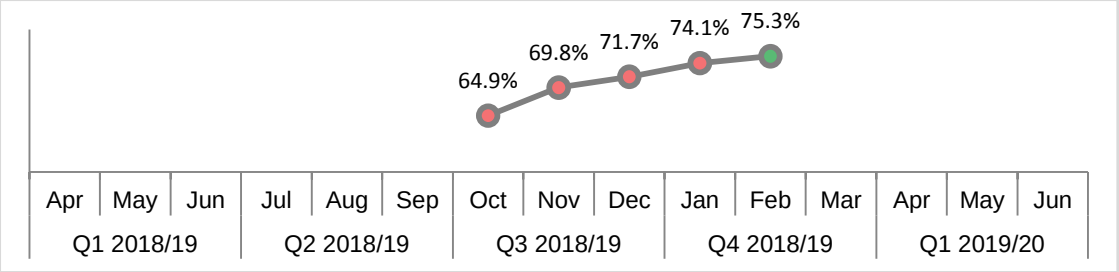
May-19	Agency Spend: Distance From Ceiling (UoR)
-11.7%	The percentage variance between Trusts expenditure on agency and external locums across all staff groups and the cap set by NHSi.
Target	The total number of agency shifts worked in this period, including shifts under cap, was 1,812 – an average of 362 per week. This is an average increase of 13 shifts per week compared to April.
<= 3%	



Actions
There were a total of 109 shifts paid at or above £100 per hour, which required Chief Executive approval, which is an average of 22 shifts per week, compared to 33 shifts per week in April.

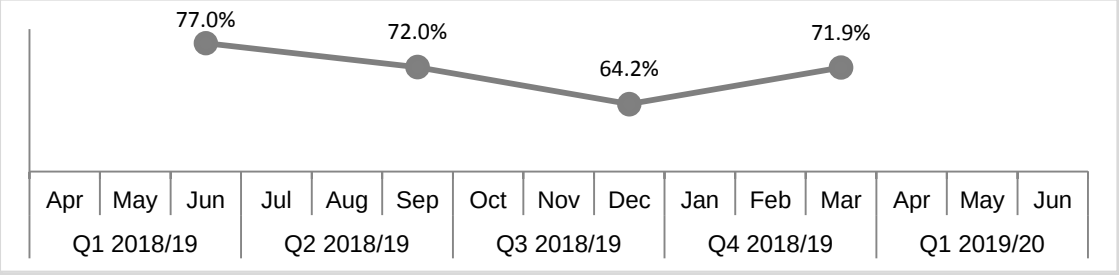
Indicator Detail

Feb-19	Flu Vacination Uptake
75.3%	The percentage of staff receiving the flu vaccination.
Target	Last year's campaign ended on 73.9% frontline uptake, this year we have achieved 79.3%.
>= 75%	



Actions
A review of the success of this year's campaign will be undertaken by the Workforce Flu Strategy group to inform plans and arrangements for this season's approach.

Mar-19	Staff Friends & Family Test: Recommend for Care
71.9%	The percentage of all surveyed staff who are extremely likely or likely to recommend the Trust for care.
Target	The overall trust staff response rate for the Friends and Family test is 64%. This data was taken from the national staff survey for Qtr 3 where 598 staff responded.



Actions
Actions - Agenda item on the Cultural engagement group (CEG) - Cultural ambassadors to promote - Extensive communication plan to commence regarding the staff survey in particular - To explore exit interviews and leavers information to make positive changes - To support new staff in the trust with initiatives such as preceptor ship and buddies - Celebrating Stockport- with staff initiatives such as Celebration of achievements

Safer Staffing Report

May-19	Day				Night				Day		Night		Care Hours Per Patient Per Day (CHPPD)				Safety Thermometer			
	Registered midwives/nurses		Non-registered		Registered midwives/nurses		Non-registered													
Ward Name	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Registered fill rate	Non-registered fill rate	Registered fill rate	Non-registered fill rate	Cumulative number of patients at 23:59 each day	Registered midwives/ nurses	Non-registered	Overall	Pressure Ulcers (new)	Falls with Harm	Catheters & UTIs (new)	New VTEs
AMU	4,092	3,240	3,348	3,270	3,720	3,258	3,069	3,003	79.2%	97.7%	87.6%	97.8%	1666	3.9	3.8	7.7	0	0	0	0
Clinical Decisions Unit	372	372	372	372	341	341	341	341	100.0%	100.0%	100.0%	100.0%	185	3.9	3.9	7.7	0	0	0	0
D4	1,163	572	791	678	682	682	682	682	49.2%	85.8%	100.0%	100.0%	478	2.6	2.8	5.5	0	0	0	0
A3	1,442	1,262	977	980	1,023	979	682	682	87.5%	100.3%	95.7%	100.0%	745	3.0	2.2	5.2	0	0	0	0
A10	2,888	2,003	2,046	2,234	2,046	2,024	1,364	1,375	69.4%	109.2%	98.9%	100.8%	779	5.2	4.6	9.8	0	0	0	1
A11	1,581	1,424	1,628	1,508	682	693	682	704	90.0%	92.6%	101.6%	103.2%	895	2.4	2.5	4.8	1	0	0	0
A12	1,209	851	605	839	682	682	682	671	70.4%	138.7%	100.0%	98.4%	487	3.1	3.1	6.2	0	0	0	2
B4	1,442	1,213	1,302	1,311	682	693	1,023	1,133	84.1%	100.7%	101.6%	110.8%	660	2.9	3.7	6.6	0	0	0	0
B6	1,209	1,209	2,077	2,005	682	682	682	637	100.0%	96.5%	100.0%	93.4%	697	2.7	3.8	6.5	0	0	0	0
Bluebell Ward	1,674	1,559	868	898	682	694	682	855	93.1%	103.5%	101.8%	125.3%	412	5.5	4.3	9.7	0	0	0	0
C4	1,209	946	605	1,032	682	682	682	825	78.2%	170.7%	100.0%	121.0%	483	3.4	3.8	7.2	1	0	0	1
Coronary Care Unit	837	744	465	433	682	682	341	330	88.9%	93.1%	100.0%	96.8%	162	8.8	4.7	13.5	0	0	0	0
Devonshire Centre for Neuro-Rehabilitation	1,070	1,050	2,000	1,950	682	682	682	1,166	98.2%	97.5%	100.0%	171.0%	543	3.2	5.7	8.9	0	0	0	0
E1	1,952	1,524	2,310	2,235	1,023	1,012	1,364	1,683	78.1%	96.8%	98.9%	123.4%	952	2.7	4.1	6.8	0	0	0	1
E2	2,279	2,249	1,581	1,988	1,023	1,001	1,023	1,364	98.7%	125.7%	97.8%	133.3%	1044	3.1	3.2	6.3	2	0	0	0
E3	2,279	2,229	1,581	1,793	1,023	1,023	1,023	1,705	97.8%	113.4%	100.0%	166.7%	1069	3.0	3.3	6.3	0	0	0	0

Safer Staffing Report

May-19	Day				Night				Day		Night		Care Hours Per Patient Per Day (CHPPD)				Safety Thermometer			
	Registered midwives/nurses		Non-registered		Registered midwives/nurses		Non-registered													
Ward Name	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Registered fill rate	Non-registered fill rate	Registered fill rate	Non-registered fill rate	Cumulative number of patients at 23:59 each day	Registered midwives/ nurses	Non-registered	Overall	Pressure Ulcers (new)	Falls with Harm	Catheters & UTIs (new)	New VTEs
A1	1,395	1,103	1,209	1,266	1,023	1,012	682	792	79.0%	104.7%	98.9%	116.1%	778	2.7	2.6	5.4	0	0	0	1
C6	935	911	1,112	1,172	682	891	682	682	97.4%	105.4%	130.6%	100.0%	576	3.1	3.2	6.3	0	0	0	0
D1	1,679	1,468	1,349	1,487	682	682	1,023	1,034	87.5%	110.2%	100.0%	101.1%	715	3.0	3.5	6.5	0	0	0	0
D2	1,634	1,177	1,442	1,459	682	614	682	1,067	72.0%	101.2%	90.0%	156.5%	596	3.0	4.2	7.2	0	0	0	0
D6	1,307	1,321	1,037	989	682	649	682	704	101.1%	95.4%	95.2%	103.2%	636	3.1	2.7	5.8	0	0	0	0
M4	1,241	1,126	977	947	682	682	594	726	90.7%	96.9%	100.0%	122.2%	457	4.0	3.7	7.6	0	0	0	0
SAU	1,851	1,803	729	705	1,023	984	682	627	97.4%	96.7%	96.2%	91.9%	406	6.9	3.3	10.1	0	0	0	0
Short Stay Surgical Unit	1,937	1,675	797	771	880	845	682	660	86.5%	96.7%	96.0%	96.8%	632	4.0	2.3	6.3	0	0	0	0
ICU & HDU	4,697	4,134	372	372	4,092	3,663	341	341	88.0%	100.0%	89.5%	100.0%	280	27.8	2.5	30.4	0	0	0	0
Birth Centre	930	855	465	458	620	540	310	310	91.9%	98.4%	87.1%	100.0%	41	34.0	18.7	52.7				
Delivery Suite	2,790	2,745	465	443	1,860	1,840	310	300	98.4%	95.2%	98.9%	96.8%	208	22.0	3.6	25.6				
Maternity 2	1,628	1,628	930	930	682	682	341	341	100.0%	100.0%	100.0%	100.0%	478	4.8	2.7	7.5				
Jasmine Ward	930	930	465	498	620	620	0	36	100.0%	107.0%	100.0%	na	218	7.1	2.4	9.6	0	0	0	0
Neonatal Unit	2,325	1,973	0	0	1,628	1,323	0	0	84.8%	na	81.3%	na	265	12.4	0.0	12.4	0	0	0	0
Tree House	2,790	2,715	465	379	1,860	1,787	0	0	97.3%	81.5%	96.1%	na	566	8.0	0.7	8.6	0	0	0	0
	54,760	48,004	34,363	35,394	34,035	32,624	22,015	24,775	87.7%	103.0%	95.9%	112.5%	18109	4.5	3.3	7.8	4	0	0	6

Safer Staffing Report

BOARD PAPERS – Quality, Safety & Experience Section : May 2019			
DESCRIPTION	**AGGREGATE POSITION**	**TREND**	**PERFORMANCE AGAINST PREVIOUS MONTH**
Registered Nurses monthly: Expected hours by shift versus actual monthly hours per shift. **Day time shifts only.**	87.7% of expected RN hours were achieved for day shifts. This is the 9th month that staffing has been below the 90% benchmark. Any RN numbers that fall below 85% are required to have a business group review & an update of actions provided to the Chief Nurse & Deputy Chief Nurse. 14 areas indicate below 90% RN levels in month.	May 87.7% April 89.6% March 88.5%	The lowest RN staffing levels during the day were on Ward D4 at 49.2% .The business groups Associate Nurse Director is reviewing these figures. There were never less than 2 RN on duty at any time. Matron's office is located on this ward for additional support. Harm free care metrics in month are optimal. Short term absence and vacancies have impacted on these staffing figures. A new ward manager has now been recruited into post.
Registered Nurses monthly: Expected hours by shift versus actual monthly hours per shift. **Night time shifts only.**	95.9% of expected RN hours were achieved for night shifts. 4 areas report below 90% RN levels in month.	May 95.9% April 95.3% March 91.9%	The lowest RN night staffing levels are reported on Neonatal Unit at 81.3% staffing levels. The neonatal acuity and cot occupancy was low throughout May. Staffing was assessed to meet the needs of the acuity on a daily basis. Harm free care metrics alongside staffing levels are reviewed to assure safe care. Closely supervised by Neonatal Matron.
Non-registered staff monthly: Expected hours by shift versus actual monthly hours per shift. **Day time shifts only.**	103% of expected non-registered hours were achieved for day shifts. 1 area reported below 90% levels in month.	May 103% April 102.3% March 101.8%	The lowest non registered staffing levels for day duty was on the Tree House at 81.5%. The non-registered staff were supported by 97.3% RN levels. Harm free care levels in month are optimal.

BOARD PAPERS – Quality, Safety & Experience Section : May 2019			
DESCRIPTION	**AGGREGATE POSITION**	**TREND**	**PERFORMANCE AGAINST PREVIOUS MONTH**
Non-registered staff monthly: Expected hours by shift versus actual monthly hours per shift. **Night time shifts only.**	112.5 % of expected Non-registered hours were achieved for night shifts. For areas with over 100% staffing levels for non-registered staff this is reviewed by matrons. It is predominately due to wards requiring 1:1 support for patients following a risk assessment, or to support RN staffing numbers when there are unfilled shifts. No areas reports below 90% levels in month.	May 112.5% April 108.0% March 112.5%	No wards below 90% in month.
RN safe staffing levels are supported by temporary staff (NHSP Bank and agency).	This is reported as demand versus NHSP and agency fill compared to substantive vacancies.	May 141.5 WTE RN filled	Trust vacancy rate is 170.06 WTE (10.54%). Of the RN 141.5 WTE (Demand 189.3 WTE) The fill rate overall is 75% of the shifts requested. 47% are NHSP and agency 28%.
Non-registered safe staffing levels are supported by temporary staff (NHSP Bank).	This is reported as demand versus NHSP and agency fills compared to substantive vacancies.	May 140.5 WTE non-registered filled	Trust vacancy rate is 44.45 WTE (5.42%). Of the non-registered 140.5 WTE (Demand 171.1 WTE) the fill rate is 82 %. Agency staff are not routinely booked with only 0.7% agency utilised in month

NHS
Stockport
NHS Foundation Trust

Board of Directors' Key Issues Report

Report Date: 20/06/19		**Report of:** Quality Committee
Date of last meeting: 18/06/19		**Membership Numbers:** Quorate

1.	**Agenda**	The Quality Committee met on 18 May 2019 and considered an agenda which included the following items:
		
		• Women, Children and Diagnostics Business Group Presentation
		• Integrated Performance Report – Quality Metrics
		• 7 Day Services Update
		• Clinical Effectiveness Outcome Report
		• Quality Improvement Faculty Update
		• CQC Safe High Quality Care Improvement Plan
		• Clinical Governance Report
		• Learning from Deaths Report
		• Key Issues Report
		  ○ Patient Experience Group
		  ○ Patient Experience Group Effectiveness Report
		• Trust Risk Register
		• Safeguarding Children and Young Persons Policy
		• Complaints and Concerns Policy

	Alert	• The Committee was alerted to potential emerging risks by the Women, Children and Diagnostics Business Group. The leadership triumvirate comprising of Dr A Jobling, Mrs R Whittington and Mrs Woodford delivered a presentation to the Committee. The Business Group identified the following risks which required further consideration and could potentially impact the Trust, if left unresolved. These included:
		  ○ Estates particularly in the Pathology Service
		  ○ Workforce challenges due to consultant vacancies in Histopathology, Micro-biology and Radiology.
		  ○ Clinical Coding and Business Intelligence

	Assurance	• The Committee considered a presentation delivered by from the Women, Children and Diagnostics Business Group. The presentation provided an overview of the risks, aspirations and challenges for the Business Group. Included in the presentation were the following key points: ○ The process around replacing the MR and CT Scanners had now been completed in Radiology following the procurement process.

		○ The challenges included the SEND inspection which was conducted by Ofsted and the CQC, ○ Aspirations included improving the assessment areas to enable patient flow and pathways. ○ Opportunities for growth and development could be achieved through updating Estates enabling the Trust to be the top choice for expectant mothers. • The Committee took positive assurance from the presentation and noted the work being undertaken in the Business Group. • The Committee considered and was assured by a report from the Medical Director. The report offered an overview of the Trust's mortality indicators and provided an update on the key areas of focus with regards to the HSMR and SHMI indicators. • The Committee took assurance from the Quarterly Clinical Audit Report which detailed the outcomes of clinical audits undertaken in the Trust. The report also highlighted audits that demonstrated good compliance levels and those with limited assurance. The Committee was assured that processes were in place regarding the audits with limited assurance and that areas requiring particular interest were escalated in line with the reporting matrix and governance framework. • The Committee was assured by the Quality Governance report. The report identified the outcome of areas of clinical governance including key themes and the lessons learnt. • The Committee received the Annual Effectiveness Report from the Patient Experience Group. The report provided assurance to the Committee as it demonstrated robust and effective quality processes and embedded governance structures.
	Advise	• The Committee received an update on the development of the Quality Improvement Faculty and the Trust's approach to building its quality improvement capability across the organisation. The Committee noted the implications and challenges of developing the framework and supported the ongoing implementation of the QI Framework. • The Deputy Chief Nurse presented a progress report on the Safe High Quality Care Action Plan. The Committee noted the evidence base that provided assurance on the two breaches to the plan. • The Committee received the Patient Experience Group Key Issues Report and the Annual Effectiveness reports. • The Committee ratified the Safeguarding Children and Young Persons Policy following its approval by the Trust Safeguarding Group. • The Committee ratified the Complaints and Concerns Policy following its approval by the Patient Experience Group.
2.	Risks Identified	The Committee identified risks in Diabetes, Sepsis, CDifficile.

3.	Report Compiled by	Mike Cheshire, Chair	Minutes available from:	Committee Secretary

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NHS Stockport NHS Foundation Trust

Board of Directors' Key Issues Report

Report Date: 20/06/19		**Report of:** Finance and Performance Committee
Date of last meeting: 19/06/19		**Membership Numbers:** Quorate
1.	**Agenda**	The Finance and Performance met on 19 June 2019 and considered an agenda which included the following items: • Financial Performance Report • Service Efficiency Programme Update • Cost Improvement Programme Progress Report • Operational Performance Report • Key Issues Reports from Executive Performance Review Meetings o Integrated Care Business Group o Medicine and Clinical Support Business Group o Women, Children and Diagnostic Business Group o Surgery, GI and Critical Care Business Group • Agency Utilisation Report • System Control Total Update • Finance and Performance Risk Register
	Alert	The Committee received the Operational Performance Report which provided an overview of the key performance metrics of the Trust at the end of May. The Committee was alerted of the following items: • The continued pressure in Oral Surgery and Orthodontic services. Ms Toal highlighted that this was not a unique position as other trusts within GM were experiencing the same challenges. • The Diagnostics standard had been impacted by the simultaneous failure of both CT scanners at the end of May had resulted in the cancellation of elective activity. • The end of May position for Clinical Correspondence improved due to the progress with the short term outsourcing. The Committee was alerted that future performance would be impacted by the change to the standard in Q2 which would be measured from clinic attendance to letter issue.
	Assurance	• The Committee reviewed the Finance Performance Report for Month 2 which set out the draft financial position and key financial issues for the Trust. The Committee took significant assurance on Q1 and Q2 performance and took limited assurance regarding the delivery of CIP programmes for the year. • The Committee took assurance from the Operational Performance Group, Key issues report which outlined progress against the performance objectives for

		the Trust as at the end of May 2019. The report outlined that the Diagnostics achieved 1.17% in May against a standard of 1% marking a significant improvement. The Committee took assurance regarding the RTT performance as the Trust remained ahead of trajectory for the waiting list size. • The Committee received the Key Issues Reports from Executive Performance Review meetings held by all four Business Groups in June. These reports and the Operational Performance Group Key Issues Report continued to provide a key source of assurance for the Committee. • Further to concerns noted in previous meetings regarding performance against the Clinical Correspondence target, the Committee was assured by the level of progress. Ms Toal outlined that the longest wait had now been reduced to 7days.		
	Advise	• The Committee received a progress update on the delivery of the Clinical Service Efficiency Programme. The report provided an outline of the total savings identified and delivered to date and the actions being taken to bridge the remaining gap in order to achieve the trajectory target of £14.2m for 2019/20. • The Director of Finance presented the System Control Update which highlighted the proposed agreement as part of the Integrated Care System Financial Framework for 2019/20. The Committee considered the proposal and agreed to recommend the commitment to the Board of Directors. • The Committee received the report by the Director of Workforce and OD which detailed the Trust's agency usage and expenditure as of May 2019. The report highlighted that Month 2 performance was within the NHSI monthly ceiling value. • The Committee reviewed and considered the Risk Register and noted the ongoing work regarding the review of the risk management process.		
2.	Risks Identified	The Committee identified the risk to the delivery of the CIP target.		
3.	Report Compiled by	Malcolm Sugden, Non-Executive Director	Minutes available from:	Committee Secretary

Board of Directors' Key Issues Report

NHS Stockport NHS Foundation Trust

Report Date: 27/06/19		**Report of:** People Performance Committee
Date of last meeting: 20/06/19		**Membership Numbers:** Quorate
1.	**Agenda**	The Committee considered an agenda which included the following: • Update on Future of Payroll Provision • Interim People Plan • Workforce Plan • Medical Education Report • Junior Doctors' Contract Update • Appraisal Report • Agency Expenditure • Apprenticeship Plan and Update • Workforce Annual Report • Workforce Flash Results • Trust Risk Register • Key Issues Reports: - Educational Governance Group - Culture & Engagement Group - Joint Local Negotiating Committee - Workforce Efficiency Group • Consent Agenda: - Policy ratification: Covering for Absent Colleagues Policy
	Alert	• In considering an Apprenticeship Scheme Update Report, the Committee was concerned to note that some key apprenticeship standards were either still in development or not ready to be delivered by local training providers, including universities. It was noted that this was a national issue but that efforts would be made to try to influence the regional position. • The Committee was advised that a risk on Annual Pension Allowance had been added to the Trust Risk Register. The Committee acknowledged the potential adverse effect the changes to the pension allowance could have on a large number of Trust staff, particularly medical staff.
	Assurance	• The Committee considered an Annual Workforce Performance Report which provided an update on workforce information and actions for the year 2018/19. The Committee took positive assurance with regard to a number of actions and noted new initiatives and progress made in key areas.

		• The Committee considered a report regarding a review of the Trust's Performance Appraisal process. It was noted that following Staff Survey feedback, a task and finish group had been established to review the appraisal process to ensure it was fit for purpose. The Committee endorsed the revised process which was due to be implemented in August 2019.		
	Advise	• Mr G Moores briefly informed the Committee on discussions relating to future payroll provision for the Trust. • Mr G Moores provided a verbal update regarding the national Interim People Plan. He advised that detailed work was ongoing to confirm that strategies and plans fully align with the national Interim People Plan, and that a consequent report would be presented to the Committee in July 2019. • The Committee received and noted a Junior Doctors Contract Update Report which provided a position update on the provisional agreements for a new Junior Doctor Contract. It was noted that the results of the BMA's member ballot were expected to be announced soon after voting closed on 26 June 2019. The Committee would be updated on progress in this area. • The Committee received an informative presentation from Ms N Armitage, Director of Medicine Business Group, regarding management of bank and agency expenditure. The presentation highlighted changes introduced by the Medicine Business Group in this area, which had consequently had a positive impact on agency expenditure.		
2.	Risks Identified	Potential impact of Annual Pension Allowance changes		
3.	Actions to be considered at the *(insert appropriate place for actions to be considered)*			
4.	Report Compiled by	Catherine Barber-Brown, Chair	Minutes available from:	Soile Curtis, Membership Services Manager

Stockport NHS
NHS Foundation Trust

Report to:	Board of directors	**Date:**	27th June 2019
Subject:	Stockport NHSFT mortality data review		
Report of:	Medical Director	**Prepared by:**	Medical Director

REPORT FOR INFORMATION

Corporate objective ref:	C4, C6, C8, C10,
Board Assurance Framework ref:	S04, s05
CQC Registration Standards ref:	8, 9, 18
Equality Impact Assessment:	☐ Completed ☒ Not required

Summary of Report

In December 2018, in response to an increase in our HSMR mortality index, to a worse than average position, an overview was presented to the Quality Committee by the Medical Director.

A number of actions were agreed, and this follow up report reviews the current position, and the progress with these actions.

The report is provided for information, and is recommended to be included on the work plan for ongoing bi-annual review at the quality committee.

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

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1. INTRODUCTION

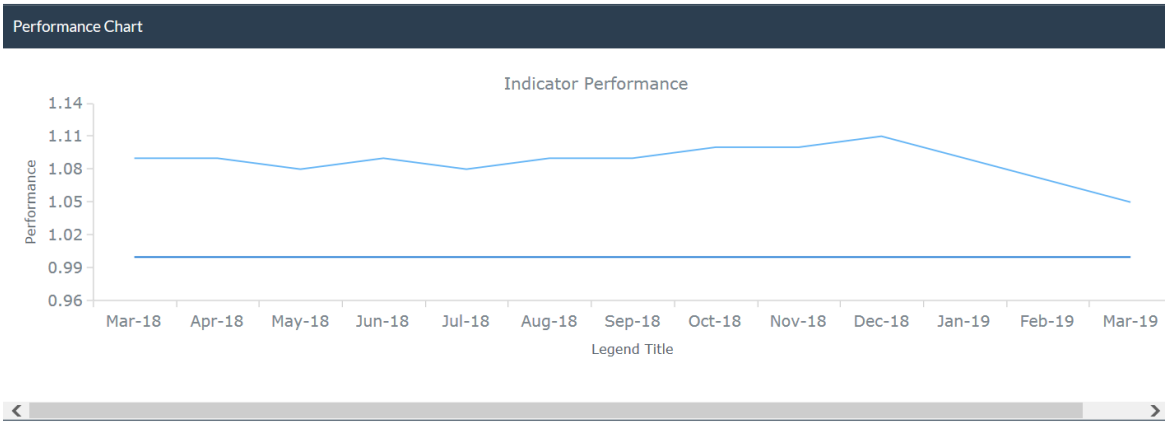
1. The trust monitors its performance using comparative statistics. These compare the outcomes seen in our patients, against those seen in other organisations that who were classified (coded) as being admitted to hospital with the same condition.

We currently monitor our outcomes using two similar statistics, HSMR provided by 'Dr Foster' (Imperial College London), and SHMI provided by CHKS – both private providers of benchmarking data. HSMR presents our results as 'worse than average', SHMI presents our results as 'better than average'.

Six months ago, a paper was presented explaining he differences between these two statistics, agreed a number of areas of focus, and to revisit the topic in six months (june19

The report updates on progress in the previously agreed areas of focus.

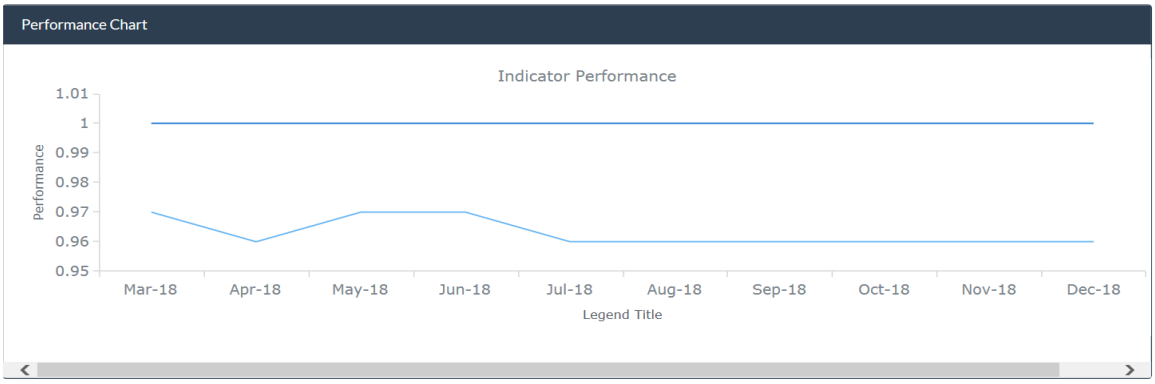
2. BACKGROUND



Main Data Table — Displaying 1 - 1 of 1

Indicator Name	Financial Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Mortality: HSMR	2018/19	1.09	1.08	1.09	1.08	1.09	1.09	1.1	1.1	1.11	1.09	1.07	1.05

Fig 1: HSMR June 2019 – data runs three months in arrears.



Main Data Table — Displaying 1 - 1 of 1

Indicator Name	Financial Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Mortality: SHMI	2018/19	0.96	0.97	0.97	0.96	0.96	0.96	0.96	0.96	0.96			

Fig 2: SHMI December 2018 – data runs six months in arrears.

These metrics continue to show a 'worse than average' outcome in HSMR (index of

1.05) and a 'better than average' outcome in SHMI (index of 0.96).

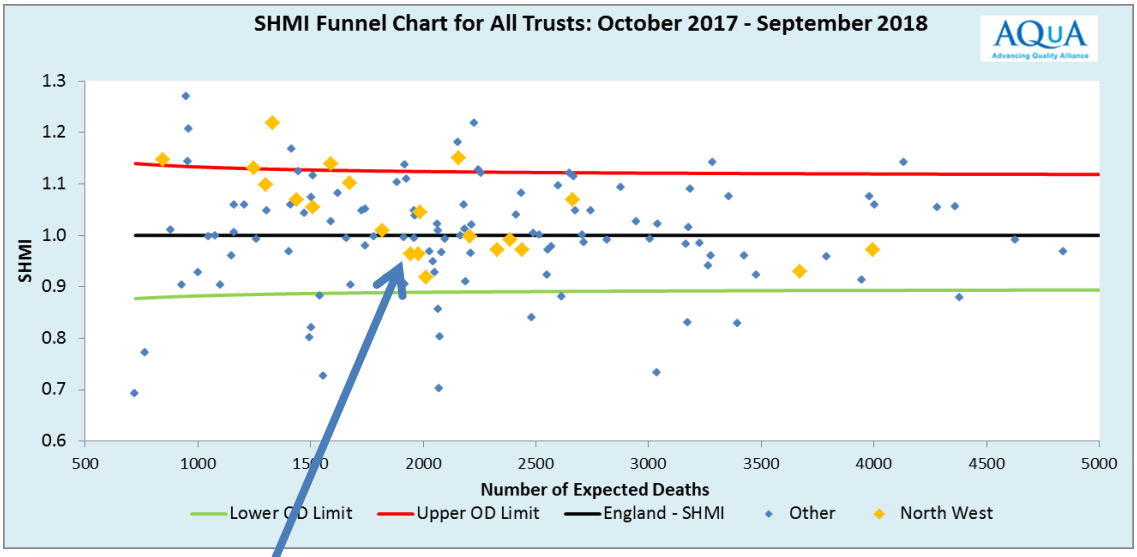
A pleasing trend in HSMR over the past three months is noted, but is not statistically significant, and at this stage is not thought to represent a fundamental change in our position.

The main difference between HSMR and SHMI is that;

- ***HSMR excludes deaths with a specialist palliative care code, SMHI does not.*** (we have a very low rate of palliative care coding)

- ***HSMR looks only at in hospital deaths, SHMI includes death within 30 days of discharge.*** *(We have a high rate of patients staying in hospital to die)*

We get our benchmarking data from a company called CHKS and a further review from AQUA, but use SHMI as their primary measure.



Stockport – SMHI blow the majority, HSMR, above the majority

Fig 3: Comparative SHMI September 2018 – North West trusts in yellow, National blue.

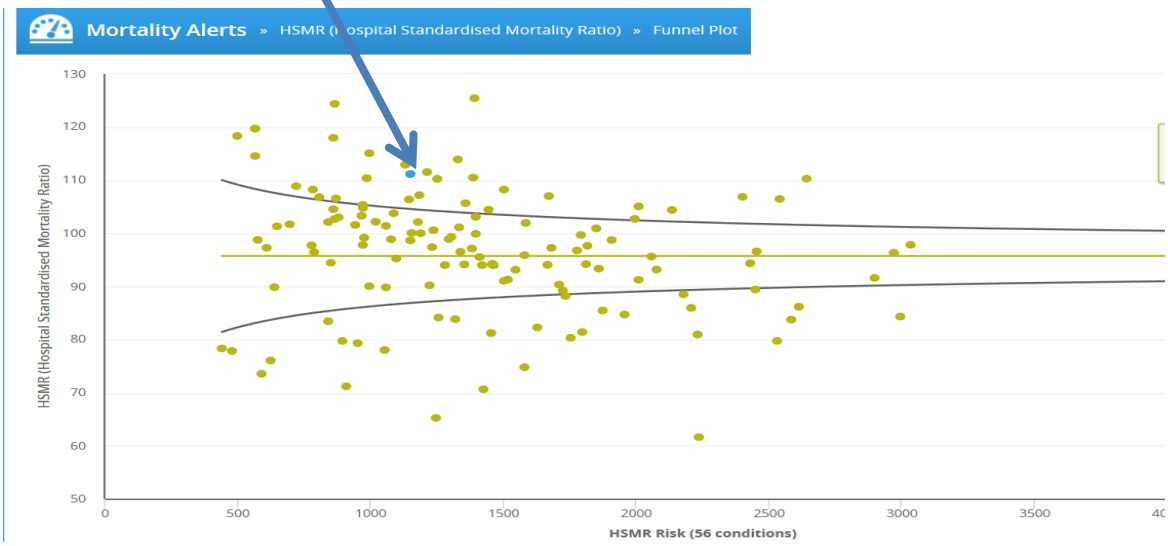


Fig 4: Comparative HSMR, December 18. (our position has improved slightly since this point)

The past three months show HSMR approaching the yellow 'average line' (matching the yellow line gives an NSMR of 1.0)

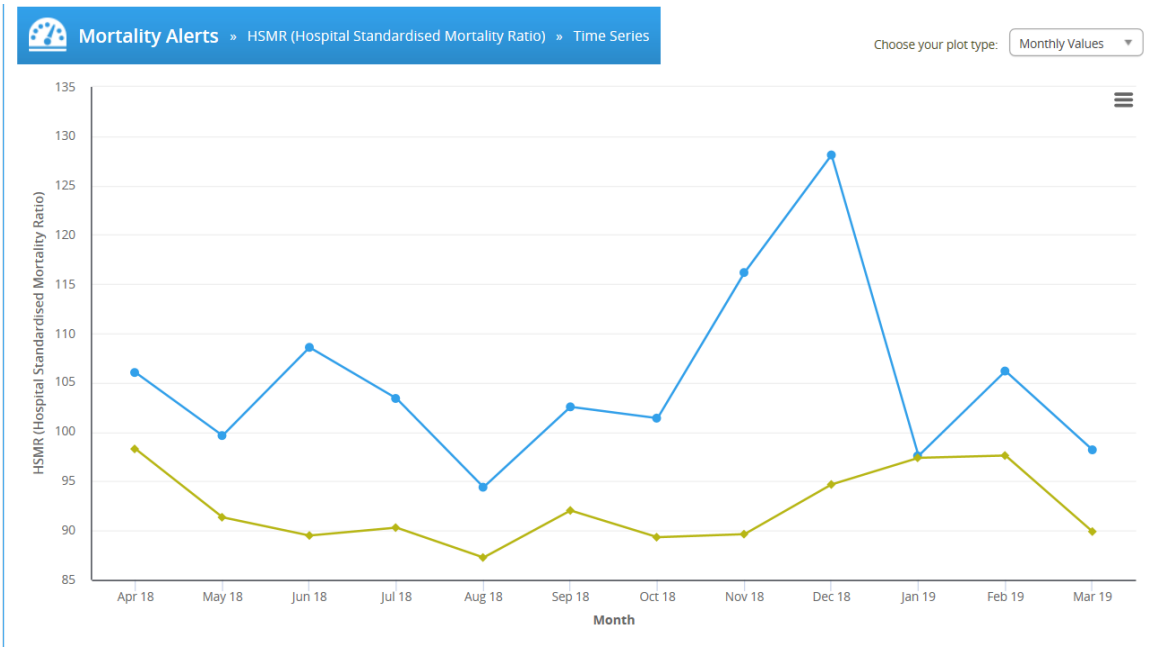


Fig 5: recent changes in HSMR against average performance.

3. Review of actions from Decembers report

1. Coding depth
2. Palliative care coding.
3. Facilitation of dying in preferred place of death
4. Review of pneumonia coding
5. Improving clinical outcomes
6. Reviewing diagnoses with excess mortality
7. Learning from deaths.

3.1

Coding depth – Poor coding of diagnosis will often reduce the expected risk of mortality, so worsen results. Coding a patient as 'Chest pain ? cause' (a physiological 'r' code based only on symptoms) has a very low expected risk of death. If that patient had a heart attack (acute coronary syndrome), and was recognised and treated for it, but no-one ever explicitly wrote 'the working diagnosis is ACS', they could remain coded as 'chest pain ? cause'. Anticipated mortality would be very low, actual mortality rate much higher. Deaths will occur in this patient group even with exemplar treatment, but poorly coded, any such deaths would drive our mortality index up.

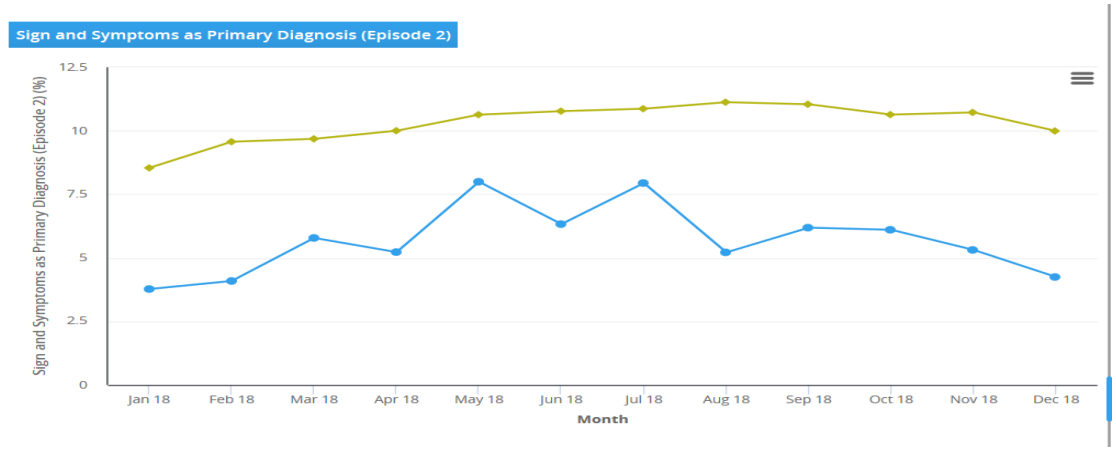


Fig 6: low use of 'signs and symptoms coding' suggests one good aspect of coding.

Our coders have been involved in an AQUA project to look at how we can improve our coding. Recent examples of change have been a rationalisation of urinary tract infection sepsis definitions.

We are undergoing a Mersey Internal Audit review of coding this year.

Good collaboration between the coding department and our clinicians is key, and remains a regular topic of discussion at our performance reviews.

3.2 **Palliative care coding –** The fact that HSMR is 'worse than average' and SHMI 'better than average' is strongly suggestive of a link to palliative care coding. We are one of the lowest palliative care coding hospitals in the region.

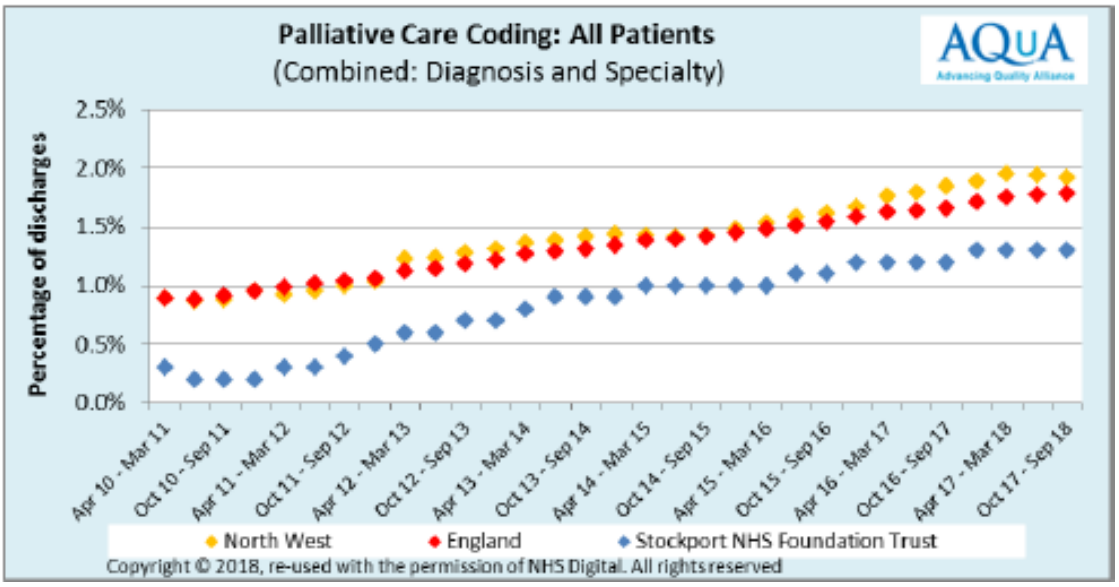


Fig 7: palliative care coding remains below peers.

While our palliative care coding rate is increasing, we are sill 50% lower than our north west peer group. This may reflect a limited specialist palliative care input, failure to document their input, or variation in interpretation of the coding rules.

In addition, a relatively low discharge to hospice, and discharge home for palliation rates will lead to this significantly impacting upon HSMR. In both cases, as HSMR excludes all death out of hospital, these have a big impact, in particular when coupled with a low use of palliative care coding. SHMI includes all patients who die within 30 days of discharge, and includes all patients who are coded as palliative care.

We have completed an AQUA palliative care / coding project, that has resulted a locally agreed policy that defines where the palliative care code can be used. While this will improve clarity of use, it is not anticipated to increase the frequency of palliative care coding.
Improvements in documentation of specialist palliative care intervention, and an additional resource to support these reviews will both have some impact later in the year (HSMR 3 months in arrears, SHMI 6 months in arrears)

3.3 Facilitation of care of dying patients in their preferred place of death.

Palliative care patients dying in our hospital include;

- Patients in whom effective symptom management **requires hospital admission**
- Patients who **prefer to be cared for in hospital** as their dependency increases very close to the end of life
- Patients who never wanted to come to hospital, but in **whom failure to plan, or lack of resources** in the community meant that their needs could not be met in the community.
- Patients who deteriorate in hospital and are recognised as dying but **in whom we fail to discharge home in spite of their stated preference**.

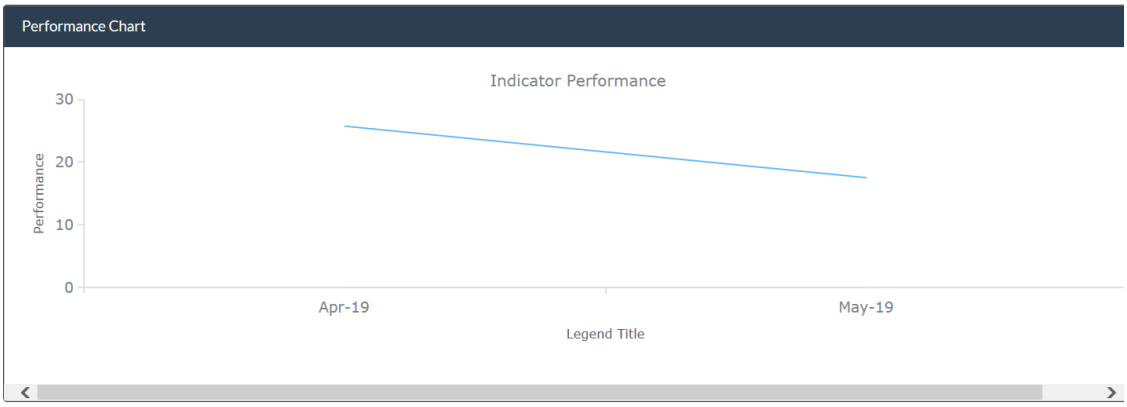
Many patients would prefer to die supported in their own homes. It is these latter two groups that we hope to influence. These choices are aided by:

- **Earlier identification** of palliative care needs and deterioration both in community and acute sectors – not just in cases of cancer, but advanced heart disease, advanced respiratory disease, advanced frailty and advanced dementia. With this identification leading to active discussions about how to manage future deteriorations and to plan for next steps and what 'a good death' means for them.
- **Future care planning discussions** with individuals and those close to them, based on their needs and degree of reversibility of their conditions and what interventions are/ are not possible. Future care planning discussions may include choices around preferred place of care and preferred place of death
- **Sharing of this key information**, with the patient's consent, with other professionals/ providers (ideally electronically). Ceilings of treatment discussions in hospital to be part of wider future care planning discussions
- To identify and acknowledge those at an earlier phase in hospital, where **hospital may no longer be the right place** for them

The above is being supported for by a number of programmes of work including:

1. **Trust Mandatory End of Life Training** on-going with specific medical training (3hr and 1 hr – depending on their roles) with additional support from Trust Communication Skills Training.
2. Delivery of **NW Standardised Advance Care Planning** training in Stockport
3. Early identification project for primary care running currently within primary care in Stockport.
4. **Learning from Deaths** has palliative care and the management of 'a good death' as common themes. A proportion of deaths are reviewed by the palliative care team.
5. **Actively seeking feedback from bereaved** families about hospital experience around the death of a relative or friend.
6. Development of a new **end of life care model business case**, focused around co-ordination/ monitoring of care and access to increased blocks of care support at home
7. Improved engagement with GP's leading to earlier flagging of patients approaching the end of life.
8. Strategy and prioritisation of end of life care being developed in line with **GM Commitments** around palliative and end of life care
9. Expansion of our palliative care consultant body from one to two now in place. Currently developing the case for a clinical fellow.

Progress with the palliative care agenda will be **monitored using the new IPR** trust metric. Length of stay will tend to fall as the options for patients at the end of life to move to their 'preferred place of death' improves.



Main Data Table — Displaying 1 - 1 of 1

Indicator Name	Financial Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Mortality: Specialist Palliative Care Length of Stay	2019/20	25.75	17.55										

Fig 8: IPR report for palliative care

3.4 **Reviewing our pneumonia coding –** Changing our coding practice for pneumonia in April 16 was the correct thing to do (we were reporting incorrectly and generating an artificially good outcome. This change had a huge impact upon our mortality indices.

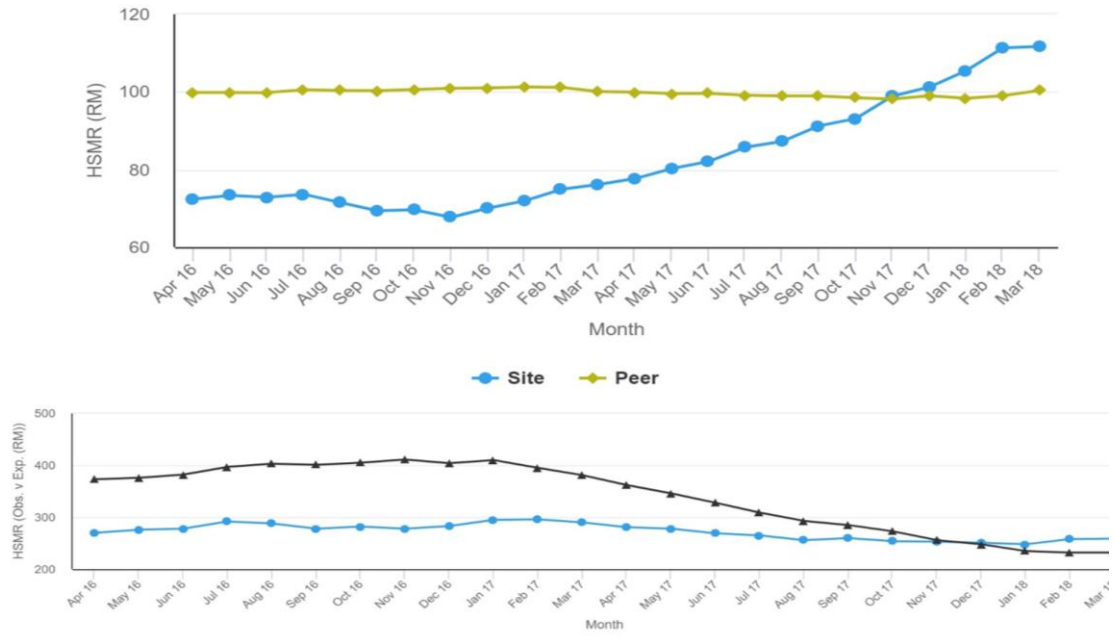


Fig 9: The impact of changing pneumonia coding on outcomes.

The action was to sense check this decision against our peers.

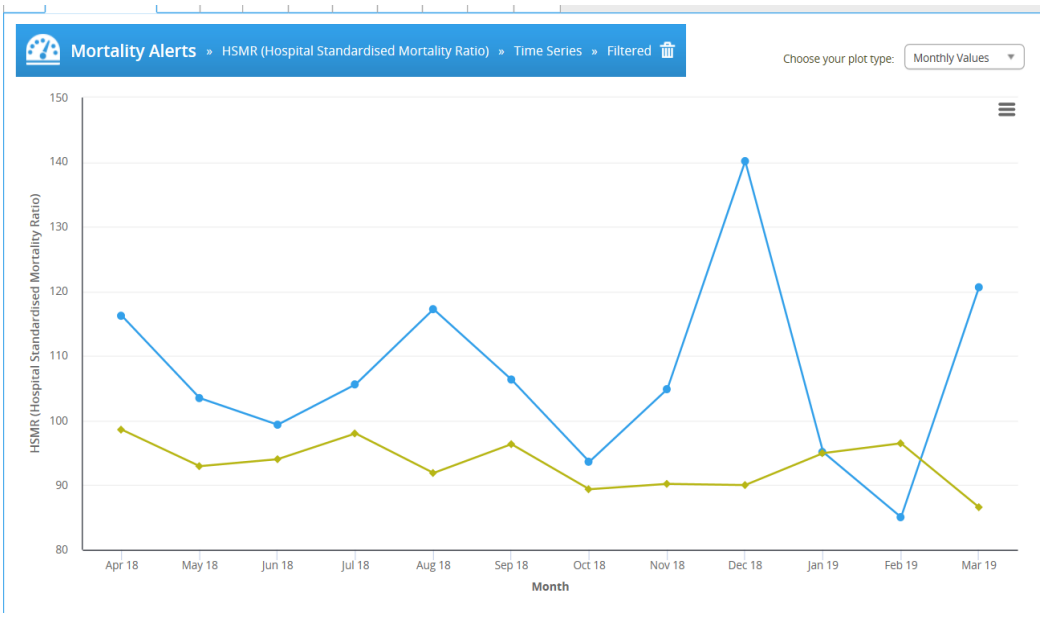


Fig 10: Pneumonia outcomes over 12 months.

Our pneumonia coding does suggest an excess mortality (blue line compared to yellow), particularly seen in December 18 shown above. This spike triangulates well with the overall increase in mortality at that time, shown in figure 1. Pneumonia is our most common cause of death, and so directly correlates to our overall outcomes.

Pneumonia will often be certified as the ultimate cause of death in frail, elderly and end stage respiratory disease patients, and patients rendered immobile from any other cause. These figures will also be impacted by the palliative care issues outlined above.

Coded spells in 17/18	Total number in Stockport	Stockport %	National average %	Local peers %
Lobar pneumonia	955	56%	57%	57%
Unspecified pneumonia	647	38%	34%	36%
Broncho pneumonia	45	3%	2%	2%

Fig 11: Pneumonia spells over 12 months.

CHKS have reviewed this data and concluded, 'this shows the distribution of primary diagnosis codes for pneumonia in 2017/18 for your trust compared to other peer groups.'

In conclusion, our coding appears to align with national practice. As pneumonia is the most commonly cited 'cause of death', it is a non specific marker, and reflection of all aspects of clinical care. These are dealt with below.

3.5 Improving clinical outcomes

Due to the degree of impact of place of death, coding and documentation, improving clinical outcomes are actually one of the least likely approaches to impact upon mortality statistics – but are the right thing to do and far more likely to impact on actual outcomes and patient experience. To detail all of these measures is not practical in this report, but key areas are as follows;

- **Recognition of deteriorating patients** – now monitored through the deteriorating patient group and using the recently introduced NEWS2 protocol.
- **Falls and pressure ulcer management** – our managed safety collaborative have demonstrated great progress in both areas, metrics of such importance that they may actually impact upon mortality statistics.
- **Improving consistency of care across 7 days** – our 7 day working program is reported in a separate report.
- **Reducing admission delays** – managing ED flow through winter. Prolonged ED stay correlates with worse outcomes. The management of flow and ED performance is covered elsewhere.
- **Reducing length of stay** – Stranded patient initiatives and SAFER.
- **Fractured neck of femur ERAS program**
- **Acute frailty network program**
- **Patient safety summit / safety culture**
- **Sepsis and CDiff infections** – discussed under risks below.

3.6 Reviewing areas of excess mortality

Mortality outliers are reported to us both by CHKS, and directly by the CQC.

SHMI Category	Condition	Cases	Observed	Expected	SHMI	Excess Deaths
37	Fluid & electrolyte disorders	349	35	24.8	140.9	10.2
75	Chronic obstructive pulmonary disease and bronchiectasis	1089	71	60.9	116.6	10.1
68	Peripheral and visceral atherosclerosis	46	19	10.0	190.7	9.0
73	Pneumonia (except that caused by tuberculosis or sexually tran	1768	308	299.3	102.9	8.7
101	Urinary tract infections	1237	58	49.9	116.2	8.1
89	Intestinal obstruction without hernia	222	26	18.6	139.6	7.4
93	Liver disease alcohol-related	135	27	22.9	117.8	4.1
130	Superficial injury contusion	700	21	17.1	122.6	3.9
109	Infective arthritis and osteomyelitis (except that caused by tube	80	7	3.4	203.7	3.6
107	Skin & subcutaneous infections	963	16	12.6	126.9	3.4
13	Cancer of pancreas	33	19	15.6	121.5	3.4
64	Cardiac arrest & ventricular fibril	22	16	12.8	125.4	3.2
112	Pathological fracture	72	8	5.3	152.0	2.7
104	Hyperplasia of prostate Inflammatory conditions of male genita	779	5	2.4	208.1	2.6
63	Cardiac dysrhythmias	957	16	13.5	118.9	2.5
16	Cancer other respiratory and intrathoracic	7	4	1.5	266.8	2.5
94	Other liver diseases	103	10	7.6	131.6	2.4
48	Multiple sclerosis and Other hereditary and degenerative nervo	51	6	3.8	160.0	2.2
122	Fracture of lower limb	429	6	3.8	158.1	2.2
31	Cancer of bone & connective tissue Cancer of thyroid Malignant	36	11	8.8	125.0	2.2

Fig 12: SHMI top 20 excess deaths

Where the numerators are small (very few deaths) single 'spikes' in morality have limited significance. Larger categories are more likely to achieve a significant result. In the past year we have had three adverse outliers. In each case we have launched a local investigation using our 'learning from deaths' methodology.

Our first review of 'acute and unspecified renal failure' concluded – an excess of end of life patients with clearly terminal diagnoses were included. There was no evidence of delays in escalation or failure to treat suggestive of avoidable deaths.

The very next month after the trigger, we had no deaths at all. Outcomes for this patient group are now the same as the national average.

We have two further mortality alerts that we have been asked to review following increased mortality reported in December 18. In both cases subsequent outcomes included other months with no deaths at all. This is highly suggestive of lack of statistical power in reviewing such small groups, or of variable coding practice.

Fig 13: Fluid and electrolyte abnormalities – mortality alert in December 18

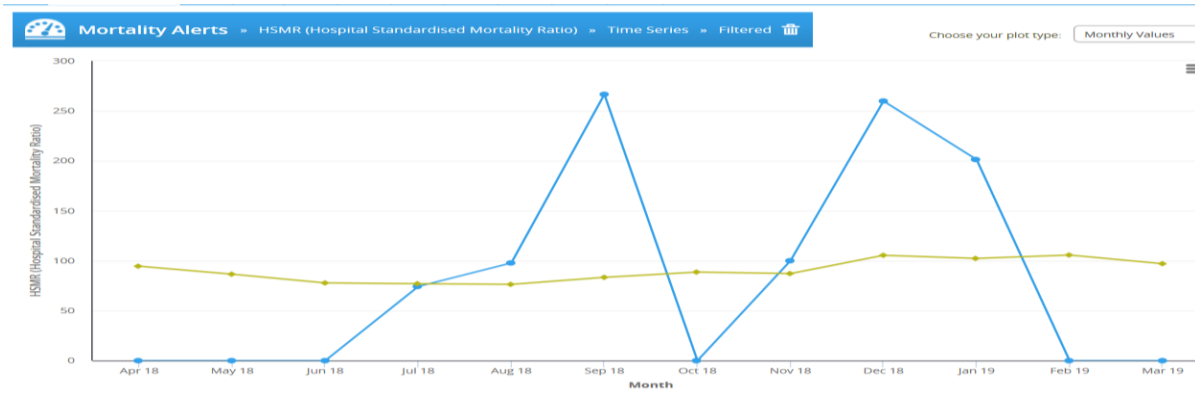


Fig 14: peripheral and visceral atheroma – mortality alert in December 18

We are currently 'learning from death' reviewing 20 case notes from each group, but as the metrics have already resolved to 'better than average'.

Reviewing outcomes based upon such mortality alerts have a poor track record of identifying deficiencies of care. To put these two 'excess mortality' alerts into context, during the same period we had seven statistically significant positive (good) outcomes, including stroke (-30 deaths), Ca colon (-8 deaths), Ca lung (-9 deaths), and Congestive Cardiac Failure (-14 deaths).

3.7 **Learning from deaths. –** An important educational role, but well covered elsewhere.

4.0 CURRENT RISKS

While we have no outstanding mortality alerts, two areas of clinical concern have been recently raised, so are considered here.

4.1 Sepsis

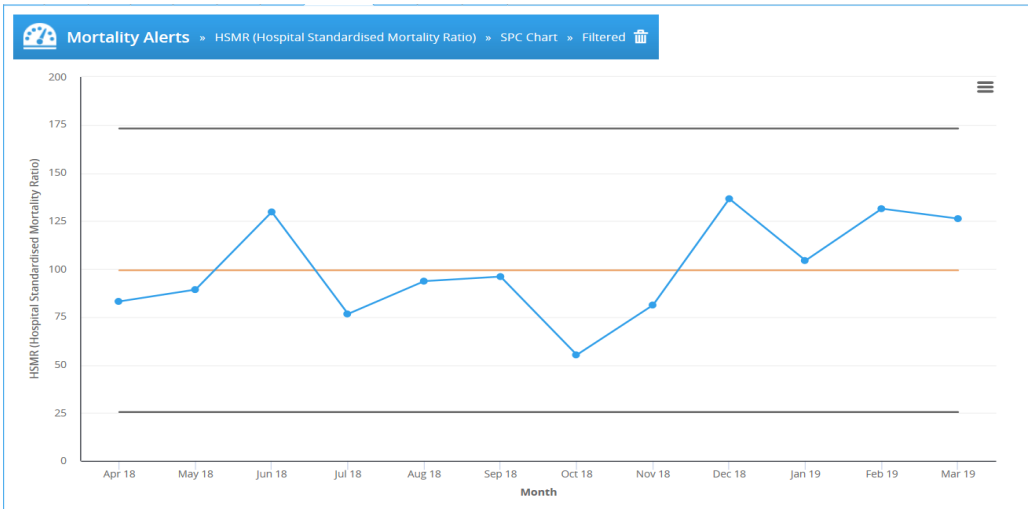


Fig 15: Sepsis outcomes

We are currently failing to consistently meet the national standards for timely identification and treatment of sepsis. These are well recognised as challenging targets, but delivery correlates well to good outcomes. This is one of our most important current risks.

Challenges in staffing our infection prevention team, who lead on sepsis and in recruiting microbiologists add to the challenges faced.

Outcomes are 'average' (0.99) over the past 12 months, but have recently risen to 112. This is not a statistical outlier, but is a cause of concern. Of greater concern is that sepsis treatment will be a significant factor in the outcomes of other diagnostic groups such as pneumonia.

We have now included monitoring of our sepsis outcomes in our board level IPR. The sepsis steering group has been enhanced and considerable focus being given to how this metric is cascaded through to the clinical staff. All performance meetings now discuss sepsis outcomes.

4.2 Renal failure –Acute and Chronic

Recent concerns have been about the ability to provide emergency renal services, in the absence of an on site dialysis unit. This is currently subject to a 'task and finish review' which will be monitored through the deteriorating patient group. A review of our mortality rates (and previous deep dive into acute renal failure deaths) offers considerable assurance in the context of the concerns raised.

This concern reflects how a review of mortality data can offer some important oversight of the impact of an issue when considering clinical concerns being raised. Mortality rates remain acceptable in both acute and chronic renal failure, but will be closely monitored over the coming 12 months.

A number of mitigating actions are already in place to ensure patient safety is maintained while medium and longer term solutions are developed.

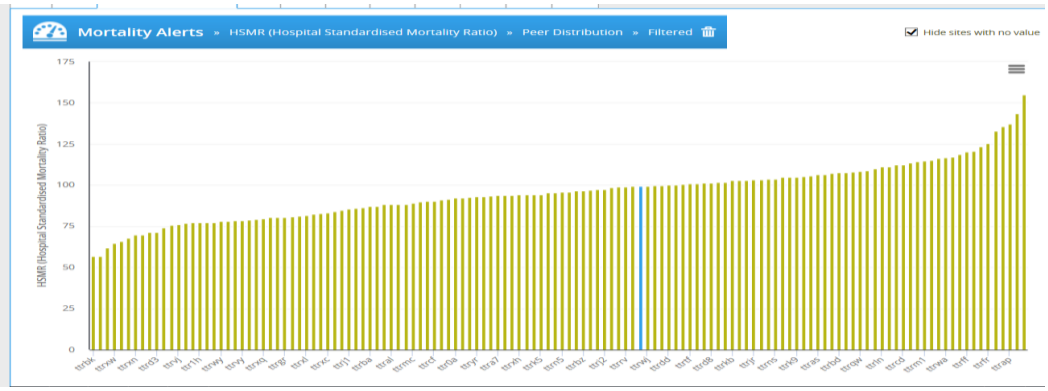


Fig 16: Acute renal failure outcomes ranking

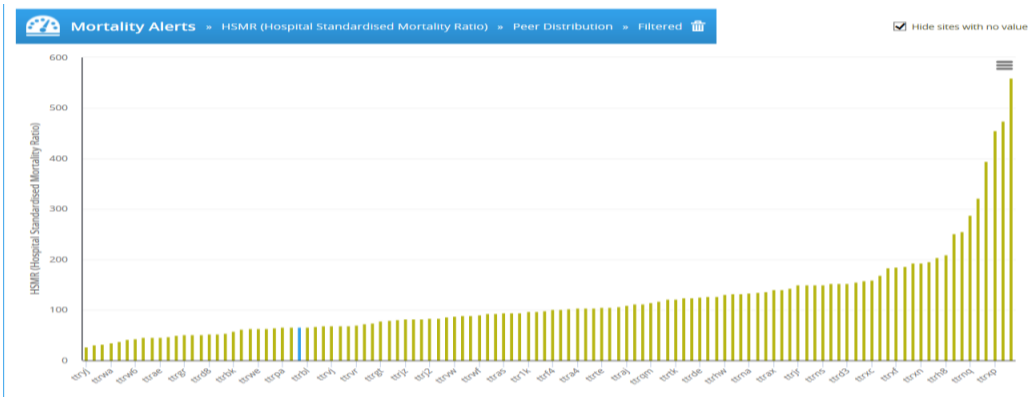


Fig 17 Chronic renal failure outcomes ranking.

4.3 CLOSTRIDIUM DIFFICILE

One of our areas of concern is an escalating incidence of CDiff infection as demonstrated in the IPR. We know that CDiff infection will increase length of stay and increase risk of death. Unfortunately, as CDiff is a complication that may develop during admission from another cause, it is not easy to track using our mortality data. None the less this is one of the key metrics that will impact upon our overall outcome data, with a small, but significant impact in all admission categories.

5.0 ONGOING DEVELOPMENT WORK

The medical director has undertaken an AQUA quality improvement project on the topic of mortality outcome metrics. This is still in development, but will offer further focus on this important topic.

6.0 CONCLUSIONS

This report has offered an overview of our mortality indicators, and update on the key areas of focus outlined at the quality board in December.

The report is provided for information.

The board of directors is recommended to include this as a biannual agenda item on the quality board

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NHS
Stockport
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	27th June 2019
Subject:	Fit and Proper Person Regulations		
Report of:	Mr A Belton, Chair of the Trust Board	**Prepared by:**	Hilary Brearley – Interim Director of Workforce & OD

REPORT FOR APPROVAL

Corporate objective ref:	5	The Care Quality Commission (CQC) introduced new requirements regarding the Fit and Proper Persons Test (FPPT) for Directors in November 2014 – becoming law in April 2015. Additional guidance was introduced in January 2018. This approach is to ensure that the Trust continues to meet its Governance requirements and to ensure that we maintain an open, honest and transparent culture within the NHS through accountability of Directors to NHS Bodies. The guidance applies to executive, non-executive, permanent, interim and associate positions irrespective of voting rights. The Trust Secretary maintains the Trust's register of compliance with the Fit and Proper Person Test. It is the responsibility of the Chair of the Trust to discharge the requirements placed on the Trust to ensure that all within scope meet the FPPT, and the Chair of NHSI to ensure that the Trust Chair fulfils the test requirements.
Board Assurance Framework ref:		
CQC Registration Standards ref:		
Equality Impact Assessment:	☐ Completed ☐ Not required	

Attachments:

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

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1. INTRODUCTION

1.1 This paper sets out the Trust's approach to assessing whether individuals falling within the scope of the regulation are fit for office and remain so for the duration of their employment or engagement with the Trust. It will also enable Board members to re-affirm their compliance with the test, whilst putting the register in the public domain.

2. BACKGROUND

2.1 The Care Quality Commission (CQC) introduced new requirements regarding the 'Fit and Proper Person Tests' for Directors in November 2014, which became law from 1 April 2015. . Additional guidance was introduced in January 2018.

This approach is to ensure that providers meet Government regulations about the quality and safety of care, to ensure an open, honest and transparent culture within the NHS to ensure accountability of Directors to NHS Bodies. The Fit and Proper Person Test is set out in regulation to ensure that providers meet their obligations to only engage individuals who are fit for their role.

2.2 In making this assessment, providers must take appropriate steps to ensure that any individuals in scope of the regulation are of good character, are physically and mentally fit, have the necessary qualifications, competence and skills, and can supply information relating to Disclosure and Barring Service checks and a full employment history.

2.3 The regulation automatically prevents providers from engaging individuals who:
'*Have been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity, or providing a service elsewhere which, if provided in England, would be a regulated activity'.*

2.4 It also sets out a number of additional grounds which will render an individual automatically unfit for a post as Director and provides criteria to be included when assessing whether an individual is of good character.

This assessment includes:

- Trusts must make every effort to ensure that, as a minimum, they seek all information to confirm the matters listed in 3.1 of this report.
- Whether an individual has been convicted in the UK or elsewhere of any offence.
- Whether an individual has been erased, removed or struck off a register of professionals maintained by a regulator of health care or social work professionals.
- Whether an individual appears in any registers including disqualified directors, bankruptcy and insolvency, and removed charity trustees.

2.5 Section 29 and Annex 6 of the Trust's Constitution also sets out criteria under which someone would be disqualified from being a member of the Board of Directors. This includes:

- A person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged.
- A person in relation to whom a moratorium period under a debt relief order applies under Part 7A of the Insolvency Act 1986.
- A person who has made a composition or arrangement with, or granted a trust deed, for his/her creditors and has not been discharged in respect of it.

- A person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him/her.
- He/she is the subject of a disqualification order made under the Company Directors Disqualification Act 1986.
- He/she has within the preceding two years been dismissed, otherwise than by reason of redundancy, from any paid employment within a health service body.
- He/she is a person whose tenure of office as the Chairman or as a member or Director of a health service body has been terminated on the grounds that his/her appointment is not in the interests of the health service, for non-attendance at meetings or for non-disclosure of pecuniary interest.
- He/she has had his/her name removed from any list pursuant to the NHS (Performers List) (England) Regulations 2013, or the equivalent lists maintained in Wales, and he/she has not subsequently had his/her name included in such a list.

2.6 The recent **Kark** review of the Fit and Proper Persons Test (FPPT) looked at how effective the FPPT is in preventing unsuitable staff from being redeployed or re-employed in the NHS. It identified a range of issues with the test and the way it is currently interpreted and applied, and concludes that the FPPT does not do anything that it holds itself out to do. The review made 7 recommendations, 2 of which have already been accepted by the Secretary of State, and the rest to be considered by Baroness Dido Harding (Chair NHSI).

The two which have been accepted are:

- All Directors should meet specific standards of competence to sit on a board of any health providing organisation. A set of high level core competencies to be set out following consultation with key bodies.
- A central database should be created, holding relevant information about qualifications and history about each director (including Non Executives Directors)

The Trust will continue to review the outcomes of the review and update the Board as appropriate.

3. CURRENT SITUATION

3.1 Standard pre-employment due diligence will usually require organisations to undertake the following checks:

- Proof of identity and right to work.
- Competence and skills required, relevant and appropriate experience, validation of qualifications and employment references.
- Consideration to the physical and mental health in line with the role and good occupational health practice.
- Good character assessment using various checks such as disqualified director checks where appropriate.
- Checks that the individual has not been responsible for, privy to, contributed to or facilitated and serious misconduct or mismanagement (lawful or otherwise) in the course of carrying on a regulated service
- Checks against the Disclosure and Barring Service (DBS) – as appropriate to the role.

This Trust deems all Executive and Non-Executive roles as falling within the scope of the regulations to be subject to DBS checks.

The Trust could choose to add other roles to the register if that was considered appropriate.

3.2 In addition, the Trust holds a register to support compliance of the 'Fit and Proper Person Test' including evidence of self-declaration of compliance against the criteria, which is administered by the Trust Secretary.

3.3 The Trust is in the process of mandating for new starters to relevant roles within the Trust, to register with the DBS update service. This requires individuals to register with the update service at the point of which the check is undertaken, this then allows for regular automated checking between the Trust ESR system and the EDBS system; providing alerts to any changes to the check status. This is a significant improvement on the traditional system, which is a one off check, and would not alert the Trust to any updated information about an individual.

3.4 As an addition to current procedures, it is proposed that all individuals falling within scope of the FPPT register with the update service.

3.5 As part of the CQC inspection for the Well-Led Review in September 2018, evidence was requested to demonstrate our compliance with the Fit and Proper Person Test. The inspection identified a number of gaps in the evidence held by the Trust with regard to FPPT checks and required the Trust to take action to be fully compliant with legislation related to FPPT.

As a result, the Trust agreed to take the following actions:

- Checklist of all required documents & checks attached to all Board position files. *Actioned*
- Proof of annual declarations in files. *Actioned*
- Review non-executive directors' job descriptions to consider specific qualification requirements. *In progress*
- Consult on moving all Board members to DBS update service. *In progress*
- Review of fit and proper persons test policy annually. *Actioned*
- Corporate HR support to sign off completed new starter files. *Actioned*
- Delivery against these actions will be measured by:
  - Annual Board report regarding completion of annual declarations
  - Completion of DBS update service consultation – June 2019
  - Annual audit of directors files.

3.6 In addition, the Trust will introduce an annual compliance statement for all Directors to evidence continued compliance with FPPT standards.

4. CONCLUSION

4.1 Directors of the Board are asked to note progress made against the CQC actions, and to consider moving to the DBS update service. This will provide the Trust with continual assurance and immediate notification of any change in the individual check status.

The Trust has made a number of changes in order to ensure compliance against the FPPT and will continue to monitor outcomes of the Kark review in order to maintain future compliance.

5. RECOMMENDATIONS

5.1 Board is asked to note the contents of this report and progress against the CQC actions.

5.2 The Chair and Director of Workforce & OD continue to review the outcomes of the Kark review and update the Board as appropriate.

5.3 That all Directors within scope of the FPPT agree to register with the DBS update service .

5.4 That the Director appraisal process is updated to include checks against the FPPT.

5.5 Core competencies to be embedded in all role descriptions, selection processes and development plans on completion of the consultation on competencies led by Baroness Dido Harding.

NHS
Stockport
NHS Foundation Trust

Report to:	Trust Board	**Date:**	27.06.2019
Subject:	7 Day Services Board Assurance Report -June 2019		
Report of:	Medical Director	**Prepared by:**	AMD , Hospital Care

REPORT FOR APPROVAL

Corporate objective ref:	2a,2b,3b,5d,	Summary of Report: *Identify key facts, risks and implications associated with the report content.* This report outlines the update on progress against the 7 day National standards with particular reference to the 4 priority clinical standards (CS 2, 5, 6 and 8) and in keeping with the board level reporting assurance requirements. This process was trialled and presented to the Quality Committee and Trust Board in February 2018 The report provides the key narrative contained in the seven day self-assessment tool and has been elaborated upon where required to give the required context. Given that there was no dedicated funding for 7DS delivery for 2019/20 it was accepted and agreed in the implementation meeting to focus on Incremental small changes to support 7DS delivery in particular if this is also aligned with other BG priorities and performance delivery. The report has already been approved by the Quality committee on 18.06.19 and the Trust Board is requested to approve this report for national submission on 28th June 2019 (deadline for submission).
Board Assurance Framework ref:	SO2,SO7	
CQC Registration Standards ref:	12,17,18,	
Equality Impact Assessment:	☐ Completed ☒ Not required	

Attachments:	7DS self-assessment template - June return

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

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1. INTRODUCTION

1.1 Historically the annual National Survey for 7 day services has been completed to show progress against the Four 7 day priority standards. After the 2018 submission of data the Trust were informed that a new process of Board Assurance would be put into place.

1.2 The Board assurance process will happen twice a year and contain a self-assessment for every Trust to complete which asks for information on every 7 day standard.

1.3 This process was trialled in February 2018 and the self-assessment with an accompanying report was put through Quality Governance Committee and Trust Board. Both committees were happy with the content of the self-assessment and this was submitted Nationally, although no results of the trial self-assessments were published. The results of this return will be published Nationally.

1.4 The self-assessment template is set nationally and so cannot be changed which makes reading the narrative placed in the February submission (appendix 1) difficult to read. Each narrative section contained in the self-assessment is contained in this report and elaborated on where required to provide more context to the data.

2. CLINICAL STANDARD 2 (CS2)

2.1 This standard states 'All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital'. Compliance target is >90% for both weekdays and weekends.

2.2 **EVIDENCE SOURCE 1: Oncall Consultant sessions / cover for key admitting specialties (data provided by HR from allocate)**

Specialty	Weekday PA CORE	Weekday PA Out of Hours	Weekend PA
Paediatrics	2.50 2.00	1.00 0.00	2.00
Acute medicine	3.25	0.83	3.00
General Surgery	2.75	0.66	2.33
Stroke	2.50	0.33	1.00
Obstetrics and Gynaecology	2.50 3.00	0.50 4.00	4.00
Gastro	2.00	0.00	0.00
Urology	2.25	0.33	1.66
T&O	2.50	0.00	1.00
Radiology	2.50	0.33	2.00
High dependency areas HSDU/ICU/HASU	2.75	0.816	4.483

For most specialties there is more consultant PAs dedicated to weekday core hours than out of hours or at the weekend. This will impact on timely patient reviews, LOS and discharges.

Over the years this gap has steadily reduced. Outline Business cases has been submitted to address this gap and was considered by the trust but presently there is no funding allocation to implement the full 7DS consultant requirements due to financial pressures and the aim is to adopt an incremental approach to 7DS compliance with Business cases for new consultants. There are also potential opportunities in some specialties for increased compliance with 7DS standards with annualized job plans but will require group job planning and agreement.

2.3 EVIDENCE SOURCE 2: Local Audit Data

An audit was undertaken in all of the key admitting specialties with random sampling of weekdays and weekend admissions in April 2019 and the overall compliance is illustrated in table 1. In our trust Acute medicine has the largest number of admissions followed by stroke and surgery and then pediatrics and Obs and Gyne. The audit excluded patients who are discharged within 14 hours and ambulatory care patients. The audit was undertaken by the Clinical Directors and or audit leads.

Specialty Data Submission compliance by specialty

Specialty	**Audit Compliance**
Acute Internal Medicine	100%
Cardiology	100%
Emergency medicine	100%
ENT	100%
General Surgery	50%
ICU	100%
Obs & Gynecology	100%
Paeditarics	100%
Stroke Medicine	100%
Trauma and Orthopedics	100%
Urology	50%
Overall Audit Compliance	**90%**

Table 1 : CS2 Compliance (April 2019)

Weekday	**Weekend**	**Overall score**
Compliance score : 85 % **No, the standard is not met for over 90% of patients admitted in an emergency**	**Compliance score : 72 %** **No, the standard is not met for over 90% of patients admitted in an emergency**	**Overall Compliance score: 78.5%**

No patient related safety concerns were noted during the audit for patients who were not compliant with CS2 standard. Sunday was noted to have the worst performance with 55% of the patients in the audit not having a consultant review within 14 hours. Overall compliance for CS2 was 85% for weekdays and 72% for weekend's admission thereby not meeting the standard.

A review of the reasons for non-compliance has identified specific actions on process which can improve the overall compliance with this standard. Examples include clarification and standardization of spinal ward consultant post take ward rounds review, an agreed process for review of weekend afternoon CCU admissions by AMU/Oncall consultant as these patients often bypass AMU and directly admitted to CCU as well as development of exception pathways for Obstetrics. These actions will be taken forward with the specialties through the 7DS implementation meeting.

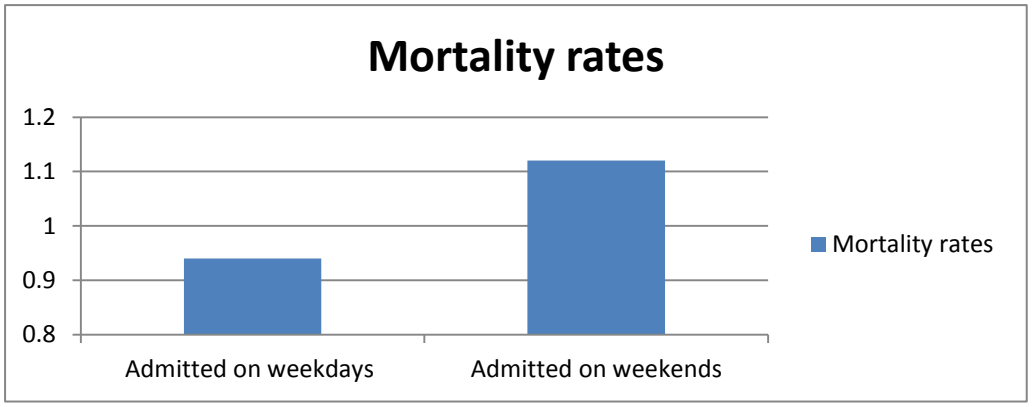
Some of the surgical and smaller specialties do not have routine evening ward rounds over the weekend. The OBC for 7DS has captured this requirement and without investment on manpower is difficult to address.

Urology is unique in that they have better compliance with this standard for weekend reviews compared to weekdays review due to the nature of their job plans and dedicated weekend consultant ward rounds of all urology patients. The urology consultant body has agreed on a revised arrangement to provide robust 7 day cover for inpatients including daily whiteboard round however this has some impact on elective care and will be taken forward with further discussion and agreement within the Surgical and critical care business group.

Acute medicine audit data was made available after the quality committee submission and has now been included within this report. Timely availability of scanned notes on evolve has been noted as a recurrent theme for most specialties impacting on overall audit compliance and has been escalated for review of evolve process. Going forward clinical audit department will identify and randomly select only scanned evolve notes for specialty audit.

2.4 EVIDENCE SOURCE 3: LOS, Mortality, Readmission, ED performance, Admission conversion rates, patient experience , GMC survey etc

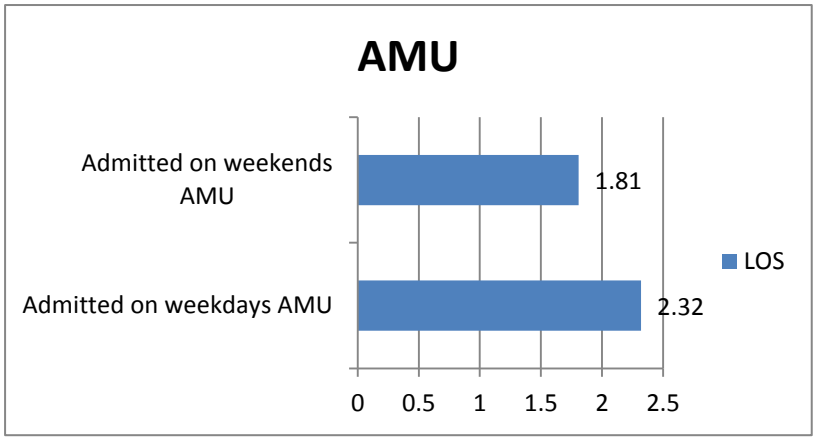
2.4 a SHMI Mortality data



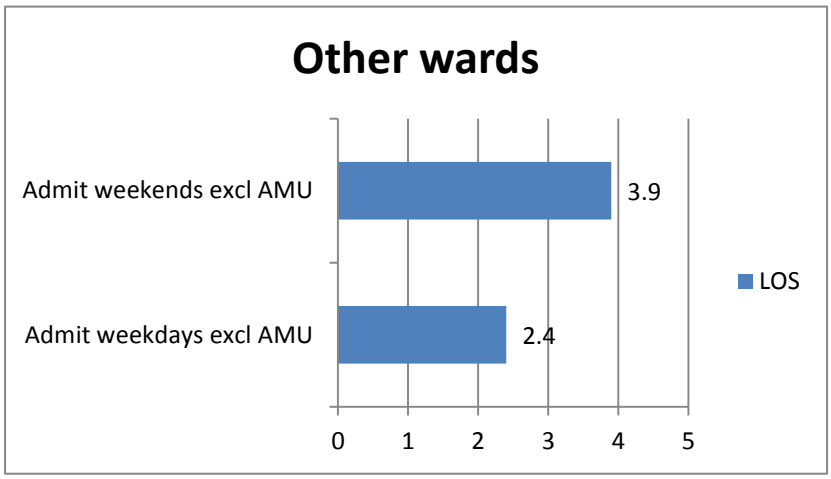
The above table shows mortality data for the period 1st January 2018-31st December 2018. This is similar to the national trend and no change compared to previous data submission. The causes for the observed variation are multifactorial including timely access to community services over the weekend and palliative care support over the weekend. In future reports we will strive to include data and trends on palliative care deaths at weekday vs weekend admissions to triangulate this further.

2.4 b **LENGTH OF STAY (LOS)**

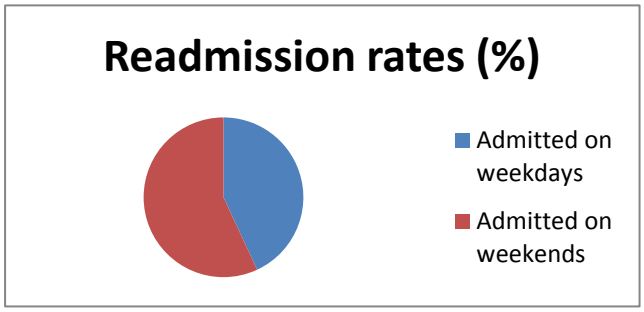
Data for Q4 2018/19 the average LOS for patients on AMU admitted on a weekday was 2.32 days and those admitted at the weekend was 1.81 days. This is different from last submission data which showed an increased LOS for patients admitted at the weekend. This data set is for one quarter compared to 2 months of data examined in the last submission. There have been numerous initiatives in AMU over the winter including additional consultant and junior workforce as well as support services and extended ACU cover which may have had an impact. We will continue to monitor this to see whether there is a changed or reversed trend in this regard.



However across the Trust for all other specialties inclusive of admission areas collectively the trend is the reverse in that patients being admitted on a weekend have a longer average stay in hospital (3.9) vs weekdays admission LOS (2.4) . Weekend Specialty ward specific consultant sessions and supporting social and ward MDT infrastructure is limited for wards other than direct admission areas and the OBC has incorporated this requirement within their business case. There are some specialties (gastroenterology, cardiology, stroke and frailty) where an incremental approach for dedicated weekend consultant ward cover would be feasible with moderate investment and the directorates has been requested to work up this requirement for agreement within the respective business groups.



2.4 c **READMISSION RATES**



This increase in readmission rates for patients admitted over the weekend may reflect more complex admissions over the weekend. This data is similar to the last 7 day submission.

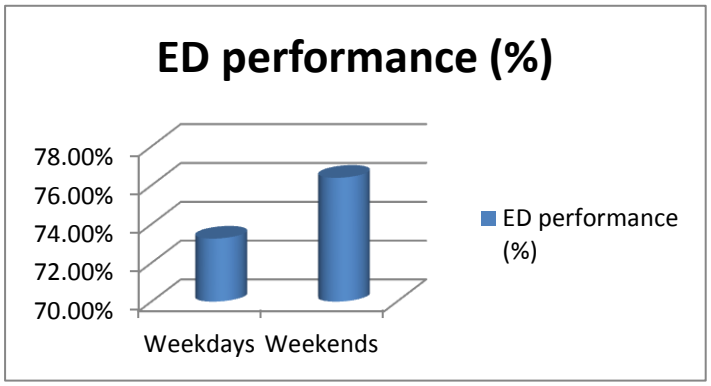
2.4 d **PATIENT EXPERIENCE**

Friends and family test had over 87% positive rate January 2019-April 2019. One of the questions was “If someone close to the patient wanted to talk to a doctor whether they had enough opportunity”. In January 2019-April 2019 this answer received a 88% positive response. Another question asked was “if a patient had important questions to ask a doctor did they get answers they understood". In January 2019-April 2019 this answer received a 95% positive response. At present the questionnaire does not subcategorize the patient response based on weekday admission vs weekend admissions.

2.4 e **GMC TRAINEE SURVEY**

This survey is completed by the Trust on an annual basis. The last survey was completed in May 2018. This showed overall Trainee satisfaction rate of 76.60%. Clinical supervision response had an 89.70% satisfaction rate with 86.55% for out of hour’s supervision indicating no major concerns with regards to out of hour’s clinical supervision and the data is reassuring in this respect. The latest submission has just been completed with results expected by the end August 2019 and will be included in the next report.

2.4 f **ED PERFORMANCE**



This data is for Q4 2018/19. As per last submission the results now show no significant variation in ED performance between weekday’s vs weekends in spite of much fewer discharges over the weekend. This may suggest albeit controversially that ED performance is more dependent on ED internal processes or variations in patient acuity in ED, number of ED attendances and or ED workforce or rather than on bed availability as the dominant factor. The medical and nursing resource for ED is broadly similar between weekdays and weekends.

2.4 g **ED ADMISSION CONVERSION RATES**

The data shows average ED conversion rates for Q4 2018/19 as 31.86% for weekdays and 31.12% for weekends. Again the results show no variation in performance between weekday's vs weekends and is similar to previous submission data.

3. CLINICAL STANDARD 5

3.1 Standard 5 states that hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week:

- Within one hour for critical patients
- Within 12 hours for urgent patients
- Within 24 hours for non-urgent patients

3.2 The Trust is currently not compliant at the weekend for Echocardiography or MRI.

	WEEKDAYS	WEEKENDS
Microbiology	Yes available on site	Yes available on site
Computerised Tomography (CT)	Yes available on site	Yes available on site
Ultrasound	Yes available on site	Yes available on site
Echocardiography	Yes available on site	No the test is only available on or off site via informal arrangement
Magnetic Resonance Imaging (MRI)	Yes available on site	No the test is not available
Upper GI endoscopy	Yes available on site	Yes available on site

3.3 CT is available at weekends but this is currently only for clinical emergencies and ED rather than routine CT scans though adhoc additional sessions are undertaken.

3.4 MRI has limited availability for Stroke on bank holidays and weekends only. Also not available after 5 pm and overnight weekdays. Opportunities exist for the trust to open up MR imaging over the weekend as largely the reporting is undertaken by external reporting arrangements in particular for pre-booked MR scanning over the weekend and will include renegotiation with the MR provider for inpatient scans.

3.5 Echocardiography provision has been recognised as a national challenge given limited expertise in trained clinicians and the solutions needs to be sector based or with a network arrangement. The Northwest 7DS peer support network is aware of this challenge and is exploring solutions but availability of trained ECHO technicians remains the main limitation.

4. CLINICAL STANDARD 6

4.1 Standard 6 states that hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.

4.2 The Trust is currently not compliant for weekdays in Interventional Endoscopy.

Critical Care	Yes available on site	Yes available on site
Interventional Radiology	Yes mix of onsite and offsite by formal arrangement	Yes mix of onsite and offsite by formal arrangement
Interventional Endoscopy	No the intervention is only available on or off site via informal arrangement	Yes available on site
Emergency Surgery	Yes available on site	Yes available on site
Emergency Renal Replacement Therapy	Yes mix of onsite and offsite by formal arrangement	Yes mix of onsite and offsite by formal arrangement
Urgent Radiotherapy	Yes available off site via formal arrangement	Yes available off site via formal arrangement
Stroke thrombolysis	Yes mix of onsite and offsite by formal arrangement	Yes mix of onsite and offsite by formal arrangement
Percutaneous Coronary Intervention	Yes available off site via formal arrangement	Yes available off site via formal arrangement
Cardiac Pacing	Yes available on site	Yes mix of onsite and offsite by formal arrangement

4.3 Interventional radiology is presently delivered with a network arrangement for vascular interventions, thrombectomy etc. but is also a key requirement of healthier together local provision, and hence is being considered as part of this development as well for in-house provision during healthier together implementation.

4.4 Cardiac pacing is provided by daytime consultant cardiology cover and requirements for weekend has been adhoc and cardiology consultant onsite sessional provision would cover this requirement in those rare infrequent circumstances. Dedicated weekend pacing will require development of a weekend service from our consultants including equipment and or technician availability, or development of an agreement from one of our neighbouring tertiary cardiac centre. The numbers are very small and hence not cost effective to have a stand-alone service locally.

4.5 For Interventional endoscopy at present gastro on call rota is only available over the weekend and in hour's weekdays. There are agreed plans to implement the gastro rota in the weekday's nights as well once the gastroenterology consultant establishment has been fully recruited to eight consultants and this will ensure full compliance with endoscopy access standard. Having a stable number of consultants is crucial for the sustainability of both the weekend and future 7 day ward cover model. The Trust hope to have this in place by August/September 2019, however there is concern that endoscopy capacity will be an issue for consultants with resultant ability for them to maintain the minimum competency requirements for the consultants.

5. CLINICAL STANDARD 7

5.1 Standard 7 states Liaison mental health services should be available to respond to referrals and provide urgent and emergency mental health care in acute hospitals with 24/7 Emergency Departments 24 hours a day, 7 days a week.

5.2 We believe that Pennine trust will be responding to this standard in their trust response as this service provision is delivered by Pennine and performance monitored by us. Mental Health Liaison Provision is currently under review by our safeguarding group and we believe that we will have more relevant information on performance against this standard once this review is completed.

6. CLINICAL STANDARD 8

6.1 Standard 8 states that all patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.

6.2 EVIDENCE SOURCE 1: LOCAL AUDIT DATA

The Trust is currently compliant against standard 8 based on the audit data.

Weekday	Weekend	Overall score
Compliance score : 100 % Once daily: Yes the standard is met for over 90% of patients admitted in an emergency	**Compliance score : 92.5%** Once daily: Yes the standard is met for over 90% of patients admitted in an emergency	**Overall Compliance score: 96%** **Standard Met based on audit data**
Compliance score : 90 % Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	**Compliance score: 100%** Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	**Overall Compliance score: 95%** **Standard Met based on audit data**

Note:

The daily consultant review (CS8) was audited only for the first 5 days of admission and the local audit compliance figures is not a reflection of consistent delivery of this standard in all inpatients.

A significant number of admitted patients (up to 40%) get discharged from the assessment unit settings where there is 7 day consultant review and this has helped with the overall compliance figures and hence we request to interpret this data with caution.

6.3 **EVIDENCE SOURCE 2: Board Rounds , MDT, Handover Protocols etc**

The Trust has agreed board round principles and protocols. The feedback on individual speciality practice from CDs and clinical leads is reflected below

ICU/HDU: In high dependency areas like ICU /HDU Twice daily review is undertaken by consultants

SURGERY: Historically surgical wards have not conducted white board rounds, however ward C6 is currently trialling this with a plan to roll out around the business group.

ACUTE MEDICINE all patients with high dependency needs or unwell are seen once a day 7 days a week. Morning handover identifies patients who have triggered on the national early warning score and flagged for consultant review. Afternoon/evening reviews are determined on a needs basis - all patients who would be potentially for escalation to level 2 or level 3 would be highlighted to the afternoon AMU consultant and the ward registrar would review again in the afternoon. This process has not been audited; however, AMU is not a level 2 facility but does care for patients requiring nursing level 2 needs although the ward is not funded for this level of care. This includes a potentially unlimited number of NIV, septic, DKA, bleeder patients.

OBSTETRICS AND GYNAECOLOGY A board round system is in place in all wards except M3 (MW led) , but there is no written protocol. As part of the work to ensure standard 2, a prospective rota has been developed for daily ward rounds in the M2 obstetric ward and was commenced in April.

PAEDIATRICS - 9am consultant led handover 7/7 of all paediatric & neonatal patients on Treehouse & Neonatal Unit plus babies under paediatric review on postnatal ward. All patients discussed & prioritised for order of review. Management & discharge plan discussed for all patients. Hot weeks are job planned for all paediatric consultants.

UROLOGY reviews all patients each day in a ward round at weekends therefore does not complete a white board round and the consultant body agreed plans for daily AM consultant ward rounds needs agreement within the BG.

T&O have a Trauma daily ward round led by the consultant which will also review any inpatients identified. Orthopaedics inpatients are seen by a consultant daily with a fixed ward round each week. ED consultants complete a ward round of CDU daily at 8am and 7pm daily.

STROKE – All wards have a board round daily and HASU twice daily ward rounds

MEDICINE: Board round is undertaken by the consultant or ST3+ doctor and ward manager Mon-Fri. There is no white board round over the weekend in speciality wards.

At present the Trust do not have a clear auditable process to decide which patients do not need a daily consultant review however there are opportunities to embed this electronically in the Advantis ward infrastructure to support this implementation in white board rounds but will need dedicated IT resource support for the same and could be incorporated into the developmental plans for this year .

6.4 **EVIDENCE SOURCE 3:** Policy for recognition and escalation for deteriorating patients

NEWS2: The Trust have successfully implemented a new system of escalation for deteriorating patients based on agreed protocols and policy in Dec 2018 ie NEWS2 National Early Warning Score tool ; one of the few trusts in the northwest to do so.

The number of triggers requiring medical review has increased with NEWS2 implementation as the tool is much more sensitive in recognizing deterioration. The newly formed deteriorating patient group will be looking into this data with actions to support and mitigate and or reduce any delay in reviews. There has also been dedicated training for ward staff in managing patients with NEWS 2 scores 1-4.

7 CLINICAL STANDARDS 1,3,4,7,9 and 10

7.1 STANDARD 1: PATIENT EXPERIENCE

This standard states that Patients, and where appropriate families and carers, must be actively involved in shared decision making and supported by clear information from health and social care professionals to make fully informed choices about investigations, treatment and on-going care that reflect what is important to them. This should happen consistently, seven days a week.

The Trust does not collate patient experience data relating to consultant presence or specific domains relating to the above.

Friends and family test had over 87% positive rate January 2019-April 2019.
One of the question was " If someone close to the patient wanted to talk to a doctor whether they had enough opportunity" . In January 2019-April 2019 this answer received a 88% positive response. Another question asked was " if a patient had important questions to ask a doctor did they get answers they understood". In January 2019-April 2019 this answer received a 95% positive response.

Moreover the present patient satisfaction questionnaires do not distinguish between experiences for patients admitted over the weekend versus weekdays

7.2 STANDARD 3 MULTIDISIPLINARY REVIEWS:

This standard states that All emergency inpatients must be assessed for complex or on-going needs within 14 hours by a multi-professional team, overseen by a competent decision-maker, unless deemed unnecessary by the responsible consultant. An integrated management plan with estimated discharge date and physiological and functional criteria for discharge must be in place along with completed medicines reconciliation within 24 hours.

Speciality	Current Arrangements (Feedback from CDs and speciality leads)
Neonatal unit	Discharge checklist in place. Discharge planning meeting held prior to discharge of complex patients. 0.8WTE Discharge planning lead post to commence March 2019. Role to coordinate discharge, disseminate learning & produce guidelines. Learning to be shared across paediatrics
Paediatrics	Vast majority of patients are short length of stay, discharge check list part

(Treehouse)	of admissions booklet. All complex patients, likely to need discharge planning, are assigned named nurse on admission who will coordinate this process. Discharge coordinators work a 7 day week, although there is a reduced service at the weekend. 7 day working is part of the new ITT review that is being completed, within this will be options appraisal for a new staffing model which will include increased support at weekend at present but will share learning from neonatal discharge planning lead and written guidance will be produced.
T&O	Daily meeting held as a multidisciplinary team to review patient care planning. This meeting acts as an MDT and shift handover.
Obstetrics and Gynaecology	Defined acute gynaecology pathway for emergency admissions and obstetric patients should be excluded from this as they have defined guidelines under MDT.
Stroke ward E1 & A10	HASU has MDT daily and acute stoke/rehabilitation have three weekly MDTs and Mon –Friday white board rounds

7.3 **STANDARD 4 SHIFT HANDOVERS**

This standard states handovers must be led by a competent senior decision maker and take place at a designated time and place, with multi-professional participation from the relevant in-coming and out-going shifts. Handover processes, including communication and documentation, must be reflected in hospital policy and standardised across seven days of the week.

Speciality	Current Arrangements (Feedback from CDs and speciality leads)
Paediatrics	Monday to Friday consultant led handover of all children/neonates under care of paediatrics takes place at 9am, 4.30pm & 9pm. Saturday & Sunday consultant led handover of the above takes place at 9am. Handover sheets are in use, stored on the paediatric I drive & updated prior to each handover. onday to Friday consultant led handover of all children/neonates under care of paediatrics takes place at 9am, 4.30pm & 9pm. Saturday & Sunday consultant led handover of the above takes place at 9am. Handover sheets are in use, stored on the paediatric I drive & updated prior to each handover.
HDU	Patients required immediate review & new admissions are highlighted
T&O	Complete shift handovers and pass any cases needed to the on call team. There is also a formal handover from day to night staff.
Obstetrics and Gynaecology	The department have a robust shift handover process at 8.30 and 20.30 where a multidisciplinary formal hand over takes place with a consultant in obstetrics and anaesthesia present at 8.30 and a registrar leading this at 20.30. Over the past year a formal written handover of patients admitted in Gynaecology ward has also been added to this.
Stroke ward A10	A daily shift handover is completed
General Surgery	Two daily handovers completed between the doctors on shift at 8am and 8pm.

7.4 **STANDARD 9: TRANSFER TO COMMUNITY, PRIMARY AND SOCIAL CARE**

This standard states that Assurance that the hospital services to enable the next steps in the patient's care pathway, as determined by the daily consultant-led review, are available every day of the week. These services should include:

- discharge co-ordinators.
- pharmacy services to facilitate discharge (e.g. provision of TTAs within same timescales on weekdays and at weekends)
- pharmacy services to facilitate discharge (e.g. provision of TTAs within same timescales on weekdays and at weekends)
- physiotherapy and other therapies
- access to social and community care providers to start packages of care
- access to transport services.

7.5 **THERAPIES** - The areas that are funded for 7 day working for therapies are: Stroke – Occupational Therapy, Physiotherapy and Speech and Language Therapy, Respiratory on call 24/7 – Physiotherapy, FRESH team in ED , T&O Saturday– Physiotherapy Sunday - Physiotherapy and Occupational Therapy, Community Neuro - rehabilitation Service – Saturday only. There is no funded establishment for the wards at weekend, MSK Out Patient Services or Adult Community Therapy Team.

A Therapy Review was carried out by GM partnership in March this year. The recommendations included therapy input to AMU and streamlining the T2A pathway and Trusted Assessor process. The resultant actions have been included within the work streams of the Trust Frailty, Dementia and End of Life Programme, supported by the Acute Frailty Network

7.6 **PHARMACY-** The Trust has a clinical pharmacy service in acute medicine 7 days a week and this facilitates discharges. There are ward based services in medicine and surgery Monday to Friday but not at the weekend. There is a pharmacist who writes discharges in medicine Monday to Friday but not at the weekend. The dispensary is open 7 days a week.

7.7 **DISCHARGE COORDINATORS** - Discharge coordinators work a 7 day week. Since the last update when cover was reduced at a weekend ITT now provide a full 7 day service. There is a core duty team covering Saturday , Sunday and Bank Holidays. Full details are circulated weekly on the Weekend Plan. The Trust are in the process of implementing a "Complex Early Discharge Team " who will be operational over 7 days and focussing on the Assessment units and Emergency Department

7.8 **ACCESS TO SOCIAL AND COMMUNITY CARE PROVIDERS TO START PACKAGES OF CARE**

ITT (Integrated Transfer Team) work closely with commissioners to provide timely packages of care. All new packages of care should be provided by our reablement service to provide an opportunity of regaining as much independence as possible in the persons own home. If this is not feasible SW request a package of care via our choosing and purchasing (C&P) colleagues within ASC. Given the current market position some POC's are more difficult to commission, with this in mind C & P prioritise all hospital requests as urgent. Working with providers to facilitate discharge as promptly as possible.

7.9 **PATIENT TRANSPORT**

The Trust has a contract with NWAS across Greater Manchester 7 days a week but not 24 hours per day. We also have a contract with EMAS which is 7 days a week and WMAS which is 5 days a week Mon – Friday eg if there are discharges to some areas such as Macclesfield then there is no service at the weekend. There is also a contract with St Johns for on the day discharges which is 2 crews 7 days a week.

7.10 **STANDARD 10 QUALITY IMPROVEMENT**

This standard states assurance that provider board-level reviews of patient outcomes cover elements of care and quality that relate to the delivery of high quality care seven days a week – such as weekday and weekend mortality, length of stay and readmission ratios – and that the duties, working hours and supervision of trainees in all healthcare professions must be consistent with the delivery of high quality, safe patient care, seven days a week.

Data relevant to this domain is evidenced and elaborated upon in section 2.4 of this report

8.0 7DS AND URGENT NETWORK CLINICAL SERVICES

8.1 This standard is only applicable for Hyper acute stroke patients as other Urgent services are not applicable for the Trust.
The Trust is compliant for all standards as below and stroke services has been consistently in the top 5% of best performing trusts over the last 18 months

	Hyperacute Stroke
Clinical Standard 2	Yes, the standard is met for over 90% of patients admitted in an emergency
Clinical Standard 5	Yes, the standard is met for over 90% of patients admitted in an emergency
Clinical Standard 6	Yes, the standard is met for over 90% of patients admitted in an emergency
Clinical Standard 8	Yes, the standard is met for over 90% of patients admitted in an emergency

8.3 For clinical standard 2 for stroke audit results shows 100% compliance

8.4 For clinical Standard 5 stroke MRI though has only limited availability for Stroke patients this requirement is met is over 90% of the stroke patients where this is indicated. Urgent and emergency clinical MR scanning indications are rare and which is not otherwise met by CT imaging for management decisions.

8.5 For clinical standard 8 for stroke the audit results show 100% compliance.

9. RECOMMENDATIONS

9.1 The Trust board is requested to make note of and approve the 7DS assurance report for national submission by 28th June 2019.

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7 Day Hospital Services Self-Assessment

Organisation	**Stockport NHS Foundation Trust**
Year	**2018/19**
Period	**Autumn/Winter**

Priority 7DS Clinical Standards

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.	**EVIDENCE SOURCE 1: Consultant sessions / cover for key admitting specialties** For most specialties there is more consultant PAs dedicated to weekday core hours than out of hours or at the weekend. This will impact on patient reviews, LOS and discharges. Outline Business cases has been submitted and considered by the trust but presently there is no funding allocation to implement the full 7DS consultant requirements due to manpower and financial pressures and the aim is to adopt an incremental approach by ensuring all new consultant recruitment considers seven day working. Paediatrics has weekday PA of 2 and 0 weekday out of core hours. The service has 2 PAs at the weekend Acute Medicine has weekday 3.25 in core hours and 0.83 outside of core hours with 3 PA at the weekend General Surgery has 2.75 PA in weekday core hours and 0.66 outside of these hours. Weekend PA is 2.33. Stroke has 2.5 PA weekday and 0.33 weekday outside of core hours with 1 PA at the weekend Obs and Gyne have 2.5 PA in weekday core hours and 0.5 outside of core hours with 4 PA at the weekend Gastro only have PA in weekday core hours Urology have 2.25 PA in weekdday core hours with 0.33 outside these hours and 1.66 at the weekend T&O have 2.5 PA in weekenday core hours with 0 outside of these hours and 1 PA at the weekend	No, the standard is not met for over 90% of patients admitted in an emergency	No, the standard is not met for over 90% of patients admitted in an emergency	Standard Not Met

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 5: Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: • Within 1 hour for critical patients • Within 12 hour for urgent patients • Within 24 hour for non-urgent patients	Q: Are the following diagnostic tests and reporting always or usually available on site or off site by formal network arrangements for patients admitted as an emergency with critical and urgent clinical needs, in the appropriate timescales?	Microbiology	Yes available on site	Yes available on site	Standard Met
		Computerised Tomography (CT)	Yes available on site	Yes available on site	
		Ultrasound	Yes available on site	Yes available on site	
	The Trust is currently not compliant at the weekend for Echocardiography or MRI.CT is available at weekends but this is currently only for clinical emergencies and ED rather than routine CT scans MRI has limited availability for Stroke on bank holidays and weekends only. Also not available after 5 pm and overnight weekdays. Opportunities exist for the trust to open up MR imaging over the weekend as largely the reporting is undertaken by external reporting arrangements in particular for pre-booked MR scanning over the weekend and will include renegotiation with the MR provider for inpatient scans. Echocardiography provision has been recognised as a national challenge given limited expertise in trained clinicians and the solutions needs to be sector based or with a network arrangement. The Northwest 7DS peer support network is aware of this challenge and is exploring solutions but availability of trained ECHO technicians remains the main limitation	Echocardiography	Yes available on site	No the test is only available on or off site via informal arrangement	
		Magnetic Resonance Imaging (MRI)	Yes available on site	No the test is not available	
		Upper GI endoscopy	Yes available on site	Yes available on site	

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 6: Hospital inpatients must have timely 24 hour access, seven days a week, to key	Q: Do inpatients have 24-hour access to the following consultant directed interventions 7 days a week, either on site or via formal network arrangements?	Critical Care	Yes available on site	Yes available on site	
		Interventional Radiology	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	

consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.	The Trust is currently not compliant for weekdays in Interventional Endoscopy.Interventional radiology is presently delivered with a network arrangement for vascular interventions, thrombectomy etc. but is also a key requirement of healthier together local provision, and hence is being considered as part of this development as well for in-house provision during healthier together implementation. Cardiac pacing is provided by daytime consultant cardiology cover and requirements for weekend has been adhoc and cardiology consultant onsite sessional provision would cover this requirement in those rare infrequent circumstances. Dedicated weekend pacing will require development of a weekend service from our consultants including equipment and or technician availability, or development of an agreement from one of our neighbouring tertiary cardiac centre. The numbers are very small and hence not cost effective to have a stand-alone service locally. For Interventional endoscopy at present gastro on call rota is only available over the weekend and in hour's weekdays. There are agreed plans to implement the gastro rota	Interventional Endoscopy	No the intervention is only available on or off site via informal arrangement	Yes available on site	Standard Met
		Emergency Surgery	Yes available on site	Yes available on site	
		Emergency Renal Replacement Therapy	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	
		Urgent Radiotherapy	Yes available off site via formal arrangement	Yes available off site via formal arrangement	
		Stroke thrombolysis	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	
		Percutaneous Coronary Intervention	Yes available off site via formal arrangement	Yes available off site via formal arrangement	
		Cardiac Pacing	Yes available on site	Yes mix of on site and off site by formal arrangement	

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 8: All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.	**EVIDENCE SOURCE 1: AUDIT DATA** The Trust is currently compliant against standard 8 based on the April local audit data. Weekday Weekend Overall score Weekday once daily Compliance score : 100 % Weekend once daily Compliance score : 92.5% Overall Compliance score : 96 % Weekday Twice daily compliance score is 100% Weekend Twice daily compliance is 95% Overall twice daily compliance score is 95% Note: The daily consultant review (CS8) was audited only for the first 5 days of admission and the audit compliance figures is not a reflection of consistent delivery of this standard in all inpatients. A significant number of admitted patients (up to 40%) get discharged from the assessment unit settings where there is 7 day consultant review and this has helped with the overall compliance figures.	Once daily: Yes the standard is met for over 90% of patients admitted in an emergency Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	Once daily: Yes the standard is met for over 90% of patients admitted in an emergency Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	Standard Met

7DS Clinical Standards for Continuous Improvement

Self-Assessment of Performance against Clinical Standards 1, 3, 4, 7, 9 and 10
STANDARD 1: PATIENT EXPERIENCE This standard states that Patients, and where appropriate families and carers, must be actively involved in shared decision making and supported by clear information from health and social care professionals to make fully informed choices about investigations, treatment and on-going care that reflect what is important to them. This should happen consistently, seven days a week.

The Trust does not collate patient experience data relating to consultant presence or specific domains relating to the above.

Friends and family test had over 87% positive rate January 2019-April 2019One of the question was " If someone close to the patient wanted to talk to a doctor whether they had enough opportunity" . In January 2019-April 2019 this answer received a 88% positive response. Another question asked was " if a patient had important questions to ask a doctor did they get answers they understood". In January 2019-April 2019 this answer received a 95% positive response.

Moreover the present patient satisfaction questionnaires do not distinguish between experiences for patients admitted over the weekend versus weekdays

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STANDARD 3 MULTIDISIPLINARY REVIEWS:

This standard states that All emergency inpatients must be assessed for complex or on-going needs within 14 hours by a multi-professional team, overseen by a competent decision-maker, unless deemed unnecessary by the responsible consultant. An integrated management plan with estimated discharge date and physiological and functional criteria for discharge must be in place along with completed medicines reconciliation within 24 hours.

The response from the business groups and specialities are as follows

Neonatal unit – discharge checklist in place. Discharge planning meeting held prior to discharge of complex patients. 0.8WTE Discharge planning lead post to commence March 2019. Role to coordinate discharge, disseminate learning & produce guidelines. Learning to be shared across paediatrics

Paediatrics (Treehouse) – Vast majority of patients are short length of stay, discharge check list part of admissions booklet. All complex patients, likely to need discharge planning, are assigned named nurse on admission who will coordinate this process. Discharge coordinators work a 7 day week, although there is a reduced service at the weekend. 7 day working is part of the new ITT review that is being completed, within this will be options appraisal for a new staffing model which will include increased support at weekend at present but will share learning from neonatal discharge planning lead and written guidance will be produced.

T&O hold a daily meeting as a multidisciplinary team to review patient care planning. This meeting acts as an MDT and shift handover.

Obstetrics and Gynaecology - a defined acute gynaecology pathway for emergency admissions and obstetric patients should be excluded from this as they have defined guidelines under MDT.

Stroke ward A10 HASU has MDT daily and acute stoke/rehabilitation have three weekly MDTs and Mon –Frid white board rounds

STANDARD 4 SHIFT HANDOVERS

This standard states handovers must be led by a competent senior decision maker and take place at a designated time and place, with multi-professional participation from the relevant in-coming and out-going shifts. Handover processes, including

7DS and Urgent Network Clinical Services

	Hyperacute Stroke	Paediatric Intensive Care	STEMI Heart Attack	Major Trauma Centres	Emergency Vascular Services
Clinical Standard 2	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust
Clinical Standard 5	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust
Clinical Standard 6	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust
Clinical Standard 8	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust

Assessment of Urgent Network Clinical Services 7DS performance (OPTIONAL)
This standard is only applicable for Hyper acute stroke patients as other Urgent services are not applicable for the Trust. The Trust is compliant for all standards as below and stroke services has been consistently in the top 5% best performing trusts over the last 18 months with the last quarter SSNAP score of 95. For clinical standard 2 for stroke audit results shows 100% compliance. For clinical Standard 5 stroke MRI though has only limited availability for Stroke patients this requirement is met is over 90% of the stroke patients where this is indicated. Urgent and emergency clinical MR scanning indications are rare that are not otherwise met by CT imaging for management decisions. For clinical standard 8 for stroke the audit results show 100% compliance.

Template completion notes
Trusts should complete this template by filling in all the yellow boxes with either a free text assessment of their performance as advised or by choosing one of the options from the drop down menus.

NHS
Stockport
NHS Foundation Trust

Report to:	Trust Board	**Date:**	27th June 2019
Subject:	Integrated Care Business Group response to the formation of Stockport Primary Care Networks May 2019.		
Report of:	Chief Operating Officer	**Prepared by:**	Business Change Manager and District Nursing Pathway Leads.

REPORT FOR APPROVAL

Corporate objective ref: -----	**Summary of Report**
Board Assurance Framework ref: -----	This report is intended to provide the Trust Board with an overview of the Trust's response to the establishment of seven Stockport Primary Care Networks (PCNs) in line with the NHS Long Term Plan (2019).
CQC Registration Standards ref: -----	The Board is asked to note • the content of the report, • the potential risks that the new networks may pose to current community services • the work being undertaken to explore how the Trust's community services can support the establishment of PCNs.
Equality Impact Assessment: ☐ Completed ✓ Not required	

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

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1. INTRODUCTION

1.1 This report is intended to provide the Trust Board with an overview of the Trust's response to the establishment of seven Stockport Primary Care Networks (PCNs) in line with the NHS Long Term Plan (2019).

- the potential risks that the new networks may pose to current community services
- the work being undertaken to explore how the Trust's community services can support the establishment of PCNs.

2. BACKGROUND

2.1 Expected delivery of the ambitions of the NHS Long Term Plan

Health and care leaders have come together to develop a Long Term Plan to make the NHS fit for the future and to get the most value for patients out of every pound of taxpayers' investment. The NHS Plan (2019) has been drawn up by those who know the NHS best, including frontline health and social care staff, patient groups and other experts.

2.2 In supporting people to age well the NHS plan (2019) aims to:

- Increase funding for primary and community care by at least £4.5bn
- Bring together different professionals to coordinate care better
- Help more people to live independently at home for longer
- Develop more rapid community response teams to prevent unnecessary hospital spells, and speed up discharges home.
- Upgrade NHS staff support to people living in care homes.
- Improve the recognition of carers and support they receive
- Make further progress on care for people with dementia
- Give more people more say about the care they receive and where they receive it, particularly towards the end of their lives.

2.3 To ensure that the NHS can achieve the ambitious improvements over the next ten years, the NHS Long Term Plan also sets out how services can overcome the challenges that the NHS faces, such as staff shortages and growing demand for services.

2.4 The Long Term Plan states a PCN consists of groups of general practices working together with a range of local providers, including across primary care, community services, social care and the voluntary sector, to offer more personalised, co-ordinated health and social care to their local populations. Networks would normally be based around natural local communities, typically serving populations of at least 30,000 and not tending to exceed 50,000. They should be small enough to maintain the traditional strengths of general practice but at the same time large enough to provide resilience and support the development of integrated teams.

2.5 Primary care networks will be expected to have a wide-reaching membership, led by groups of general practices. This should include providers from the local system such as community pharmacy, optometrists, dental providers, social care providers, voluntary sector organisations, community services providers or local government. Primary care networks will provide proactive, coordinated care to their local populations, in different ways to match different people's needs, with a strong focus on prevention and personalised care. This means supporting patients to make informed decisions about their own health and care and connecting them to a wide range of statutory and voluntary services to ensure they can access the care they need first time. Networks will also have a greater focus on population health and addressing health inequalities in their local area, using data and technology to inform the delivery of population scale care models.

In summary the core characteristics of a PCN are:

- Practices working together and with other local health and care providers, around natural local communities that geographically make sense, to provide coordinated care through integrated teams
- Typically a defined patient population of at least 30,000 and tend not to exceed 50,000
- Providing care in different ways to match different people's needs, including flexible access to advice and support for 'healthier' sections of the population, and joined up care for those with complex conditions
- Focus on prevention and personalised care, supporting patients to make informed decisions about their care and look after their own health, by connecting them with the full range of statutory and voluntary services

2.6 Membership of a primary care network will be down to local agreement, dependent on the needs of the local population. However, each PCN should have a boundary that makes sense to: (a) its constituent practices; (b) to other community-based providers, who configure their teams accordingly; and (c) to its local community.

2.7 In typically serving populations of 30,000 - 50,000 the Primary Care Networks will be able to operate at a level which maximises economies of scale, but is small enough to ensure understanding of local population needs. PCNs can be bigger than 50,000 if they meet all the registration requirements under the Network Contract DES but in reality, may require organising themselves into smaller neighbourhood teams within the 30,000 to 50,000 population size. But it would create extra bureaucracy to require each of these internal teams to register as a separate network.

2.8 The guidance around PCN size is provided to help areas early in their journey of developing PCNs have some structure to work around. It is anticipated that those PCNs with very different sizes will be able to articulate a clear reason why; and how they are working in a network way with other partners.

2.9 Each PCN will be required to appoint a named accountable Clinical Director who does not have to be a GP.

2.10 **Stockport Primary Care Networks**

The requirement for a PCN minimum population of 30,000 was absolute and two of the Stockport current Integrated Neighbourhoods had populations below this level. The 50,000 was not absolute and there was mention in the regulations of up to 100,000 populations.

2.11 There was significant pressure on Stockport GP practices, by the CCG, to maintain the neighbourhood configuration as much as possible. There will be no change to the following neighbourhoods:

- Tame Valley
- Cheadle
- Werneth
- Bramhall

There are changes to the following neighbourhoods:

- Minor change to Victoria with the inclusion of the Cedar House practice which was geographically in this area.
- The Heatons neighbourhood took in all the patients registered with the Heaton Moor practice and the Manor practice that was formerly in Stepping Hill.
- The balance of the Stepping hill neighbourhood practices i.e. Beech House and Springfield join the Marple area to create a new network.

The PCNs are expected to be in place from 1st July 2019.

2.12 Stockport CCG have advised the configuration they have endorsed and submitted to NHS England is as below:

2.13

BRAMHALL & CHEADLE HULME

57,256

Dr Louise Monk

Bramhall Health Centre

Bramhall and Shaw Heath Medical Group

Cheadle Hulme Health Centre

Hulme Hall Medical Group

The Village Surgery

CHEADLE

34,526

Dr Viren Mehta

Cheadle Medical Practice

Gatley Medical Centre

Heald Green Health Centre 1

Heald Green Health Centre 2

HAZEL GROVE, HIGH LANE & MARPLE

40,612

Dr Howard Sunderland*

Beech House Medical Practice

High Lane Medical Centre

Marple Bridge Surgery

Marple Cottage Surgery

Marple Medical Practice

Springfield Surgery

HEATONS

60,119

Dr Rebecca Locke

Manor Medical Practice

Heaton Mersey Medical Practice

Heaton Moor Medical Group

TAME VALLEY

44,113

Dr James Higgins

Park View Group Practice

Family Surgery

Brinnington Surgery

Vernon Park Surgery

Heaton Norris

South Reddish Medical Centre

The Surgery

VICTORIA

45,907

Dr Paul McGuigan

Bracondale Medical Centre

Dial House Medical Centre

Stockport Medical Group

Adshall Road Medical Practice

Cale Green Surgery

Cedar House

WERNETH

31,113

Dr Abdul Ghafoor

Alvanley Family Practice

Archwood Medical Centre

BL Medical Practice

Bredbury Medical Practice

Chadsfield Medical Practice

Guywood Medical Practice

Woodley Village Surgery

The Stockport PCN associated boundaries are illustrated in Appendix 1

2.14 **Impact of the seven PCNs on the Trust Adult Community Services**

2.15 The CCG acknowledged the arrangements in place in community services and adult social care to support the current eight Integrated Neighbourhoods. The CCG also expressed regret that the change was coming at this time, however, in endeavouring to fit the national requirement to the local circumstances as much as possible they were keen that the good work that had taken place in building the neighbourhoods could be further developed with the support of the GP networks.

2.16 Roger Roberts, CCG Director for General Practice Development, wrote to the Director of Integrated Care and to the Director of Adult Social Care expressing an interest in knowing if and how it is possible for the neighbourhood arrangements to be adapted to the new shape of PCNs.

2.17 In response, the Business Group Director of Integrated Care organised a workshop, on 17th June 2019, with community service leads. The aim of the session was to inform the community leaders within Integrated Care of the new PCNs in Stockport and to consider the impact on community services, specifically services which are Neighbourhood aligned.

2.18 The outputs from the workshop are detailed in Appendix 2.

2.19 The NHS Plan guidance advises: 'Membership of a primary care network will be down to local agreement, dependent on the needs of the local population. However, each PCN should have a boundary that makes sense to: (a) its constituent practices; (b) to other community-based providers, who configure their teams accordingly'.

2.20 There are options for the Trust community services to ensure the proposed seven PCNs are supported in a coordinated and cohesive manner and that the aspirations in the NHS Long Term Plan to meet the needs of the local patient population are realised. It is, however, key to the success of the PCNs and to the Trust community services that the intentions of the Local Authority Adult Social Care are also part of the discussions. It is understood that Adult Social Care services are currently undergoing a service review and it has been indicated that there will be changes to their current structures and configuration of service provision. We are not yet aware of what the impact will be on the current neighbourhood delivery model and if the local authority will align services to the seven PCNs.

2.21 **Next Steps**

The Director of Integrated Care will be writing to the CCG inviting attendance at a similar workshop to enable open discussions. This session should include PCN Clinical Directors if possible.

3. RISK & ASSURANCE

3.1 The risks associated with the formation of seven Stockport Primary Care Networks are in brief, risks related to the following:-

- Potential for a greater fragmentation of services if Adult Social Care re-organise services differently to the Trust Adult Community Services in response to the PCNs.
- Reputation of the Trust and wider health and social care economy leaders if services that were re-organised in line with the Stockport Neighbourhood Care vision and model are again re-structured
- Benefits to patients / service users that are being realised as a result of the closer collaboration of health and adult social care staff around identified GP practices in neighbourhoods are not replicated in any new way of working

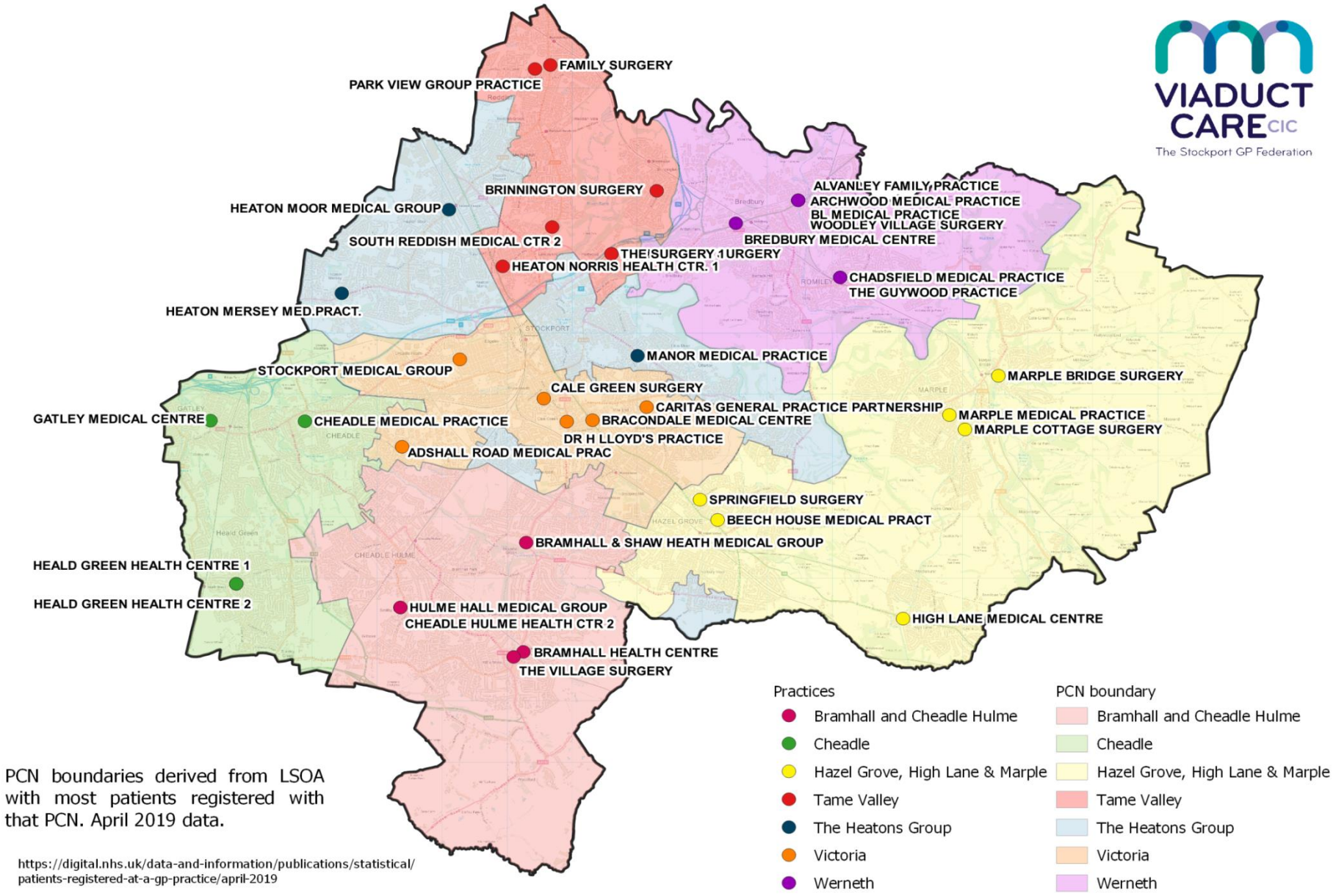
- Negative impact on staff morale as staff are required to work in different ways at a time when community services are under increasing pressure re workloads potentially impacting on the quality of care
- Investment in infrastructure and co-location of community and adult social care services is seen by staff as being “wasted”. This is likely to be a particular problem for the Stepping Hill Integrated Neighbourhood which does exist as a PCN.
- Current expectations on delivery of services in view of additional investment and now potential reduction in funding and delivery of service.
- Potential decommissioning of Trust Adult Community Services.

4.0 RECOMMENDATIONS

4.1 The Board is asked to note this report and actions the Trust are taking to ensure we are engaging with both the CCG and the PCN Clinical Directors to unsure risks are minimised and benefits are realised.

4.2 The Director of Integrated Care has indicated to the Director of Adult Social Care that we would want to work in partnership if transformation of services is to change, to ensure the close collaboration resulting from integrated relationships between health and social care teams is not lost.

Appendix 1



PCN boundaries derived from LSOA with most patients registered with that PCN. April 2019 data.

https://digital.nhs.uk/data-and-information/publications/statistical/patients-registered-at-a-gp-practice/april-2019

Outputs from Workshop : Stockport Primary Care Networks and Impact on Integrated Care Community Services **11th June 2019**	
Aim of the session: The aim of the session was to inform leaders in Integrated Care of the new Primary Care Networks in Stockport and to consider the impact this will have on community services, specifically services which are Neighbourhood aligned.	
Overview of the session	
2	Chair presented an overview of the following: • Drivers for change - The NHS Long Term Plan published in January 2019 set out 5 major changes to the NHS service model • Funding • Primary Care Networks (PCNs) • Risks • The Stockport Picture
3	**Chair then invited questions - Questions raised during the session:** • What do the PCNs expect? What is the ask? • Have Primary Care considered impact when agreeing the PCNs • How were patients engaged in the process? What are patient views?
4	**Options to support PCNs** **2 options were considered:** ➢ **Options 1 - Aligning Community Services to the 7 Primary Care Networks** ➢ **Option 2 – Geographical working with named DN Team Lead and Band 6 Caseload Manager**

Option 1 - Aligning Community Services to the 7 Primary Care Networks - SWOT Analysis	
Strengths	**Weaknesses**
General feedback – the group struggled to identify strengths from a community perspective but do see strengths for GPs working in Networks • Staff working in Heatons now have an "entity" • 2 mile limit on radius may benefit some teams, • Change can be invigorating, this may improve momentum - GPs engagement with the Health and Social Care partnerships has been dwindling recently • This model should not impact on Therapy services as they are currently aligned to East and West of the Borough • May be potential for greater focus at MDTs/Triage as will potentially be discussing PCN patients – sometimes some patients are not discussed because they may live in the neighbourhood but are not registered with the GP practice • Having an identified Chief Operating Officer for Primary Care Networks makes accountability clear on a PCN footprint - this may also be a weakness as if it legitimises practices to work differently • PCN wider teams (pharmacist, social prescribers, physio etc.) • May be more of a balance in terms of deprivation a mix of social and demographic needs • Could focus money and ultimately services differently based on needs of population	• PCN Clinical Directors (Chief Accountable Officers) may not know the neighbourhood – Marple vs Bramhall for instance • Destabilisation of whole system – whilst some neighbourhoods are not affected they will be as some patients may have to get to know different staff – neighbourhood – Marple for instance • PCNs are not based on the Neighbourhood model – does not take into account the vast work that has been put in to develop Neighbourhoods – Impact to patient outcomes and staff moral • Destabilisation of whole system – whilst some neighbourhoods are not affected directly there will be implications as some patients may have to get to know different staff – experience confirms that this can impact on patients care • Stockport reputation – A lack of engagement in designing the PCNs can affect reputation – Stockport already has a reputation of being autocratic not collaborative and this can affect staffs' decision to work here • Risk to recruitment • The PCN model could cause issues with retention for staff – risk of increased mileage. Due to Agenda for Change staff can only get paid for 3000 annual miles at higher rate, any additional mileage will be paid at the lower rate and therefore staff will be "out of pocket" – impact on staffs ability to pay for petrol (Risk to retention) • Lack of estate to accommodate the changes to base • Destabilises links to provider organisations such as Adult Social Care and residential and nursing homes that are set up with neighbourhoods – lots of work has been put in to establishing effective working relationships in Neighbourhoods – this can put those relationships at risk • The proposal does not take into account the amount of work staff had put in place to set up and sustain the

	neighbourhood model and the excellent links they have made Pharmacy, Residential and Nursing Providers, 3rd Sector etc.. • Possible clinical risks reduced response times… how are you going to get there if you are driving further? • Reduce face to face time, clinical time • Increased complaints • Loss of local knowledge • Will require a lot of changes to infrastructure – EMIS has been built around the 8 neighbourhoods • GPs reluctance to share data NOTE: *Hugh Mullen is working with the LMC to resolve the IG sharing issue and has involved the Trust solicitors in drawing up terms of indemnity* • GPs employing physios will impact on recruitment as we are all pulling from the same pool
Opportunities	**Risks**
• Opportunity – to change the DN band 7 role – we currently have 8 band 7s, having 7 Neighbourhoods instead of 8 would allow us to double up the band 7s in the area with the most population and also free up some of this time to buddy up in other localities	• Cost – realignment would be costly, do we have the budget to cover the costs? There is a risk that any additional funding received would be swallowed up in changes to infrastructure and increased travel and would not be used to improve patient care • Reduced staff retention – Impact of increased travel • Reduced staff morale – due to reduced face to face contact increasing demand • Risk of increased stress due to increased capacity • Risk of reduced capacity requiring an increased workforce • Risk to working relationships established through development of Neighbourhoods

Option 2 – Geographical Working with named DN Team Lead and Band 6 Caseload Manager alignment - SWOT Analysis

Strengths	Weaknesses
• Staff satisfaction • Links to providers such as residential & nursing providers • Improved MDT working • Quicker response times • Funding may be available to use where needed – may be more focussed on population needs • Clarity of boundaries – clear area teams • Continuity of care for patients • Less travel / mileage costs, quicker response times • Increased face to face contact • Less disruptive for staff (increased morale and staff retention) • Builds on existing strong collaboratives	• May not be the same solution as Adult Social Care – this should be agreed with them • Challenge of responding to MDT / Gold Standared Framework meetings • Access to GP if not in geographical patch • Impact on aligned trusts • Data sharing concerns
Opportunities	**Risks**
• Can target resources (staff) to areas of need (demand)	• Some geographical areas do not get well represented strategically by the PCNs

5

Outcome & Recommendations

Outcome:

- Option 1 was discounted due to the weaknesses and risks identified above
- Options 2 would be preferable, however members agreed that we cannot make a whole system change until we know what Adult Social Care plan to do as there is a risk of working to three separate models across the Borough

Recommendation:

Members unanimously agreed that an interim solution should be put forward at this time and the permanent solution should be aligned to the councils approach

- Interim solution – Community Services to continue working to current Neighbourhood model and to set up a Single Point of Access (SPA) for GP referrals for Crisis Response, Advanced Nurse Practitioners and DNs so that patient referrals can be routed to the correct team

	Benefits of a SPA: ➢ One point of contact for all GPs - easier to communicate and manage change ➢ Assurance that referral gets a response and will be managed ➢ Shared knowledge and relationship building through staff working together as teams ➢ Better patient experience – less hand offs ➢ Better experience for Primary Care – once the referral has been passed on they can be confident that they do not need to take any further action ➢ Opportunities to reconfigure staff who are already in place to support this model (Contact Assessment and Triage team (CAT) / Crisis Response team. CAT currently stop accepting referrals at 4.00 pm.) **The following tasks and considerations were identified as essential to the to support this interim solution:** ➢ Set up a SPA ➢ Provide each GP with names and contact details of the teams/staff that will be supporting them and provide reassurance that leaders will attend Neighbourhood meetings (MDT/ management) ➢ Referrals to Crisis Response to go through Mastercall – Referrals should go straight through to the Crisis Response service – the agreement is that this is streamlined

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NHS
Stockport
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	27 June 2019
Subject:	Governance Declarations		
Report of:	Interim Director of Corporate Affairs	**Prepared by:**	Mrs C Parnell

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

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

Attachments:	Appendix 1 – Draft Governance Declarations Appendix 2 – Induction, training and development programme for governors

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

2. BACKGROUND

2.1 Declarations relating to Provider Licence Condition FT4, 'the Corporate Governance Statement', and Governor Training are required to be self-certified by the Board of Directors by the deadline of 30 June 2019.

2.2 Guidance issued by NHS Improvement in April 2017 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.

3. CURRENT SITUATION

3.1 A draft self-certification template is included for consideration by the Board at Appendix 1 to this report. In considering responses to the various elements, the Board should take into account assurances recently provided in relation to the Annual Report & Accounts 2018-19 such as:

- External Audit reports on audit of the 2018-19 Financial Statements and Annual Quality Report
- Director of Internal Audit Opinion 2018-19
- Compliance declarations in relation to the NHS Foundation Trust Code of Governance
- Annual Governance Statement 2018-19

3.2 Other relevant factors to consider include embedding of enhancements to governance arrangements developed in 2017-18 as a result of the Review of Undertakings, and implementation of a Quality Framework and year one of the Quality Improvement Plan. A number of risks to continued compliance are included in the draft template at Appendix 1. The Board should consider whether there are any additional risks to forward compliance that are relevant for inclusion.

In June 2018 the Board of Directors considered and approved these declarations in relation to its corporate governance arrangements and training for governors.

For 2019-20 the Trust has developed a more detailed induction, training and development programme for governors (appendix 2) that will be presented to the Council of Governors meeting in July for approval.

4. RECOMMENDATIONS

4.1 The Board of Directors is recommended to:

- Consider and approve the draft declarations included at Appendix 1 to the report.

This template may be used by NHS foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS provider licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

Self-Certification Template - Condition FT4

Stockport NHS Foundation Trust

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

Corporate Governance Statement - in accordance with Foundation Trust condition 4 (Foundations Trusts and NHS trusts)
Certification on training of Governors - in accordance with s151(5) of the Health and Social Care Act (Foundation Trusts only)

These self-certifications are set out in this template.

How to use this template

1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "FT4 declaration"

Corporate Governance Statement (FTs and NHS trusts)

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

1	Corporate Governance Statement	Response	Risks and Mitigating actions	
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	The Board continues to apply principles and standards of good corporate governance following the development of it Quality Framework in 2017-18, which was informed by outcomes of both a CQC inspection and a Review of Undertakings carried out by NHS Improvement. It has supported the successful implementation of	Please complete Risks and Mitigating actions
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	The Board has robust systems in place to assess and respond to guidance issued by NHS Improvement.	Please complete Risks and Mitigating actions
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	The Board adopts a continuous improvement approach to both Board and Committee arrangements with developments informed by best practice and outcomes of relevant reviews. The governance architecture for reporting to the Quality Committee was fundamentally reviewed and revised during 2017-18 and it has embedded during 2018-19. In line with best practice the Trust is continuing to review its risk management framework, including the ongoing development of its	Please complete Risks and Mitigating actions
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	The Board confirms that the Trust meets this requirement in the context of continued application of an additional licence condition relating to achievement of the 4-hour A&E standard. During 2018-19 the Trust's progress in mitigating associated risks was subject to regular review by NHS Improvement with formal monitoring through a monthly Quality Improvement Board involving regulatory and local system stakeholders. As a direct result of the progress made this arrangement was formally stood down in April 2019. With regard to 4d The Board has carefully considered the Trust's ability to continue as a going concern. A key consideration was the overall availability of cash for the Trust to meet its financial obligations. The Trust accessed revenue support funding for the first time in August 2018. The Trust has satisfied borrowing requirements and has governance systems in place for a draw down of revenue support in 2019-20. In addition, the Trust's financial performance is subject to regular oversight meetings with NHS Improvement.	Please complete Risks and Mitigating actions
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	With regard to requirement 5c, the Board notes that the limited assurance report on the Annual Quality Report 2018-19 consists in part to a data collection issue around the nationally mandated indicator of the percentage of patients with a total discharge time in A&E of 4 hours or less from arrival to admission, transfer or discharge. Progress in addressing this data collection issue will be monitored during 2019-20 by the Audit Committee. With regard to requirement 5f, practice and accountability for quality of care has been significantly enhanced through the implementation and embedding of a Board approved Quality Governance Framework and delivery of year one of a Quality Improvement Plan.	Please complete Risks and Mitigating actions
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	Robust recruitment and selection processes are in place for both Non-Executive Director and Executive Director positions. During 2018-19 the Trust successfully recruited substantively to the roles of Chief Executive, Director of Finance and Director of Workforce & OD. Recruitment is currently on-going to a vacant Non-Executive Director role, which has attracted a high level of interest from excellent	Please complete Risks and Mitigating actions

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature _____ **Name** Adrian Belton

Signature _____ **Name** Louise Robson

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A:

Please Respond

Worksheet "Training of governors"

Certification on training of governors (FTs only)

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

2 Training of Governors

1	The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	Confirmed	OK

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	Adrian Belton	Name	Louise Robson
Capacity	Chair	Capacity	Chief Executive
Date	27 June 2019	Date	27 June 2019

Further explanatory information should be provided below where the Board has been unable to confirm declarations under s151(5) of the Health and Social Care Act

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Council of Governors draft development plan 2019-20

Induction

Mandatory for all new governors, provided in-house, to include:

- Introduction to the Trust – overview of hospital and community services, geographic area covered by services, population health statistics, challenges and opportunities.
- The structure of the NHS and where the Trust fits.
- How the Trust is funded and regulated, including role of NHSI, CQC.
- The national, regional and local health and social care context eg Long Term Plan, GM, Healthier Together, and how the local system works together.
- The Trust's corporate governance structure, including the role of the Board of Directors, the Chair and other Non-Executive Directors, and where the Council of Governors fits.
- Assurance – including what is assurance, how does the Board of Directors get assurance, and how does the Council of Governors hold Non-Executive Directors to account for the Board's delivery against the terms of the Trust's operating licence.
- The role of governors – what the role is and is not. The Code of Conduct and what it means for governors. How governors can engage and represent their constituents.

Rolling in-house programme – all governors to attend each session at least once in their tenure

- Understanding NHS finances – the Trust's financial position and performance.
- Understanding NHS performance standards – the quality, safety and operational targets the Trust is measured against nationally and regionally, as well as those we set ourselves.
- Strategy – how the Trust develops and updates its strategy, and how governors can influence that.

Tailored training to suit governor's identified needs (may be provided in-house or externally)

- Assertiveness
- Public speaking
- Chairing skills

Presentations/workshops at each Council of Governors meeting on key issues, services or topics crucial to the Trust's performance or future development, for example:

- Our neighbourhood model of community services
- Sepsis
- Frailty
- Urgent care
- Cancer
- Dementia care
- Quality improvement plan