NHS
Stockport
NHS Foundation Trust

BOARD OF DIRECTORS

PUBLIC MEETING

1 NOVEMBER 2019

Your Health. Our Priority.

Board of Directors bundle - PUBLIC MEETING - 1 November 2019 - FINAL v2

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Board of Directors Meeting
Friday, 1 November 2019

Held at 9.30am in the Committee Room, Oak 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		**J Graham**
0950	**5.**	Minutes of Previous Meeting: 26 September 2019	✓	**A Belton**
	6.	Action Log	✓	**A Belton**
0955	**7.**	Chair's Report	✓	**A Belton**
1000	**8.**	Chief Executive's Report	✓	**L Robson**
	9.	**FOR ASSURANCE**		
1010	9.1	Performance Report	✓	**H Mullen**
1040	9.2	Key Issues Reports from Assurance Committees • Quality Committee • Finance & Performance Committee • People Performance Committee	✓	**Committee Chairs**
1050	9.3	Pressure Ulcer Presentation		**A Lynch / J Conway**
1105	9.4	Safe, High Quality Care Improvement Plan	✓	**A Lynch**
1120	9.5	Nurse Staffing (Presentation)	✓	**A Lynch**
1135	9.6	Board Assurance Framework	✓	**A Lynch**
1145	9.7	Trust Risk Register	✓	**A Lynch**
1155	9.8	Health & Safety Key Issues Report	✓	**A Lynch**
1205	9.9	Winter Preparedness	✓	**S Toal**
1220	9.10	Trust Strategy	✓	**H Mullen**
1230	9.11	Brexit Update	✓	**H Mullen**
1240	9.12	Freedom to Speak Up Guardian Report	✓	**P Gordon**
	10.	**FOR DECISION / APPROVAL**		
1250	10.1	Proposal to Amend the Trust's Committee Structure and Board Cycle	✓	**C Parnell**

	11.	**CONSENT AGENDA**		
1300	11.1	Safety Annual Report	✓	
	11.2	Approval of People Performance Committee Terms of Reference	✓	
	12.	**DATE, TIME & VENUE OF NEXT MEETING**		
	12.1	Thursday, 28 November 2019, 9.30am in Lecture Theatre A, Pinewood House, Stepping Hill Hospital.		
	12.2	Review of Meeting Effectiveness	*Verbal*	**All**
	12.3	Resolution: *"To move the resolution that the representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to commercial interests, sensitivity and confidentiality of patients and staff, publicity of which would be premature and/or prejudicial to the public interest".*		

STOCKPORT NHS FOUNDATION TRUST

Minutes of a meeting of the Board of Directors held in public
on Thursday, 26 September 2019
9.30am in Lecture Theatre A, Pinewood House, Stepping Hill Hospital

Present:

Mr A Belton	Chair
Mrs C Anderson	Non-Executive Director
Mrs C Barber-Brown	Non-Executive Director
Mr M Beaton	Non-Executive Director
Dr M Cheshire	Non-Executive Director
Mr J Graham	Director of Finance
Mr D Hopewell	Non-Executive Director
Mr G Moores	Director of Workforce & OD
Dr M Logan-Ward	Non-Executive Director
Ms A Lynch	Chief Nurse & Director of Quality Governance
Mrs C Parnell	Interim Director of Corporate Affairs *
Mrs L Robson	Chief Executive
Mr M Sugden	Non-Executive Director
Ms S Toal	Chief Operating Officer
Dr C Wasson	Medical Director

** indicates a non-voting member*

In attendance:

Mrs S Curtis	Membership Services Manager
Mrs K Glass	Quality Support Practitioner
Ms C Lloyd	Integrated Transfer Team Lead
Ms A Hussain	Equality, Diversity & Inclusion Manager
Mrs E Rogers	Matron for Patient Experience
Ms M Wheelden	Ward Manager

214/19 Apologies for Absence

An apology for absence was received from Mr H Mullen.

215/19 Declaration of Interests

Mrs Barber-Brown advised the Board of her appointment as a member of the Scrutiny Committee for Cheshire and Warrington Local Enterprise Partnership (LEP).

216/19 Chair's Opening Remarks

Mr Belton welcomed all Board members and observers to the meeting. He made particular reference to Dr Logan-Ward and Mr Beaton who were attending their first Board meeting since being appointed as Non-Executive Directors. He also congratulated Mrs Parnell on her appointment as substantive Director of Communications & Corporate Affairs.

Mrs Glass, Ms Lloyd, Mrs Rogers and Ms Wheelden joined the meeting.

217/19 Patient Story

Mr Belton reminded the Board that the purpose of patient stories was to bring the patient's voice to the Board, providing real and personal examples of the issues within the Trust's quality and safety agendas.

Mrs Lynch introduced the story of Ken, who had been admitted to Stepping Hill Hospital on 24 February 2019 with hallucination and self-neglect. She advised that, due to communication and process issues between the Trust and out of area healthcare providers, Ken's discharge pathway had been unnecessarily long and complicated. As a consequence, Ken had become deconditioned and would require long term care.

The Board welcomed Mrs Glass, Ms Lloyd, Mrs Rogers and Ms Wheelden to the meeting. The Board was shown a video which detailed the patient story in Ken's words. Ms Lloyd and Mrs Glass delivered a presentation, which included the following subject headings:

- Background
- Lessons learned
- Context within Trust Quality Improvement Plan
- Where is Ken now.

Dr Cheshire thanked the team for the presentation and expressed a concern regarding Ken's patient experience, noting that the story reflected immaturity of assessment of vulnerable people. He commented on the importance of staff training and noted an issue with regard to safeguarding. Ms Lynch acknowledged Dr Cheshire's comments and noted the powerful lessons learned from Ken's story.

Mr Sugden echoed Dr Cheshire's comments, noting that while the story had been a negative one, it was important for the Board to be aware of it. He queried how similar outcomes could be avoided for other out of area patients. Ms Lloyd advised that the Stockport Clinical Commissioning Group (CCG) led on out of area referrals. She explained new processes that were being established to enable closer working and improve outcomes for out of area patients.

In response to a question from Mr Sugden, who asked if the presentation could be delivered at a CCG Board meeting, Ms Lynch commented that the presentation would be shared at the Patient Safety Conference on 2 October 2019, which would be attended by CCG colleagues.

In response to a question from Mr Sugden, who asked why the issues had not been identified through the whiteboard rounds, Ms Lloyd noted that the issues had been raised but not escalated to her in a timely manner. She advised that the new process set up with Cheshire would improve escalation arrangements going forward.

Ms Toal noted the frailty piece of work at the 'front door', which enabled intervention at an early stage. She also commented that when Emergency Departments were under

pressure, diversions to out of area hospitals did not provide the best patient experience.

In response to a question from Mrs Barber-Brown, Ms Lloyd advised that the expectation was for any discharge related issues to be escalated to her as soon as possible, and within 24 hours. She commented that she worked very closely with the teams to enable timely escalation.

In response to a question from Dr Cheshire, Ms Lloyd clarified that patients, such as Ken, were classed as out of area in terms of the CCG and local authorities. She advised that in such cases, the Trust had to rely on in-reach support.

Ms Toal noted that Ken had been medically optimised after four days and she queried at which stage he had become a delayed transfer of care. Ms Lloyd said that this had been once all the assessments had been completed, which was in June 2019.

Ms Lynch showed a video to the Board with regard to the 'Hello My Name Is' campaign, which was important in promoting person-centred, compassionate care.

Mr Belton thanked the team for the presentation. The Board endorsed Mr Sugden's suggestion that the presentation should be delivered to the CCG Board. Mrs Robson commented that the story had also been shared and referred to at various forums, including at a system-wide Emergency Care Board.

The Board of Directors:

- Received and noted the Patient Story and endorsed a suggestion that the presentation be delivered to the CCG Board.

Mrs Glass, Ms Lloyd, Mrs Rogers and Ms Wheelden left the meeting.

218/19 Minutes of the previous meeting

The minutes of the previous meeting held on 31 July 2019 were agreed as a true and accurate record of proceedings. The action log was reviewed and annotated accordingly.

219/19 Chair's Report

Mr Belton presented a report informing the Board of recent activities in relation to:

- Supporting colleagues
- Governance
- Board development
- Out and about
- Annual members' meeting
- National news.

Mr Belton commented on the continuing performance challenges and the consequent impact of the immense pressure on staff. He noted that it was important for the Board

to be conscious of its responsibility regarding duty of care to staff during these difficult times.

Mrs Anderson noted an error in s3 of the report, advising that she was the Non-Executive lead for security management.

The Board of Directors:

- Received and noted the Report of the Chair.

220/19 Report of the Chief Executive

Mrs Robson presented a report providing an update on national and local strategic and operational developments. She briefed the Board on the content of the report and made particular reference to the following subject areas:

- System working
- Strategy development, including the development of clinical service strategies
- GM system and the launch of the Elective Care Programme
- Consultant engagement sessions
- Establishment of a Senior Leadership Group
- New team briefing arrangements
- £30.5m capital funding on the development of an emergency care campus
- Emergency Department challenges
- New NHS Oversight Framework
- Transfer of Breast Services

Mrs Robson paid tribute to the Breast Services team for their professionalism during the transfer of the service to another provider. The Board recorded their thanks to the team for all their hard work over the years and wished them well for the future.

The Board of Directors:

- Received and noted the Report of the Chief Executive.

221/19 Performance Report – Month 5

The Board of Directors considered the Trust Performance Report for Month 5.

<u>Chief Operating Officer</u>

Ms Toal noted that August had been a particularly challenging month with regard to operational performance. She reported that performance against the Accident & Emergency four-hour standard had been adversely affected by staffing shortages, issues with flow and an increase in the number of non-admitted and overnight breaches. Ms Toal commented that patient safety and staff welfare remained the Trust's top priority during these challenging times, noting that the Board would discuss Emergency Department performance in greater detail later in the afternoon.

With regard to the Referral to Treatment (RTT) standard, Ms Toal advised that Business Groups had been asked to provide recovery plans by 27 September 2019. In

response to a question from Mr Belton, Mr Graham and Mrs Robson commented that the expectations would be emphasised at the weekly Performance Wall meetings and that Business Groups would be held to account for the delivery of the recovery plans at Performance Reviews.

Ms Toal referred to the earlier patient story, which had highlighted issues regarding patient flow. She advised the Board that during the week commencing 7 October 2019, the Trust would run a 'Perfect Week' initiative, which was an exercise to continually review and assess the management of patient flow and identify potential areas for improvement.

With regard to Emergency Department (ED) performance, Ms Toal advised that the Trust was focusing on non-admitted breaches. Mrs Robson commented that, while it was known that work on non-admitted breaches had a positive impact on ED performance, the issue was having enough staff to keep the process running 24/7. She noted that this would be tested again during the Perfect Week.

In response to a question from Mr Beaton, regarding forecasting, Ms Toal advised that the non-admitted breaches had an adverse impact of approximately 8% to ED performance. She noted the importance of additional bed capacity in order to improve performance, but commented that this was not being adequately addressed by the current Winter Plan.

Dr Cheshire noted that, earlier in the year, the intention had been to have a full year plan instead of a Winter Plan, and he sought assurance on the plan's effectiveness. Ms Toal commented that due to the unexpected, significant performance challenges over the summer, combined with high bed occupancy rates, it had been necessary to bring the winter plans forward. She noted that consequently there were no contingencies left for the actual winter.

Mr Graham commented that August had also been a challenging month nationally. Referring to Mr Beaton's earlier question about forecasting, Mr Graham advised that while the Trust undertook daily activity forecasting, the numbers continued to exceed expectations. In response to a question from Mr Beaton, who queried whether the action plan needed to be adjusted as a consequence, Mr Graham noted the importance of system-wide working to enable sustainable improvements.

Dr Cheshire commented that there appeared to be a misperception that ED attends in Stockport were lower than the national average. Mrs Robson noted that while this was stated in the CCG's strategy, a recent Get It Right First Time (GIRFT) visit had identified that the Trust's Emergency Department had higher than average numbers of people aged 70+, ambulance attendances and GP referrals. She added that the visit had provided positive feedback regarding the Trust's use of resources.

Dr Logan-Ward queried how the Trust was responding to the system with regard to such negative narrative, noting the adverse impact the message had on the Trust's reputation. Mrs Robson advised that the Trust was in constant dialogue with its partners to emphasise the importance of a consistent message.

Mr Sugden noted that the Finance & Performance Committee had been unable to take any satisfactory assurance with regard to performance against a number of operational and financial metrics.

Medical Director

Dr Wasson presented an update regarding the following indicators:

- A&E 12-hour trolley waits – Dr Wasson made reference to adverse patient experience due to trolley waits. He noted the Trust's focus on patient safety and supporting staff during the challenging times.

- Diabetes Reviews – Dr Wasson reported compliance against this target and advised that the Trust was recruiting to diabetic posts on consultant levels. He noted, however, that the metric only highlighted that a review had been undertaken, but did not indicate the conclusion of the review.

- Sepsis – Dr Wasson advised that the Trust was focusing on the delivery of consistent performance in this area.

- Medication Errors – Dr Wasson advised that the Chief Pharmacist had delivered a presentation to the Quality Governance Group regarding the subject area. He commented that, on a positive note, errors were being reported.

- Mortality: HSMR – Dr Wasson reported a continued improvement in performance. He advised the Board of the development of a mortality dashboard, which would be presented to the Quality Committee on a quarterly basis, and also to the Board in November 2019, in order to improve the Board's line of sight.

Chief Nurse & Director of Quality Governance

Ms Lynch presented an update regarding the following indicators:

- C Difficile rates – Ms Lynch advised that the Quality Committee had considered a report regarding this subject matter. She advised the Board of the development of a composite action plan to address the increase in C Difficile cases.

  In response to a question from Mr Graham, Ms Lynch briefed the Board on the C Difficile target, noting that the annual trajectory for 2019/20 was 51.

- MSSA and E.Coli infection rates – Ms Lynch advised that the Trust had agreed the following tolerance thresholds with the Clinical Commissioning Group:

  - MSSA - 3 per quarter
  - E.Coli - 9 per quarter

  Ms Lynch was pleased to report that the Trust had been identified as one of three trusts whose E.Coli infection rates had reduced by 10%.

- Pressure Ulcers: Device Related, Category 2 – Ms Lynch reported that the slight increase was being addressed.

- Emergency C-Section rate – Ms Lynch advised that the metric would be reviewed by the Maternity Transformation Board in October 2019, to establish the best approach. She advised that the Quality Committee had taken positive assurance from a report on this subject matter.

- Friends & Family Test: Response Rate – Ms Lynch reported a slight decrease in performance, noting themes around waiting times, attitude and treatment. She advised that the Patient Experience Action Group was triangulating the responses with inpatient surveys.

- Complaints Response rates – Ms Lynch was disappointed to report a decline in performance, and noted additional education and training in this area. She thanked Dr Logan-Ward for attending a Patient Experience Action Group meeting, which had been well received by the teams.

- Referral to Treatment 52-day Breaches – Ms Lynch advised that an analysis in this area had not identified any harm.

- Mixed-Sex Accommodation – Ms Lynch reported that there had been two breaches against this standard in September 2019.

In response to a question from Mrs Barber-Brown, Ms Lynch acknowledged that the CQUIN section had inadvertently been missed out from the report. She agreed to circulate the information to Board members and ensure the section was included in future reports.

Director of Finance

Mr Graham presented an update regarding the financial position for August 2019. He advised the Board that while the Trust had delivered against the financial plan in month 5, there were a number of pressures, including lower than forecast income due to reduced activity, and a high proportion of cost improvement initiatives being delivered on a non-recurrent basis. The Board noted that these issues had been the subject of a focused discussion at a recent Finance & Performance Committee meeting. Mr Graham also noted consequences between the financial plan delivery and the Trust's cash position.

In response to a question from Ms Lynch, Mr Graham briefed the Board on the findings of an external review of the Trust's Cost Improvement Programme. He advised that the final review report would initially be presented to the Executive Team and the Finance & Performance Committee, following which it would be presented to either the October or November Board meeting.

Director of Workforce & OD

Mr Moores presented an update regarding the following Workforce indicators:

- Substantive Staff in Post – Mr Moores noted that while the Trust was compliant against this indicator, there were a number of challenges with regard to establishment rates. He briefed the Board on mitigating actions, noting that e-rostering would help to identify gaps in a more strategic way.

- Sickness Absence – Mr Moores advised that stress was the highest cause of sickness absence and highlighted work in this area, including mental health first aid training. With regard to the rolling 12-month sickness rate, Mr Moores highlighted the Estates department as an area of concern. He advised the Board of the implementation of a new Sickness Absence Policy and commented that the Staff Survey was an important tool in gaining understanding of any underlying issues.

- Workforce Turnover – Mr Moores reported an increased turnover figure and noted ongoing work to establish the reasons why staff left the organisation.

- Appraisal Rates – While the Trust was non-compliant against this target, the Board was pleased to note improved performance. Mr Moores commented that the new appraisal form had been well received by staff.

- Agency expenditure – Mr Moores noted a challenge regarding medical agency expenditure. He advised that the external review into the Trust's Cost Improvement Programme had highlighted good grip and control with regard to agency expenditure, but had also identified some actions to improve grip further.

- Staff Suspensions – Mr Moores advised that this was a new indicator.

Mr Belton commented that staffing was a big challenge for the Trust and that it was important for the Board to be sighted on the sheer depth of the challenge.

Mr Hopewell commented on the adverse financial effects relating to turnover and sickness absence, and queried whether the current targets were realistic. Mr Moores noted that the sickness absence target was not realistic in the short term, and that while the turnover target was more realistic, the Trust faced challenges due to its geography.

In response to a question from Dr Wasson regarding recruitment and retention, Ms Lynch briefed the Board on challenges in this area, noting in particular the high unseasonal activity and associated consequences. Ms Lynch noted valued support received from senior staff and non-clinical teams, including the Finance team, in providing practical support to wards. Dr Wasson commented that staff engagement events were a useful way in identifying ways in which non-clinical staff could provide practical support to front-line staff.

<u>Safer Staffing</u>

Ms Lynch briefed the Board on fill rates and noted the support provided to teams. She advised the Board of the development of a 'heat map' to complement the Safer Staffing Report, which would include roster compliance. The heat map would be considered at meetings of the People Performance Committee.

Mrs Robson paid tribute to Executive Team members for their 'hands on' support in the Emergency Department and across the hospital during peak pressures, noting that they were doing this in addition to their existing and significant workloads.

In response to a comment from Mrs Barber-Brown, Ms Lynch thanked her for taking part in a recent Community Team strategic staffing review and advised that the Trust was taking learning from the event. She reported that the Trust had also completed a first Allied Health Professionals strategic staffing review.

Mr Belton summarised the discussions, noting the adverse impact of the unanticipated pressures on performance indicators. He highlighted staffing as one of the biggest challenges for the Trust which required urgent action, both in the short and long term.

The Board of Directors:

- Received and noted the Performance Report.

222/19 Key Issues Reports

Mr Belton welcomed Committee Chairs to raise any key issues that had not been covered during consideration of the Performance Report.

Quality Committee

Dr Cheshire presented key issues reports from meetings of the Quality Committee held in August and September 2019. He referred to the August key issues report and advised the Board of eight areas that were off track with regard to quality metrics, noting that the Committee would be updated on progress in this area.

He then referred to the September key issues report, and advised the Board that the Trust was not an outlier with regard to caesarean section rates compared to its Greater Manchester peers.

Dr Cheshire advised that the Committee had welcomed the inclusion of a summary of Quarter 1 CQUIN position in the Integrated Performance Report. The Committee had agreed to consider a wider suite of quality related metrics, including linking ED performance with quality.

Ms Lynch referred to the 'Alert' section of the report and advised the Board that the issue relating to temperature probes in refrigerators was being considered by the Executive Team.

In response to comments from Dr Cheshire and Mr Sugden regarding the significant size of Committee meeting packs, Mr Belton agreed to discuss this issue with Mrs Robson and Mrs Parnell outside of the meeting.

Finance & Performance Committee

Mr Sugden noted that the risks identified by the Committee had already been covered during consideration of the Performance Report.

He referred the Board to the 'Assurance' section of the report and highlighted the Clinical Correspondence presentation as a real success story. He commented that the Committee had requested that principles of the project should be cascaded to other areas, and that the success of the roll out reported back to the Committee.

Mrs Robson noted that one of the challenges for the Trust was about capacity, capability and focus on establishing priorities for implementation. She commented that the success of the Clinical Correspondence project was a good example and agreed the need to review the method of improvement. Mrs Anderson noted that the Committee had highlighted administration as a key area that could benefit from this type of methodology.

People Performance Committee

Mrs Barber-Brown commented that, while the most recent Committee meeting had not been quorate, the Committee had held useful discussions and had made recommendations that would be shared virtually with Committee members and presented for ratification at the next meeting.

She referred the Board to the 'Alert' section of the report and advised that the Committee had considered a report on the potential implications to the Trust following a recent ruling in the case of Hallett v Derby Hospitals NHS Foundation Trust. In response to a question from Mrs Anderson, Mr Moores confirmed that the associated financial risks would also be considered by the Finance & Performance Committee.

Mrs Barber-Brown referred the Board to the 'Advise' section of the report and said that the Committee had been pleased to note that a full roll-out of electronic rostering (eRostering) was anticipated within 12 months of the rostering team being in post, and perhaps even sooner if the Trust was successful in obtaining external support in this area.

She advised that the Committee had received a presentation on the 2019 Staff Survey and that the Committee had commended the stretching targets and initiatives to improve the response rate.

Audit Committee

Mr Hopewell reported that, contrary to the People Performance Committee, the Audit Committee had expressed concern with regard to the ongoing delays in the implementation of the eRostering system and had concluded that a stock take was urgently required.

In response to a question from Mr Belton, Mr Moores agreed that a stock take on eRostering would be helpful and advised that the external Cost Improvement Programme review had identified some significant savings if the roll-out of eRostering could be further accelerated. In response to a question from Mr Belton, Mr Moores advised that the People Performance Committee would be updated on progress in this area.

The Board of Directors:

- Received and noted the Key Issues Reports.

223/19 Pressure Ulcer Presentation

It was noted that the presentation would be deferred to the next meeting, due to the unavailability of the Tissue Viability Nurse.

Ms Hussain joined the meeting.

224/19 Equality Report

Ms Hussain presented a report updating the Board on progress of Equality, Diversity & Inclusion (EDI) work in the Trust. She briefed the Board on the content of the report and provided an overview of key projects, including increasing staff engagement and awareness of staff networks, past and planned events, and plans for a multi-faith centre.

Ms Hussain then presented a report which included action plans for Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES), noting that both action plans required Board approval.

Ms Hussain briefed the Committee on the content of the report and highlighted the following areas as key priorities for the Trust:

- Bullying & harassment
- Career progression
- Staff feeling pressured to come to work despite being unwell.

In response to a comment from Mr Belton, who emphasised the importance of EDI, it was suggested that some Board members could work with Mr Moores and Ms Hussain to think about strategic priorities in this area. Any interested Board members were asked to contact Mr Moores.

The Board of Directors:

- Received the Equality, Diversity & Inclusion Update Report.
- Approved the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) action plans to enable their publication as per legislative requirement.

Ms Hussain left the meeting.

225/19 Winter Plan

Ms Toal presented a report informing the Board of the system-wide analysis of winter 2018/19, the proposed whole system Winter Plan for 2019/20 and the process to be completed prior to the final ratification of the plan. She briefed the Board on the content of the report and advised that each of the proposed winter schemes needed to fit within the following four quadrants:

- Stay Well
- Home First
- Patient Flow
- Discharge.

Ms Toal referred the Board to s4.1 of the report which detailed the key risks with regard to the Winter Plan and associated mitigations. She noted that the plan had not anticipated the increased capacity demand, particularly regarding bed capacity, in light of the unexpected pressures experienced over the summer. Ms Toal advised that the final Stockport Winter Plan was due to be submitted to NHS Improvement and the Greater Manchester Health & Social Care Partnership by 11 October 2019. She noted that the Board was not asked to sign off the Winter Plan today, but that the intention of the report was to alert the Board to the risks associated with the Winter Plan.

Mr Belton commented that the mitigations detailed in the report did not appear to be enough to mitigate the associated risks. Ms Toal referred to the risk of insufficient capacity outside of the hospital and noted that the SMBC schemes were minimal, amounting to about £500k against the £1.2m they had been given to spend in this area. She advised that the Trust had raised this issue at the Urgent Care Delivery Board and was making its own enquiries with private providers. Mrs Robson advised that she had also raised this issue with regulators and Greater Manchester (GM), outlining that if we had to purchase extra capacity from private providers, we should not be expected to pay for it ourselves.

In response to a question from Mr Belton, Mrs Robson noted that any extra capacity purchased from private providers should already be staffed, and was not expected to be staffed by Trust employees.

Ms Toal referred to the risk of insufficient staff to safely operate the winter wards and noted associated cost implications and the need for clarity regarding funding. In response to a question from Dr Wasson, Ms Toal advised that the Trust could open an additional 40 beds if staffing was not an issue. In response to a question from Dr Cheshire, Ms Toal noted that the length of stay of 'winter patients' was longer due to their higher acuity and complexity.

Mr Sugden raised a concern regarding the approval of the Winter Plan, as he felt it was very much Trust-driven. He commented that the Winter Plan needed to change significantly for it to be fit for purpose to and ensure the Trust was not solely left holding the operational and financial implications.

Mrs Robson advised that GM had commissioned a demand and capacity piece of work across the system as other providers were also experiencing challenges with regard to urgent and emergency care.

It was consequently agreed that a letter from the Board, signed by the Chair, articulating the Board's concerns regarding the Winter Plan would be sent to partners. In response to a question from Mr Sugden, Mrs Robson noted that the Board was not under any obligation to sign off the Winter Plan if it was not happy with its content. Ms Toal commented that it was also important not to lose focus on the areas the Trust could influence.

The Board of Directors:

- Noted the Winter Plan Report.
- Noted the risks associated with the Winter Plan in its current state and the inequity in system contribution.
- Agreed to write to partners with regard to the Board's concerns regarding the Winter Plan.

226/19 Annual Board Report on the Management of Appraisal & Revalidation

Dr Wasson presented a report prepared for annual review by the Board of Directors on the subject of Medical Appraisal & Revalidation. He briefed the Board on the content of the report and Mrs Barber-Brown advised that the report had also been considered by the People Performance Committee. He noted that good progress had been made with regard to medical appraisal and revalidation.

In response to a question from Mr Belton, Dr Wasson confirmed that the report format followed a new mandated template.

The Board of Directors:

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

227/19 Consent Agenda

The Board of Directors took the following actions with the Consent Agenda items:

- **Annual Report on Emergency Preparedness, Resilience and Response**

  The Board received the report and noted continued compliance with statutory requirements relating to Emergency Preparedness, Resilience and Response (EPRR) requirements.

  Mrs Robson noted the importance of the frequency of major incident training.

  Dr Wasson commented that the Clinical Directors' Forum had reviewed the Trust's major incident plan, and that an updated version would be cascaded to staff.

  Mrs Robson advised that she was liaising with Mr Mullen to ensure regular simulations were arranged for all staff.

- **Safeguarding Annual Report**

  The Board received and noted the Safeguarding Annual Report.

- **Infection Prevention Annual Report**

  The Board received and noted the Infection Prevention Annual Report.

228/19 Date, time and venue of next meeting

There being no further business, the Chair closed the meeting and advised that the next public meeting of the Board of Directors would be held on Friday, 1 November 2019, commencing at 9.30am in the Committee Room, Oak House.

Signed:_____Date:_____

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BOARD OF DIRECTORS: ACTION TRACKING LOG

Ref.	Meeting	Minute Ref	Subject	Action	Responsible
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 19 –** This would be reviewed at the April Board meeting. **Update 29 May 19 –** Ms Toal advised that this would come through in the next meeting. **Update 27 Jun 19 –** Deferred to the July meeting. **Update 31 Jul 19 –** Ms Toal advised that the Winter Plan review had been considered by the Finance & Performance Committee and that the Committee had requested a further update to be made to the **September** Board. Mr Sugden confirmed that the Committee was happy with the progress being made. Mrs Robson noted that the Trust was leading the whole system approach to ensure that there was a single plan across the whole system. **Update 26 Sep 19 –** On agenda. Action complete.	S Toal (Chief Operating Officer)
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. **Update 28 Mar 19 –** Action carried forward. **Update 25 Apr 19 –** The action was ongoing with the expectation that this would be presented as a patient story in September. **Update 28 Jun 19 –** Following the Pressure Ulcer collaborative event, the Tissue Viability Nurse had been invited to present in September 2019. **Update 26 Sep 19 –** Ms Lynch advised that, due to the unavailability of the Tissue Viability Nurse, the presentation would be deferred to the October meeting.	A Lynch (Chief Nurse)
10/09	26 Sep 19	217/19	Patient Story	The Board endorsed a suggestion to deliver the 'Ken's Story' presentation to the CCG Board.	A Lynch (Chief Nurse)

11/19	26 Sep 19	222/19	Quality Committee Key Issues Report	Mr Belton agreed to discuss the significant size of Committee meeting packs with Mrs Robson and Mrs Parnell.	A Belton / L Robson / C Parnell
12/19	26 Sep 19	225/19	Winter Plan	It was agreed that a letter from the Board, signed by the Chair, articulating the Board's concerns regarding the Winter Plan would be sent to partners.	S Toal / A Belton

NHS
Stockport
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	1 November 2019
Subject:	Chair's Report		
Report of:	Chair	**Prepared by:**	Mrs C Parnell

REPORT FOR INFORMATION

Corporate objective ref:	N/A
Board Assurance Framework ref:	N/A
CQC Registration Standards ref:	17
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
- Governance
- Board development
- Out and about
- National 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
- Governance
- Board development
- Out and about
- National news.

2. PARTNERSHIP WORKING

The importance of effective partnership working is one I regularly reflect on in my reports to the Board of Directors, and I make no apology for that as it is crucial to the delivery of a health and social care system that best meets the needs of the communities we support.

All Directors have a key role to play in developing and maintaining healthy and productive relationships with our partners in both the statutory and voluntary sectors. The importance and relevance of this has been emphasised by a number of meetings I have attended in the last month.

At Stockport Clinical Commissioning Group's (CCG) recent annual meeting I was struck by how many components of the system were well rated by external regulators, including the CCG itself, primary care services and local care homes. Despite this partners are finding it difficult to develop a robust and effective plan within existing resources to ensure we continue to provide safe care for people over the winter. We know that such a plan is vital as our services, which are already under significant pressure now, are likely to face even more demands.

It is a real challenge for all partners to find the time away from the current intense operational pressures to focus on how we can strengthen our approach to system working. So it was good to join Dr Cath Briggs, Chair of the CCG, to walk the urgent care pathway that many of our patients follow.

It was really thought provoking to see first-hand the challenges of assessing a patient in the emergency department, working through the diagnosis process and the decision to admit to hospital for treatment, and then onto our wards where we saw the progress being made to accelerate discharge for those patients who no longer need hospital care. Our tour coincided with the Perfect Week initiative that the Trust ran with our system partners, and it gave us the opportunity to attend an escalation meeting as well as see in practice how our organisations are working together to identify opportunities to improve the flow of patients through the local system.

At a recent meeting of Stockport Health and Wellbeing Board it was good that all partners were able to reflect on the progress we have made since the Care Quality Commission's review of the system last summer, despite the current pressures on our health and care services. It is the first time that all partners have had substantive appointments to Chair, Chief Executive and Accountable Officer roles for a significant period of time. This should bode well for our ability to work effectively together, and it was very helpful to share our individual and joint challenges at a recent meeting with the Chairs of the CCG and Viaduct, as well as Stockport's lead councillor for health and care.

A good example of how we work together and shape our joint thinking on local challenges is the development of a locality plan for Stockport. Developed in line with the NHS Long Term Plan, our locality plan will soon be submitted to NHS Improvement/NHS England (NHSI/E), and it will set out how we will work together to focus on population health, ill-health prevention, self-care, and reducing health inequalities.

Clearly we are not alone in facing the challenge of increasing demand for services placing a huge strain on health and care services, and the staff who provide that care. This was clearly articulated by many of my fellow Chairs at a recent regional meeting also attended by Mr Bill McCarthy, North West Regional Director with NHSI/E. The meeting highlighted how important it is that all partners have a shared understanding of the challenges we all face, and work together to assess how best we can rise to those challenges.

3. GOVERNANCE

Ms Rebecca Southall from NHS Improvement and Mr David Holden continue to support the Trust in improving our governance arrangements. They have begun a deep dive into the governance arrangements within our business groups, and reflections from Mr Holden are helping to continue to shape and improve the working of our Board and its Committees.

The paper on today's Board agenda aims to address some areas for improvement we identified prior to their review, and I am sure we will continue to make further changes in the coming months as we continue to refine our approach to governance and risk.

4. **BOARD DEVELOPMENT**

The appointment of Dr Marisa Logan-Ward and Mr Mark Beaton as Non-Executive Directors has enabled us to review the membership of our Board Committees, as well as other key groups in the Trust that our Non-Executive Directors contribute to.

5. OUT AND ABOUT

- Community services - On a practical level many of our services are effectively working in partnership every day, and this was very evident to both the Chief Executive and I when we visited Kingsway House recently. We learned about how important it is for re-ablement services provided by Stockport Metropolitan Borough Council to work hand in hand with our crisis response team to provide the best possible care and support to patients in the community.

- Safety Conference - Safety is always at the top of our priorities but it has been a particular theme of activities this month, not least the Trust's excellent Quality Conference that we held in Manchester. It was good to see many of our partners at the event, and I was particularly struck by a presentation on the Safety 2 initiative that we will be a pilot site for.

- Annual meeting - Safety and quality were two of the themes of our annual members meeting, and our most recent Council of Governors meeting. Both these events highlighted a number of the initiatives and improvements we are trying to make to services, and it was

really heartening to see our governors and members take such an interest in the work we are doing to provide safe, high quality care for local people.

- East Cheshire – Our neighbours at East Cheshire NHS Trust are facing similar challenges as ourselves so it was good to meet up recently with Lynn McGill, its Chair, to discuss the issues they are facing and how we can continue to work together to meet the needs of local people.

- NHS Providers Conference – the work the Trust has done around developing a Veterans Passport was chosen to be showcased on a stand at the recent NHS Providers Conference in Manchester. It was good to see Mr Matt Hancock, Secretary of State Health and Care, visit the stand and leave with a copy of the passport, and I am very much looking forward to attending the Armed Forces Employer Recognition Award to receive, on behalf of the Trust, a silver award.

6. NATIONAL NEWS

- Screening – Prof. Sir Mike Richards has completed his review of adult screening programmes, which do so much to help with the early detection of illnesses and conditions. His report identifies a lot that screening services should be proud of but it also makes a number of recommendations, including upgrading cancer screening, giving people greater choice over where and when they access screening, and improving the design of screening programmes.

- Maternity and neonates – The National Institute for Health and Care Excellence (NICE) has published its impact report on how evidence based guidance has contributed to maternity and neonatal services. It identifies that as a result of the guidance there has been decreases in both the number of neonatal admissions, as well as emergency caesarean section rates.

- Every Mind Matters – Public Health England has launched its Every Mind Matters campaign designed to help people discover simple advice on how to improve their mental health. The campaign focuses on a free online tool kit that offers expert advice and practical tips.

7. 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:**	1 November 2019
Subject:	Chief Executive's Report		
Report of:	Chief Executive	**Prepared by:**	Mrs C Parnell

REPORT FOR NOTING

Corporate objective ref:	N/A
Board Assurance Framework ref:	N/A
CQC Registration Standards ref:	8
Equality Impact Assessment:	☐ Completed X Not required

Summary of Report

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

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

British Summer Time has officially ended, heralding the start of winter, but for many of our services it has felt as though winter pressures have continued throughout the year.

Our emergency department has been under considerable pressure in recent weeks and we are not alone in that, regionally or nationally. But Stockport has some particular issues in managing the demand on our emergency department, including the challenge of providing care to communities with a large proportion of elderly and frail people, working in a unit not designed to accommodate the number of people currently coming through our doors, and a number of vacancies in our front-of-house nursing team.

The Board of Directors has agreed to invest in extra international recruitment to try to fill the staffing gaps, and we are working closely with our local health and care partners on the development of a robust plan to ensure we can continue to provide safe care for local people as the usual winter ailments start to impact the communities we serve.

However welcome these actions are, they do not ease the current day-to-day pressures on the staff working in our emergency department. I have the greatest admiration for the way they remain focused on providing the best possible care for people despite the demand for services, and I would like to thank them and everyone else working in the Trust who has rallied round in recent weeks when things have been particularly difficult.

NHS staff are great when things a tough, but it is wrong for them and our patients to operate at a heightened level all of the time. We are working closely with our partners to try to create more capacity in our health and care system to ease that demand on our services in the short term, including creating more GP appointments, packages of care, step up and step down capacity to ensure people can be seen in the right place, at the right time to meet their needs.

These actions all have a cost, which we and our commissioners had not budgeted for at the beginning of year when none of us could have predicted that the demand for care would continue at such a high rate throughout the year. Spending more on staff and beds puts added pressure on our financial plan for the year, and it is crucial that as well as providing safe care for local people we also deliver our financial plan if we are to put ourselves in the best position for 2020-21.

These two areas are taking up a lot of the time for our senior staff and Executive Directors, and it is not surprising that with such key areas of performance off track that our regulators should be taking an interest in our position, as well as offering their support. With our partner organisations we are having regular meetings and conference calls with North West NHS Improvement and Greater Manchester Health and Social Care Partnership to share the work we are doing together to try to improve the current position. Across the country NHS organisations are having system conference calls with Ms Pauline Philips, National Director of Urgent & Emergency Care, as emergency departments are dealing with unprecedented demand for care.

Earlier this month we held a "Perfect Week" event to test out some of the initiatives we believe may help us better cope with the demand on our emergency department and improve the flow of patients through our services. Despite having limited time to plan the initiative, it did provide us with an opportunity to work with partners to try out some different ways of working. This has resulted in the introduction of new multi-agency system-wide arrangements, focused specifically on reducing long lengths of stay in hospital.

The performance of our emergency department has often been under the spot light, and when the organisation is dealing with such operational pressures it is too easy to forget how much progress the Trust has made in recent years.

In preparation for their regular inspection of the Trust and our services the Care Quality Commission recently asked us to complete a comprehensive information return. Staff from across the organisation have been involved in providing the required information, and reviewing that data clearly demonstrates what progress the organisation has made in terms of both the quality and leadership of services, but also in developing and embedding our governance arrangements. Staff should be really proud of all they have achieved so far, and I encourage them use the forthcoming inspection as a way of sharing that pride and the improvements they have made.

Undoubtedly preparation for such inspections also highlight areas where we need to make further improvements, but there is a real commitment within the Board and the wider Trust to continue to make those changes and further embed our approach to the consistent delivery of high quality safe services.

Safety is at the heart of the services we provide and I was really inspired by the enthusiasm and commitment demonstrated by all those staff and partners who attended our recent annual Safety Conference, which was attended by over 150 of our clinical staff and many of external partners. I was particularly impressed by a presentation on the Safety 2 programme, for which we will be a pilot site.

The traditional NHS approach to safety focuses on learning lessons when things go wrong but the Safety 2 approach, which really seemed to capture the imagination of conference delegates, encourages staff to also learning from things when they go right, building resilience in organisations, and supporting professionals to strengthen their ability to prevent issues that may cause harm. Being a pilot site for this approach is a really exciting opportunity for the organisation, and one I am sure many of our staff will be keen to adopt.

Our staff's commitment to safety is evident from the way they respond to our annual calls for flu vaccinations. Last year the organisation was one of the highest performers in the country for the number of staff to receive their flu immunisations, and around half of our staff have already had their jabs this year. We are continuing to provide a range of opportunities to access the vaccination as this is such an important way of protecting our staff, their families, our patients, and local communities.

When our emergency department is under such pressure as it current is it would be easy for us to forget the other great services that we are proud to provide. That is why I am really keen to get out and about in the Trust as much as possible to learn more about the full range of services we provide.

With the Chair, I recently visited Kingsgate House, where we saw a great example of our Crisis Response Team working in partnership with services provided by the local council. We also met

staff from the community teams providing nutrition and dietetics, physiotherapy, orthotics, diabetes and podiatry services. These services are doing such fantastic and often innovative work to meet the health and care needs of local people. I am committed to visiting many more of our community services in the coming months as they play such an important role in supporting patients to remain in their own homes or local communities, as well helping them to return home after hospital treatment.

I have always been a big supporter of research and innovation as it is crucial to the future of healthcare. Without research we would not have the current treatments, techniques and equipment that our patients benefit from, so I was very pleased to have the opportunity to visit our research department earlier this month.

Our research team is doing a great job of spreading the word about the importance of encouraging our patients and staff to get involved in research projects. We are a key clinical research site in Greater Manchester, committed to undertaking studies that involve over 1,000 people each year, and we exceed that number by involving over 3,000 people last year. We are keen to develop this area as it is not only important to the future of healthcare but it is also highly attractive to clinicians thinking about joining our organisation.

3. NEWS AND EVENTS

- Stockport Moves – congratulations to everyone who took part in the recent Stockport Moves week. It was great to see both staff and patients getting involved in a wide range of activities from outdoor Zumba to seated exercises, encouraging us all to move more.
- Black History Month – the Trust hosted another great event for this annual celebration and we were privileged to welcome Simply Red guitarist Aziz Ibrahim and author Linford Sweeney to the event at Stepping Hill Hospital.
- Stockport Frogs – colourful frogs have been hopping about around Stockport in recent weeks, and an auction of these larger-than-life characters raised over £31,000 for our Treehouse Unit. Thank you to everyone who contributed to this amazing fundraising event.
- AHP Day – a host of events were held across the Trust to mark AHP Day and the important contribution that our allied health professional staff make to our services and patients.

4. AWARDS

- Placement – Our children's community nursing team have been nominated for the Placement of the Year Award in the University of Manchester's Excellence in Practice Awards.
- Pain Management – Jill Hulme-Duvall and Colette Wharton, our senior clinical nurse specialists in pain management, have shared the Acute Pain Nurse of the Year Award given in the national Acute Pain Symposium Awards. They were honoured for the extra support they provide to patients with complex issues.
- Public health – Jan Sinclair, our public health nurse, won the Sports and Physical Active Award presented by Stockport Metropolitan Borough Council and Life Leisure UK.

5. RECOMMENDATION

The Board of Directors is recommended to receive this report.

Report To:	Trust Board	**Date:**	31 Oct 2019
Subject:	Integrated Performance Report		
Report of:	Director of Stratgy & Planning	**Prepared by:**	BI & 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

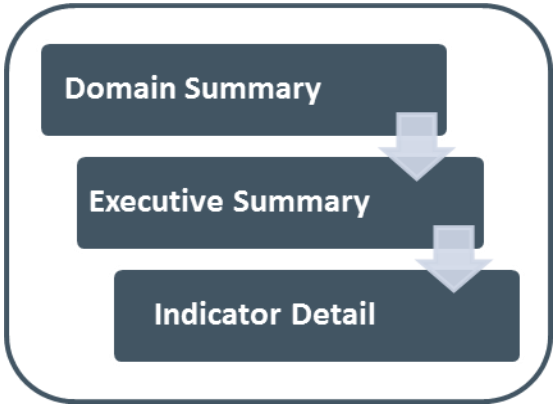
The Board is asked to note the performance against the reported metrics, particularly noting the key areas of change from the previous month.

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:



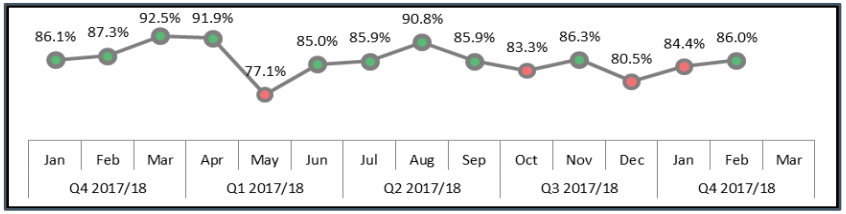
Domain Summary: Provides a high level summary of performance against the Trusts' Key Performance Indicators. The indicators are grouped by the Care Quality themes of Safe, Caring, Responsive, Effective and Efficient. The summary page reflects the Trusts' performance against the Single Oversight Framework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

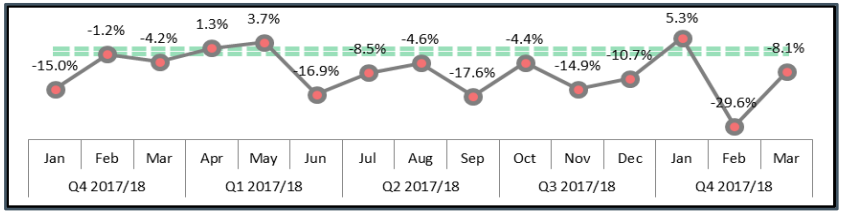
Indicator Detail: Provides detailed information for each indicator. This includes clear descriptions of the indicator, a chart representing the performance trend, and narrative describing the actions that are being undertaken to either maintain or improve performance.

Chart Summary

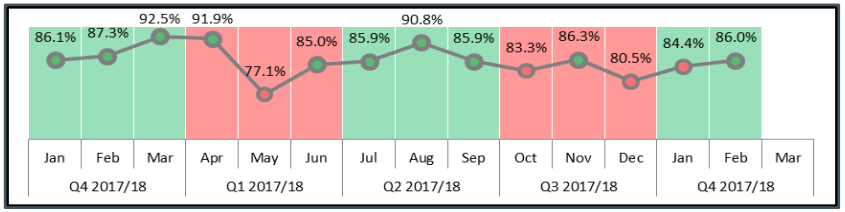
The following chart types are in use throughout the report:



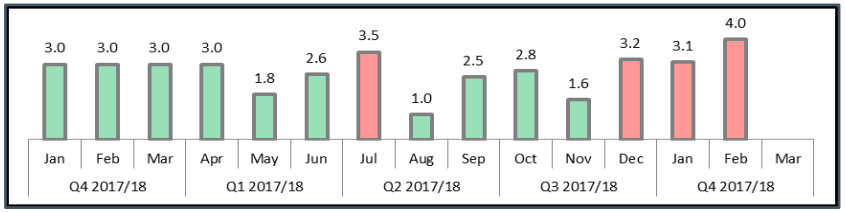
Trends are represented as a line where possible, with each monthly marker coloured to indicate achievement or non-achievement against target.



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



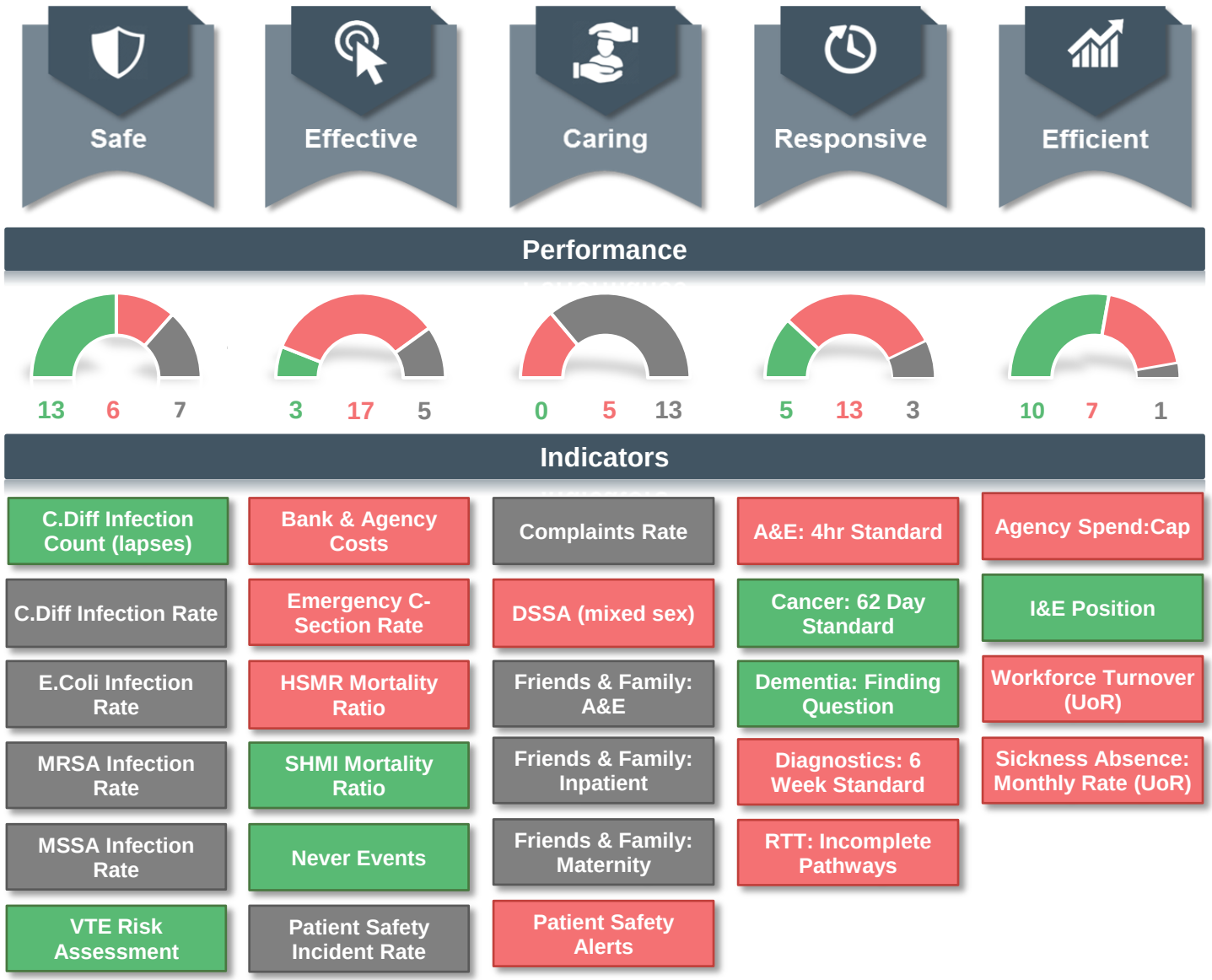
Where applicable, quarterly performance is indicated as coloured columns behind the main trend line.



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 red to green in month:

- Cancer: 62 day standard
- Length of Stay: Elective

Metrics changing from green to red in month:

- Outpatient DNA rate
- Elective Day Case Activity
- Stranded Patient Count
- Delayed Transfers of Care
- Emergency Readmission Rate
- Diabetes reviews
- Safety Thermometer: Hospital
- Patient Safety Alerts: Completion
- Term Babies Admitted to the Neonatal Unit
- DSSA (mixed sex accommodation)

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	Sep-19	<= 1%	5.8%							2.8%		14
Cancer: 62 Day Standard	Responsive	Sep-19	>= 79.7%	79.8%							76.3%		14
Cancer: 104 Day Breaches	Responsive	Aug-19	<= 0	4.0							18.0		15
Referral to Treatment: Incomplete Pathways	Responsive	Sep-19	>= 88.4%	81.5%							83.1%		15
Referral to Treatment: Incomplete Waiting List Size	Responsive	Sep-19	<= 23769	24444									16
Clinical Correspondence	Safe	Sep-19	>= 95%	95.8%							80.6%		16
Outpatient Hospital Cancellation Rate (UoR)	Responsive	Sep-19	<= 9%	10.7%							10.5%		17
Outpatient DNA rate (UoR)	Effective	Sep-19	<= 7.4%	7.6%							6.9%		17
Outpatient Clinic Utilisation (UoR)	Effective	Sep-19	>= 90%	85.1%							84.1%		18
Outpatient New to Follow-up Ratio (UoR)	Effective	Sep-19	<= 1.77	2.24							5.14		18
Theatres: Delivered Sessions vs. Plan	Effective	Sep-19	>= 100%	95.1%							93.9%		19
Theatres: Overall Touch-time Utilisation (UoR)	Effective	Sep-19	>= 85%	81.8%							81.4%		19
Theatres: In-Session Touch-time Utilisation (UoR)	Effective	Sep-19	>= 85%	73.0%									20

* Target/performance applies to the cumulative YTD value, not the in-month value

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	Sep-19	>= *0%*	-0.3%							-0.3%		20
Elective Day Case Income vs. Plan	Responsive	Sep-19	>= *0%*	1.6%							1.6%		21
Elective Inpatient Activity vs. Plan	Responsive	Sep-19	>= *0%*	-3.4%							-3.4%		21
Elective Inpatient Income vs. Plan	Responsive	Sep-19	>= *0%*	-4.9%							-4.9%		22
Outpatient Activity vs. Plan	Responsive	Sep-19	>= *0%*	-2.4%							-2.4%		22
Outpatient Income vs. Plan	Responsive	Sep-19	>= *0%*	-5.3%							-5.3%		23
Length of Stay: Non-Elective (UoR)	Effective	Sep-19	<= *9*	12.01							11.06		23
Length of Stay: Elective (UoR)	Effective	Sep-19	<= *2.6*	2.44							2.59		24
Stranded Patient Count (UoR)	Effective	Sep-19	<= *288*	319									24
Super-Stranded Patient Count (UoR)	Effective	Sep-19	<= *113*	140									25
Delayed Transfers of Care (DTOC) (UoR)	Effective	Sep-19	<= *3.3%*	4.6%							3.8%		25
Medical Optimised Awaiting Transfer (MOAT)	Effective	Sep-19	<= *40*	72							465		26
Discharges by Midday	Effective	Sep-19	>= *33%*	15.6%							15.6%		26

* Target/performance applies to the cumulative YTD value, not the in-month value

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
Chief Operating Officer													
A&E: Overnight Breaches	Effective	Sep-19		1441		↑						Δ	27
A&E: 4hr Standard	Responsive	Sep-19	*>= 82%*	67.2%		↓					72.5%	Δ	27

* Target/performance applies to the cumulative YTD value, not the in-month value

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													
A&E: 12hr Trolley Wait	Responsive	Sep-19	<= 0	18							125		28
Emergency Readmission Rate (UoR)	Effective	Jul-19	<= 7.9%	8.2%							8.4%		28
Diabetes Reviews	Caring	Jul-19	>= 90%	88.9%							89.7%		29
VTE Risk Assessment	Safe	Sep-19	>= 95%	97.9%							97.2%		29
Sepsis: Timely Identification	Safe	Sep-19		84.7%							81.9%		30
Sepsis: Timely Treatment	Safe	Sep-19	>= 90%	48.1%							42.9%		30
Medication Errors: Rate	Safe	Sep-19		4.39									31
Discharge Summaries	Safe	Sep-19	>= 95%	91.2%							90.9%		31
Mortality: Deaths in ED or as Inpatient	Effective	Sep-19		92							691		32
Mortality: Case Note Review Rate	Effective	Sep-19		48.9%							33.4%		32
Mortality: Specialist Palliative Care Length of Stay	Caring	Sep-19		18.04							27.76		33
Mortality: HSMR	Effective	Jul-19	<= 1	1.05									33
Mortality: SHMI	Effective	Jan-19	<= 1	0.98									34

* Target/performance applies to the cumulative YTD value, not the in-month value

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	Sep-19	<= 0	0							0		34
Duty of Candour Breaches	Effective	Sep-19		0							1		35
Serious Incidents: STEIS Reportable	Responsive	Sep-19		18							96		35

* Target/performance applies to the cumulative YTD value, not the in-month value

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	Aug-19		21.02		↓					19.75	△	36
C.Diff Infection Count	Safe	Aug-19	<= 51 *	3		↓					23	△	36
MRSA Infection Rate	Safe	Aug-19		0.00		→					0.00	△	37
MSSA Infection Rate	Safe	Aug-19		6.07		↓					5.59	△	37
E.Coli Infection Rate	Safe	Aug-19		22.89		↑					19.75	△	38
E.Coli Infection Count	Safe	Aug-19		6		→					21	△	38
Falls: Total Incidence of Inpatient Falls	Safe	Sep-19	<= 550 *	73		↓					483	△	39
Falls: Causing Moderate Harm and Above	Safe	Sep-19	<= 13 *	1		↑					11	△	39
Pressure Ulcers: Hospital, Category 2	Safe	Aug-19	<= 38 *	11		↑					46	△	40
Pressure Ulcers: Hospital, Category 3	Safe	Aug-19	<= 9 *	1		↓					6	△	40
Pressure Ulcers: Hospital, Category 4	Safe	Aug-19	<= 1 *	0		→					0	△	41
Pressure Ulcers: Community, Category 2	Safe	Aug-19	<= 80 *	18		↑					61	△	41
Pressure Ulcers: Community, Category 3	Safe	Aug-19	<= 19 *	1		→					12	△	42

* Target/performance applies to the cumulative YTD value, not the in-month value

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	Aug-19	<= 3 *	0							5		42
Pressure Ulcers: Device Related, Category 2	Safe	Aug-19	<= 13 *	2							16		43
Pressure Ulcers: Device Related, Category 3	Safe	Aug-19	<= 3 *	1							1		43
Pressure Ulcers: Device Related, Category 4	Safe	Aug-19	<= 0 *	0							0		44
Safety Thermometer: Hospital	Safe	Sep-19	>= 95%	94.6%							96.2%		44
Safety Thermometer: Community	Safe	Sep-19	>= 95%	96.7%							97.2%		45
Patient Safety Incident Rate	Effective	Sep-19		58.94									45
Patient Safety Alerts: Completion	Caring	Sep-19	>= 100%	83.3%							92.3%		46
Emergency C-Section Rate	Effective	Sep-19	<= 15.4%	20.2%							17.5%		46
Term Babies Admitted to the Neonatal Unit	Effective	Sep-19	<= 5	6									47
Dementia: Finding Question	Responsive	Aug-19	>= 90%	91.1%							92.6%		47
Dementia: Assessment	Responsive	Aug-19	>= 90%	100.0%							100.0%		48
Dementia: Referral	Responsive	Aug-19	>= 90%	100.0%							100.0%		48

* Target/performance applies to the cumulative YTD value, not the in-month value

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
Chief Nurse & Director of Quality Governance													
Friends & Family Test: Response Rate	Caring	Aug-19		22.1%		↑					21.6%	△	49
Friends & Family Test: Inpatient	Caring	Aug-19		95.6%		↑					95.1%	△	49
Friends & Family Test: A&E	Caring	Aug-19		87.7%		↓					87.9%	△	50
Friends & Family Test: Maternity	Caring	Aug-19		96.1%		↓					95.6%	△	50
DSSA (mixed sex)	Caring	Sep-19	<= 0	1		↑					1		51
Learning Disability: Adjusted Care Plans	Caring	Jun-19	>= 100%	83.3%		↑						△	51
Compliments	Caring	Sep-19		193		↑					1017	△	52
Complaints Rate	Caring	Sep-19		0.8%		↑					0.8%	△	52
Complaints: Response Rate 45	Caring	Sep-19	>= 95%	52.0%		↓					73.6%	△	53
Complaints: Parliamentary & Health Service Ombudsman Cases	Caring	Sep-19		0		→					1	△	53
Complaints Closed: Overall	Caring	Sep-19		25		↓					227	△	54
Complaints Closed: Upheld	Caring	Sep-19		2		↓					46	△	54
Complaints Closed: Partially Upheld	Caring	Sep-19		16		↓					102	△	55

* Target/performance applies to the cumulative YTD value, not the in-month value

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	Sep-19		7							80		55
Litigation: Claims Opened	Responsive	Sep-19		9							46		56
Litigation: Claims Closed	Responsive	Sep-19		4							24		56
Referral to Treatment: 52 Week Breaches	Responsive	Sep-19	<= 0	3							26		57

* Target/performance applies to the cumulative YTD value, not the in-month value

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
Director of Finance													
Financial Controls: I&E Position	Well-Led / Efficient	Sep-19	>= 0%	0.5%									57
Cash	Well-Led / Efficient	Sep-19	<= 0%	-29.2%									58
CIP Cumulative Achievement	Well-Led / Efficient	Sep-19	>= 0%	33.9%									58
Capital Expenditure	Well-Led / Efficient	Sep-19	+/- 10%	-28.4%									59
Financial Use of Resources	Well-Led / Efficient	Sep-19	<= 3	3									59

* Target/performance applies to the cumulative YTD value, not the in-month value

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													
Substantive Staff-in-Post	Well-Led / Efficient	Sep-19	>= 90%	90.5%							91.1%		60
Sickness Absence: Monthly Rate (UoR)	Well-Led / Efficient	Sep-19	<= 3.5%	4.3%							4.5%		60
Sickness Absence: Rolling 12-Month Rate (UoR)	Well-Led / Efficient	Sep-19	<= 3.5%	4.6%									61
Sickness Absence: Long-term	Well-Led / Efficient	Sep-19	<= 0	0									61
Workforce Turnover (UoR)	Well-Led / Efficient	Sep-19	<= 13.94%	14.3%									62
Staff Friends & Family Test: Recommend for Work	Well-Led / Efficient	Jun-19		51.3%							51.3%		62
Staff Friends & Family Test: Recommend for Care	Caring	Jun-19		71.2%							71.2%		63
Appraisal Rate: Medical	Well-Led / Efficient	Sep-19	>= 95%	95.8%							96.4%		63
Appraisal Rate: Non-medical	Well-Led / Efficient	Sep-19	>= 95%	90.1%							91.8%		64
Statutory & Mandatory Training	Well-Led / Efficient	Sep-19	>= 90%	91.1%							90.8%		64
Bank & Agency Costs	Effective	Sep-19	<= 5%	11.5%							11.3%		65
Agency Shifts Above Capped Rates	Well-Led / Efficient	Sep-19	<= 0	745							4335		65
Agency Spend: Distance From Ceiling (UoR)	Well-Led / Efficient	Sep-19	<= 3%	-14.1%							-14.1%		66

* Target/performance applies to the cumulative YTD value, not the in-month value

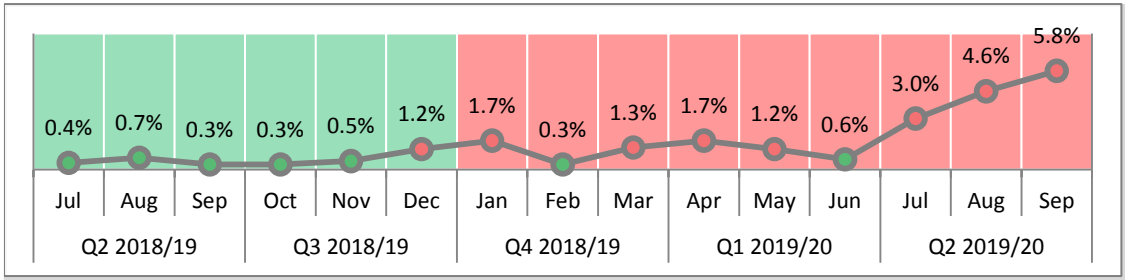
Domain Summary

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 Suspensions	Well-Led / Efficient	Sep-19	<= 0	0									66
Recruitment Lead Time	Well-Led / Efficient	Sep-19	<= 20	24.54									67
Flu Vacination Uptake	Safe	Feb-19	>= 75%	75.3%									67

* Target/performance applies to the cumulative YTD value, not the in-month value

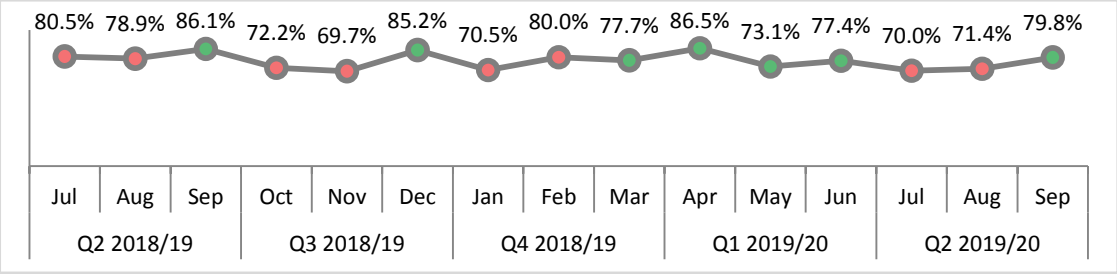
Indicator Detail

Sep-19	Diagnostics: 6 Week Standard
5.8%	The percentage of patients refered for diagnostic tests who have been waiting for less than 6 weeks.
Target	The diagnostic standard was not achieved in September as a result of on-going work to address the backlog of planned Endoscopy patients becoming overdue identified earlier in the year.
<= 1%	



Actions
The service is currently reviewing recovery plans, and options to increase specialist staffing levels, to deliver compliance against the standard by the end of quarter 3.

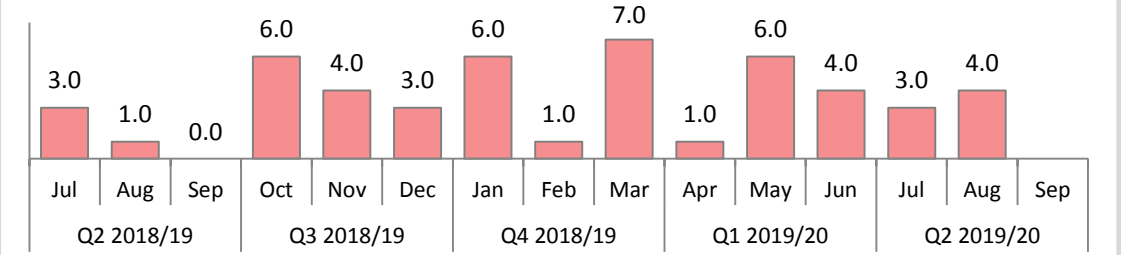
Sep-19	Cancer: 62 Day Standard
79.8%	The percentage of patients on a cancer pathway that have received their first treatment within 62 days of their GP referral. Please note: This indicator is measured against an agreed improvement trajectory, not the national standard.
Target	Data is still subject to final validation but it is expected that the Trust will meet the trajectory target set in September however, it is unlikely to be sustained as a significant number of breaches have been carried forward into October.
>= 79.7%	



Actions
Some of the new 'Straight to test' pathways will have a positive impact on performance going forward. The Gynae team is attending a GM 'faster diagnosis' event in October to map out plans to reduce time to diagnosis/treatment.

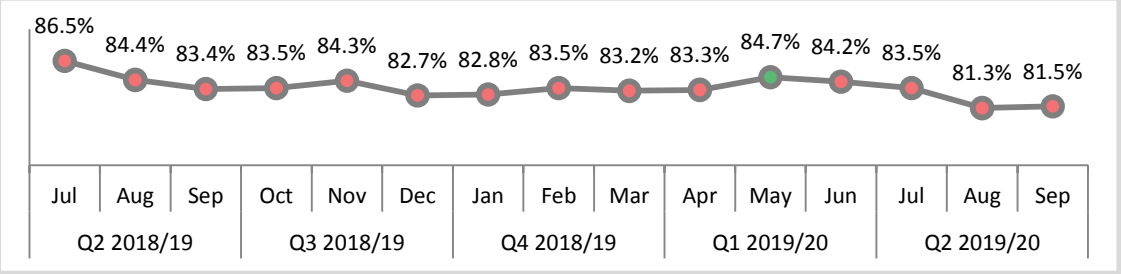
Indicator Detail

Aug-19	Cancer: 104 Day Breaches
4.0	The number of patients that have pathway length of 104 days or more at the point of treatment.
Target	4 patients commenced treatment beyond day 104 of their pathway in August. These were 1 x UGI; 1 x Colo/Haem & 2 x Urology. A common theme was prolonged work up as a result of multi-specialty involvement. One breach was shared with Wythenshawe and one was not a Trust breach as was a late referral from Macclesfield.
<= 0	



Actions
Actions: Learning from 104 days being shared across BGs - Process and pathways under review

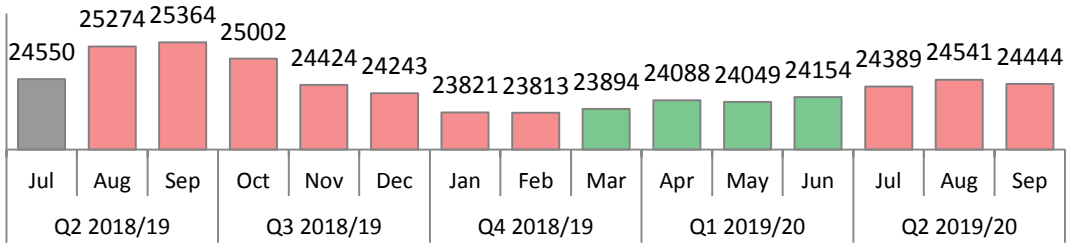
Sep-19	Referral to Treatment: Incomplete Pathways
81.5%	The percentage of patients on an open pathway, whose clock period is less than 18 weeks. Please note: This indicator is measured against an agreed improvement trajectory, not the national standard.
Target	RTT performance improved slightly in September to 81.5%. Several large specialties are meeting the 90% trajectory and T&O achieving the national 92% standard. Number of patients waiting longer than 18 weeks particularly increased in ENT, Oral Surgery and Gynaecology.
>= 88.4%	



Actions
Gynaecology have reclaimed some new outpatient capacity, thus reducing the wait for a new appointment. Recruitment to a locum consultant post to provide capacity to see long-waiting ADHD patients is on-going. In the meantime, existing consultants are providing additional clinics to address the backlog. ENT are continuing to undertake work to address their clinic templates and reduce the wait for a new appointment.

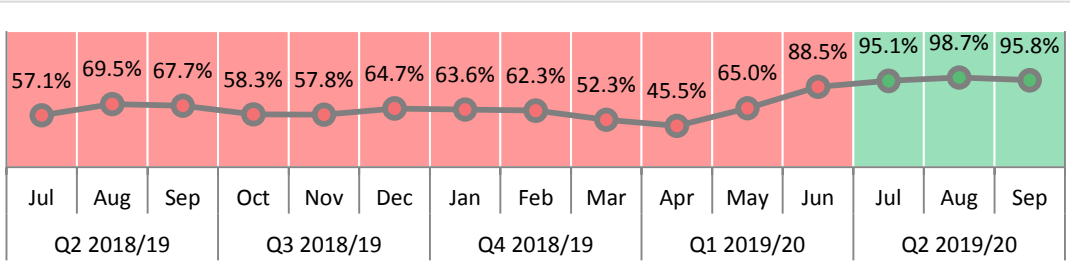
Indicator Detail

Sep-19	Referral to Treatment: Incomplete Waiting List Size
24444	The total number of patients on an open pathway. Please note: This indicator is measured against an agreed improvement trajectory.
Target	The waiting list size remains behind trajectory but has improved a little in month.
<= 23769	



Actions
Continued effort to expedite consultant reviews and chasing of results letters, to enable timely closing of open pathways. Introduction of a process to ensure patients who were overdue surveillance patients who have since had their endoscopy, have their pathways closed in a timely manner. Endoscopy are also continuing to enact their recovery plan for overdue surveillance patients.

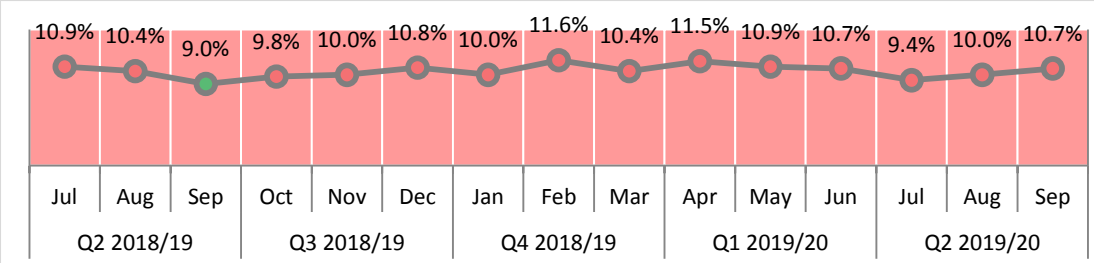
Sep-19	Clinical Correspondence
95.8%	The percentage of clinical correspondence typed within 7 days.
Target	Target achieved in month.
>= 95%	



Actions
There is an on-going review of each component of the typing pathway with a view to reporting from clinic to letter dispatch in the future.

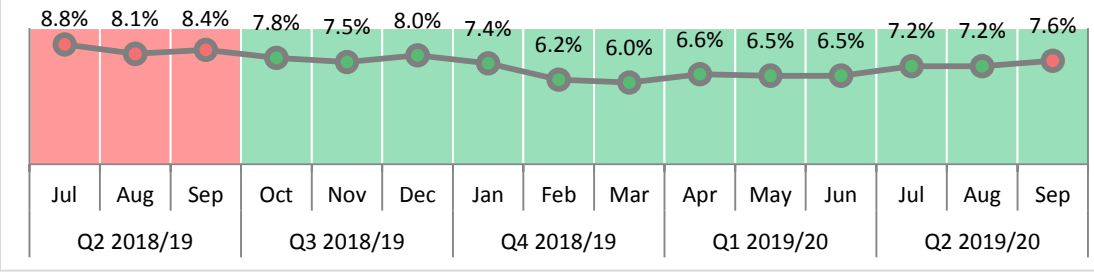
Indicator Detail

Sep-19	Outpatient Hospital Cancellation Rate (UoR)
10.7%	The percentage of outpatient appointments where the hospital has cancelled the appointment. This indicator combines new and follow-up appointment types.
Target	A slight deterioration in performance occurred in September.
<= 9%	



Actions
A review of the reporting dataset has clarified the denominator dataset. Benchmarking with other Trusts is underway to ensure consistency in approach.

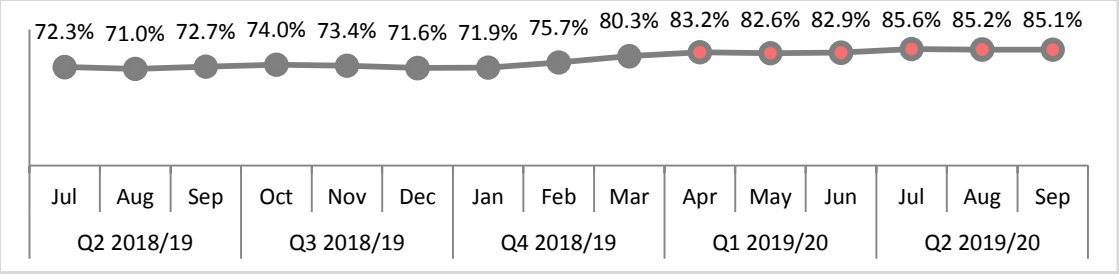
Sep-19	Outpatient DNA rate (UoR)
7.6%	The percentage of outpatient appointments where the patient did not attend (DNA). This indicator combines new and follow-up appointment types.
Target	Performance exceeded target for the first time this year in September.
<= 7.4%	



Actions
An investigation is underway into the reasons for the gradual deterioration in performance in year.

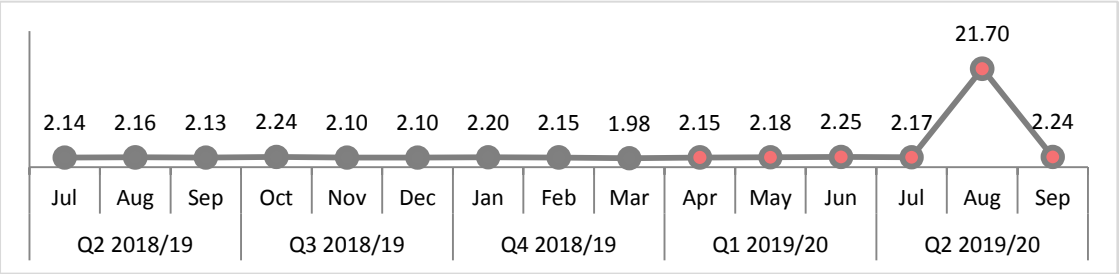
Indicator Detail

Sep-19	Outpatient Clinic Utilisation (UoR)
85.1%	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	Although slightly down on the August position, clinic utilisation is being maintained at a higher level than reported last year.
>= 90%	



Actions
The Outpatient improvement work continues to focus on clinic templates and utilisation. - Business Groups are reviewing their processes for short notice cancellations and considering how cancelled appointments can be utilised. - A review of the use of 'Bookwise', the room booking system and wider roll out of the two way text reminder service are continuing.

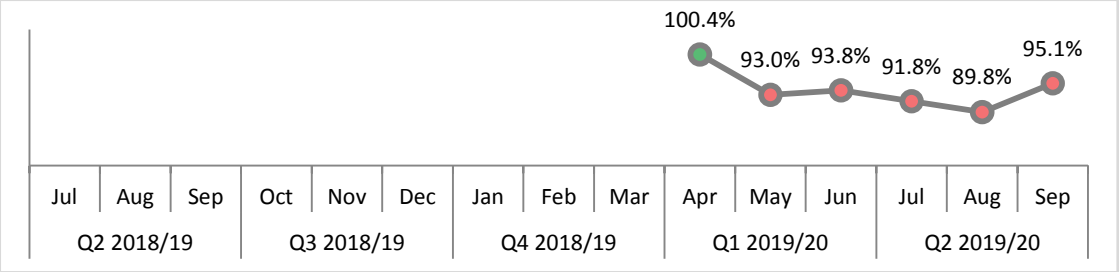
Sep-19	Outpatient New to Follow-up Ratio (UoR)
2.24	The number of outpatient follow-up attendances that took place for every one outpatient new attendance.
Target	The new to follow up ratio increased in month
<= 1.77	



Actions
The continuing work within some specialties to reduce the Outpatient Waiting List (OWL) is having a disproportionate impact on the new to follow up ratio.

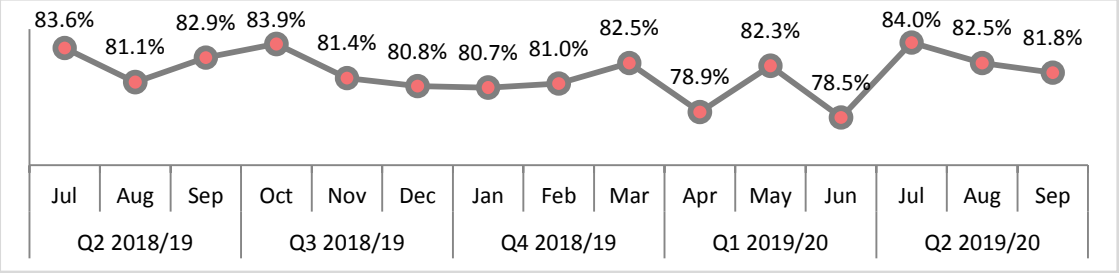
Indicator Detail

Sep-19	Theatres: Delivered Sessions vs. Plan
95.1%	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 delivered just over 95% of all its planned theatre sessions in month.
>= 100%	



Actions
The Business Groups have provided exception reports, with recovery plans, by specialty, for all the theatre metrics. These are currently being reviewed by the Exec team. This metric is closely monitored via a monthly Theatre meeting.

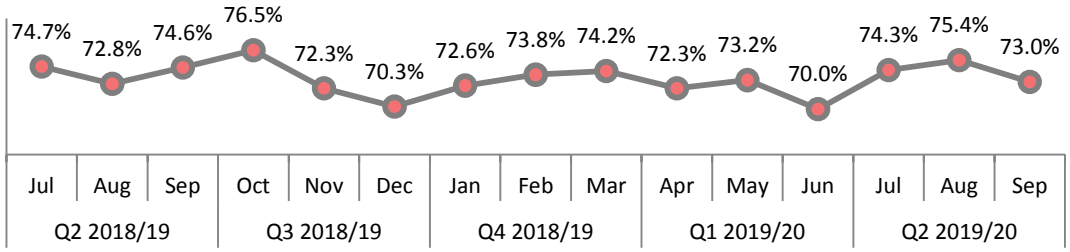
Sep-19	Theatres: Overall Touch-time Utilisation (UoR)
81.8%	The overall time spent operating, calculated as a percentage of the overall planned session time. Touch-time will include any case overlap time and session over-run time. Excludes emergency/trauma sessions, obstetric and endoscopy activity. Planned session time based on delivered sessions only.
Target	Utilisation dipped slightly in month.
>= 85%	



Actions
Theatre efficiency and elective activity is closely monitored via the monthly theatre meetings. Clarity over the specifics of this indicator and whether it aligns to the that used in other GM trusts is under reviewed. The new theatre management information system that is being procured will support better list planning and therefore theatre utilisation.

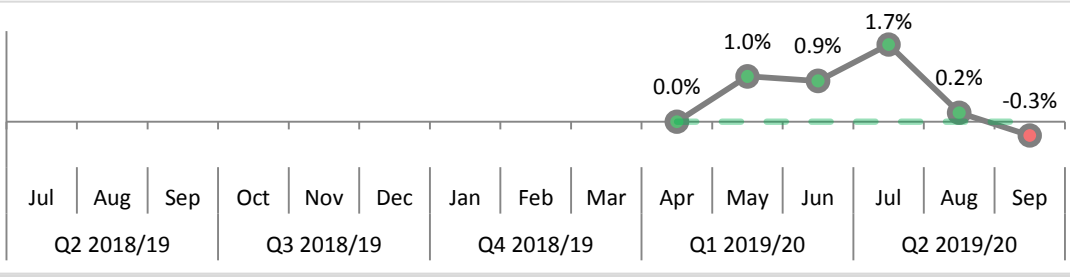
Indicator Detail

Sep-19	Theatres: In-Session Touch-time Utilisation (UoR)
73.0%	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	Performance dipped slightly in month but overall Q2 performance is an improvement of that of Q1
>= 85%	



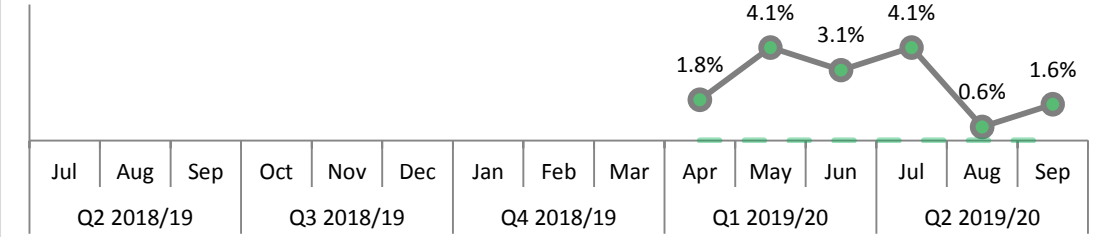
Actions
Monthly monitoring of this indicator is via the monthly theatre meeting. Investigation into the ambiguity between some job plans and theatre start times is on-going.

Sep-19	Elective Day Case Activity vs. Plan
-0.3%	The percentage variance between planned elective day case activity and actual elective day case activity.
Target	Elective day case activity has slipped to below plan in September (-56 spells). The variance for the year to date is -0.3%
>= 0%	



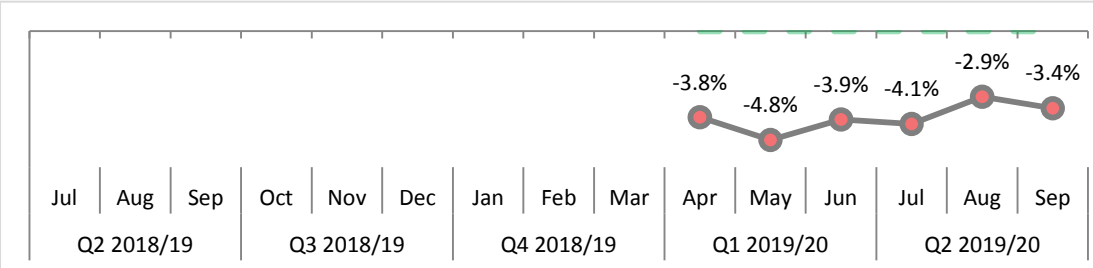
Actions
Extreme pressures within urgent care and unprecedented demand in T&O and surgery experienced at the end of September and in early October resulted in the displacement of some elective work. The full impact of this is not yet known. The Business Groups have provided specialty level recovery plans and trajectories which are currently being evaluated.

Sep-19	Elective Day Case Income vs. Plan
1.6%	The percentage variance between planned elective day case income and actual elective day case income.
Target	In month income from Elective day case activity has slipped but remains ahead of income plan by just under £183k. (YTD variance 1.6% above plan).
>= 0%	



Actions
The afore mentioned pressures experienced in Urgent care and high demand in T&O and surgery that resulted in cancellation of some elective work is yet to be quantified but Business Groups have prepared specialty level recovery plans that are currently being review by the Executive team.

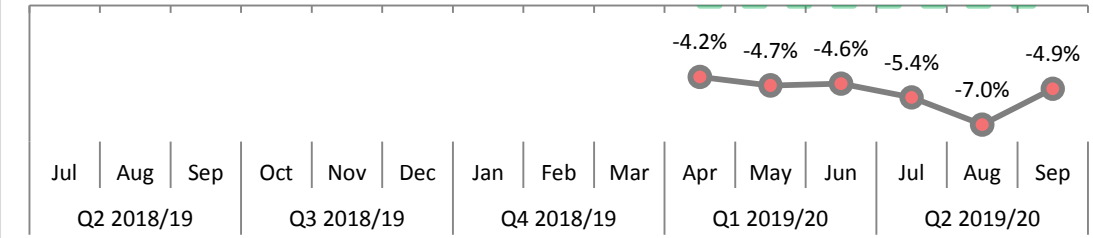
Sep-19	Elective Inpatient Activity vs. Plan
-3.4%	The percentage variance between planned elective inpatient activity and actual elective inpatient activity.
Target	Elective in-patient activity was 101 cases below plan in September, much of which is as a result of low demand in sub-specialty areas of Orthopaedics.
>= 0%	The year to date variance to 3.4% below plan



Actions
BGs have provided reports outlining realistic recovery plans to the end of the financial year which are currently being reviewed by the Executive team.

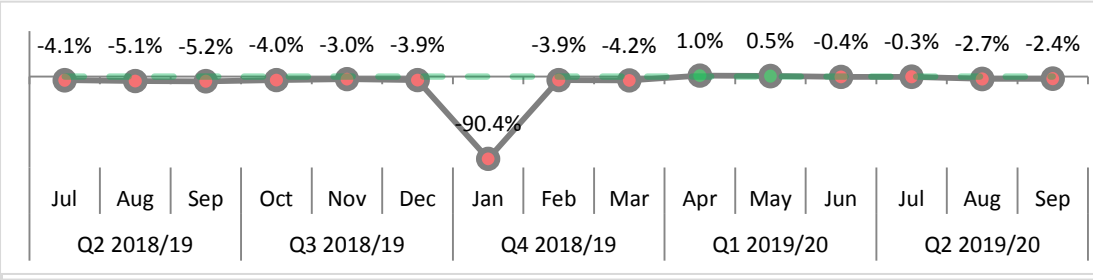
Indicator Detail

Sep-19	Elective Inpatient Income vs. Plan
-4.9%	The percentage variance between planned elective inpatient income and actual elective inpatient income.
Target	Elective in-patient income is behind plan by £0.37m (variance 3.7%) at the end of month 6.
>= 0%	



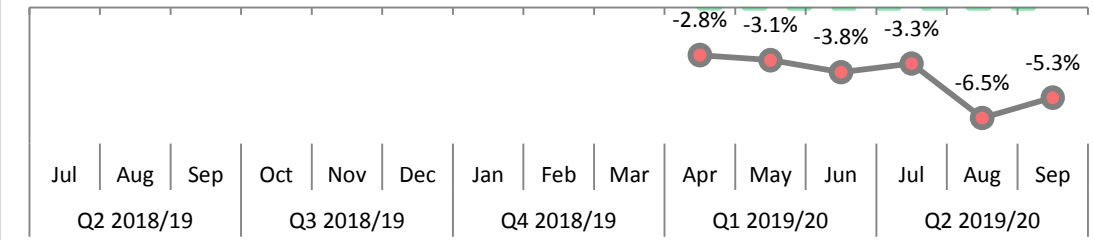
Actions
Extreme pressures within urgent care and unprecedented demand in T&O and surgery experienced at the end of September and in early October have resulted in the displacement of some elective work. The longer term impact on Elective income verses plan is, as yet, not quantifiable.

Sep-19	Outpatient Activity vs. Plan
-2.4%	The percentage variance between planned outpatient activity and actual outpatient activity.
Target	Total out-patient attendances at the end of month 6 are 2,266 behind plan (a variance of -2.4% on plan).
>= 0%	



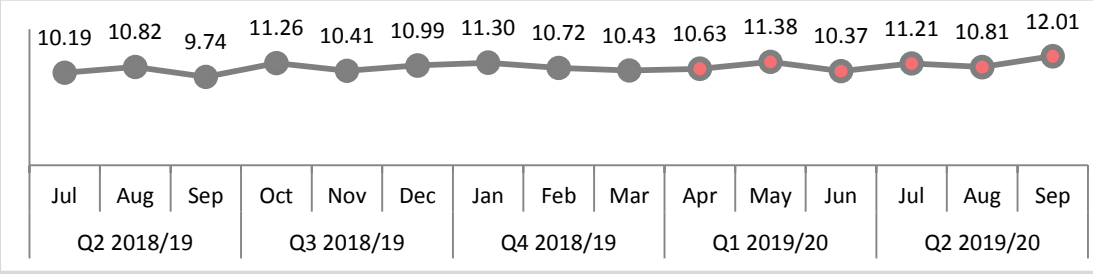
Actions
Capacity and demand are still not aligned in some specialties. Recent intense pressures within urgent care have resulted in the cancellation of some clinics as specialty doctors have been asked to review patients for discharge. The full impact on activity verses plan is yet to be quantified. The Business Groups have provided specialty level recovery plans and trajectories which are currently being evaluated.

Sep-19	Outpatient Income vs. Plan
-5.3%	The percentage variance between planned outpatient income and actual outpatient income.
Target	Out-patient income is just over £1m adverse to plan at the end of September (a variance of -6.2% for the year to date)
>= 0%	



Actions
The Business Groups have provided specialty level recovery plans and trajectories which are currently being evaluated.

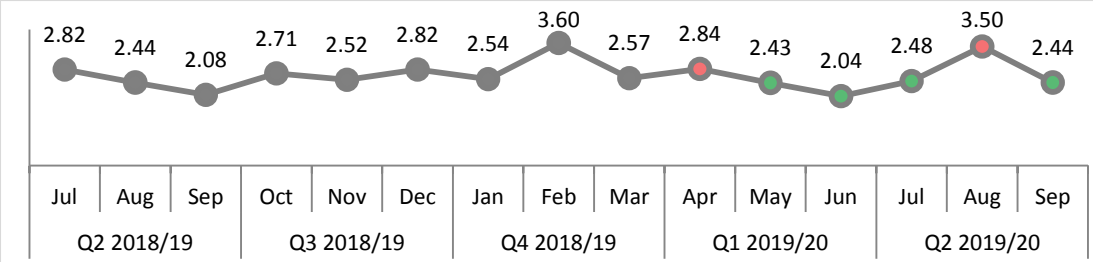
Sep-19	Length of Stay: Non-Elective (UoR)
12.01	The average length of a patient spell, from admission to discharge. Calculated using non-elective admissions only. Excludes Obstetrics/Maternity. Excludes admissions of 0 and 1 days length of stay. Reported by month of discharge.
Target	The average length of patient spell increased in September and is reflective of the increase in length of stay reported for +7 day longer length of stay patients, MOATs and DToCs.
<= 9	



Actions
Improvement actions related to the programme of work on reducing the numbers of longer length of stay patients continue to be worked through.

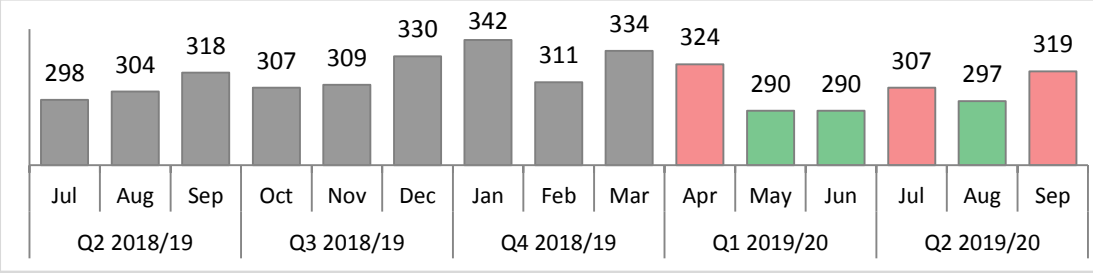
Indicator Detail

Sep-19	Length of Stay: Elective (UoR)
2.44	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	Performance Improved in September and is now within target
<= 2.6	



Actions
Work continues focusing on discharging patients by mid-day; improving use of the discharge lounge and, at ward level, increasing compliance with the SAFER metrics.

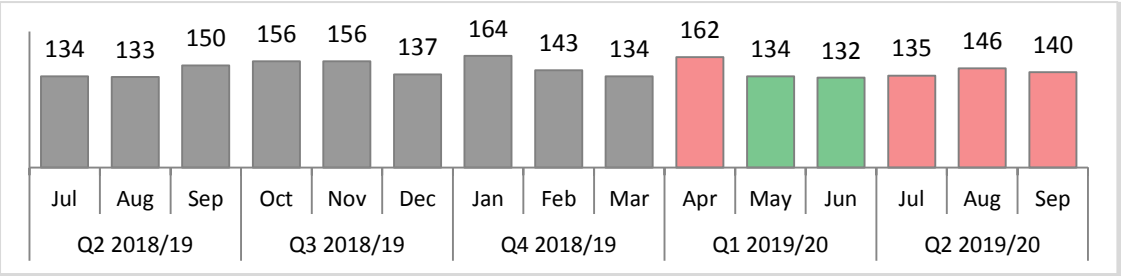
Sep-19	Stranded Patient Count (UoR)
319	The total number of patients with a length of stay of 7 days or more. Performance based on a snapshot taken on the last Monday of the reporting month. Please note: This indicator is measured against an agreed improvement trajectory.
Target	The number of +7 day Longer Length of Stay patients increased in month.
<= 288	



Actions
Improvement actions continue within the ITT with a weekly meeting with ITT Manager/Clinical Nurse Lead for CSC and the Delivery Director. A focus on red to green and 'Home, why not today' across all wards is in place.

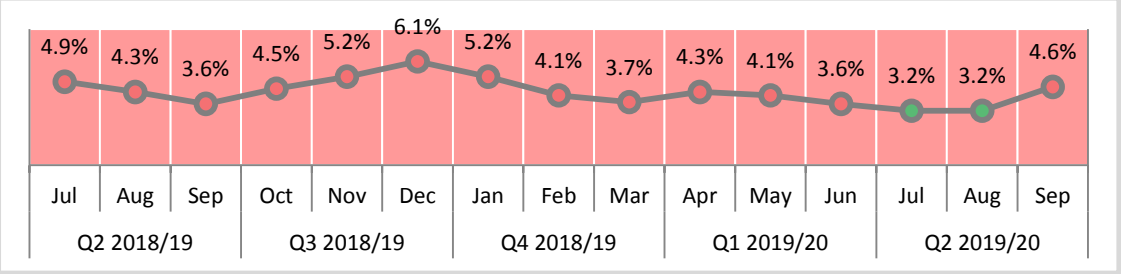
Indicator Detail

Sep-19	Super-Stranded Patient Count (UoR)
140	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	The number of +21 day Longer Length of Stay patients reduced in September but is still above the Trust's agreed trajectory.
<= 113	



Actions
Improvement actions and remedial work continue within the ITT.

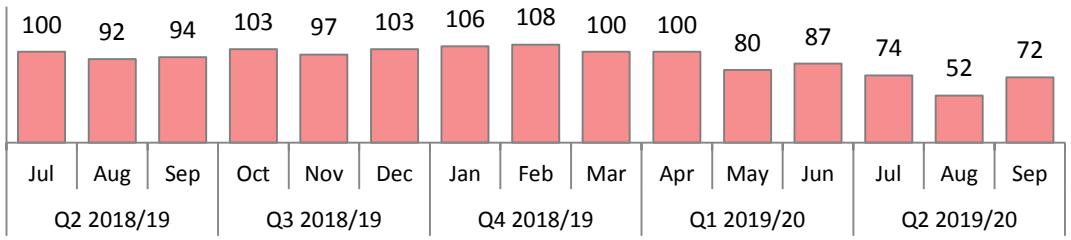
Sep-19	Delayed Transfers of Care (DTOC) (UoR)
4.6%	The percentage of patients that have remained in their hospital bed beyond their transfer of care date. This is an average number calculated using daily snapshot data.
Target	The percentage of patients subject to a delayed transfer of care increased in month.
<= 3.3%	



Actions
The focus on actions identified to reduce longer lengths of stay continues.

Indicator Detail

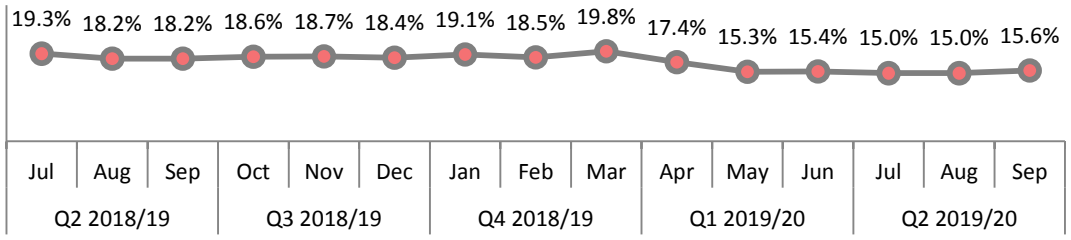
Sep-19	Medical Optimised Awaiting Transfer (MOAT)
72	Total number of patients each day who have been medically optimised. This is an average number calculated using daily snapshot data. 'Medical optimisation' is the point at which care and assessment can safely be continued in a non-acute setting.
Target	The impact o the MADE event held at the end of August was not sustained and the number of MOAT patients increased again in September.
<= 40	



Actions

The Bluebell ward opened as a Transfer to Assess Unit at the end September enabling earlier discharge from an acute bed. Positive early indications are that the desired flow through the unit is being achieved.

Sep-19	Discharges by Midday
15.6%	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	In September there was a slight improvement in performance against this indicator.
>= 33%	



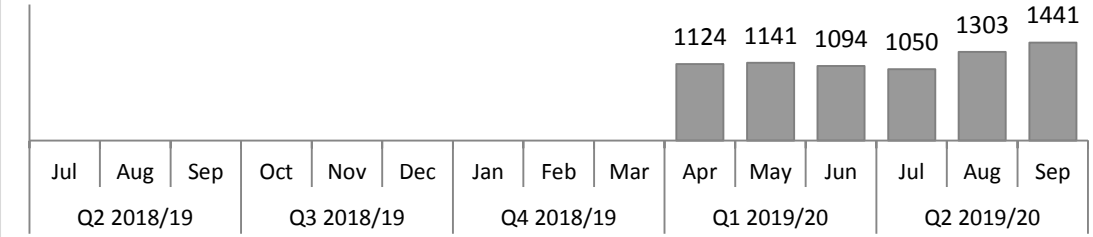
Actions

A focus on reporting and promoting the 'New World Metrics', which includes the discharged by 10 am and mid-day indicators, has seen the dashboard added to the agenda at the BG monthly performance review meetings.

Performance is also reviewed weekly at the 'Start of the Week Performance Wall'.

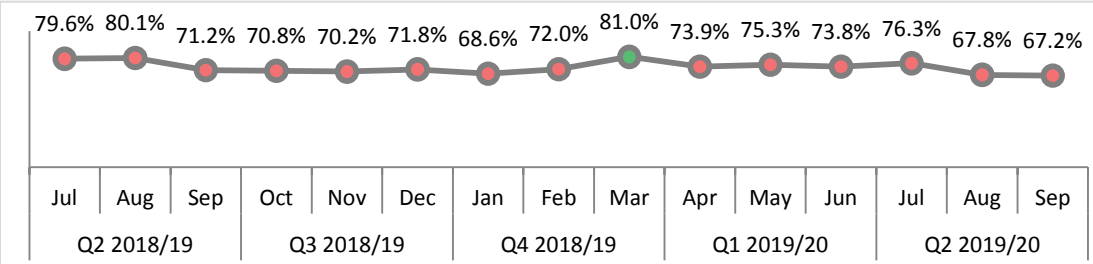
Indicator Detail

Sep-19	A&E: Overnight Breaches
1441	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	The substantial increase in the number of overnight breaches experienced in August continued through September.



Actions
Actions continuing include: - - A renewed focus on red rigour - Earlier discharges from AMU - Having a consultant presence in ED until midnight - Having a sub 1.5hr wait to be seen in ED at evening handover - Waiting room Doctor - Navigator at the front door In addition the Trust are expediting winter ward schemes including the introduction of 'Super Tuesdays'

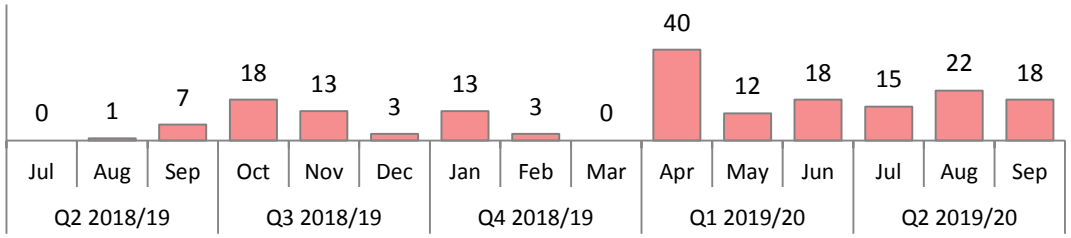
Sep-19	A&E: 4hr Standard
67.2%	The percentage of patients who were admitted, discharged, or leave A&E within 4 hours of their arrival. Please note: This indicator is measured against an agreed improvement trajectory, not the national standard.
Target >= 82%	September's performance against trajectory deteriorated further. ED attendances were particularly high at the end of September but despite slightly improved staffing levels, streaming was compromised and the department was frequently congested as a result of reduced flow and an increasing number of patients' awaiting beds



Actions
A forensic review of processes at night has been undertaken and lessons learned from this and from the 'Perfect Week' initiative w/c 7.10.19 will be shared and actions implemented. Initiatives underway to improve ED performance include; - Improved nurse staffing, as the Trust is actively engaged in International recruitment of registered nursing staff and welcome the first tranche in mid-October; - Commencement of the Ambulatory Majors stream; - As part of the winter plan, introduction of 'Super Tuesdays'.

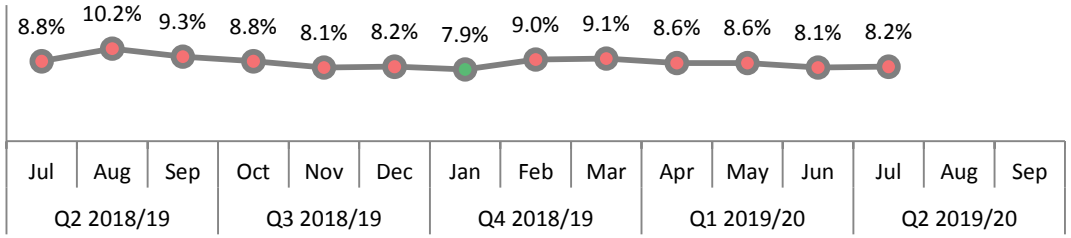
Indicator Detail

Sep-19	A&E: 12hr Trolley Wait
18	Total number of patients whose decision to admit from A&E was over 12 hours from their actual admission.
Target	Following a sustained period of challenging demand, we have continued to see 12 hour trolley breeches in August.
<= 0	



Actions
We have opened escalation beds, activated OPEL 3 at peak times, and have now opened our winter ward on B5. We are currently planning what further escalation can be facilitated later in the winter season.

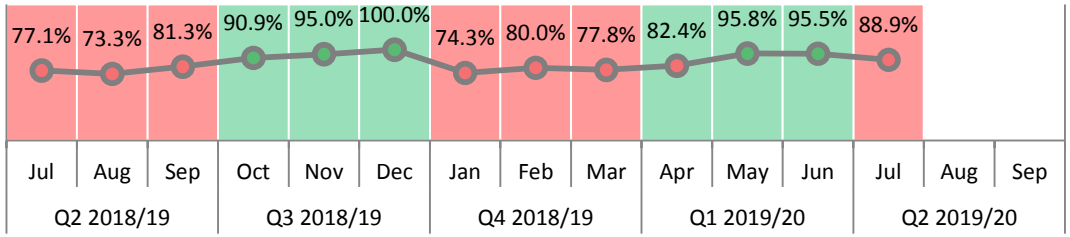
Jul-19	Emergency Readmission Rate (UoR)
8.2%	The percentage of emergency re-admissions within 28 days following an inpatient discharge. This indicator includes admissions for all conditions, and is not restricted to re-admissions for the same condition as the original admission.
Target	
<= 7.9%	



Actions

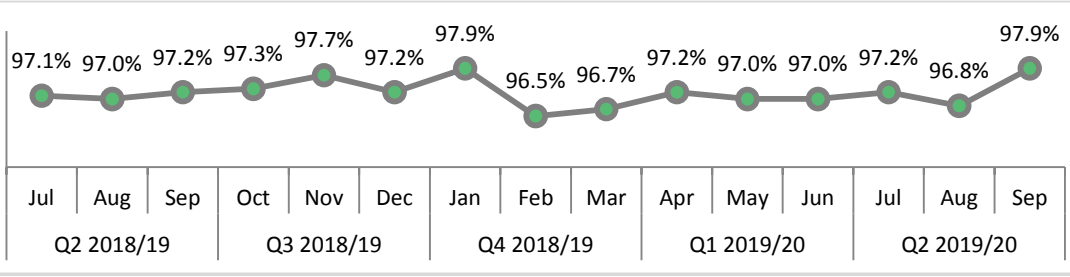
Indicator Detail

Jul-19	Diabetes Reviews
88.9%	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	
>= 90%	



Actions

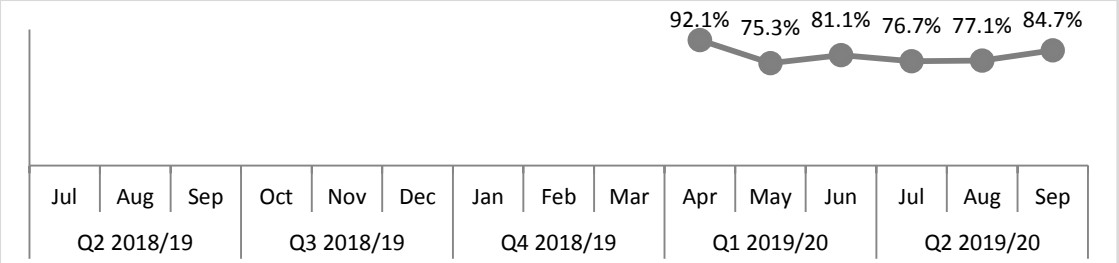
Sep-19	VTE Risk Assessment
97.9%	The percentage of eligible admitted patients who have been given a VTE risk assessment.
Target	
>= 95%	



Actions

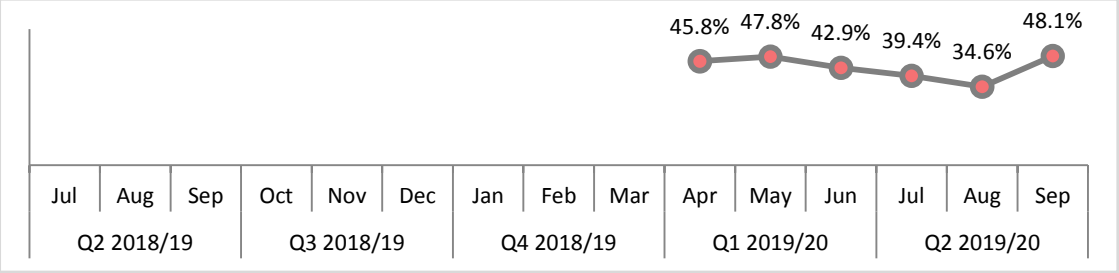
Indicator Detail

Sep-19	Sepsis: Timely Identification
84.7%	The number of patients who are screened for sepsis, as a percentage of all eligible patients who meet the criteria .
Target	Percentage of inpatients that have undergone a sepsis screening - a continued area of focus, with sepsis awareness week helping with this in September.



Actions
During September a total of:- 695 patients triggered on the NEWS2 as a possible sepsis 307 patients (out of the 695) were reviewed by the IP&C service team after the exclusion criteria was applied 273 patients (out of the 307) were escalated by nursing staff to the medical teams for review 260 patients (out of the 307) were reviewed and screened for sepsis by the medical team 27 patients (out of the 307) following review were recording as having sepsis During Q1 & Q2 the data collected has concentrated on Dr review time to antibiotics being given within an hour.

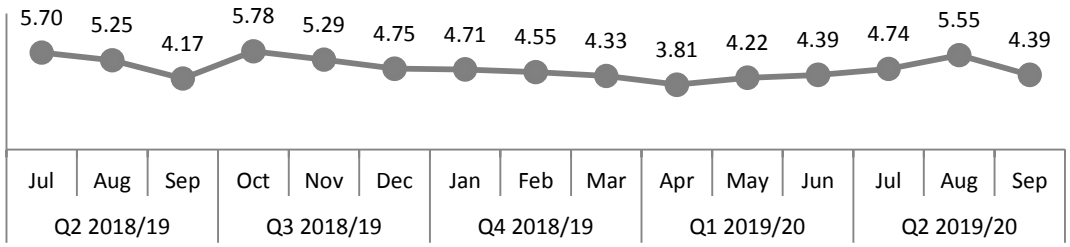
Sep-19	Sepsis: Timely Treatment
48.1%	The number of patients who received IV antibiotics within 1 hour, as a percentage of all eligible patients found to have sepsis.
Target	Percentage of inpatients clinically found to be septic and who received their antibiotics within an hour of the diagnosis
>= 90%	



Actions
NICE guidelines state that if patients meet the high risk criteria (i.e. NEWS2 score 5 or above) they should be reviewed and given antibiotics within an hour. During September:- 13 of the 27 patients were given antibiotics within the hour of diagnosis. 16 of the 27 patients were reviewed within the hour of diagnosis Only 10 of the 27 patients were reviewed and given antibiotics within an hour of diagnosis. During Q1 & Q2 the data collected has concentrated on Dr review time to antibiotics being given within an hour. Going forward the Trust will be following NICE guidance and reporting from the trigger time to Dr review and antibiotics being given within an hour, which is a more challenging target to achieve.

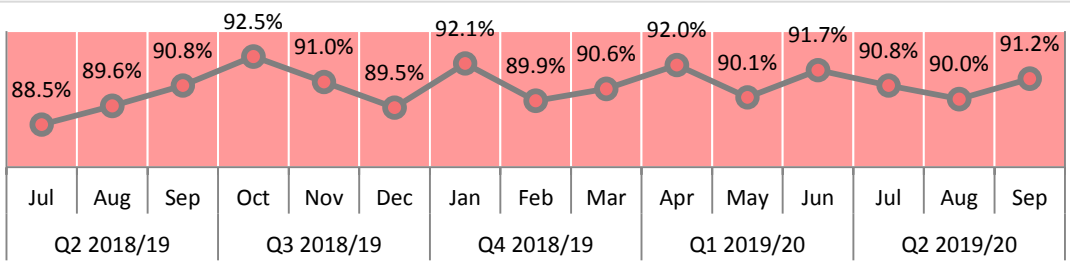
Indicator Detail

Sep-19	Medication Errors: Rate
4.39	Rate of medication errors, calculated as incidence per 1000 bed days.
Target	In September the medication incident rate decreased from 5.5 to 4.39 incidents per 1000 bed days. No medication incidents causing moderate harm or above, were reported for the month of September.



Actions
Medication errors are reviewed weekly at the patient safety summit meeting. Reminders about specific medication errors have been circulated via the Patient Safety Summit updates during September. These include; Reminding staff about the issue of extravasation (fluid infused into a cannula which is no longer sitting in a vein, but in the tissues) - and the importance of removing cannulas in a timely fashion. A reminder that Total Parental Nutrition (TPN) expires after 24 hours. Therefore a bag is only safe for 24 hours and anything left after that time period should be discarded.

Sep-19	Discharge Summaries
91.2%	The percentage of discharge summaries published within 48hrs of patient discharge.
Target	
>= 95%	

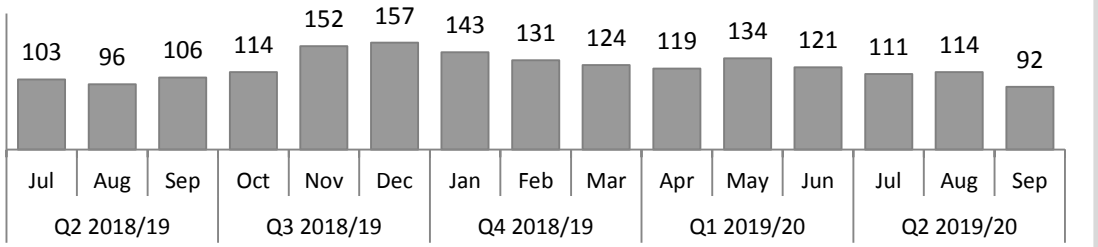


Actions
A continued focus at performance reviews.

Indicator Detail

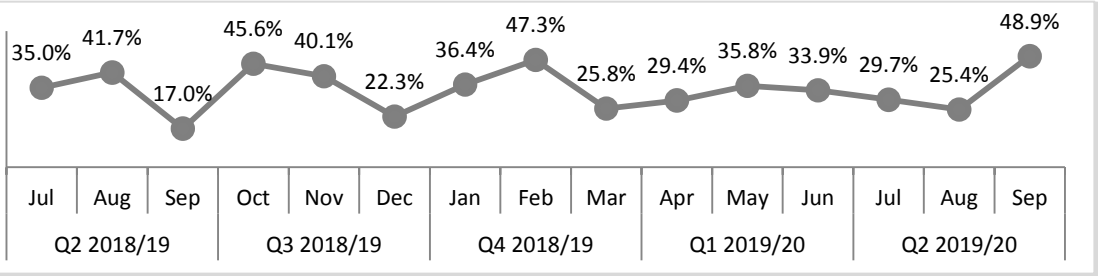
Sep-19	Mortality: Deaths in ED or as Inpatient
92	Total number of patient deaths while patient was in the emergency department or as an inpatient.
Target	In September the number of deaths that occurred in the emergency department or as an inpatients was much lower than previous months.

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



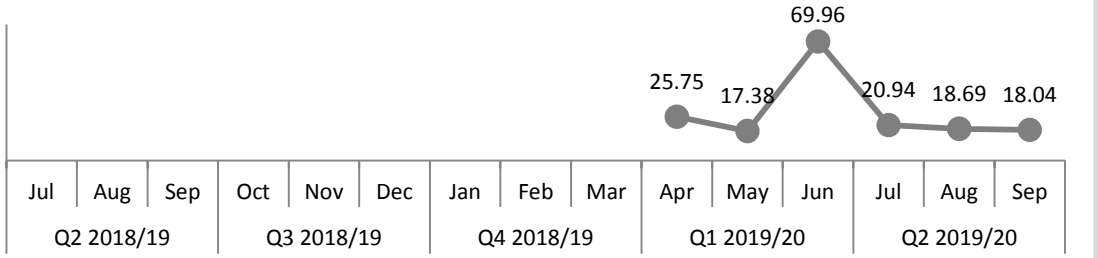
Sep-19	Mortality: Case Note Review Rate
48.9%	The number of case note reviews that taking place in month, as a percentage of all patient deaths while patient was in the emergency department or as an inpatient.
Target	In September, a case note review was undertaken in 48.9% of deaths.

Actions
Learning form the case note reviews is shared widely through out the organisation.



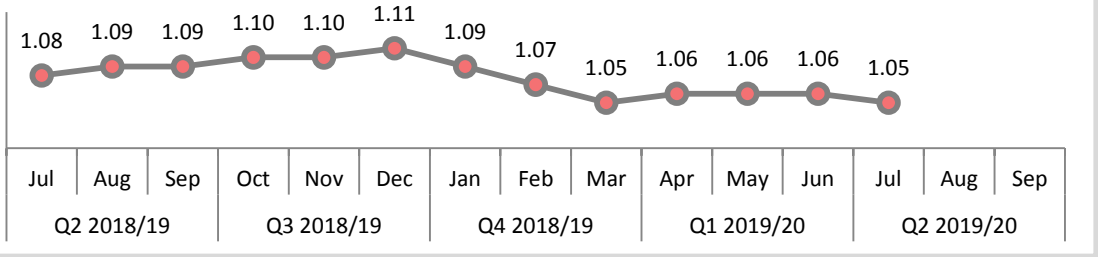
Indicator Detail

Sep-19	Mortality: Specialist Palliative Care Length of Stay
18.04	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	The average length of spell for specialist palliative patients who dies in hospital has reduced for the fourth month.



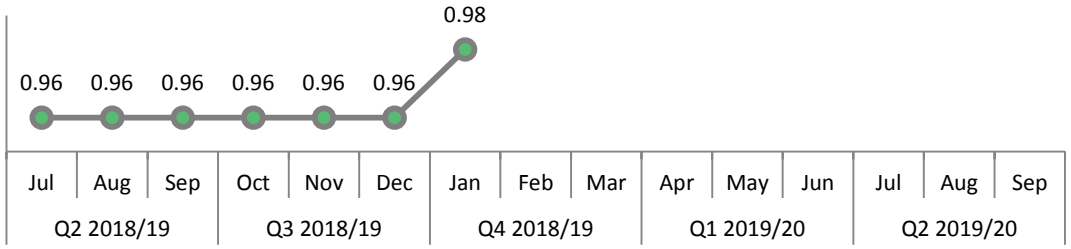
Actions
Work continues to support patient choice.

Jul-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	Sustained improvement
<= 1	



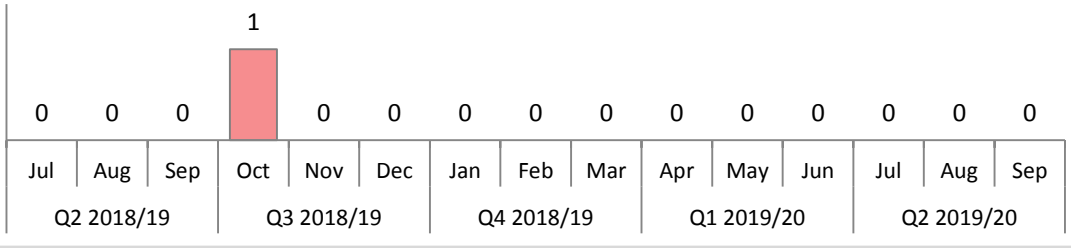
Actions
Development of a mortality dashboard to be presented quarterly at quality committee, and annually at board.

Jan-19	Mortality: SHMI
0.98	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 average mortality index.
<= 1	



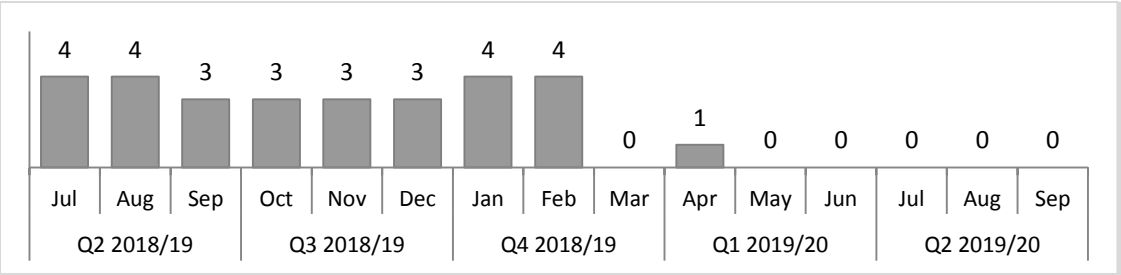
Actions

Sep-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	There were no never events recorded in September.
<= 0	



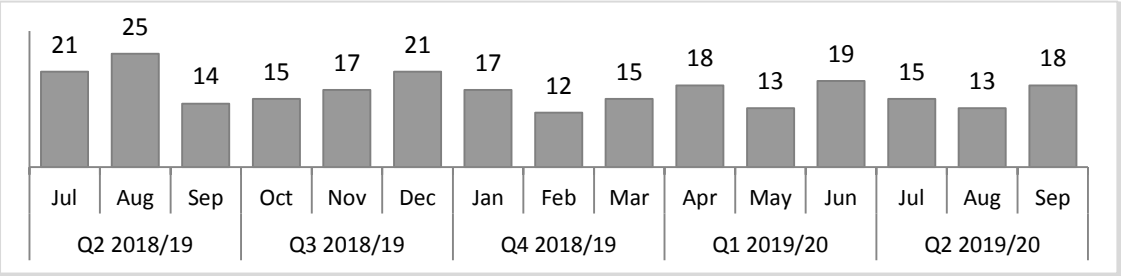
Actions
The last never event in the organisation occurred in October 2018.

Sep-19	Duty of Candour Breaches
0	Total number of duty of candour breaches of regulation in month.
Target	There were no Duty of Candour breaches in Spetember.



Actions
Opening of Duty of Candour is monitored on a weekly basis. Timeliness of the opening conversation and the written apology has improved.

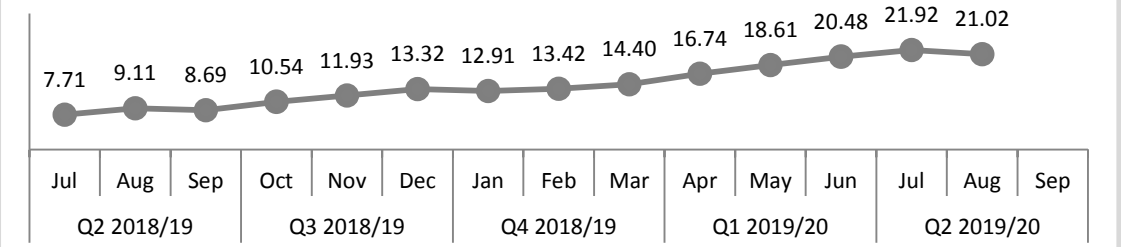
Sep-19	Serious Incidents: STEIS Reportable
18	The total number of STEIS reportable incidents.
Target	There were 18 serious incidents reported via StEIS during September 2019.



Actions
There were 10 instances where patients waited more than 12 hours in the emergency department and met the criteria for a 12 hour trolley wait. There were 6 category 3 pressure ulcer incidents. There were 2 instances where the delivery suite in maternity was placed on divert.

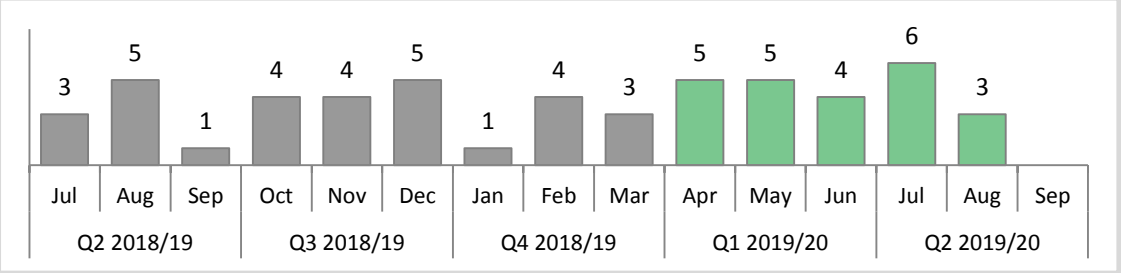
Indicator Detail

Aug-19	C.Diff Infection Rate
21.02	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 12 month 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 gradual increase in cases over the past few years, David Charlesworth from NHS improvement has been invited to visit the Trust on 17th October 2019. David will be meeting key stakeholders across the Trust offering guidance, support and ideas to assist in reducing our rates.

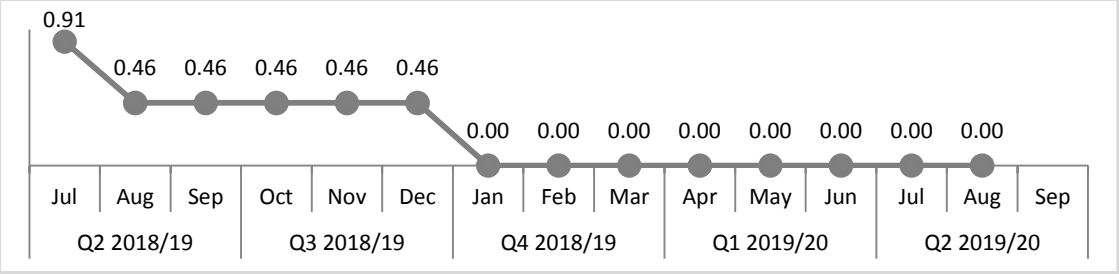
Aug-19	C.Diff Infection Count
3	Total number of C.Diff infections.
Target	The 2019-20 target set by the Department of Health for hospital acquired Clostridium difficile toxin positive cases is 51
<= 51 *	



Actions
During August there were 3 cases of Clostridium difficile Each CDI case is listed for the Healthcare Acquired Infections (HCAI's) panel chaired by the Director of Infection Prevention & Control (DIPC) immediately the case is confirmed. At present, each CDI case is being investigated and presented to the HCAI panel within 4 weeks, with the aim of reducing this to 2 weeks by the end of September

Indicator Detail

Aug-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

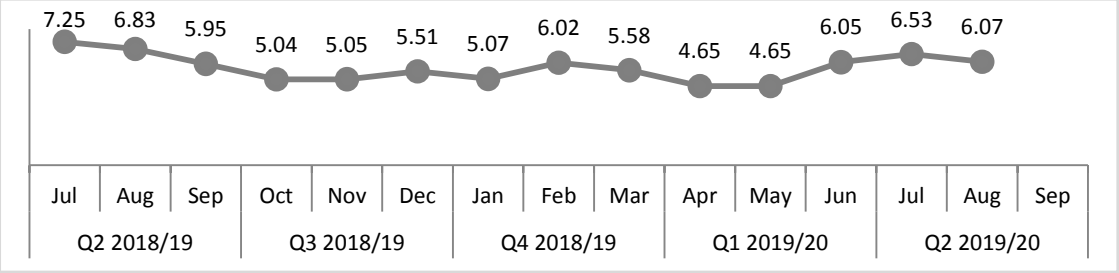


Actions

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

The target is monitored through the infection prevention & control group

Aug-19	MSSA Infection Rate
6.07	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. The figures represented within this report are Trust acquired cases

This is monitored through the Infection prevention & control group

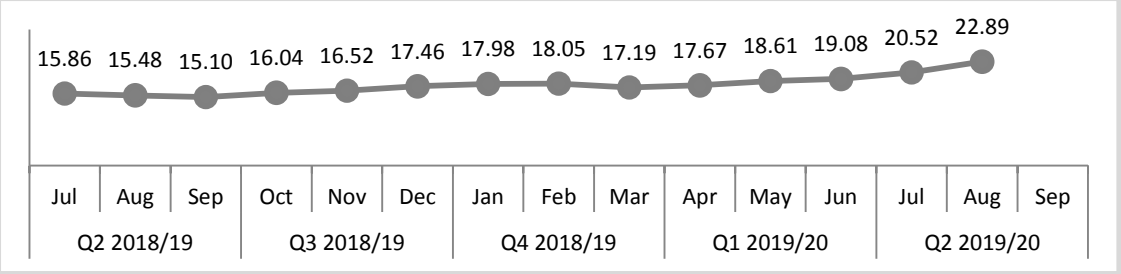
Following consultation, the CCG have agreed a target tolerance of 12 for the Trust in relation to MSSA infections. To meet this target the Trust needs = 3 per quarter; during quarter two there have so far been 1 MSSA infections

Concurrent to this agreement is the development of a pro-forma to undertake concise investigations which will be heard during the bi-weekly HCAI Panels from Q3.

Indicator Detail

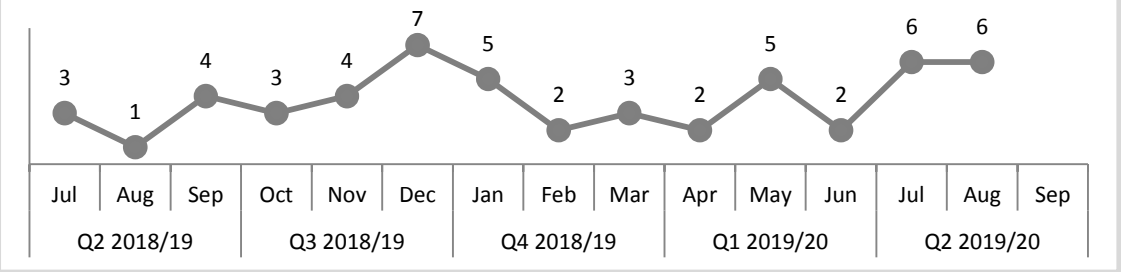
Aug-19	E.Coli Infection Rate
22.89	Average number of E.Coli infections for every 100,000 bed days, calculated using a rolling 12 month number of Trust-attributable E.Coli infections compared to the rolling 12 month average number of bed days per 100,000.
Target	Rolling 12-month count of all E. coli infections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



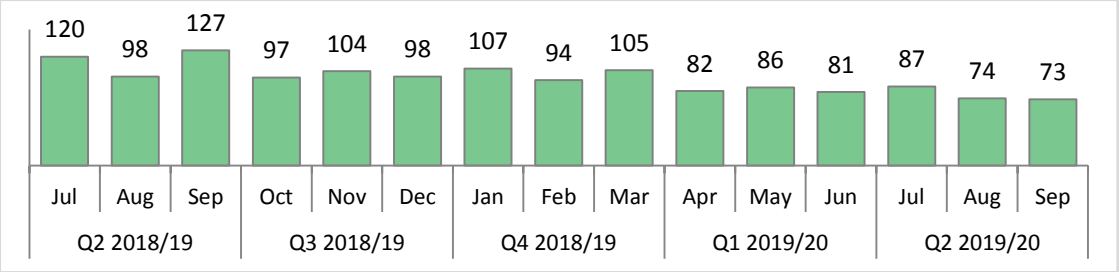
Aug-19	E.Coli Infection Count
6	Total number of E.Coli infections.
Target	The E Coli infection count is monitored as a whole health economy with no target. The figures represented within this report are trust acquired cases

Actions
This is monitored through the Infection prevention & control group Following consultation, the CCG have agreed a target tolerance of 36 for the Trust in relation to E-coli infections. To meet this target the Trust needs = 9 per quarter; during quarter two there have been so far 12 E-coli infections The development of a pro-forma to undertake concise investigations will be heard during the bi-weekly HCAI Panels from Q3.



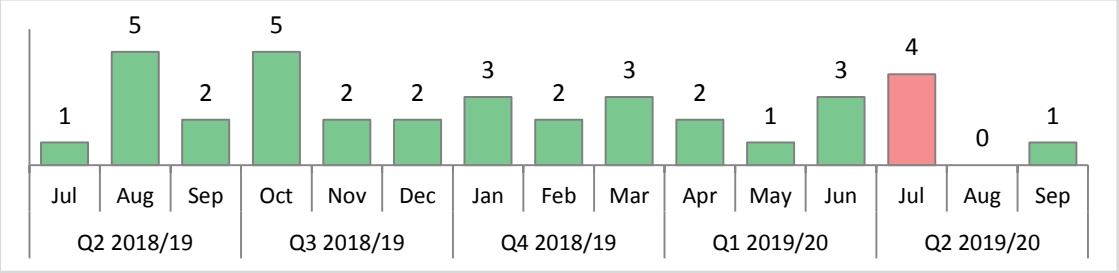
Indicator Detail

Sep-19	Falls: Total Incidence of Inpatient Falls
73	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.
<= 550 *	This will be < 1100



Actions
There have been a total of 73 in-patient falls during the month. 73 falls is the lowest monthly total number of falls this year to date. Sept 19 again continues the trend noted since December 18 with a month on month reduction in comparative data from the previous year (Sept 18- 105 falls; Sept 19 - 73 falls equating to a 43% reduction). Running total for the year to date is 483 New falls risk assessment devised and approved, awaiting publication and delivery to wards. There has been a slight delay with printing and the new paperwork is expected on the ward in early October 19.

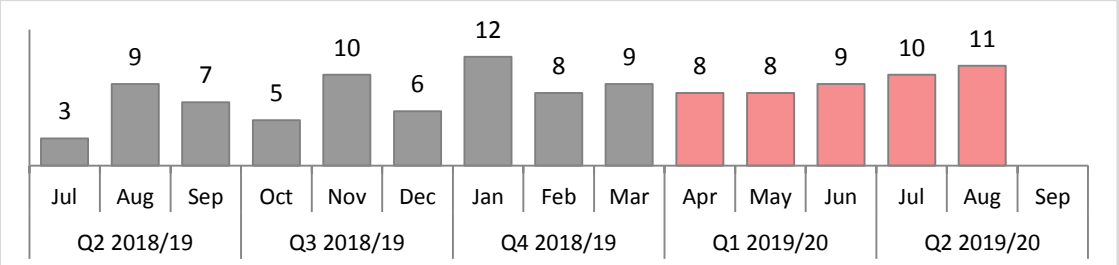
Sep-19	Falls: Causing Moderate Harm and Above
1	Total number of falls causing moderate harm and above.
Target	The Trust has set a target of 10% reduction of in-patient falls resulting in moderate or above harm level for 2019/20 in comparison to 2018/19.
<= 13 *	This will be <26 falls with harm.



Actions
There has been 1 fall in month resulting in moderate or above harm. This fall was within the Surgery, GI and Critical Care BG and is currently being investigated; this resulted in fractured ribs. Running total for the year to date is 11 The Trust achieved 47 days fracture free between July and Sept 19

Indicator Detail

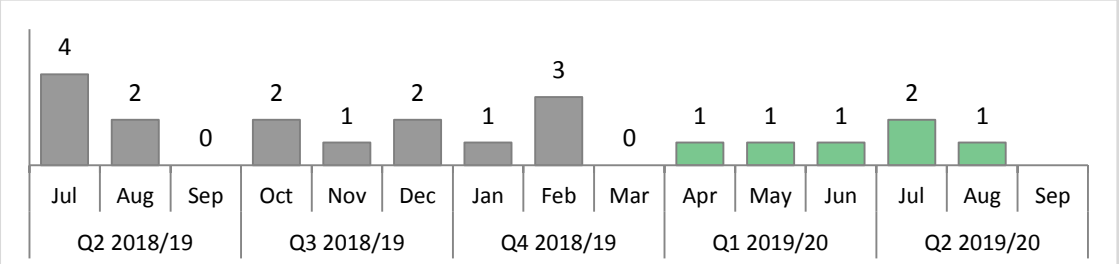
Aug-19	Pressure Ulcers: Hospital, Category 2
11	Total number of category 2 pressure ulcers in a hospital setting.
Target	The Trust has set a target to reduce the overall number of Hospital acquired pressure ulcers (p u) by 10% over the next 12 months. This month (August data) we have had 11 Category 2 PU reported in the hospital.
<= 38 *	



Actions

Approximately 50% of all of the hospital PU reported this year to date, have occurred in 4 clinical areas across medicine, orthopaedics and integrated care acute Business Groups. Therefore meetings with the relevant ward manager, Matron and Tissue Viability are in the process of being scheduled to undertake a 'Deep Dive' of these specific incidents and identify the key trends that we need to learn from.

Aug-19	Pressure Ulcers: Hospital, Category 3
1	Total number of category 3 pressure ulcers in a hospital setting.
Target	work The Trust has set a target to reduce the overall number of Hospital acquired pressure ulcers (p u) by 10% over the next 12 months. This month (August data) we have had one Category 3 PU reported in the hospital.
<= 9 *	

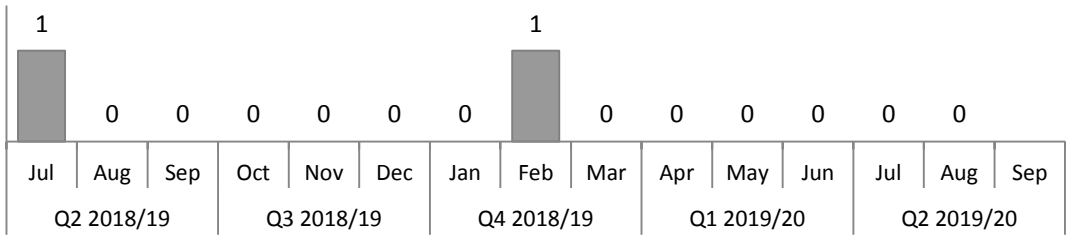


Actions

Work resulting from the PU collaborative that took place in June is ongoing.

Indicator Detail

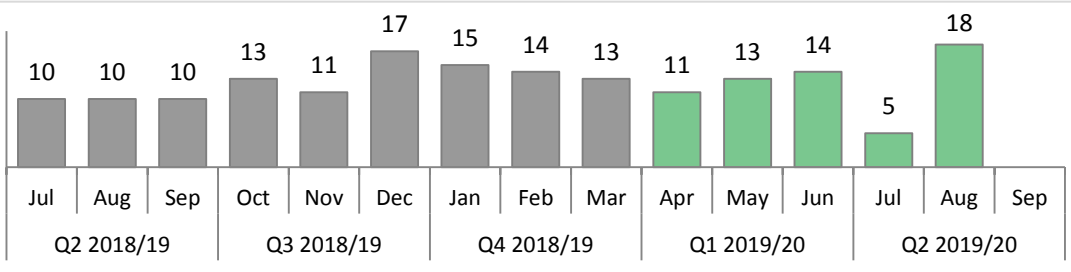
Aug-19	Pressure Ulcers: Hospital, Category 4
0	Total number of category 4 pressure ulcers in a hospital setting.
Target	The Trust has set a target to reduce the overall number of Hospital acquired pressure ulcers (p u) by 10% over the next 12 months. This month (August data) we have had no category 4 PU reported in the hospital
<= 1 *	



Actions

Work resulting from the PU collaborative that took place in June is ongoing.

Aug-19	Pressure Ulcers: Community, Category 2
18	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 pressure ulcers (p u) by 10% over the next 12 months. This month (August data) we have had 18 Category 2 PU reported in the community
<= 80 *	

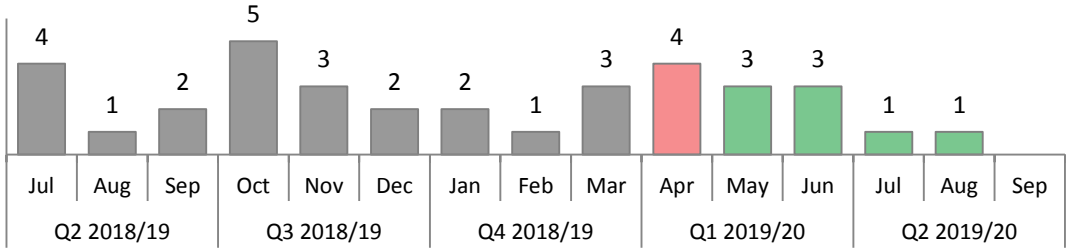


Actions

Work resulting from the PU collaborative that took place in June is ongoing.

Indicator Detail

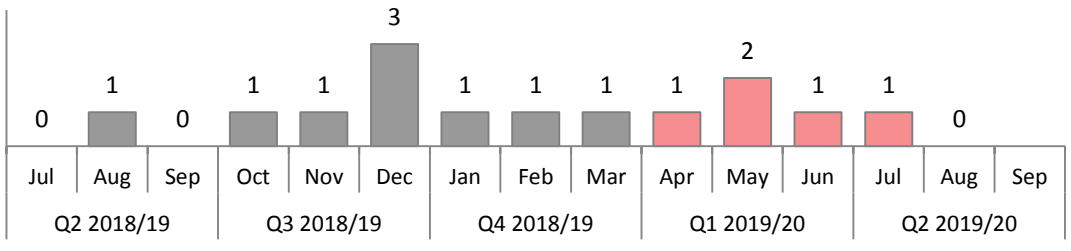
Aug-19	Pressure Ulcers: Community, Category 3
1	Total number of category 3 pressure ulcers in a community setting.
Target	The Trust has set a target to reduce the overall number of community acquired pressure ulcers (p u) by 10% over the next 12 months. This month (August data) we have had 1 Category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



Actions

Work resulting from the PU collaborative that took place in June is ongoing.

Aug-19	Pressure Ulcers: Community, Category 4
0	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 pressure ulcers (p u) by 10% over the next 12 months. This month (August data) we have had no category 4 pu reported in the community.
<= 3 *	



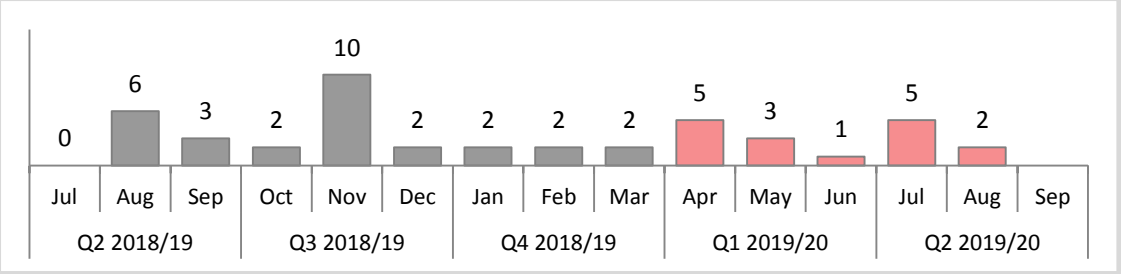
Actions

There has been no category 4 PU reported this month.
However we are currently over trajectory for category 4 pressure ulcers in the community.

The Equipment T&F group that has been established as part of the Pressure Ulcer Collaborative has identified that achieving a minimum standard of 6 hourly repositioning can be a challenge when caring for patients with very complex needs, who are at very high risk of pressure ulcer development, and are living at home alone with the support of packages of care. To help address this issue the Trust is, in partnership with Social Service colleagues, clinically evaluating a turning platform that can be used in conjunction with high risk dynamic mattresses

Indicator Detail

Aug-19	Pressure Ulcers: Device Related, Category 2
2	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 (August data) there have been 2 Category 2 medical device related pressure ulcer that have occurred.
<= 13 *	



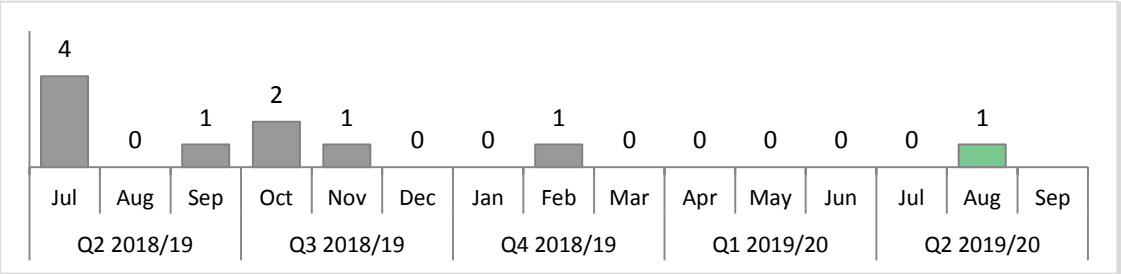
Actions

The Integrated Care and Medicine Business Groups are both exceeding their threshold for this key performance indicator.

Application of Aircast Boots (ACB) are the singular most frequent device that is contributing to the development of MDRPU followed closely by application of POP, and relate to almost 50% of all MDRPU reported.

A Medical Device T&F group has been established. They are devising a risk assessment tool to be completed prior to application of ACBs and reviewing competency training.

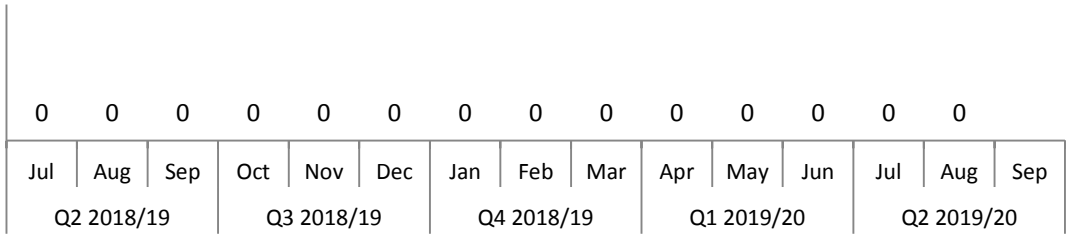
Aug-19	Pressure Ulcers: Device Related, Category 3
1	Total number of device-related category 3 pressure ulcers. Includes those from both a hospital and community setting.
Target	The Trust has set a target to reduce medical device related pressure ulcers (MDRPU) by 25% by the end of March 2020. This month (August data) there has been 1 Category 3 medical device related pressure ulcer reported.
<= 3 *	



Actions

Work resulting from the Medical Device task and finish group is ongoing.

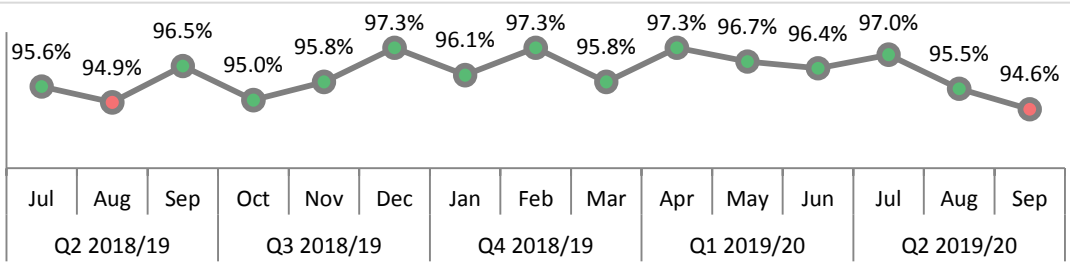
Aug-19	Pressure Ulcers: Device Related, Category 4
0	Total number of device-related category 4 pressure ulcers. Includes those from both a hospital and community setting.
Target	There have been no category 4 medical device related pressure ulcers reported in month.
<= 0 *	



Actions

Implementation of actions identified by the medical devices task and finish group are on-going.

Sep-19	Safety Thermometer: Hospital
94.6%	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 September show that we have achieved 94.6%.
>= 95%	



Actions

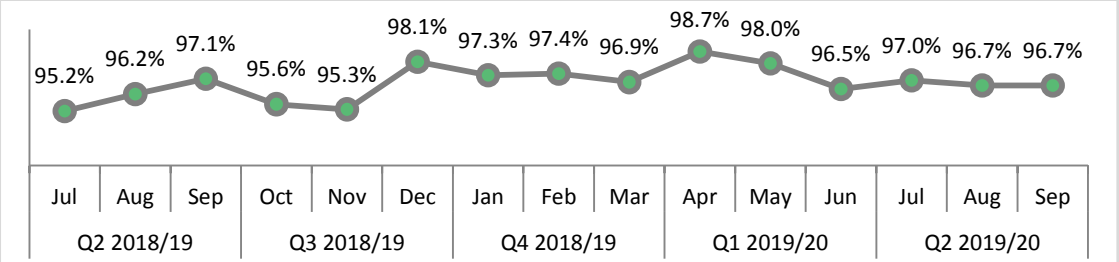
Weekly validation meetings continue to be undertaken to improve the quality of the data.

The Matron for Patient Experience and the Informatics Team are working together to create the new solution in-house audit tool.

The Quality Metrics, which incorporate incidents of Falls and Pressure Ulcers, are now being monitored by the Senior team on a weekly basis and are fed back through the Business Group Quality boards.

Indicator Detail

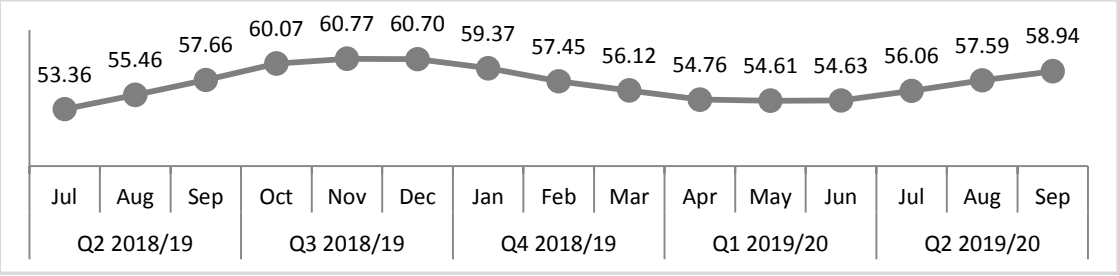
Sep-19	Safety Thermometer: Community
96.7%	The percentage of patients receiving harm-free care, calculated using a point prevelance sample based on falls, pressure ulcers, UTIs and VTE assessments.
Target	The Trust aim is that greater than 95% of patients receive harm free care as monitored by safety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



Actions

No actions required.

Sep-19	Patient Safety Incident Rate
58.94	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 increased slightly from 57.59 to 58.94. This is the fourth month in a row where the rate has increased. This is indicative of an improving safety culture.



Actions

Each week, following the patient safety summit, an update is circulated to all staff. Key themes this month have been;

Safe feeding - ensuring the right diet is for the right patient

Use of abbreviations in notes/patient documents

Communication - between teams and accurate handovers at shift/team changes

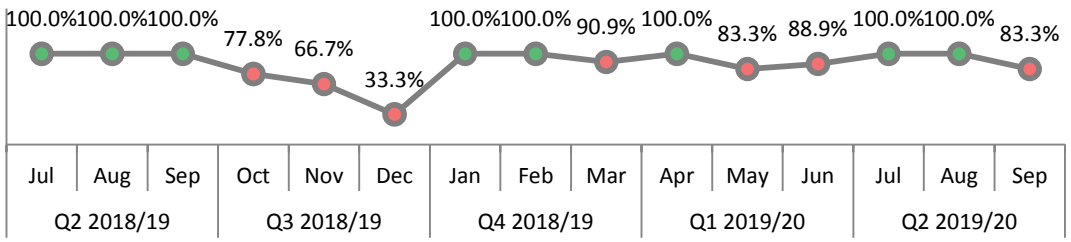
Common themes around the transfer of patients

transfer of care between specialties,
communication,
timing of moves,
giving medication

A reminder regarding the Missing and absconding patient policy

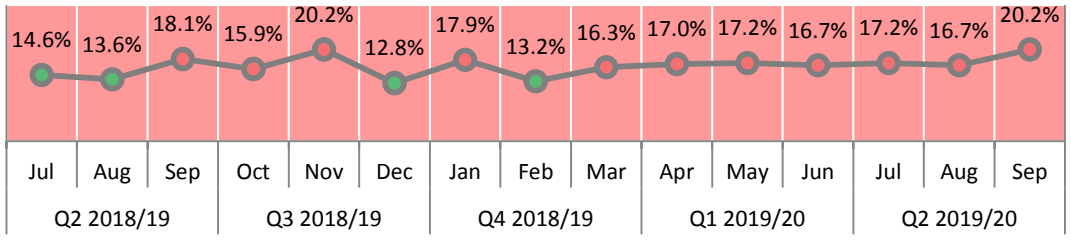
Indicator Detail

Sep-19	Patient Safety Alerts: Completion
83.3%	The percentage of Patient Safety Alerts that are completed within their due date.
Target	There were 7 alerts completed in the month of September. There was one alert that was not completed within the timescales; 'Anti-ligature' type curtain rail systems: Risks from incorrect installation or modification.
>= 100%	



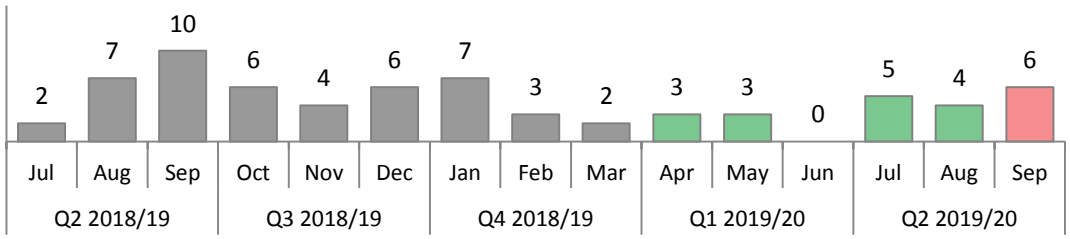
Actions
Work continues within the facilities team to ensure that the outstanding alert can be signed off in October 2019. One alert remains outstanding for May 2019 NHS/PSA/RE/2018/007 Management Of Life Threatening Bleeds From Arteriovenous Fistulae And Grafts. Information is available on the microsite and topic has been discussed at huddles. Currently awaiting further information from the regional transplant unit to incorporate as they are updating their policy and guidance. A new SOP has been drafted and is awaiting Quality Board approval. The 7 alerts completed in the month of September 2019: 3 Drug Alerts (EL) / (INC) 2 Medical Device Alert (MDA) 1 Field Safety Notice (FSN) 1 Supply Disruption Alert (SDA)

Sep-19	Emergency C-Section Rate
20.2%	The number of patients having an emergency c-section, as a percentage of all patients having registerable births.
Target	An increase in the percentage of women undergoing emergency caesarean section was noted in September to 20.2%.
<= 15.4%	



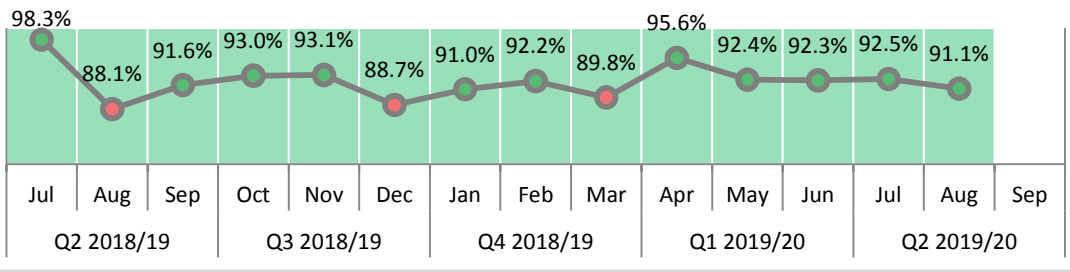
Actions
The emergency caesarean section rate needs to be taken into account alongside the increased complexities of women giving birth e.g. raised BMI and over aged 40 years compared to a few years ago as these women have a higher risk of emergency caesarean section and therefore as our percentage of these women increases, so will our emergency caesarean section rate. The emergency caesarean section rate is monitored closely within the business group and also at the Greater Manchester and East Cheshire strategic clinical network.

Sep-19	Term Babies Admitted to the Neonatal Unit
6	Number of term babies (greater than or equal to 37 weeks) admitted to SCBU/NICU, at birth, unexpectedly.
Target	In September, there were 6 babies admitted to the neonatal unit , which is an increase from August data of 4 and above our target of 5.
<= 5	



Actions
The business group will monitor the number of unexpected admissions of babies to the neonatal unit.

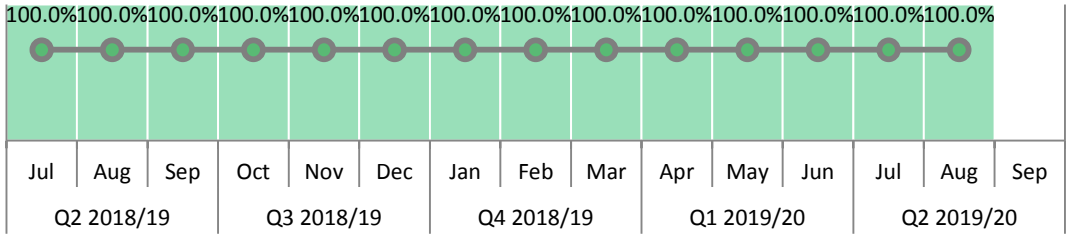
Aug-19	Dementia: Finding Question
91.1%	The percentage of eligible patients who have a diagnosis of dementia or delirium or to whom case finding is applied.
Target	The target has been achieved in month.
>= 90%	



Actions
No actions required.

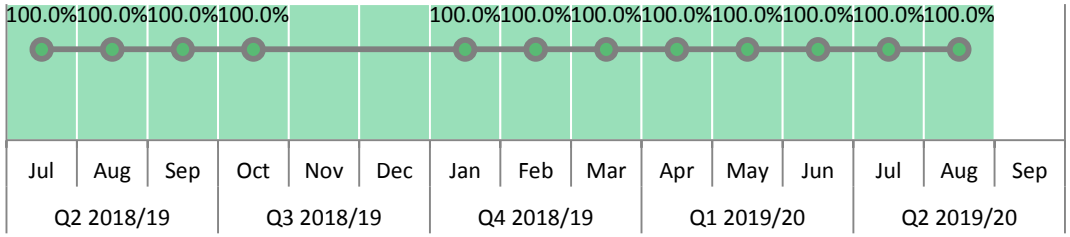
Indicator Detail

Aug-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.

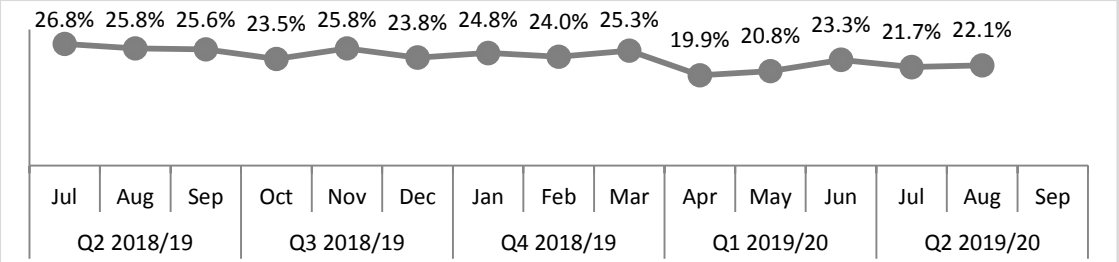
Aug-19	Dementia: Referral
100.0%	The percentage of eligible patients where the outcome was positive or inconclusive, are referred on to specialist services.
Target	The target has been achieved in month.
>= 90%	



Actions
No actions required.

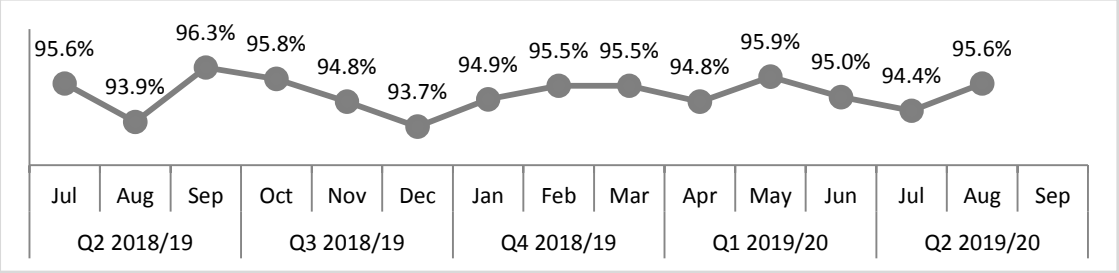
Indicator Detail

Aug-19	Friends & Family Test: Response Rate
22.1%	The percentage of eligible patients completing an FFT survey.
Target	The percentage of 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.

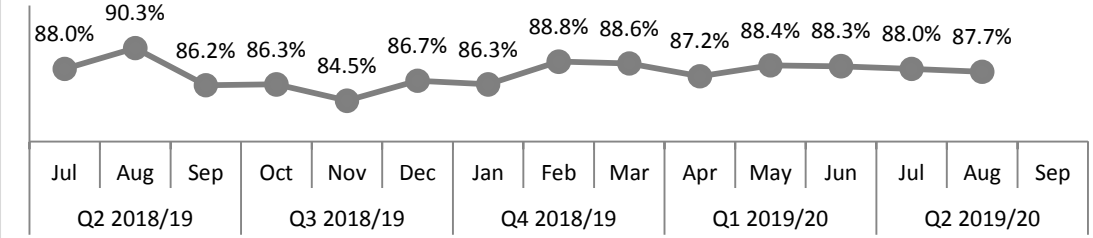
Aug-19	Friends & Family Test: Inpatient
95.6%	The percentage of surveyed inpatients who are extremely likey or likely to recommend the Trust for care.
Target	The percentage of surveyed inpatients who are extremely likely or likely to recommend the Trust for Care.



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 Patient Experience Action Group monitor results on a monthly basis which feeds into the bi-monthly Patient Experience Group.

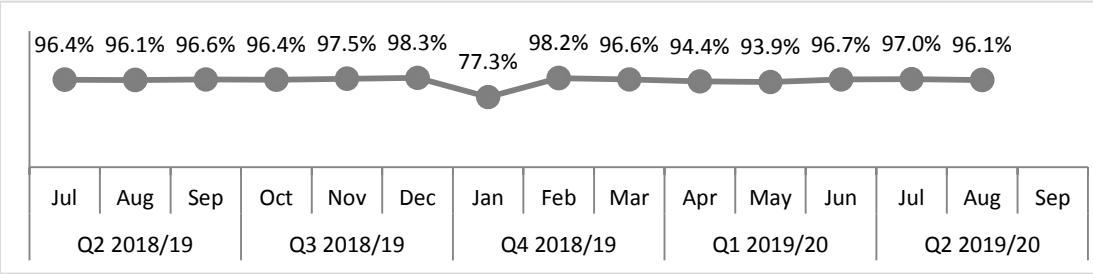
Indicator Detail

Aug-19	Friends & Family Test: A&E
87.7%	The percentage of surveyed A&E patients who are extremely likey or likely to recommend the Trust for care.
Target	The percentage of surveyed patients 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 Patient Experience Action Group monitor results on a monthly basis which feeds into the bi-monthly Patient Experience Group.

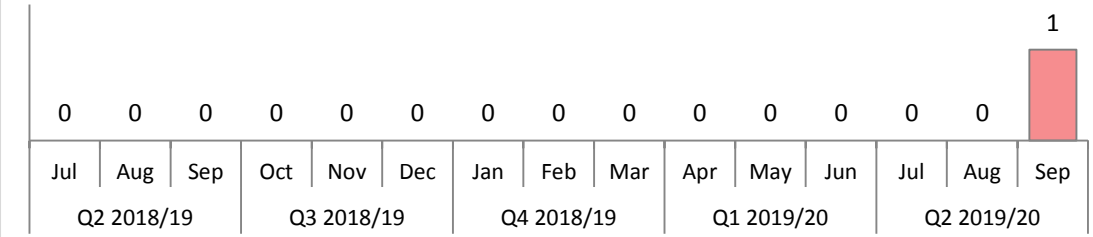
Aug-19	Friends & Family Test: Maternity
96.1%	The percentage of surveyed maternity patients who are extremely likey or likely to recommend the Trust for care.
Target	The percentage of surveyed patients who are extremely likely or likely to recommend the Trust for Care.



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 Patient Experience Action Group monitor results on a monthly basis which feeds into the bi-monthly Patient Experience Group.

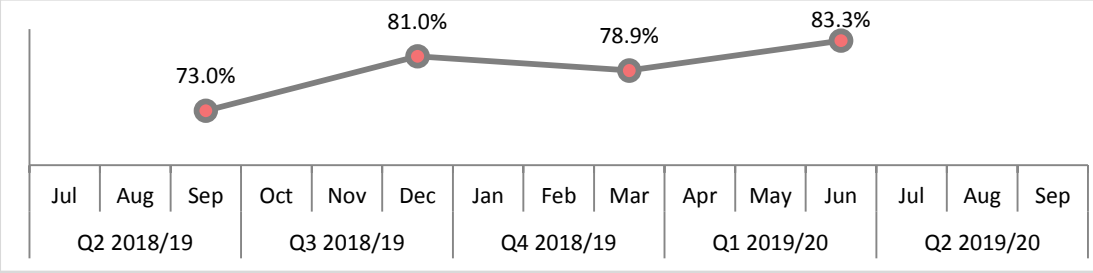
Indicator Detail

Sep-19	DSSA (mixed sex)
1	Total number of occasions sexes were mixed on same sex wards
Target	There was one mixed sex breach in September
<= 0	



Actions
The Business Group are investigating this incident in line with National Standards.

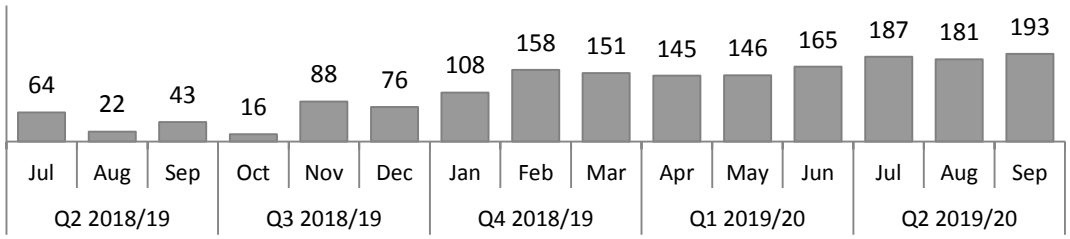
Jun-19	Learning Disability: Adjusted Care Plans
83.3%	The number of inpatients with a learning disability who have a reasonable adjustment care plan in place, as a percentage of all patients with a learning disability.
Target	Compliance for Qtr 1 was 83.3%
>= 100%	



Actions
The compliance target has been altered from 75% to 100% from May 2019 From notes available to audit we have achieved 83.3%, meaning there were 5 patients missed in the quarter. In June the safeguarding team worked with Clinical Audit to set up an AMaT audit to be used by Matrons to demonstrate their checks. This was completed for 4 patients. The safeguarding team continue to collate the information from Advantis to alert business group leads of admitted patients with Learning Disabilities. AMaT will be used to monitor this indicator going forward.

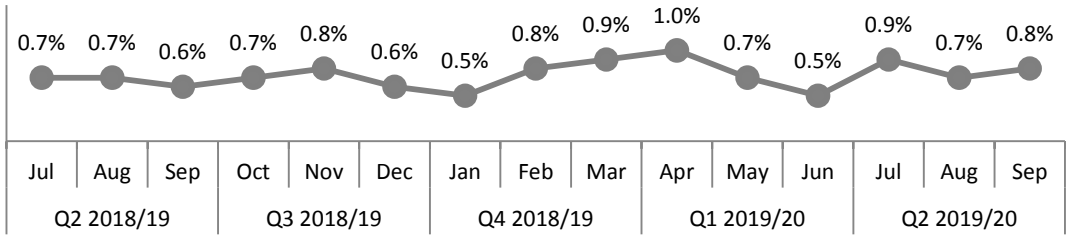
Indicator Detail

Sep-19	Compliments
193	Total number of compliments received.
Sep-19	For the month of September, 193 compliments were received from patients following care they received.



Actions
Any compliments received by the patient and customer 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 the staff member with a Proud to Care certificate in recognition of their care and compassion. Ward and Department managers continue to collate the compliments received on a monthly basis and record this on the datix system. The Matron for Patient Experience shares all compliments received through Care Opinion with the appropriate business group.

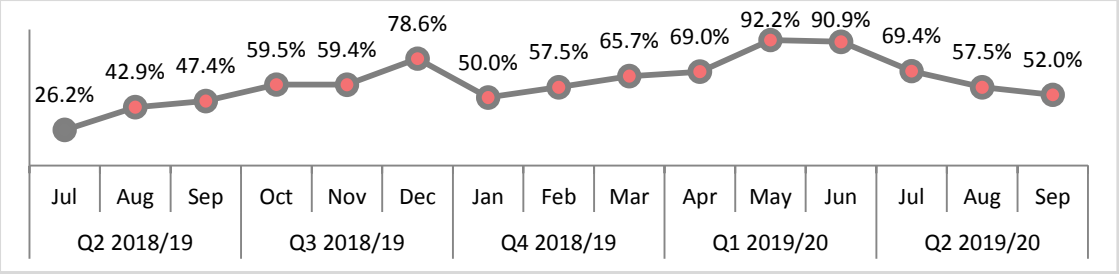
Sep-19	Complaints Rate
0.8%	The total number of formal written complaints received compared with the whole time equivalent staff.
Target	36 complaints were received in September 2019: Integrated Care = 10, Medicine = 3, Surgery = 17, WCDS = 4 and Estates & Facilities 2



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

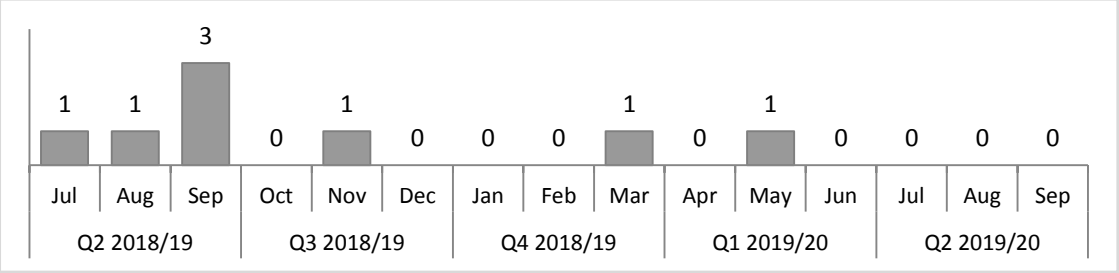
Indicator Detail

Sep-19	Complaints: Response Rate 45
52.0%	The percentage of formal complaints responded to within 45 days.
Target	Of the 25 closed in September, 13 were responded to on time resulting in a 52% response rate. The business group response rate is as follows: integrated care: 100%, WCDS: 60%, surgery: 45.5% and medicine: 33.3%
>= 95%	



Actions
The patient and customer services team continue to liaise with the business groups and the executive team with the aim of improving 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

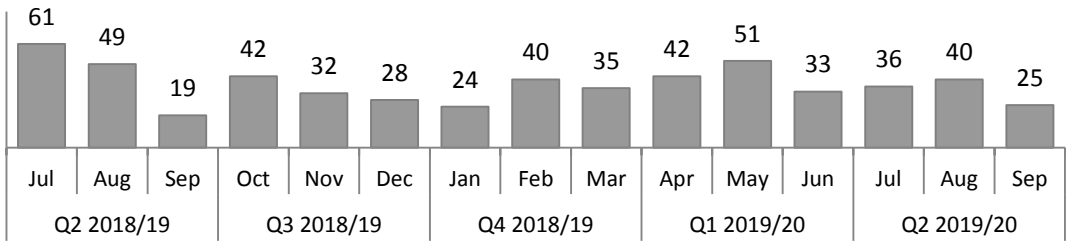
Sep-19	Complaints: Parliamentary & Health Service Ombudsman Cases
0	The total number of open Ombudsman cases.
Target	In September 2019, there were 0 referrals received from the Parliamentary and Health Service Ombudsman and no final reports were received in month.



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

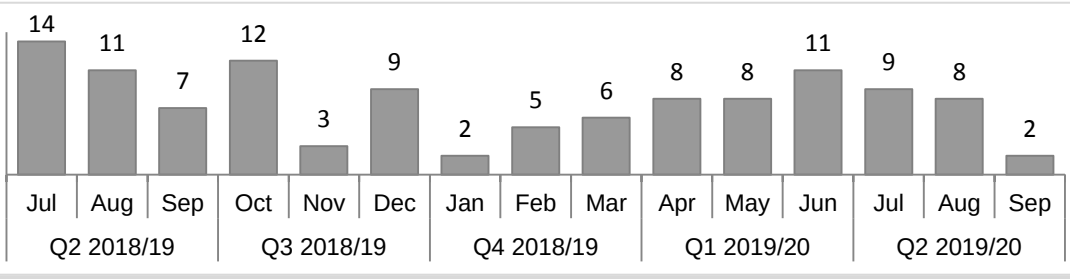
Indicator Detail

Sep-19	Complaints Closed: Overall
25	The total number of formal complaints that have been closed.
Target	In the month of September 2019, 25 responses were closed in month: integrated care closed 3, medicine closed 6, surgery closed 11 and women, children & diagnostic services closed 5.



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

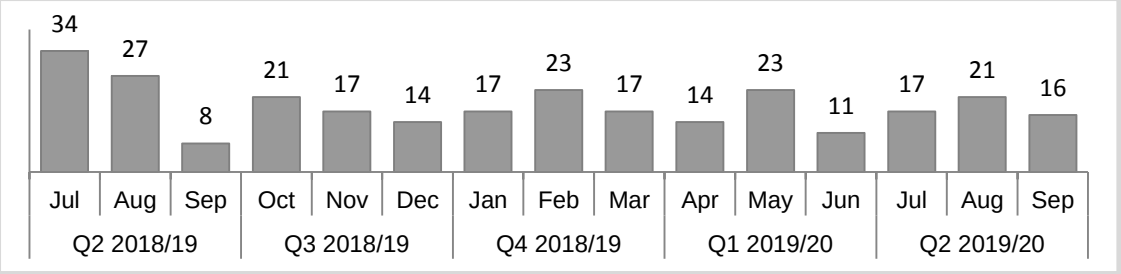
Sep-19	Complaints Closed: Upheld
2	The total number of upheld formal complaints that have been closed.
Target	For September 2019, 2 cases were upheld out of the 25 Closed.



Actions
All actions and learning identified as a result of complaint are shared with the complainant. Any actions or learning is then uploaded to Datix by the business group and assigned to staff. A selection of closed complaints are also reviewed by the Complaints Review Panel. The purpose of the group is to provide an overview and scrutiny to the Patient Experience Group to ensure systems and processes are fit for purpose. The panel will undertake to: Quality assess a complaint response ensuring that all aspects of the complaint were addressed; that the response was open, honest and transparent; the complaint was responded to within timescales; the language used was appropriate; the complainant was advised of the next steps; that lessons learned and actions have been documented with appropriate timescales for completion agreed and that apologies were offered as appropriate.

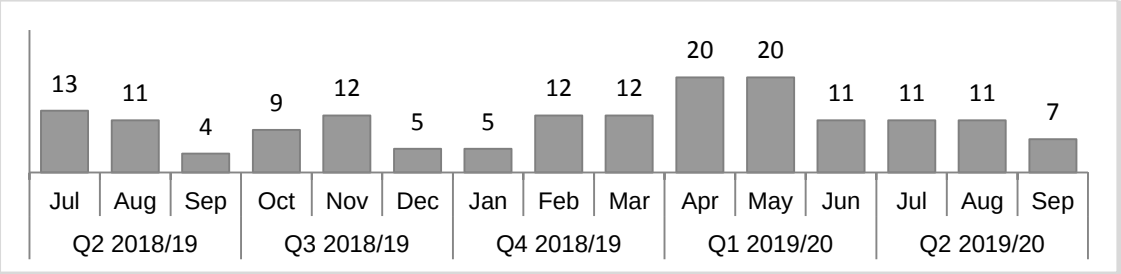
Sep-19	Complaints Closed: Partially Upheld
16	The total number of partially upheld formal complaints that have been closed.
Target	In September 2019, 16 of the cases were partially upheld of the 25closed.

Actions
Where learning points are identified on a complaint that has been partially upheld, this will be reflected within the complaint response and shared with the complainant.

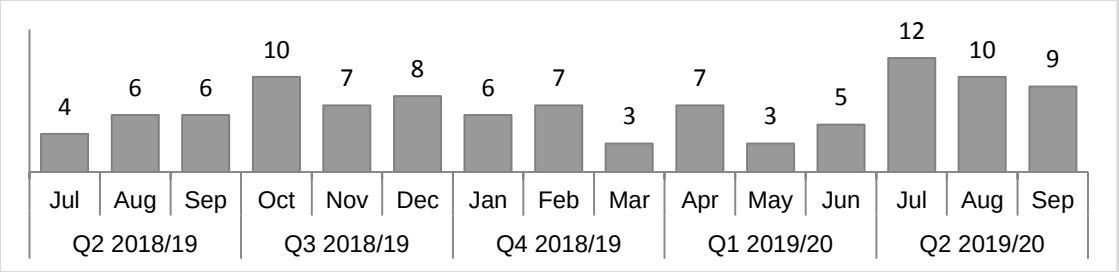


Sep-19	Complaints Closed: Not Upheld
7	The total number of not upheld formal complaints that have been closed.
Target	In September 2019, 7 of the cases were not upheld of the 25 closed.

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.

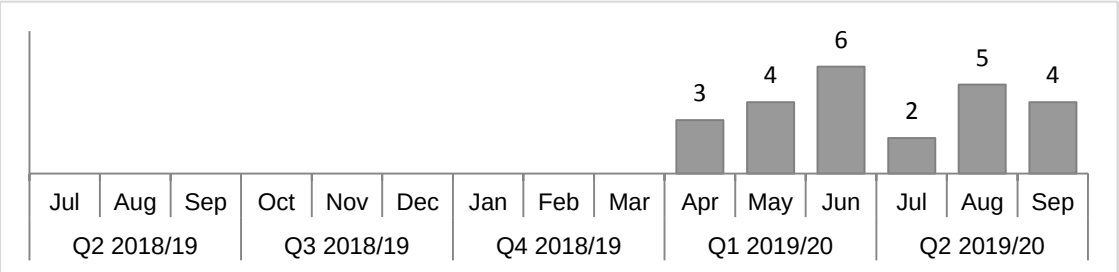


Sep-19	Litigation: Claims Opened
9	Total number of claims opened in month.
Target	There were 9 claims opened in September 2019



Actions
The process for investigating the claims received has commenced in line with policies and procedures. The claims deemed as high risk include 1 allegation of a missed diagnosis 1 allegation of a delayed diagnosis In addition there were 7 allegations of sub-optimal care

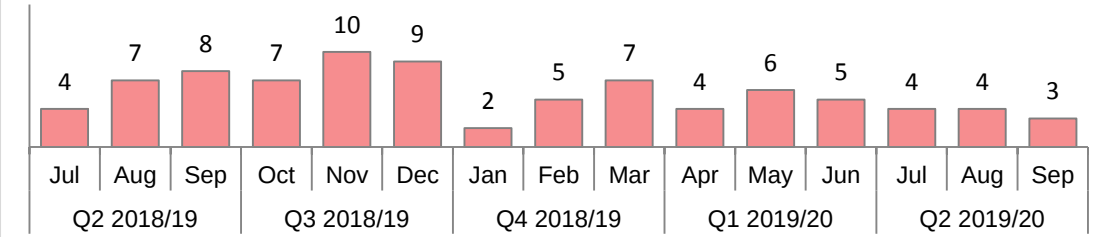
Sep-19	Litigation: Claims Closed
4	Total number of claims closed in month.
Target	There were 4 claims closed in the month of September. These were 3 employment claims and 1 medical negligence claim.



Actions
All 4 claims were repudiated by the Trust and all were closed by NHSR.

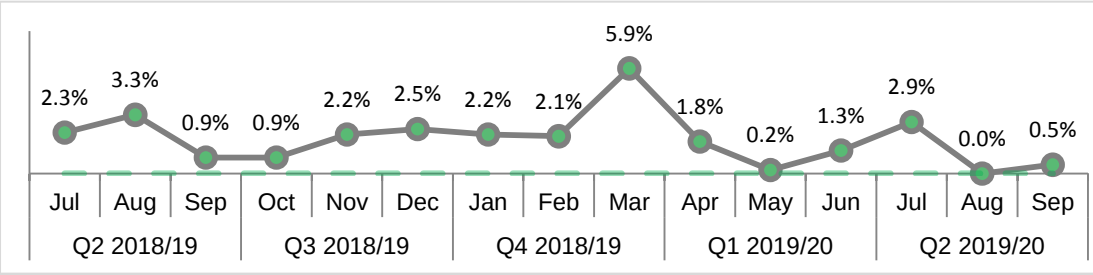
Indicator Detail

Sep-19	Referral to Treatment: 52 Week Breaches
3	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 3 patients over 52 weeks at the end of September. For two of the cases, long waits for first appointments, and the complexity of the patients' pathways are the cause, as well as an element of patient choice. For the remaining patient, a clerical error had resulted in the pathway being closed prematurely.
<= 0	



Actions
Training to be undertaken with teams where pathway errors have been made, to mitigate the risk of the same error reoccurring. Daily tracking of patients is ongoing, with all options to expedite the patients explored. Oversight of all patients over 38 weeks during the weekly 'Performance Wall' meeting, as well as detailed discussions around all patients >44 weeks within Business Group meetings.

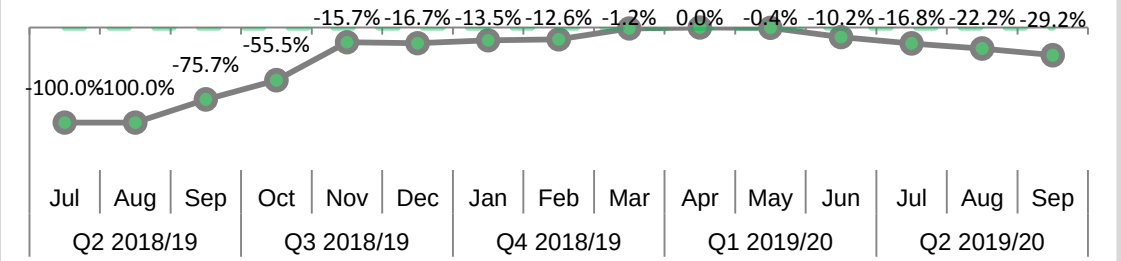
Sep-19	Financial Controls: I&E Position
0.5%	The percentage variance between planned financial position and the actual financial position.
Target	In the twelve months to 31st March 2020 the Trust has a planned underlying deficit of £24.5m after the planned achievement of a £14.2m CIP. This excludes non-recurring 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
At the half way point in the financial year the Trust has reported to NHS Improvement (NHSI) a loss of £8.3m, which is in line with the planned overall deficit and control total. However in achieving this the Trust has delivered less activity and income than plan by £2.2m, but also spent less than plan so the expenditure underspend has been removed to CIP. As costs have not reduced in line with income, the Trust has had to release balance sheet items totalling £0.7m to date to deliver the financial position.

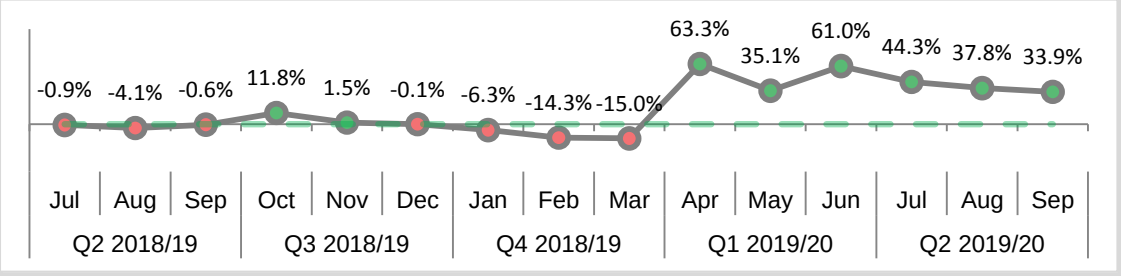
Indicator Detail

Sep-19	Cash
-29.2%	The percentage variance between planned borrowing-to-date and the actual borrowing-to-date.
Target	Cash in the bank was £11.8m on 30th September 2019. The Trust has borrowed a total of £30.1m since September 2018. Q1 financial recovery fund (FRF) and provider sustainability fund (PSF), which is earlier than advised.
<= 0%	



Actions
Cash in the bank on 30th September 2019 was £11.8m. This is linked to capital underspends against the profiled plan and the Trust's continued efforts to maintain a balance higher than the minimum cash balance allowed to protect working capital. The Trust has borrowed a total of £30.1m since September 2018. The Trust has received £3.1m Q1 financial recovery fund (FRF) and provider sustainability fund (PSF), which is earlier than advised and so has improved the cash balance. NHS England has therefore badged specific loan requests as "cash advances" in relation to these outstanding payments, which is not technically treated as a loan.

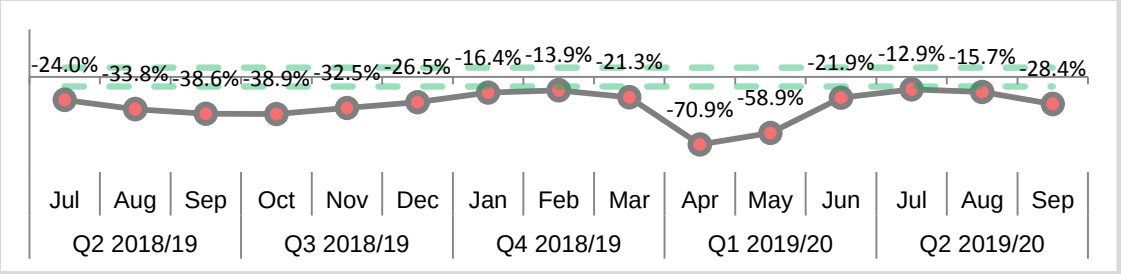
Sep-19	CIP Cumulative Achievement
33.9%	The percentage variance between planned CIP achievement and the actual CIP achievement.
Target	The cost improvement plan (CIP) is £1.4m favourable to date at the half way point of the financial year, with £5.7m delivered against the £4.3m half year target. Of the CIP delivered in the first six months, £2.3m (40%) is non-recurrent vacancy factor.
>= 0%	



Actions
The Trust is £1.4m favourable to the profiled CIP plan to date, however this has been delivered through non-recurrent measures including £2.3m of non-recurrent vacancy factor (NRVF) and there remains a risk to the delivery of the total CIP programme in 2019/20. The Trust has identified £12.1m of schemes, which has remained static for several months as new schemes have been used to replace red rated schemes that have been removed. Recurrent CIP delivery is £4.1m, and has increased by less than £0.1m in month. This leaves a £10m recurrent pressure for the underlying financial position, which will have a strong bearing on the Trust's ability to accept NHS England (NHSE) and NHSI's proposed improvement trajectory and indicative Financial recovery Fund (FRF) allocation for 2020/21.

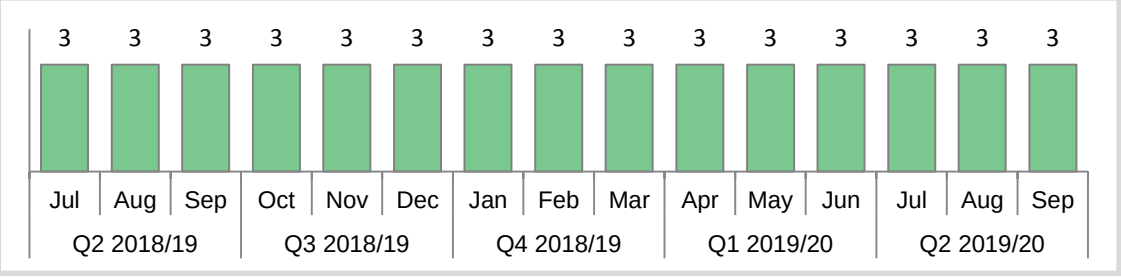
Indicator Detail

Sep-19	Capital Expenditure
-28.4%	The percentage variance between planned capital expenditure and the actual capital expenditure. Capital expenditure includes such things as buildings and equipment.
Target	Capital costs of £3.2m have been incurred in the first half of the financial year against a plan of £4.4m and so is £1.2m behind plan. This relates to the early termination of a finance lease (£0.6m) where expenditure will now fall later in the year for IT system stabilisation and the data warehouse.
+/- 10%	



Actions

Sep-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

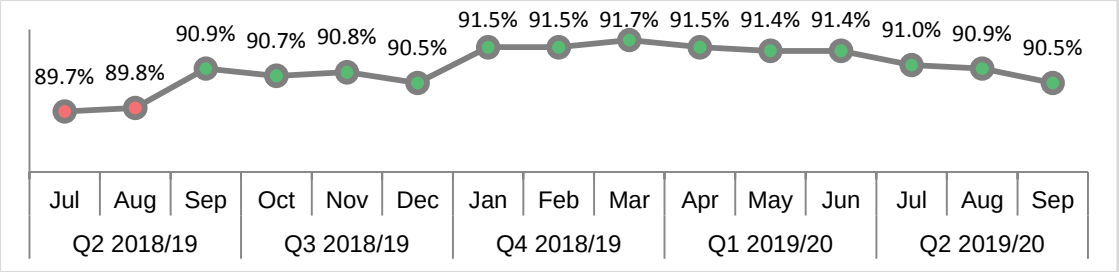
Individual scores under the Finance & Use of Resources Metrics are shown below:

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.

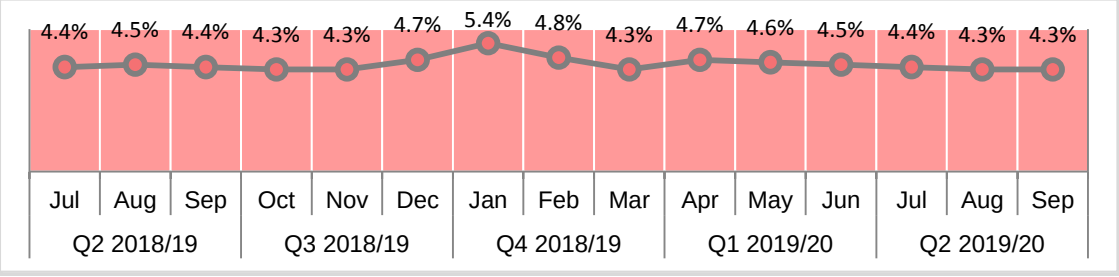
Indicator Detail

Sep-19	Substantive Staff-in-Post
90.5%	The percentage of whole time equivalent staff in post compared with the current establishment.
Target	The Trust staff in post figure for September 2019 is 90.5% of the total establishment including re-charges; a marginal reduction from the position last month.
>= 90%	



Actions
Performance is above target. Vacancy rates fluctuate by staff group & hot spot areas are being actively addressed.

Sep-19	Sickness Absence: Monthly Rate (UoR)
4.3%	The total number of staff on sickness absence, calculated as a percentage of all staff-in-post whole time equivalent.
Target	The in-month unadjusted sickness absence figure for September 2019 is 4.35%; an increase of 0.09% compared to the adjusted previous month's figure of 4.26%.
<= 3.5%	

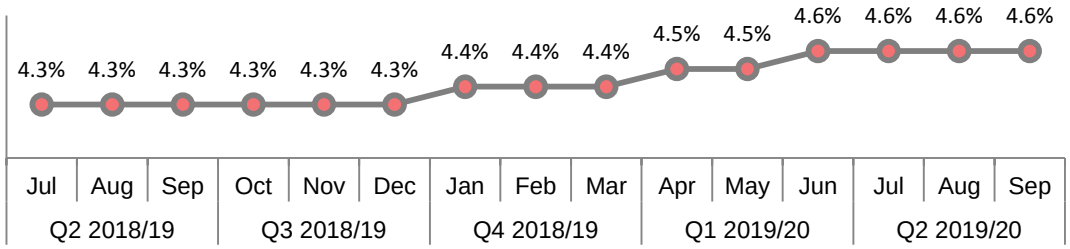


Actions
The unadjusted cost of sickness absence in September 2019 is £480,096; a decrease of £8,129 from the adjusted figure of £488,225 in the previous month. This does not include the cost to cover the absence. The top reasons for sickness are Stress/Anxiety (31.90%), Back/Muscular Skeletal problems including Injury/Fracture (23.38%), Cold/Cough/flu/Chest/Respiratory Problems (9.88%), and Gastrointestinal Problems (9.20%). The Trust is dedicated to staff health & wellbeing and supporting staff to return and remain in work. Initiatives include: Mental health champion training for staff representative across the Trust Promotion and encouragement for staff to have the flu vaccination and making this easily accessible Localised support from HR for each business group to ensure staff and managers are supported.

Indicator Detail

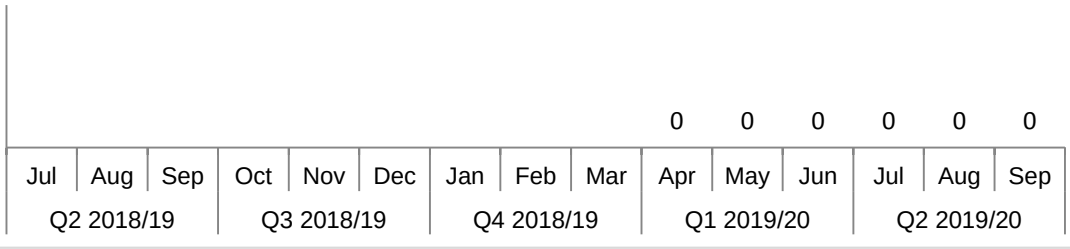
Sep-19	Sickness Absence: Rolling 12-Month Rate (UoR)
4.6%	The total number of staff on sickness absence, as a percentage of all staff-in-post whole time equivalent. Calculated as a 12-month rolling average.
Target	The 12-month rolling sickness percentage for the period October 2018 to September 2019 is 4.55%.
<= 3.5%	

Actions
This is 1.05% above the Trust target. A review of this key performance indicator will be undertaken via PPC in November.



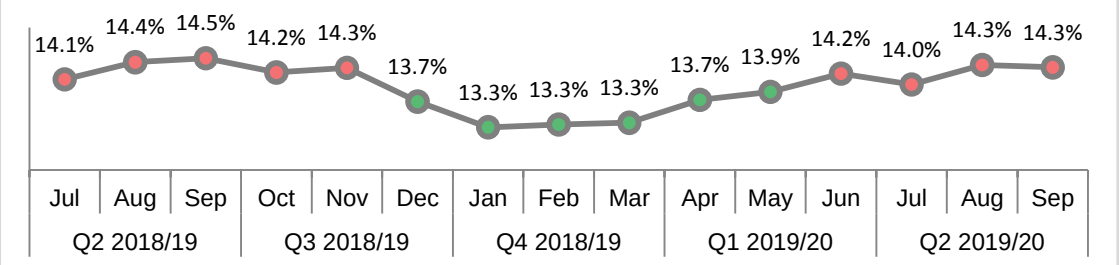
Sep-19	Sickness Absence: Long-term
0	Number of staff who have been absent from work on sick leave for 365 days or more.
Target	Number of staff who have been absent from work on sick leave for 365 days or more is 0.
<= 0	

Actions
No action required.



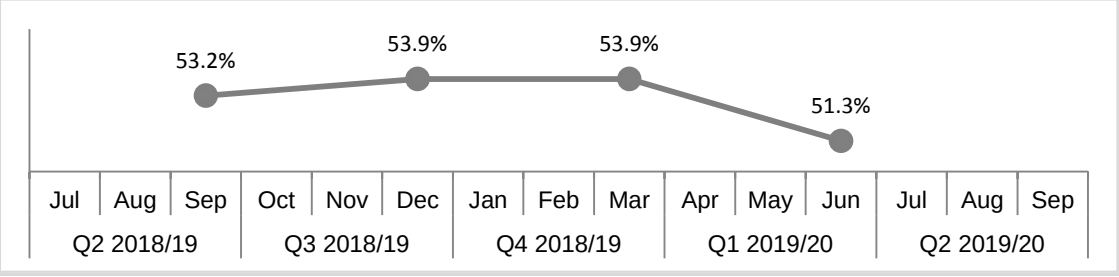
Indicator Detail

Sep-19	Workforce Turnover (UoR)
14.3%	The percentage of employees leaving the Trust and being replaced by new employees.
Target	The rolling 12-month permanent headcount unadjusted turnover figure at the end of September 2019 is 14.30%, which is 0.37% above the Trust target. The adjusted rolling 12-month permanent headcount turnover figure for the same period is 13.24%.
<= 13.94%	



Actions
The top adjusted known leaving reasons are: Work Life Balance together with Dependents 18.45%, Relocation 17.71%, Retirement 14.43%, and Promotion 13.54%. Integrated Care has the highest overall turnover rate at 18.12%, and when adjusted is 17.14%. The Trust recognsies the importance and challenges of staff retention and the Business Groups have introduced a number of initiatives in order to improve turnover. These include: •Practice educators recruited to a number of areas to increase staff training. •Review of induction programme for new staff. •Review of exit interview process with staff who indicate a desire to leave or have resigned. •Band 5 and 6 development programmes in place •Wider access to senior managers for staff at numerous 'listening events'. •Proactively recruiting to all clinical vacancies, including international recruitment initiatives

Jun-19	Staff Friends & Family Test: Recommend for Work
51.3%	The percentage of all surveyed staff who are extremely likely or likely to recommend the Trust as a place of work.
Target	The Q1 results for staff recommending the Trust as a place to work has reduced marginally to 51.5% from the last results of 53.9%

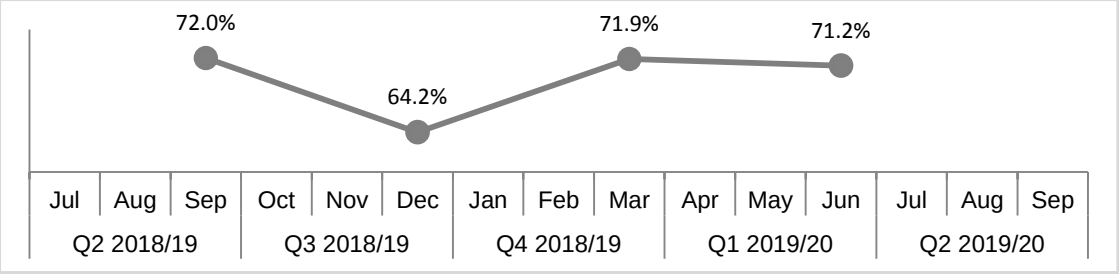


Actions
Significant work is underway to refresh the Trust values and behaviours. A revised approach to the national staff survey results for 2019 is planned, including incentives, which is hoped will improve the response rate. In addition the revised values and behaviours launch, supported by other initiatives, such as 'meet the execs' is anticipated to yield more data to better understand the issues driving this position. Ensuring appropriate mitigating actions are implemented to improve the position.

Indicator Detail

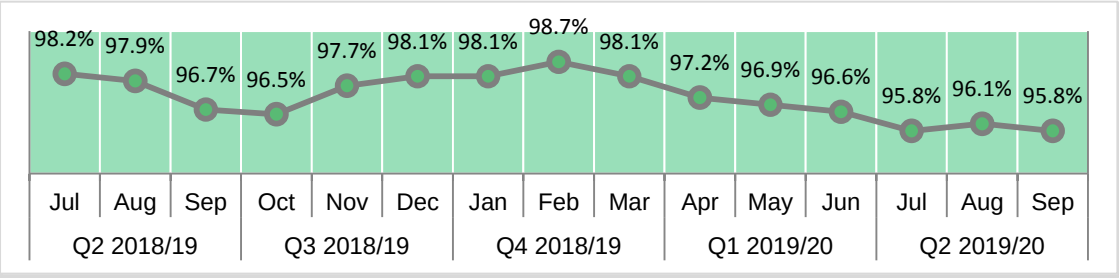
Jun-19	Staff Friends & Family Test: Recommend for Care
71.2%	The percentage of all surveyed staff who are extremely likely or likely to recommend the Trust for care.
Target	The Q1 results for staff recommending the Trust as a place to receive care has reduced marginally to 71.2% from the last results of 71.9%

Actions
The results will be analysed in order to determine the challenges and drivers impacting on this position. Upon completion of this an action plan will be developed which looks to ensure an improved position.



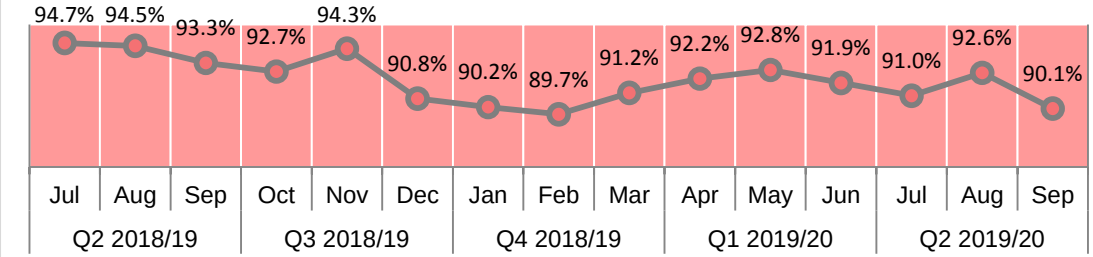
	Appraisal Rate: Medical
95.8%	The percentage of medical staff that have been appraised within the last 15 months.
Target	The medical appraisal rate for September 2019 is 95.81%, a decrease on the last month's figure of 96.14% but is above the Trust target of 95%.
>= 95%	

Actions
No action.



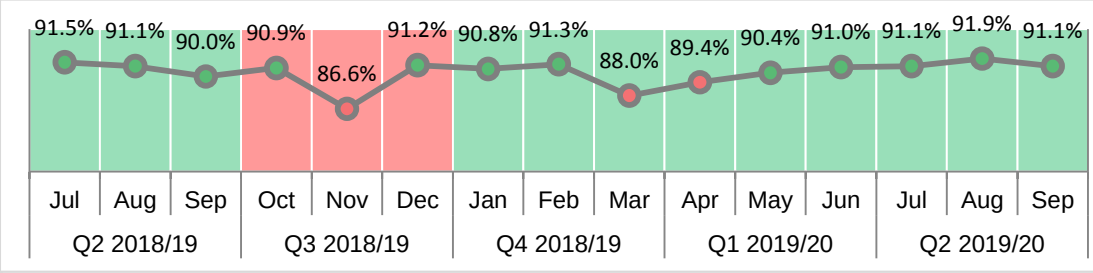
Indicator Detail

Sep-19	Appraisal Rate: Non-medical
90.1%	The percentage of non-medical staff that have been appraised within the last 15 months.
Target	The Trust's total appraisal compliance for September 2019 is 90.11%, a decrease from the previous month's data which was 92.60%, and is 4.89% below target. All business groups are below the target of 95%.
>= 95%	



Actions
Allied Health Professionals and Medical staff are the only staff groups that have achieved the Trust target with compliance rates of 95.78% and 95.81% respectively. Targeted support is being provided to areas of concern; with a focused oversight by the executive team via the performance reviews.

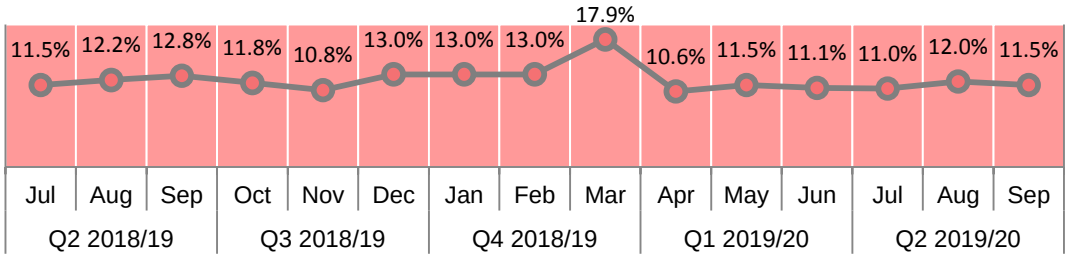
Sep-19	Statutory & Mandatory Training
91.1%	The percentage of statutory & mandatory training modules showing as compliant.
Target	Statutory and Mandatory training has decreased in September 2019 to 91.12% but is above the Trust compliance target.
>= 90%	



Actions
In order to improve Statutory and Mandatory Training by November 2019 there will be targeted actions for specific areas where compliance has declined. Estates and Facilities will receive additional bespoke sessions that will delivered at weekends and evenings. Sessions will be delivered in different modes to accommodate different styles of learning to engage and meet the requirements of the staff group. A texting service will be piloted in November 2019 to remind staff about training sessions which will increase compliance and reduce the DNA rates. a review of the management information is underway to better support line managers in addressing non-compliance.

Indicator Detail

Sep-19	Bank & Agency Costs
11.5%	The total bank & agency cost as percentage of the total pay costs
Target	Bank and agency costs in September 2019 account for 11.63% (£2.22M) of the £19.28M total pay costs. This is a £80K decrease from the position reported in the previous month (£2.30M).
<= 5%	

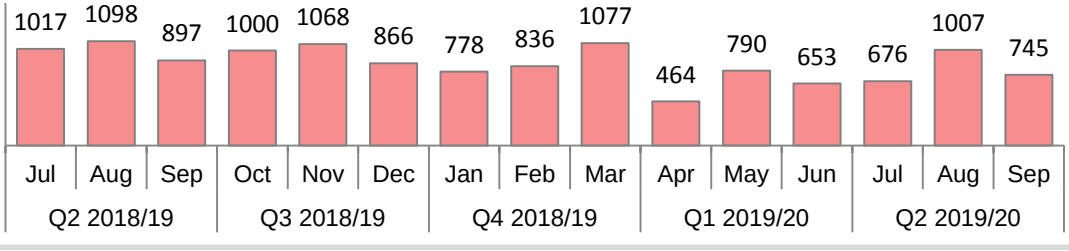


Actions

The Medicine & CS Business Group bank and agency spend has decreased by £38K to £730K in September 2019, but continues to have the highest spend on bank and agency equating to 32.82% of the Trust overall bank and agency spend.

A review of ECP terms of reference is underway; with anticipated revised approach implemented form November ; with enhanced oversight of long-standing bank & agency usage particularly nursing.

Sep-19	Agency Shifts Above Capped Rates
745	Number of agency shifts above above the provider spend cap.
Target	There were a total of 745 shifts paid above the NHSI cap rate during the 5 week period from 2nd to 29th September 2019. This equates to an average of 186 shifts per week, which is a decrease of 15 shifts per week compared to August's figures.
<= 0	

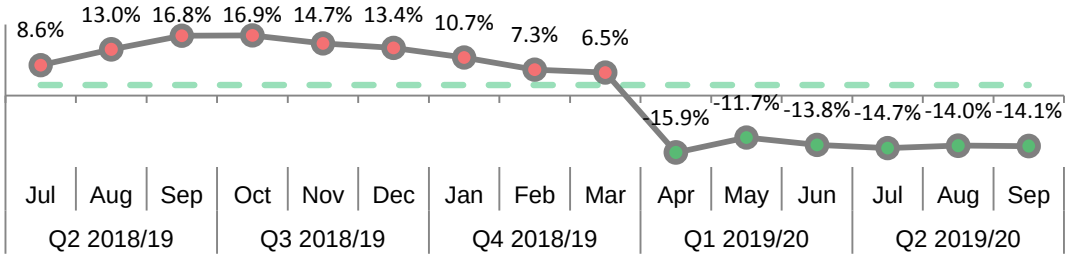


Actions

This is also a decrease compared to the 224 shifts per week in September 2018. Medicine recorded the highest number of agency cap breaches with an average of 74 shifts per week, which is mainly attributed to medical shifts (68 per week). This is followed by Surgery with 60 shifts per week who have an average of 23 medical shifts per week (a reduction of 15 compared to August) and 29 nursing agency cap breaches.

Indicator Detail

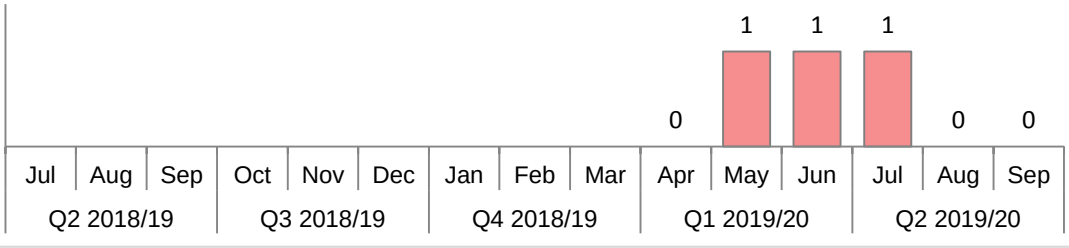
Sep-19	Agency Spend: Distance From Ceiling (UoR)
-14.1%	The percentage variance between Trusts expenditure on agency and external locums across all staff groups and the cap set by NHSi.
Sep-19	The total number of agency shifts worked in this period, including shifts under cap, was 1,572 – an average of 393 per week.
<= 3%	



Actions

This is an average increase of 11 shifts per week compared to August. There were a total of 104 shifts paid at or above £100 per hour, which required Chief Executive approval, which is an average of 26 shifts per week, compared to 32 shifts per week in August.

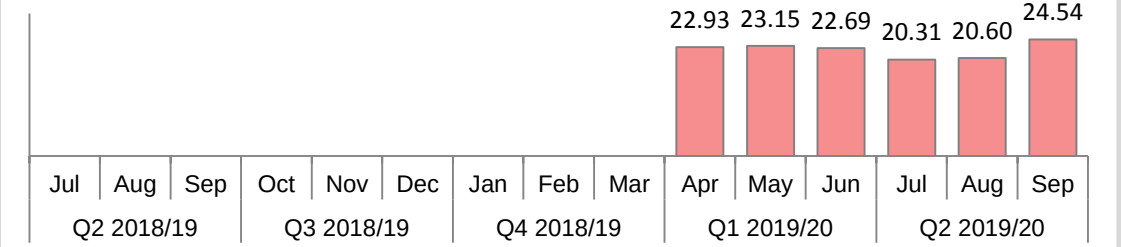
Sep-19	Staff Suspensions
0	Number of staff who have been suspended from work for 90 days or more.
Target	There are no staff on suspension for over 90 days.
<= 0	



Actions

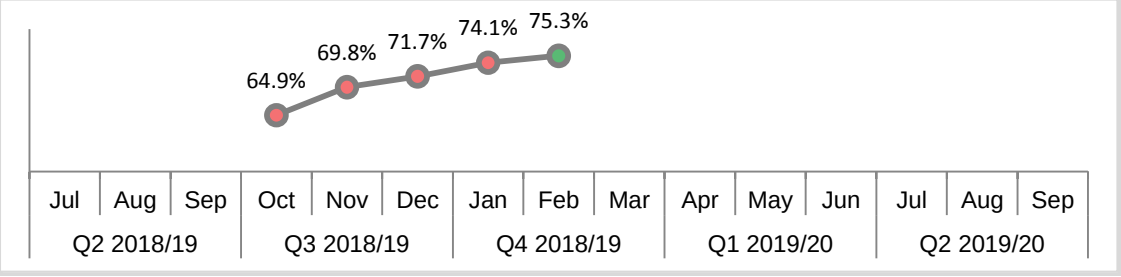
No action.

Sep-19	Recruitment Lead Time
24.54	Average waiting time between issuing of a conditional offer to issuing an unconditional offer across all staff groups
Target	The recruitment team are 4.54 days above our target ; this has been impacted by the increased international recruitment and visa requirements.
<= 20	



Actions
Development recruitment dashboard is underway; providing business groups with oversight of recruitment performance in order to address areas which fall below expected performance.

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.

Safer Staffing Report

Sep-19	Day				Night				Day		Night		Care Hours Per Patient Per Day (CHPPD)				Safety Thermometer				ACE Status
	RNs / midwives		Care Staff		RNs / midwives		Care Staff		Average fill rate - RNs / mid-wives (%)	Average fill rate - care staff (%)	Average fill rate - RNs/ mid-wives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	RNs / mid-wives	Care Staff	Over-all	Pressure Ulcer (new)	Falls with Harm	Catheters & UTIs(new)	New VTEs	Status
Ward Name	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours													
AMU	3960	3222	3240	3372	3600	2786	2970	3152	81.36%	104.07%	77.39%	106.13%	1645	3.65228	3.965957	7.618237	0	0	0	0	White
CDU	360	360	360	360	330	330	330	330	100.00%	100.00%	100.00%	100.00%	198	3.484848	3.484848	6.969697	0	0	0	0	n/a
D4	1125	929.5	765	840	660	649	660	704	82.62%	109.80%	98.33%	106.67%	472	3.34428	3.271186	6.615466	0	0	0	0	Silver
A3	1395	1080	945	900	990	858	660	638	77.42%	95.24%	86.67%	96.67%	726	2.669421	2.118457	4.787879	0	0	0	1	Silver
A10	2797.5	2025	1980	2325	1980	1628	1320	1617	72.39%	117.42%	82.22%	122.50%	706	5.174221	5.583569	10.75779	0	0	0	0	Gold
A11	1530	1260	1575	1275	660	583	660	825	82.35%	80.95%	88.33%	125.00%	802	2.298005	2.618454	4.916459	0	0	0	0	Silver
B4	1170	704	585	921	660	660	660	660	60.17%	157.44%	100.00%	100.00%	477	2.859539	3.314465	6.174004	0	0	0	0	Gold
B6	1395	1219.5	1260	1155	660	682	990	1254	87.42%	91.67%	103.33%	126.67%	660	2.881061	3.65	6.531061	1	0	0	0	Silver
Bluebell	1170	1128	2010	1962	660	614	660	1824	96.41%	97.61%	93.03%	276.36%	725	2.402759	5.222069	7.624828	0	0	0	0	White
C3	1620	1402.5	840	892.5	660	660	660	726	86.57%	106.25%	100.00%	110.00%	409	5.042787	3.957213	9	0	0	0	0	Gold
C4	1170	840	585	859	660	660	660	737	71.79%	146.84%	100.00%	111.67%	479	3.131524	3.331942	6.463466	0	0	0	2	Gold
CCU	810	795.5	450	239.75	660	640	330	330	98.21%	53.28%	96.97%	100.00%	157	9.143312	3.628981	12.77229	0	0	0	0	n/a
Devonshire	1035	1023	1935	1871.5	660	660	660	990	98.84%	96.72%	100.00%	150.00%	461	3.650759	6.207158	9.857918	1	0	0	0	Silver
E1	1881	1295.75	2235	1934.75	990	888	1320	1433.25	68.89%	86.57%	89.70%	108.58%	928	2.353179	3.62931	5.982489	0	0	0	0	Silver
E2	2205	2205	1530	1970	990	978	990	1320	100.00%	128.76%	98.79%	133.33%	997	3.192578	3.2999	6.492477	0	0	0	0	White
E3	2205	2205	1530	1758	990	956	990	1705	100.00%	114.90%	96.57%	172.22%	1040	3.039423	3.329808	6.369231	0	0	0	0	Gold
A1	1350	1245	1170	1135	990	858	660	649	92.22%	97.01%	86.67%	98.33%	789	2.665399	2.26109	4.926489	0	0	0	0	Silver
C6	907.5	907.5	1072.5	1402.5	660	660	660	968	100.00%	130.77%	100.00%	146.67%	471	3.328025	5.032909	8.360934	0	0	0	0	Silver
D1	1627.5	1296.25	1305	1348.5	660	627	990	1067	79.65%	103.33%	95.00%	107.78%	710	2.708803	3.402113	6.110915	0	0	0	0	Silver

Sep-19	Day				Night				Day		Night		Care Hours Per Patient Per Day (CHPPD)				Safety Thermometer				ACE Status
	RNs / midwives		Care Staff		RNs / midwives		Care Staff														
Ward Name	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - RNs / mid-wives (%)	Average fill rate - care staff (%)	Average fill rate - RNs/ mid-wives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	RNs / mid-wives	Care Staff	Over-all	Pressure Ulcer (new)	Falls with Harm	Catheters & UTIs(new)	New VTEs	Status
D2	1575	1063.5	1395	1476	660	596	660	759	67.52%	105.81%	90.30%	115.00%	618	2.685275	3.616505	6.30178	1	1	0	0	Silver
D5	1267.5	1207.5	1012.5	963	660	671	660	792	95.27%	95.11%	101.67%	120.00%	665	2.824812	2.639098	5.46391	0	0	0	0	Bronze
D7/SSSU	1812	1538	774	729	847	775	660	650	84.88%	94.19%	91.50%	98.48%	689	3.357039	2.001451	5.358491	0	0	0	0	Gold
M4	1189.5	970	945	841.5	660	649	561	550	81.55%	89.05%	98.33%	98.04%	441	3.671202	3.155329	6.826531	0	0	0	0	Silver
SAU	1785	1671	705	681	990	957	660	627	93.61%	96.60%	96.67%	95.00%	475	5.532632	2.753684	8.286316	0	0	0	0	Silver
ICU/HDU	4545	3693	360	48	3960	3236	330	264	81.25%	13.33%	81.72%	80.00%	276	25.10507	1.130435	26.23551	0	0	0	0	n/a
Birth Centre	900	900	450	450	600	600	300	300	100.00%	100.00%	100.00%	100.00%	13	115.3846	57.69231	173.0769					n/a
Delivery Suite	2700	2325	450	375	1800	1635	300	300	86.11%	83.33%	90.83%	100.00%	213	18.59155	3.169014	21.76056					n/a
Maternity 2	1575	1509	900	867	660	660	330	297	95.81%	96.33%	100.00%	90.00%	432	5.020833	2.694444	7.715278					n/a
Jasmine	900	900	450	469.5	600	600	0	16.5	100.00%	104.33%	100.00%	na	226	6.637168	2.150442	8.787611	0	0	0	0	Silver
Neonatal Unit	2250	1931	0	0	1575	1282.75	0	0	85.82%	na	81.44%	na	166	19.35994	0	19.35994	0	0	0	0	n/a
Tree House	2700	2423	450	609	1800	1748	0	22	89.74%	135.33%	97.11%	na	558	7.47491	1.130824	8.605735	0	0	0	0	n/a
Trust Total	**52912.5**	**45274.5**	**33264**	**34030.5**	**32932**	**29786.75**	**21291**	**25506.75**	**85.56%**	**102.30%**	**90.45%**	**119.80%**	**17624**	**4.259036**	**3.378192**	**7.637228**	**3**	**1**	**0**	**3**	

Safer Staffing Report

BOARD PAPERS – Quality, Safety & Experience Section : September 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.**	85.6% of expected RN hours were achieved for day shifts. This is the 13th 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. 17 areas indicate below 90% RN levels in month's area (Birth centers) figures in month still need to be ratified by the business group as are not correct and may be over reported.	Sept 85.6% August 85.8% July 87.8%	The lowest RN staffing levels during the day were on Ward B4 at 60.2%. The ward is supported by 157.4% non-registered whilst awaiting qualified new starters as reflected in previous reports . Harm free care metrics are optimal. D2 orthopedics is reporting RN rates of 67.5% with 108% non-registered to support. Harm free care metrics indicate a pressure ulcer and fall. The business group Associate Nurse Director is undertaking a full review of the staffing levels on D2.
Registered Nurses: Monthly expected hours by shift versus actual monthly hours per shift. **Night time shifts only.**	90.4% of expected RN hours were achieved for night shifts. 6 areas report below 90% RN levels in month.	Sept 90.4% August 90.0% July 93.2%	The lowest RN night staffing levels are reported on the neonatal unit with 81.4% RN levels. The business group is reviewing staffing levels on the neonatal wards and will report back to the Chief Nurse in relation to safe staffing assurance .
Non-registered staff: Monthly expected hours by shift versus actual monthly hours per shift. **Day time shifts only.**	102.3% of expected non-registered hours were achieved for day shifts. 3 areas report below 90% levels in month.	Sept 102.3% August 103.9% July 101.7%	The lowest non registered staffing levels for day duty is on the intensive care at 13.0% supported by 81.3% registered staff . The unit has low established numbers of non- registered staff and therefore when there is sickness the %age unfilled reports as a high percent. The unit maintains 1:1 care for level 3 patients and 2:1 care for level 2 patients at all times. Close support by Matron to assure safe staffing. Harm free care metrics optimal in month.

BOARD PAPERS – Quality, Safety & Experience Section : September 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.**	119.0 % 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.	Sept 119.0% August 113.0% July 114.1%	All areas report above 90% non-registered staff 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.	September RN rates indicate 156.8 WTE Filled	Of the RN 156.8 WTE (demand 212.4 WTE) The fill rate overall is 73.8% of the shifts requested. 45.7% are NHSP and agency 28.1% The substantive RN/RM vacancies in month are 165.99 WTE.
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.	September Non registered rates indicate 149.5 WTE Filled	Of the non-registered 149.5 WTE (Demand 183.4 WTE) the fill rate is 81.5%. NHSP . No agency usage . The variance from establishment in month established is 11.27 WTE

CQUIN Report

Aug-19

Background

The national Commissioning for Quality and Innovation (CQUIN) payment framework allows Commissioners to reward excellence, by linking a proportion of a healthcare Providers' income to the achievement of quality improvement goals and innovations.

The Trust is required to provide its commissioning bodies with quarterly evidence submissions for each CQUIN indicator. This evidence demonstrates how the Trust has performed against the milestones set out within each CQUIN indicator.

Bi-monthly meetings are held with the Deputy Chief Nurse and CQUIN Leads to review progress and provide assurance. CQUIN updates are provided quarterly to the Quality & Safety Improvement Strategy Group (QSISG) and Quality Governance Group (QGG).

This report provides a confirmed summary of achievement for Qtr 1 2019-20.

KEY: **Green =** Achieved / Full Payment **Amber =** Part Payment **Red =** Not Achieved / No Payment

	CQUIN Indicator	Quarter 1				
		Target	Result	Value	Value Secured	
1	**Antimicrobial Resistance -** Lower Urinary Tract Infections in Older People	90%	22%	£72,726	0%	£0
2	**Antimicrobial Resistance -** Antibiotic Prophylaxis in Colorectal Surgery	90%	95%	£72,726	100%	£72,726
3	**Frontline Staff Flu Vaccinations**	N/A	N/A	N/A	N/A	N/A
4	**Alcohol and Tobacco** – Screening	80%	91%	£48,484	100%	£48,484
5	**Alcohol and Tobacco** – Tobacco Brief Advice	90%	38%	£48,484	0%	£0
6	**Alcohol and Tobacco** – Alcohol Brief Advice	90%	20%	£48,484	0%	£0
7	**Three High Impact Actions To Prevent Hospital Falls**	80%	47%	£145,452	40%	£58,181
8	**Same Day Emergency Care** – Pulmonary Embolus	75%	80%	£48,484	100%	£48,484
9	**Same Day Emergency Care** – Tachycardia with Atrial Fibrillation	75%	68%	£48,484	72%	£34,908
10	**Same Day Emergency Care**– Community Acquired Pneumonia	75%	25%	£48,484	0%	£0
11	**Medicines Optimisation**	N/A	Pass	£9,062	100%	£9,062
12	**National Dose Banding for Adult Intravenous Anticancer Therapy (SACT)**	N/A	100%	£7,720	100%	£7,720
	Total	-	-	**£598,590**	**47%**	**£279,565**

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Board of Directors' Key Issues Report

Report Date: 01/11/19		**Report of:** Quality Committee
Date of last meeting: 22/10/19		**Membership Numbers:** Quorate

1.	**Agenda**	The Quality Committee met on 22 October 2019 and considered an agenda which included the following items:
		
		• Integrated Performance Report – Quality Metrics
		• CQC Safe High Quality Care Improvement Plan
		• Quality Improvement Plan
		• Quality Improvement Priorities
		• Quality Improvement Plan
		• Quality Improvement Priorities Q.2 update
		• Learning from Deaths Report
		• Clinical Governance Report
		• Quality Governance Framework update
		• Patient Experience Annual Report
		• BAF Update Report
		• Medication Incident Report
		• Key Issues Reports from subgroups
		  ○ Quality Governance Group
		  ○ Patient Experience Group
		  ○ Medicines Optimisation Group
		• Trust Risk Register
		• Consent Agenda – Policy Ratification
		  ○ Comments, Concerns, Complaints and Compliments Policy

	Alert	• The Committee expressed concern regarding a previously discussed issue relating to the temperature probes in the refrigerators. Whilst it had been noted that the delays were associated with resources and cost implication, it was agreed that there was a need for further discussion. • The Committee was alerted by the Chief Nurse & Director of Quality Governance of a Never Event that had occurred in October. This related to the administration of the wrong dose of insulin due to use of a non-insulin syringe for administration. Safety Alert immediately distributed, regulators informed and STEIS report made. A Level 2 investigation is under way.
	Assurance	• The Committee considered a presentation delivered by the Integrated Care

		Business Group. The presentation provided an overview of the key risks, challenges, successes, and aspirations of the Business Group. The Committee was advised that the Business Group remained committed and enthused to deliver against the Service Transformation and Development. Furthermore, the Group was involved in other transformational workstreams that were progressing. The Business Group highlighted that they were proud of their staff who remained resilient despite the constant pressure and challenges. The Committee took positive assurance from the presentation and commended the Business Group for their continual efforts. • The Committee received assurance from the Annual Patient Experience Report which provided an overview of core services that formed part of the Trust's Patient Experience portfolio. The report showcased the wider work being undertaken to improve the experience of patients, carers, friends, and families. The Committee welcomed the report and commended the team for producing the first Annual Patient Experience Report. • The Committee took assurance from the Medication Incident Report presented by the Chief Pharmacist. The report provided an analysis of the medication incidents taking place in each Business Group and identified actions that were underway in order to mitigate ensure there was continual focus on reducing medication incidents. • The Committee was assured by the Learning from Deaths progress report and welcomed in particular, the inclusion of the Learning from Deaths newsletter. • The Committee received the Clinical Governance Report which provided a summary of activity and mechanisms in place with regards to the safe provision of care within the Trust. The Committee reviewed the completed serious incidents reviews, noting an incident that had been subject of a 'deep dive' by the Senior Leadership Group. The Committee was assured that a comprehensive review of the incident had taken place and noted the actions being undertaken to reduce reoccurrence. • The Committee received the Key Issues Reports from the Quality Governance Group; Infection, Prevention and Control Group; and the Safeguarding which continued to provide a key source of assurance for the Committee.		
	Advise	• The Committee received the Safe High Quality Care Improvement Plan update which indicated that seven actions were off track and had breached the August 2019 milestone. Whilst the Committee expressed concern regarding the progress on the medical equipment action, they recognised the wider context of the work currently being undertaken in Estates. • Following a recommendation for approval from the Patient Experience Group, the Comments, Concerns, Complaints and Compliments Policy was ratified.		
2.	Risks Identified	Nil		
3.	Report Compiled by	Mike Cheshire, Chair	Minutes available from:	Committee Secretary

NHS Stockport NHS Foundation Trust

Finance & Performance Committee Key Issues Report

Report Date: 01/11/2019		**Report of:** Finance & Performance Committee
Date of last meeting: 23/10/2019		**Membership Numbers:** QUORATE
1.	**Agenda**	The Group considered an agenda which included the following: • External Service Efficiency Review Presentation • Financial Performance Report • Financial Recovery Plan • Long Term Plan 2020/21 – 2023/24 • Pharmacy Shop – Financial Position • Agency Utilisation Report • Historical Banding Claims update • Operational Performance Report • Performance Review Meetings – Key Issues Reports • Capital Programme – Progress Report • Extension to Evolve System Support and Maintenance Contract • Draft Operational Plan • External Strategic Change Programmes (GM & East Cheshire) • Finance & Performance Risks • Stockport Q1 2019-20 Locality Assurance Minutes
	Alert	• The Committee received the report detailing the long term plan and discussed this in detail noting the challenges to the delivery of the trajectories and recognising a number of issues and uncertainties eg that the contracting process had not yet got underway, and agreed to support a paper being submitted to the next Board of Directors meeting and noting the submission date of 1st November to GM. • The Committee received the report detailing the financial recovery plan and were advised that further work was taking place on the SIRO for each of items and a final version with actions quantified financially will be submitted to the November Board and then submitted to NHSI once this has been through the Trust governance process. • The Committee received the report detailing the Operational performance and noted that the Executive Team has held enhanced escalation meetings with the Business Groups the previous day and a paper will be presented

		to Board detailing the actions arising from those escalation meetings, with particular attention on RTT, 4hr Target and Cancer.		
	Assurance	• The Committee reviewed the finance performance report for month 6 which set out the progress and assurance against the financial objectives of the Trust. The Committee took a low level of assurance on delivery of the year end position although it took a high level of assurance of delivering Q3. • The Committee received the presentation on the CIP Review by James Fleet and Kayley Taggart which was well received and the Committee felt this was a positive external review. The Trust now has to consider the pace of the operational delivery along with the required resource to deliver the savings. • The Committee received the report on agency utilisation which set out the month 6 agency usage for the Trust. The Committee took a moderate level of assurance on delivering under the ceiling at the end of Q4.		
	Advise	• The Committee received a report on the extension to the Evolve System Support and Maintenance Contract and recommend approval of the 5 year extension to the current contract with RPI scaled costs of 6.5% that had previously received endorsement from the Senior Management Team and the Executive Team. • The Committee received an update on historical banding claims		
2.	**Risks Identified**	• Risk to the delivery of the full year financial plan; • Operational Metrics – RTT, 4hr Target & Cancer; • System Winter Plan resilience.		
3.	**Report Compiled by**	Malcolm Sugden	Minutes available from:	Committee Secretary

Board of Directors' Key Issues Report

Report Date: 01/11//19		**Report of:** People Performance Committee
Date of last meeting: 24/10/19		**Membership Numbers:** Quorate
1.	**Agenda**	The Committee considered an agenda which included the following: • Director of Workforce & OD Briefing • Apprenticeship Plan and Update • Freedom to Speak Up Guardian Report • NHSI Culture & Engagement Programme Update • Values & Behaviours Update • Talent Management Pilot Update • Agency Expenditure • Nurse Staffing • Job Planning • Workforce Flash Results • Trust Risk Register • Key Issues Reports - JLNC - EDI Steering Group - Resourcing Group • Policies for Validation: - Supporting Attendance Policy • Employee Relations Cases / Confidential Staff Matters.
	Alert	• During consideration of the Workforce Flash Report, the Committee was alerted to a number of hotspot issues, including turnover rate (particularly in the Emergency Department) and appraisal performance. The Committee was particularly concerned to note the issues given that performance was likely to deteriorate further during the winter period.
	Assurance	• The Trust's newly appointed Learning & Development Manager presented an Apprenticeship Scheme update report, and the Committee heard about actions in place to improve performance in this area. • The Committee considered a Freedom to Speak Up (FTSU) report and took positive assurance on the approach and activities in this area, and noted the results of the findings of an FTSU survey. • The Committee was pleased to hear that, to date, there had been good response rates with regard to the Staff Survey and the Values & Behaviours

		work. The Committee was advised about emergent themes and next steps regarding the Values & Behaviours work. • The Committee considered a report on Agency Expenditure, which at Month 6 continued to be within the monthly agency ceiling. The Committee took positive assurance on performance in this area, noting that the Trust was on track to deliver against the 2019/20 agency ceiling. • The Committee considered a Job Planning report, and was pleased to note a significant improvement in performance regarding the agreement of job plans for consultants and SAS doctors.		
	Advise	• The Committee received an informative presentation on nurse recruitment and retention. The presentation would also be delivered at the October Board meeting, following a request from the Committee. • The Committee heard that the Trust had recently signed up to a Talent Management pilot, run by NHS Leadership Academy, to facilitate improved performance in this area. The Committee would receive a report on the subject matter at a future meeting. • The Committee discussed the Trust Risk Register and identified top five Workforce related risks. It was agreed that Mr Moores would progress the risks to ensure they were reflected on the Trust Risk Register.		
2.	Risks Identified	• Performance against a number of Workforce indicators		
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

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Report to:	Board of Directors	**Date:**	1 November 2019
Subject:	Safe High Quality Care Improvement Plan Update		
Report of:	Chief Nurse & Director of Quality Governance	**Prepared by:**	Deputy Director of Quality Governance

REPORT FOR INFORMATION

Corporate objective ref:	2a, 2b, 3a, 3b, 5a, 5c, 6a
Board Assurance Framework ref:	SO2, SO3, SO5, SO6
CQC Registration Standards ref:	10, 17, 18
Equality Impact Assessment:	☐ Completed ☒ Not required

Summary of Report

This report outlines the progress to date against the Safe High Quality Care Improvement Plan (new) as at 30 September 2019.

The plan is monitored through the Patient Quality Summit.

There are seven actions that do not have evidence of being on track and breached the August 2019 milestone.

- One of these is a 'must do' actions associated with medical equipment
- Six are 'should do' actions relating to; Handwashing facilities at Bluebell, development of a talent map, senior nurses representation in medicine, the crisis response team carry out the expected nursing assessments, access to information for patients in the community and action to create a positive culture in the Emergency Department.
- There are 20 actions that are partially completed

Action Leads have identified risks to future delivery, which have been identified in the report.

Members requested to note the progress.

Attachments:

This subject has previously been reported to:

☐ Board of Directors	☐ People Performance Committee
☐ Council of Governors	☐ Charitable Funds Committee
☐ Audit Committee	☐ Exec Management Group
☐ Executive Team	☐ Remuneration Committee
☐ Quality Committee	☐ Joint Negotiating Council
☐ Finance & Performance Committee	☐ Other – Safety & Risk Group

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1. INTRODUCTION

1.1 The Safe High Quality Care Improvement Plan (new) has been created in response to the publication of the CQC report detailing their findings from the unannounced visit, well-led assessment and use of resources assessment in December 2018.

1.2 In 2017, the CQC rated the Trust as 'requires improvement' overall, but also as 'inadequate' for safety in Medicine and in Urgent and Emergency Services and as 'inadequate' in well led for Urgent and Emergency Services. In 2018 the CQC continued to rate the Trust as 'requires improvement' overall but there was improvement in 12 areas including the removal of the three inadequate areas described.

1.3 Following the publication of the CQC report, detailing their findings from the unannounced visit, well-led assessment and use of resources assessment, a new improvement plan has been developed. This report provides an overview of the progress made with the Safe High Quality Care Improvement Plan (new).

1.4 The plan is managed through the Audit Management and Tracking (AMaT) system, and monitored at the Patient Quality Summit (PQS).

2 PROGRESS TO DATE

2.1 The Safe, High Quality Care Improvement Plan describes progress against the actions required to address the must do and should do areas identified in the December 2018 CQC report

2.2 There are 7 actions that do not have evidence of being on track and breached the September 2019 milestone;

- The trust must ensure that equipment is maintained in line with its polices and process and manufactures guidelines
    - The delay in meeting the agreed milestone date relates to being able to provide absolute assurance that maintenance schedules and service records for equipment maintained via external service contracts is accurate and appropriately recorded
    - Progress has been made in the following areas;
        - All medical equipment maintained internally by EBME technicians is maintained using a planned preventative maintenance programme (PPM). Each item of equipment has a maintenance plan based on relevant legislation, regulations, best practice guidance and manufacturer's recommendations.
        - The recruitment to the contract coordinator post has been successful, with a candidate appointed in October 2019 – the primary focus of their work will be on consolidating all external service contracts into the management of EBME department and providing assurance that PPMs are in place as per those in place for any equipment maintained internally.
        - Options have been developed for a medical equipment library and a suitable location has been identified – minor works will be required to make the space suitable, initial planning has commenced with our capital, estates and facilities team.
        - The revised policy for the management of medical devices was approved by the Medical Devices Committee in May 2019 and the Safety & Risk Group and Quality Governance Committee in July 2019.

- The trust should ensure that sufficient clinical handwashing facilities are accessible to staff in patient care areas at Bluebell
    - This has been delayed due the negotiation required with the premises owners.

- The trust should ensure that there is senior nurse representation at Department of Medicine for Older People Quality Board meetings
    - Attendance at meetings is being tracked for the DMOP CGM. Matrons are prioritizing attendance at CGM meetings and the action is being reviewed as part of the BG governance structures. Attendance at CGMs has been hindered by unplanned gaps within the matron team. Matrons have been engaging in other formal governance structures such as Harm Free Care panels, investigations and complaints and weekly quality meetings. This position is likely to improve from August onwards following the matron team returning to full establishment.

- The trust should consider developing a documented talent map or succession plan
    - Progress continues. A scoping exercise has been completed and we are taking part in the GM earlier adopter talent management programme.

- The trust should ensure that the Crisis Response Team (CRT) carry out the expected nursing assessments based on the acuity and referral criteria of the patient
    - SOP has been updated with the referral criteria. Triage assessment document has been reviewed and included within the SOP,
    - An audit has been undertaken on AMaT to confirm appropriate implementation of nursing assessment completed within CRT in relation to patient acuity. See attached.
    - SOP reviewed due to skill mix and for review August 2019 at Business Group Neighbourhood Quality Assurance meeting and ratification at Business Group Quality Board.
    - Triage assessment tool ratified.

- The trust should improve arrangements for meeting individual patient needs and access to information
    - Schedule of service's annual patient surveys being developed for 19/20. Additional question to be added.
    - Head of Borough Wide Services to meet with Head of Communications to discuss Trust plan for internet improvement for patient access
    - All community services are currently reviewing individual service details upon the internet for accuracy.
    - The Associate Director of Nursing: Integrated Care is meeting with the Trust Head of Communications to plan and evaluate the effectiveness of the information on the Internet and how we engage more fully with Health Watch partners:
    - All services reviewing currently what is on the internet. The Associate Nursing Director for Neighbourhood Services is meeting with Informatics team to understand feasibility of a link being put on the system to facilitate easy access.

- The trust should take action to promote a positive culture within the emergency department
    - Action plan in progress as per presentation at the executive team meeting in September

2.3 In addition there are 20 actions that are partially completed, and awaiting evidence of implementation or outcome.

2.4 Action leads have identified risks associated with the delivery of some of the timescales agreed. These include:-

- There is a risk that some actions will not be completed within the timescales due to competing priorities for staffing in the organisation.
- There is a risk that clinical staff will not be able to be released for training due to staffing and clinical challenges.
- There is a risk that the financial support required to enable the actions to be completed is not available due to competing priorities

The September 2019 position is detailed below.

RAG rating		
	Blue "Complete/BAU"	Completed: Improvement / action delivered
	Green "On track"	Improvement on trajectory either: a) On track – not yet completed b) On track – not yet started
	Amber "Problematic"	Delivery remains feasible issues / risks require additional intervention to deliver the required improvement e.g. Milestones breached.
	Red "Delayed"	Off track / trajectory – milestone / timescales breached. Recovery plan required.

	Current RAG status	Change from previous month
Regulation 5 HSCA (RA) Regulations 2014: Fit and proper persons: directors		
The trust must ensure that it is fully compliant with the requirements laid out in legislation applicable to fit and proper persons: directors.		↔
Regulation 9 HSCA (RA) Regulations 2014: Person centred care		
The trust must ensure that care and treatment meets individual needs of patients including those with learning disabilities and mental capacity concerns		↔
The trust must ensure that the best interests' decision making is documented within patient records		↔
The trust must ensure patients restricted under the Deprivation of Liberty Safeguards receive an on-going review or assessment of their needs		↔
The trust must take appropriate actions so that patients restricted under the Deprivation of Liberty Safeguards receive an on-going review or assessment of their needs		↔
Regulation 15 HSCA (RA) Regulations 2014: Premises and Equipment		
The trust must ensure that equipment is maintained in line with its polices and process and manufactures guidance		↔
Regulation 17 HSCA (RA) Regulations 2014: Good Governance		
The trust must ensure that it has systems and processes in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. This includes legacy risks from the previous recording system.		↔
The trust must improve the quality and consistency of serious incident investigations.		↔

The trust must improve performance in prescription of patients' regular medications.		↔
The trust must ensure that governance processes are sufficient to mitigate identified clinical risks.		↔
Regulation 18 HSCA Regulations 2014:Staffing		
The trust must take appropriate actions so that sufficient numbers of trained nursing staff are in place at all times.		↔
The trust must ensure that compliance with mandatory training is increased, including safeguarding training, particularly for medical staff.		↔
Should		
The trust should consider developing a documented talent map or succession plan		↓
The trust should move at pace to implement the medium term financial strategy		↔
The trust should consider involving patients in the development of the patient experience strategy.		↔
The trust should consider improving the quality of appraisals		↔
The trust should consider embracing the spirit of duty of candour in all applicable incident investigations		↔
The trust should consider board level clinical staff sign off of all clinical serious incidents.		↔
The trust should consider auditing all areas for medicines reconciliation		↔
The trust should strengthen performance management arrangements for the business units.		↔
The trust should consider improving Governor's understanding of the trust's strategic direction		↔
The trust should ensure the ambient temperature of the medicines storage room is monitored to make sure medicines are stored within their accepted temperature range		↔
The trust should take appropriate actions so that staff competency records are reviewed, maintained and kept up to date.		↑
Medicine		
The trust should take appropriate actions so that sufficient numbers of trained nursing staff are in place at all times. (In addition see actions under regulation 18)		↔
The trust should take appropriate actions so that acute non-invasive ventilation patients receive care and treatment in line with British Thoracic Society (BTS) Quality Standards. (Adults)		↑
The trust should take appropriate actions to improve staff mandatory training and appraisal process compliance		↔
The trust should take appropriate actions to improve staff compliance in fluid balance monitoring and the management of patients with sepsis		↔
The trust should take appropriate actions to reduce patient moves to other beds and wards during the night		↔
The trust should take appropriate actions to improve the average length of patient stay for non-elective patients in geriatric medicine and cardiology specialties		↔
The trust should take appropriate actions so that records are		↔

maintained for medicines returned to pharmacy for disposal.		
Bluebell		
The trust should ensure there is sufficient pharmacy oversight of prescribing on site including lithium blood level monitoring, timing of administration for pre-food medications and allergy recording on hard copy medication records.		↔
The trust should ensure that sufficient clinical hand washing facilities are accessible to staff in patient care areas		↔
The trust should ensure that there is senior nurse representation at department of medicine for older people quality board meetings		↔
Community Adults		
The trust should consider reviewing the security arrangements at Kingsgate House		↔
The trust should ensure that the crisis response team carry out the expected nursing assessments based on the acuity and referral criteria of the patient		↔
The trust should ensure the crisis response team review their terms of reference and key performance indicators		↔
The trust should improve arrangements for meeting individual patient needs and access to information		↔
The trust should consider reviewing targets for referral to treatment times.		↔
Devonshire		
The trust should take appropriate action so staff can access all mandatory training.		↔
The trust should secure patient records at all times		↔
The trust should secure the doors leading to the ward area at all times		↔
The trust should consider introducing regular engagement with patients and their families to identify areas requiring improvement that will improve care and experience.		↔
The trust should take appropriate actions so patients have access to psychiatric support.		↔
The trust should take action so that patients have regular access to an activity co-ordinator		↔
The trust should provide appraisals to all members of staff		↔
Maternity		
The trust should consider installing neonatal resuscitation equipment in all birthing areas to prevent separation of mum and baby in an emergency		↔
The trust should continue to work towards staffing the unit to full establishment for safety of women and babies, to improve the access and flow for women and to optimise their choices of place of birth		↔
The trust should consider redesign of the birthing room where the toilet is behind a curtain		↔
Urgent and Emergency services		
The trust should ensure patient records evidence capacity and delirium assessments		↔
The trust should ensure a review of the staffing model in the paediatric department is completed to ensure staffing complies with		↔

the Royal College of Paediatrics and Children's Health standards		
The trust should ensure that patients receive care in a timely way and work towards improving performance against national standards such as the time from arrival to treatment and median total time in the department		↔
The trust should ensure that all patients receive an initial assessment within 15 minutes of arrival, in line with the Royal College of Emergency Medicine standards		↔
The trust should ensure that plans for a new room for mental health assessments are completed		↔
The trust should ensure staff follow national guidance and patient pathways to ensure patients receive treatment that meets best practice		↔
The trust should continue to develop the number of substantive medical staff		↔
The trust should ensure that privacy and dignity of patients is always maintained		↔
The trust should take action to promote a positive culture within the emergency department.		↓

3. NEXT STEPS

3.1 The actions will continue to be progressed and monitored by the action leads through the Patient Quality Summit.

3.2 Work continues through the Safety and Quality Leadership Group to ensure delivery against agreed actions.

3.3 Clinical Service Reviews will be undertaken fortnightly to assess progress in the clinical areas.

4. SUMMARY

4.1 Members are asked to note the contents of the report and the progress made.

Stockport NHS Foundation Trust

Safe High Quality Care Improvement Plan

Following the Care Quality Commission Report December 2018

'Your Health: Our Priority

1. Purpose of this document

The purpose of this document is to outline the monitoring and escalation process for any gap analysis / improvement plan / after action review undertaken at Stockport NHS Foundation Trust (SNHSFT).

2. Process for monitoring and escalation of gap analysis / improvement plan / after action review (see flowchart in Appendix 1)

The **Initial "RAG" Rating** will be rated as follows:

Key:	**Compliant CLOSED**	**Partial – Compliance**	**Non – Compliant**
Key (Audits):	**Adherence > 90%**	**Adherence 80% - 89%**	**Adherence < 79%**

The overall **Current Position Rating** will be rated as follows:

Classification of progress		
Colour	**Narrative**	**Description**
B	Blue "Complete/BAU"	Completed: Improvement / action delivered
G	Green "On track"	Improvement on trajectory either: a) On track – not yet completed b) On track – not yet started
A	Amber "Problematic"	Delivery remains feasible issues / risks require additional intervention to deliver the required improvement e.g. Milestones breached.
R	Red "Delayed"	Off track / trajectory – milestone / timescales breached. Recovery plan required.

Stockport NHS Foundation Safe, High Quality Care Improvement Plan

INTRODUCTION:

This plan describes the actions to be taken in order to ensure compliance with the Health and Social Care 2008 (Regulated Activities) Regulations 2014. The plan has been developed in response to the Use of Resources Care Quality Commission inspection of September 2018, unannounced core services inspection in September 2018 and well led inspection in October 2018. The plan is part of an overarching Quality Improvement Plan, however it purposively addresses the MUST and SHOULD do actions from the CQC Report published December 2018.

The RAG ratings included are the INITIAL RAG ratings. The plan will be monitored bi-weekly at the Patient Quality Summit where RAG ratings will be reviewed.

Initial RAG	Standard/Process/ Issue/Gap Identified	Improvement required and action to be taken	By	Current RAG	How we will measure the action	By	Self - assessment	Responsible Lead	1st Line	2nd L:ine	3rd Line	Overall RAG
Regulation 5 HSCA (RA) Regulations 2014: Fit and proper persons: directors								Reporting and assurance structure				
	The trust must ensure that it is fully compliant with the requirements laid out in legislation applicable to fit and proper persons: directors.	• The trust will implement the following; ○ Checklist of all required documents & checks attached to all Board position files. ○ Proof of annual declarations in files. ○ Review non-executive directors' job descriptions to consider specific qualification requirements. ○ Consult on moving all Board members to EDBS system. ○ Review of fit and proper persons test policy annually. ○ Corporate HR support to sign off completed new starter files	Mar 2019		• Annual Board report re completion of annual declarations • Completion of EDBS consultation - April 2019 • Annual audit of directors files	Apr 2019		Director of Workforce & OD Chairman	People & Performance Committee	Remuneration Committee	Board of Directors	
Regulation 9 HSCA (RA) Regulations 2014: Person centred care								**Reporting and assurance structure**				
	The trust must ensure that care and treatment meets individual needs of patients including those with learning disabilities and mental capacity concerns	• The trust will implement a system where the business group matrons will be alerted to every patient with a diagnosis of learning disability or Dementia. • The trust will ensure each patient who requires it will have a relevant person centred care plan in place. • The trust will ensure that the safeguarding team will have an overview of all patients who have a learning disability or mental capacity concerns	Mar 2019		• Monthly audit against standard • A quarterly report to the Safeguarding Group.	Jun 2019		Deputy Chief Nurse	Operational Safeguarding Group	Safeguarding Group	Quality Committee	
	The trust must ensure that the best interests' decision making is documented within patient records	• The trust will carry out best interest meetings for all decisions that require multi agency shared care arrangements. • The trust will ensure that staff clearly document in the notes of the person at the centre of the care decision, the best interest meetings and decisions	Mar 2019		• Quarterly audit against standard	Jun 2019		Deputy Chief Nurse	Operational Safeguarding	Safeguarding Group	Quality Committee	

Initial RAG	Standard/Process/ Issue/Gap Identified	Improvement required and action to be taken	By	Current RAG	How we will measure the action	By	Self - assessment	Responsible Lead	1st Line	2nd L:ine	3rd Line	Overall RAG
	The trust must ensure patients restricted under the Deprivation of Liberty Safeguards receive an on-going review or assessment of their needs	• The trust will ensure that all patients who are unable to consent to stay within the care environment for care and treatment will have an application for or authorised DoLs in place. • The trust will treat all patients who have not had a formal supervisory body assessment, under best interest as defined by the Mental Capacity Act. • The trust will ensure that all patients who have a DoLs in place will have a copy of the application form, a Mental Capacity Assessment around the specific question of consent to stay within the care environment. • The trust will ensure that business groups complete a daily assessment of compliance to the standard.	Mar 2019		• Quarterly audit of compliance with the agreed standards	Jun 2019		Deputy Chief Nurse	Operational Safeguarding Group	Safeguarding Group	Quality Committee	
	The trust must take appropriate actions so that patients restricted under the Deprivation of Liberty Safeguards receive an on-going review or assessment of their needs	• The trust will monitor the use of DoLs care plan and review processes. • The trust will ensure that a senior review of individualised care planning takes place • The trust will ensure that business groups have oversight of all patients requiring DoLs within their responsibility	Mar 2019		• Quarterly audit against standards	Jun 2019		Deputy Chief Nurse	Operational Safeguarding Group	Safeguarding Group	Quality Committee	

Initial RAG	Standard/Process/ Issue/Gap Identified	Improvement required and action to be taken	By	Current RAG	How we will measure the action	By	Self - assessment	Responsible Lead	1st Line	2nd L:ine	3rd Line	Overall RAG
Regulation 15 HSCA (RA) Regulations 2014: Premises and Equipment								Reporting and assurance structure				
	The trust must ensure that equipment is maintained in line with its polices and process and manufactures guidance	• The trust will establish a task and finish group with agreed terms of reference. • The trust will develop a quality system for all medical equipment which includes a standard operating procedure. • The trust will identify all assets within Backtraq to clarify the need and frequency for maintenance including those where pieces of equipment that have no maintenance requirement. • The trust will agree standard reports in a format that satisfies the requirements of the Medical Devices Group and Medical Equipment Purchasing Group • The trust will review the Medical Equipment Policy, and alterations made to reflect the most current MHRA guidance. • The trust will recruit to the Quality Manager post. • The trust will develop a business case for RIFD Tracking and or an equipment library • The trust will assign appropriate planned maintenance profiles to assets • The trust will centralise contract control within the EBME and HSDU for all medical equipment • The trust will develop a business case for EBME Contract Manager.	Complete Jun 2019 Complete Feb 2019 Apr 2019 Jun 2019 Jun 2019 Jan 2019 Jun 2019 Feb 2019		• TOR of Task and Finish Group and action plan • Audit of processes	Jan 2019 Jun 2019		Director of Estates and Facilities	Medical Devices Group	Dafety & Risk Group	Finance & Performance Committee	

Initial RAG	Standard/Process/ Issue/Gap Identified	Improvement required and action to be taken	By	Current RAG	How we will measure the action	By	Self - assessment	Responsible Lead	1st Line	2nd L:ine	3rd Line	Overall RAG
Regulation 17 HSCA (RA) Regulations 2014: Good Governance								Reporting and assurance structure				
	The trust must ensure that it has systems and processes in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. This includes legacy risks from the previous recording system.	• The trust will assess the progress against risk management framework (RMF) • The trust will identify a process for sharing of risks • The trust will review the current risks by business group and ensure visibility to others • The trust will complete a training needs analysis and deliver training on risk management to all staff identified • The trust will conduct a review to ensure that any legacy risks are incorporated into the trust risk register	Apr 2019		• Completed assessment against RMF • Audit of process • Review complete and spot audit completed • TNA completed and training programme commenced • Legacy risk review	Jun 2019		Deputy Director of Quality Governance	Safety & Risk Group	Quality Governance Group	Quality Committee	
	The trust must improve the quality and consistency of serious incident investigations.	• The trust will implement a revised template once agreed. • The trust will identify and circulate guidance on writing reports. • The trust will implement NHSI sign off form to ensure consistency of investigations. • The trust will deliver training to panel chairs to ensure consistency • The trust will deliver training to investigators to support consistency	Apr 2019		• Audit use of forms • Audit compliance with rules • Audit compliance with sign off • Training completed	Jun 2019		Deputy Director of Quality Governance	Safety & Risk Group	Quality Governance Group	Quality Committee	

Initial RAG	Standard/Process/ Issue/Gap Identified	Improvement required and action to be taken	By	Current RAG	How we will measure the action	By	Self - assessment	Responsible Lead	1st Line	2nd L:ine	3rd Line	Overall RAG
	The trust must improve performance in prescription of patients' regular medications.	• The trust will implement EPMA in ED to reduce different prescribing systems in use. • The trust will Review other areas not using EPMA and consider implementation of EPMA for standardisation of prescribing. • The trust will implement an electronic chemotherapy prescribing system. • The trust will consider electronic discharge in maternity. • The trust will implement a process that will ensure surgical patients have the regular medications prescribed	Dec 2019 Mar 2019 Jun 2019 Mar 2019 Mar 2019		• Implementation of EPMA system in ED • Evidence of review • Implementation of Chemotherapy system • Evidence of review • Audit of patients	Jan 2019 Jun 2019 Jun 2019 Jun 2019 Jun 2019		Chief Pharmacist Associate Medical Director, Surgery Business Group	Safe Medicines Group	Medicines Optimisation Group	Quality Committee	
	The trust must ensure that governance processes are sufficient to mitigate identified clinical risks.	• The trust will assess the progress against risk management framework (RMF) • The trust will identify a process for sharing of risks • The trust will review the current risks by business group and ensure visibility to others • The trust will complete a training needs analysis and deliver training on risk management to all staff identified	Apr 2019		• Completed assessment against RMF Audit of process • Review complete and spot audit completed • TNA completed and training programme commenced	Jun 2019		Deputy Director of Quality Governance	Safety & Risk Group	Quality Governance Group	Quality Committee	

Initial RAG	Standard/Process/ Issue/Gap Identified	Improvement required and action to be taken	By	Current RAG	How we will measure the action	By	Self - assessment	Responsible Lead	1st Line	2nd L:ine	3rd Line	Overall RAG
Regulation 18 HSCA Regulations 2014:Staffing								**Reporting and assurance structure**				
	The trust must take appropriate actions so that sufficient numbers of trained nursing staff are in place at all times.	• The trust will work as part of the NHSI collaborative. • The trust will deliver actions outlined in the recruitment and retention strategy. • The trust will monitor progress in reducing the vacancy numbers for RN's. • The trust will monitor agency and NHSP usage. • The trust will report the NHSP usage to Board of Directors via the IPR. • The trust will continue to deliver the actions relating to recruitment and retention with the GM partnership. • The trust will assist in the delivery of the people strategy in specific relation to the objective - creating a workplace that attracts and retains people with the right skills, and commitment to providing high quality, safe care. • The trust will triangulate temporary staffing fill rate against agreed establishment. • The trust will undertake daily assessments of staffing levels.	Jun 2019		• Monthly temporary staffing data • Audit of policies	Jun 2019		Deputy Director of Workforce and OD Deputy Chief Nurse	Education Governance Group Business Group monthly Performance meetings	Workforce Efficiency Group	People & Performance Committee Board of Directors	
	The trust must ensure that compliance with mandatory training is increased, including safeguarding training, particularly for medical staff.	• The trust will proactively identify areas/subjects of low compliance for mandatory training. • The trust will review the provision of mandatory training in areas identified and work with teams/staff groups to develop a trajectory for improved compliance levels. • The trust will develop a targeted approach for medical staff.	Mar 2019 Jun 2019 Mar 2019		• Mandatory training compliance audit • Integrated Performance Report includes compliance against targets	Sep 2019 Jun 2019		Deputy Director of Workforce and OD Deputy Chief Nurse	Education Governance Group Business Group monthly Performance meetings	Workforce Efficiency Group	People & Performance Committee Board of Directors	

Initial RAG	Standard/Process/ Issue/Gap Identified	Improvement required and action to be taken	By	Current RAG	How we will measure the action	By	Self - assessment	Responsible Lead	1st Line	2nd L:ine	3rd Line	Overall RAG
Should												
	The trust should consider developing a documented talent map or succession plan	• The trust will develop a strategy for talent management and succession planning arrangements as part of its People Strategy. • The trust will implement the strategy and associated actions.	Sep 2019 Sep 2019		• Strategy developed and approved • Audit of outcomes	Sep 2019 Sep 2019		Deputy Director of Workforce and OD	Culture and Engagement Group	People & Performance Committee	Board of Directors	
	The trust should move at pace to implement the medium term financial strategy	• The trust will consider the control total for 2019/20 and agree the overall target • The trust will agree the Cost Improvement Target for 2019/2020 • The trust will develop and implement the clinical services efficiency programme for 2019/20	Jan 2019 Apr 2019 Mar 2019		• Monthly monitoring of financial performance • Execution of the performance management framework	Apr 2019 Mar 2019		Deputy Director of Finance	Business Group monthly Performance meetings	Finance & Performance Committee	Board of Directors	
	The trust should consider involving patients in the development of the patient experience strategy.	• The trust will share the strategy with patient and the carer representative • The trust will assess any changes required following feedback	Mar 2019 Jun 2019		• Evidence of the sharing of information via the patient experience action group minutes	Jun 2019		Deputy Chief Nurse	Patient Experience Action Group	Patient Experience Group	Quality Committee	
	The trust should consider improving the quality of appraisals	• The trust will implement a task and finish group to review the appraisal process, documentation and training. • The trust will develop an action plan to ensure steps are taken to improve the experience of appraisal for staff.	Mar 2019		• Terms of reference of task and finish group • Action plan delivery • Increase of staff satisfaction in annual staff survey.	Mar 2019 Jun 2019 Jan 2020		Deputy Director of Workforce and OD	Culture & Engagement Group	People & Performance Committee	Board of Directors	

Initial RAG	Standard/Process/ Issue/Gap Identified	Improvement required and action to be taken	By	Current RAG	How we will measure the action	By	Self - assessment	Responsible Lead	1st Line	2nd L:ine	3rd Line	Overall RAG
	The trust should consider embracing the spirit of duty of candour in all applicable incident investigations	• The trust will review process when including patients and their relatives in the investigation of serious incidents • The trust will ensure new template includes section and guidance on patient engagement • The trust will review process to include a patient liaison contact	Mar 2019		• Bi-annual audit of Serious Incident panel hearings • Bi-annual audit of patient input into investigations	Jun 2019 Jun 2019		Deputy Director of Quality Governance	Safety & Risk Group	Quality Governance Group	Quality Committee	
	The trust should consider board level clinical staff sign off of all clinical serious incidents.	• The trust will ensure that all clinical Serious Incidents panels to be chaired by a Clinical Executive	Dec 2018		• Bi- annual audit of Serious Incident panel hearings	Jun 2019		Deputy Director of Quality Governance	Safety & Risk Group	Quality Governance Group	Quality Committee	
	The trust should consider auditing all areas for medicines reconciliation	• The trust will commence monthly audits in surgery business group in addition to the existing medicine business group medicines reconciliation audits • The trust will undertake a review of all the areas where medicines reconciliation does not take place and risk assessment will be completed to ensure all areas are appropriately managed	Dec 2018 Feb 2019		• Monthly audit • Risk assessment	Jun 2019 Jun 2019		Chief Pharmacist	Senior Pharmacy Management Group	Medicines Optimisation Group	Quality Committee	
	The trust should strengthen performance management arrangements for the business units.	• The trust will put in place monthly performance management meetings with each business group, covering key indicators in quality, operational performance, finance and workforce. • Development of the triumvirates and business managers	Dec 2018 Dec 2019		• Key issue reports to EMG and Finance & Performance Committee	Jun 2019 Jun 2019		Associate Director of Strategy and Planning	Executive Management Group	Executive Team	Finance & Performance	

Initial RAG	Standard/Process/ Issue/Gap Identified	Improvement required and action to be taken	By	Current RAG	How we will measure the action	By	Self - assessment	Responsible Lead	1st Line	2nd L:ine	3rd Line	Overall RAG
	The trust should consider improving Governor's understanding of the trust's strategic direction	• The trust will deliver a workshop to facilitate Governor understanding of new strategy following Board approval in January 2019. • The trust will include strategic development as a standing agenda item at Council of Governors meetings.	Mar 2019 Mar 2020		• Record of Workshop • Agendas and minutes of meetings.	Mar 2019		Associate Director of strategy & Planning Head of	Strategy & Planning Oversight Group	Council of Governors	Board of Directors	
	The trust should ensure the ambient temperature of the medicines storage room is monitored to make sure medicines are stored within their accepted temperature range	• The trust will introduce a temperature monitoring scheme across all clinical areas (treatment rooms and drug fridges) in the hospital. • The trust will undertake a continuous rolling programme of monitoring of treatment rooms until the Estates work is completed. • The trust will manage the medicine stock expiry dates according to the temperatures reported.	Jun 2019		• Monthly audit	Sep 2019		Chief Pharmacist	Safe Medicines Group	Medicines Optimisation Group	Quality Committee	
	The trust should take appropriate actions so that staff competency records are reviewed, maintained and kept up to date.	• The trust will implement a task and finish group to design a system for mapping competency requirements • The trust will develop a system for accurately recording and updating compliance against competency of staff.	Jun 2019		• Terms of reference of the Task and Finish Group • Bi-annual audit of records	Jun 2019 Jun 2019		Deputy Director of Workforce and OD Deputy Chief Nurse	Task and Finish Group	Education Governance Group	People & Performance Committee	

Initial RAG	Standard/Process/ Issue/Gap Identified	Improvement required and action to be taken	By	Current RAG	How we will measure the action	By	Self - assessment	Responsible Lead	1st Line	2nd L:ine	3rd Line	Overall RAG
Medicine												
	The trust should take appropriate actions so that sufficient numbers of trained nursing staff are in place at all times. (In addition see actions under regulation 18)	• The Business Group will review staffing numbers to ensure safety on each shift across the Business Group on a daily basis. • The Business Group will create a retention plan specific to the needs of the Business Group and implement the actions.	Dec 2018 Sept 2019		• Reduction in turnover figures • Improved vacancy figures	Mar 2020 Mar 2020		Associate Nursing Director, Medicine	Ward Managers Forum	Medicine & CS Business Group Quality Governance Board	People & Performance Committee	

Initial RAG	Standard/Process/ Issue/Gap Identified	Improvement required and action to be taken	By	Current RAG	How we will measure the action	By	Self - assessment	Responsible Lead	1st Line	2nd L:ine	3rd Line	Overall RAG
	The trust should take appropriate actions so that acute non-invasive ventilation patients receive care and treatment in line with British Thoracic Society (BTS) Quality Standards. (Adults)	• The trust will establish a task and finish group that will ensure that staff on duty have the appropriate training to care for patients who are being treated with non-invasive ventilation in accordance to BTS quality standards	Mar 2019		• Quarterly report from Task and Finish Group	Sept 2019		Associate Nursing Director, Medicine	Task and Finish Group	Medicine & CS Business Group Quality Governance Board	Quality Committee	
	The trust should take appropriate actions to improve staff mandatory training and appraisal process compliance	• The trust will review mandatory training provision in the unit; with provision of dedicated support to resolving access issues. • The trust will develop a trajectory to deliver the required compliance levels.	Mar 2019 Mar 2019		• Compliance with mandatory training figures • Agreed improvement trajectory achieved	Sept 2019 Sept 2019		Business Group Director, Medicine Deputy Director of Workforce and OD	Ward Managers Forum	Medicine and CS Business Group Quality Governance	People & Performance Committee	
	The trust should take appropriate actions to improve staff compliance in fluid balance monitoring and the management of patients with sepsis	• The trust will ensure that all staff have appropriate training and knowledge about fluid balance monitoring • The trust will ensure that all staff have appropriate training and knowledge about managing patients with sepsis • The trust will ensure each ward review sepsis alerts on a daily basis.	Jun 2019		• Compliance with training • Monthly audit of compliance with fluid balance monitoring standard • Monthly compliance with NEWS 2 standards • Monthly compliance with sepsis bundle	Sept 2019 Sept 2019 Sept 2019 Sept 2019		Associate Nursing Director, Medicine	Medicine & CS Business Group Quality Governance Board	Quality Governance Group	Quality Committee	

Initial RAG	Standard/Process/ Issue/Gap Identified	Improvement required and action to be taken	By	Current RAG	How we will measure the action	By	Self - assessment	Responsible Lead	1st Line	2nd L:ine	3rd Line	Overall RAG
	The trust should take appropriate actions to reduce patient moves to other beds and wards during the night	• The trust will define and implement agreed standards for moving patients within appropriate timescales. • The trust will develop a database and establish a baseline audit of patients who are moved out of hours. • The trust will agree a target reduction of the number of patients who are moved out of hours • The trust will ensure that Clinical Site Co-ordinators to support the movement of patients earlier in the day (including patients who may be cared for in areas outside of their speciality	Jan 2019 Jan 2019 Mar 2019 Mar 2019		• Audit of compliance against agreed trajectory • Audit of transfer guidance	Sept 2019		Lead Nurse for patient flow	Deteriorating Patient Group (under development)	Quality Governance Group	Quality Committee	
	The trust should take appropriate actions to improve the average length of patient stay for non-elective patients in geriatric medicine and cardiology specialties.	• The trust will improve length of stay for geriatric and cardiology wards. Actions to progress this will be: • The trust will redesign cardiology pathways. • The trust will implement a consultant of the week model. • The trust will develop transfer to assess model. • The trust will embed SAFER principles on the wards. • The trust will develop pathways with community services to improve LOS.	Sept 2019		• LOS metric • Readmission rate metric	Sept 2019		Business Group Director, Medicine	Cardiology and DMOP Clinical Governance meetings	Operational Board for Medicine & CS Business Group	Operational Performance Group	

Initial RAG	Standard/Process/ Issue/Gap Identified	Improvement required and action to be taken	By	Current RAG	How we will measure the action	By	Self - assessment	Responsible Lead	1st Line	2nd L:ine	3rd Line	Overall RAG
	The trust should take appropriate actions so that records are maintained for medicines returned to pharmacy for disposal.	• The trust will review best practice and national standards to ensure records, when appropriate, are maintained for medicines returned to pharmacy for disposal. • The trust will benchmark against other trusts to identify how recording of medicines disposal is managed elsewhere. • The trust will continue to document controlled drug returns • The trust will complete a risk assessment of medicines not recorded • The trust will ensure drug recycling continues and the stock is entered onto the pharmacy system	Mar 2019 Jan 2019 Dec 2018 Jan 2019 Dec 2018		• Monthly recycling figure • Audit of records in CD book • Annual review of the risk	Sept 2019		Chief Pharmacist	Senior Pharmacy Management Group	Medicines Optimisation Group	Quality Committee	

Initial RAG	Standard/Process/ Issue/Gap Identified	Improvement required and action to be taken	By	Current RAG	How we will measure the action	By	Self - assessment	Responsible Lead	1st Line	2nd L:ine	3rd Line	Overall RAG
Bluebell												
	The trust should ensure there is sufficient pharmacy oversight of prescribing on site including lithium blood level monitoring, timing of administration for pre-food medications and allergy recording on hard copy medication records.	• The trust will increase the pharmacy oversight of prescribing on the Bluebell Ward. Actions to progress this will be: • The trust will identify if financial resource is available within the Trust for additional pharmacist support • The trust will recruit an additional pharmacist, if resources are available. • The trust will introduce EPMA on Bluebell Ward to enable regular review of medicines • The trust will flexibly allocate pharmacists from other areas of the trust onto Bluebell Ward and amend risk assessment on pharmacy capacity accordingly, if no additional resources are available.	Mar 2019 Sept 2019 Sept 2019 Sept 2019		• Evidence of review with Business Group • Regular review from pharmacy • Implementation of EPMA • Updated risk assessment	Sept 2019		Chief Pharmacist	Safe Medicines Group	Medicines Optimisation Group	Quality Committee	
	The trust should ensure that sufficient clinical hand washing facilities are accessible to staff in patient care areas	• The trust will install hand washing facilities in Bluebell Ward supported by estates team • The trust will develop a business case for approval and funding, noting that the Meadows is a PFI facility not managed by the trust.	Sept 2019 Sept 2019		• Governance meeting for Bluebell to monitor installation progress	Dec 2019		Business Manager Medicine	Medicine & CS Business Group	Business Group monthly	Finance & Performance	
	The trust should ensure that there is senior nurse representation at department of medicine for older people quality board meetings	• The trust will ensure that the matron for Bluebell Ward attends quality board meetings on a regular basis	Jan 2019		• Attendance matrix for governance meetings	Dec 2019		Business Group Director, Medicine	Medical Governance Board	Medicine & CS Business Group	Quality Governance Group	

Initial RAG	Standard/Process/ Issue/Gap Identified	Improvement required and action to be taken	By	Current RAG	How we will measure the action	By	Self - assessment	Responsible Lead	1st Line	2nd L:ine	3rd Line	Overall RAG
Service for community adults												
	The trust should consider reviewing the security arrangements at Kingsgate House	• The trust will review security arrangements at Kingsgate House to prevent unsupervised patient access to clinical rooms on floor 2 • The trust will implement new security arrangements / complete Risk Assessment	Jan 2019 Jan 2019		• Evidence of decision making and risk assessment	Mar 2019		Director of Estates and Facilities	Integrated Care BG Quality &	Operational Performance	Finance & Performance	
	The trust should ensure that the crisis response team carry out the expected nursing assessments based on the acuity and referral criteria of the patient	• The trust will produce a new Standard Operating Procedure. • The Crisis Response Team will undertake appropriate nursing assessments in line with the new Standard Operating Procedure on clinical documentation.	Apr 2019 Apr 2019		• Monthly audit of clinical records against SOP standards	Sep 2019		Associate Nurse Director Community	Neighbourhood Care Quality Assurance Group	Integrated Care Quality Assurance Board	Quality Committee	
	The trust should ensure the crisis response team review their terms of reference and key performance indicators	• The trust will review Crisis Response service criteria and KPIs with CCG and other key stakeholders. • The trust will implement the agreed KPI's in line with community contract.	Mar 2019 Mar 2019		• New KPI's in place • Monthly monitoring of KPI's	Sep 2019		Business Group Director, Integrated Care	Integrated Care Operational Group	Operational Performance Group	Urgent Care Delivery Board	
	The trust should improve arrangements for meeting individual patient needs and access to information	• The trust will clarify the process for managing the trust internet • The trust will work with Healthwatch to seek feedback about the appropriateness of public information. • The trust will review the community services information on the trust internet. • The trust will add a question regards the trust internet to the community services' annual patient surveys.	Jun 2019		• A quarterly patient report collating responses by service	Sep 2019		Associate Nurse Director Community Head of communications	Neighbourhood Care Quality Assurance Group	Integrated Care Quality Assurance Board	Quality Committee	

Initial RAG	Standard/Process/ Issue/Gap Identified	Improvement required and action to be taken	By	Current RAG	How we will measure the action	By	Self - assessment	Responsible Lead	1st Line	2nd L:ine	3rd Line	Overall RAG
	The trust should consider reviewing targets for referral to treatment times.	• The trust will review services' targets for referral and treatment times with the CCG. • The trust will update the service specifications as required. • The trust will incorporate the updated referral and treatment times into the performance monitoring process.	Apr 2019		• Monthly performance report	Sep 2019		Business Group Director, Integrated Care	Integrated Care Operational Group	Community Services Quality and Performance Forum	Business Group monthly Performance meeting	
Devonshire												
	The trust should take appropriate action so staff can access all mandatory training.	• The trust will undertake a review of mandatory training provision in the unit; with provision of dedicated support to resolving access issues. • The trust will develop a trajectory to ensure deliver of the required compliance levels.	Sep 2019		• Compliance with mandatory training figures • Agreed improvement trajectory achieved.	Sep 2019		Associate Nursing Director, Medicine Deputy Director of Workforce and OD	Medicine Business Group Quality Board	Education Governance Group	People & Performance Committee	
	The trust should secure patient records at all times	• The trust will ensure lockable medical records trollies are in use at the Devonshire Unit. • The trust will ensure that patient records are kept in a locked office at all times when not in the possession of a healthcare professional.	Apr 2019		• Monthly audit of record security.			Associate Nursing Director, Medicine	Neuro Rehabilitation Governance Group	Medicine & CS Business Group Quality Governance	Quality Governance Group	
	The trust should secure the doors leading to the ward area at all times	• The trust will review the security of the Devonshire Unit to ensure compliance.	Mar 2019		• Monthly audit of compliance to agreed standard	Jun 2019		Associate Nursing Director, Medicine	Neuro Rehabilitation Governance Group	Medicine & CS Business Group Quality Governance	Quality Committee	

Initial RAG	Standard/Process/ Issue/Gap Identified	Improvement required and action to be taken	By	Current RAG	How we will measure the action	By	Self - assessment	Responsible Lead	1st Line	2nd L:ine	3rd Line	Overall RAG
	The trust should consider introducing regular engagement with patients and their families to identify areas requiring improvement that will improve care and experience.	• The trust will promote the use of the patient and visitor suggestion box. • The trust will work with the patient experience matron and communications lead to develop further opportunities for patient engagement • The trust will encourage families to meet with the MDT team weekly to ensure close involvement in care	Mar 2019		• FFT results • Patient survey focussed on engagement	Jun 2019		Associate Nursing Director, Medicine	Neuro Rehabilitation Governance Group	Medicine & CS Business Group Quality Governance Board	Quality Committee	
	The trust should take appropriate actions so patients have access to psychiatric support.	• The trust will continue to work with Pennine Care to develop a memorandum of understanding /service level agreement in the development of the Core 24 service.	Mar 2019		• Audit of timeliness of access for patients requiring mental health support	Jun 2019		Business Group Director, Medicine	Operational Safeguarding Group	Safeguarding Group	Quality Committee	
	The trust should take action so that patients have regular access to an activity co-ordinator	• The trust will publicise a calendar of activities for patients. • The trust will consider the use of activity coordinator role.	Mar 2019		• FFT and patient/ relative complaints and feedback • Bi-monthly report of activities at the Devonshire Unit	Jun 2019		Associate Nursing Director, Medicine	Neuro Rehabilitation Governance Group	Medicine and CS Business Group Quality Governance	Quality Committee	
	The trust should provide appraisals to all members of staff	• The trust will ensure that all staff to have appraisals in a timely manner	Jan 2019		• Compliance report	Mar 2019		Associate Nursing Director, Medicine	Neuro Rehabilitation Governance	Education Governance Group	People & Performance Committee	

Initial RAG	Standard/Process/ Issue/Gap Identified	Improvement required and action to be taken	By	Current RAG	How we will measure the action	By	Self - assessment	Responsible Lead	1st Line	2nd L:ine	3rd Line	Overall RAG
Maternity												
	The trust should consider installing neonatal resuscitation equipment in all birthing areas to prevent separation of mum and baby in an emergency	• The trust will obtain costings for wall mounted/ freestanding resuscitation equipment to be placed in all birth rooms on the Birth Centre. • The trust will add the equipment to the capital programme list • The trust will purchase and install the equipment	Apr 2019		• Evidence of equipment installed	Jun 2019		Head of Midwifery	Women's' Children's & Diagnostics Governance and	Women's' Children's & Diagnostics Quality Board	Quality Governance Group	
	The trust should continue to work towards staffing the unit to full establishment for safety of women and babies, to improve the access and flow for women and to optimise their choices of place of birth	• The trust will resubmit the outline business case for additional registered midwifery staffing to the Executive Management Group for approval and onward escalation when ratified • The trust will clearly articulate the staffing deficit on the risk register and review every three months. • The trust will ensure timely reporting of staffing related risks on the incident reporting system.	Apr 2019		• Audit of staffing incidents • Evidence of risk review	Jun 2019		Head of Midwifery	Women's' Children's & Diagnostics Governance and Risk Group	Women's' Children's & Diagnostics Quality Board	People & Performance Committee	
	The trust should consider redesign of the birthing room where the toilet is behind a curtain	• The trust will take the birthing room out of use following a review by the Estates Team. • The trust will undertake a review of the birthing rooms and collate plans for redesign of the birth environment to meet current standards • The trust will assess the cost for the works to be undertaken to birthing rooms and submit an outline business case.	Apr 2019		• Work Completed	Sep 2019		Head of Capital Projects	Estates Capital Group	Capital Programme Development Group	Finance & Performance Committee	

Initial RAG	Standard/Process/ Issue/Gap Identified	Improvement required and action to be taken	By	Current RAG	How we will measure the action	By	Self - assessment	Responsible Lead	1st Line	2nd L:ine	3rd Line	Overall RAG
Urgent and Emergency Services												
	The trust should ensure patient records evidence capacity and delirium assessments	• The trust will ensure that staff document mental capacity assessments. • The capacity assessment tool will be incorporated into Advantis ED as a mandatory field.	Mar 2019		• Quarterly audit against standards	Jun 2019		Associate Nurse Director Urgent care	Operational Safeguarding	Safeguarding Group	Quality Committee	
	The trust should ensure a review of the staffing model in the paediatric department is completed to ensure staffing complies with the Royal College of Paediatrics and Children's Health standards	• The trust will ensure that the paediatric emergency department model is compliant with the RCPCH standards. • The trust will arrange for an external peer review to be undertaken. • The trust will review the findings of the external report and implement actions to meet standard.	Apr 2019		• A report following the review	Jun 2019		Associate Nurse Director Urgent care	Urgent Quality Assurance meeting	Integrated Care Quality Assurance Board	People & Performance Committee	
	The trust should ensure that patients receive care in a timely way and work towards improving performance against national standards such as the time from arrival to treatment and median total time in the department	• The trust will review the current pathways to improve performance against national standards. • The trust will reconfigure the urgent care estate, completing the work on the 'front door' • The trust will continue to monitor daily performance of admitted and non-admitted pathways.	Apr 2019		• A weekly compliance report	Apr 2019		Associate Director Urgent care	Urgent Care Quality Assurance meeting	Operational Performance Group	Urgent Care Delivery Board	

Initial RAG	Standard/Process/ Issue/Gap Identified	Improvement required and action to be taken	By	Current RAG	How we will measure the action	By	Self - assessment	Responsible Lead	1st Line	2nd L:ine	3rd Line	Overall RAG
	The trust should ensure that all patients receive an initial assessment within 15 minutes of arrival, in line with the Royal College of Emergency Medicine standards	• The trust will develop a triage plan to achieve the 15 minute standard, which will include actions around training, competencies for diagnostic ordering and response to surge / increase in patient demand. • The trust will implement the actions of the plan and monitor progress.	Mar 2019		• A weekly compliance report	Apr 2019		Associate Director Urgent care	Urgent Quality Assurance meeting	Integrated Care Quality Assurance Board	Quality Committee	
	The trust should ensure that plans for a new room for mental health assessments are completed	• The trust will complete the estate work for additional major assessment areas, designed and planned in partnership with Pennine Care NHS Foundation Trust.	Mar 2019		• A monthly utilisation report	Apr 2019		Associate Director Urgent Care	Urgent Care Operations Group	Operational Performance Group	Urgent Care Delivery Board	
	The trust should ensure staff follow national guidance and patient pathways to ensure patients receive treatment that meets best practice	• The trust will review and update the clinical pathways / national guidance available on the intranet. • The trust will revise the emergency department induction programme, to ensure all staff are able to access clinical pathways / national guidance on the intranet. • The trust will develop an urgent care clinical pathway audit programme for 2019/20.	Apr 2019		• Audit patient records to ensure pathways used when applicable • Induction compliance figures	Jun 2019		Clinical Director Urgent Care	Urgent Quality Assurance meeting	Integrated Care Quality Assurance Board	Quality Governance Group	

Initial RAG	Standard/Process/ Issue/Gap Identified	Improvement required and action to be taken	By	Current RAG	How we will measure the action	By	Self - assessment	Responsible Lead	1st Line	2nd L:ine	3rd Line	Overall RAG
	The trust should continue to develop the number of substantive medical staff	• The trust will improve the number of substantive staff in place to meet Royal College guidance. • The trust will develop and implement a workforce strategy, addressing the recruitment of Physician Associates, Acute Care practitioners and international recruitment.	Sep 2019 Mar 2019		• Monthly update on progress	Sep 2019		Clinical Director Urgent Care	Urgent Quality Assurance meeting	Integrated Care Quality Assurance Board	People & Performance Committee	
	The trust should ensure that privacy and dignity of patients is always maintained	• The trust will ensure that patients are being cared for and treatment is being delivered with dignity and compassion in suitable environments. • The trust will adopt a zero tolerance approach regarding examinations performed outside of cubicle space. • The trust will implement the emergency department safety checklist. • The trust will implement an escalation process in the event that standards are not maintained.	Mar 2019		• Monthly audits against standard	Sep 2019		Associate Nurse Director Urgent care	Integrated Care Quality Assurance Board	Patient Experience Group	Quality Committee	
	The trust should take action to promote a positive culture within the emergency department.	• The trust will assess the culture in the department and develop and action plan based on the results in conjunction with the team	Sep 2019		• Staff surveys	Sep 2019		Associate Director Clinical Director Associate Nurse Director Urgent care	Urgent Quality Assurance meeting	Integrated Care Quality Assurance Board	People & Performance Committee	

Appendix 1

PROCESS FOR MONITORING AND ESCALATION OF IMPLEMENTATION PLAN / GAP ANALYSIS / AFTER ACTION REVIEW

Trust standard template completed by identified lead

↓

Template submitted to the named committee/group responsible for that area

Implementations and timescales monitored by the named committee/group

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Timescale breaches for any action potentially resulting in major or catastrophic harm (as defined on the risk matrix) requires immediate escalation to the Chair of the relevant Board sub-committee

If a timescale breaches by 2 months, named committee/group Chair to escalate to reporting committee/group or where appropriate the relevant Board sub-committee

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If a timescale breaches by 4 months, the Board sub-committee considers escalation to the Board of Directors

The identified lead is responsible for ensuring that all actions are completed within the timescales agreed in conjunction with the person responsible for the action

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SHQIP Monthly movement

	Feb 19	Mar 19	April 19	May 19	June 19	July 19	Aug 19	Sep 19	
Regulation 5 HSCA (RA) Regulations 2014: Fit and proper persons: directors									
The trust must ensure that it is fully compliant with the requirements laid out in legislation applicable to fit and proper persons: directors.									
Regulation 9 HSCA (RA) Regulations 2014: Person centred care									
The trust must ensure that care and treatment meets individual needs of patients including those with learning disabilities and mental capacity concerns									
The trust must ensure that the best interests' decision making is documented within patient records									
The trust must ensure patients restricted under the Deprivation of Liberty Safeguards receive an on-going review or assessment of their needs									
The trust must take appropriate actions so that patients restricted under the Deprivation of Liberty Safeguards receive an on-going review or assessment of their needs									
Regulation 15 HSCA (RA) Regulations 2014: Premises and Equipment									
The trust must ensure that equipment is maintained in line with its polices and process and manufactures guidance									
Regulation 17 HSCA (RA) Regulations 2014: Good Governance									
The trust must ensure that it has systems and processes in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. This includes legacy risks from the previous recording system.									
The trust must improve the quality and consistency of serious incident investigations.									
The trust must improve performance in prescription of patients' regular medications.									
The trust must ensure that governance processes are sufficient to mitigate identified clinical risks.									
Regulation 18 HSCA Regulations 2014:Staffing									
The trust must take appropriate actions so that sufficient numbers of trained nursing staff are in place at all times.									
The trust must ensure that compliance with mandatory training is increased, including safeguarding training, particularly for medical staff.									
Should									
The trust should consider developing a documented talent map or									

	Feb 19	Mar 19	April 19	May 19	June 19	July 19	Aug 19	Sep 19	
succession plan									
The trust should move at pace to implement the medium term financial strategy									
The trust should consider involving patients in the development of the patient experience strategy.									
The trust should consider improving the quality of appraisals									
The trust should consider embracing the spirit of duty of candour in all applicable incident investigations									
The trust should consider board level clinical staff sign off of all clinical serious incidents.									
The trust should consider auditing all areas for medicines reconciliation									
The trust should strengthen performance management arrangements for the business units.									
The trust should consider improving Governor's understanding of the trust's strategic direction									
The trust should ensure the ambient temperature of the medicines storage room is monitored to make sure medicines are stored within their accepted temperature range									
The trust should take appropriate actions so that staff competency records are reviewed, maintained and kept up to date**.**									
Medicine									
The trust should take appropriate actions so that sufficient numbers of trained nursing staff are in place at all times. (In addition see actions under regulation 18)									
The trust should take appropriate actions so that acute non-invasive ventilation patients receive care and treatment in line with British Thoracic Society (BTS) Quality Standards. (Adults)									
The trust should take appropriate actions to improve staff mandatory training and appraisal process compliance									
The trust should take appropriate actions to improve staff compliance in fluid balance monitoring and the management of patients with sepsis									
The trust should take appropriate actions to reduce patient moves to other beds and wards during the night									
The trust should take appropriate actions to improve the average length of patient stay for non-elective patients in geriatric medicine and cardiology									

	Feb 19	Mar 19	April 19	May 19	June 19	July 19	Aug 19	Sep 19	
specialties									
The trust should take appropriate actions so that records are maintained for medicines returned to pharmacy for disposal.									
Bluebell									
The trust should ensure there is sufficient pharmacy oversight of prescribing on site including lithium blood level monitoring, timing of administration for pre-food medications and allergy recording on hard copy medication records.									
The trust should ensure that sufficient clinical hand washing facilities are accessible to staff in patient care areas									
The trust should ensure that there is senior nurse representation at department of medicine for older people quality board meetings									
Community Adults									
The trust should consider reviewing the security arrangements at Kingsgate House									
The trust should ensure that the crisis response team carry out the expected nursing assessments based on the acuity and referral criteria of the patient									
The trust should ensure the crisis response team review their terms of reference and key performance indicators									
The trust should improve arrangements for meeting individual patient needs and access to information									
The trust should consider reviewing targets for referral to treatment times.									
Devonshire									
The trust should take appropriate action so staff can access all mandatory training.									
The trust should secure patient records at all times									
The trust should secure the doors leading to the ward area at all times									
The trust should consider introducing regular engagement with patients and their families to identify areas requiring improvement that will improve care and experience.									
The trust should take appropriate actions so patients have access to psychiatric support.									

SHQIP Monthly movement

	Feb 19	Mar 19	April 19	May 19	June 19	July 19	Aug 19	Sep 19	
The trust should take action so that patients have regular access to an activity co-ordinator									
The trust should provide appraisals to all members of staff									
Maternity									
The trust should consider installing neonatal resuscitation equipment in all birthing areas to prevent separation of mum and baby in an emergency									
The trust should continue to work towards staffing the unit to full establishment for safety of women and babies, to improve the access and flow for women and to optimise their choices of place of birth									
The trust should consider redesign of the birthing room where the toilet is behind a curtain									
Urgent and Emergency services									
The trust should ensure patient records evidence capacity and delirium assessments									
The trust should ensure a review of the staffing model in the paediatric department is completed to ensure staffing complies with the Royal College of Paediatrics and Children's Health standards									
The trust should ensure that patients receive care in a timely way and work towards improving performance against national standards such as the time from arrival to treatment and median total time in the department									
The trust should ensure that all patients receive an initial assessment within 15 minutes of arrival, in line with the Royal College of Emergency Medicine standards									
The trust should ensure that plans for a new room for mental health assessments are completed									
The trust should ensure staff follow national guidance and patient pathways to ensure patients receive treatment that meets best practice									
The trust should continue to develop the number of substantive medical staff									
The trust should ensure that privacy and dignity of patients is always maintained									
The trust should take action to promote a positive culture within the emergency department.									

NHS
Stockport
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	1 November 2019
Subject:	Nurse Staffing: Recruitment and Retention		
Report of:	Chief Nurse & Director of Quality Governance	**Prepared by:**	Deputy Chief Nurse Assistant Chief Nurse (Recruitment & Retention

REPORT FOR INFORMATION/ASSURANCE

Corporate objective ref:	SO2a, SO3a,b,c; SO5a, b	**Summary of Report / Presentation** The purpose of this report and presentation is to provide an overview of the Trusts nurse staffing recruitment and retention programme. It aims to provide the executive team with an overview of the following:
Board Assurance Framework ref:	SO2, SO3, SO6	The current number of vacancies, including %vacancy rate Hot spot areas - turnover The recruitment strategy, local and international NHSI retention collaborative
CQC Registration Standards ref:	17	Nursing associate plan Advanced practitioners Update to the Strategic Staffing Review
Equality Impact Assessment:	☐ Completed X Not required	**Recommendations:** **The Board of Directors are asked to note the presentation and assurance provided of the workstreams in place that support improvement in the status of nurse staffing, through the recruitment and retention programme.**

Attachments:	The Nurse Recruitment and Retention Presentation is attached.

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 1.2	This report and presentation details the schedule of work that relates to nurse staffing across the Trust. It is intended to provide assurance of the workstreams in place that support improvement in the status of nurse staffing, through the recruitment and retention programme. The presentation will provide an overview of the current position, and help provide a backdrop for discussion about future plans for nurse recruitment that are linked to the People Strategy and Workforce Plans.
2.	**BACKGROUND**
2.1 2.2 2.3	There are currently around 165 registered nurse vacancies across the Trust. The Trust risk register includes risks related to nurse staffing in all business groups. There are almost 40,000 nurse posts vacant in the NHS in England, with serious gaps in care homes, independent hospitals as well as NHS provider Trusts. The Trust want there to be enough nursing staff, with the right skills and knowledge and right place at the right time. This includes nursing healthcare assistants who are vital to meeting the needs of patients across all services. Patient safety is endangered by nursing shortages; this is well recognised. The Board of Directors are responsible for ensuring safe nurse staffing and receive a bi-annual strategic staffing review. The strategic staffing review describes that nurse establishments are set at appropriate levels to provide the best possible care based on acuity and dependency and professional judgement. However, it is the ability to recruit and retain staff in the context of the national and local situation that creates the context for the staffing concerns.
3.	**PURPOSE OF THE PRESENTATION**
3.1	With the background described above, it is important that the Board of Directors take stock and note the programmes of work that are in place to support safe levels of nurse staffing.
4.	**RISK & ASSURANCE**
4.1	Risks that relates to nurse staffing are well known and reported on the risk register, and reported to Board of Directors via the Integrated Performance Report. It will be useful for the executive team to consider whether the programmes of work represent sufficient mitigation/control to support the delivery of safe nurse staffing and provide assurance.
5.	**RECOMMENDATIONS**
5.1	The Board of Directors are asked to : • note the presentation • consider whether the programme of work provides sufficient control of risks associated to nurse staffing

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Stockport NHS
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	1 November 2019
Subject:	Board Assurance Framework		
Report of:	Chief Nurse & Director of Quality Governance	**Prepared by:**	Deputy Director of Quality Governance

REPORT FOR APPROVAL

Corporate objective ref:	N/A	**Summary of Report** The purpose of this report is to present the Quarter 2 summary of risks associated with the delivery of the strategic objectives outlined in the Board Assurance Framework. The principle risks against each strategic objective have been reviewed and risk scoring reflects the current position. The Quarter 2 summary has also been completed. At the end of Quarter 2, the risk scoring for 2 principle risks (Strategic Objectives 2 and 6) were increased. The risk scoring for the remaining 5 principle risks remained the same. During 2019/20 the Board Assurance Framework will be refreshed in line with the recommendations from the recent governance review. Members of the Board of Directors are asked to note the contents of the report.
Board Assurance Framework ref:	SO 5	
CQC Registration Standards ref:	10,17,18	
Equality Impact Assessment:	☐ Completed X Not required	

Attachments:	Annex A – Board Assurance Framework

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

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1. INTRODUCTION

1.1 The purpose of this report is to present the Quarter 2 summary of risks associated with the delivery of the strategic objectives outlined in the Board Assurance Framework.

2. BACKGROUND

2.1 The Stockport NHS Foundation Trust Board Assurance Framework identifies the strategic objectives and the principle risks facing the organisation in achieving them.

2.2 The format of the current Board Assurance Framework was introduced in April 2018 alongside the Risk Management Framework. It is updated at the end of each quarter by the executive director responsible for the delivery of each strategic objective. The document included at Annex A represents the current position of the Board Assurance Framework.

3. CURRENT SITUATION

3.1 The current Board Assurance Framework, which is included for reference at Annex A of the report, has been reviewed by the relevant risk owners and updated accordingly.

3.2 At the end of Quarter 2, the risk scoring for 2 principle risks (Strategic Objectives 2 and 6) were increased. The risk scoring for the remaining 5 principle risks remained the same.

3.2.1 Strategic objective 1: To achieve full implementation of the Trust's refreshed strategy

- Risk: There is a risk that the strategy will not be implemented during 19/20 which may lead to a detrimental score in a well led review
- Initial rating 16: Current rating 12: Target rating 4
- Movement in quarter: Remains the same
- The mitigated score relates to a review of the strategy content and further engagement with all staff groups and partners
- Quarter 2 commentary: Over 850 staff have been engaged in the values and behaviours consultation which will be fed into the refreshed strategy. The plan is to that it will be submitted to the Board of Directors during Quarter 3

3.2.2 Strategic Objective 2: To deliver outstanding clinical quality and patient experience

- Risk: There is a risk that the Trust will fail to achieve the 2019/20 developments set out in the Quality Improvement Plan, resulting in not consistently providing the safest highest quality care to patients, their families and carers
- Initial rating 25: Current rating 20: Target rating 10
- Movement in quarter: Increased from 15 to 20
- The mitigated risk score is 20 relates to increased demand and activity in Quarter 2 with additional pressure of staffing vacancies, turnover and sickness across the trust. This impacts on the capacity to deliver the quality improvement plan.
- Quarter 2 commentary: The Clinical Services Review was completed in July which identified areas of improvement. However continued focus is required in safeguarding, information governance, documentation, infection prevention and control, signage and general tidiness of the environment.

3.2.3 Strategic Objective 3: To strive to achieve financial sustainability

- Risk: There is a risk that the Trust will fail to meet its financial control total for 2019/20 which may impact on the Trust's compliance with the NHS Improvement Provider Licence and impact on the safe and effective care for patients
- Initial rating 20: Current rating 16: Target rating 8
- Movement in quarter: Remains the same
- The mitigated risk score relates to the actions that the Trust has enacted in order to deliver the financial plan.
- Quarter 2 commentary: Issues in respect of the trusts operational and financial performance were discussed at the September Board. Further actions are to be undertaken post meeting. A recovery plan is being developed and will be submitted to the Finance & Performance Committee and Executive Team for approval.

3.2.4 Strategic Objective 4: To achieve the best outcomes for patients through full and effective participation in local strategic partnership programmes including Stockport Health Partnership / Stockport Neighbourhood Care / Integrated Service Solution

- Risk: There is a risk that the best outcomes for patients will not be achieved due to financial pressure, changing relationships and partnerships , and potential transition from neighbourhoods to Primary Care Networks, and balancing partner interest versus system interest
- Initial rating 20: Current rating 20: Target rating 12
- Movement in quarter: Remains the same
- The risk score has been assessed at this rating as there is currently a gap in the finance and a changing landscape of partners.
- Quarter 2 commentary: Stockport Health Partnership Board has not concluded the process to identify the appropriate cost reduction. Stockport NHSFT is re-evaluation the extent of the cost pressure.

3.2.5 Strategic Objective 5: To secure full compliance with the requirements of the NHS Provider Licence through fit for purpose governance arrangements

- Risk: There is a risk of not delivering the NHS Improvement Single Oversight Framework Operational Performance Metrics impacting on the quality of care we provide, patient and staff experience and the Trust's provider licence.
- Initial rating 20: Current rating 20: Target rating 10
- Movement in quarter: Remains the same
- The risk is assessed at this rating due to the ED performance not sustaining its trajectory for quarter 2
- Quarter 2 commentary: The emergency department continues to fail to meet the 4 hour standard improvement trajectory. Winter schemes have been expedited without realising improvements in performance. There is concern for Quarter 3 as increased pressure is expected during the winter months.

  RTT remains off trajectory, whilst cancer pathways met the trajectory at the end of quarter 2. Same risk exists giving limited assurance of improvement against trajectory. Diagnostics did not meet their trajectory on August and September due to endoscopy capacity.

3.2.6 Strategic Objective 6: To develop and maintain an engaged workforce with the right skills, motivation and leadership

- Risk: There is a risk that the trust fails to recruit, develop and retain suitably skilled and motivated workforce which will impact on quality and safety of services and financial sustainability
- Initial rating 16: Current rating 16: Target rating 8
- Movement in quarter: Increased from 12 to 26
- Current mitigation includes recruitment and retention strategy, comprehensive 3-5 year People Strategy, comprehensive leadership and skills training and development programmes in place and emerging culture and engagement work. The risk rating has increased as vacancy pressures have changed from Quarter 1.
- Quarter 2 commentary: Nurse vacancy levels have increased over the last quarter, although there has significant activity to address this has been undertaken. Medical vacancies in some specialities continue to be very hard to fill. Over 850 staff have been engaged in the values and behaviours work across the Trust

3.2.7 Strategic Objective 7: To create an environment that maximises the use of resources to improve efficiency, patient experience and clinical quality

- Risk: There is a risk that compliance to statutory and mandatory guidance is not adhered to.
- Initial rating 20: Current rating 20: Target rating 10
- Movement in quarter: Remains the same
- The trust has commissioned an external review which has identified areas of focus. Good progress continues against plan
- Quarter 2 commentary: The funding has been agreed to support the optimisation programme of the existing electronic systems. The first optimisation board is taking place on the 14 October

  Good progress continues against the estates operational and maintenance programme the team is now looking at issues that extend beyond the external report.

4. NEXT STEPS

4.1 During 2019/20 the Board Assurance Framework will be refreshed in line with the recommendations from the recent governance review.

5. RECOMMENDATIONS

5.1 Members of the Board of Directors are asked to note the contents of the report and support the proposed developments.

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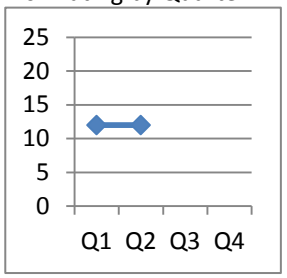
Strategic Objective 1:
To achieve full implementation of the Trusts refreshed strategy

Principal risk	There is a risk that the strategy will not be implemented during 19/20 which may lead to a detrimental score in a well led review

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHS Improvement Oversight Framework	Accountable Executive Director	Executive Management Group	Designated Board Committee
01 July 2019	July 2018	October 2019	Well Led NHSI – Use of Resources	Director of Strategy, Planning and Partnerships	Board of Directors	Finance and Performance

Risk Rating by Quarter



Initial Risk Rating (Unmitigated)			Current Risk Rating (Mitigated)			Target Risk Rating (Tolerance / Risk Appetite)			
Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Target Date
4	4	16	4	3	12	4	1	4	December 2019

Executive commentary for the Current Risk Score

The mitigated score relates to a review of the strategy content and further engagement with all staff groups and partners

Corporate objectives

Links to other Strategic Objectives:	SO2, SO3, SO4, SO5, SO6, SO7
Adequacy of Assurance (Level of Confidence)	
Overall Assessment of Assurance	
Quarter 1 Commentary:	Work has begun on reviewing the vision and values which will be incorporated into the refreshed strategy.
Quarter 2 Commentary:	Over 850 staff have been engaged in the values and behaviours consultation which will be fed into the refreshed strategy. The plan is to that it will be submitted to the Board of Directors during Quarter 3
Quarter 3 Commentary:	
Quarter 4 Commentary:	
Links to the Trust Risk Register (Current Risk Rating 15 & above)	

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

Risk ID	Risk Title	Risk Rating	Date of Initial Assessment	Q1 19/20	Q2 19/20	Q3 19/20	Q4 19/20
	No risks identified above 15						

SO2

Key Controls / Influences Established (What are we currently doing about the risk?)		Key Controls / Influences (What additional controls should we seek?)	Assurance Providers 2018 / 2019 (How do we know if the things we are doing are having an impact?)			Gaps in Assurance on Controls / Influences (What additional assurances should we seek?)	Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)
			Local Management (1st Line of Defence	Corporate Oversight (2nd Line of Defence)	Independent / External (3rd Line of Defence)		
1	2018- 20 Strategy in place	• Timescales for delivery of refreshed Strategy	• 1:1s • Team meetings • Stakeholder events	• Executive Management Group • Board of Directors • EMG minutes • Board minutes	• NHSI Oversight	• Monitoring of Strategy and annual review	• Strategy review in progress • Communication Plan in place
2	Work to define the visions and values of the organisation	• Vision and values defined and agreed	• Task and finish group	• Executive team • Finance and performance	• Trust Board	Agreed and finalised strategy	• Task and finish group to progress

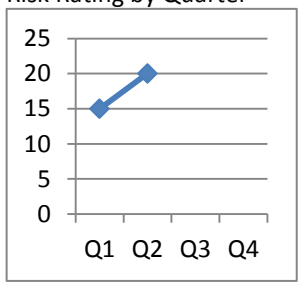
Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

Strategic Objective 2:
To deliver outstanding clinical quality and patient experience

Principal risk	There is a risk that the Trust will fail to achieve the 2019/20 developments set out in the Quality Improvement Plan resulting in not consistently providing the safest, highest quality care to patients, their families and carers.

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHS Improvement Oversight Framework	Accountable Executive Director	Executive Management Group	Designated Board Committee
July 2019	July 2019	October 2019	Safe, Effective, Responsive, Caring & Well Led NHSI – Quality Metrics	Chief Nurse & Director of Quality Governance Medical Director	Quality Governance Group Patient Experience Group Safeguarding Group Medicines Management Group Infection Prevention and Control Group	Quality Committee

Risk Rating by Quarter



Initial Risk Rating (Unmitigated)			Current Risk Rating (Mitigated)			Target Risk Rating (Tolerance / Risk Appetite)			
Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Target Date
5	5	25	5	4	20	5	5	10	March 2020

Executive commentary for the Current Risk Score

The mitigated risk score is 20 relates to increased demand and activity in Quarter 2 with additional pressure of staffing vacancies, turnover and sickness across the trust. This impacts on the capacity to deliver the quality improvement plan.

Corporate objectives

Links to other Strategic Objectives:	SO3, SO4, SO5, SO7
Adequacy of Assurance (Level of Confidence)	
Overall Assessment of Assurance	
Quarter 1 Commentary:	Work continues against plan and baselines established that help to identify additional controls required. The Clinical Services Review on the 9th July will identify further areas of focus.
Quarter 2 Commentary:	The Clinical Services Review was completed in July which identified areas of improvement. However continued focus is required in safeguarding, information governance, documentation, infection prevention and control, signage and general tidiness of the environment.

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

Quarter 3 Commentary:	
Quarter 4 Commentary:	

Links to the Trust Risk Register (Current Risk Rating 15 & above)

Risk ID	Risk Title	Risk Rating	Date of Initial Assessment	Q1 19/20	Q2 19/20	Q3 19/20	Q4 19/20
505	The risk of the lack of capacity in cellular pathology on turn round times and patient pathways	20	02/07/2018				
457	There is a risk to patient safety due to a lack of Haematology/ Transfusion Staff in Post	20	19/04/2018		↑20		
989	There is a risk of Delaying Treatment Especially Cancer Patients With the Removal of Fax Machines	16	17/04/2019	New			
991	There is a risk that the current safeguarding structure does not meet required national standards	16	18/04/2019	New			
872	There is a risk to patient experience and safety due to endoscopy capacity	16	04/12/2018				
934	There is a risk of reduced critical care capacity due to staffing shortages	16	28/01/2019				
1015	There is a risk that patient care and flow may be compromised due to significant staffing shortages within ACU	16	20/05/2019	New			
183	Failure to meet the 62 day Cancer target standards	16	20/04/2010				
429	Inadequate capacity to meet demand in Paediatric ADHD Services	16	14/02/2018				
618	There is a risk of a failure to recognise and adequately treat sepsis within our organisation	16	14/08/2018				
50	Risk of maternity diverts and clinical incidents related to unsafe staffing levels in maternity.	16	11/03/2015				
686	There is a risk that patient care may be compromised due to significant staffing shortages within AMU	16	05/10/2018				
125	Medical staff vacancies in Emergency Department	16	10/05/2016				
67	There is a risk to service delivery due to the lack of Consultant Microbiologist Cover	16	18/07/2017		↑16		
1069	There is a risk of POCT management failure due to the pressure on the staff and limitations of resources	16	23/05/2019		New		
1138	There is a risk that patient care is compromised due to significant nurse staffing shortages within the ED	16	10/09/2019		New		
407	There is a risk to patient safety due to the number and length of the Respiratory Overdue Waiting List (non-confirmed cancer)	15	04/03/2018				
576	There is a risk to patient safety due to the long wait of time to be seen by the Respiratory Team for new patients	15	01/06/2018				

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

916	There is a risk that due to gaps in Orthodontic medics we are unable to meet demand for the service	15	10/01/2019		New		

SO2							
Key Controls / Influences Established (What are we currently doing about the risk?)		**Key Controls / Influences (What additional controls should we seek?)**	**Assurance Providers 2018 / 2019 (How do we know if the things we are doing are having an impact?)**			**Gaps in Assurance on Controls / Influences (What additional assurances should we seek?)**	**Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)**
			Local Management (1st Line of Defence	**Corporate Oversight (2nd Line of Defence)**	**Independent / External (3rd Line of Defence)**		
1	Quality Governance & Risk Management Frameworks in place 2018/2020	• Revised monthly governance reports • Revised quarterly risk register reports at business group/corporate level in development. • Well-Led / Use of Resources initial review required (NHSI Framework).	• 1:1 Meetings • Team Meetings • Monthly Business Group Quality Boards • Monthly Performance Meetings • Patient Quality Summit	• Quality Governance Group • QG and sub-groups key issues reports (KIR) • Quality Committee • QC KIR • Integrated Performance Report • Board of Directors • Alliance Provider Board • Quarterly BAF / Risk Register Report • Well-Led Review *(Please note the above oversight structure will be referred to as*	• Quality Account • CQC rating RI in October 2017 • NHSI Improvement Board • Annual Governance Statement-April 2018 • Quarterly Review Meetings with NHSI • MIAA Review of Committees Report: Partial Assurance • CQC insights report • Internal Audit Programme • MIAA Risk Management & Corporate	Mock CQC inspection June 2018 Externally facilitated Developmental Review NHSI Well Led Framework required in 2018	Reports to Quality Committee from December 2017 with quarterly monitoring Well-Led / Use of Resources Initial Review April 2018
2	Governance Teams in place	• Review of Governance Team					• Complete and progress Governance Team review
3	Systems in place to address external clinical alerts						

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

				Quality Governance oversight throughout the document)	Governance Report: Partial Assurance		
4	Infection Prevention & Control (IPC) Team and supporting strategies & policies	• MRSA Bacteraemia x 2 • Business case relating to IPC Service	• 1:1 / Team Meetings • Harm Free Care Panels • Monthly Business Group Quality Boards • Monthly Performance Meetings	• Infection Prevention and Control Group • IPCG KIR • Monthly MESS data return • Account-April 2018 • *Quality Governance oversight*	• CQC RI rating-October 2017 • CCG Contract meetings monthly • CCG Quality Visits • NHSE/NHSI Feedback • Single Oversight Framework Segmentation • Quality Account-April 2019		• Business Case being progressed
5	Maternity Dashboard	• MMBRACE	• Maternity champion meetings • 1:1 meetings • Labour ward forum • Maternity Performance meeting • Women's and Children's Quality Board	• *Quality Governance oversight*	• GM Maternity transformation Board • Board of Directors		Bi-monthly maternity champions meetings

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

6	Quality Improvement Strategy 2018/2019 implementation	• Data access & collective intelligence • Quarterly CQUIN reports	• 1:1 Meetings • Monthly Business Group Quality Boards • Monthly CQUIN report • Monthly Performance Meetings	• Professional Advisory Group • Quality Safety and Improvement Strategy Group • *Quality Governance oversight*	• CQC RI rating-October 2017 • CCG contract meetings monthly • CCG Quality Visits • NHSI Improvement Board • Monthly QIS reports • CQC Inpatient Survey-March 2019 • Internal Audit Programme • Quality Account-April 2019		• Quarterly review to commence June 2018 • Development of reports / data collection in progress including Model Hospital data.
7	Processes in place to deliver the CQUINs & Quality Schedule	• Data access & collective intelligence Quarterly CQUIN reports					
8	Safety Team established with objectives and associated policies & procedures	• Data access & collective intelligence. • Dashboards by CQC Domains • Accreditation for Continued Excellence (ACE) • Quarterly Quality Reviews • Business Case to support Quality improvements completed •					• Progress Business Case
9	Patient & Public Involvement Strategy implementation	• PPI Strategy • Patient Experience Strategy • Carers Strategy • Equality and Diversity Strategy	• 1:1 / Team Meetings	• Patient Experience Action Group • Patient Experience Group • People and Performance Committee • PPC KIR • Alliance Provider Board • *Quality Governance oversight*	• CQC RI rating-October 2017 • CCG contract meetings monthly • CCG Quality Visits • Monthly QIS reports • CQC Inpatient Survey-March 2019 • Internal Audit Programme • Quality Account-	• There is no current PPI, Patient Experience or Carers Strategy • An E&D strategy is in place	• Strategies to be developed and in place by Q4 2018/19

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

					April 2019 •		
10	Quality Impact Assessment (QIA) Process	• QIA process in place – requires overarching document from May 2018.	• Programme/ Project Team in place	• Medical Director & Chief Nurse reviews • Finance Improvement Group • FIG KIR • Finance and Performance Committee • F&P KIR • *Quality Governance oversight*	• Single Oversight Framework Segmentation • NHSI Improvement Board • CQC Good rating- January 2015 • CQC RI rating- October 2017 • Quality Account- April 2019 • Quarterly Review Meetings with NHSI	• Strengthen reporting and monitoring of QIA process	• Revised QIA Procedure to be implemented
11	Adult & Child Safeguarding Team & policies & procedures.		• 1:1 Meetings • Patient Safety Summit • Patient Quality Summit • Monthly Business Group Quality Boards • Monthly Performance Meetings	• Safeguarding Group • SG KIR • *Quality Governance oversight*	• Local Safeguarding Adult's Board • Local Safeguarding Children's Board		
12	Nursing, Midwifery and Allied Health Professionals Strategy	• Annual Strategic Staffing Reviews	• 1:1 Meetings	• Nurse Leadership walkarounds • Professional Advisory Group • *Quality Governance oversight*	• Single Oversight Framework Segmentation • NHSI Improvement Board • CQC Good rating-		

					January 2015 • CQC RI rating- October 2017 • Quality Account- April 2019 • Quarterly Review Meetings with NHSI		
13	Learning from Deaths Policy & Mortality Review Process	Report to Quality Committee	• Mortality and Morbidity Reviews • Learning from Deaths Process • 1:1 Meetings • Patient Safety Summit • Patient Quality Summit • Monthly Business Group Quality Boards • Monthly Performance Meetings	• Trust Mortality Reduction Group • CHKS and BIU data & reports • *Quality Governance oversight* • Quarterly Learning from Deaths Report from December 2017 • Quality Account- April 2019	• CQC RI rating- October 2017 • NHS Improvement data • CCG Contract meetings monthly • CCG Quality Visits • CQC Outlier Alert process • Nationally benchmarked mortality data • Advancing Quality Quarterly Safety Reports • Internal Audit Programme:	• Mortality data / reporting systems • Lack of triangulation	• Triangulated learning from deaths report • Mortality review structured assessment process • Deteriorating Patient Group eastablished
14	7 Day Clinical Services	Clinical Directors Forum	1:1 / Team meetings Business Group Quality Boards Monthly Performance Meetings	• Quality Governance Group			

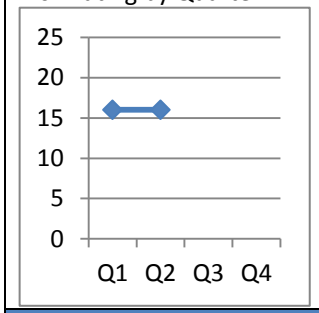
Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

Strategic Objective 3:
To strive to achieve financial sustainability

Principal risk	There is a risk that the Trust will fail to meet its financial control total for 2019/20 which may impact on the Trust's compliance with the NHS Improvement Provider Licence and impact on the safe and effective care for patients

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHS Improvement Oversight Framework	Accountable Executive Director	Executive Management Group	Designated Board Committee
July 2019	July 2019	October 2019	Well led NHSI -Finance and use of resources	Director of Finance	Executive Team	Finance and Performance Committee

Risk Rating by Quarter



Initial Risk Rating (Unmitigated)			Current Risk Rating (Mitigated)			Target Risk Rating (Tolerance / Risk Appetite)			
Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Target Date
4	5	20	4	4	16	4	2	8	31/03/2020

Executive commentary for the Current Risk Score

The mitigated risk score relates to the actions that the Trust has enacted in order to deliver the financial plan.

Corporate objectives

Links to other Strategic Objectives:	SO1
Adequacy of Assurance (Level of Confidence)	
Overall Assessment of Assurance	
Quarter 1 Commentary:	The current actions include a full review of all CIP schemes being undertaken. External support has been commissioned to assist with this work. Review of year end forecasts and has been completed.
Quarter 2 Commentary:	Issues in respect of the trusts operational and financial performance were discussed at the September Board. Further actions are to be undertaken post meeting. A recovery plan is being developed and will be submitted to the Finance & Performance Committee and Executive Team for approval.
Quarter 3 Commentary:	

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

Quarter 4 Commentary:							
Links to the Trust Risk Register (Current Risk Rating 15 & above)							
Risk ID	**Risk Title**	**Risk Rating**	**Date of Initial Assessment**	**Q1 19/20**	**Q2 19/20**	**Q3 19/20**	**Q4 19/20**
586	There is a risk due to the significant estate backlog in maintenance	20	21/06/2018				
978	There is a risk that the Trust will not deliver its 2019/20 financial performance	20	01/04/2019				
78	There is a risk to patient safety and BG finances due to the excessive registered nursing staffing deficit within Medicine & CS	16	21/11/2016		↓12		
127	There is a risk that the Medicine & CS BG overspends due to agency costs	16	22/06/2017				
1030	There is a risk the Integrated Care BG will not meet the CSEP target of £2.4m	16	06/06/2019		New		

SO2

Key Controls / Influences Established (What are we currently doing about the risk?)		**Key Controls / Influences (What additional controls should we seek?)**	**Assurance Providers 2018 / 2019 (How do we know if the things we are doing are having an impact?)**			**Gaps in Assurance on Controls / Influences (What additional assurances should we seek?)**	**Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)**
			Local Management (1st Line of Defence	**Corporate Oversight (2nd Line of Defence)**	**Independent / External (3rd Line of Defence)**		
1	Annual Plan & delegated budgets	• Availability / access to capital funding • Agency spending – medical & nursing • Long term health economy with clear governance structure	• 1:1 / Team Meetings • Business Group Accountants 1:1s • Bi-weekly Exec-BG finance meetings • Quality Impact Assessments	• Monthly Performance Meetings • Finance & Performance Committee • Internal Audit Reports to Audit Committee • Board of Directors • Board of Directors minutes • F&P Minutes/KIR • Annual	• Internal Audit Programme • NHSI / NHSE financial oversight meetings • External interim CIP support • Executive contract Group with CCG	• Use of Resources metric assessment • Routine use of Model Hospital	• Transformation projects • Cost Improvement Plan • CCG contract in place.
2	Identified CIP schemes	• Well-Led / Use of Resources initial review required (NHSI Framework).					
3	Monthly finance & activity review meetings	• Review of financial /activity delivery					
4	Performance management	• Review of delivery and identification of improvement					

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

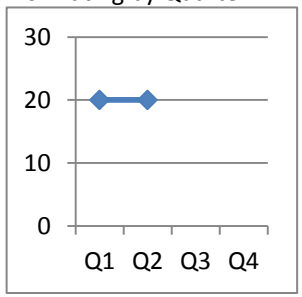
	reporting systems	plan		budget/planning • Monthly Integrated Performance Report Contracting and activity finance group Quality Governance Committee			
5	Job descriptions contain financial responsibilities	• Clear accountability	Recruitment process				
6	CCG Contract	Review performance and agree improvement trajectories	Monthly CCG meetings				
7	CQUIN Schemes & process to deliver	Monthly meetings to ensure compliance	Monthly CCG meetings				
8	Monthly Performance Report	Identify any variance to plan or changes to forecast	• 1:1 / Team Meetings • Business Group Accountants 1:1s • Weekly CIP development meetings chaired by COO • Operational performance group to hold Business Group directors to account				

Strategic Objective 4:
To achieve the best outcomes for patients through full and effective participation in local strategic partnership programmes including Stockport Health Partnership / Stockport Neighbourhood Care / Integrated Service Solution

Principal risk	There is a risk that the best outcomes for patients will not be achieved due to financial pressure, changing relationships and partnerships , and potential transition from neighbourhoods to Primary Care Networks, and balancing partner interest versus system interest

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHS Improvement Oversight Framework	Accountable Executive Director	Executive Management Group	Designated Board Committee
July 2019	July 2019	October 2019	Safe, effective, responsive and well led NHSI – Quality of care, operational performance, strategic change	Chief Operating Officer	Executive team	F&P Stockport Health Partnership Board

Risk Rating by Quarter



Initial Risk Rating (Unmitigated)			Current Risk Rating (Mitigated)			Target Risk Rating (Tolerance / Risk Appetite)			
Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Target Date
4	5	20	4	5	20	4	3	12	31/03/2020

Executive commentary for the Current Risk Score

The risk score has been assessed at this rating as there is currently a gap in the finance and a changing landscape of partners.

Corporate objectives

Links to other Strategic Objectives:	
Adequacy of Assurance (Level of Confidence)	
Overall Assessment of Assurance	
Quarter 1 Commentary:	The introduction Primary Care Networks and their impact is not yet understood. The solution to the financial gap has not yet been identified
Quarter 2 Commentary:	Stockport Health Partnership Board has not concluded the process to identify the appropriate cost reduction. Stockport NHSFT is re-evaluation the extent of the cost pressure.

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

Quarter 3 Commentary:	
Quarter 4 Commentary:	

Links to the Trust Risk Register (Current Risk Rating 15 & above)

Risk ID	Risk Title	Risk Rating	Date of Initial Assessment	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19
	No risk on trust risk register						

SO2

Key Controls / Influences Established (What are we currently doing about the risk?)		Key Controls / Influences (What additional controls should we seek?)	Assurance Providers 2018 / 2019 (How do we know if the things we are doing are having an impact?)			Gaps in Assurance on Controls / Influences (What additional assurances should we seek?)	Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)
			Local Management (1st Line of Defence	Corporate Oversight (2nd Line of Defence)	Independent / External (3rd Line of Defence)		
	Continued engagement with Stockport Neighbour hoodcare triumphant working	• Impact assessment of the potential removal of some of the services	• SNC meetings • 1:1 s • Integrated Care BG Board • Performance meetings	• Executive team • Board of directors •	• Board of directors • Stockport Health Partnership Board	• Scale & pace of change • Relationship building with key partners • Governance Arrangements	
1	Engagement in Stockport Health Partnership Board	• Trust Strategy	• 1:1's • Team meetings	• Executive Team • Board of Directors	• Greater Manchester Combined Authority	• Scale & pace of change • Relationship building with key partners • Governance Arrangements	

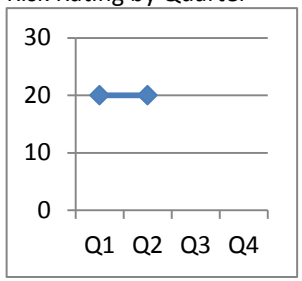
Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

Strategic Objective 5:
To secure full compliance with the requirements of the NHS Provider Licence through fit for purpose governance arrangements

Principal risk	There is a risk of not delivering the NHS Improvement Single Oversight Framework Operational Performance Metrics impacting on the quality of care we provide, patient and staff experience and the Trust's provider licence.

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHS Improvement Oversight Framework	Accountable Executive Director	Executive Management Group	Designated Board Committee
July 2019	July 2019	October 2019	Well led, safe NHSI Leadership and improvement capability	Chief Operating Officer	Urgent Care Ops Group Safer Board Business Group Performance Meetings	Finance & Performance Committee

Risk Rating by Quarter



Initial Risk Rating (Unmitigated)			Current Risk Rating (Mitigated)			Target Risk Rating (Tolerance / Risk Appetite)			
Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Target Date
4	5	20	4	5	20	5	2	10	31/10/2018

Executive commentary for the Current Risk Score

The risk is assessed at this rating due to the ED performance not sustaining its trajectory for quarter 2

Corporate objectives

Links to other Strategic Objectives:	
Adequacy of Assurance (Level of Confidence)	
Overall Assessment of Assurance	
Quarter 1 Commentary:	Emergency department performance has not sustained its trajectory for the first quarter . RTT diagnostics and cancer pathways are on trajectory but not meeting the national standards. Diagnostics will be on plan at the end of Q1
Quarter 2 Commentary:	The emergency department continues to fail to meet the 4 hour standard improvement trajectory. Winter schemes have been expedited without realising improvements in performance. There is concern for Quarter 3 as increased pressure is expected during the winter months. RTT remains off trajectory, whilst cancer pathways met the trajectory at the end of quarter 2. Same risk exists giving limited assurance of improvement against trajectory. Diagnostics did not meet their trajectory on August and September due to endoscopy capacity.

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

Quarter 3 Commentary:	
Quarter 4 Commentary:	

Links to the Trust Risk Register (Current Risk Rating 15 & above)

Risk ID	Risk Title	Risk Rating	Date of Initial Assessment	Q1 19/20	Q2 19/20	Q3 19/20	Q4 19/20
505	The risk of the lack of capacity in cellular pathology on turn round times and patient pathways	20	02/07/2018				
183	Failure to meet the 62 day Cancer target standards	16	28/04/2010				
599	There is a risk to the timely delivery of ECDS (new contract data set for A&E)	16	25/07/2018				
407	There is a risk to patient safety due to the number and length of the Respiratory Overdue Waiting List (non confirmed cancer)	15	04/03/2018				
576	There is a risk to Patient safety due to the long wait of time to be seen by the respiratory team for new patients.	15	01/06/2018				
1112	There is a risk to the organisation due to noncompliance with BSQ Regulations due to Loss of Traceability of blood components	16	06/08/2019		New		

SO2

Key Controls / Influences Established (What are we currently doing about the risk?)		Key Controls / Influences (What additional controls should we seek?)	Assurance Providers 2018 / 2019 (How do we know if the things we are doing are having an impact?)			Gaps in Assurance on Controls / Influences (What additional assurances should we seek?)	Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)
			Local Management (1st Line of Defence	Corporate Oversight (2nd Line of Defence)	Independent / External (3rd Line of Defence)		
1	Monthly Performance Reports	• External influences on medically fit for discharge patients • Insufficient out of hospital capacity	• 1:1/ 2:1 meetings • Team Meetings • Monthly Senior Management Team Meetings • Monthly BG Boards • Monthly Performance Review Meetings	• Finance & Performance Committee • F&P minutes and KIR • Board of Directors • Executive Team • Urgent care operational group	• CQC rating overall • NHSI Quarterly Review Meetings • Cancer Peer Review • Monthly CCG Contract Meetings • Urgent and Emergency Care	•	

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

			• Weekly performance wall		Delivery Board • Internal Audit Programme:		
2	Improving patient flow programme	• Staff engagement • Transformation support • Finance support • Winning hearts and Minds • Changing culture • Embedded new practice	• 1:1/ 2:1 meetings • Team Meetings • Monthly Senior Management Team Meetings • Monthly BG Boards • Monthly Performance Management Group Meetings • Finance improvement Group • Operational Performance Group • OPG minutes and KIR	• Finance & Performance Committee • F&P minutes and KIR • Board of Directors • Executive Team	• CQC rating overall • NHSI Quarterly Review Meetings • Cancer Peer Review • Monthly CCG Contract Meetings • Urgent and Emergency Care Delivery Board • Internal Audit Programme:		
3	Quality Impact Assessment Process	• Development of overarching document • Completing the Quality Impact Assessments •	• 1:1/ 2:1 meetings • Team Meetings • Monthly Senior Management Team Meetings • Monthly BG Boards • Monthly Performance Management	• Medical Director and Chief Nurse & Director of Quality Governance approval of QIAs • F&P Committee • Board of Directors	• CQC rating Monthly CCG meetings • NHSI Oversight	• Strengthen reporting and monitoring of QIA process	

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

			Group Meetings • Financial Improvement Group (FIG)				
4	Emergency Planning (EP) & Business Continuity	•	• 1:1 meetings • Desktop exercises	• Emergency Planning Group • Board of Directors • NHSE Emergency Preparedness, Resilience and Response Self-Assessment Substantial Assurance Return-October 2017 – did that go in	• Emergency Preparedness, Resilience and Response NHS England submitted-when did we submit?		
5	Non elective performance	Capacity and demand oversight Analysis reports Data and KPI Performance monitoring	• Urgent care operational group • Programme development group	• Urgent care delivery Board • Executive Team • Finance and performance committee	• CQC • NHSI • GMCA		
6	Elective performance	Business Group PTL's Trust wide PTL's RTT and Cancer Monitoring OWL Clinical pathways Staff training	• Cancer Board	• Executive Team • Finance and performance committee	• CQC • NHSI • GMCA		

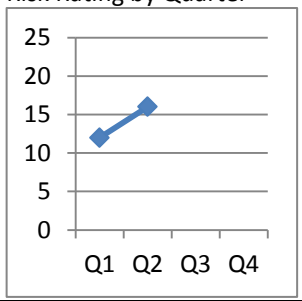
Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

Strategic Objective 6:
To develop and maintain an engaged workforce with the right skills, motivation and leadership

Principal risk	There is a risk that the trust fails to recruit, develop and retain suitably skilled and motivated workforce which will impact on quality and safety of services and financial sustainability

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHS Improvement Oversight Framework	Accountable Executive Director	Executive Management Group	Designated Board Committee
July 19	July 19	October 2019	Safe, effective responsive caring NHSI – use of resources	Director of Workforce & Organisational Development	Workforce Efficiency Group Culture and Engagement Group Executive team	People and Performance Committee

Risk Rating by Quarter



Initial Risk Rating (Unmitigated)			Current Risk Rating (Mitigated)			Target Risk Rating (Tolerance / Risk Appetite)			
Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Target Date
4	4	16	4	3	16	4	2	8	31/03/2020

Executive commentary for the Current Risk Score

Current mitigation includes recruitment and retention strategy, comprehensive 3-5 year People Strategy, comprehensive leadership and skills training and development programmes in place and emerging culture and engagement work. The risk rating has increased as vacancy pressures have changed from Quarter 1

Corporate objectives

Links to other Strategic Objectives:	SO2, SO3
Adequacy of Assurance (Level of Confidence)	
Overall Assessment of Assurance	
Quarter 1 Commentary:	Nurse recruitment having positive outcomes. Medical and other registered professionals require further attention and focus. Quarter 2 will see the launch of the engagement of staff and stakeholders to shape trust values and behaviours
Quarter 2 Commentary:	Nurse vacancy levels have increased over the last quarter, although there has significant activity to address this has been undertaken. Medical vacancies in some specialities continue to be very hard to fill. Over 850 staff have been engaged in the values and behaviours work across the Trust
Quarter 3 Commentary:	
Quarter 4 Commentary:	

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

Links to the Trust Risk Register (Current Risk Rating 15 & above)							
Risk ID	**Risk Title**	**Risk Rating**	**Date of Initial Assessment**	**Q1 18/19**	**Q2 18/19**	**Q3 18/19**	**Q4 18/19**
457	There is a risk to patient safety due to a lack of Haematology/ Transfusion Staff in Post	20	19/04/2018		↑20		
125	Medical staff vacancies in Emergency Department	16	10/05/2016				
50	Risk of maternity diverts and clinical incidents related to unsafe staffing levels in maternity.	16	11/03/2015				
686	There is a risk that patient care may be compromised due to significant staffing shortages within AMU	16	05/10/2018				
934	There is a risk of reduced critical care capacity due to staffing shortages	16	28/01/2019				
991	There is a risk that the current safeguarding structure does not meet required national standards	16	18/04/2019	New			
1015	There is a risk that patient care and flow may be compromised due to significant staffing shortages within ACU	16	20/05/2019	New			
67	There is a risk to service delivery due to the lack of Consultant Microbiologist Cover	16	18/07/2017		↑16		
1069	There is a risk of POCT management failure due to the pressure on the staff and limitations of resources	16	23/05/2019		New		
1138	There is a risk that patient care is compromised due to significant nurse staffing shortages within the ED	16	10/09/2019		New		
916	There is a risk that due to gaps in Orthodontic medics we are unable to meet demand for the service	15	11/01/2019		New		
825	There is a risk to loss of activity due to staffing levels in theatre	15	14/11/2018		Closed		
587	There is a risk to the operation of the Trust electronic systems due to the need to recruit senior IT Technical support	15	25/05/2018				

SO2								
Key Controls / Influences Established (What are we currently doing about the risk?)		**Key Controls / Influences (What additional controls should we seek?)**	**Assurance Providers 2018 / 2019 (How do we know if the things we are doing are having an impact?)**			**Gaps in Assurance on Controls / Influences (What additional assurances should we seek?)**	**Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)**	
			Local Management (1st Line of Defence	**Corporate Oversight (2nd Line of Defence)**	**Independent / External (3rd Line of Defence)**			
1	Recruitment and	• GM theme 3 – employer	• WEG	• People and	• Greater	• Employment	• Workforce remodelling	

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

	retention strategy: Building line manager capability Using reward in recruitment and retention Targeted recruitment campaigns	banding and streamlining • Develop guidance on job design for managers • Undertake a review of all vacancies that are not filled and those that are vacated in a year to ensure jobs are designed well • Include benefit and reward information in recruitment campaign for applicants and the induction process for new starters • Implement 'refer a friend' scheme for difficult to fill posts • Benchmark with other Trusts in Greater Manchester and identify associated costs - Prepare proposal paper. • Run focussed campaigns for areas with high vacancy rate to include: • National advertising • Development of recruitment microsite • Vacancy and business group specific recruitment literature • Ensuring a Trust presence at profession specific events	• CEG • Staff survey • Workforce reports • Staff friends and family • Workforce KPI's • Temporary staff meetings • JLMC • JNC • Training needs analysis • Schwartz rounds	performance Committee • Executive management board • Trust Board	Manchester Combined authority • NHSI • CQC	market – key skills shortage • Building leadership skills to support change and improvement	• Proactive workforce plan • Just culture programme

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

	Socially responsible employer Develop the organisation as a socially inclusive employer Maintaining links with Jobcentre Plus Induction Development and career planning	• Open days for specific professions • Target under represented age group (16-24) within the Trust • Work with local community to engage with school leavers • Raise awareness of employment opportunities within the Trust to attract a more diverse workforce. • Work with Job Centre Plus to utilise employment schemes to recruit the long term unemployed to suitable positions and/or target job seekers who may wish to work within the Trust. • Graduate nurse programme • HCA secondment to nursing/midwifery degrees • Identify difficult to fill roles which can be provided as developmental opportunities • Develop well defined career pathways to contribute to improved retention rates • Develop the Talent					

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

		Management strategy to reflect the local, GM and national plans					
	Staff involvement and engagement	• Support flexible working • Improve the physical working environment for staff • Continue to ensure staff feel safe in the workplace • Undertake an audit of stress within the organisation and develop a strategy to address causes of work related stress • Regularly monitor sickness absence and ill health retirement to identify underlying causes • Use national staff survey data to benchmark against other Trusts and address concerns and issues raised by staff					

2	Culture and engagement programme	• NHSI culture programme
		  ○ Culture dashboard
		  ○ Diagnostic
		  ○ Focus groups
		  ○ Action planning
		• Triumvirate leadership programme
		• Ongoing coaching and development and support					

3	People strategy: Education & Practice	• Signed off strategy • Develop skills & competencies					

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

	Development	to ensure the highest levels of patient care					
	Culture & Engagement	• Fully developed coaching framework that offers skilful coaching support to individuals and teams					
	Leadership Development	• Equality advocate role developed to support EDS2/WRES/WDES, and used to develop proactive EDI approach					
	Resourcing	• Develop enhanced retention plans • Develop workforce planning processes to support the implementation of the strategy • Continued development of new roles/working models to meet changing system priorities					
	High Performing	• Design and commence the NHSI culture programme • Scoping of sharing services / collaboration opportunities • Implementation of the TRAC recruitment system • Appraisal process includes strengthened career planning and progression for colleagues • Full e-Rostering roll-out and consistent use of all functions					

		• Implementation of the 'Just Culture' approach to restorative practice, learning and support					
4	Operational plan	• Delivery of plan					

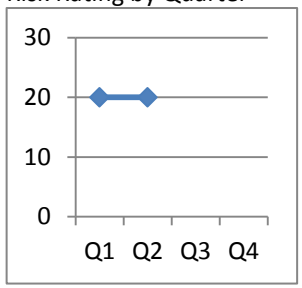
Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

Strategic Objective 7:
To create an environment that maximises the use of resources to improve efficiency, patient experience and clinical quality

Principal risk	There is a risk that compliance to statutory and mandatory guidance is not adhered to

Initial Date	Date of Update	Review Date	Care Quality Commission Domain / NHS Improvement Oversight Framework	Accountable Executive Director	Executive Management Group	Designated Board Committee
July 2019	July 2019	October 2019	Well led NHSI finance and use of resources	Director of Strategy, Planning and Partnerships	Executive Team	Finance & Performance Committee

Risk Rating by Quarter



Initial Risk Rating (Unmitigated)			Current Risk Rating (Mitigated)			Target Risk Rating (Tolerance / Risk Appetite)			
Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Consequence	Likelihood	Risk Rating	Target Date
5	4	20	5	4	20	5	2	10	31/12/2019

Executive commentary for the Current Risk Score

The trust commissioned an external review which identified areas of focus. Good progress continues against plan

Corporate objectives

Links to other Strategic Objectives:	
Adequacy of Assurance (Level of Confidence)	
Overall Assessment of Assurance	
Quarter 1 Commentary:	The trust took the decision to stand down the implementation of the EPR and has embarked upon an optimisation programme bringing the existing systems up to date. The trust is focusing on the estates operational and maintenance programme with particular focus on statutory compliance
Quarter 2 Commentary:	The funding has been agreed to support the optimisation programme of the existing electronic systems. The first optimisation board is taking place on the 14 October Good progress continues against the estates operational and maintenance programme the team is now looking at issues that extend beyond the external report.

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

Quarter 3 Commentary:	
Quarter 4 Commentary:	

Links to the Trust Risk Register (Current Risk Rating 15 & above)

Risk ID	Risk Title	Risk Rating	Date of Initial Assessment	Q1 19/20	Q2 19/20	Q3 20/21	Q4 20/21
586	There is a risk due to the significant estate backlog in maintenance	20	21/06/2018				
1004	There is a risk of significant breaches of the Regulatory Reform (fire safety) Order 2005	20	08/05/2019				
765	There is a risk to the delivery of the CT service and patient safety due to a delay in installing 3rd CT scanner	16	25/10/2018				
1046	There is a risk the Trust is non-compliant with statutory H&S legislation due to non appointment to statutory positions	16	39/05/2019		New		
905	There is a risk of severe service disruption if we have failures of flexible endoscopes	15	10/01/2019				
957	There is a risk to patient care if the Laboratory Information Management System (Telepath) Fails	15	07/03/2019				
1006	There is a risk to Health and Safety if CL3 facility is not functioning properly	15	15/05/2019	New	↓9		
86	There is a risk of the Trust's Telephony System failing due to aged telephone technology/infrastructure	15	09/08/2017		↑15		

SO2

Key Controls / Influences Established (What are we currently doing about the risk?)		Key Controls / Influences (What additional controls should we seek?)	Assurance Providers 2018 / 2019 (How do we know if the things we are doing are having an impact?)			Gaps in Assurance on Controls / Influences (What additional assurances should we seek?)	Agreed Actions for Gaps in Controls / Influences or Assurances (What more should we do, including timescales for delivery)
			Local Management (1st Line of Defence	Corporate Oversight (2nd Line of Defence)	Independent / External (3rd Line of Defence)		
1	Risk assessment for each area	Further review on all risks	• CPDG	• Executive management Group • Finance and performance committee	• Greater Manchester CA		
2	Signed off capital programme for 18/19	Review when changed information	• CPDG	• Executive management	• Greater Manchester CA		

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

	operational plan			Group • Finance and performance committee			
3	External reports identify areas focus	Oversight of progress	• Weekly operational meeting • Formal update to ET fortnightly •	• Monthly to Trust Board	• GM FRS		

Assurance Ratings:	*Significant Assurance*	*Significant Assurance with minor improvement opportunities*	*Partial assurance with improvements required*	*No assurance*

NHS
Stockport
NHS Foundation Trust

Report to:	Board of Directors	**Date:** 1 November 2019
Subject:	Trust Risk Register	
Report of:	Chief Nurse & Director Quality Governance	**Prepared by:** Deputy Director Quality Governance

REPORT FOR INFORMATION

Corporate objective ref:	2a, 3a, 3b
Board Assurance Framework ref:	SO2,SO3, SO5, SO6
CQC Registration Standards ref:	17
Equality Impact Assessment:	☐ Completed ☒ Not required

Summary of Report

The data for this report was collated on 22nd October 2019

This paper provides an overview of the current Trust Risk Register and the top risks on the risk register.

The top risks with a current risk rating of 20 are associated with:

- Capacity of cellular pathology: Risk 505; current risk of 20
- Finance: Risk 978; current risk of 20, consequence of 5
- Estate backlog maintenance: Risk 586; current risk of 20
- Estate breach of fire regulations: Risk 1004; current risk of 20
- Performance in the Emergency Department; Risk 130; current risk of 20

The top risks with assessed as having a catastrophic consequence that is possible to occur are

- Finance: Risk 978; current risk of 20, consequence of 5
- Failure of telepath system: Risk 957; current risk of 15 consequence of 5
- Staffing to support IT network: Risk 587; current risk of 15 consequence of 5

There are 27 risks rated 15 or above on the Trust Risk Register with corporate approval. This is 4 less than last month.

Members are asked to note the risks and the identified actions to mitigate those risks.

Attachments:

This subject has previously been reported to:

☐ Board of Directors	☐ People Performance Committee
☐ Council of Governors	☐ Charitable Funds Committee
☐ Audit Committee	☐ Exec Management Group
☐ Executive Team	☐ Remuneration Committee
☐ Quality Committee	☐ Joint Negotiating Council
☐ Finance & Performance Committee	☐ Other

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1. Introduction

1.1 There are 416 approved risk records on the Datix Risk Module. The risk records have been reviewed to ensure that the correct Risk Register type was assigned to the risk record. There are also 21 approved risk assessments, 15 approved equipment trial records and 47 Business approved generic hazard inventory forms.

1.2 There are 57 risk records awaiting Business Group approval; of these 30 are Business Group risks, 25 risk assessments, 1 equipment trial assessment and 1 general hazard inventory assessment.

1.3 There are no risks awaiting trust risk register approval at time of preparing the report

2. Top Risks

2.1 The top risks with a current risk rating of 20 are associated with:

- Capacity cellular pathology : Risk 505; current risk of 20
- Estate backlog maintenance: Risk 586; current risk of 20
- Finance: Risk 978; current risk of 20, consequence of 5
- Estate breach of fire regulations: Risk 1004; current risk of 20
- Performance in the Emergency Department; Risk 130; current risk of 20

2.2 The top risks assessed as having a catastrophic consequence that is possible to occur are

- Finance: Risk 978; current risk of 20, consequence of 5
- Failure of telepath system: Risk 957; current risk of 15 consequence of 5
- Staffing to support IT network: Risk 587; current risk of 15 consequence of 5

2.3 Details of the risks can be found in Appendix 1.

3. Risk Trends

3.1 The risk register is presented in order of current rating.

3.2 Across the 27 risks rated 15 or higher that have been corporately approved;

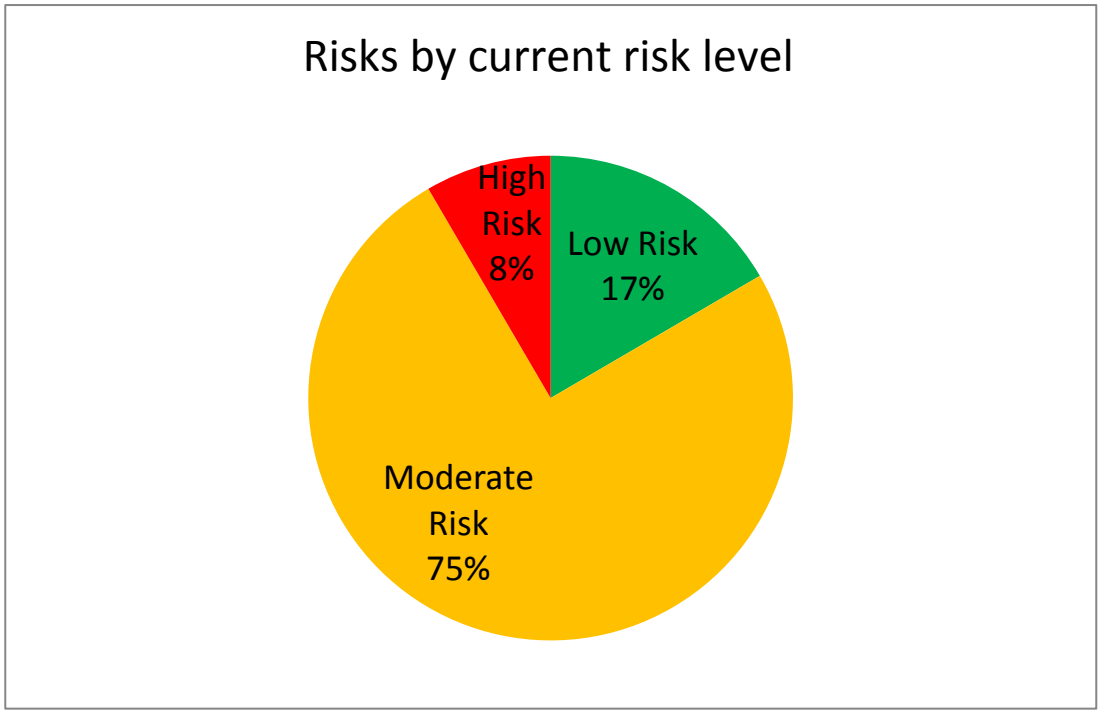
- 8 risks are associated with staffing issues: (50, 67, 78, 125, 505, 686, 916, 1138)
- 6 risks are associated with compliance (with standards/mandatory or legislative: (400, 586, , 996, 1004, 1112 and 1046)
- 6 risks are associated with capacity issues or increase in demand: (130, 183, 407, 429, 872 and 1069)
- 2 risks are associated with financial issues (978, 1030)
- 2 risks are associated with IT systems (587 and 957)
- 2 risks associated with equipment (86 and 989)
- 1 risk associated with Resilience, Emergency Planning & Business Continuity (765)

4. Risk Profile

4.1 The trust wide distribution of risks is shown below of approved risks.

	Low				Significant			High			Very High		Severe	Unacceptable
Rating	**1**	**2**	**3**	**4**	**5**	**6**	**8**	**9**	**10**	**12**	**15**	**16**	**20**	**25**
Number of risks	5	8	9	32	3	63	36	58	18	17	7	14	4	0

4.2 The risk level distribution is shown below



4.3 The corporately approved risks that are on the trust risk register are distributed across the Business Groups as detailed below:-

Business Group	Risk Score 15	Risk Score 16	Risk Score 20	Risk Score 25	Total
Corporate	2	2	3	0	7
Integrated Care	0	4	1	0	5
Medicine and Clinical Support	3	1	0	0	4
Surgery, GI and Critical Care	0	1	0	0	1
Women's and Children and Diagnostic	2	7	1	0	10

4.4 The table below shows the movement of risks that are on the trust risk register at 1st October

Risk number	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	
130	20	20	12	12	12	12	12	20						↑
457	20	20	20	20	20	20	20	12						↓
505	20	20	20	20	20	20	20	20						↔
586	20	20	20	20	20	20	20	20						↔
978			20	20	20	20	20	20						↔
1004				20	20	20	20	20						↔
67	16	16	8	8	8	20	16	16						↔
1015				20	16	16	16	12						↓
618	16	16	16	16	16	16	16	12						↓
765	16	16	16	16	16	16	16	16						↔
125	16	16	16	16	16	16	16	16						↔
127	16	16	16	16	16	16	16	12						↓
429	16	16	16	16	16	16	16	16						↔
183	16	16	16	16	16	16	16	16						↔
50	16	16	16	16	16	16	16	16						↔
78	16	16	16	16	16	16	12	16						↑
686				16	16	16	16	16						↔
872	16	16	16	16	16	16	16	16						↔
934	16	16	16	16	16	16	16	12						↓
989				16	16	16	16	16						↓
991				16	16	16	16	9						↔
1046						16	16	16						↔
1069						16	16	16						↔
1112						16	16	16						↔
1030							16	16						↔
1138							16	16						↔
86					15	15	15	15						↔
400								15						↑
407	15	15	15	15	15	15	15	15						↔
576	15	15	15	15	15	15	15	12						↓
587	15	15	15	15	15	15	15	15						↔
916					15	15	15	15						↔
957		15	15	15	15	15	15	15						↔
996					15	15	15	15						↔

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

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

Risk number	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20
46	20												
124	20	12											
231	15	15	15	15	12								
355	15	C											
363	15	15	15	C									
408	15	12											
461	16	C											
466	16	C											
469	15	10											
476	15	15	C										
499	15	12											
513	15	9											
576	15	15	15	15	15	15	15	12					
599	16	16	16	16	16	16	C						
686	16	16	12										
816	16	12											
825	15	15	15	15	15	15	C						
869	16	16	12										
905				C									
938				16	16	4							
1031				16	12								

5. Risk Movement

5.1 There are 27 risks on the trust risk register; four more than the last report.

5.2 There were 3 risks approved at the Safety & Risk Group this month. (78, 130 and 400). Seven risks have been reduced to below a score of 15 and therefore removed from the trust risk register (127, 457, 576, 618, 934, 991 and 1015).

5.3 There 2 risks sitting on the Business Group risk registers of 15 and above and have not yet received corporate approval at time of writing report.

6. Summary

6.1 Members are asked to note the risks and the identified actions to mitigate those risks.

RISK ASSESSMENT SCORING/RATING MATRIX

LIKELIHOOD OF HAZARD

LEVEL	DESCRIPTER	DESCRIPTION
5	Almost certain	Likely to occur on many occasions, a persistent issue - 1 in 10
4	Likely	Will probably occur but is not a persistent issue - 1 in 100
3	Possible	May occur/recur occasionally - 1 in 1000
2	Unlikely	Do not expect it to happen but it is possible - 1 in 10,000
1	Rare	Can't believe that this will ever happen - 1 in 100,000

The risk factor = severity x likelihood

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

	CONSEQUENCE				
LIKELIHOOD	**1**	**2**	**3**	**4**	**5**
	Low	**Minor**	**Moderate**	**Major**	**Catastrophic**
5 - Almost Certain	AMBER *(significant)*	AMBER *(high)*	RED *(very high)*	RED *(severe)*	RED *(unacceptable)*
4 - Likely	GREEN *(low)*	AMBER *(significant)*	AMBER *(high)*	RED *(very high)*	RED *(severe)*
3 - Possible	GREEN *(low)*	AMBER *(significant)*	AMBER *(high)*	AMBER *(high)*	RED *(very high)*
2 - Unlikely	GREEN *(low)*	GREEN *(low)*	AMBER *(significant)*	AMBER *(significant)*	AMBER *(high)*
1 - Rare	GREEN *(low)*	GREEN *(low)*	GREEN *(low)*	GREEN *(low)*	AMBER *(significant)*

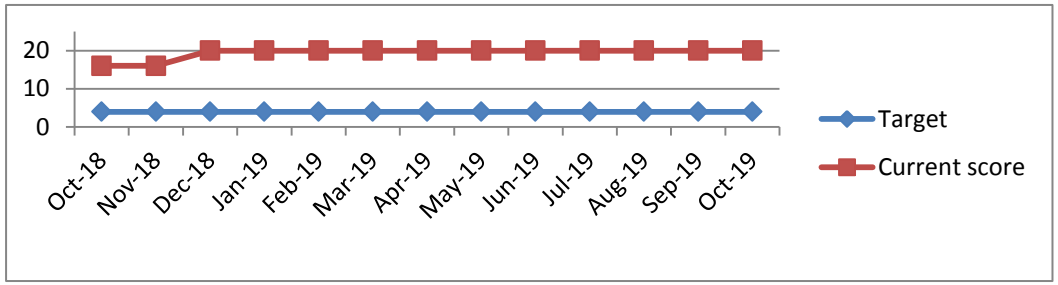
QUALITATIVE MEASURE OF CONSEQUENCE

Impact Score	1	2	3	4	5
Domains / Description	**NEGLIGIBLE / LOW**	**MINOR**	**MODERATE**	**MAJOR**	**CATASTROPHIC**
Impact on the safety of patients, staff or public (physical / psychological harm)	Minimal injury requiring no intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for <7 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 7-14 days Increase in length of hospital stay by 4-15 days RIDDOR / agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity / disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects Fatality Multiple permanent injuries/irreversible health effects	An event which impacts on a large number of patients Multiple Fatalities
Quality / complaints / audit	Peripheral element of treatment or service suboptimal Informal complaint / inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints / independent review Low performance rating Critical report Inquest / ombudsman negative finding	Totally unacceptable level or quality of treatment / service Gross failure of patient safety if findings not acted on Gross failure to meet national standards
Human resources / organisational development / staffing / competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective / service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory / key training	Uncertain delivery of key objective / service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory / key training	Non-delivery of key objective / service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training / key training on an ongoing basis
Statutory duty / inspections	No or minimal impact or breech of guidance / statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations / improvement notice Register concern	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity / reputation	Local Press >1 Potential for public concern	Local media coverage >1 Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. Full Public Inquiry MP concerned (questions in the House) Total loss of public confidence
Business objectives / projects	Insignificant cost increase / schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims / cost	Small loss Risk of claim remote < £2k	Loss of 0.1–0.25 per cent of Trust budget Claim / cost less than £2- 20k	Loss of 0.25–0.5 per cent of Trust budget Claim(s) / cost between £20k -£1M	Uncertain delivery of key objective / Loss of 0.5–1.0 per cent of Trust budget Claim(s) / cost between £1m and £5m Purchasers failing to pay on time	Non-delivery of key objective / Loss of >5 per cent of Trust budget Failure to meet specification / slippage Loss of contract / payment by results Claim(s) >£5 million
Service / business interruption Environmental impact	Loss / interruption of >1 hour Minimal or no impact on the environment	Loss / interruption of >8 hours Minor impact on environment	Loss / interruption of >1 day Moderate impact on environment	Loss / interruption of >1 week Major impact on environment in more than one critical area	Permanent loss of service or facility Catastrophic impact on environment
Project related	Insignificant impact on planned benefits	Variance on planned benefits <5% and <£50k	Variance on planned benefits >5% or >£50k	Variance on planned benefits >10% or >£500k	Variance on planned benefits >25% or >£1m

Stockport NHS Foundation Trust

Strategic Priority / Objective: To deliver outstanding Clinical Quality and patient experience	**BAF Ref:** SO2	**Corp Ref:** 2a, 3a	**CQC Ref:** 12, 17
Risk ID: 505 **Risk Description:** The risk of the lack of capacity in Cellular Pathology on turnaround times and patient pathways	**Assurance Committee:** Finance & Performance Committee	**Date entered on register:** 02.07.2018	**Executive Director lead:** Chief Operating Officer
	Current risk score (C x L): 4 x 5 = 20	**Risk Direction:** ↔	**Last reviewed:** 01.10.2019
	Target risk rating: 4	**Target Gap score:** 16	**Date of next review:** 01.11.2019

Risk movement:



Risk Appetite:

None	
Low	
Moderate	
High	
Significant	

Rationale for current score:
Service/reporting delayed for more than 1 week
Refer to incidents 10451 and 10449 under linked records

Date when risk score expected to be achieved

Rationale for risk appetite

Controls:
Escalation spreadsheet on shared drive to monitor progress of urgent cancer cases.
Met with Salford Dermatology team to address delayed TAT and produce spreadsheet on shared drive for them
Communication to all clinical teams to use tracker and management escalation for urgent or MDT dependant cases.
Pathology operational lead attends Trust PTL and Elective performance meetings
Specific Pathology performance meeting with monitoring team instigated

Assurance:
Internal:
Business Group Quality Board
Business Group Performance meetings
External: Health and Safety Executive
ISO inspection
MHRA

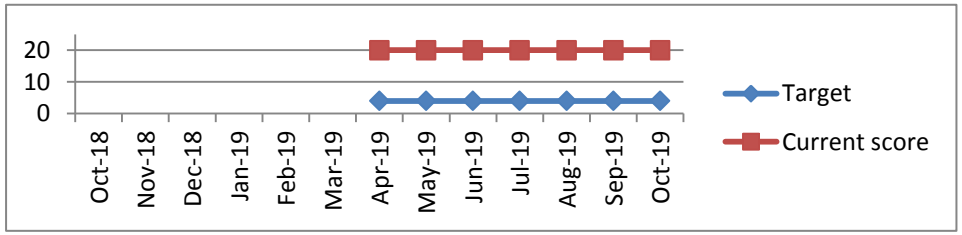
Mitigating actions	Lead	Timescale
Recruitment to vacant posts	Margaret Drury	

Gaps in assurance:

Stockport NHS Foundation Trust

Strategic Priority / Objective: To strive to achieve financial sustainability	**BAF Ref:** SO3	**Corp Ref:** 3a, 3b, 3c	**CQC Ref:** 17
Risk ID: 978 **Risk Description:** There is a risk that the Trust will not deliver its 2019/20 financial performance	**Assurance Committee:** Finance & Performance Committee	**Date entered on register:** 01.04.2019	**Executive Director lead:** Director of Finance
	Current risk score (C x L): 5 x 4 = 20	**Risk Direction:** ↔	**Last reviewed:** 17.09.2019
	Target risk rating: 5	**Target Gap score:** 15	**Date of next review:** 18.10.2019

Risk movement:



Risk Appetite:

None	
Low	
Moderate	
High	
Significant	

Rationale for current score:
The consequence is catastrophic - financial balance is a key objective of the Trust and the loss of access to the PSF and FRF funding would represent more than 5% of the Trust budget

The likelihood is rated as likely. The Trust does not yet have full plans in place to deliver the £14.2m CIP target therefore it is likely that mitigating plans will need to be put in place to manage this.

Date when risk score expected to be achieved

Rationale for risk appetite

Controls:
Performance Management through monthly Business Group meetings
Performance Wall - updated weekly to review previous weeks performance and review the next 3 weeks forecast
Operational and Financial Metrics - reported to EMG fortnightly
CIP - weekly reporting is in place
Responsibilities for financial management signed off with each triumvirate specialty team

Assurance:
Internal:
Business Group Performance meetings
Internal Auditors
External:
NHSI
External Auditors

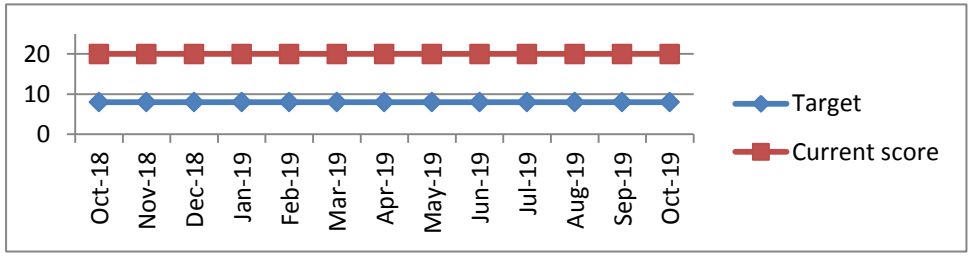
Mitigating actions	Lead	Timescale
Review of CIP scoping opportunity	Kay Wiss	30/09/2019
Fortnightly reporting to NHSI is required		31/03/2020
Investigation underway following a confirmed significant negative variance in the month 3 non elective SLAM position.		30/09/2019
A new performance management framework is being developed to ensure delivery of the required operational and financial performance		31/10/2019

Gaps in assurance:
The focus remains on identifying the gap in the CIP plan for this year through the weekly Clinical Services Efficiency Group.
Financial position as at the end of month 4 was a deficit of £6m which is £0.2m favourable to plan. CIP is £1m favourable to plan however the phasing of the plan is not in equal twelfths. £6.1m has been delivered against the £14.2m target, which is an increase of £1.2m in month. However recurrent CIP is £3m which leaves a significant gap for 20/21. There continues to be concern over non-elective income.

Stockport NHS Foundation Trust

Strategic Priority / Objective: To create an environment that maximises the use of resources to improve efficiency, patient experience and clinical quality.	**BAF Ref:** SO7	**Corp Ref:** 7b, 7c	**CQC Ref:** 15
Risk ID: 586 **Risk Description:** There is a risk of deterioration of the hospital site due to a significant increase in Estate Backlog Maintenance	**Assurance Committee:** Finance & Performance Committee	**Date entered on register:** 21.06.2018	**Executive Director lead:** Deputy CEO/Executive Director of Strategy, Planning and Partnerships
	Current risk score (C x L): 4 x 5 = 20	**Risk Direction:** ↔	**Last reviewed:** 20.08.2019
	Target risk rating: 8	**Target Gap score:** 12	**Date of next review:** 30.09.2019

Risk movement:



Risk Appetite:

None	
Low	
Moderate	
High	
Significant	

Rationale for current score:
Quality Complaints and Audit; Non-compliance with national and statutory standards.
Project Related; Variance on planned benefits >10%
Service Business Interruption; major impact on environment win more than one critical area. Loss/interruption of greater than 1 week.
Adverse Publicity / Reputation; National media coverage with greater than 3 days service well below public reasonable expectation.

Date when risk score expected to be achieved

Rationale for risk appetite

Controls:
Prioritisation of high and significant risk areas identified within the 5 facet survey and individually risk assessed. Ensuring areas with associated statutory requirements are prioritised.
Planned Preventative Maintenance (PPM) schedule of works.
Regular walk rounds/visual checks undertaken by Estates Staff.
Estates Helpdesk: Facility to report jobs.
On-going review & monitoring of DATIX Incidents & appropriate remedial action.

Assurance:
Internal:
CDPG
Executive Management Group
External:
Greater Manchester CA
HSE

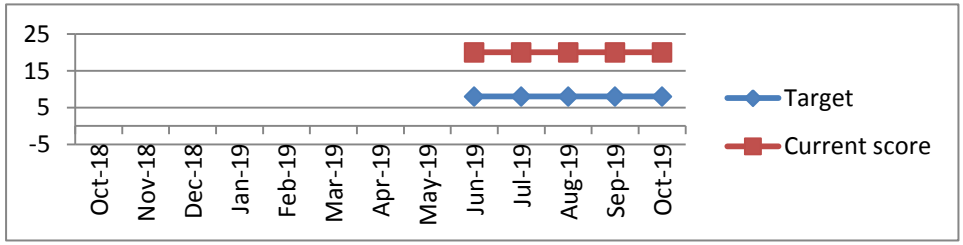
Mitigating actions	Lead	Timescale

Gaps in assurance:
The reportable backlog maintenance figure has risen considerably from £15m up to £94m based on an external provider commissioned to undertake a detailed and independent review of the estate condition via a 5 facet survey which considered and evaluated the hospital's physical condition, statutory compliance, functionality, quality and environmental management. The overall risk is that the current capital expenditure levels are not sufficient enough to reduce the identified backlog maintenance significantly

NHS Stockport NHS Foundation Trust

Strategic Priority / Objective: To create an environment that maximises the use of resources to improve efficiency, patient experience and clinical quality.	**BAF Ref:** SO7	**Corp Ref:** 7b, 7c	**CQC Ref:** 15
Risk ID: 1004 **Risk Description:** There is a risk of significant breaches of the Regulatory Reform (Fire Safety) Order 2005	**Assurance Committee:** Finance & Performance Committee	**Date entered on register:** 12.06.2019	**Executive Director lead:** Deputy CEO/Executive Director of Strategy, Planning and Partnerships
	Current risk score (C x L): 4 x 5 = 20	**Risk Direction:** ↑	**Last reviewed:** 25.09.2019
	Target risk rating: 8	**Target Gap score:** 12	**Date of next review:** 31.10.2019

Risk movement:



Risk Appetite:

None	
Low	
Moderate	
High	
Significant	

Rationale for current score:
During an inspection of the Maternity Block Greater Manchester Fire & Rescue Service (GMFRS) identified significant breaches of the Regulatory Reform (Fire Safety) Order 2005.

Date when risk score expected to be achieved

Rationale for risk appetite

Controls:
Action Plan agreed with GMFRS.
Monthly Meetings with GMFRS to monitor progress against action plan

Assurance:
Internal:
CDPG
Executive Management Group
External:
Greater Manchester CA
Grater Manchester Fire Service

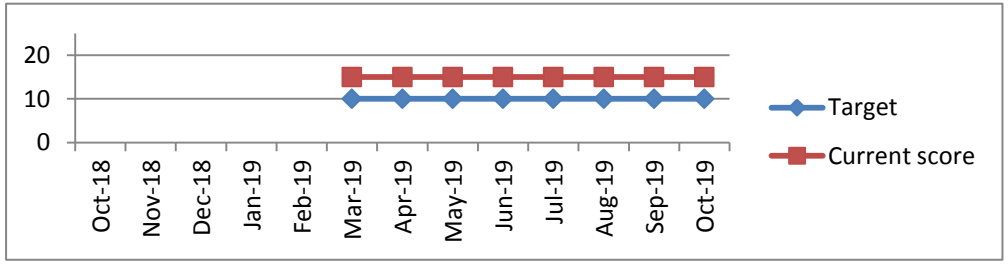
Mitigating actions	Lead	Timescale
Complete the action plan which includes training, estates work, review of evacuation plans	Graham Ware & Jennifer Kilheeney	19/11/2019

Gaps in assurance:
GMFRS have written to the Trust outlining actions to be taken to remedy the failures and ensure compliance with the Regulatory Reform (Fire Safety) Order 2005.
An action plan (including timescales) has been agreed between the Trust and GMFRS, progress against which is to be monitored by GMFRS in the form of monthly meetings. NB: The action plan does not have the same legal standing as a Formal Enforcement Notice issued under Article 30 of the Regulatory Reform (Fire Safety) Order 2005.

Stockport NHS Foundation Trust

Strategic Priority / Objective: To create an environment that maximises the use of resources to improve efficiency, patient experience and clinical quality.	**BAF Ref:** SO7	**Corp Ref:** 2a, 3a, 7c	**CQC Ref:** 12, 15
Risk ID: 957 **Risk Description:** There is a risk to patient care if the Laboratory Information Management System (Telepath) Fails	**Assurance Committee:** Finance & Performance Committee	**Date entered on register:** 07.03.2018	**Executive Director lead:** Deputy CEO/Executive Director of Strategy, Planning and Partnerships
	Current risk score (C x L): 5 x 3 = 15	**Risk Direction:** ↔	**Last reviewed:** 30..09.2019
	Target risk rating: 10	**Target Gap score:** 5	**Date of next review:** 31.10.2019

Risk movement:



Risk Appetite:

None	
Low	
Moderate	
High	
Significant	

Rationale for current score:
Age of system
Poor system support
Loss of expertise within manufacturer
Failure to comply with NHS Digital standards
Single point of failure

Date when risk score expected to be achieved

Rationale for risk appetite

Controls:
To have contingency plans in place and documented.
To put in place a new system that would mitigate the risk of the system failing and not being retrievable.

Assurance:
Internal:
Business Group Quality Board
Business Group Performance meetings
CDPG
Executive Management Group
External: Health and Safety Executive
ISO inspection
MHRA

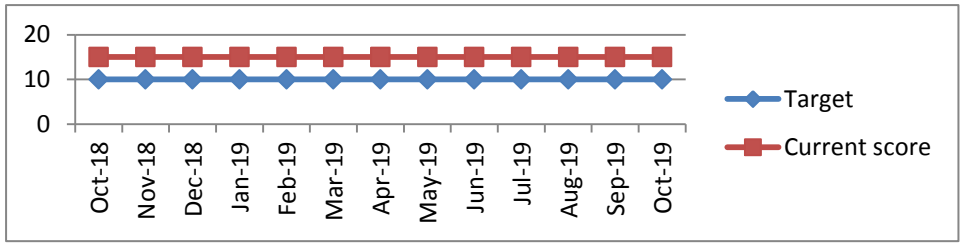
Mitigating actions	Lead	Timescale
Explore replacement LIMS	Margaret Drury	30/09/2019

Gaps in assurance:

Stockport NHS Foundation Trust

Strategic Priority / Objective: To develop and maintain an engaged workforce with the right skills motivation and leadership	**BAF Ref:** SO6, SO2	**Corp Ref:** 6d	**CQC Ref:** 12, 18
Risk ID: 587 **Risk Description:** There is a risk to the operation of the Trust electronic system /network due to the need to recruit Senior IT Technical Support	**Assurance Committee:** People & Performance Committee	**Date entered on register:** 25.05.2018	**Executive Director lead:** Director of Workforce & OD
	Current risk score (C x L): 5 x 3 = 15	**Risk Direction:** ↔	**Last reviewed:** 03.09.2019
	Target risk rating: 10	**Target Gap score:** 5	**Date of next review:** 30.09.2019

Risk movement:



Risk Appetite:

None	
Low	
Moderate	
High	
Significant	

Rationale for current score:
Consequence = 5: Risk of total loss of key IT systems affecting eg email; ordering & reporting of tests, PAS/ Patient Centre, EMIS, electronic prescribing, ED system - non delivery of key service due to staffing shortages.

Likelihood = 3: Possible - post holders has to take holidays and may need elective procedure during this financial year.

Date when risk score expected to be achieved

Rationale for risk appetite

Controls:
1. Deputy Systems Manager is being trained up but cannot yet do the majority of security updates and patching.
2.Asst Director IT (Infrastructure) has signed a document to say he accepts he needs to work more than 45 hours per week - some additional payment.
3. Re-advertising both posts following JD and advert reviews
4. ECP agreed could recruit agency in interim

Assurance:
Internal:
Business Group Quality Board
Business Group Performance meetings
WEG
CEG
External:
Greater Manchester Combined Authority
NHSI

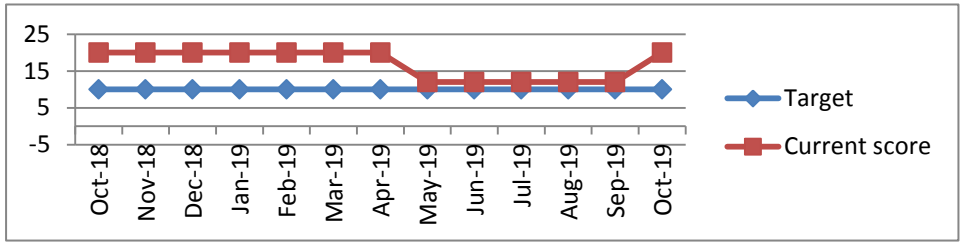
Mitigating actions	Lead	Timescale
Recruitment to vacant posts	Peter Hughes	30/09/2019

Gaps in assurance:

Stockport NHS Foundation Trust

Strategic Priority / Objective: To deliver outstanding Clinical Quality and patient experience	**BAF Ref:** SO2	**Corp Ref:** 2a, 3a	**CQC Ref:** 12, 17
Risk ID: 130 **Risk Description:** There is a risk that the ED 4 Hour Standard will not meet its required monthly trajectory	**Assurance Committee:** Finance & Performance Committee	**Date entered on register:** 01.09.2017	**Executive Director lead:** Chief Operating Officer
	Current risk score (C x L): 4 x 5 = 20	**Risk Direction:** ↑	**Last reviewed:** 23.09.2019
	Target risk rating: 10	**Target Gap score:** 10	**Date of next review:** 23.10.2019

Risk movement:



Risk Appetite:

None	
Low	
Moderate	
High	
Significant	

Rationale for current score:
Reviewed by BG, agreed given current Trust performance the score should be raised to a 20

Date when risk score expected to be achieved

Rationale for risk appetite

Controls:
Daily review of the system flow with teleconferences in place with all system partners
Daily monitoring and controls in place within department to ensure patient safety, staffing meetings, patient safety workarounds
Bed management control: site coordination team review ED continually.
Redesign of the Urgent Care footprint will support improved flow.

Assurance:
Internal:
Executive Team
External:
Greater Manchester CA
CQC

Mitigating actions	Lead	Timescale
4 Quadrants of the Urgent Care Delivery Board recovery plan outline the actions of system to address the capacity and demand pressure in Urgent Care. This action will remain open until the full implementation of the UCDB plan and recovery is achieved.	Jen Freer	01.10.2019

Gaps in assurance:
Performance remains below trajectory agreed

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Risk ID	Date Risk Identified	Business Group	Risk Title	Rating (initial)	Summary of Controls	Consequence (current)	Likelihood (current)	Rating (current)	Mitigating Actions in Place	Action Due Date	Expected Target Date	Rating (Target)
130	01/09/2017	Integrated Care Business Group	There is a risk that the ED 4 Hour Standard will not meet its required monthly trajectory	20	Combined oversight of PGD into UCDB looking at full system solutions to poor flow and other root causes of poor performance	4	5	20	Please refer to actions of the Programme Delivery Group (PGD)	16/12/2019	16/12/2019	10
505	02/07/2018	Women Children and Diagnostics Business Group	The risk of the lack of capacity in Cellular Pathology on turnaround times and patient pathways	16	Escalation spreadsheet on shared drive to monitor progress of urgent cancer cases. Met with Salford Dermatology team to address delayed TAT and produce spreadsheet on shared drive for them Communication to all clinical teams to use tracker and management escalation for urgent or MDT dependant cases. Pathology operational lead attends Trust PTL and Elective performance meetings Specific Pathology performance meeting with monitoring team instigated	4	5	20	Recruit to vacant histopathologist posts	31/10/2019	31/10/2019	4
586	21/06/2018	Estates and Facilities	There is a risk of deterioration of the hospital site due to a significant increase in Estate Backlog Maintenance	20	Prioritisation of high and significant risk areas identified within the 5 facet survey and individually risk assessed. Ensuring areas with associated statutory requirements are prioritised. Planned Preventative Maintenance (PPM) schedule of works. Regular walkrounds/visual checks undertaken by Estates Staff. Estates Helpdesk: Facility to report jobs. On-going review & monitoring of DATIX Incidents & appropriate remedial action.	4	5	20	Risk Review Due	31/03/2020	31/03/2020	8
									Distressed Capital Funding	30/11/2019		
									Mapping Exercise - Significant Risks	30/11/2019		
978	01/04/2019	Finance	There is a risk that the Trust will not deliver its 2019/20 financial performance	20	A number of controls are in place including strong performance management via monthly BG meetings, weekly performance wall, fortnightly financial reporting to EMG and weekly CIP monitoring	5	4	20	Agreement of the Performance Management Framework	31/10/2019	31/03/2020	5
									Fortnightly reporting of CIP to NHSI	31/03/2020		
									Non Elective Income Investigation	31/10/2019		
									Trust Recovery Plan	01/11/2019		
1004	08/05/2019	Estates and Facilities	There is a risk of significant breaches of the Regulatory Reform (Fire Safety) Order 2005	20	Action Plan agreed with GMFRS. Monthly Meetings with GMFRS to monitor progress against action plan.	4	5	20	Stand alone Fire Risk Assessment for Theatres	31/12/2019	02/09/2020	8
									Fire Stopping - Maternity Block	09/11/2019		
									Compartmentation Sizing	09/11/2019		
									Principles of Prevention to be covered in annual Fire Safety Training	02/09/2020		

Risk ID	Date Risk Identified	Business Group	Risk Title	Rating (initial)	Summary of Controls	Consequence (current)	Likelihood (current)	Rating (current)	Mitigating Actions in Place	Action Due Date	Expected Target Date	Rating (Target)
									Review Fire Evacuation Plans	09/11/2019		
									Annual programme of fire drills in the form of a "Walkthrough" to be undertaken	02/09/2020		
									Fire Safety Training	09/05/2020		
									Fire Safety Training Records	09/05/2020		
									Risk Review Due	30/11/2019		
1030	06/06/2019	Integrated Care Business Group	There is a risk the BG will not meet the CSEP target of £2.4m	16	BG has escalated concerns to Executive Team Completed impact assessment across all affected areas Communicated the position to BG service leads to ensure awareness and engagement BG continuing to engage in the trust CSEP and weekly track progress using the delivery tool BG management Team meet weekly with Finance, HR and Transformation colleagues	4	4	16	Overview of BG services	31/10/2019	31/10/2019	12
1046	29/05/2019	Estates and Facilities	There is a risk the Trust is non-compliant with statutory H&S legislation due to non appointment to statutory positions	20	Gap Analysis undertaken & Statutory Compliance Tracker created External Review of Estates Function Estates Statutory Compliance Work Plan produced & establishment of E&F Task & Finish Group to monitor progress against the action plan. Fortnightly reporting to Trust Exec Team.	4	4	16	Statutory Compliance Tracker - Progress Monitoring	31/03/2020	31/03/2020	8
									Risk Review Due	31/12/2019		
1069	23/05/2019	Women Children and Diagnostics Business Group	There is a risk of POCT management failure due to the pressure on the staff and limitations of resources	16	Ketone Vtrust meters - not meeting specification for full connectivity, any results out of the analytical range give the same error whether high or low and are not transmitted to the patients electronic record. Any insufficient samples display the same error. 2 risk assessments with actions in place. INR meters - End of life - quote received from company Urisys1100 dipstick readers - All negative results require manual confirmation negating the purpose of the meter. Quality governance guidance in place to visually read all negative, if discrepant this is referred to senior staff and Datix'd. Procedure and documentation put into place to mitigate risk and monitor staff	4	4	16	Address, action and document UFSN	28/11/2019	27/07/2020	8
									Business case for increase in establishment for POCT	01/11/2019		
									ADT feed for Cobas IT	29/11/2019		
									Procure replacement Ketone solution	23/10/2019		
									Scope peer to peer training for OOH trouble shooting	13/07/2020		
									Gap analysis to ISO accreditation	27/07/2020		
									Contract KPIs negotiation	01/04/2020		
1112	06/08/2019	Group	There is a risk to the organisation due to	16	All the policies and SOPs in place are to comply with the Blood Safety & Quality Regulations.	4	4	16	Relaunch Transfusion Policy	29/11/2019	29/11/2019	4

Risk ID	Date Risk Identified	Business Group	Risk Title	Rating (initial)	Summary of Controls	Consequence (current)	Likelihood (current)	Rating (current)	Mitigating Actions in Place	Action Due Date	Expected Target Date	Rating (Target)
		Women Children and Diagnostics Business	noncompliance with BSQRegulations due to Loss of Traceability of blood components						Observe activity on wards during transfusion (RCA)	25/10/2019		
									Increase awareness of training video on microsite for bedside check	29/11/2019		
									Create poster for traceability Returns process for wards	28/10/2019		
									Explore "Empty pockets at handover" policy	31/10/2019		
									Explore feasibility of electronic system	25/10/2019		
									Safety Collaborative meeting	31/10/2019		
1138	10/09/2019	Integrated Care Business Group	There is a risk that patient care is compromised due to significant nurse staffing shortages within the ED	16	Continued recruitment to vacancies. NHSP working to fill shifts through bank and agencies via the trust agreed agency cascade Cancellation of non-clinical shifts	4	4	16	Recruitment of International Nursing	06/01/2020	06/01/2020	8
									Recruitment of Nurses	16/12/2019		
									Retention of Staff	16/12/2019		
989	17/04/2019	Women Children and Diagnostics	There is a risk of delaying treatment especially cancer patients with the removal of fax machines	16	The areas that have been affected by the removal of fax machines will need to set up an nhs.net account as this is encrypted. The reports can then be sent out with a prompt to the referrer that this has happened. This is	4	4	16	Review of Service	27/12/2019	27/12/2019	4
									Internal e-mail system	27/12/2019		
125	10/05/2016	Integrated Care Business Group	There is a risk that patients care could be compromised due to insufficient Emergency Department Medical Staffing	12	Dependant on internal cover and locum bookings	4	4	16	Discuss opportunities with upcoming CCT holders	06/01/2020	06/01/2020	8
429	05/01/2018	n Children and Diagnostics Business Group	Inadequate capacity to meet demand in Paediatric ADHD Services	20	Capacity deficit raised with Stockport Commissioner Additional OWL lists monthly (not covering current demand)	4	4	16	Additional Consultant PA's in post to provide ADHD service	31/10/2019	31/10/2019	8

Risk ID	Date Risk Identified	Business Group	Risk Title	Rating (initial)	Summary of Controls	Consequence (current)	Likelihood (current)	Rating (current)	Mitigating Actions in Place	Action Due Date	Expected Target Date	Rating (Target)
		Women										
									Review pathway for ADHD service	31/10/2019		
686	05/10/2018	Integrated Care Business Group	There is a risk that patient care may be compromised due to significant staffing shortages within AMU	20	NHSP working to fill shifts through bank and agencies via the trust agreed agency cascade. Continued recruitment to vacancies Cancellation of non-clinical shifts Cancellation of training as required Daily review by Business Group senior management team	4	4	16	Recruitment of medication administration pharmacy technicians	16/12/2019	16/12/2019	8
765	25/10/2018	Women Children and Diagnost	There is a risk to the delivery of the CT service and patient safety due to a	16	Due to the increase in workload another 2 CT scanners are required. This has been planned for. Mobile CT scanner is being used to maintain waiting list times but	4	4	16	Replacement Programme for CT/MR	24/12/2019	24/12/2019	4
872	04/12/2018	Surgery GI and Critical Care	There is a risk to patient experience and safety due to Endoscopy Capacity and Demand	16	The capacity and demand business case demonstrates that there is a need for more capacity compared to the demand. Therefore we are proposing a 4th room build which will reduce the cost associated with the insourced Alliance Lists and WLI sessions.	4	4	16	Schedule patients into additional insourced lists with Alliance	29/11/2019	29/11/2019	1
183	28/04/2010	Executive teams	Failure to meet the 62 day Cancer target standards	12	Monthly Cancer Board. Tracking team review all patients on pathway. Cancer Services Manager reviews patients using "Predictor" tool. Patients discussed at weekly tumour specific PTL meetings, Business Group meetings and Trust-wide PTL. Escalation policy in use	4	4	16	Cancer Services Manager to review Department roles and responsibilities to ensure staff are engaged with targets	31/10/2019	01/12/2019	8
									Faster Diagnosis action plan will have positive effect on achieving 62 day target	01/12/2019		
									Awaiting outcome of discussions on potential loss of Urology cancer activity and impact on Trust 62 day Cancer performance, this is dependent on the future service model design. (scenario paper produced by Performance Team)	01/12/2019		
									Diagnostic waits negatively impacting on cancer performance	01/09/2019		

Risk ID	Date Risk Identified	Business Group	Risk Title	Rating (initial)	Summary of Controls	Consequence (current)	Likelihood (current)	Rating (current)	Mitigating Actions in Place	Action Due Date	Expected Target Date	Rating (Target)
50	11/03/2015	Women Children and Diagnostics Business Group	Risk to maternity service continuity and safety due to midwifery staffing levels	16	- Birth Rate Plus staffing review undertaken June 2017 - Business case collated and submitted August 2017 - additional staff recruited. - Midwife to Birth Ratio reviewed on a monthly basis and reported on dashboard - Evaluation of maternity service diverts undertaken June 2018 - Escalation of concern reports formally submitted to Quality Board, Quality Governance Committee and People and Performance Committee as appropriate (see documents) - Ongoing recruitment taking place to address any long term deficits. - Maternity leave tracked and recorded to highlight staffing deficit. - RM staff 8.0wte employed in excess of funded establishment to cover maternity leave and deficit highlighted by Birth Rate Plus review following submission of a business case in August 2017.	4	4	16	Resubmit outline business case	30/11/2019	30/11/2019	8
67	18/07/2017	Women Children and Diagnostics Business Group	There is a risk to service delivery due to the lack of Consultant Microbiologist Cover	16	Recruitment processes being followed Temporary staffing processes in place which is not sustainable and requiring substantial management to engage. OH support to staff where necessary. Laboratory and pharmacy support	4	4	16	Recruit bank staff	31/12/2019	31/12/2019	8
78	21/11/2016	Medicine and Clinical Support	There is a risk to patient safety due to the registered nursing staffing deficit within Medicine & CS	20	Twice daily assessment of staffing across the Business Group Band 7 on each ward to regularly monitor off duty for changes, ensure accurate numbers, significant gaps to be escalated to Matrons Staff re-deployed to balance the risk across the Business Group Reference to the Minimum safe staffing escalation policy Monitor of DATIX and Red Flags Pro-actively put shifts out to NHSP and Agency Ongoing local and international recruitment	4	4	16				8

Risk ID	Date Risk Identified	Business Group	Risk Title	Rating (initial)	Summary of Controls	Consequence (current)	Likelihood (current)	Rating (current)	Mitigating Actions in Place	Action Due Date	Expected Target Date	Rating (Target)
86	09/08/2017	Estates and Facilities	There is a risk of the Trust's Telephony System failing due to aged telephone technology/infrastructure	12	Day-to-Day Management by Facilities Team Maintenance Contract with GE-Tronics with confirmation of on-going support until 2022 Establishment of a Replacement Program Task & Finish Group to oversee the system replacement. Business Continuity Plans for all services accross the Trust.	3	5	15	Risk Review Due	31/01/2020	31/01/2020	15
									Project Board	04/12/2019		
400	27/02/2018	Women Children and Diagnostics Business Group	There is a risk to 18 week targets and compliance with NICE guidance.	15	1) Local offer defines the limitations on the provision for different parts of the service 2) The service has requested a review by the CCG to re-define priorities and re-define the local offer to aim to increase capacity and improve access times for assessment. AS part of this each area of service is	3	5	15	Clarity of provision and assurance the service can meet the contract	31/03/2020	31/03/2020	9
									Proposal to CCG for funding to improve waiting times	31/10/2019		
407	04/03/2018	Medicine and Clinical Support	There is a risk to patient safety due to the number and length of the Respiratory Overdue Waiting List (non confirmed cancer)	12	- Urgent OWL codes used to identify patients who need to be prioritised for urgent Follow Up. - Consultants doing some validation of longest waiting patients to see if may be better managed in Primary Care. - monitoring of OWL in Trust performance meetings.	3	5	15	AQuA Project relating to OWL	20/12/2019	20/12/2019	6
916	11/01/2019	Medicine and Clinical Support	There is a risk that due to gaps in Orthodontic medics we are unable to meet	15	- recruit both temporarily and permanently. - attempts to secure locum - clinical priorities of patients	3	5	15	Prioritisation of patients	28/10/2019	28/10/2019	3
									Options paper for orthodontics	21/10/2019		
957	07/03/2019	Women Children and Diagnostics	There is a risk to patient care if the Laboratory Information Management System (Telepath) Fails	15	To have contingency plans in place and documented. To put in place a new system that would mitigate the risk of the system failing and not being retrievable.	5	3	15	Create Project / Action plan for procurement	31/12/2019	31/12/2019	10
587	25/05/2018	Information and IT	There is a risk to the operation of the Trust electronic syst/ntwrk due to	15	Advertising 2 key post; in interim attempting to recruit agency to be in place until substantive recruitment successful.	5	3	15	Recruit to 2 senior IT posts	30/09/2019	30/09/2019	10
996	25/04/2019	dicine and Clinical Support	This is a risk of the Trust not achieving a 7 day target for Clinical Correspondence	8	Internal review of KPI. Internal review of capacity and demand. Internal review of resource ic clinicians Internal review of technology efficiencies. Outsourcing. Monitor TAT's on report Develop a prediction tool	3	5	15	To review staffing resource in correspondence hub.	30/11/2019	30/11/2019	6
									Review Trust 7 day metrics	30/11/2019		
									Prediction Tool for capacity and demand	30/11/2019		
									Digital delivery of clinical correspondence	30/11/2019		

Risk ID	Date Risk Identified	Business Group	Risk Title	Rating (initial)	Summary of Controls	Consequence (current)	Likelihood (current)	Rating (current)	Mitigating Actions in Place	Action Due Date	Expected Target Date	Rating (Target)
		Me							Electronic sign-off of clinical letters	30/11/2019		

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Health and Safety Joint Consultative Group Key Issues Report

Report Date: 21ST October 2019		**Report of:** Health and Safety Joint Consultative Group		
Date of last meeting: 1st October 2019		**Membership Numbers:** 12 Quorate – Management : 3 & Chairperson, Safety Representative : 3		
1.	**Agenda**	The Group considered an agenda which included the following: • Action log • Group's Workplan • Review of the Terms of Reference • Staff-Side Issues • CQC Safe, High, Quality Care Improvement Plan • Annual Safety Report • Condensed Monthly Clinical Governance Report • Quarter 1 Learning from Experience Report • Proposed Health & Safety Bid : Fire Warden Training Rig		
2	**Alert**	The Group would like to alert members of the Board of Directors that • The Learning from Experience, Quarter 1 2019/2020 report highlighted that there remains a significant number of incidents that have been open over 60 days, trajectories have been set across the Business Groups to support a more timely investigation and sign off process		
3	**Assurance**	The Group would like to assure members of the Board of Directors that • The condensed Monthly Clinical Governance report identified that no RIDDOR cases had been reported in August 2019 • The Annual Safety report was received by members and members will share wider with their teams		
4	**Advise**	The Group would like to advise members of the Board of Directors that • A communication plan is to be developed for all staff following the approval of the Security Strategy, including support to staff concerning patient or patient families behaviour • The Terms of Reference of the Health and Safety JCG were reviewed following discussions held with the Executive Team concerning changes to the governance reporting structure • Managers are to remind staff that prior to any furniture or changes to work environments are carried out that a workplace/display screen assessment must be undertaken • The Health and Safety JCC supported the proposal to raise a bid for Health and Safety monies for a Fire Warden Training Rig • Concerns were raised about the training for porters in Manual Handling. The Facilities team will provide support to ensure staff are aware of their responsibilities and adherence to training		
5	**Risks Identified**	None were identified		
6	**Actions to be considered** at Board of Directors	• Report to be noted		
7	**Report Compiled by**	Chief Nurse & Director of Quality Governance	**Minutes available from:**	PA to Deputy Director Quality Governance

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Stockport NHS
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	1 November 2019
Subject:	Winter Plan Summary: 2019/20		
Report of:	Chief Operating Officer	**Prepared by:**	Deputy Chief Operating Officer

REPORT FOR UPDATE

Corporate objective ref: -----	**Summary of Report** This report is intended to provide a summary view of the Stockport System Winter plan. The report includes an overview of the schemes proposed, the timeframes associated and their indicative costs. The report provides a high-level view of the plan split by the four quadrants of the Stockport System Urgent Care: Stay Well, Home First, Patient Flow and Discharge.
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
- ☐ F&P Committee
- ☐ Workforce & OD Committee
- ☐ Charitable Funds Committee
- ☐ Nominations Committee
- ☐ Remuneration Committee
- ☐ Joint Negotiating Council
- ☐ Other

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1. INTRODUCTION

This report is intended to provide a summary view of the Stockport System Winter plan. The report also includes a high level view of the additional capacity being provided in and out of the hospital.

2. WINTER PLAN HEADLINES

The Stockport System Winter plan is going to put in place the following from November 2019 to March 2020:

System Capacity:

- 34 additional Acute beds
- 8 additional Transitional Support Flats
- 46 additional spot purchase beds
- 350hrs of additional Packages of Care (equivalent to 16 Acute beds)
- 45 additional Urgent GP appointments 5 days per week

Staffing Capacity:

- **16** additional Consultant shifts per week
- **23** additional Junior Doctor shifts per week
- **1** additional General Practitioner working in ED per week
- **4** additional full time Social Workers per week
- **303** additional hours of patient flow and discharge support staff

3. WINTER PLAN SUMMARY

Appendix 1 contains a further view of the schemes being put in place across the System, grouped by the 4 Quadrants of the Urgent Care Plan.

4. RECOMMENDATION

Please note the schemes in place and the progress made to date with the delivery of the System Winter Plan.

APPENDICES

APPENDIX 1 – Winter Plan Summary

Urgent Care Plan Theme	Summary Scheme	Scheme Lead	Indicative Cost	Start Date	End Date
Home First	**SCCG** - Implementation of Discharge to Assess	S.Williamson	-	01/10/2019	31/12/2019
Stay Well	**SCCG -** Implementation and Utilisation of the NART tool	A.Khan	£100 per C.Home	01/10/2019	31/11/2019
	SMBC Flu Strategy, including POCT, a mass immunisation programme and an incentive scheme for social care staff.	S.Turner	£45,500	01/10/2019	31/03/2020
	Viaduct Schemes, including 45 additional GP Appointments per day Mon- Fri and 1 extensivist GP in ED Mon - Fri.	K.Bottrell	£308,000	07/10/2019	31/03/2019
Patient Flow	**Mastercall -** NWAS deflection service	T.Davison	£131,357	05/11/2019	31/03/2019
	SFT Escalation Beds, including an additional ward and flexing of additional beds. (inc. early opening of Ward B5)	D. Forrest	£1,174,200	01/10/2019	31/03/2020
	SFT Additional Clinical Staffing, including additional Consultant staff for Urgent Care, Acute and Specialty medicine.	D. Forrest	£802,426	01/10/2019	31/03/2020
Discharge	**SFT Additional Staffing support for discharge,** including 3rd Sector support	C. Lloyd	£55,500	01/11/2019	31/03/2020
	SMBC Additional Staffing support for social work assessment and discharge planning	V. Fraga	£88,000	01/11/2019	30/03/2019
	SMBC Additional Community Capacity, including tranisitional support, ring fenced capacity and ED deflection support	V. Fraga	£435,000	01/11/2019	01/05/2020

NHS
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NHS Foundation Trust

Report to:	Board of Directors	**Date:**	1 November 2019
Subject:	Trust Strategy development update		
Report of:	Director of Strategy, Planning & Partnerships	**Prepared by:**	Associate Director Strategy & Planning

REPORT FOR INFORMATION

Corporate objective ref: -----	**Summary of Report** This report provides the Board of Directors with a brief update on the Trust Strategy, this includes: • a reflection of the current position • a reminder of work undertaken over the past 18 month to develop our strategy • a timeline for how a final version will be completed; and • the resulting next steps This report is provided in order to provide assurance that the strategy will be completed prior to the expected date for the CQC Well led inspection. Annex A also provides a consistent narrative for the Board regarding our strategy development.
Board Assurance Framework ref: -----	
CQC Registration Standards ref: -----	
Equality Impact Assessment: ☐ Completed ☐ Not required	

Attachments: Annex A – Trust Strategy development

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 provides the Board of Directors with a brief update on the Trust Strategy, this includes:

- a reflection of the current position
- a reminder of work undertaken over the past 18 monthS to develop our strategy
- a timeline for how a final version will be completed; and
- the resulting next steps

2. CURRENT POSITION

2.1 A revised version of the strategy was shared with the Board at the meeting on 30 September 2019. Unfortunately, there was not sufficient time for detailed discussion and this was subsequently circulated to the Board for comment.

2.2 The CQC Provider Information Request (PIR) was submitted on Wednesday 23 October 2019. Part of the request included a position statement on progress with the Trust strategy and a request for the current strategy itself.

2.3 Annex A is two slides depicting progress we have made on strategy development over the past 18 months – this was sent as supporting evidence to the response provided within the PIR, as it was agreed we are not in a position to share a version of the strategy until completion.

2.4 This diagram also acts as a reminder of where the Board has shaped development of the strategy, depicts where there has been engagement with staff and stakeholders and explains some of the rationale/decisions made on the steps that have been taken.

2.5 A final version is currently being pulled together by the strategy team incorporating the most recent content circulated to the Board and comments received back on the structure and content. We are planning to meet with the new Non-executive Directors to capture their input having not been involved in the development to date.

3. NEXT STEPS

3.1 A final strategy will be complete by mid-November for review by the Executive team prior to the Board of Directors in November. A key part of this is incorporating a revised vision and set of values for the organisation - based on the feedback from the engagement exercise, the working group identified some key themes/words and a proposed set of new values and USP. This is being discussed at the Executive Team meeting on 29 October.

4. RECOMMENDATIONS

4.1 The Board of Directors are recommended to:

- Note the update provided and received assurance on the plan to complete the strategy

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TRUST STRATEGY DEVELOPMENT >>

NHS Stockport NHS Foundation Trust

STRATEGY REFRESH

- Developed with support from Attain to produce a refreshed strategic view (Q2 2018)
- Progress was presented to the Board in Jun, Jul and Sep 2018
- Consultation process with staff and stakeholders; 1 Oct 2018 -31 Jan 2019
- Outputs were reported to the Board in Q3 2019

STRATEGY ENGAGEMENT
We spoke directly with over 650 staff and partners via face to face briefings. All staff were engaged in the consultation process

Progress and feedback on consultation was communicated in May 2019

Questions and prompts to reach agreement on key aspects of strategy

Board held strategy development sessions in Apr & May 2019

BOARD SESSIONS
Shaped areas of key agreement for inclusion in the strategy; our approach to Partnerships, Culture, Transformation and what we stand out for

VISION & VALUES

- Consensus that existing content was not inspiring or aspirational enough
- It did not capture essence of the Trust
- Had not included a refreshed vision or set of values

VALUES ENGAGEMENT
We engaged all staff and met with almost 1,000 staff to hear their views to inform a refreshed set of values and behaviours – have received over 2,500 pieces of feedback

Publication of NHS Long Term Plan. National, regional and local system development

Public Board Jul 2019 describing alignment with LTP to our strategic approach

Style of narrative for our strategy revised and shared with Board in Sep 2019

CURRENT POSITION >>

DRAFT STRATEGY

- Final version currently being produced which captures a new vision & outputs of values engagement

VALUES & BEHAVIOURS
The feedback has helped to shape a proposed new set of values, our USP and strapline for the organisation

NEXT STEPS >>

NHS Stockport NHS Foundation Trust

REVISED STRATEGY

- Final version Ensures connection with detail of key Board agreements from earlier strategy sessions & approach to Quality (Adopting Safety II)
- Will be presented to Board of Directors for approval in Nov 2019

COMMS & ENGAGEMENT

- Launch event planned to communicate new Trust Values
- Plan to communicate the revised strategy widely
- Embedding core vision priorities supported by a new communications and engagement strategy
- Reinforced by our approach to transformation and how we embed change

TRANSFORMATION
Executive Team held a session in Oct to formulate a shared view of what transformation means for the organisation – this will be key to embedding our values and vision

CLINICAL SERVICE STRATEGY

- Development of service level strategies linked to organisational strategy
- Will incorporate alignment to strategic and corporate objectives
- Opportunity for each service to articulate their vision and ambition
- Must also be realistic to deliver quality, performance and finances
- Service level planning will link to national, regional and local system developments

CLINICAL SERVICE STRATEGY DEVELOPMENT
An approach has already been developed and endorsed at Senior Leadership Group, Clinical Directors and Senior Manager forums

Initial phase expected to take 6 months – incorporate review and ongoing development into quarterly business group and annual planning processes

NHS
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Report to:	Trust Board	**Date:**	1st November 2019
Subject:	EU Exit		
Report of:	Accountable Emergency Officer	**Prepared by:**	Emergency Preparedness Resilience & Response Manager

REPORT FOR INFORMATION

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

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

At the time of writing this paper (24.10.19), there remains the possibility that the UK will leave the EU on Thursday 31st October 2019 **without** a deal. Consequently, the NHS (in line with other public bodies) is required to prepare to leave the EU on 31st October 2019 without a deal.

Attachments:	• Provider EUX Sample Return

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

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1. INTRODUCTION

1.1 At the time of writing this paper (24.10.19), there remains the possibility that the UK will leave the EU on Thursday 31st October 2019 **without** a deal. Consequently, the NHS (in line with other public bodies) is required to prepare to leave the EU on 31st October 2019 without a deal.

The NHS role is to be non-political – focused on coordinating the best possible operational response for patients and the public.

2. BACKGROUND

2.1 In the national context, a significant amount of planning was undertaken in the lead up to the original EU exit dates (29th March, 12th April and 22nd May 2019). Within the Trust an EU Exit Group was established as a sub-group of the Trust's Emergency Preparedness Resilience Response (EPRR) Group with membership comprising of key individuals aligned to the following workstreams;

- Supply of Medical Devices and Consumable Goods
- Supply of Non-Clinical Consumables, Goods & Services
- Workforce
- Reporting Assurance & Information
- Data Sharing, Processing & Access
- Communication & Escalation
- Research & Clinical Trials
- Reciprocal Healthcare & Overseas Charging

Following the decision to delay EU Exit until 31st October 2019 and parliament's summer recess very little information had been circulated to facilitate planning since May 2019. However, a series of regional workshops, facilitated by Professor Keith Willett (EU Exit Strategic Commander) were held throughout September 2019 to impart the latest position in terms of national contingency planning and to re-focus local planning arrangements.

3. CURRENT SITUATION

The Trust's EU Exit Group re-convened on 16th October ahead of the announcement that daily 'SitRep' Reporting would re-commence on Monday 21st October 2019, the SitRep is aligned to the workstreams detailed in 2.1 and a sample template is attached to this report.

3.1 Professor Keith Willett (EU Exit Strategic Commander) was due to deliver 'EU Exit Decision Implication Webinars' throughout w/c 21st October 2019, however, owing to the ongoing uncertain political landscape these were stood down. A webinar has been scheduled for Tuesday 29th October 2019 the aim of which is to discuss the next steps for NHS preparations following the latest political arrangements.

4. RISK & ASSURANCE

4.1 Assurance can be given that the Trust continues its efforts to prepare to leave the EU on 31st October 2019 without a deal.

5. CONCLUSION

5.1

- There is an established EU Exit Group with leads identified for each of the key workstreams.
- The Trust is submitted daily SitReps
- The Trust will be participating in the Webinar (29.10.19) facilitated by Professor Keith Willett (EU Exit Strategic Commander) to ensure receipt of latest information and planning expectations.
- The Board can be assured that the Trust continues its efforts to prepare to leave the EU on 31st October 2019 without a deal.

6. RECOMMENDATIONS

6.1 It is recommended that the content of this paper be noted.

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Please do not cut and paste - this will break the proforma and you will need to download a new one and start over

Providers

	Questions	Response	
	General sitrep questions on essential patient services	**Please keep responses to less than 255 characters, including spaces**	**Please answer all yellow cells**
P1	Are there any EU Exit related issues which are expected to impact business critical services until the next daily sitrep submission is due?		
P2	Are you assured you can provide appropriate emergency department care until the next daily sitrep submission is due? (For Mental Health and/or Community - Please confirm that you can maintain mental health crisis intervention teams for the duration of EU exit transition)		
P3	Are you assured you can provide acute medicine (including PPCI and acute stroke services, as applicable) care until the next daily sitrep submission is due?		
	Please confirm you have taken each of the following actions to protect the urgent and emergency care pathway:		
P4	Are you assured you can provide emergency paediatric and neonatal (as applicable) care until the next daily sitrep submission is due?		
P5	Are you assured you can provide critical care staff, equipment and clinical consumables until the next daily sitrep submission is due?		
P6	Are you assured you can provide emergency maternity care until the next daily sitrep submission is due?		
P7	Are you assured you can provide trauma care (to your normal organisational level of care) until the next daily sitrep submission is due?		
P8	Are you assured you can provide emergency surgery until the next daily sitrep submission is due?		
P9	[MTC Only] please confirm that you have appropriate arrangements in place to maintain a full major trauma pathway service until the next daily sitrep submission is due?		Non MTCs need to select Not Applicable
P10	Are you assured you can maintain urgent cancer treatments until the next daily sitrep submission is due?		
P11	If necessary, are you able to establish a major incident response, in line with your Incident Response Plan, until the next daily sitrep submission is due?		
P12	Do you have plans in place to ensure equipment and supplies for diagnostics are maintained until the next daily sitrep submission is due?		
P13	Do you have plans in place to ensure laboratory equipment and reagents for pathology investigations are maintained until the next daily sitrep submission is due?		
P14	Please detail any events you are aware of which may have an impact on your organisation's ability to deliver patient care until the next daily sitrep submission is due (such as staff training, start of new supplier contract, loss of store capacity)?		If no events to record, please leave blank
P15	If identifying an event above, please confirm appropriate mitigation has been undertaken to protect patient services?		
P16	If EU exit related issues have been identified, have you worked collaboratively with partner organisations to maximise collective solutions to identify and if necessary address supplies, medicines and staff shortages until the next daily sitrep submission is due?		
P17	Do you have arrangements in place for executive oversight, command and control and escalation until the next daily sitrep submission is due?		
P18	If EU exit service disruption has been identified, do you have a plan for the recovery to business as usual following any disruptions experienced until the next daily sitrep submission is due (including elective activity)?		
P19	Do you have in place appropriate arrangements for informing patients, carers, relatives and staff regarding any identified impacts of EU exit transition and for handling media enquiries, including spokespeople until the next daily sitrep submission is due?		
P20	Is your organisation planning to suspend any patient services until the next daily sitrep submission is due?		
P21	If yes to P20, please list		
P22	Are you planning to cancel any elective procedures or operations which are directly related to shortages arising from EU exit before the next daily sitrep submission is due?		
P23	If yes to P22, please list		
P24	Since the last daily sitrep submission was due, has your organisation reported any other patient safety incidents where, at the time of reporting, there is reason to believe it was caused or contributed to by EU exit transition?		
P25	If yes to P24, were any of these Serious Incidents reported on StEIS?		
P26	If yes to P25, please provide the StEIS number		
	Workforce	**Please keep responses to less than 255 characters, including spaces**	
P27	Does your organisation have sufficient staff rostered on until the next daily sitrep submission is due for the next 7 days to maintain existing patient services?		
P28	If no to P27, please detail which services have been disrupted/cancelled		
P29	If no to P27, does your organisation have a recovery plan to bring these services back into operation?		
P30	Has your organisation implemented mutual aid to address staffing issues that have arisen as a result of EU exit transition?		
P31	If yes to P30, does your organisation have a recovery plan to cease use of mutual aid?		
P32	What number of EU citizens are employed in your organisation as of the last ESR cut off date?		
	Clinical Trials	**Please keep responses to less than 255 characters, including spaces**	
P33	Do you have appropriate supplies of investigational medicinal products, medical devices, IVDs, advanced therapy medicinal products, radioisotopes and other clinical consumables used in clinical trials which you are recruiting into/participating in, maintained for the next 96 hours (unless normal stock level is shorter period due to trial protocol)?		
P34	If answer to above is no, have you raised the shortage with the lead recruiting NHS site, the clinical trial Sponsor or organisation managing the clinical trial (such as a Clinical Research Organisation or Clinical Trial Unit)?		
P35	If you have escalated, are they able to address the shortage?		
	Data sharing, processing & access	**Please keep responses to less than 255 characters, including spaces**	
P36	Has the organisation experienced any operational difficulties since the last daily sitrep submission was due, due to data stored overseas or data transfer and storage issues?		
P37	If yes to P36, have these difficulties prevented the delivery of patient services since the last daily sitrep submission was due?		
P38	If yes to P37, please summarise the service(s) impacted		
P39	If yes to P37, does your organisation have a recovery plan to bring these services back into operation?		
P40	If yes to P39, has your organisation escalated this to the NHSE regional EU exit coordination centre?		
	Supply of Medicines & Pharmacy	**Please keep responses to less than 255 characters, including spaces**	
P41	Has your organisation escalated any medicines shortage related issues through business as usual process since the last sitrep submission?		
P42	If yes to P41, how many?		
P43	Since your last sitrep submission, are you aware of any incidents of medicines shortages that have resulted in potential or actual harm to individual patients that resulted in you submitting a local incident report?		
P44	If yes to P43, please provide details of the incident		
P45	Since your last sitrep submission, are shortages of any particular medicines having an impact on your ability to provide care for particular groups of patients?		
P46	If yes to P45, please provide details on the impact		
	Supply of Medical Devices & Clinical Consumables	**Please keep responses to less than 255 characters, including spaces**	
P47	Has your organisation escalated any issues to the National Supply Disruption Response (NSDR)?		
P48	If yes to P47, in total how many issues do you currently have logged with the NSDR?		
P49	If yes to P47, are any of these issues essential to the delivery of your critical patient services?		
P50	If unresolved, in how many days will the issues raised with NSDR impact on the delivery of patient services?		
P51	If less than 7 days, have you escalated to the NHSE regional EU exit coordination centre?		
	Supply of non-clinical consumables, goods and services	**Please keep responses to less than 255 characters, including spaces**	
P52	Is your organisation experiencing any service disruptions as a result of interuption to supply of non-clinical consumables, goods and services?		
P53	If yes to P52, please summarise which supplies are you experiencing difficulties obtaining?		
P54	If yes to P52, are any of these supplies essential to the delivery of your critical patient services?		
P55	If unresolved, in how many days will this shortage impact on the delivery of patient services?		
P56	If less than 7 days, have you escalated to the NHSE regional EU exit coordination centre?		
	Supply of blood products, transplant organs and tissues	**Please keep responses to less than 255 characters, including spaces**	
P57	Since the last sitrep submission, has your organisation experienced any service disruptions as a result of interuption to supply of blood products, organs and tissues?		
P58	If yes to P57, what supplies are you experiencing difficulties obtaining?		
P59	Are any of these supplies essential to the delivery of your critical patient services?		
P60	In how many days will this shortage impact on the delivery of patient services if unresolved?		
P61	If less than 7 days, have you escalated to the NHSE regional EU exit coordination centre and NHSBT?		
	Estates & Facilities	**Please keep responses to less than 255 characters, including spaces**	
P62	Is your organisation experiencing problems in relation to a shortage of linen?		
P63	If unresolved, in how many days will this shortage impact on the delivery of patient services?		
P64	If less than 7 days, have you escalated to the NHSE regional EU exit coordination centre?		
P65	Is your organisation experiencing any difficulties with existing arrangements for food supplies?		
P66	If unresolved, in how many days will this disruption impact on the delivery of patient services?		
P67	If less than 7 days, have you escalated to the NHSE regional EU exit coordination centre?		
P68	Is your organisation experiencing difficulties with existing arrangements in relation to unavailability of parts needed for repairs (eg lifts, EBME, general maintenance parts for generators, infrastructure etc)?		
P69	If unresolved, in how many days will this disruption impact on the delivery of patient services?		
P70	If less than 7 days, have you escalated to the NHSE regional EU exit coordination centre?		
	Reciprocal Healthcare	**Please keep responses to less than 255 characters, including spaces**	
P71	In the trust how many EU national patients have their treatment on hold awaiting clarification of eligibility to access free NHS care?		Put 0 if no patients have had this issue
P72	For what treatment types (i.e Dialysis)?		If P71 isn't zero, please state for what treatment type (eg dialysis)
	Sign off	**Please keep responses to less than 255 characters, including spaces**	
P73	Name of SRO for organisation:		
P74	Single Point of Contact for organisation (email):		Please enter a valid email address
P75	Name of Sitrep returning officer:		
P76	Contact phone number for sitrep returning officer		
P77	Has this submission has been approved by the SRO (or their nominated Exec lead deputy)?		
P78	Please state name of approver:		

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Stockport NHS
NHS Foundation Trust

Report to:	Board of Directors	**Date:**	1 November 2019
Subject:	Freedom to Speak Up Report		
Report of:	Freedom to Speak Up Guardian	**Prepared by:**	P Gordon

REPORT FOR INFORMATION

Corporate objective ref:	2a, 6b
Board Assurance Framework ref:	SO6
CQC Registration Standards ref:	N/A
Equality Impact Assessment:	☐ Completed X Not required

Summary of Report

The purpose of this report is to provide the Board of Directors with:

- An update on Trust progress in development of the Freedom to Speak Up agenda
- Assurance on the approach and activities of the Freedom to Speak Up Guardian
- The results and findings of the Trust Freedom to Speak Up Survey

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 The purpose of this report is to provide the Board of Directors with:

- An independent perspective on Trust progress in development of the Freedom to Speak Up (FTSU) agenda.
- Assurance on the approach and activities of the Freedom to Speak Up Guardian (FTSUG).
- The results and findings of the Trust Freedom to Speak Up Survey.

2. NATIONAL DEVELOPMENTS

2.1 The National Guardian Office (NGO) has refreshed its Board self-review tool. This will be taken forwards by the Executive Lead for speaking up.

2.2 The NGO has published guidelines regarding provision of FTSU training for all staff. The FTSUG attended an initial task and finish group in early October, with the aim of agreeing and recommending a consistent approach to meeting these guidelines across Greater Manchester.

2.3 October is Freedom to Speak Up month. North-West FTSUGs have agreed to each visit a FTSUG in a neighbouring Trust, and to collate and share learning.

2.4 The FTSUG is also involved in preparations for the Trust's Bullying and Harassment campaign, to be launched in February 2020.

3. BOARD RESPONSIBILITIES

3.1 The Board is responsible for overseeing progress towards the Board self-review tool, meeting NGO recommendations, and creating a FTSU vision / strategy.

3.2 In May 2019 the FTSUG reported not being aware of any Executive-led reporting arrangements for monitoring progress towards these.

3.3 In September 2019 the Trust appointed a Director of Communications and Corporate Affairs, who is also the Executive Lead for FTSU. The Executive Lead will take this forward in collaboration with the Director of Workforce and OD, with the FTSUG providing support.

4. FTSUG SUPPORT AND ACCOUNTABILITY

4.1 The FTSUG meets monthly with the Executive Lead. To ensure support and accountability, the meetings discuss the following as standard:

- Confirmation of ongoing open access to all senior leaders.
- Ensuring the psychological safety and emotional wellbeing of the FTSUG.
- Progression towards NGO recommendations.
- Timesheets, task lists and anonymised casework.

5. TRUST FREEDOM TO SPEAK UP SURVEY

5.1 The FTSUG completed a Trust-wide survey of speaking up in September 2018. The results were reported to the public Board of Directors meeting in May 2019, and compared against the results of the 2018 NHS Staff Survey. It was agreed that the FTSU survey would be repeated in September 2019, to allow for the results to be shared with the Board of Directors in October 2019.

5.2 A very similar survey design was used to allow for comparison of results. For the question "my job is…", the answer options were changed to mirror those that the NGO uses in their collection of quarterly speaking up data, and to allow for analysis of results by professional group.

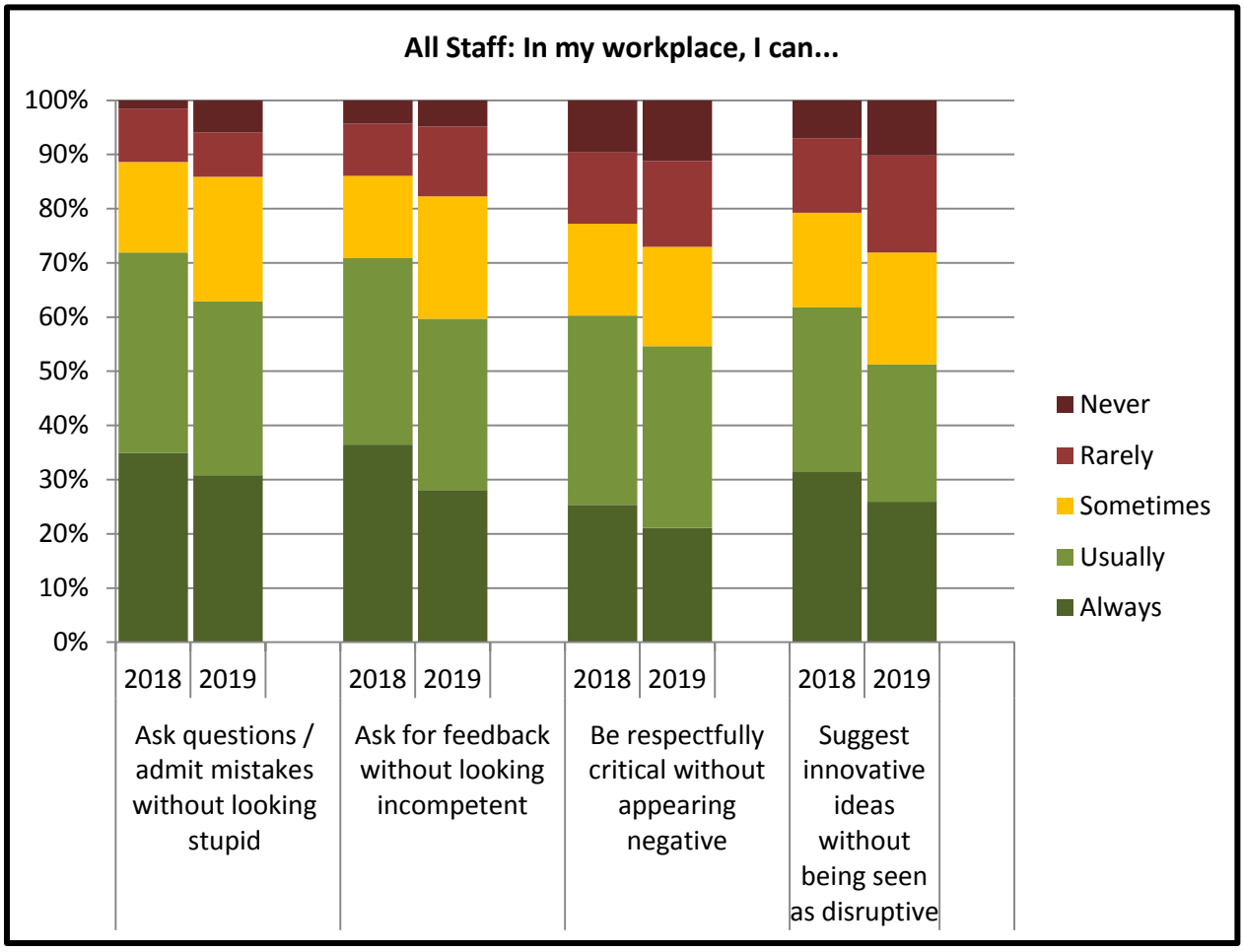
5.3 In order to improve engagement amongst areas that saw a low response rate in 2018, paper copies of the survey were provided to portering and domestic staff, and the online link was circulated to medical staff via the doctors.org mailing list.

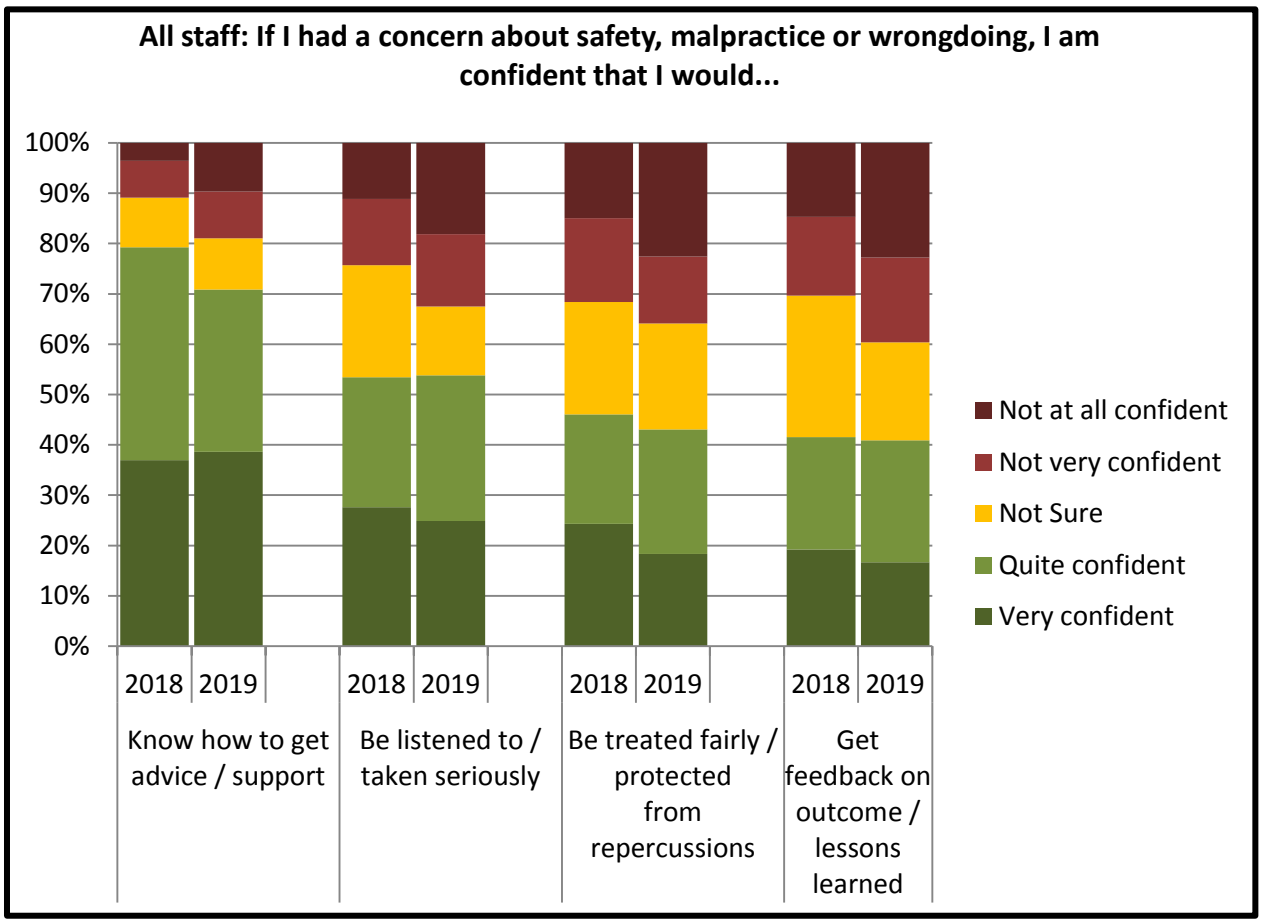
5.4 For the 2018 FTSU survey, 395 responses were received, ensuring that Trust-wide findings were statistically significant. This year, 474 responses were received, representing 9% of the workforce.

5.5 Two sets of four questions were repeated from the 2018 FTSU survey:

Psychological safety In my workplace, I can… • Ask questions / admit mistakes without looking stupid. • Ask for feedback without looking incompetent. • Be respectfully critical without appearing negative. • Suggest innovative ideas without being seen as disruptive.
Expected response to concerns If I had a concern about safety, malpractice or wrongdoing, I am confident that I would: • Know how to get advice / support. • Be listened to / taken seriously. • Be treated fairly / protected from repercussions. • Get feedback on the outcome / lessons learned.

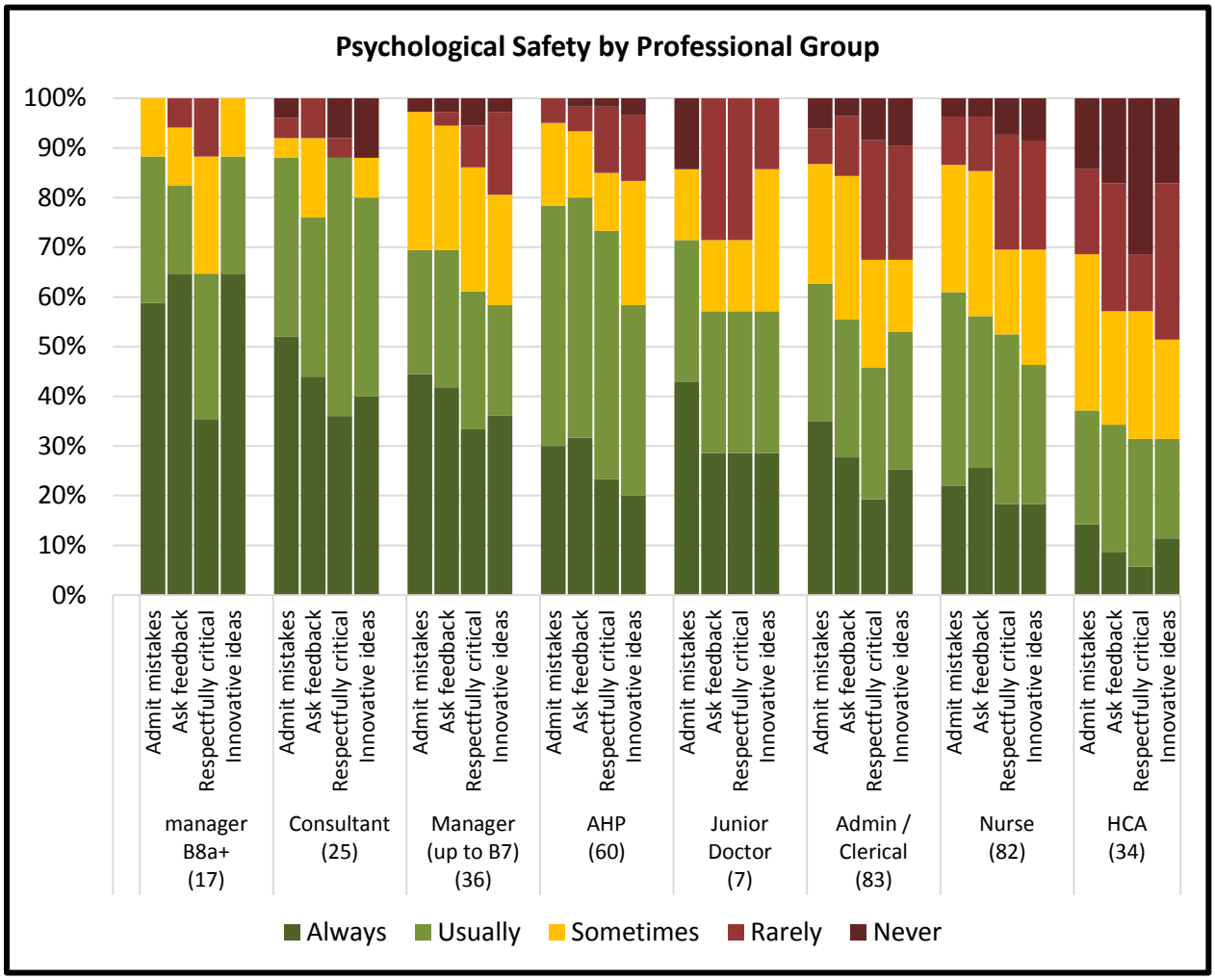
5.6 The Trust-wide results for 2019 indicated a deterioration across all questions:

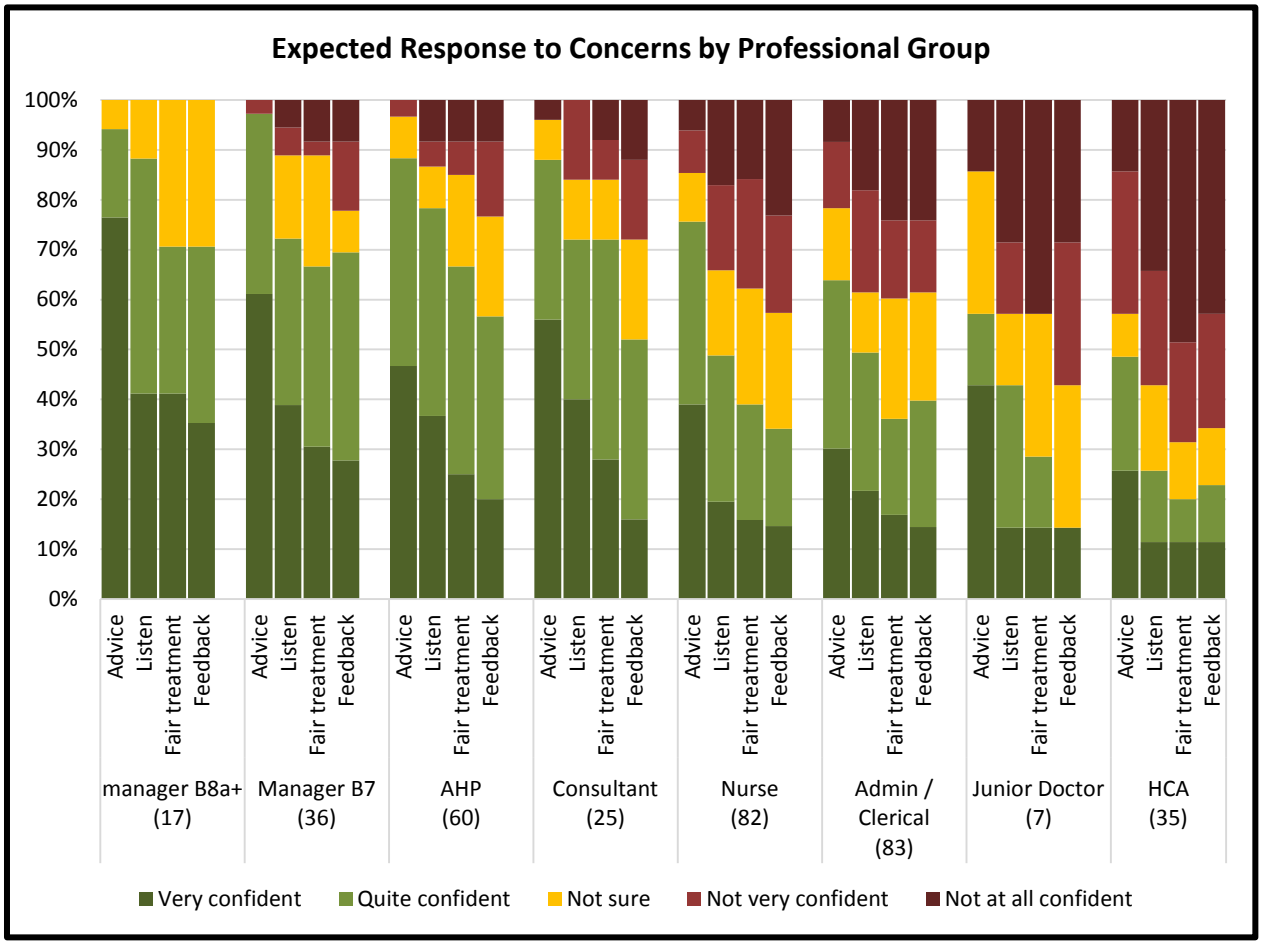




5.7 The following two graphs show the detailed responses to all questions by professional group. The main findings / comments are:

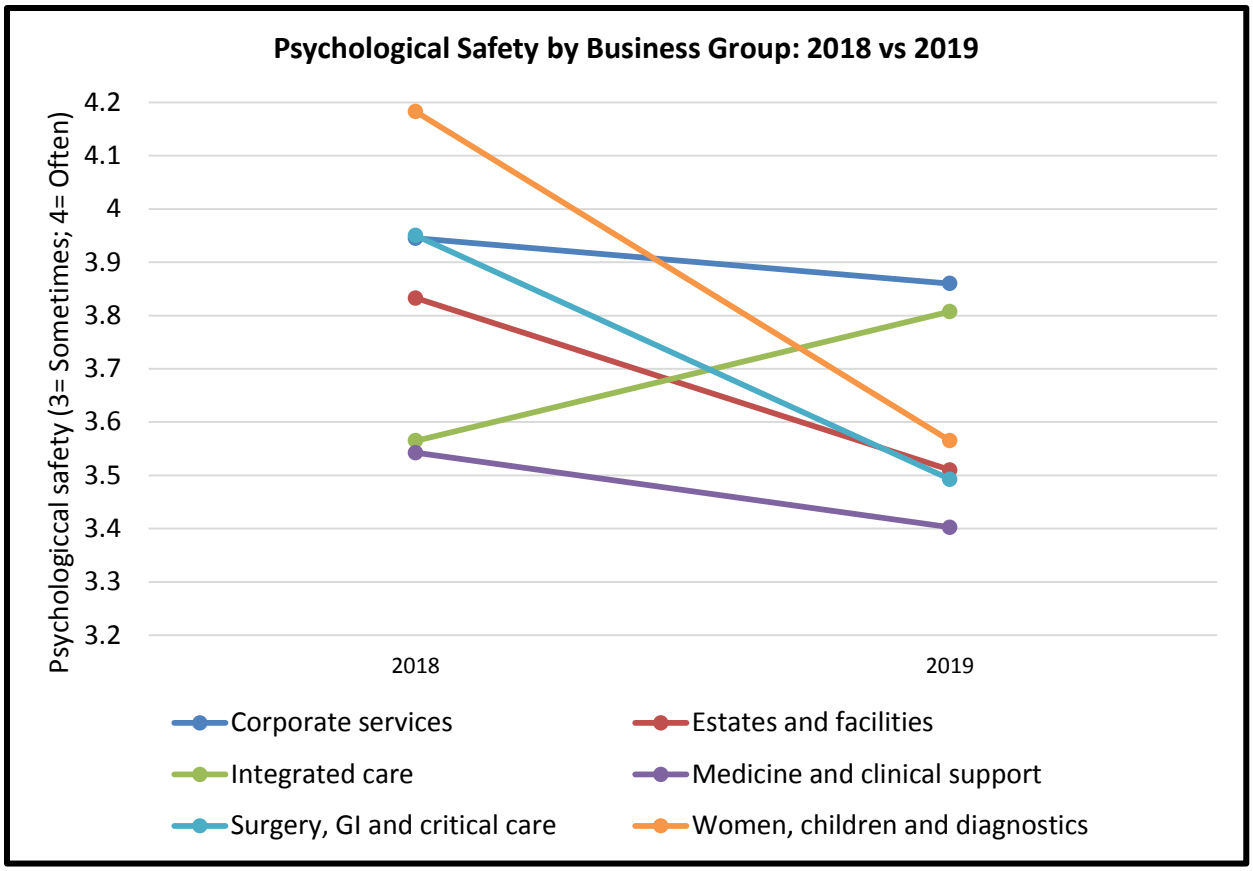
- Professionals groups in traditional positions of relative seniority report a higher level of psychological safety and a greater confidence in the expected response to concerns.
- Some groups had a low response rate for "sometimes" or "not sure", indicating a polarisation of views within these cohorts.
- The responses for those in "other" professional groups was in line with the average, and the results those responding "rather not say" were below average. (These responses were omitted from the graphs for clarity).

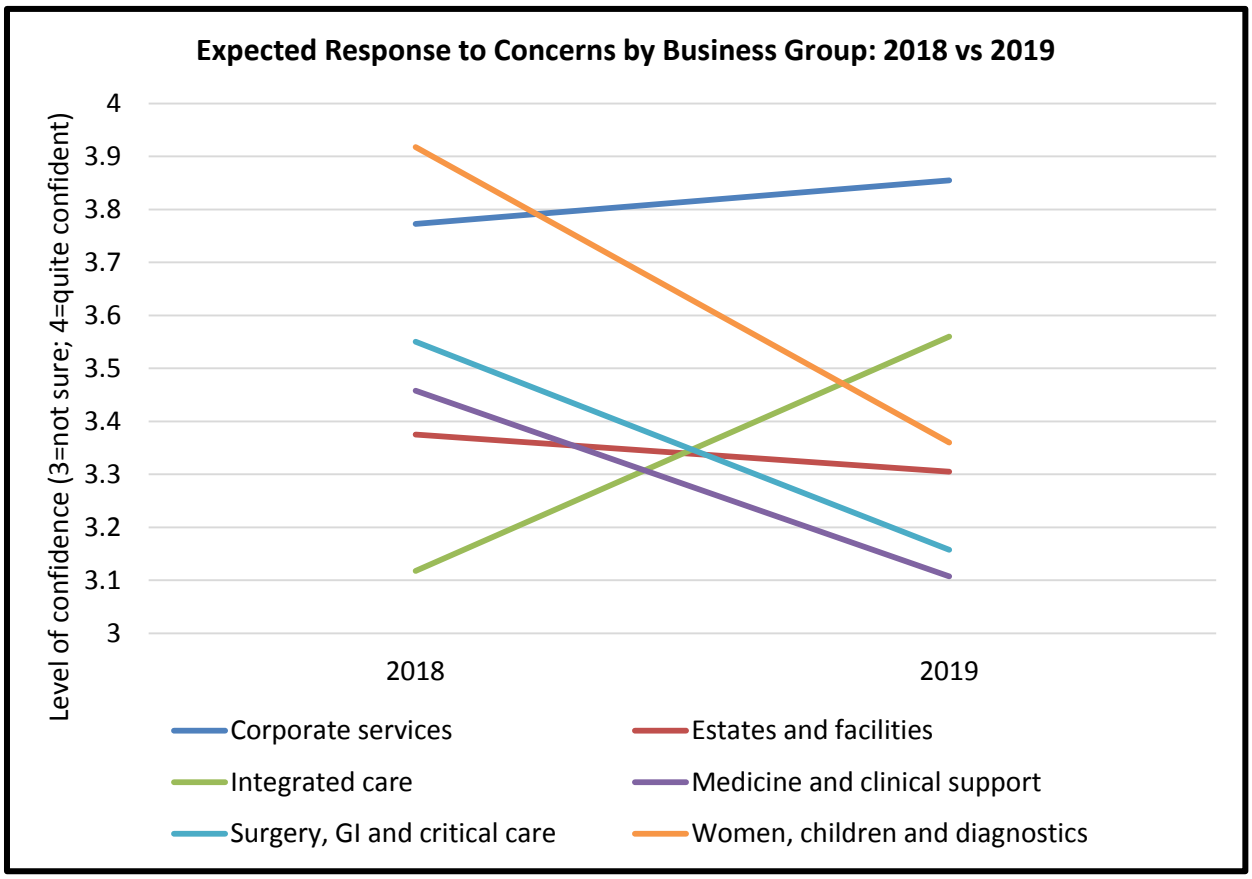




5.8 Within each Business Group, the results were compared for each professional group where there were ten or more respondents. In every case, the professional groups traditionally seen as being in relative seniority provided more positive responses across all questions.

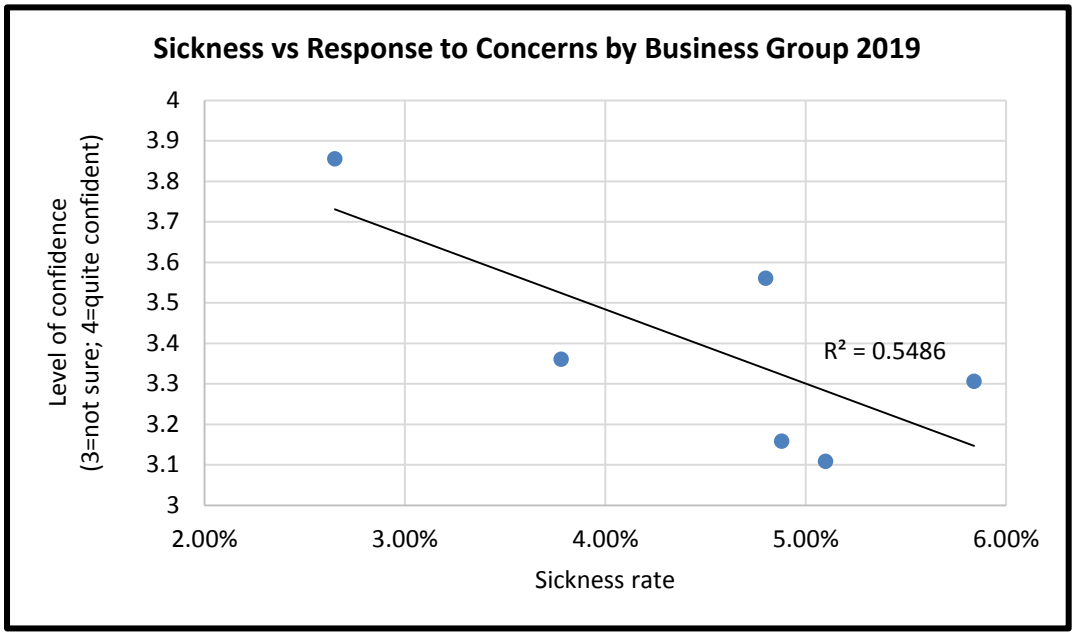
5.9 An average for each Business Group was also taken for each set of four questions related to (a) psychological safety (b) expected response to concerns. The graphs below show that for both domains between 2018 and 2019, the results show improvement for Integrated Care, little movement for Corporate Services, and a deterioration for all other Business groups:





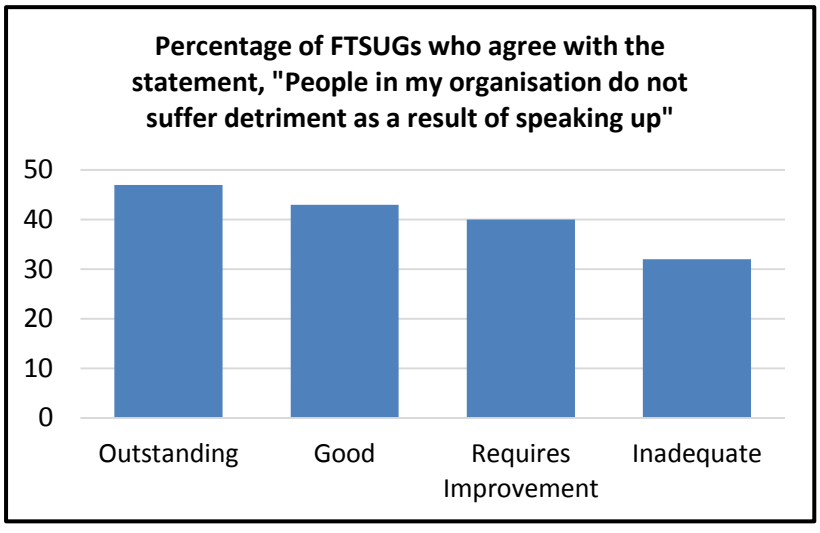
5.10 The 2018 Freedom to Speak Up survey indicated that across Business Groups, there was a very strong correlation between psychological safety and turnover. The analysis was repeated for the 2019 results, and no correlation was found.

5.11 The 2018 Freedom to Speak Up survey indicated a moderate correlation between the expected response to concerns and sickness rates. There is a similar correlation of 55% in the 2019 results:



6. EXTERNAL BENCHMARKING

6.1 The Trust FTSU survey indicates that 43% of staff are confident that if they had a concern, they would be treated fairly and protected from repercussions. In the NGO Freedom to Speak Up Guardian Survey 2018[1], FTSUG responses were grouped according to the organisation's CQC rating. The result for the most comparable question is shown below, indicating that the response to the Trust survey is consistent with organisations rated "Good" by the CQC:



[1] Available at: https://www.cqc.org.uk/sites/default/files/20181101_ngo_survey2018.pdf

6.2 In October 2019, the NGO published a FTSU Index report[1]. The FTSU Index is calculated by taking the average percentage of respondents who agree or strongly agree to the following questions from the NHS Staff Survey:

- My organisation treats staff who are involved in an error, near miss or incident fairly.
- My organisation encourages me to report errors, near misses or incidents.
- If I was concerned about unsafe clinical practice, I would know how to report it.
- I would feel secure raising concerns about unsafe clinical practice.

6.3 The 2018 FTSU index for Stockport NHS Foundation Trust falls just below the national median:

	FTSU Index
Highest Score (Nationally)	87%
Median (Combined acute and community Trusts)	78%
Stockport NHS Foundation Trust	77%
Lowest Score (Nationally)	68%

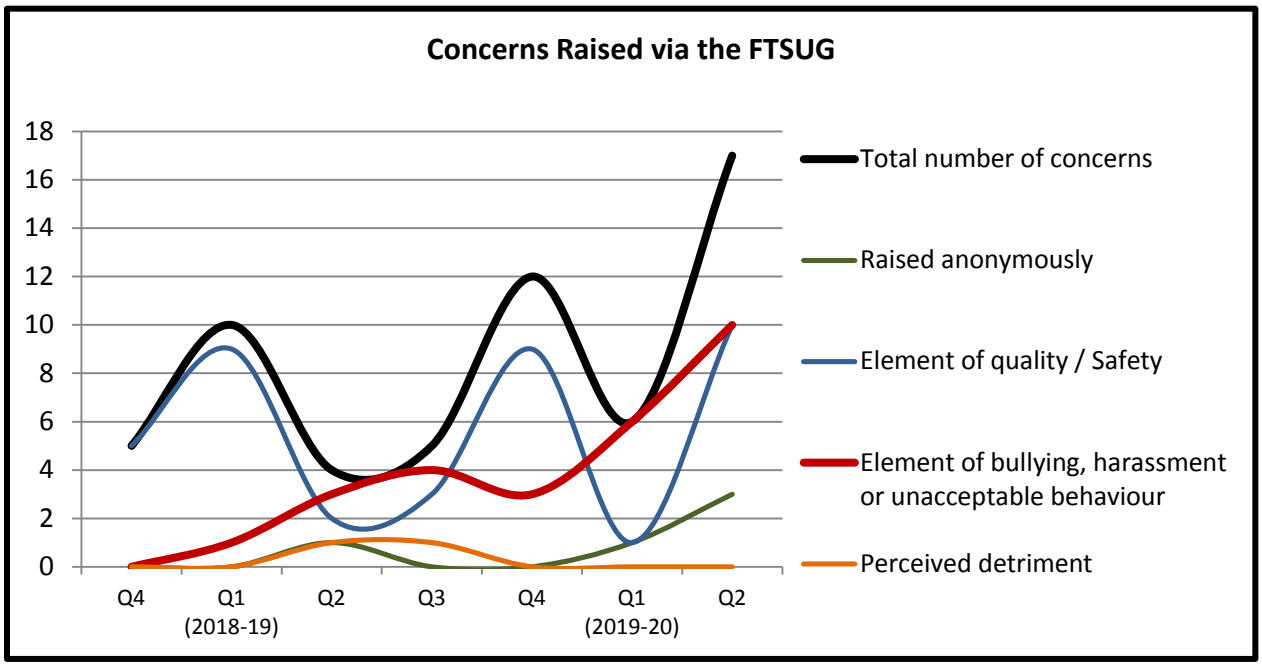
6.4 The 2019 Trust FTSU survey has been completed at a similar time to the NHS Staff Survey. When the 2019 NHS Staff Survey and corresponding FTSU Index are available, it will be possible to triangulate these with the Trust FTSU survey results.

7. FTSUG CASEWORK

7.1 The NGO has not yet published the latest national quarterly figures due to a recent procurement process.

7.2 The culture of speaking up is indicated by the nature of the concerns raised, whether the concerns are raised anonymously, and whether individuals perceive detrimental treatment. Enough data is now available to monitor trends.

7.3 The graph below shows the total number of concerns raised via the FTSUG, and the number within these that contain different elements:



[1] https://www.nationalguardian.org.uk/wp-content/uploads/2019/10/ftsu-index-report-2019-final2.docx

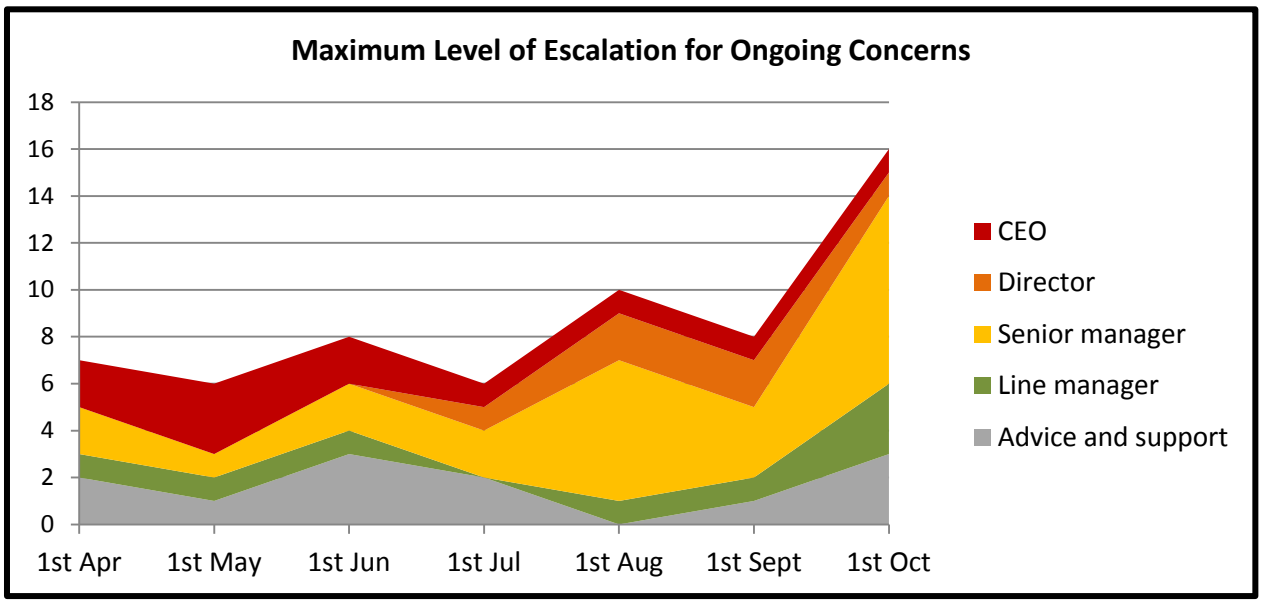
7.4 The graph indicates:

- The number of concerns related to quality and safety rises and falls in tandem with the total number.
- The numbers for anonymous concerns and those with an element of perceived detriment remain low (as the numbers are low, just one concern with one of these elements is enough to be considered above the national average).
- There is a steady rise in concerns including an element of bullying / harassment or unacceptable behaviour.

7.5 The FTSUG casework was looked into further to explore the above trends:

- Of the concerns raised to the FTSUG involving a reported element of bullying / harassment or unacceptable behaviour between April and September 2019, four were raised by non-clinical staff, and six were raised by nursing staff (involving seven individuals). Four of these contacts related to one manager: the individuals reported a range of perspectives on the situation, with a desire for their concerns to be resolved informally and constructively. The FTSUG is currently liaising with the senior manager that the concerns have been escalated to.
- The concerns raised by non-clinical staff relate in part to perceived fairness and consistency of disciplinary processes. The FTSUG has discussed this with Human Resources and has been informed that the Trust has very recently adopted elements of the Just Culture approach. The FTSUG will continue to monitor this trend.

7.6 Concerns were escalated to every part of the organisation:



7.7 A small minority of concerns were raised to very senior management, indicating that following contact with the FTSUG, staff feel confident and secure enough to not need to escalate their concerns to very senior leaders.

7.8 There has been a sudden increase in concerns raised, with an additional four contacts received by the FTSUG (in different areas) in the first ten days of October. Three of these include an element of perceived unacceptable behaviours: however there are no trends to report in addition to those already mentioned.

8. EQUALITY AND DIVERSITY

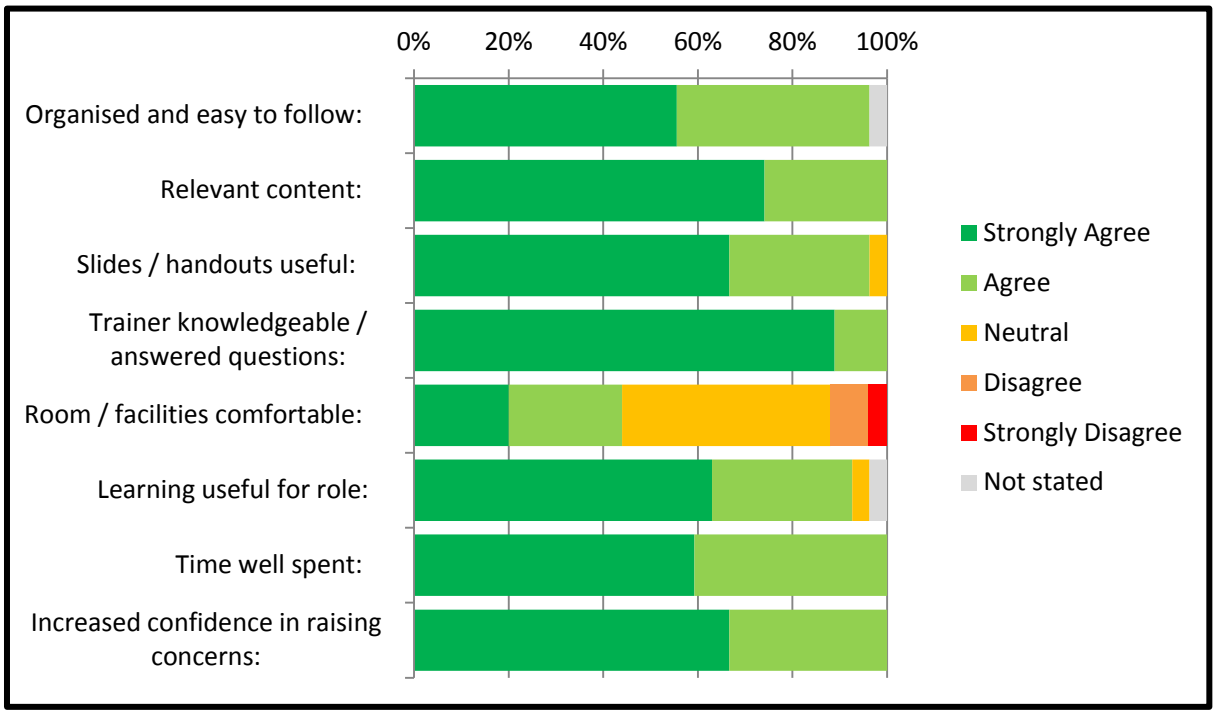
8.1 Individuals who raise concerns via the FTSUG can now provide their feedback via an anonymous online questionnaire. Following optional equality monitoring questions, the respondent is asked:

- When speaking up, did you feel treated less favourably as a result of any of the above?
- Given your experience, would you speak up again?

8.2 There is no indication in the casework of unfavourable treatment based on any protected characteristics.

9. FTSUG-LED TRAINING AND DEVELOPMENT

9.1 The FTSUG provided a bespoke training session to 27 trainee nurse associates with the following feedback:



10. RECOMMENDATIONS

10.1 The Board of Directors is recommended to:

- Note the independent perspective provided in sections 1-3.
- Note the positive assurance on the approach and activities of the FTSUG (sections 4-9).
- Note the results of the findings of the FTSU survey in Section 5 and consider whether any further action needs to be taken in addition to those documented.

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Report to:	Board of Directors	**Date:**	1 November 2019
Subject:	Proposal to amend the Trust's Committee structure and Board cycle		
Report of:	Interim Director of Corporate Affairs	**Prepared by:**	Mrs C Parnell

REPORT FOR APPROVAL

Corporate objective ref:	2a, 3a
Board Assurance Framework ref:	SO5
CQC Registration Standards ref:	17
Equality Impact Assessment:	☐ Completed X Not required

Summary of Report

This report:

- outlines a series of proposals to strengthen the Trust's governance around health and safety and risk management
- sets out a proposal to amend the Committee and Board meetings cycle
- presents a draft Board business plan.

The Board is asked to:

- support the establishment of a Health and Safety Committee,
- support the establishment of a Risk Management Committee supported by the development of a risk manager role,
- support changes to the committee and Board cycle to more effectively manage the business of those meetings.
- receive a draft Board business cycle that will be subject to on-going refinement.

Attachments: Draft Board business cycle

This subject has previously been reported to:

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

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1. INTRODUCTION

The Trust's governance arrangements have been in place for some time, and have helped to improve the Board of Director's level of oversight and assurance in relation to quality, finance, performance, and people issues.

However, it is good practice to keep an organisation's system of governance under review to take into account national good practice and the changing needs of an organisation. This paper sets out a number of recommendations for changes to the Trust's approach to:

- Health and safety
- Risk management
- Committee and Board cycle
- Board business plan

2. HEALTH AND SAFETY

Health and safety issues are currently discussed and reviewed at the Safety and Risk Group, which reports into the Quality Governance Group and ultimately the Board's Quality Committee. Chaired by the Deputy Director of Quality Governance, the role of the Safety and Risk Group is to:

- Co-ordinate the identification of risk across the Trust,
- Monitor the Trust's management of health and safety and environmental issues.

The Trust also has a Health and Safety Joint Consultative Group, which reports into the Safety and Risk Group. It's role is to:

- Develop and promote health and safety, patient safety and risk management strategies,
- Provide assurance that key risk issues with health and safety, patient safety, and risk management aspects are managed,
- Provide a forum for consultation between safety representatives and management on risk related issues,
- Discuss health and safety matters identified by safety representatives and management, which have not been resolved by appropriate divisional processes,
- Comment on draft health and safety policies and procedures,
- Consider any matters that generally affect the health and safety of employees,
- Review the effectiveness of health and safety training for employees,
- Consider the impact of new legislation and guidance that may affect health and safety matters in the trust,
- Act as a communication challenge to increase awareness about health and safety matters, and promote employees' responsibilities in safety and incident prevention.

Responsibility for health and safety has until recently sat in the portfolio of the Chief Nurse and Director of Quality Governance, but this has now moved to the Director of Strategy, Planning & Partnership/Deputy Chief Executive as much of the corporate services responsible for health and safety eg estates and facilities, rests with this Executive Director.

Earlier this year the Trust's internal systems identified compliance issues in the estates department. As work has progressed to address those issues the Board has taken the view that the organisation would benefit from higher level oversight and assurance around health and safety. Therefore, it is now proposed that a Committee of the Board should be developed. Chaired by a Non-Executive Director and meeting on at least a quarterly basis, the new Committee would aim to provide the Board with assurance that key issues in relations to health and safety are being identified and appropriately managed.

If the Board of Directors should support the creation of a Health and Safety Committee, then at the Committee's first meeting terms of reference will be reviewed and recommended to the Board for approval. An annual work plan would also be developed, and the effectiveness of the Committee would be reviewed on an annual basis, in line with other Board Committees. Under this proposal the Health and Safety Joint Consultative Group would report directly into the Health and Safety Committee.

As well as directly responding to the Board's wish to have greater oversight and assurance around health and safety, the proposed Committee would also support ongoing work to address one of the "must do" actions identified in the 2018 CQC report that required the Trust to "*ensure that it has systems and processes in place to assess, monitor and mitigate the risks relation to the health, safety and welfare of service users."*

3. RISK MANAGEMENT

The Trust's approach to risk management is set out in the Risk Management Policy and Framework, and is due for a full review in 2020. However, as the Trust has embedded its approach to risk management into the organisation and started to further refine its approach to the use of risk registers and the Board Assurance Framework, the Chief Executive, Chief Nurse & Director of Quality Governance, Interim Director of Corporate Affairs and Deputy Director of Quality Governance have been looking nationwide at examples of good practice from other NHS organisations.

They have found that the approach to risk management is more deeply embedded and effective in those organisations with greater Executive Director over sight of the identification and management of risk. They are particularly impressed by the system that has been established at Leeds NHS Teaching Trust over a period of years, and colleagues there have been very helpful in sharing their experiences, systems and processes.

Learning from the experiences at Leeds, it is proposed to form a Risk Management Committee. Although it will report into the Board of Directors, it would be distinct from the other Board Committees, which primarily have an assurance focus. Instead it would focus on the effective identification and management of risk, and particularly risks to the delivery of the Trust's strategy.

Chaired by the Chief Executive and attended by all Executive Directors, as well as a representative from the Non-Executive Directors, the Committee would meet monthly to review all new risks scored 15 and above. It would hold business groups to account for the effective management of their risk registers by services presenting to the Committee on a rotational basis. The Committee would also have a role in identifying potential up-coming risks, and agreeing the Trust risk register and Board Assurance Framework for presentation to the Board.

It is obvious from the work carried out at Leeds that the key to the success of this approach is the input of their risk manager, who would work closely with business group triumvirate teams to understand their key risks, ensure those risks are appropriately evaluated, and that effective risk management strategies are developed and undertaken. The Trust currently does not have a member of staff fulfilling such a role, and this has also been highlighted as a gap by David Holden in his ongoing review of governance arrangements.

As well as support from Mr Holden, the Trust has recently sought external support from NHS Improvement to review a number of aspects of its governance. Ms Southall from NHS Improvement and Mr Holden are currently carrying out a deep dive into processes within the business groups, which is expected to influence how the organisation further develops and embeds its approach to governance and risk management.

A significant amount of the Trust's investment in governance roles sits within the business groups, and it is proposed to use the outcome of the review to help identify existing resources to create a risk manager role. This position would not only support the Risk Management Committee, but also improve the effectiveness of the Trust's approach to risk management overall.

Subject to the outcome of the on-going governance review and any requirement for formal consultation with staff, it is expected that subsequent improvements to the Trust's approach to risk management, including the creation of a risk manager role, would be implemented by the start of the 2020-21 financial year.

4. COMMITTEE AND BOARD CYCLE

Earlier this year the Trust's commissioned the current Interim Director of Corporate Affairs to carry out a review of corporate governance. One of the stand-out themes from that review was the frustration Board members had with the current cycle of Committees and Board meetings.

Currently all meetings are held in the last two weeks of the month, and while this means that Board members can benefit from the most up-to-date performance and finance information there are a number of draw backs with the current systems that all Directors have experienced and expressed.

Therefore, it is proposed to move the Board meeting to the first week of the month and People Performance Committee to the second week of the month. Quality Committee would continue to held in the third week of the month, and Finance and Performance Committee would move to the fourth week to ensure Committee members have the most up-to-date information on these key areas.

This move would spread the main meetings over the month, making it easier to administer, improving management of the business of the meetings, and providing more time for Directors to prepare and review papers. It would also ensure that as far as possible the Board did not clash with school holidays, helping to support full attendances at meetings.

Moving the Board meeting would require careful scheduling of key documents that require Board sign off e.g national returns and declarations. Alternatively the Board could consider delegating sign-off of these items to its Committees with a follow up report to the Board.

If the Board was to support this proposal it would be intended to move to the amended Committee and Board cycle from the start of the 2020-21 financial year.

5. BOARD BUSINESS PLAN

The Board of Directors should have a comprehensive business plan, which together with the Board Assurance Framework, guides the agenda for its meetings. To date the Board's business plan has simply been a rolling programme of items that have previously been to the Board, and while this can act as a helpful reminder it does not adequately guide the strategic business of the Board.

Using experience of Board business plans in other organisations, coupled with information provided by NHS Improvement and the national Trust Secretaries Network, the attached annual plan for the Board has been drafted and will be subject to on-going review.

Currently a number of the items included in the plan are delegated to Board Committees, and the Board may want to take a view on whether this is appropriate. However, the attached document reflects good practice in relation to what NHS Foundation Trust Board's should be receiving and discussing on a regular basis.

6. RECOMMENDATIONS

The Board of Directors are asked to:

- Support the establishment of a Health and Safety Committee,
- Support the establishment of a Risk Management Committee supported by the development of a risk manager role,
- Support changes to the committee and Board cycle to more effectively manage the business of those meetings,
- receive a draft Board business cycle that will be subject to on-going refinement.

Annual Board Business Cycle

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Core items	Patients story Chairs report CEOs report IPR Risk register Key issues committee reports Business development report	Patient story Chairs report CEOs report IPR Risk register Key issues reports Business development report	Patient story Chairs report CEOs report IPR Risk register Key issues reports Business development report	Patient story Chairs report CEOs report IPR Risk register Key issues reports Business development report	Patient story Chairs report CEOs report IPR Risk register Key issues reports Business development report	Patient story Chairs report CEOs report IPR Risk register Key issues reports Business development report	Patient story Chairs report CEOs report IPR Risk register Key issues reports Business development report	Patient story Chairs report CEOs report IPR Risk register Key issues reports Business development report	Patient story Chairs report CEOs report IPR Risk register Key issues reports Business development report	Patient story Chairs report CEOs report IPR Risk register Key issues reports Business development report	Patient story Chairs report CEOs report IPR Risk register Key issues reports Business development report	Patient story Chairs report CEOs report IPR Risk register Key issues reports Business development report
Strategy & planning	Quality improvement plan	Winter plan Patient experience strategy	People strategy	Research & development strategy		People strategy	Winter plan	Estates strategy Trust strategy	People strategy Risk management strategy	Communications & Engagement strategy	Transformation strategy	Operational plan including finance & CIPs People strategy
Services & change		Cancer services	End of Life Care					PLACE				7 day services
People	FSUG NED independence Register of interests	Guardian of Safe Working	Safe staffing		Guardian of safe working	Safe staffing Medical appraisal & revalidation WRES	FSUG Fit & Proper person	Guardian of safe working	Strategic staffing review/Safe staffing		Flu vaccinations Guardian of safe working	Safe staffing NHS Staff Survey
Quality			Safeguarding	Quality improvement plan	Patient experience	Safeguarding	Quality improvement plan	Patient experience	Safeguarding	Quality improvement plan	Patient experience	Safeguarding
Assurance & governance	Sustainability development management report Mortality	Trust report, accounts, related governance statements declaration	NHS maternity incentive scheme Corporate	EPPR Learning from deaths BAF	Corporate objectives	BAF Contract sign offs	Mortality	BAF Corporate objectives		Mortality BAF	Controlled drugs Corporate objectives	Health & Safety Complaints

	Info governance toolkit Review of board effectiveness Use of common seal	DIPC BAF, including corporate objectives	governance G6(4) FT4(8)									

Colour Key:

- For approval
- For progress update
- Self assessment/certification
- Annual reports/declarations

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ANNUAL SAFETY REPORT 2018/2019

CONTENTS

SECTION 1

1.1 Introduction

Stockport NHS Foundation Trust (SNHSFT) provides hospital and community health services at over 24 sites across Stockport. Our aim is to deliver excellent, caring and safe healthcare. Stockport NHS Foundation Trust is committed to providing and maintaining a safe and healthy workplace and to provide suitable resources, information, training and supervision on health and safety to staff, patients, contractors and visitors.

Stockport NHS Foundation Trust, as a caring and responsible employer, seeks to achieve high standards in the management of health and safety. The Trust does not pursue this aim simply to achieve compliance with current legislation, but because it is in the best interests of patients, staff, visitors and other stakeholders.

The Board of Directors accepts that health and safety management is a key and integral part of its governance agenda, and that the identification, assessment, control of health and safety and other associated risks is a managerial responsibility.

This report provides an update on the incidents reported during the financial year 2018/2019 and outlines general themes and actions taken. It also serves to highlight both the performance within the Trust regarding health and safety topics and the identification of any themes and trends.

This report will highlight actions and current plans in place to reduce risk and identify any challenges for the coming year. It will identify the actions required to reduce any risk associated with those challenges.

The report covers the following areas;

- Key topics;
    - incidents (equipment, medication, access),central alerts, general hazard inventories, controls of substance hazardous to health, fire safety, moving and handling
- External reporting
    - RIDDOR, IRMER, NRLS, CQC
- Incidents
- Education and training

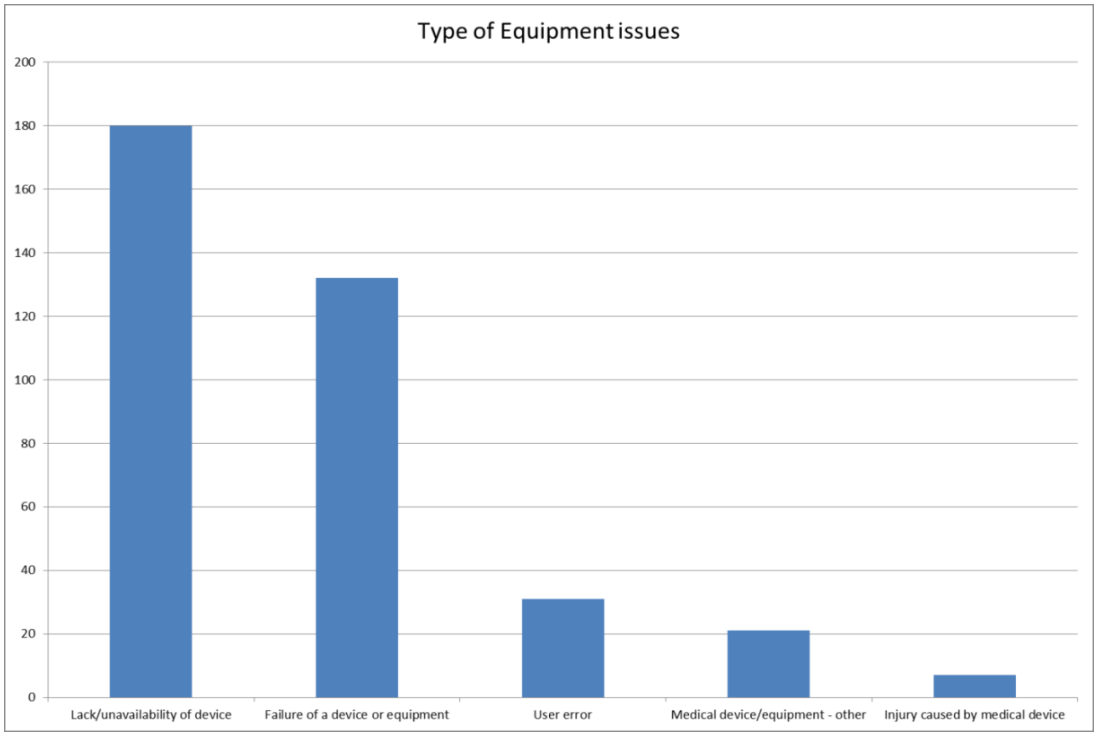
SECTION 2 - Key Topic Areas

The following section highlights key topics that are pertinent to the health and safety agenda within the organisation

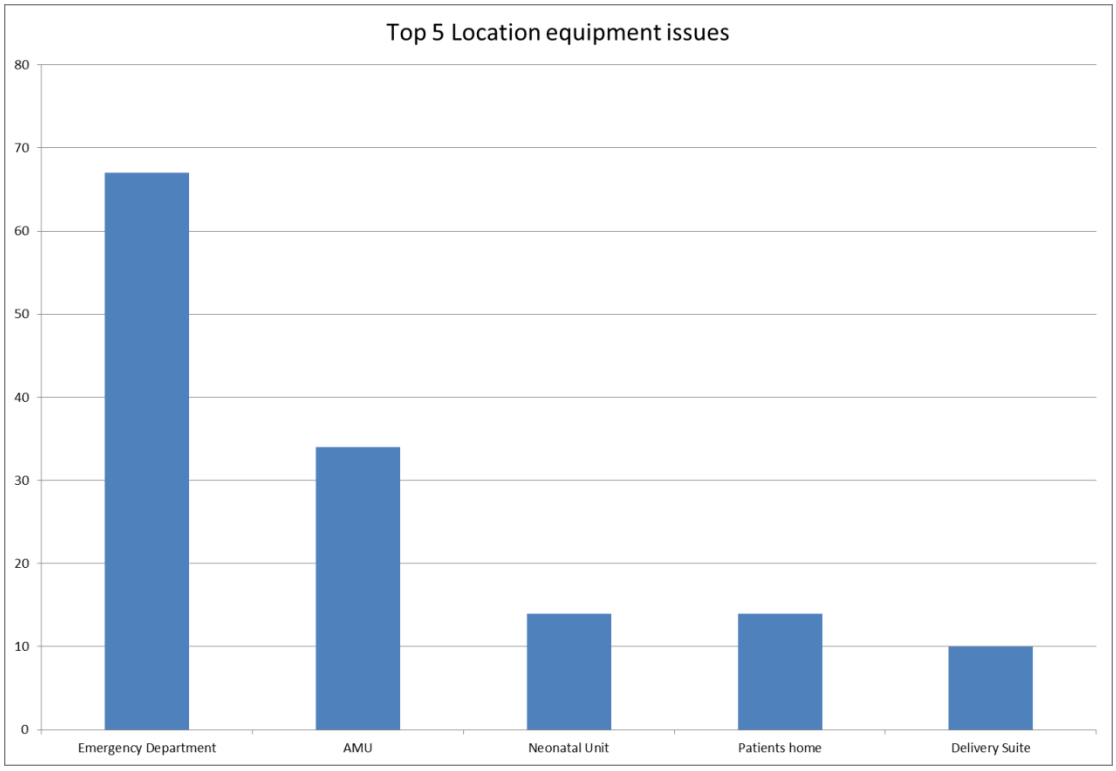
2.1 Equipment

2.1.1 Incidents reported

There were 380 incidents reported 2018/19



2.1.2 Top 5 Locations



2.1.3 Developments/changes to practice

There are a number of initiatives being undertaken in relation to the management of equipment;

- The electrical and biomedical engineering (EBME) department are trialling RF-ID tagging for medical equipment to help with the track and traceability of a medical device. This will save time for a nurse looking for equipment.
- The facilities team are writing a business case for an equipment library, which will keep a stock of frequently used devices and therefore minimising the risk of staff being unable to find a piece of equipment when required.
- The facilities team are updating EBME's asset management system and servicing schedules. This will improve record keeping and provide the medical devices group with accurate data analysis on outstanding planned preventative maintenance and missing equipment
- The facilities team are in the process of recruiting a contracts manager to oversee medical devices on external contracts, efficiently.
- The facilities team are carrying out monthly audits on random medical equipment to give feedback on accuracy of location and whether they are in or out of service.
- EBME engineers are visiting high risk areas on a 'daily round' to help with any equipment issues, reducing the downtime of equipment being out of service.
- Better and more up-to-date test equipment has been purchased, which enables service work to be carried out in-situ resulting in less down time of equipment being out of service.

2.1.4 Challenges for the forthcoming year and action plan

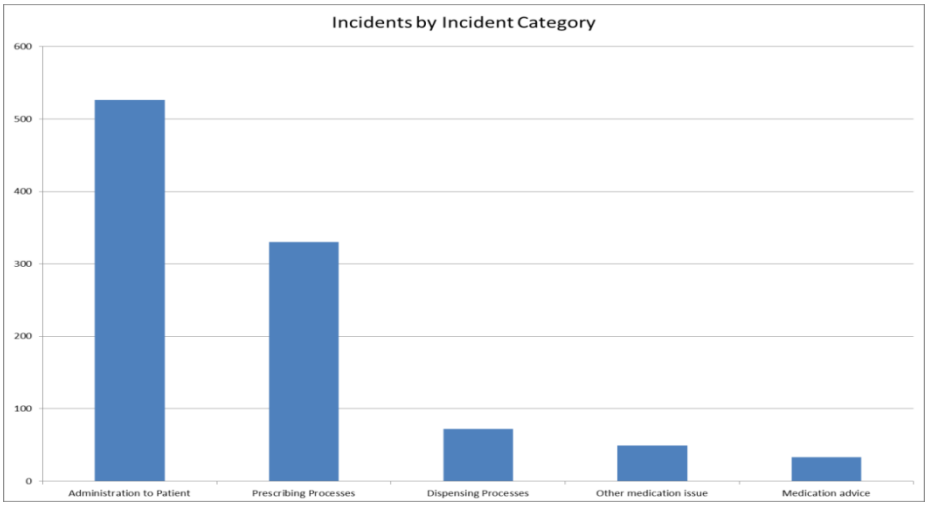
The actions to be undertaken this year include:

- Further refining the asset register to ensure that it is accurate.
- Provide appropriate assurance by undertaking regular audits.
- Introducing a better flow of medical devices, what's coming in and what's being disposed, working with procurement.

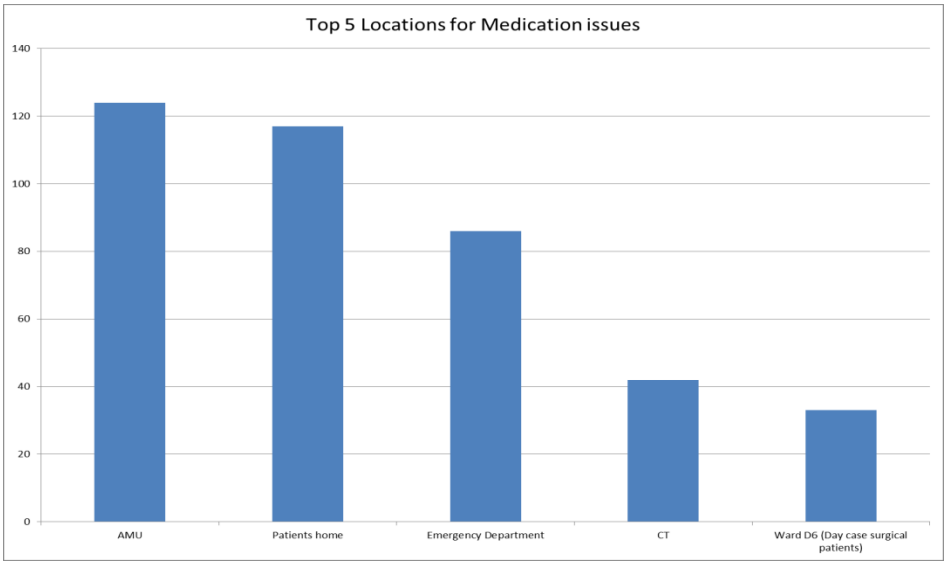
2.2 Drugs/Medicine Related Incidents

There were 1088 Medication incidents reported during 2018/2019

2.2.1 Top Five Medication Incidents by category of incidents



Top 5 Locations



2.2.3 Developments and changes to practice

Nine training sessions for Foundation Years (FY) 1 and eight for Foundation Years 2 were completed over the year. This included case presentations and discussions in subjects such as anticoagulation, Insulin, Therapeutic Drug Monitoring, Parkinson's and Palliative Care.

Presentations were based on medication incidents that had occurred within the trust. Pharmacy regularly input into the Patient Safety Summit Newsletter based on errors or themes that have occurred.

In August 2018 Pharmacy designed and delivered prescribing OSCEs for the new Foundation Year doctors starting in the trust, which involved participation of consultants. 8 OSCE workstations were designed with varying subjects such as how to prescribe controlled drugs for discharge, how to convert medicines from oral to IV for patients with epilepsy and Parkinson's disease, identifying drug interactions. The feedback to the FY1 doctors was given immediately, and tailored to each

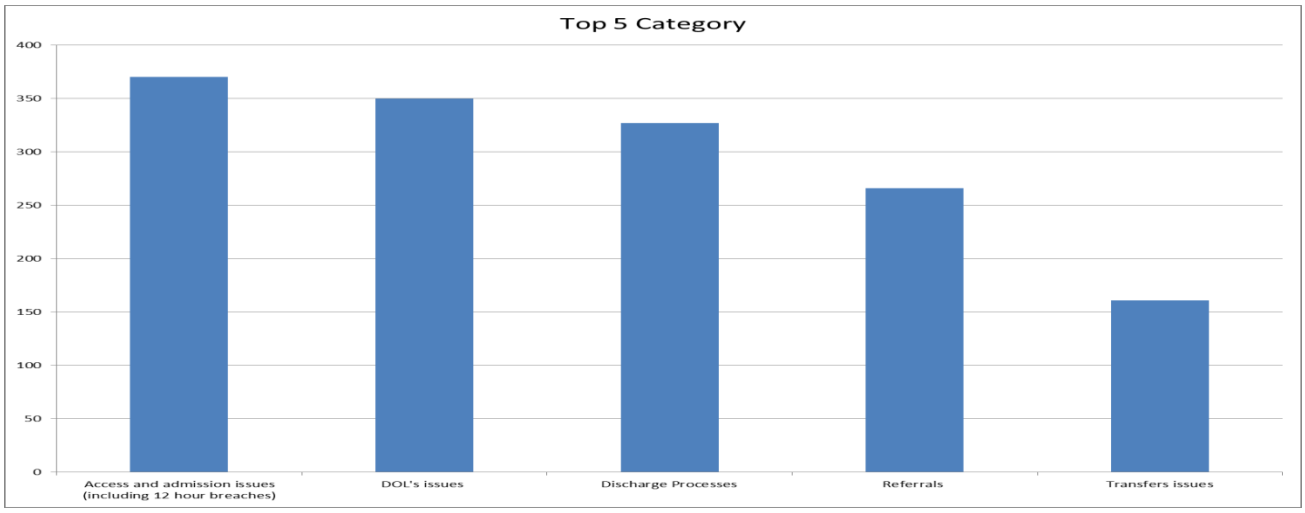
individual, which was well received. The feedback from the FY1 doctors was very positive with a few issues that we have now taken on board for the next FY1 OSCE assessment.

ePMA was introduced in December 2018 in the Emergency Department (ED) replacing paper charts which greatly reduced the number of reported errors. This was also with the addition of a pharmacist working in ED where some patients were able to have the medicines reconciliation completed before they saw a clinician.

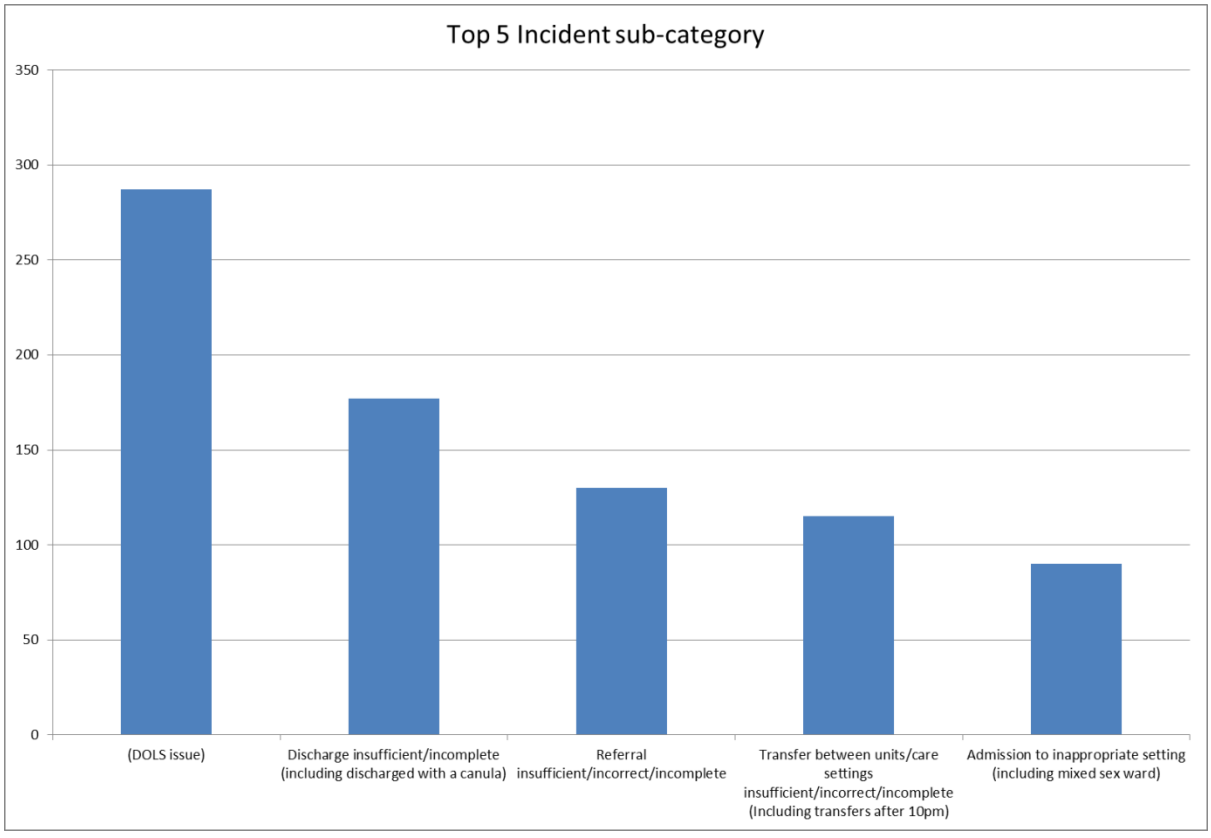
2.3 Access, Admission, Discharges, Transfers and DOL's issues

2.3.1 Incident Analysis

1750 incidents reported



2.3.2 Top 5 locations



2.3.3 Developments and changes to practice

Deprivations of Liberty incidents are predominantly regarding an expired application following submission to Stockport Metropolitan Borough Council. The application is completed by ward staff following an assessment of whether a person is able to consent to stay in the care environment for the purpose of care and treatment. If the assessment shows the person cannot consent, a Deprivation of Liberty (DoLs) is applied for. The Supervisory Body should then provide a Best Interest Assessor and a Mental Health Assessor, to visit the individual and undertake their own assessments. It is the result of these assessments that dictate the outcome of the DoLs application. The Supervisory Body may decide that there is no reason to deprive someone of their liberty and not issue an authorisation or decide that there is reason to deprive the individual of their liberty and so authorise the deprivation with a finite time limit included. However, if the Supervisory Body does not complete this within 7 days, the emergency application is expired. At that point, the patient would continue to be cared for under their best interests.

The Trust has introduced a transfer policy which describes the importance of reducing the number of moves a patient makes during their hospital stay and particularly transferring patients at night. Staff have have been encouraged to report incidents where patients are transferred at night, particularly if the patient is suffering from confusion.

The Transfer of Patients Group has been set up and the number of transfers is monitored through the Patient Safety Summit. The Clinical Site Coordinators continue to work closely with ward teams to support early discharge and move patients to the Discharge Lounge when appropriate.

The trust have an Integrated Transfer Team (ITT) who manage complex discharges from hospital back into the community. ITT adopt a Home First approach when planning all discharges and use a robust multi-disciplinary approach. The trust works closely with the SMBC Quality Team, this is to support timely and safe discharge to the relevant social care setting. We encourage providers to report any unsafe discharge to us so they can be looked in to and lessons learned. A complex case panel is held each week. Wards can refer any patient who they feel is complex in nature and may require an MDT approach to discharge.

2.4 Central Alerting System (CAS) – Alert Notices

Patient safety alerts are issued from NHS Improvement (NHSI) via the Central Alerting System (CAS), a web-based cascading system for issuing alerts, important public health messages and other safety critical information and guidance to the NHS and other organisations.

Incidents are identified using the reporting system to spot emerging patterns at a national level, so that appropriate guidance can be developed and issued to protect patients from harm.

There has been a change in the process in the way alerts are processed within the organisation.

Type of Alert/Notice	Total:
MHRA Medical Device Alerts	48
NHS Improvement Estates and Facilities	23
MHRA Drug Alerts	19
NHS Improvement	9

CMO Messaging	5
DHSC Supply Disruption Alert	3
MHRA Dear Doctor Letter	3
CAS Helpdesk Team	1
NHS England Operations and Information Directorate & National Primary Care Commissioning Team	1

Alert reports are compiled monthly and submitted to the medical devices group. There is a section within the clinical governance monthly report that shows compliance with safety alert completion.

2.4.1 Developments/changes to practice

- The trust Standard Operating Procedure for alerts has been updated to reflect the changes implemented in managing the alerts across the organisation.
- When the alerts are sent via the CAS website the alert is checked with relevant departments to see if it is relevant to the organisation. Only then if relevant the alert is cascaded through to the business groups
- The safety alert module was set up and trialled for a period of three months July – September. However it was found that it could not collate all comments recorded on the system.
- A decision was made to use the incident reporting system for the central risk team only so that reports could be designed and used.
- An audit was undertaken of all alerts from December 2016 to September 2018, to assess the Trust response and any action plan associated with the alert.

2.4.2 Challenges for the coming year and action plan

- To implement a change for patient safety alerts to prevent deadlines being missed and to ensure action plans and evidence are managed robustly.

2.5 General Hazard Inventories

2.5.1 A General Hazard Inventory is required to be undertaken every 2 years. The previous inventory was undertaken in 2016/2107. An inventory was undertaken between September 2018 to May 2019.

2.5.2 Datix was used for the first time to record such an inventory by using the risk module and amending the risk form to mirror the General Hazard Inventory Form used in previous years. This has enabled the specialist leads to have sight of the information easily. Business groups and directorates can see which areas have been completed and be able to review the information easily

2.5.3 Staff completed the forms between the months of September 2018 to May 2019. 152 forms were completed. There were 2 forms that had no identifiable information as to the location of the inventory undertaken and therefore they were rejected. The information from the forms were separated into their different sections and placed onto a General Hazard Inventory Datix dashboard. Each section lead were then able to review their areas.

2.5.4 Challenges for the coming year and action plan

- To review the current format of the form with the Business Groups to ensure they are easy to use.
- To add additional questions relating to ligature assessment
- To use the information to support the estates maintenance risks
- A re-audit will be conducted by the Business Groups in September 2019 and reported into the Safety and Risk Group in November 2019, following collation of all the data

2.6 Control of Substances Hazardous to Health (COSHH)

2.6.1 Incidents Reported

The number of chemicals or substance exposures incidents reported continues to be small and generally comprises exposure to disinfecting agents or body fluids.

Patient risk from prescribed drugs and medicines are excluded in the COSHH Regulations. Most clinical areas will only have a limited number of approved cleaning agents which are similar to household cleaners which come under the COSHH Regulations, with only few specialist chemicals. Care needs to be used in handling disinfectants, given they have a risk of releasing chlorine or chlorine related compounds on contact with organic substances.

A few specialised areas in the trust will use additional chemicals relevant to the areas clinical role e.g. the Estates department, Pathology Laboratory, and Quality Control North West. Detailed risk assessment and controls are in place and kept up to date.

Management of substance exposure is achieved with the use of standard operating procedures, appropriate local exhaust ventilation and personal protective equipment. Appropriate environmental monitoring is undertaken annually and satisfactory results have been achieved. Air measurements of chemicals give assurance that staff are not unduly exposed to risk and the Trust is complying with regulations.

The Trust has had one serious incident relating to workplace chemicals in the last 12 months. This was a formalin spillage on theatres.

2.6.2 Developments/Change to Practice

The COSHH Intranet site provides hazard data sheets and COSHH specific hazard & risk assessments for all our substances, which employees can access to help them keep safe and well.

2.6.3 Challenges for the coming year

Compliance with the COSHH Regulations is an ongoing process in order to ensure that datasheets and appropriate risk assessments are undertaken and kept up-to-date and needs to continue despite other workload pressures and demands.

Steps are being taken to identify suitable training for COSHH responsible persons to ensure they maintain their knowledge and assist business groups to remain compliant with good practice and the regulations.

2.7 Resilience (Fire, Emergency Preparedness & Business Continuity)

2.7.1 Resilience

During the period 1st April 2018 – 31st March 2019, the Resilience Team comprised of 1 full time Emergency Preparedness Resilience & Response (EPRR) Manager and one 0.6 wte Fire Safety Officer working three days per week.

The trust has business continuity plans across all business groups and a programme is in place for reviewing & updating plans and exercising them via table-top scenarios. Going forward it will be important to ensure that business continuity plans continue to be "fit for purpose" and take account of inevitable changes to organisational structures, services, personnel and technology.

During the reporting period there have been seven incidents which have necessitated the establishment of 'Command & Control' to coordinate the incident response across the Trust – further details are shown in the table below;

Incident Date:	Incident Description:
21.05.2018	Loss of non-essential power supply across hospital site
31.10.2018	Fault with '483' Telephone Lines (affecting main switchboard)
04.12.2019	Powerburst at local substation affecting power on hospital site
11.12.2018	Formalin Spill in Theatres
27.12.2018	IT Failure
30.01.2019	Adverse Weather (Snow)
05.02.2019	Site Wide Power Issues

Each of these incidents were subjected to a post incident review/de-brief and several were reported as serious incidents via the StEIS reporting process. A number of lessons were identified for each of these incidents, action plans were implemented and progress was monitored via appropriate forums.

The Trust's Emergency Preparedness Resilience & Response (EPRR) Group, chaired by the Trust's Accountable Emergency Officer (AEO) continued to meet quarterly throughout the reporting period. The group has representation from all business groups and during 2018/19 we secured the attendance of a Non-Executive Director which is a welcome addition to the group. The purpose of the group is to embed a positive, pro-active culture towards resilience within the trust and to provide a forum where EPRR issues can be discussed.

The trust submitted a 'Substantially Compliant' status against the 2018 EPRR Core Standards. An action plan is in place to address the areas of 'Non' or 'Partial' compliance, progress against the action plan is monitored via the EPRR Group and the Stockport Health Economy Resilience Group (HERG).

All trust guidance plans and procedures are available on the Emergency Planning Microsite.

2.7.2 Fire Safety

The trust has a statutory duty to manage all risks associated with fire and to ensure that our staff, patients and visitors are safe from fire under the Regulatory Reform (Fire Safety) Order 2005. Additionally we are required to comply with Department of Health guidance as detailed within the "FireCode" series of Health Technical Memoranda (HTM).

The original programme of Fire Risk Assessments (FRA) was completed during 2009/10 to provide a baseline for all buildings on the Stepping Hill Hospital Site, Swanbourne Gardens, The Meadows and The Devonshire Unit. Since that time an annual programme of Fire Safety Audits (FSA) has been established, the purpose of which is twofold;

- To ensure the original FRA remains accurate and valid
- To identify any fire safety weaknesses and to initiate action accordingly

During the reporting period Fire Safety Audits (FSA) were completed in accordance with the audit schedule.

Following an inspection of the Maternity Building by Greater Manchester Fire & Rescue Service (GMFRS) they identified significant breaches of the Regulatory Reform (Fire Safety) Order 2005. These breaches were in relation to;

- Risk Assessment
- Duty to Undertaken General Fire Safety Precautions
- Principles of Prevention
- Fire Safety Arrangements
- Fire Fighting & Fire Detection
- Emergency Routes & Exits
- Maintenance
- Training
- Maintenance of measures provided for the protection of Fire-Fighters

A series of monthly meetings are in place involving Estates & Facilities Staff and representatives from GMFRS to ensure remedial actions are completed. This issue has been documented on the Trust Risk Register.

2.7.3 False Alarms

False alarms drain our resources and interrupt normal service delivery. Additionally, they place an unacceptable burden on Greater Manchester Fire and Rescue Service - whilst they are responding to a false alarm they are not available for genuine emergencies.

There were a total of 44 false fire alarms during the reporting period – this represents a slight increase on the previous year. Raising the alarm for genuine reasons is not to be discouraged however, it should be recognised that false alarms are largely preventable, the table below details 38 false alarms which could have been prevented during the reporting period;

Description:	Number of Occurrences:
False alarm due to cooking (typically toast)	4 (10%)
False alarm due to patients/visitors (including contractors) accidentally breaking a manual call point	29 (76%)
False alarm due to technical apparatus faults	5 (13%)

2.7.4 Fire Training Provision

The table below details Fire Safety training figures for the reporting period:

Title:	Target Audience:	Number Attended:
Local Specific	Fire Safety Training for those working in areas of particularly high fire risk or with specific consideration across the hospital e.g. pharmacy, radiology, Treehouse etc.	293
Fire Warden Training	Staff delegated fire safety responsibilities at ward/dept. level.	44
Evacuation Training	Patient facing staff from wards that would be involved in the evacuation of non-ambulatory patients.	21
Volunteers	All volunteers to receive fire safety induction training.	60
Nursing students	All students to receive fire safety induction training.	148
Doctors	All “New” Intake of doctors to receive fire safety induction.	148

2.8 Moving and Handling

2.8.1 Incidents reported

There were 42 staff manual-handling incidents reported during 2018/2019, with 6 patient related manual-handling incidents reported.

2.8.2 Developments/ changes to practice

There have been a number of developments and changes to practice during 2018/2019;

- New starters will be required to complete their theory by an eLearning session first prior to their practical assessment
- eLearning has replaced classroom delivered theory for all staff - two yearly for clinical staff and three yearly for non-clinical staff. This is in line with the core skills framework.
- Facilities and estates will be provided with video learning to update their theory of manual handling
- Non clinical staff will receive a practical assessment only if necessary. This will be identified at their annual appraisal
- An additional 2000 slide sheets have been purchased by the Laundry Department
- The Trust Manual Handling Policy has been updated.
- An amended Key Trainer Disclaimer Form has been developed.
- Manual handling protocols have been developed and are available on the manual handling microsite
- A new competency document form that will replace the old assessment form

2.8.3 Challenges for the coming year and action plan

Actions to be progressed include;

- Continue to increase compliance with manual handling training from 87% to 95%.
- Review hoisting equipment across the trust and seek capital funding if required.
- To review risk assessments for non-patient manual handling to ensure that they are in date and are available to staff.

2.9 Sharps related Incidents

2.9.1 Incidents Reported

Inoculation Injuries are reported to the Occupational Health (OH) service for management and numbers are also recorded on Datix.

- There were 63 staff inoculation incidents which include dirty or clean sharps
- There was 1 patient affected inoculation incident
- There were 2 public/visitors who sustained an inoculation injury

The recording of inoculation incidents is undertaken with occupational health software and the numbers for the whole year to end March 2019 were reported to the Infection Prevention Committee. Entries are made to the Datix system via each area.

- There were 195 sharps related incidents to staff (including bites, scratches and splashes) reported during the financial year of 2018/2019, this a slight increase from previous years- 2017/18=193, 2016/17=190, 2015/16=190.
- Sharps related incidents remain one of the commonest types of injury to staff, with between 10 and 21 incidents per month
- Nursing was the highest occupational group.
- Total of 73 incidents related to handling of a hollow bore needle that had been used for either injection or venepuncture.
- A splash of biological fluids, scratch or a bite accounted for 29 of the incidents (46 last year).
- The needle protected safety blood collection sets used widely across the Trust continues to cause incidents. 36 such incidents are recorded (21 last year).
- There were 25 incidents in total in relation to giving insulin injections or disassembling the device (there were 25 last year).
- In the last 12 months, there have been 4 sharps injuries to domestic or portering staff, the same figure as last year. This tends to suggest that use needles or sharps are being left in the wrong place and putting this staff group at risk.
- Staff are encouraged to report all sharps incidents and to take measures to reduce the number of incidents. Taking the sharps bin to the site where the sharp is to be used and putting the used sharp directly into adjacent sharps bin may prevent the still relatively common injuries that occur when sharps are in transit prior to disposal.
- There was not an annual needlestick awareness day in 2018 due lack of support from representatives to attend the event.

2.9.2 Challenges for the coming year

The Quality Board for each Business Group need to identify a way of reducing the number of incidents occurring within their business group, in order to demonstrate compliance with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. This process needs to be documented to show compliance. Needlestick injury figures, per business group, is provided monthly by the occupational health service.

The Occupational Health Service gives feedback to managers on individual incidents to see what learning can be gained from the incident and so prevent further similar incidents
The needlestick incidents are presented to the Infection Prevention Committee, the two main areas identified which could reduce the number of needlestick incidents are in relation to the use of insulin injections and safety blood collection sets. The use of safety blood collection sets is currently being looked at by a working group.
A needlestick awareness day is being planned for September 2019.

All information/details of the process to follow in the event of a needlestick type incident are on the Occupational Health microsite

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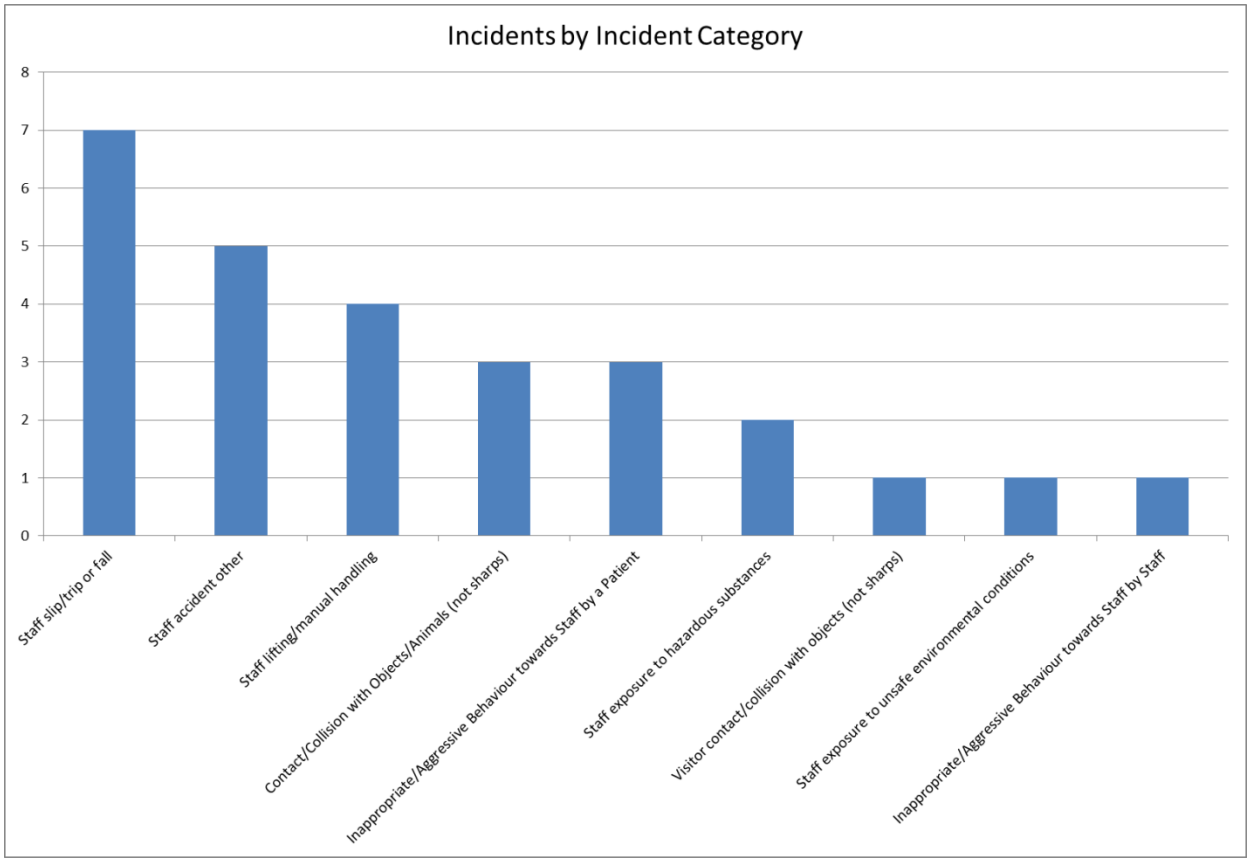
Section 3 - External Reporting

3.1 Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)

There were 27 RIDDOR incidents reported for 2018/2019 to the Health & Safety Executive



3.2 Ionising Radiation (Medical Exposure) Regulations (IRMER)

There have been 7 incidents reported under this regulation during 2018/2019 with actions plans put in place and completed. All were reported under unintended doses category. One incident was reported by Alliance Medical Ltd. The examination was performed by their Radiographers so they reported it.

3.3 National Reporting and Learning System (NRLS)

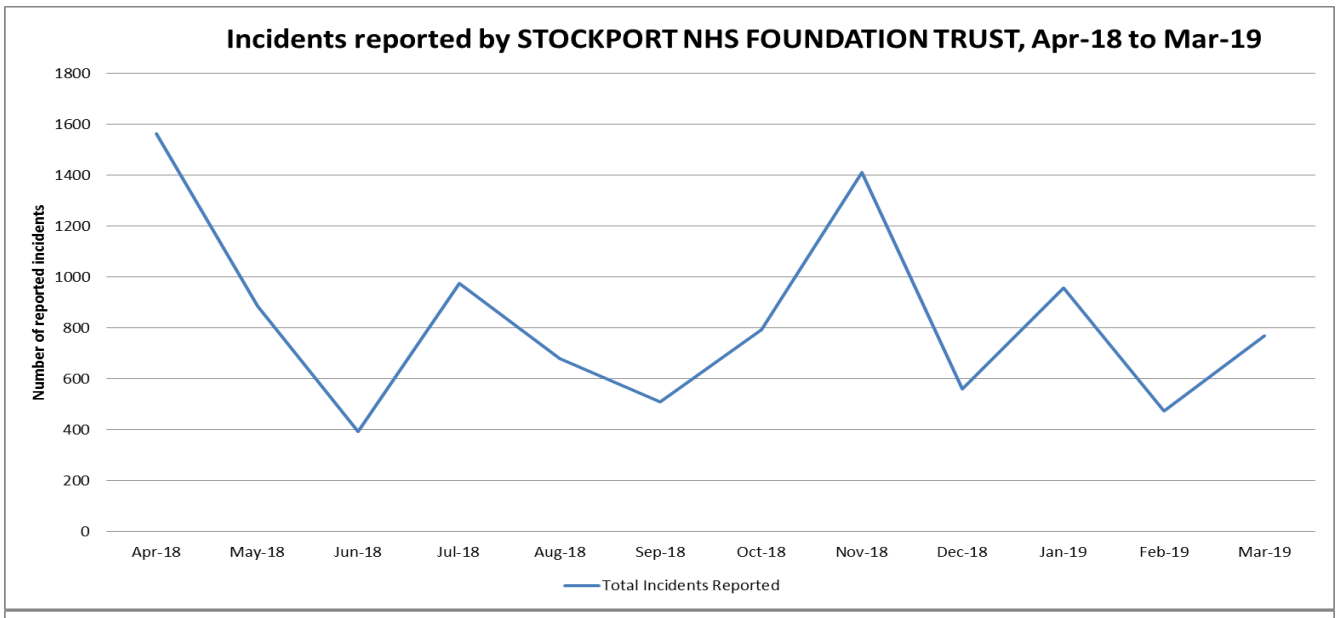
Stockport NHS Foundation Trust continues to submit incident information to the National Reporting and Learning System (NRLS). This involves the reporting of all patient related incidents

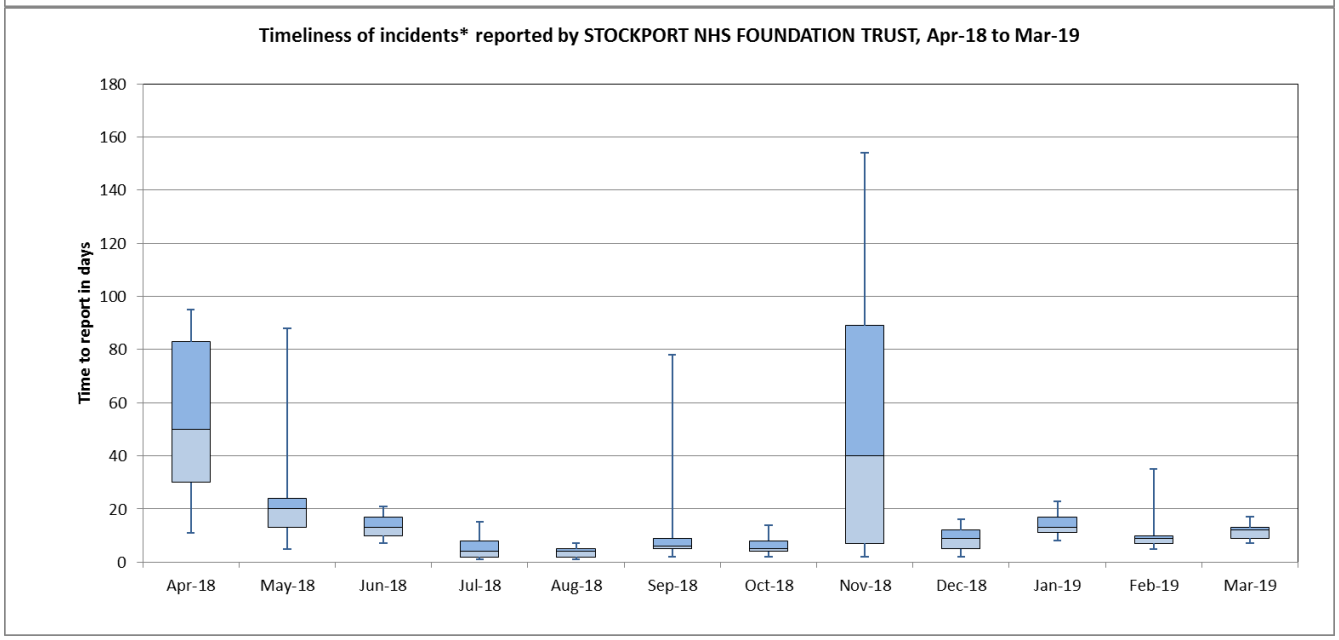
The NRLS analyses information from healthcare providers across the UK, to develop advice and guidance for the NHS about reducing risks to patients. Reports from the NRLS identify the Trust as being an average reporter of incidents, which is indicative of an organisation that has an improving safety culture.

Analysis of the NRLS data shows that the quality of data is good and that the consistency of scoring the severity of harm has improved.

Although the number of incidents reported has increased significantly, the number of patient safety incidents has only increased slightly over the last 2 years.

The NRLS publish provisional monthly reports on Trust's patient safety incidents which are available on the NHS Improvement website. 6 monthly reports are also produced.





Section 4 - External Assurance

4.1 CQC

In 2017, the CQC rated the Trust as 'requires improvement' overall, with 'inadequate' ratings for safety in medicine and in urgent and emergency services and 'inadequate' in well led for urgent and emergency services.

An action plan was developed and during 2018, the Patient Quality Summit and Safety and Quality Leadership Group led the response to the CQC report and the actions identified. The plan included areas around medication safety, safeguarding, documentation and facilities improvements.

In December 2018, the CQC continued to rate the Trust as 'requires improvement' overall, but there was improvement in 12 areas, including the removal of the three inadequate ratings. Following the publication of the report, detailing their findings from the unannounced visit, well-led assessment and use of resources assessment, a new improvement plan was developed.

The 2018 report identifies 12 'must do' actions and 45 'should do' actions. The plan is monitored through the patient quality summit.

The trust has met with CQC inspectors through engagement meetings and continues to respond to any areas of concern and provides information with regard to serious incidents.

SECTION 5

5.1 Incidents Reported

Incident reporting and analysis is an essential part of the identification of hazards that have, or have the potential to, cause harm to a person or the organisation. It is a process that assists in identifying whether we need to change our practices or processes to improve patient safety.

Accurate incident reporting identifies where we need to focus resources, such as training and finances and we can measure our performance against our aims to reduce harm from incidents.

We report all our patient safety incidents and near misses to the National Reporting and Learning System (NRLS) to meet our statutory and legal requirements to record incidents and this information is reviewed nationally to identify themes and trends across all NHS funded organisations.

Reporting incidents and near misses helps us to identify our risks - this information helps us formulate our risk register and formulate action plans to reduce those risks.

The total number of incidents reported by Stockport NHS Foundation Trust (SNHSFT) from April 2018 to March 2019 is shown below. The previous year's figures are included for comparison.

Stockport NHS Foundation Trust	2017/2018	2018/2019
Total Reported Incidents	13474	17247
Total Reported Patient Incidents	10619	12350

5.2 Severity Ratings

When the incident reporting system (Datix) changed in November 2017, the way in which the severity of incidents were reported also changed in line with the NPSA recommendations. This enabled staff report near misses and no harm incidents. An additional severity of incident was added to identify 'Learning from death' reviews. If the review identifies lapses of care that have caused harm, then the harm level is changed.

Severity is now recorded by the reporter and then verified by the reviewer or governance team on reviewing the incident; all incident reports have a severity recording.
Incidents are classified by the degree of harm they cause and are categorised by the following severity ratings:

5.2.1 No Harm:
Impact prevented: Any patient safety incident that had the potential to cause harm but was prevented, resulting in no harm to people receiving NHS-funded care.
Impact not prevented: Any patient safety incident that ran to completion but no harm occurred to people receiving NHS funded care.

5.2.2 Low Harm:
Any patient safety incident that required extra observation or minor treatment and caused minimal harm, to one or more persons receiving NHS-funded care

Minor treatment is defined as first aid, additional therapy, or additional medication. It does not include any extra stay in hospital or any extra time as an out-patient, or continued treatment over and above the treatment already planned. Nor does it include a return to surgery or re-admission

5.2.3 Moderate Harm:
Any patient safety incident, that resulted in a moderate increase in treatment and which caused significant but not permanent harm, to one or more persons receiving NHS-funded care.
Moderate increase in treatment is defined as a return to surgery, an unplanned re-admission, a prolonged episode of care, extra time in hospital or as an out-patient, cancelling of treatment, or transfer to another area such as intensive care as a result of the incident.

5.2.4 Severe Harm:
Any patient safety incident, that appears to have resulted in permanent harm to one or more persons receiving NHS-funded care.
Permanent harm directly related to the incident and not related to the natural course of the patients illness or underlying condition is defined as permanent; lessening of bodily functions, sensory, motor, physiologic or intellectual, including removal of the wrong limb or organ, or brain damage.

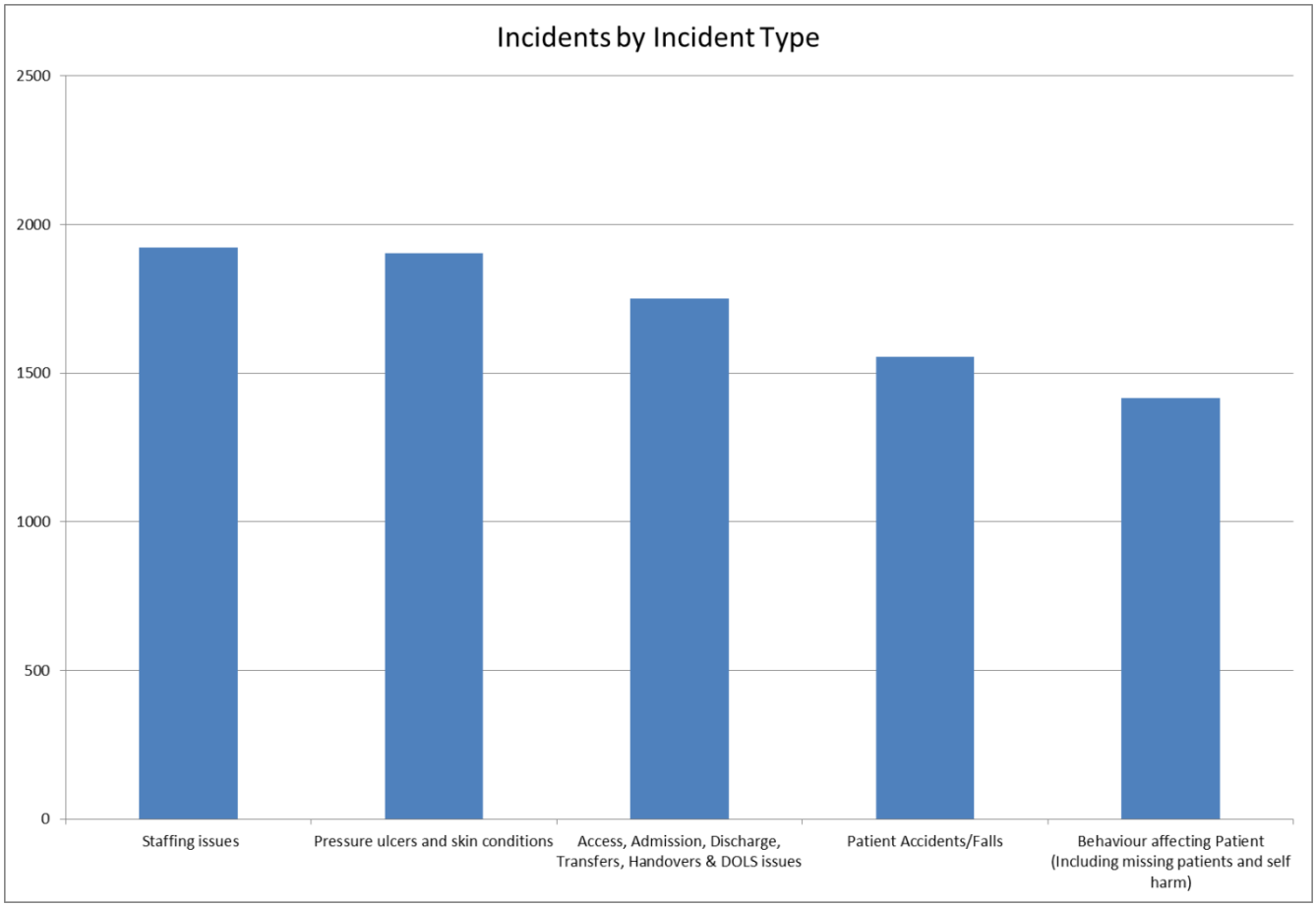
5.2.5 Death:
Any patient safety incident that directly resulted in the death of one or more persons receiving NHS funded care.
The death must relate to the incident rather than to the natural course of the patients illness or underlying condition.

All detailed information and learning from incidents, claims, inquests and complaints are reported monthly via the Clinical Governance report. In addition a quarterly report identifies the themes and trends, including triangulation and is submitted to the Safety and Risk Group up through Quality Governance Group to the Quality Committee.

5.2.6 Total Number of Incidents Reported Categorised by Severity:

Severity of Harm	2018/2019	%
Learning from Death	471	3%
No Harm	13770	80%
Minor Harm	2636	15%
Moderate Harm	322	2%
Severe Harm	30	0.2%
Death caused by the incident	12	0.1%

5.3 Top Five reported incidents by type



All incidents are categorised so that themes and trends can be identified and strategies developed to help reduce occurrence of similar incidents. The top five reported type are shown in the graph above.

5.4 Pressure Ulcers

There have been 1902 pressure ulcers reported between April 2018 - March 2019 and pressure ulcers consistently remain in the 'top 5' most reported incidents within the Trust.

Of the total number of pressure ulcer incidents reported last year, 24% (456) were either low harm*, or moderate harm** compared to 504 incidents the year before, which shows an overall 10% reduction in harm as a consequence of pressure damage across the Trust.

* Low harm incidents includes category 2 and deep tissue injuries (DTI's)
** Moderate harm incidents includes category 3, 4, and unstageable pressure ulcers.

The table below shows **new** pressure ulcer related incidents for categories 2-4, i.e. developed whilst under the care of Stockport NHS Foundation Trust, split by Community and Acute care settings which totalled 324.

5.4.1 New Pressure Ulcers by Category:

Category of Pressure Ulcer	Category 2	Category 3 & 4	Totals
Acute Hospital	51 (avoidable) 41 (unavoidable) 0 (to be confirmed)	17 (avoidable) 5 (unavoidable) 2 (to be confirmed)	
Acute Hospital total	**92**	**24**	**116**
Community	19 (avoidable) 140 (unavoidable) 0 (to be confirmed)	15 (avoidable) 32 (unavoidable) 2 (to be confirmed)	
Community total	**159**	**49**	**208**
Organisation Total:	**251**	**73**	**324**

The Trust uses the NPSA 2010 definition of avoidable harm:

Avoidable means that the person receiving care developed a pressure ulcer and the provider of the care did not do one of the following:

- Evaluate the person's clinical condition and pressure ulcer risk factors,
- Plan and implement interventions that are consistent with the persons needs and goals, and recognised standards of practice
- Monitor and evaluate the impact of the interventions,
- Or revise the interventions as appropriate.

Governance systems have improved over the last 12 months; the process for verification and investigation of pressure ulcers has been updated, and the introduction of a Harm Free Care panels, has allowed business groups to review and investigate all pressure ulcer incidents. This has resulted in any learning to be identified and trends and themes can be more accurately analysed to improve pressure ulcer prevention strategies.

Going forward, and in keeping with national recommendations, pressure ulcer incidents will not be determined to be avoidable or unavoidable, rather the focus will be on identifying lapses in care and the lessons for wider learning from all pressure ulcer incidents reported, in order to improve both the quality of care delivered and the patient experience.

5.4.2 Incident Analysis

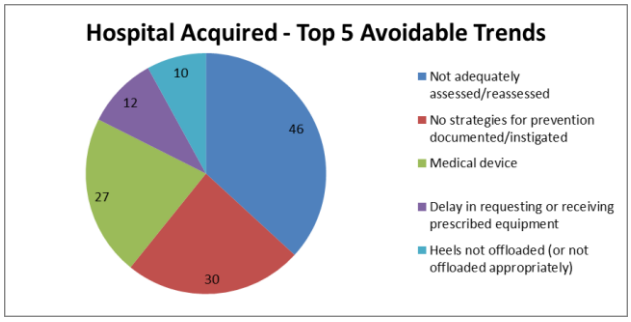
The main cause of pressure ulcer development continues to be failure to follow pressure ulcer guidelines. This predominantly relates to the inaccurate assessment of the patient, which includes inadequate skin inspection, both on admission to the episode of care either in the hospital or the

community setting, and on an on-going basis. The standard should be a minimum of daily inspections for all patients who have been identified as being at risk of pressure ulcer development, and are in receipt of 24 hour nursing care.

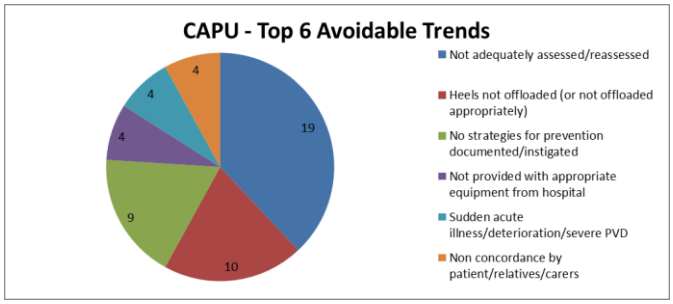
As a consequence of poor assessment, the correct interventions for prevention are not always instigated. This includes:

- Not adequately offloading heels in high risk patients, such as those who have diabetes or who have known or suspected circulatory impairment, in those patients that are also immobile.
- Or a delay in providing appropriate pressure relieving equipment in a timely manner.

5.4.3 Hospital Acquired Avoidable Causes of Pressure Ulcers:



5.4.4 Community Acquired Avoidable Causes of Pressure Ulcers:



5.4.5 Developments / Changes in Practice

Over the last 12 months, a number of improvements and changes in practice have occurred, which include the following:

- Updating processes for the reporting and monitoring of new pressure ulcer incidents. Clinical leads/matrons are now responsible for leading the Root Cause Analysis investigations into pressure ulcers that meet the serious incident (SI) criteria, and harm free care panels have been established to review all harms associated with pressure ulcers.

- ACE accreditation audits that include tissue viability standards commenced in April 2018.

- A Tissue Viability Operational Group has been established

- PURPOSE - T a new pressure ulcer risk assessment tool has been implemented across most Business Groups across the Trust, excluding Critical Care and Women's & Children.

- Essential training relating to tissue viability has been delivered to senior Band 6 and 7 nurses within the Trust. A new pressure ulcer prevention 3 hour update session for nursing staff

commenced in September 2018 which 138 staff have now attended. In addition, a critical care PU study day event took place in January 2019.

- Multiple 'Tool-Box' training sessions have taken place; these are short training sessions targeting a specific area of learning to capture staff during their working day (to prevent the need to take staff out of practice for training); focusing on PURPOSE - T, preventing medical device related pressure ulcers (MDRPU) and the introduction of the medical device core care plan and check chart.

- The Trust has participated in the NHS Improvement – National Stop the Pressure (NSTTP) Collaborative, where a "two glide sheets at every bedside" initiative was implemented, and a pressure ulcer verification training package and competencies were devised.

- Skin inspection mirrors have been issued to support skin inspection as an "Always Event".

- A heel protection guidance poster has been developed and circulated to all wards and community teams to promote the correct off-loading strategies. Access to heel off-loading devices has been streamlined for community teams.

- In March 2019, 250 electric beds have been delivered into the Trust, supported by a roll out of training in the correct use of profiling beds to support patient repositioning.

5.4.6 Challenges for the Forthcoming Year

Medical device related pressure ulcers continue to be an area where improvement is required. A Trust target has been introduced to reduce these incidents by 25% over the next 12 months. The Medical Device task & finish group will be re-established to build on the work already done.

In addition, the Trust is committed to ensuring a further 10% reduction in all other category 2, 3 and 4 pressure ulcers across both hospital and community in 2019-20. This is going to be a significant challenge, as national guidance now stipulates that all deep tissue injuries (DTI's), as well as all unstageable damage, require tracking until a definitive category of damage can be determined. As the tracking processes improves, the impact of this is that more of the DTI's and unstageable pressure ulcers, will be verified to a category 2, 3 or 4 pressure ulcer, and increase previously reported numbers within these categories. In addition, the cohort of patients being cared for are increasing in complexity with multiple co-morbidities, particularly those within their own homes who are living alone with only packages of care to support them.

There is a requirement, therefore, to review posture management and seating itself. Also the correct provision, assessment, ordering, and implementation of pressure relieving equipment has been highlighted as an area that needs to be targeted for improvement. An equipment task & finish group will be established with members across all Business Groups and to include the wider MDT (Physiotherapists, Occupational therapists and Podiatry colleagues) in these initiatives.

5.5 Slips, Trips and Falls

5.5.1 Incident Analysis

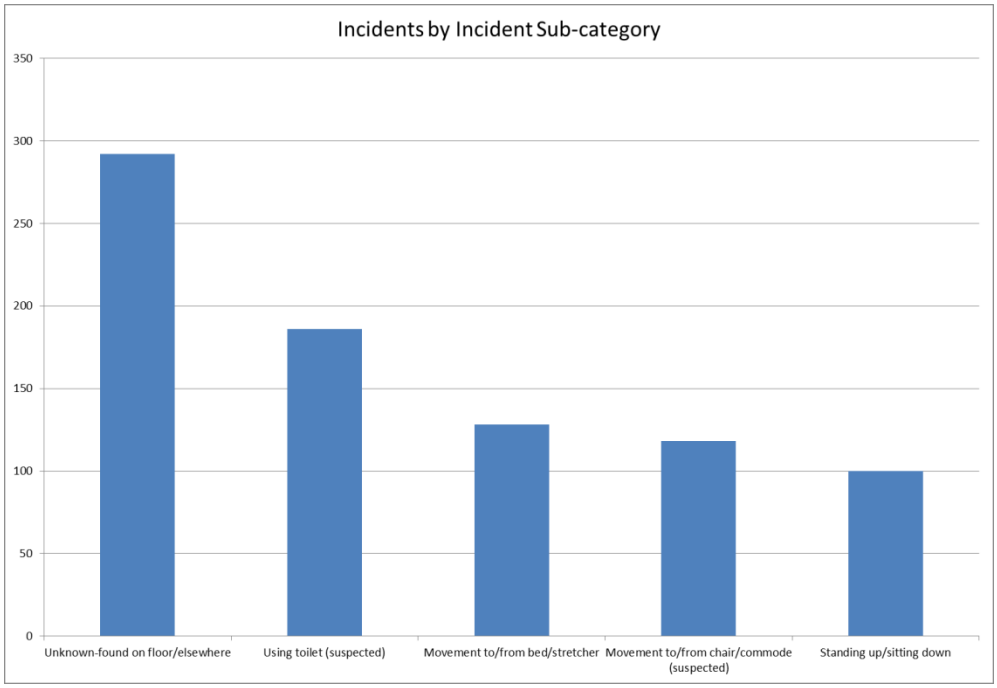
With the introduction of the new incident reporting system in November 2017 a new common classification coding was introduced. Patient falls are now spilt into suspected and witnessed falls.

- Total patient falls = 1401
- Suspected falls = 969
- Witnessed falls = 432

The Trust Quality Improvement Plan set a target of a 10% reduction of all in-patient falls. The final position resulted in the reduction of the overall number of falls exceeding the 10% target reduction with a total of 309 less falls which equates to a 20% reduction.

There was also a target for a 25% reduction in falls resulting in moderate or above harm in 18/19. The reduction on falls resulting in moderate or above harm also exceeded the target set. There were 29 in-patient falls with moderate or above harm compared to 41 in 17/18. This is a 29% reduction.

5.5.2 Patient Falls by Sub-category



5.5.3 Developments/Changes to Practice

The safer mobility collaborative was initiated within 2018/2019 with the aim of achieving the reduction targets set and raising awareness of falls prevention across the organisation.

There were a number of developments introduced during the year, which are noted below:

- Introduction of Standard Operating Policy for Bay Tagging
- Post Fall Matron Review and corresponding paperwork

- Introduction of Falls E-learning within the role specific mandatory training
- Introduction of the falling leaf symbol to identify patient at risk of falling at a glance
- Call don't fall posters in every ward bathroom
- Approved vision test
- Patient information leaflet reviewed and refreshed

5.5.4 Challenges for the Coming Year and Action Plan

The improvement falls reduction target for 2019/2020 has been set for a further 10% reduction on all in-patient falls, aiming to bring the total number to less than 1100.

There is also a further 10% reduction target set against falls with moderate or above harm levels.

Key issues and actions include:

- Additional Datix sub category for patients who have been lowered to the floor.
- Falls sensor project will be undertaken on 3 high falls areas from July 2019. Wards A10, E3 and AMU will participate in this project.
- Improve compliance with Lying and Standing Blood pressure.
- Adopt Royal College of Physicians guidance on Lying and Standing Blood Pressure
- Trial of double tread anti-slip socks
- Achieve 90% compliance with Falls E-learning
- Learning from falls poster for every fall with moderate or above harm
- National Falls prevention CQUIN is underway for 19/20, auditing 3 high impact actions to prevent in-patient falls.
- Lying and Standing Blood Pressure recording
- Medication review for hypnotics or antipsychotics
- Mobility assessment documented within 24 hours

5.6 Patient behaviour and security incidents

Patient behaviour and security incidents are captured on the Trust's electronic incident reporting system (Datix), during 2018/19 there was a total of 1,269 incidents reported by security guards.

A Security & Safeguarding' Group was established during the reporting period. The group meets weekly with representation from Security, Adult Safeguarding, Emergency Department, Dementia Matron, Greater Manchester Police (GMP) and the onsite Mental Health Liaison Service (Pennine Care). The group is working towards securing representation from the following business groups;

- Medicine & Clinical Support

- Surgery, GI & Critical Care
- Women, Children & Diagnostics

The purpose of the 'Security & Safeguarding' Group is to collectively review all security incidents which have occurred in the preceding seven days to provide assurance that incidents are being handled appropriately and where required appropriate routes of escalation are identified.

Security Incidents were included as a standing item at weekly meetings of the Patient Safety Summit (PSS) during the reporting period.

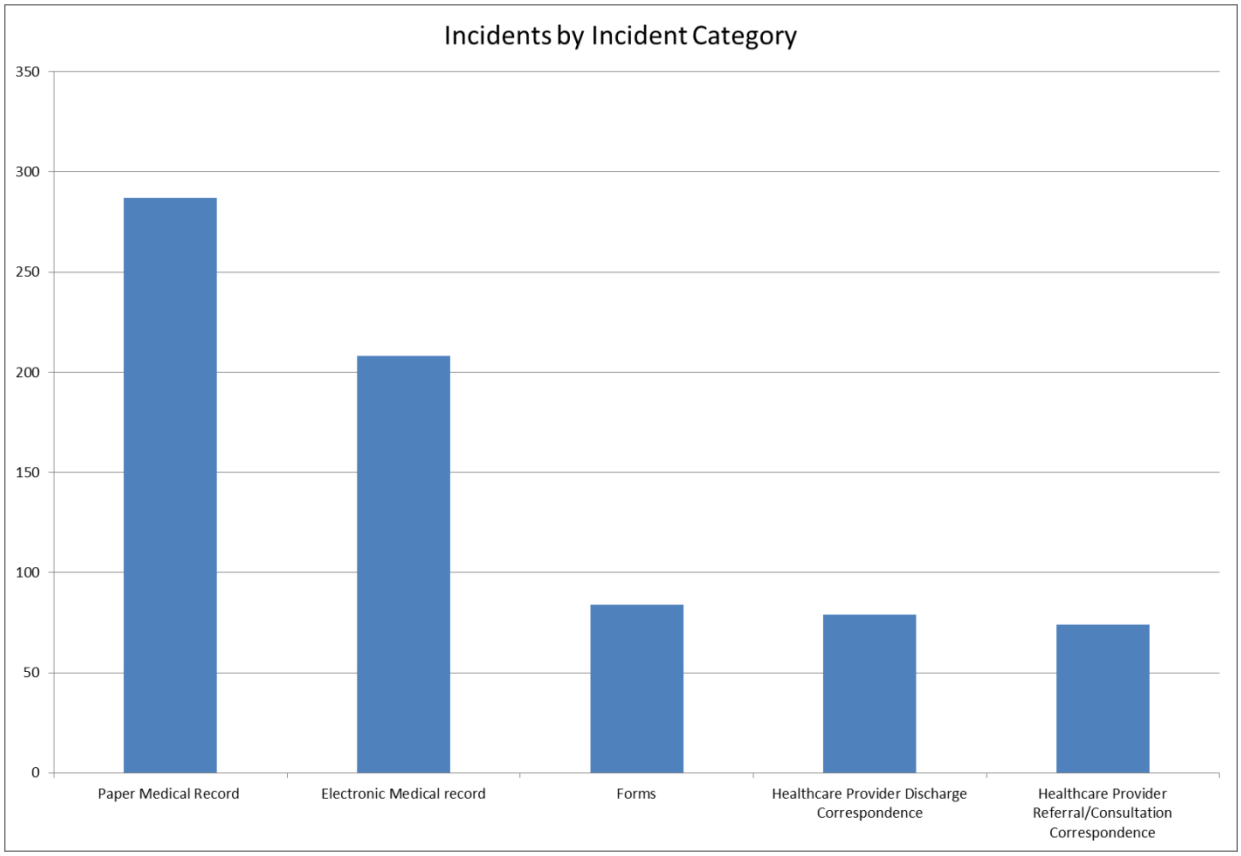
The table below illustrates the "Top 5" categories for Security incidents for the reporting period.

	Total
Uncooperative patient behaviour	549
Organisation property other	236
Missing Patient (absconded/abducted patient)	173
Self-harming Behaviour	44
Visitor behaviour other	30
Total	**1032**

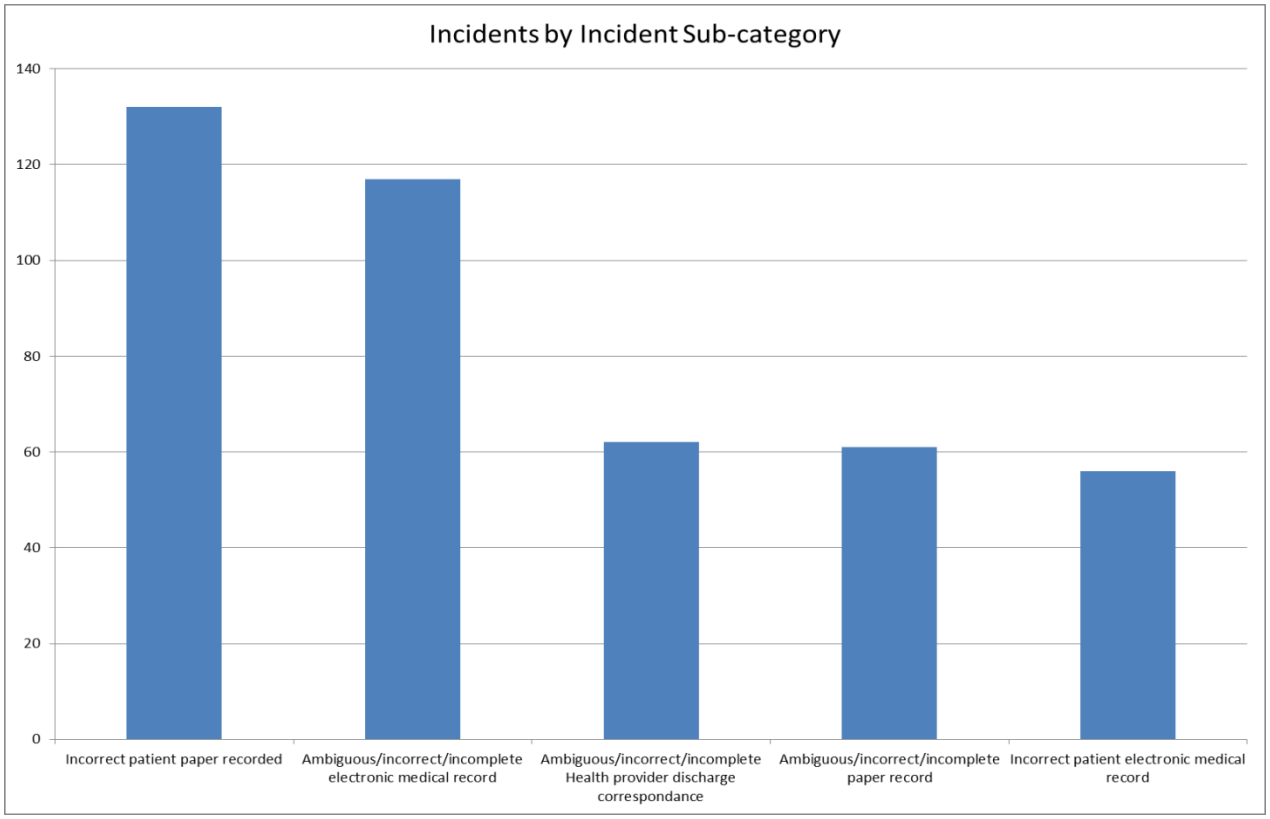
Significant work has been undertaken around the use of safe holding and the joint management of patients who have special requirements.

5.7 Documentation

In 2018/2019, there have been 1130 incidents in relation to patient documentation reported. A breakdown of the top 5 types of documentation is detailed below:



5.7.1 Top 5 Sub-Category



5.7.2 Developments/changes to practice

The trust is promoting paper free ways of working, which is overseen by the paper switch off board, by utilising existing and upgraded electronic systems. Improvements have also made to the scanning of health records process to ensure accuracy and availability of records.

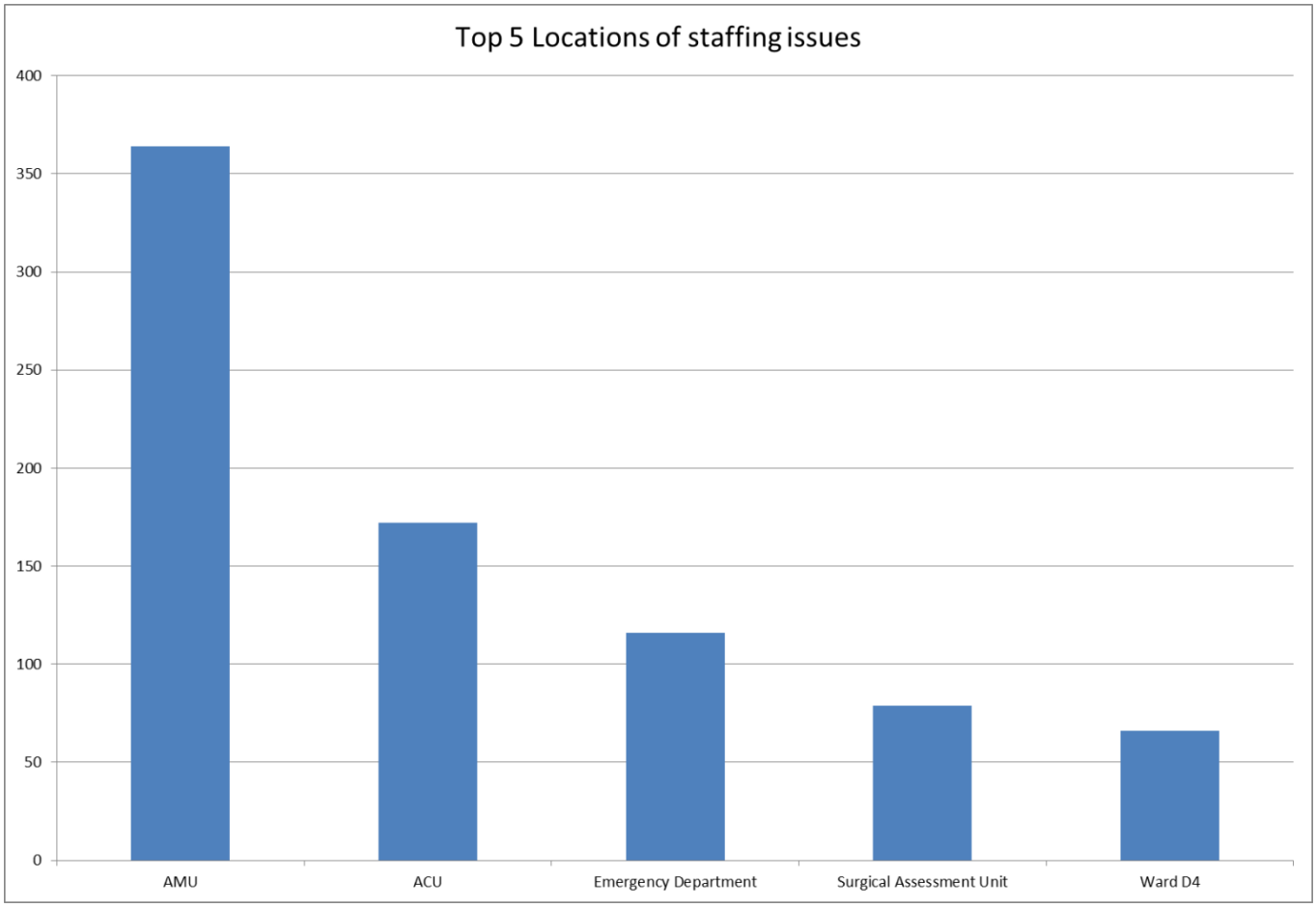
The Community Electronic Paper Record system has been further developed and deployed across all community services replacing paper records and allowing use of mobile devices across all community sites. The system has also been interfaced with GP systems to enable managed electronic referrals and data sharing of community and GP records, ensuring access to accurate records and support patient care. Access to GP records is already available within the emergency department and will be extended to other areas of urgent care.

A programme to phase out faxes commenced in early 2019 and is making steady progress to ensure alternative secure means of communicating information, such as email and electronic systems, in conjunction with all stakeholders.

5.8 Staffing

5.8.1 Incident Analysis

There were 1748 in relation to staffing issues in 2018/2019



5.8.2 Development/Changes to Practice

During 2017, the minimum Nursing and Midwifery staffing escalation policy was introduced which, in line with NICE guidance, also provided staff with the ability to report staffing related incidents against pre-determined triggers. In 2018 a staffing in extremis guidance document was also developed to support safe staffing.

The trust continues to report significant Registered Nurse vacancies averaging 160 WTE. Safe staffing is supported by utilisation of NHS Professionals and agency workers to an average of 150 WTE RN per month to support safe staffing. UK recruitment campaigns are ongoing with an external company employed to try and boost our UK recruitment. The Trust has also committed to recruiting 24 international staff to support the medicine business group and AMU in particular.

A new workforce pipeline, nurse associates, has been embraced with an average of 40 wte per annum in training. These will be employed in vacant post. The first cohort qualified in March 2019 and it is anticipated circa 20 every 6 months will qualify.

The trust has participated in cohort 2 of the NHSI retention plan, and demonstrated a 0.9% RN reduction in turnover in 12 months, but plans are on-going to achieve a more robust reduction of 1.5%.

Non registered recruitment is optimal with low vacancies, no agency usage and NHSP usage above vacancy levels, to support safe staffing.

Stockport community nursing levels were subject to a detailed review during 2017 which culminated in an increase to registered nurse staffing levels but they also are facing challenges particularly at band 6 level where there are significant vacancies. To mitigate this the integrated care business group invested in training for community nurses to upskill band 5 staff to achieve the qualification to enable them to apply for band 6 roles.

In 2019 the integrated care business group has demonstrated, with this revised approach, a focus on recruitment and retention issues. By providing excellent support from their management team in recruitment and retention initiatives and input from their practice based educators, their vacancy levels have reduced significantly.

5.9 Patient Safety Culture

The safety of both the patients and staff in a healthcare organisation is influenced by the extent to which safety is perceived to be important across the organisation. The 'safety culture' can be a difficult one to assess and change (MaPSaF, 2006).

Between January 2019 and March 2019, a survey monkey was circulated to trust staff seeking their views on the patient safety culture at Stockport NHS Foundation Trust.

369 members of staff completed the questionnaire, approximately 7% of the staff employed. The responses for each question can be seen at Appendix A.

The results can be plotted against the MaPSaF evaluation sheet.

Dimension of Patient Safety Culture	A	B	C	D	E
1. Commitment to overall continuous improvement	6%	12%	18%	50%	13%
2. Priority given to safety	2%	15%	23%	36%	25%
3. System errors and individual responsibility	2%	8%	24%	37%	30%
4. Recording incidents and best practice	2%	4%	22%	50%	23%
5. Evaluating incidents and best practice	6%	10%	17%	41%	26%
6. Learning and effecting change	2%	7%	31%	41%	19%
7. Communication about safety issues	5%	14%	30%	35%	16%
8. Personnel management and safety issues	17 %	15%	22%	23%	24%
9. Staff education and training	8%	7%	38%	27%	20%
10. Team working	3%	5%	30%	37%	25%

Results for perceived improvement over last 2 years

	No much worse	No worse	No the same	Yes better	Yes much better
Has the safety culture improved over the last 2 years	2%	4%	33%	46%	14%

The comments expressed show that, whilst it is recognised that improvements have been made in relation to the patient safety culture, further changes are required for staff to feel that there is a transparent and open culture.

Comments suggest that staff are discouraged from reporting incidents. There remains issues with timeliness and quality of feedback from incidents, communication, inconsistency across departments, unsupportive managers time to complete the form, blame culture and a lack of change seen as a result of reporting.

Work continues to support a fair and transparent culture.

- Managers and governance teams have been requested to review feedback to ensure meaningful feedback is received by the reporter and improve the timeliness of the closure of an incident.
- Some types of incidents, for example staffing incidents, have a condensed form to reduce the time it takes to complete.
- Senior managers have been reminded of the importance of encouraging staff to report all clinical incidents.
- Engagement is being undertaken around values and behaviours

Section 6 - Education and Training

The following table indicates numbers of staff trained.

Course Title	16/17	18/19	Comments
Corporate Welcome	Clinical 505 Non Clinical 249	693	No longer split between clinical and non-clinical registers
Investigation of Incidents, Complaints and Claims	12	7	Training is given on an individual basis as required
Manual Handling – Key Trainers (Patient)	38	76	These figures are for the key trainers
Manual Handling – Key Trainers Update (Patient)	79	54	These figures are for the key trainers
Junior Doctor Induction	154	141	Some Doctors on corporate welcome
Conflict Resolution Training	918	2366 in date 493 required	This is a three yearly requirement
Falls Prevention and Management	351	1392 in date 253required	This is a three yearly requirement
Understanding Consent/Advanced Consent	9	2249 in date 450 required	Over a three yearly period
Risk Assessment for Managers	11	0	2 classes on OLM, 12/04/018 no delegates booked on and 13/09/18 was cancelled.

A new schedule of risk assessment training and root cause analysis training has been implemented in 2019/2020 to ensure all appropriate staff are able to attend.

Section 7 - Health and Safety Budget

The process to access the patient safety budget is completed via risk assessments which should have been used to support bids. The process involves reviewing scores, cross-checking with reported incidents and challenging management plans to ensure robustness. Only one submission was made during 2018/2019

As a result of this process, the following purchases were made using Health and Safety monies:

Action/Bid	Business Group
Privacy Signs	Corporate

Section 8 – Summary

Stockport NHS Foundation Trust is committed to providing and maintaining a safe and healthy workplace and to provide suitable resources, information, training and supervision on health and safety to staff, patients, contractors and visitors.

The improved incident reporting and investigation, and analysis of the patient safety culture in the trust, serves to demonstrate the commitment to be a learning organisation with safety at the heart of business as usual.

There continues to be identification of areas that we can improve on, and support our staff, to deliver outstanding healthcare. A focus of delivering targeted training and strengthening policies and procedures will provide the robust infrastructure that is required.

Report to:	Board of Directors	**Date:**	1 November 2019
Subject:	People Performance Committee Terms of Reference		
Report of:	Interim Director of Corporate Affairs	**Prepared by:**	S Curtis

REPORT FOR APPROVAL

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

Attachments:	Annex A – Draft People Performance Committee Terms of Reference

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

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1. INTRODUCTION

1.1 The purpose of this report is to present the Terms of Reference for the People Performance Committee for Board approval.

2. BACKGROUND

2.1 The Board will be aware that the Committees' Terms of Reference are not due for annual review until early next year. However, due to some changes to the People Performance Committee membership and reporting groups, it was suggested that the Committee's Terms of Reference be amended to reflect those changes.

3. CURRENT SITUATION

3.1 The People Performance Committee completed a review of its Terms of Reference during a meeting held on 19 September 2019 and the proposed amendments can be identified by use of bold italics / strikethrough in the draft Terms of Reference included at Annex A to the report.

4. RECOMMENDATIONS

4.1 The Board of Directors is recommended to:

- Approve the Terms of Reference for the People Performance Committee included at Annex A to this report.

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PEOPLE PERFORMANCE COMMITTEE

TERMS OF REFERENCE

1. CONSTITUTION

1.1 The Board of Directors hereby resolves to establish a Committee, to be known as the People Performance Committee *(hereinafter referred to as 'the Committee')*. The Committee has no executive powers, other than those specifically delegated within these terms of reference.

2. REMIT AND FUNCTIONS OF THE COMMITTEE

2.1 The Committee is established to seek assurance on matters relating to workforce, education and learning, equality and diversity and organisational development. The Committee will also seek assurance on the development ***and implementation*** of strategic plans in these subject areas and make recommendations as appropriate to the Board of Directors.

2.2 The main functions of the Committee are to:

i. Review draft strategies relating to Workforce & Organisational Development and make recommendations as appropriate to the Board of Directors.

ii. Seek assurance on delivery of approved Workforce & Organisational Development-related strategies

iii. Consider and approve Workforce & Organisational Development-related policies

iv. Seek assurance on performance against Workforce & Organisational Development metrics and periodically review the range of agreed metrics

v. Monitor the effectiveness of controls to mitigate high level (score of 12 or above) Workforce & Organisational Development-related risks

vi. Obtain assurance on the effectiveness of learning and development activities across the Trust

vii. Approve annual workforce, education, commissioning and training plans having obtained assurance that such plans are consistent with Trust strategy

viii. Consider the outcomes from staff surveys and the Culture & Engagement Dashboard and seek assurance on the effectiveness of associated management actions

ix. Obtain assurance on discharge of the Trust's responsibilities relating to equality, diversity and inclusion

x. Consider evidence and/or proposals relating to Workforce & Organisational Development-related best practice and advise accordingly

xi. Consider initiatives aimed at promoting and sustaining a healthy workforce.

3. COMPOSITION AND CONDUCT OF THE COMMITTEE

3.1 The Committee shall comprise the following membership:

- Non-Executive Director (Chair)
- Two x Non-Executive Directors (one of whom will be Deputy Chair)
- Director of Workforce & Organisational Development
- ***Director of Finance***
- ~~Chief Operating Officer~~
- Chief Nurse & Director of Quality Governance
- Deputy Medical Director

There is an expectation that members will attend all Committee meetings during each financial year. Individual attendance levels will be monitored by the Chair of the Committee who will take appropriate measures to address any repeated instances of non-attendance.

3.2 The following post-holders shall routinely attend meetings of the Committee in an advisory capacity:

- Deputy Director of Workforce & Organisational Development
- Head of Learning & Organisational Development
- Director of Medical Education
- Head of Communications
- Freedom to Speak Up Guardian

3.3 Nominated deputies shall attend in the event of absence of any member; however this shall be in an advisory capacity only and attendance of a deputy shall not count towards the attendance level set out in s3.1.

3.4 Other Officers of the Trust shall attend at the request of the Committee in order to present and provide clarification on issues, and with the consent of the Chair will be permitted to participate in the debate. However, only members of the Committee are permitted to vote.

3.5 ***Quorum***. No business shall be transacted unless at least four members, to include at least one Non-Executive Director, are present. Deputies in attendance do not count towards the quorum.

3.6 ***Notice of meeting***. Before each meeting, a notice of the meeting specifying the business proposed to be transacted shall be sent by post or electronic mail to the usual place of business or residence of each member, so as to be available at least three clear days before the meeting.

3.7 ***Frequency of meetings***. The Committee will, as a minimum, meet on a monthly basis. The Chair may, however, call a meeting at any time provided that notice of the meeting is given as specified in s. 3.6 above.

3.8 ***Minutes***. The minutes of meetings shall be formally recorded by a member of the Corporate Governance team, checked by the Chair and submitted for agreement at the next ensuing meeting, whereupon they will be signed by the person presiding at it.

3.9 ***Administration***. The Committee shall be supported administratively by the Corporate Governance team, whose duties shall include: agreement of the agenda with the Chair and collation of papers; producing the minutes of the meeting and advising the Committee on pertinent areas.

4. DELEGATED AUTHORITY

4.1 The Committee is authorised by the Board of Directors to:

i. investigate any activity within its terms of reference
ii. seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee

5. RELATIONSHIP WITH THE BOARD OF DIRECTORS

5.1 The Committee will report to the Board of Directors by means of a Key Issues Report summarising business conducted by the Committee together with key actions and/or risks. A Key Issues Report will be forwarded to the Board of Directors following each Committee meeting.

6. RELATIONSHIP WITH OTHER COMMITTEES / GROUPS

6.1 The Committee will receive reports, in the form of Key Issues Reports, from the following Committees / Groups:

- Equality, Diversity & ~~Human Rights~~ ***Inclusion*** Steering Group
- ~~Workforce Efficiency Group~~
- ~~Culture & Engagement Group~~
- ~~Education Governance Group~~
- Joint Consultative & Negotiating Committee
- Joint Local Negotiating Committee
- ***People Strategy Implementation Group***
- ***Joint Medical Education Training Board.***

The Committee will also receive reports from any task and finish group it may elect to establish from time to time.

7. REVIEW

7.1 The Committee will evaluate its own membership and review the effectiveness and performance of the Committee on an annual basis. The Committee must review its terms of reference annually and recommend any changes to the Board of Directors for approval.

7.2 Compliance with the Terms of Reference will be monitored on an ongoing basis by the member of the Corporate Governance team providing support to the Committee. Any concerns in relation to compliance will be reported to the Chair of the Committee. In addition, the annual review described in s7.1 will include a summary on compliance with the Terms of Reference.